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AN ANALYSIS OF THE IMPLEMENTATION

OF

HEALTH POLICY IN NEW ZEALAND

1991-1996

by

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ABSTRACT

In July 1991 Simon Upton, Minister of Health for the National Government released the green and white paper Your Health and the Public Health: a Statement of Government Health Policy. The policy involved considerable restructuring of the health system and was to be implemented within two years. The stated primary objective of the policy was "to secure, for everyone, access to an acceptable level of health care" (Upton 1991:1). This was to be achieved by Government explicitly defining a core of services to which everyone would be entitled. The unstated objective of the policy was to control fiscal risk in health spending. This was to be achieved by targeting Government subsidised health care services only to high users and those on low incomes. Others, the majority, would take financial responsibility for their own health care. It also involved establishing a managed market in the health system to increase efficiency in health service delivery. This was to be achieved by: separating the roles of purchasers and providers; introducing competition between both purchasers and providers; providing choice of purchaser; separating the funding, purchasing and providing of public health services from personal health services; and larger public hospitals becoming commercial enterprises competing with private hospitals and each other for the provision of services. The policy also included integrating the funding of primary and secondary care, and accident-related and non-accident related care; and extending user part charges.

This thesis researches the process of implementation of the policy as it was taking place. It analyses the nature of the policy and its implementation strategy, it situates it in an historical and international perspective, focuses on significant areas of the policy during implementation, and analyses the policy changes which have taken place.

Though crucial aspects of the policy were not implemented as planned, a substantially changed health system has resulted from the introduction of the policy. I argue that the unstated objective of the policy has been substantially achieved through the introduction of market principles and by shifting responsibility for health care onto individuals. The stated primary objective has not been achieved. There is no explicit definition of the core of services to which everyone was to have access, and for a large section of the population access to Government subsidised health care services has been reduced through targeting and increases in user part-charges.

The policy contained flaws which were illuminated during the implementation process and which induced the Government to make changes. The content of the policy and its implementation process were inextricably linked, not separate categories in a linear sequence.

I examined the implementation literature, especially that contained within the Top-Down Bottom-Up debate. I argue that this literature is not adequate to explain the implementation of this particular policy. The substantive content of the policy influenced the process of its implementation and the experience of implementation had an important influence on the eventual outcome of the policy.

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ABBREVIATIONS

ACC	Accident Compensation Corporation
AHB	Area Health Board
AJHR	Appendices to the Journals of the House of Representatives
ARCI	Accident Rehabilitation and Compensation Insurance Corporation
CCMAU	Crown Companies Monitoring and Advisory Unit
CCU	Communications and Co-ordination Unit
CEO	Chief Executive Officer
CHB	Community Health Business
CHE	Crown Health Enterprise
CHEEC	Crown Health Enterprise Establishment Committee
CHEEU	Crown Health Enterprise Establishment Unit
CSC	National Advisory Committee on Core Health and Disability Support Services
CT	Community Trust
DHA	District Health Authority
FHSA	Family Health Services Authority
GMS	General Medical Services Benefit
GP	General Practitioner
HBL	Health Benefits Limited
HCP	Health Care Plan
HMO	Health Maintenance Organisation
HRD	Health Reforms Directorate
IPA	Independent Practice Association
IPO	Independent Practice Organisation

LMC	Lead Maternity Carer
MCO	Managed Care Organisation
NHC	National Health Committee (previously the CSC)
NHS	National Health Service
NIPB	National Interim Provider Board
NZMA	New Zealand Medical Association
NZPD	New Zealand Parliamentary Debates
OECD	Organisation for Economic Co-operation and Development
PHA	Public Health Agency
PHC	Public Health Commission
PHCIG	Public Health Commission Implementation Group
PPO	Preferred Provider Organisation
PPP	Pre-paid Health Plans
RHA	Regional Health Authority
SACHSO	Special Advisory Committee on Health Services Organisation

Chapter 1

INTRODUCTION

In July 1991 Simon Upton, Minister of Health for the National Government, released his green and white paper Your Health and the Public Health: a Statement of Government Health Policy. The paper set out the Government's intentions to restructure radically the complex set of practices known as New Zealand's health care system.

A substantially changed health system has resulted from the introduction of the policy but some significant aspects have not been implemented as planned resulting in a very different health system from that envisaged by Upton and the National Government.

My focus for this thesis is on the nature of the 1991 policy, the process of its implementation, the factors which influenced the substantial changes which took place during implementation and the implications for health care. I argue that while significant aspects of the policy have not been implemented as planned, the Government's unannounced intention to reduce its fiscal responsibility has been successful, resulting in substantial changes to the purchasing and provision of health services, and reduced access to health services for a large section of the population; and finally that the 'top-down bottom-up' debate within policy implementation literature is not adequate to explain the implementation of this particular policy.

Whilst addressing the policy as a whole and evaluating the changes which came about during implementation, I focus my research on the four areas which not only I judge to be central to the policy. Upton also claimed that each of these areas was crucial to the successful implementation of the policy. They are: an explicitly defined core of services to which everyone was to have access, alternative Health Care Plans, general practitioners entering into remunerative contracts with Regional Health Authorities, and a separate structure to purchase and provide public health services.

By focusing on these four areas, I have been able to follow the process of implementation - the practical implications of attempting to put into practice these radical policy initiatives - analysing the factors influencing the implementers, their explanations as to why these areas were not implemented as planned, and the implications for health care.

These four areas, I argue, are crucial to the philosophical intent of this particular policy, rather than to health policy *per se*, or the provision of health care services. Upton claimed the policy "is, expressly, not ideologically driven" (Upton, 1991:2). I disagree. I argue it is concerned with introducing a managed market (regulated competition) into the health environment, and echoes the monetarist philosophy underlying other recent Government policies.

The stated primary objective of the policy is "to secure, for everyone, access to an acceptable level of health care" (op cit, p.1). This was to be achieved by Government explicitly defining a core of services to which everyone would be entitled. Access to these services was to be affordable, not necessarily free (op cit, p.3).

What was not stated was in my contention the corollary of this shift, namely that universal free secondary health services and subsidised primary health services, established with the introduction of the 1938 Social Security Act, were no longer to be the right of every New Zealander.

The unstated objective of the policy was to exercise stricter control over the health budget[1]. Upton claimed in his forward to the policy: "the Government can no longer afford to commit itself to providing social services without being able to limit its liability" (ibid). This is as close as Upton came to stating what I have called the Government's unannounced intention. Rather than being primarily concerned with increasing the health status of the population, the deeper concern of the policy was fiscal constraint.

The Government's intention to "limit its liability" involved the targeting of health services to high users and those on low incomes, explicitly rationing services, and establishing a managed market in the health environment. Upton and the National Government believed that the introduction of market principles would result in a more cost efficient health service, and consequently a more effective one.

Establishing a managed market involved substantial restructuring of the health system. In particular the purchaser and provider roles of the existing area health boards were to be separated and competition was to be introduced at both levels. It was the separation of the purchaser and provider roles and the introduction of competition at both levels that, National believed, would lead to a more efficient and effective health service (op cit, pp.23-26).

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[1] Personal comment made to me by a policy advisor to the Prime Minister during the formulation of the policy.

The 14 Area Health Boards (AHBs) would be dis-established, their purchasing functions taken over by 4 Regional Health Authorities (RHAs). Larger public hospitals, the major providers of secondary health services, would be run in a "business-like way" as Crown Health Enterprises (CHEs). They would compete with each other and with private and voluntary organisations to obtain contracts with the RHAs to provide secondary health care services. Smaller community hospitals were to be offered to their communities to be run as community trusts (op cit, pp.3-4).

Alternative health care plans (HCPs) were to be established to provide competition at the purchaser level. People could elect to take their government-funded entitlement and receive their total health care requirements from alternative HCPs. Both HCPs and RHAs would be obliged to ensure that their clients had affordable access without unreasonable waiting time to "core health services" (op cit, p.75). The Government would explicitly define the health services to be included in the core, after consultation with the National Advisory Committee on Core Health Services[2] (CSC), which was to represent the values and preferences of the people.

Funding and purchasing of primary and secondary health care services would be integrated and the purchasing of accident-related care would be integrated with the purchasing of sickness-related care. The Accident Compensation Corporation (ACC) would remain the funder of accident-related care.

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[2] In August 1992 the brief of the National Advisory Committee on Core Health Services was extended to become the National Advisory Committee on Core Health and Disability Support Services, still to be known as the CSC.

General practitioners and other providers of primary care services would compete to provide primary health care services.

The funding, purchasing and provision of public health services (population based services) would be separated out from personal health services by establishing a separate public health structure.

The focus in the policy is on the individual as consumer, making choices between purchasers and providers of health care services (op cit, pp.10,21-22). This policy is part of a radical change in political philosophy in New Zealand[3].

Since 1984 New Zealand has undergone radical upheaval and transformation in its social and economic policies. The changes were first introduced by Roger Douglas, Minister of Finance for the fourth Labour Government. Douglas, in compliance with Treasury[4], introduced a free market response as the only possible response to the very real fiscal crisis the country was facing[5]. According to Upton (1987) Douglas recognised free market monetarism as the most efficient generator of wealth, but then redistributed it according to socialist ends (p.45).

The National Government, since its election in December 1990, has continued with even more vigour than its Labour predecessor, to introduce free market monetarist policies to

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[3] See Kelsey, J. (1995) The New Zealand Experiment A World Model for Structural Adjustment? for an account of the application of pure neo-liberal economic theory in New Zealand since 1984. As well see Boston J et al (1991) "The Theoretical Underpinnings of Public Sector Restructuring in New Zealand" in Reshaping the State for a discussion of the various theories which have influenced the nature and course of the reforms in New Zealand since 1984. Also see James, C. New Territory The transformation of New Zealand 1984-92 for an account of the changes that have taken place in most fields of government policy since 1984. Douglas, R.O. "The Role of the State in the Economy" in The New Zealand Centre for Independent Studies, The Role of the State, the proceedings of a conference held in Wellington on 30 June 1988, explains what he believes the role of the state should be.

[4] See Easton, B, The Making of Rogernomics for an account of Treasury's influence over the fourth Labour Government's economic policy advice (pp.76-77).

[5] For Roger Douglas' account of the crisis and his response as Minister of Finance, see Douglas, R and L.Callan, Roger Douglas Toward Prosperity, chapters 4, 5 and 8.

alleviate what was described by Treasury as "an alarming fiscal situation" (Treasury, 1990:2). Prime Minister Jim Bolger argued "No commentator, of any persuasion, disputes the fact that our economy is in deep recession, which is getting deeper every week" (Bolger, Richardson, Birch, 1990:5).

The overall policy initiatives of the National government have been based on the free market monetarist values of efficiency, individualism, competitiveness and liberty. Monetarism is based on the view that individuals seek to maximise their own self interest at all times, even in times of hardship and sickness, and they do this most effectively when there are few barriers or limitations to their competition for resources with other individuals[6]. The underlying assumptions of monetarist philosophy are that all individuals have the necessary knowledge, circumstances and finance to provide for themselves and their families at all times, including times of sickness and hardship. In its purest form there is no recognition of the social factors causing sickness[7] and no acceptance of collective responsibility.

The concern for the National Government has been for individuals to become more responsible for themselves and their families, and for a reduction in state spending on welfare (Bolger, Richardson, Birch, 1990:11), (Richardson, 1991:5-18), (Shipley, 1991:1-2).

Under the fourth Labour Government the health system was subject to three different Ministers of Health, each proposing to change the direction of health policy (Blank, 1994:132-3). Despite these changes the 1938 Social Security Act and its underlying

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[6] See George Macesich (1983) Monetarism Theory and Policy (pp.3-16) for a discussion of monetarism.

[7] For a discussion of the social factors causing disease see Doyal, L, and I, Pennell, (1979) The Political Economy of Health.

philosophy of collective responsibility for health care, had formed the basis of New Zealand's health service until National introduced its 1991 health policy.

Under the first Labour Government's 1938 Social Security Act, health and welfare became the concern of the collective. Every New Zealander, by right of citizenship, was entitled to free health care. Free primary care was never fully realised due to the non-cooperation of doctors, but New Zealanders accepted free hospital and related services, and subsidised doctors' visits as their right. Access to health services was based on need rather than the ability to pay.

With the ensuing years Government subsidies for primary care did not keep abreast of inflation, resulting in individuals paying a higher proportion of primary care fees. Increasing demands for free secondary services resulted in rationing by waiting lists. This prompted those who could afford health insurance[8] premiums to use the private hospital system .

Though pledging in their 1990 manifesto to retain Area Health Boards, the mainstay of secondary health services, within seven months of being elected to office, the National Government had released its new health policy designed to completely restructure the existing health system and dis-establish Area Health Boards.

The 1991 policy statement is often referred to as "the green and white paper". Most of it is a 'white paper', a statement of government intent. The green aspect represents the two issues in the paper where the Government invited submissions

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[8] Private health insurance was introduced in 1961 by a group of Auckland surgeons. Clients were reimbursed the majority of their costs for services in private hospitals and for primary care services.

from the public: (1) How core health services should be defined, and (2) how the core health services should be financed (Upton, 1991:134).

Submissions were to be received within 5 months of publication of the policy. In the foreword to the report on the submissions on how core health services should be defined, Minister of Health Simon Upton announced: "[t]he clear preference is for a general positive list, allowing for regional prioritisation, coupled with a short listing of those services to be excluded from public funding" (Bridgeport Group, 1992:v). Following the review of the submissions on how the core health services should be financed, the decision was made to continue with a tax-funded health system.

The white aspects of the paper, representing those areas whereby the Government had made firm policy decisions, were:

- separating purchasing from provision of health services;
- integrating funding for all types of personal health service...so that care is managed as a total package;
- allowing choice among health care plans;
- separating the funding of public health services from personal health care services (Upton, 1991:133).

In August 1992 disability support services were included in the terms of reference for the policy but for the purposes of this thesis I will be concentrating on the health policy and its implementation[9].

[9] The decision to align disability services with health policy has been a point of major dispute, especially for those with disabilities.

The Health and Disability Services Act legislating for the newly structured health system was enacted on 1 July 1993 as planned.

To ensure the policy would be implemented within the time-frame determined by the Government, a "special change management structure" and a "timetable for change" were part of the policy design (op cit, p.128).

Significant areas of the policy which were introduced but soon discarded were hospital in-patient charges, the original schedule for targeting assistance to low-income groups, and the Public Health Commission (PHC)[10]. Hospital in-patient charges and the Interim Targeting Regime were introduced 1 February 1992 but following Bill Birch's appointment as Minister of Health in March 1993, in-patient charges were abolished on 24 March 1993 and the Interim Targeting Regime was modified[11].

The PHC was established within the timeframe proposed by Upton but within seventeen months of the enactment of the 1993 Health and Disability Services Act, current Minister of Health Jenny Shipley announced that the PHC would be dis-established from 1 July 1995. Its functions were to be integrated into other health agencies, particularly the Ministry of Health (Shipley, media release, 13 December 1994).

The integration of accident and sickness-related care has not been achieved. In November 1995 the Government announced that RHAs would be responsible for purchasing acute care for accident victims but the Accident Rehabilitation and Compensation Insurance

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[10] The Public Health Commission was to be the sole purchaser of public health services and was to have responsibility for advising on public health policy and for developing and promulgating regulations (Upton ,1991:110).

[11] For a discussion of the national Government's targeting of social assistance see Jonathan Boston "Grand Designs and Unpleasant Realities: The Fate of the National Government's Proposals for the Integrated Targeting of Social Assistance" in Political Science, July 1994, Vol 46 (1).

Corporation[12] (ARCI) would be responsible for purchasing accident-related primary care and elective procedures[13]. ARCI remains the funder of accident-related care.

Areas of the policy that were implemented as planned include the setting up of the four Regional Health Authorities as the purchasers of health services, establishing the larger public hospitals as Crown Health Enterprises, and establishing a new Crown Health Enterprise Ministry "to represent the Crown's interest as the owner of public hospitals and associated services" (Upton, 1991:4). Integrating the funding for primary and secondary services has only been partly successful due to the continued separation of the funding and purchasing of accident-related care.

Despite the Government appointing implementers sympathetic to its policy intentions and including a strategy for implementation in the policy design, significant areas of the policy have not been implemented as planned resulting in major changes to the policy. The implementation of this particular policy, I argue, demonstrates that implementation is an important part of the policy making process and the failure to successfully implement significant areas of the policy cannot be explained adequately by the Top-Down Bottom-Up debate within policy implementation literature. The content of the policy and the socio-political context into which the policy was introduced were significant factors in the implementation of this particular policy.

The first part of the thesis, Chapters 1 to 6 inclusive, locates the policy in a theoretical, historical and international context and discusses the research methods used. In Chapter 2 I

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[12] The re-constituted ACC.

[13] See Shipley, J., Policy Guidelines for Regional Health Authorities 1996/97.

review the literature on health policy and discuss policy making and the current Top-Down Bottom-Up debates in the literature on implementation analysis.

Chapter 3 discusses the research strategies I used to collect, analyse and evaluate my data, and outlines the methodological and ethical problems and issues I experienced in my research practice. It also discusses my joint roles of researcher and health professional as I continued to work in the health system during the implementation of the policy.

In Chapter 4 I give an historical account of New Zealand's health system from 1840 through to the present showing that New Zealand's health policy was not just a series of fragmented, ad hoc provisions responding to perceived needs, but was driven by three factors: 1. the local-central relationship governing hospitals which has existed since the provincial period of government; 2. the power and influence of the medical profession; and 3. people's growing expectations that the state should provide subsidised health care services by right of citizenship.

Chapter 5 outlines the National Government's 1991 health policy explaining its genesis in the two preceding decades and the factors influencing its design. It discusses the policy intentions, the implementation strategy and the time-frame for change outlined by Upton.

Chapter 6 provides a comparative analysis of the implementation of the policy in an international context. It compares the implementation of the policy with the implementation of recent similar policy changes in the Netherlands and Great Britain and the proposed policy changes in the United States.

The second part of the thesis, Chapters 7 to 11 inclusive, deals with the specific areas of the policy that I have focused on in this thesis. Chapter 7 discusses why Upton considered an explicit core to be crucial in the new health system, the reasons the CSC gave for not defining a core, and the implications for New Zealanders not knowing to which services they are entitled to expect affordable access.

Chapter 8 likewise discusses alternative Health Care Plans, why they were considered crucial to the policy, the reasons they were not developed, and the implications for health care.

Chapter 9 deals with the non-cooperation of the general practitioners. It discusses the doctors' dissent and shows how the power of the medical profession in New Zealand again enabled it to resist attempts by Government to exercise control over the profession. It compares the doctors' refusal to co-operate with the RHAs by not entering into contracts with them as at 1 July 1993, with the profession's refusal to co-operate with the first Labour Government's 1938 Social Security Act. It discusses the profession's impact on the intentions of the policy, the subsequent arrangements that have been entered into, and the implications that will ensue.

Chapter 10 discusses the separate public health structure that was to be established to purchase and provide public health services. It considers the contradictory nature of the public health agency in relation to the rest of the policy, and discusses the establishing and then disbanding of the Public Health Commission. It considers too the implications of the Government's decision to again integrate the purchasing and provision of public health services with personal health services.

Chapter 11 reviews the overall process of implementation, the areas of the policy that have been implemented as planned, those implemented and then discarded, those only partially implemented, and those not implemented at all. It discusses the significantly changed health environment which now exists and its implications for health care. It discusses the factors which influenced implementation and examines these in relation to the Top-Down Bottom-Up debate within policy implementation literature. It concludes that the Top-Down Bottom-Up debate is inadequate to account for the major changes to the policy which took place during the process of implementation. The substantive content of the policy and the socio-political context into which the policy was introduced were important factors in the implementation process, and the implementation process itself influenced the subsequent policy changes which took place.

Chapter 2

LITERATURE REVIEW

Introduction

The National Government's 1991 Green and White Paper outlining the restructuring of the health care system was entitled Your Health and the Public Health a statement of Government health policy. However a Government's health policy is more than a policy statement about the restructuring of health service provision. It is reflected in all social policy which explicitly or implicitly portrays a Government's concern for the health status of its citizens. In this chapter I will discuss health policy as an aspect of public policy, and the varying perceptions of health policy used by health policy analysts. I will then discuss health policy analysis with an emphasis on implementation analysis and outline the Top-Down versus Bottom-Up debate within the literature on implementation analysis. Finally I will address the problems with this literature and its inadequacy for analysing the implementation of particular policies.

Health policy

According to Palmer and Short (1989) health policy is a branch of public policy. Public policies are primarily the responsibility of Governments, carried out "in the name of the people as a whole, and they affect the public interest" (p.22). Palmer and Short define health policy as embracing:

> courses of action that affect that set of institutions, organisations, services and funding arrangements that we have called the health care system. It includes actions or intended actions, by public, private and voluntary organisations that have an impact on health. The term includes also political parties' policies that may be translated into government action at a later stage (ibid).

The World Health Organisation, in its 'Health for All' initiatives at Geneva in 1977, identified health policy as much more than providing health care services. It included all those policies that impact on the health of citizens.

Brown (1992) also proposed that health policy is reflected in all social policy. She suggested that "health policy is a crucial, but often unidentified, element in all social policy"(p.91). It is frequently not explicitly stated but needs to be discerned from implications and assumptions underlying social policies. According to Brown a government's concern for the health status of its citizens is reflected in all its social policy, including economic policy, policies to increase employment, to provide a pollution-free environment, the provision of adequate housing, as well as health care policy. Health care policy is concerned with the provision of health care services, Brown describes it as a "subset" of health policy. "There is an inaccurate but pervasive assumption that a health care policy subsumes a health policy;" she suggests "whereas the reverse is more often the case" (op cit, p.94).

Walt (1994) defines health policy as:

> embrac[ing] courses of action that effect the set of institutions, organizations, services, and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health (p.41).

Therefore, for Walt too, health policy is not only concerned with the provision of health care services but also with " environmental and socio-economic effects on health" (ibid).

> Health is also affected by many policies which have nothing to do with health care or services: environmental pollution, insecurity and instability, (whether caused by unemployment or violence), economic regulation and deregulation, contaminated water and poor sanitation all increase morbidity and mortality (op cit, p.5).

She also differentiates between 'high politics', systemic or macro level policies such as the 1991 policy, and 'low politics', sectoral or micro level policies such as the introduction of screening procedures.

Blank (1994) categorised a statement of health policy such as New Zealand's 1991 health policy as 'formal health policy'. He defined formal health policy as: "consisting of those courses of action proposed or taken by a government which affect health care institutions, organisations, service, and finance" (p.1).

He recognised too the close interrelationship of health policy with other social policy.

> [A]lthough health policy can be conceptually distinguished from other areas of public policy, it is in reality closely related to social and economic policy in general...Health and health policy cannot be understood in isolation from social welfare, unemployment, poverty, housing, and general economic policies. In fact it can be argued that the health of a population is as dependent on these policies as it is on formal health policy (p.1).

While recognising that a Government's health policy is more than its policy statements about the ways health care services will be provided, in this thesis I will be focusing on what Blank refers to as 'formal health policy' and Walt refers to as 'high politics'.

Health policy analysis

Palmer and Short claim that health policy is different from other areas of social policy and should therefore be studied as a "separate, legitimate field of study" (Palmer and Short, 1989:25). They argue that while it is necessary to consider "the very formidable body of literature dealing with policy science, policy studies and policy analysis" (ibid), the distinctive features of health policy indicate the need for considerable caution in applying these tools of analysis, interpretation and evaluation (ibid).

The three distinctive features they claim are of critical importance and not paralleled in other social and economic policy are: firstly, the role of the medical profession in shaping and constraining policy; secondly, "the complexity of health care provision, and the inability of individual consumers to distinguish between good and poor quality services" (ibid); and thirdly, the different nature of decision making where life and death issues may be involved. I agree with their contention that the health policy environment is different from other policy environments. A further distinctive element, I suggest, is the particular institutional relationships which exist between health providers, and between providers and users of the health system.

Health care is not simply a commodity that can be bought and sold in the market place like other commodities[14]. The provision of health care services is complex. Providers of health care, often medical professionals, are required to act in the interests of their clients both as providers of information and as providers of treatment services; in the interests of the whole

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[14] See Easton Is Health an Economic Commodity? (1992).

population, as rationers of health care services; and usually in their own interests as private enterprise practitioners. The transactions are further complicated through regulations imposed by governments, ethics committees and professional bodies, and because the clients are not always the full funders of their own health care services. Some services are fully publicly funded and some are partly publicly funded. In addition some clients have private medical insurance which either fully or partly covers their health care costs.

While recognising these distinctive elements within the health policy environment, I draw on the work of other social policy analysts and adapt it in my analysis of New Zealand's 1991 health care policy.

Palmer and Short (1989), following Ham and Hill (1984), suggest there are three broad levels of emphasis within health policy analysis; 1. micro-level, the decision making level within organisations; 2. middle level, focusing on the policy making process and the " actions and mechanisms whereby the agenda is defined, and policies brought into practice" (p.27); and 3. macro-level, whereby the health system is analysed and evaluated within the economic, political and cultural context in which it exists (ibid).

This thesis is concerned with the second and third levels of analysis. While taking into account the distinctive features of health policy, it is concerned with the formulation, substantive content and implementation of a macro level policy, and the implications for health care.

As well as considering the different levels of analysis, comprehensive critical analysis requires, Palmer and Short suggest, a multi-disciplinary approach.

Multi-disciplinary perspectives on health policy

Economics, political science and sociology all offer particular perspectives which combine to provide a more comprehensive approach to policy analysis. Within each of these disciplinary perspectives there are numerous theoretical perspectives, each offering a partial explanation of the complexities of health policy and the health environment[15].

Despite the close relationship between the disciplinary perspectives, each perspective contributes its own concepts and particular frame of reference providing a more comprehensive approach.

Flynn (1993) suggested there is general consensus about the need for a multidisciplinary approach in the analysis of health policy but there is no obvious agreement "as to *how* this coherent, integrated, multi-level explanation is to be achieved. It remains an ideal-type" (pp.64-5).

Policy making and implementation

Policy making is regarded by many policy analysts as a sequential pattern of stages. Political scientist James E Anderson (1984) suggested a model of five key stages:

1. Agenda setting
2. Policy formation
3. Adoption

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[15] For a discussion of these different disciplinary perspectives see Palmer and Short (1989:35-44).

4. Implementation

5. Evaluation (cited in Palmer and Short, 1989:31).

Though recognising that "it is not always possible to identify each of these stages when examining actual cases of policy making, the model has considerable explanatory power" suggested Palmer and Short (op cit, p.30). The model, or one similar, is used by many policy analysts and implementation theorists. It implies that each of these stages can be regarded as distinct phases in a linear process.

In contrast Flynn (1993) stated:

> policy [making] and implementation are not separate categories, nor phases in a linear sequence. Rather, they are emergent properties - problematic, more or less open to dispute and negotiation, depending on the mobilisation of resources and the differential capacity of actors to secure relative autonomy, and to exercise influence (p.60).

The Top-Down Bottom-Up debate

These two distinctive approaches give rise to a debate within policy analysis literature known as the 'Top-Down Bottom-Up' debate[16]. The Top-Down approach begins with a particular policy and regards implementation as a sequential stage in the policy making process. It perceives the locus of power in the hands of the policy makers (often politicians) and contends that policies will be implemented successfully if the policy directives of the policy makers are complied with. In contrast, the Bottom-Up approach begins with a problem area and perceives the locus of power in the hands of those who actually implement the policies

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[16] See Hill(1993:2-8) for a discussion of the Top-Down Bottom-Up debate within policy implementation literature.

which evolve. For Bottom-Up supporters, implementation is part of the policy making process and effective policy implementation requires consensus and flexibility to adapt policies to their organisational contexts. The Bottom-Up approach takes into account the people actually involved with implementing policies, their existing organisational arrangements and procedures, their perceived problems and the strategies they have developed to deal with them.

Blank (1994) used a Top-Down approach in his comparative study of New Zealand's 1991 health policy. He began with the Government's statement of health policy, compared it with health policies in the United States, Japan and Singapore, and discussed the likelihood of New Zealand's policy being implemented according to the policy intentions. He used Brewer and deLeon's six stages of initiation, estimation, selection, implementation, evaluation and termination to discuss the policy process (p.7), and their six criteria for successful policy implementation to discuss the likelihood of successful implementation. The six criteria are : 1. source of the policy; 2. clarity of the policy; 3. support for the policy; 4. complexity of the administration; 5. incentives for the implementers; and 6. resource allocation (op cit, p.137).

According to Nakamura and Smallwood (1980) the "classical model" of administration (implementation as it came to be called) in the early years of this century was based on an assumption that it was "a separate, neutral, professionalised, and nonpolitical activity, [and] could be carried out on the basis of objective principles of scientific rationality" (p.8). This model "minimised the significance of implementation in the policy process precisely because it is based on a Top-Down command structure that allowed very little discretionary authority, and certainly no political latitude, to subordinate administrators " (ibid). The model was based on Weber's 'ideal' bureaucracy consisting of "a highly rationalised, legalistic kind of

authority and structure controlled at the top by a small group of decision makers whose policies were dutifully implemented by subordinate administrators" (op cit, pp.7-8).

The model was based on the following preconceptions:

> 1. Policy making and policy implementation are bounded, separate, and sequential.
>
> 2. These boundaries exist between policy makers and policy implementers because
>
> a. there is a clear division of labour between policy makers, who set goals, and policy implementers, who carry out these goals.
>
> b. policy makers are capable of stating policies definitively because they can agree on a priority among different goals.
>
> c. policy implementers possess the technical capability, the obedience, and the will to carry out policies specified by the policy makers.
>
> 3. Since both policy makers and implementers accept the boundaries between their tasks, the process of implementation unfolds in a chronological, sequential fashion in which policy making precedes policy implementation.
>
> 4. The decisions that are involved in the implementation of policies are *nonpolitical* and *technical* in nature. It is the responsibility of the implementer to carry out policies in a neutral, "objective," "rational," and "scientific" fashion (op cit, p.10).

According to Berman (1978), Elmore (1978), and Sabatier (1986a), implementation research developed from the realisation that this is an oversimplified view of the policy making process and does not explain why the objectives of many national and local policies were not being realised, or programmes were not working as intended. Following Pressman and Wildavsky's (1973) seminal work in this field, implementation analysis was concerned with identifying and analysing variables which influenced the success or failure of effective implementation of policies. Their research was concerned with improving the effectiveness of implementation.

Pressman and Wildavsky's 1973 work was an analysis of an employment promotion scheme in Oakland, United States, focusing on why the formal objectives of the Federal policy were not realised. They concluded:

> Our normal expectation should be that new programs will fail to get off the ground and that, at best, they will take considerable time to get started. The cards in this world are stacked against things happening, as so much effort is required to make them move. The remarkable thing is that new programs start at all (Pressman and Wildavsky, 1973:109).

Pressman and Wildavsky and other early implementation scholars, Berman (1978), Elmore (1978), Mechling (1978), used case studies to focus on the factors causing implementation failure.

Berman (1978) described early implementation analysis as being a series of cross-sectoral, individual studies lacking a theoretical base or conceptual framework within which comparisons could be made and generalisations reached.

For Bardach (1980),

> the implementation process...is a transition process. It takes whatever social, political and economic arrangements exist before the policy mandate is adopted and sets them in a different configuration (p.139).

Its success can be determined by evaluating how closely the reconfiguring of the social, political and economic arrangements resemble the arrangements intended in the policy mandate (ibid).

In The Implementation Game (1977), he used the metaphor of 'the game' to illustrate the implementation process as the playing out by political and bureaucratic actors, "all manoeuvering with and against each other both for end results and for strategic advantages". Implementation games, he asserted, are part of the larger game of politics and representative government.

Bardach stressed the importance of including in policy designs, strategies to withstand the stresses and strains caused by the constantly shifting set of political and social pressures during the implementation phase. He recognised too, however, that policy design cannot rule out all potential problems. Many implementation problems, he claimed, are inherently unpredictable.

The classic symptoms of problems he described as underperformance, delay, and escalating costs. When these symptoms appear, he contended, the policy should be able to be set back on course by 'fixers', either individuals or groups who can repair damage as it is detected (Bardach, 1977:6).

Berman (1978) suggested successful implementation of policy decisions is neither automatic nor assured. He argued that most implementation problems stem from the interaction of a policy with its institutional setting. He recognised the power that implementers have to adapt policy decisions and believed that a more scientific approach to implementation studies would promote improved policy performance.

In his study of macro and micro-implementation, he offered some 'building blocks' towards the development of a conceptual framework. He distinguished between the different

institutional settings at the macro and micro levels of policy implementation and discussed concepts such as loose coupling, implementation passages, mutation, mutual adaptation, and the phases of micro-implementation.

Elmore (1978) drew on organisational theory to explain why social programmes fail. He believed that a knowledge of organisations is central for implementation analysis but suggested that there is no one body of theory that could explain implementation problems, but rather a collection of conflicting and contradictory theories. He proposed that by applying distinct models, each emphasising different features of organisations, to the same set of events, the different features of the implementation process would become distinguishable.

The four models Elmore suggested using are: 'the systems management model' which views implementation as an ordered, goal-directed activity; 'the bureaucratic process' which views implementation as a process of continually controlling discretion and changing routine; 'the organisational development model' which views implementation as a process in which implementers shape policies and claim them as their own; and 'the conflict and bargaining model' which views implementation as a bargaining process in which only temporary solutions are reached and no stable result eventuates (Elmore, 1978:185-6).

Each of these models is a construct or 'ideal type' providing a means of analysis for implementation problems in different contexts.

Mechling (1978) used a case study of the introduction of new technology into the cleaning and collection services of New York's Environmental Protection Agency, to demonstrate that

even when the implementation of policies is expected to be straightforward and easy, success can not be taken for granted.

> In most cases, the new policies required the preparation of detailed implementation plans, continued bargaining over key steps in the plan, further analysis, or some other kind of involvement by high level officials, line managers, and staff analysts. Implementation did not just happen; it had to be accomplished (Mechling, 1978:270).

Mechling suggested a significant lesson learned from this case study was the importance of bridging the gap between policy-makers and those responsible for the implementation of the policies. He described four tasks he believed to be important for successful policy implementation.

1. developing an implementation strategy
2. getting commitment to a detailed plan
3. controlling and revising that plan, and
4. creating an overall climate of credibility (op cit, p.278).

Mechling also discussed the value of interpersonal skills which he believed were just as important as cognitive and technical skills for the successful implementation of policies.

Sabatier and Mazmanian (1980) made a major contribution towards the development of a conceptual framework for implementation analysis. They identified and explained a set of five conditions which they believed were "sufficient and generally necessary" for a policy that seeks substantial social change to achieve its objective. The framework, they claimed, applies

to all government programmes that seek to change the behaviour of a target group. A policy will achieve its objectives if:

> 1. it incorporates a valid 'technical theory' linking target group behaviour to those objectives;
>
> 2. it contains unambiguous policy directives and structures the implementation process so as to maximise the probability of target group compliance;
>
> 3. the leaders of implementing agencies are supportive of those objectives and skilful in utilising available resources;
>
> 4. the program is supported by active constituency groups and a few key legislators throughout the implementation process, with the courts being neutral or supportive; and
>
> 5. the program is not undermined by changing socio-economic conditions (Sabatier and Mazmanian, 1980:500).

At a later stage Sabatier and Mazmanian added a sixth condition: clear and consistent objectives (Sabatier, 1986a:23).

Sabatier and Mazmanian argued that if all of these conditions were met then any policy, no matter how ambitious, would be effectively implemented. They recognised, however, that in practice policy-makers and policy-implementers face substantial constraints in their efforts to realise policy objectives. They suggested steps that could be taken to overcome deficiencies in the given conditions and like Bardach, they believed a "fixer" is essential for effective implementation.

In his 1986 critical analysis and suggested synthesis of the Top-Down and Bottom-Up approaches, Sabatier defended the Top-Down approach using the Sabatier and Mazmanian framework as his reference point. The framework, he argued, was tested over twenty times in a variety of policy areas and political systems by other researchers as well as themselves, and

revealed some very real strengths. At the same time he recognised that the emphasis on "clear and consistent policy objectives" was too strong as few programmes or policies meet this criterion. "The vast majority" he suggested "incorporate a multitude of partially-conflicting objectives" (Sabatier, 1986a:29).

Sabatier argued that just as the Top-Downers can be criticised for over-emphasising the importance of the policy-makers and the effects of their decisions on those in the periphery, the Bottom-Uppers can be criticised for over-emphasising the periphery and their ability to frustrate the decisions of the policy-makers, and for underestimating the influence the policy-makers have had on the institutional structure in which individuals operate.

For the Bottom-Up proponents the fundamental flaw in the Top-Down approach is:

> that they start from the perspective of (central) decision-makers and thus tend to neglect other actors. Their methodology leads top-downers to assume that the framers of the policy decision (e.g.statute) are the key actors and that others are basically impediments. This, in turn, leads them to neglect strategic initiatives coming from the private sector, from street level bureaucrats or local implementing officials, and from other policy subsystems (Sabatier, 1986a:30).

Many critics of the Top-Down approach have indicated the narrowness of the perspective, arguing that much of the implementation process is left unexplained (Barrett and Fudge, 1981; Elmore, 1979; Hjern, 1982; Hjern and Hull, 1982; O'Toole, 1989). They argue that the Top-Down approach infers that if the policy-makers (the top) could just design their policies properly their policy objectives would be realised. They point out that implementation failure is more complex than this.

Another criticism of Top-Down models is that they are difficult to use when there is no clear policy but a multitude of incremental governmental directives. Further criticisms include the lack of interest shown in the strategies used by street level bureaucrats and target groups to get around policies and/or divert them for their own ends (Elmore, 1978; Berman, 1978). Also the clear distinction between policy formation and policy implementation used by the Top-Downers, ignores the fact that some organisations are involved in both, and policies are often changed as they are being implemented.

Hill and Bramley (1986) suggest this distinction is based upon:

> an important value assumption in democratic government, that there should be a group of politicians who are answerable to the electorate who make policy, and that those policies should be implemented by others whose duty it is to carry out the will of their political masters (p.139).

For Hill and Bramley the policy process involves "a flow of activities in which concrete system outputs on the ground are determined by activities and interactions throughout the whole policy process" (ibid).

However, Sabatier (1986a) argues that obliterating the distinction between policy formulation and policy implementation will have two very significant costs.

> First, it makes it very difficult to distinguish the relative influence of elected officials and civil servants - thus precluding an analysis of democratic accountability and bureaucratic discretion, hardly trivial topics. Second, the view of the policy process as a seamless web of flows without decision points (Majone and Wildavsky, 1978; Barrett and Fudge,1981) precludes policy evaluation (because there is no policy to evaluate) and the analysis of policy change (as there is never a defined policy at t0 which changes into another defined policy at t1" (p.31).

The Bottom-Up approach begins by identifying the network of actors involved with implementing a policy and asking them about their goals, strategies, activities and contacts. It does not require a careful analysis of policy itself (op cit, pp.32-3).

Hjern et al (1978) developed an "explicit and replicable" Bottom-Up methodology which enabled them to identify a policy network and ascertain the actors' perceived problems and the strategies they have developed to deal with them. Sabatier (1986a) explains the methodology:

> It then uses the contacts as a vehicle for developing a network technique to identify the local, regional, and national actors involved in the planning, financing, and execution of the relevant governmental and non-governmental programs. This provides a mechanism for moving from street-level bureaucrats (the 'bottom') up to the 'top' policy-makers in both the public and private sectors (op cit, p.32).

The methodology, Hjern et al claimed, enables them to see the consequences, both intended and unintended, of policies, and to assess the consequences of many incremental governmental directives. The approach also gives the opportunity to assess the strategic interaction of a wide range of actors over time (op cit, p.34).

Sabatier recognised that Hjern et al's networking methodology is a useful starting point for identifying actors involved in policy implementation, but he believes:

> it needs to be related via an explicit theory to social, economic, and legal factors which structure the perceptions, resources, and participation of those actors (op cit, p.35).

O'Toole (1989) suggested that part of the difference in perspective between the Top-Down approach and the Bottom-Up approach reflects judgements about the proper locus of power in the policy setting. As mentioned above, the Top-Down approach perceives power in the hands of political authorities and the Bottom-Up approach perceives power in the hands of the street level bureaucrats - those who actually implement policies (p.2).

This can be seen in the arguments of Bottom-Up supporters Palumbo and Calista (1990). They suggested that the delivery of services shapes policy outcomes more than the design of the policy itself. Bureaucrats, they claimed, are influenced in their delivery by the complex political, organisational, social and economic context in which they work. According to Palumbo and Calista implementers are crucial to the policy networks that shape policy. They shape policy most significantly because of "the enormous and irreducible discretion they have, particularly at the street level" (Palumbo and Calista, 1990:14).

Walt (1994) illustrated the power of interest groups in initiating policy. In 1984 in the Netherlands the Government's official policy regarding heart transplants was to wait until the procedures had been further developed before embarking on a programme that would have meant investing in facilities and equipment. However heart surgeons in collaboration with two hospitals and with the support of the Heart-Patient Society, secretly performed a heart transplantation. Within three months central government changed its policy and granted licences to three hospitals (p.156).

Walt rejected the notion that policy process is linear or that policy formulation is separate from implementation. "Policy making is interactive," she claimed, "with formulation and

implementation two elements in a continuous loop, and both as political as the other" (op cit, pp.156-7).

The debate between the Top-Down and Bottom-Up approaches centers around whether implementation analysis should be concerned with prescribing ways by which implementation of policy objectives can be more assured, or describing what is actually happening in the real world regarding the implementation of policy initiatives. Sabatier summarises the different motivations of the two approaches:

> Top-downers have been preoccupied with (a) the effectiveness of specific governmental programs and (b) the ability of elected officials to guide and constrain the behaviour of civil servants and target groups. Addressing such concerns requires a careful analysis of the formally-approved objectives of elected officials, an examination of relevant performance indicators, and an analysis of the factors affecting such performance. Bottom-uppers, on the other hand, are far less preoccupied with the extent to which a formally enacted policy decision is carried out and much more concerned with accurately mapping the strategies of actors concerned with a policy problem. They are not primarily concerned with the implementation (carrying out) of a policy per se but rather with understanding actor interaction in a specific policy sector (Sabatier, 1986a:35-6).

Sabatier (1986a) explained attempts to synthesise the two approaches. He reviewed the "advocacy coalition framework" which uses the Bottom-Uppers' unit of analysis, a policy problem rather than a policy decision, and their concerns "with understanding the perspectives and strategies of all major categories of actors (not simply program proponents)" (p.39). It then adopts the Top-Downers' concerns with "the manner in which socio-economic conditions and legal instruments constrain behaviour" (ibid) and applies this to the analysis of policy change, rather than implementation, over periods of a decade or more. Finally, it attempts to develop theory by applying theoretical constructs. Sabatier reports: "[i]t is

primarily concerned with theory construction rather than with providing guidelines for practitioners or detailed portraits of particular situations" (ibid).

Bottom-Up supporter Fox (1990), argued that a synthesis of the two approaches is impossible because of the "positivist methods" of the Top-Downers. Positivist science, he contended is designed to predict and control, and the models used by the Top-Downers are designed to ensure the policymakers (the government) will get their way unilaterally (p.206)

Fox attempted to move beyond positivism. He proposed a phenomenological approach. Instead of attempting to close the 'gap' between the making of policy and its implementation (the concern of earlier researchers), Fox suggested we should accept the gap and recognise that it is:

> the ongoing working out of societal values about the policy issue which is being implemented, values that change over time and exist in multiple versions simultaneously (Fox, 1990:225).

Values, he asserted, cannot be understood ontologically, they are not objective facts. They can only be interpreted. He suggested a phenomenological approach offers a new set of research questions that will expand the analysis of implementation.

The inadequacies of the Top-Down Bottom-Up debate

The debate between the Top-Down and Bottom-Up approaches is too simplistic to account for the implementation of all policies. According to the terms of the debate, a Top-Down approach is the most appropriate to use when researching the implementation process of a particular policy. However, as mentioned above this approach assumes a clear distinction

between policy formulation and implementation and assumes that any alterations made to policy during implementation come about because of the discretionary power of the implementers, and the failure of the policy makers to overcome this by suitable implementation strategies. It assumes also, that policies fulfilling certain criteria, for example those included in Sabatier and Mazmanian's framework, will be implemented successfully.

Neither the Top-Down nor the Bottom-Up approach take into account the considerable impact on implementation of the substantive *content* of a policy - the particular policy initiatives - or the linkage between *substance* and *process* in the implementation of policies. Hill and Bramley (1986), bottom-up supporters, recognised the distinction and suggested that policy analysis "should always contain a lively awareness of both aspects" (p.18), but I suggest further that the two are inextricably linked. The substance, or content of the policy affects the process of implementation, and likewise the process has an important effect on the eventual content and outcome of the policy. This proposition is part of the central argument of this thesis.

Grindle (1980) argued that policy content is often a critical factor for countries in the third world "because of the real or potential impact it may have on a given social, political and economic setting" (p.10). I contend that policy content always has considerable impact on implementation, not only in third world countries.

Grindle is concerned with the effects on implementation of both the substantive content of policies and the political context in which implementation takes place. For her implementation is:

> an ongoing process of decision making by a variety of actors, the ultimate outcome of which is determined by the content of the program[17] being pursued and by the interaction of the decision makers within a given politico-administrative context (Grindle, 1980:5-6).

My concern is not restricted to the influence of content on the political context into which policies are introduced, but the influence of content on the implementability of policies. Not all policies are well designed and the Top-Down approach does not take this factor into account. It assumes that policies are well researched, policy makers have given consideration to the feasibility of the policy initiatives and implementers are merely required to carry out the intentions of the policy makers. In practice some policies are poorly thought through, the problems only becoming evident during the implementation process. It is not always implementers at the bottom who become aware of the inadequacies. In some cases government appointed implementers advise governments of the problems, governments then make the necessary changes to the policies to make them more implementable.

Bottom-Up supporters Hill and Bramley recognised that some government policies are "highly uncertain or ambiguous, or indeed even sometimes containing contradictions" (Hill and Bramley, 1986:139). But they attribute policy changes to implementers who "frequently operate in ways which create or transform or subvert what might have been regarded as the 'policies' handed down to them" (ibid). For them the power is at the bottom, with the implementers who are concerned with adapting policies in their own interests.

Top-Down supporters assume too that public policies are not implemented until they have been enacted in legislation. In a country such as New Zealand with a unicameral parliament,

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[17] Grindle uses the words policy and programme interchangeably. For her programmes are the means by which the goals of policies are realised (p.6).

and until October 1996 a first past the post voting system, radical polices such as the 1991 health policy were able to be introduced and implementation could begin immediately. This policy was not enacted until 2 years later during which time major changes had taken place to the content of the policy. In other countries such as the United States or the United Kingdom with different parliamentary systems, policies cannot be introduced with such speed resulting in more political and public debate, often leading to policies being adjusted to adapt to the social and political environment in which they will be implemented.

Neither the Bottom-Up approach nor the attempts to synthesise the two approaches are appropriate when the research is focusing on the process of implementation of a particular policy. As already mentioned, these approaches begin with a problem and are only usefully applied several years after implementation of a policy. They assume input into policy making from those at the periphery of the policy environment, and assume that those at the periphery have determined the problem and the need for new policy decisions.

These approaches are also not adequate for analysing the process of implementation of radical policies, such as the 1991 health policy, formulated from the top without input from the bottom.

Conclusion

The Top-Down Bottom-Up debate is not adequate to account for the implementation of all policies. Neither approach recognises the inextricable linkage between policy content and process. The Top-Down approach is too rigid viewing implementation as a stage in a linear process and the Bottom-Up approach is so fluid it does not recognise governments' policies as firm statements of intent but rather as recommended strategies open to change and

subversion by implementers. It does not recognise that governments can make changes to policies during the implementation process to make them more implementable.

In my analysis of the implementation process of this particular policy I will focus on the linkage between the substantive content of the policy and the implementation process. I will also examine the changes that have taken place to the policy during implementation.

Chapter 3

METHODOLOGY

Introduction

This research is concerned with the process of implementation, the process whereby the Government attempted to reconfigure the social, political and economic arrangements within the health system to resemble the arrangements intended by its 1991 statement of health policy. This chapter discusses the methods and techniques I used to generate, analyse and evaluate the data for the research. It discusses also issues and problems I encountered during the research.

The focus of my research

During the exploratory stage of my research, following a literature search and interviews with some key informants in the implementation agencies, I became aware that some important policy initiatives were not being implemented as was originally intended. As mentioned in Chapter 1 the four areas which I selected to focus on were not only deemed by me to be important aspects of the policy, but were seen by Upton to be crucial to the successful implementation of the policy. These four areas are: an explicit definition of a core of services to which everybody was to have access, health care plans, general practitioners entering into remunerative contracts with Regional Health Authorities, and a separate structure for the purchasing and provision of public health services.

Focusing my research on these four significant areas of the policy and the factors influencing the policy changes that took place, has provided me with the opportunity to critically analyse the process of implementation of this particular policy.

Whilst concentrating my research on these four areas, I have also addressed aspects of the policy that were implemented as planned, and those areas which were implemented and then within a short time abandoned.

A qualitative approach

I have used a qualitative approach for the research to enable me to explore the complexities of the process of implementation. It has provided me with the opportunity to examine: the process as it progressed; the taken for granted world and discretionary decision making power of the implementers; and the linkages between agencies and organisations at different levels.

As Sarantakos (1993) suggested the steps within the process of qualitative research are not as distinct as they are in quantitative research (p.279). Data collection using qualitative methods "involves a dynamic process of gathering, thinking, evaluating, analysing, modifying, expanding, gathering further, thinking again and so on" (ibid).

This dynamic process describes well my own experiences with this research. Using qualitative methods to research the process of implementation as it was taking place meant the research could be driven by the subject matter rather than a particular method. I was concerned with generating data which would provide insights into the process of implementation of this particular policy.

Methods employed

The research involved analysing: policy implementation literature; the socio-political context of the health policy environment; the historical and international contexts of the health policy environment; the factors influencing the design of this specific policy; the substantive nature of the policy; why these four areas were regarded by Upton as crucial to the successful implementation of the policy; who was responsible for not implementing them; when the decisions were made not to implement them; the reasons given for not implementing them; the resulting changes to the policy that were introduced; and what the implications are for health care.

I used a variety of qualitative methods to generate multi-faceted information to increase my understanding of the topic area. A single method would have been inadequate to explore and express the complexities of the health policy environment.

Library research enabled me to place the policy in a theoretical, historical and international context.

I used semi-structured, face-to-face interviews, and some telephone interviews, with expert informants and key informants in the health policy arena. This approach was supported by content analysis of both primary and secondary sources: policy documents, policy related speeches and press releases of Ministers of Health (Upton, Birch and Shipley), relevant Cabinet papers and Parliamentary debates, documents and publications released by the new agencies, media reports, and current publications addressing the health restructuring. In addition I attended public meetings, conferences and seminars pertaining to the restructuring of the health

system, and had many informal discussions with purchasers, providers and users of the health services.

Also, during the period of my research I worked as a part-time health educator within the health system and this provided me with the opportunity to adopt the role of participant observer during the implementation process.

Choice of expert and key informants

The expert informants included academics specialising in the fields of public policy, political science, health economics, health management, health education, health research, community health, health sociology and medical anthropology, along with health professionals and public health consultants.The key informants occupied significant positions in policy making and the implementation process. They included Simon Upton as Minister of Health and author of the policy statement. I discussed my research intentions with Upton in October 1992 and interviewed him in November 1994. An interview with Jenny Shipley, as current Minister of Health, was carried out on my behalf by her press secretary using my questions. The Minister's replies were taped and later transcribed and the transcription was forwarded on to me. The unsatisfactory nature of this method of information gathering was demonstrated when only pages one and three of the transcription were sent to me and the information these contained was contradictory[18]. I contacted Shipley's press secretary and requested page 2 be forwarded to me but again pages 1 and 3 were sent. I concluded the transcript had been edited and page 2 would not be made available to me.

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[18] See Chapter 7 for details.

I also interviewed a policy advisor in the Department of the Prime Minister at the time the policy was formulated, members of the special implementation agencies, members of the Regional Health Authorities, the Crown Health Enterprises, the Public Health Commission, the chairperson of the Board of the Public Health Commission, the spokesperson for the Core Services Committee, the Chief Advisor Strategic Policy at the Ministry of Health who was previously a senior member of the Health Services Taskforce secretariat, and members of the Coalition for Public Health[19].

Informal discussions at seminars, conferences and public meetings also provided some useful contacts and opportunities to discuss ideas and pursue lines of inquiry.

My choice of key and expert informants was determined by my search for specific information. During the exploratory stage of my research I was introduced to some key members in the implementation agencies and Department of the Prime Minister by academics at Victoria University and the Wellington School of Medicine. They in turn suggested others who would be able to provide me with the information I required. This form of networking proved to be invaluable as a means for obtaining access to key and expert informants.

Once I had determined the four areas on which I was going to focus my attention, I was keen to gain a broad range of perspectives on why these areas were not implemented as planned. Consequently my participants were drawn from the implementation agencies, the purchasers and providers of health care services, health professionals, academics and members of the Coalition for Public Health.

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[19] The Coalition for Public Health is a national body of concerned citizens, health professionals and academics who meet regularly to examine critically the restructuring of the health system and its implications for health care.

Restrictions of time, finance and distance meant I had to select informants who were available and willing to meet with me during the time I was able to spend in the various cities. Some who were unavailable for face-to-face interviews agreed to telephone interviews and one suggested I fax her questions and she would fax back replies. Only two requested anonymity for fear of repercussions in their places of employment.

The Interviewing process

The semi-structured nature of the interviews[20] not only provided me with answers to the questions I had set, but also allowed new lines of inquiry to develop providing me with new insights and new information to analyse and evaluate. It also provided opportunities for clarification and discussion on a wider basis for both myself as interviewer and the interviewees.

Because the health policy was such a 'hot topic' and the resulting restructuring of the health system was so radical and far reaching, many participants were unfamiliar with the changes taking place in areas other than their own. The interview situation provided them with the opportunity to enquire about other initiatives and for us to discuss these in general terms, and for some to voice their concerns about the changes taking place.

Following the exploratory stage of the research, the face-to-face interviews were audio-taped, the tapes later transcribed, coded according to topic, analysed using a multi-disciplinary approach, and evaluated[21]. Analysis and evaluation did not only take place after the interviews, but were part of a cyclical process occurring before, during and after the interviews. This cyclical process involved identifying patterns and regularities, discovering trends and drawing

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[20] See Sarantakos (1993:187-199) for a discussion of interviewing for qualitative research.

[21] For a discussion of analysis and interpretation in qualitative research see Sarantakos (1993:297-311).

conclusions to guide the research further. The research that followed then helped to refine, confirm and test the validity of the conclusions drawn so far[22].

The telephone interviews involved note-taking rather than audio-taping, the data collected was then treated the same as that collected during the face-to-face interviews.

My status as a health professional and health educator positively influenced my access to some people and the quality of some interviews. This became obvious early in the research process when interviewing a General Practitioner (GP) advisor in one Regional Health Authority (RHA). Initially he was resistant to discuss GP arrangements with me or to provide me with RHA publications relating to GP contracting. He suggested I would not understand the terminology used but when I explained that I was a health professional he immediately became more co-operative, responding to my questions and providing me with additional information and documents. He also agreed to me making further contact with him as necessary to clarify concerns and verify media reports of GP contracting arrangements.

In subsequent interviews I ensured that interviewees were aware of my health professional status and it served to provide a rapport as most assumed I had a background knowledge of the health system, and health professionals assumed I shared their interests and concerns about the policy changes. In a sociological sense, I belonged to their culture and spoke their language.

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[22] For a discussion of this cyclical process of analysis see Sarantakos (1993:300-301).

Documentary research

Documentary research[23] initially involved identifying the relevant documents and gaining access to them. A literature search alerted me to the existence and relevance to my research of various publications, reports and public documents. Key and expert informants and fellow researchers also proved helpful in alerting me to Ministerial speeches and press releases, reports and publications released by the implementation and purchaser agencies, and specific Cabinet papers relevant to my research. In addition I collected media reports related to the health restructuring.

Analysis of the documents involved multiple readings and reflection, critically determining the underlying assumptions, the themes, the contradictions, the influences, the specific and non-specific intentions, and the implications of the discourses. The data was coded according to topic and evaluated.

I obtained Cabinet papers and confidential reports under the terms of the 1982 Official Information Act. These were forthcoming from the Minister of Health and the Ministry of Health once I was able to provide them with specific information about particular reports: when they were furnished, and by whom.

When researching the medical profession's reactions to the proposed remunerative contracts for GPs, I searched the various medical practitioner journals but concentrated on the New Zealand Medical Association's Newsletter which is included in the Associations' fortnightly journal. The newsletter was addressed to the profession as a whole, not just GPs. It demonstrated a well

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[23] For a discussion of issues and problems involved in documentary research see Platt (1981:31-66).

researched understanding of the complex issues involved, and reflected well the concerns of the profession. Some of the other journals reflected the division within the ranks of GPs provoked by the reforms rather than representing the concerns of the profession as a whole.

Informal interviews with some GPs early in the research process convinced me that few really understood the implications of the reforms, and therefore a survey of GPs, or interviewing a sample, would not produce the data I required.

Participant observation

My employment as a health educator during the term of my research was undertaken to provide me with funding. However it immediately became obvious that I could not stop being researcher whilst carrying out my role as educator of health professionals. The two roles were closely intertwined as my role as health educator very often involved working inside the health institutions whilst they were undergoing major changes brought about by the policy. During these times, therefore, I was a participant observer experiencing the effects of the restructuring and some of the implications of the policy initiatives.

Those I worked alongside freely discussed the changing 'culture' of the institutions they were working within and the different norms pertaining to the new health environment. Some were aware of my role as researcher, others were not. I did not purposely conceal my research interests but it was not always appropriate to make them known. I was there primarily as an educator and needed to be recognised in that role.

My concurrent roles meant that I was often in a position of trust where I had to be acutely aware of the confidential nature of information at my disposal[24]. Whilst judging not to use particular information in my thesis, I was aware that it often influenced my thinking and interpretation of events.

My role as participant observer extended to attendance at conferences and public meetings organised by the Coalition for Public Health and purchasing and providing agencies, and a political meeting organised by the Council of Trade Unions (CTU). In addition to the data gathered at these conferences and meetings, they provided opportunities to extend my networking and arrange interviews with key participants.

An exclusionary language

With the release of the policy in 1991 an extensive new language was introduced[25]. It was a language of acronyms, for example, RHAs, CHEs, PHC, HCPs, HRD, NIPB. The words represent the new structures within the restructured health system but did not originate from within the health system itself.

It is a language of the technocrats responsible for the implementation of the health restructuring, not a language used by most of the health professionals working within the health system. It is in fact an exclusionary language with few words understood by health professionals or the general public.

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[24] The issue of confidentiality will be dealt with below.

[25] See list of abbreviations pp.x-xi.

It was necessary for me to be fluent in the use of this language as the key informants I interviewed used the new words freely and assumed fluency on my part. Therefore not only was my access to health professionals enhanced by my knowledge of their particular language but my access to technocrats responsible for the implementation of the policy initiatives, was enhanced by my knowledge of this particular language.

Confidentiality

Ethical considerations of confidentiality were of paramount importance in establishing relationships with my informants. As I moved between different actors within the system and those involved in public action against the health reforms, I was acutely aware at times of being in possession of information that I judged should not be shared with others. This was of particular importance in the new market environment where information that had previously been readily available was now regarded as 'commercially sensitive'.

Whilst acknowledging its cognitive influences, confidential and 'commercially sensitive' information gained during the time I was employed as a health educator in the newly restructured health system, has not been referred to in my thesis.

Timing

An interesting facet of my research was the timing. I was researching the process of implementation whilst it was taking place. The timing inevitably influenced the data I gathered and consequently the conclusions I drew. Researching whilst the process was taking place,

especially as a participant observer, provided me with valuable insights and enabled me to monitor the social and political context of the policy environment.

The radical and rapid changes taking place in the health system were without precedent in this country, and those I interviewed early in the process did not have the benefit of hindsight or experience on which to base their responses. As mentioned above, supporters of the policy were still caught up in their ideological commitment to the ideas underlying the proposed changes, and those opposing the policy likewise were influenced by their resistance. This became obvious when I re-interviewed some respondents at a later date to clarify some points. The lapse of time and the experience of implementation produced different explanations resulting at times in contradictory data.

Comparative Analysis

To explore the international influences on the policy I have analysed recent health policies and their implementation in the United Kingdom and the Netherlands, and proposed and current health policy practices in the United States.

Examining and evaluating the New Zealand policy by comparing and contrasting it with the policies of these other countries has permitted a more comprehensive analysis of the New Zealand policy.

Focused cross national comparison illustrates the common problems encountered by quite diverse countries, both in their policy environments and in their attempts to implement their policies. It also highlights the similarities and differences in their approaches to ameliorate these

problems. As Blank (1994) suggests, it demonstrates the experiences "of a wide range of applications" (p.5).

The difficulties experienced with cross national comparative analysis is explained well by Flynn (1993):

> quite apart from the availability of data, there are always difficulties in 'standardising' units for comparison, in determining whether apparently similarly described organisations and services, for example, actually share common features, and in deciding whether particular features are culturally specific, and if so why. Descriptions of institutions and occupations in two or more countries (for example, hospitals and doctors) may appear identical, but the organisation of production and system of resourcing and remuneration may mean that their power and significance is very varied. Policies (and policy processes) which superficially seem similar may have quite different meanings and consequences in different societies (p.62).

Not withstanding these methodological obstacles the comparison of New Zealand's policy with those in the above-mentioned countries has served to illustrate the international influences and the New Zealand Government's determination to go further in its restructuring and to go faster.

Conclusion

The use of a variety of methods and techniques to generate data enhanced the rigor and validity of the research, and provided a richer and far more accurate interpretation of the implementation process and the changes that have taken place in the health system.

In a sense the research is unreplicable in that interviews taking place at a later time would be coloured by hindsight, and the participant observation during the restructuring could not be repeated. Also a different researcher with a different background would generate different data.

I recognise that the nature and quality of my research findings has been strongly influenced by my own positioning as a health professional concerned about the implications of the restructuring of the health system. Likewise for the participants, their ideological commitments for or against the intended restructuring, influenced their participation in the research and the quality of the data generated. Especially early in the process, those in support of the Government's intentions were keen to promote the policy and to explain why it was 'necessary'. Likewise those opposing the policy were enthusiastic in expressing their concerns.

Chapter 4

THE DEVELOPMENT OF NEW ZEALAND'S HEALTH SYSTEM

Introduction

In this chapter I offer a focussed investigation, largely historical, of the development of New Zealand's health system and people's attitudes towards it. My intention is to show how the particular form of our health system, the extent of the provisions, and the way services are distributed, have been influenced by the historical, social, and political context in which policy decisions were made, and that this development led to concerns which the National Government tried to address in its 1991 health policy.

The health system which has evolved over the past 155 years is a complex mix of public and private, remunerated and voluntary services and resources. In 1984 Fraser descibed the system as:

> the product of a number of complex processes which include administrative growth and control in central government, fluctuating initiatives and responses from local authorities and voluntary societies, and more or less sustained interventions by a diverse array of special interest groups. In essence, it is a patchwork of provisions which are the result of ad hoc, pragmatic responses to an everchanging mix of economic, political and ideological factors (Fraser, 1984:53)

While there certainly are instances of ad hoc pragmatism in New Zealand's health system history, I argue that the system is best understood as the consequence of three main factors. These are:

1. The local-central relationship governing hospitals which has existed since the provincial

period of government. 2. The power and influence of the medical profession. By medical profession I am referring to doctors of medicine, not other health professionals. 3. People's growing expectations that the state should provide subsidised health care services by right of citizenship.

Following the establishment of provincial government in 1853, the separate provinces took over control of 'their' hospitals, establishing local control as the basis of the organisation of the hospital system for the next 140 years. With the abolition of the provinces in 1876, central government became the major funder of the hospitals but control remained in the hands of locally elected boards. This local/central relationship characterised the public hospital system until the implementation of the 1991 health policy. The disestablishment of this relationship was at the heart of the National Government's health policy.

The medical profession has strongly influenced the way primary health care has developed and has also had considerable influence in the development of the secondary sector. In the laissez-faire ethos of the nineteenth century, the dominant form of health care available was private enterprise primary care. The medical profession created and maintained a market situation within primary health care by charging their patients a fee-for-service. Their success in constructing and dominating a market for their scientific-based medical care established their monopoly position and ensured that services were available on the basis of ability to pay rather than on the basis of need.

A dual system of privately provided primary care and state provided secondary care and public health services, became the cornerstone on which later health policy initiatives were based.

This dual system was complicated by the development of a private hospital system, which was accelerated by the introduction of medical insurance in 1961. This developed alongside the state funded system displacing some of the costs of public sector provision. The private system backed by the state provides an alternative choice for mainly elective surgery, rather than providing alternative secondary and tertiary services.

People's growing expectations that the government should provide access to publicly funded health services developed from the state's early reluctant interventions in the 1840s to the first Labour Government's intentions to provide universal free health care. This was never fully realised but the predominantly government funded health system that developed and existed through to the 1990s was supported by both major parties until National released its 1991 health policy.

The National Government also considered the three factors delineated above were propelling the health system. It sought to restructure the health system, to create a managed market, and to integrate the funding of primary and secondary care by compelling general practitioners to contract with Regional Health Authorities. It sought too to change people's expectations of the Government's role in providing health care by targeting Government assistance only to those on low incomes and those deemed 'high users' of health care services. This would mean that medium and high income earners would have to take responsibility for their own health care needs.

In its 1991 health policy the National Government claimed the health system was unsustainable in the medium to long term, given the changes in the population, people's expectations, and the advances in medical technology (Upton, 1991:8). It maintained that the health system was

"structurally flawed" (p.9) and in its attempts to limit its liability, it introduced a radically new structure and market principles to the health environment.

Crown colony government and the New Zealand Company: Britain's influence

The health system which evolved in New Zealand following colonisation, was strongly influenced by the prevailing ideas and practices in Britain. In Britain there was a strong drive towards individual and family responsibility in times of hardship and sickness. This was evidenced by the passing in 1834 of the new and more restrictive Poor Law which was based on the underlying assumption that poverty, and the sickness that very often accompanied it, could be attributed to moral fault in the individual. There was little recognition of the social causes of poverty and sickness.

Sutch suggested that England's hospital system was not carried over to New Zealand because there was no local government machinery and therefore no taxes, and because "the provision of hospitals and services for the destitute had not occurred to the authorities as a likely need" (Sutch, 1966:45).

Sutch described hospitals in England as:

> either voluntary general hospitals governed by private incorporated bodies, maintained by private subscriptions with an honorary visiting staff and catering for a selected group of the poor, or they were Poor Law infirmaries maintained by local rates, serving those of the poor who were suffering from chronic illness or whose medical condition did not demand the most specialised attention (Sutch, 1966:44-45).

Care of the sick was generally palliative. Most care of the sick was done on an informal or semi-formal basis and usually by women (Doyal and Pennell, 1979:28). According to Brearley et al

(1978), the public did not look to the medical profession for major improvements in health. Doctors did not have much to offer in the way of personal health services. There was only very limited pharmacopoeia available to them. Anaesthetics were not discovered until the late 1840s and internal surgery was just beginning.

Edward Gibbon Wakefield and the New Zealand Company and those responsible for the Crown Colony settlements were strong proponents of the values of individual and family responsibility for welfare, enforcing them to an even greater degree than in England. Thomson suggested that in the early years of colonisation "there was an extreme swing towards family responsibility, making individuals and their relatives bear prime responsibility in all welfare matters" (Thomson, 1987:8).

Sutch suggested Wakefield and the New Zealand Company intended to reproduce in New Zealand the civilisation of England, but without its harsher side, particularly poverty, sickness and unemployment. They saw little need therefore to make any provision for times of sickness or hardship due to unemployment (Sutch, 1966:7).

To the intending immigrants New Zealand was painted as a paradise of natural resources, providing employment and an ideal lifestyle. Despite the idealised picture painted by Wakefield and the New Zealand Company, the reality proved to be very different for the settlers. Many were reduced to bare subsistence and consequent ill-health[26].

Sutch maintained "the government's record, however, was equally bad" (op cit, p.44). In discussing the situation for immigrants in Auckland, Sutch suggested lack of planning and

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[26] Despite their promises, the New Zealand Company did little towards providing sustenance or employment for those unable to find work. See Michael Turnbull The New Zealand Bubble: The Wakefield Theory in Practice. (1959) for a discussion of this.

"bungling and lack of co-ordination at the New Zealand end brought prolonged suffering to the thousands of poverty-stricken labourers with which the government had glutted the labour market" (op cit, p.42). The government, with no funds, absolved itself of any responsibility for the misery and destitution of the immigrants.

Individual and family responsibility for welfare were the prevailing values in the early years of colonisation.

The beginnings of the public hospital system

Despite it being the New Zealand's Company's policy not to provide health care services, following the arrival of the first settler ships it found it necessary to erect a temporary hospital in Wellington for its staff (op cit, p.45).

In 1840 concern was expressed at public meetings in Wellington and Kororareka by early settlers, for the effect European introduced diseases were having on the Maori. Maori were devastated by diseases for which they had no natural immunity. This same concern was being expressed in Auckland and resulted in the establishing of a makeshift hospital there in 1841. It was supervised by the Colonial Surgeon, the first state medical officer. The hospital provided free care for Maori. European patients were required to pay 1s 6d (fifteen cents) per day if they could afford it and they had to apply to the Colonial Secretary for admission to the hospital. Convalescing patients were required to assist with ward duties and serve meals or they were discharged (ibid).

By 1846 Governor Grey had persuaded the British Government to provide money to build further hospitals. Sutch suggested it was the plight of the Maori rather than that of the settlers

that persuaded the British Government to provide the money (op cit, p.46). Nevertheless these hospitals marked the beginning of New Zealand's public hospital system. Initially four hospitals were built, in Auckland, Taranaki, Wanganui and Wellington, centres of joint Maori and European occupation.

Wright-St Clair postulated that Grey believed these hospitals "would offer the best of British medicine to the Maori and thus advance the cause of their civilisation" (Wright-St Clair, 1987:9).

Europeans suffering from illness or accidents were expected to be cared for in their own homes or in hotels. The sick and destitute with no families and no-one else to care for them, could only be admitted to the hospitals after receiving an order from the Colonial Secretary (Sutch, 1966:46), (New Zealand Department of Health, 1974:13).

> By restricting European admissions to the indigent, the State merely followed the English custom of organising State hospital services on the basis of economic need rather than of social equality (op cit, p.13)

The first recorded hospitals in the South Island were at Dunedin in 1851 and Lyttelton in 1853 (Sutch, 1966:46).

Thus the beginnings of the public hospital system were motivated largely by concern for the plight of the Maori. Hospital care was only extended to Europeans who were sick and destitute and unable to care for themselves. Targeting of health services was established.

The development of private enterprise general practice

Doctors who had emigrated to the new colony all worked as general practitioners, often dispensing their own medicines. Many had specialist qualifications and others no qualifications at all. Compulsory national registration of doctors did not take place until 1868 (Wright-St Clair, 1989:14). The practice of medicine in New Zealand developed in terms of the scientifically based biomedical model[27]. Health problems were individualised. Causes and treatments were concentrated on individuals. There was no recognition given to the social causes of illness and no public health provisions made until 1872. The model fitted well with the contemporary understandings of both medicine and social and public policy.

Doctors worked as private enterprise practitioners, charging their patients fees for their services and thus introducing a market framework to New Zealand's health services. Medical services became available on the basis of ability to pay rather than on the basis of need; though it has been suggested that doctors waived fees for their poorest patients (Sutch, 1966:ch.3).

The inability of many people to afford the fees for doctors' services stimulated the formation of lodges and friendly societies. The first recorded was in Wellington as early as 1843 (Tennant, 1989:14), (Hay, 1989:17). Members of friendly societies paid an annual subscription and in return received free medical attention for themselves and their families. Each friendly society appointed an attending doctor who was granted an annuity to take care of their sick (Wright-St Clair, 1989:15). These institutions benefitted mainly those who were in regular employment and could afford the subscriptions.

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[27] The biomedical model focusses on the biological and physical causes of disease and illness and treatment aims to control or modify the disturbed bodily function (Salmond 1994(a):348).

Private subscription schemes operated in some areas to assist people to obtain medical assistance. Groups of people paid subscriptions into a fund similar to a friendly society, and they were able to obtain medical services for themselves or others that they recommended for health services. As an illustration of this, Henry Falwasser honorary secretary to the Auckland Dispensary, wrote in the *Auckland Times* 14 December 1842, that any subscriber would be entitled to recommend, conjointly with a member of the committee, patients for treatment. The accompanying form suggested that a patient must be "labouring under severe illness" and be "a proper person to receive medical assistance".

In 1867 with the passing of the Medical Practitioners Act, doctors of medicine established themselves in legislation as a recognised body of medical professionals who alone could provide certain services (Wright-St Clair, 1987:4). Private enterprise general practice was established with friendly societies and subscriber schemes assisting many people to obtain doctors' services.

State care for the mentally ill

The mentally ill, or lunatics as they were referred to, were perceived to be a threat to public order rather than as sick people requiring health care, as they are in the 1990s. With the 1846 Lunatics Ordinance the state took responsibility to provide custodial care for the mentally ill, irrespective of the individual's or their family's financial status (Tennant, 1989:13).

The 1846 Ordinance provided for the apprehension, maintenance and keeping in custody (in prisons), of `dangerous lunatics'. The insane who were not dangerous to the community, were placed in 'lunatic asylums'. A number of psychiatrically disturbed persons (including alcoholics) had been included amongst the settlers and it was deemed desirable by those in power to remove

them from the community (Ordinances of the Legislative Council of New Zealand, 1846), (Tennant, 1989:13).

Free, universal care for the mentally ill appears at odds with the state's reluctance to provide free health care in general but the mentally ill were regarded as a custodial concern rather than a health concern. They were seen to be a threat to the public order.

Family responsibility for the destitute

The destitute, however, remained the responsibility of their families. They were not regarded as a threat to public order but as a threat to the public purse.

In the same year as the state became responsible for the mentally ill, the Destitute Persons' Ordinance was passed making parents, grandparents and children liable to support their own destitute[28] (Ordinances of the Legislative Council of New Zealand, 1871), (Thomson, 1987:8-9). Tennant suggested that this ordinance drew heavily upon England's New Poor Laws of 1834 which were designed to discourage pauperism (Tenant, 1989:13). Under the Ordinance the family was to be the source of all welfare, and the 'family' could be defined by the State.

Provincial control of hospitals

Provincial control of hospitals was established as a result of provincial government being instituted in New Zealand. In 1852 the British Parliament passed the New Zealand Constitution Act granting self government to New Zealand. In 1853 landowners elected a central

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[28] This Ordinance was further extended in 1877 to give a broader definition of family. It included step-parents, step-brothers and step-sisters (Sutch, 1966:84).

government and six provincial governments in Auckland, Taranaki, Wellington, Nelson, Canterbury and Otago.

Following the establishment of provincial government, each province took over control of 'its' hospital(s). Hospitals were given the authority to authorise emergency admissions but non-urgent admissions still had to be considered by the Provincial Governments (New Zealand Department of Health, 1974:13), (Hay, 1989:19).

Though not officially adopting England's Poor Law, there was a grudging official recognition during the 1850s that local governments should take some, albeit minimal, responsibility for the poor. Many poor, already malnourished, were pushed into absolute destitution as a result of sickness. Hospitals gradually became responsible for the granting of charitable aid, establishing a "New Zealand tradition of associating poor relief with medical services" (Royal Commission of Inquiry, 1972:39), (Hay, 1989:19).

Growing state involvement in the provision of health care worried those responsible for administering the early hospitals. They did not believe the state should be responsible for providing health care. Private charity was thought to be the appropriate method of poor relief, not state funded poor relief (Sutch, 1966:47, (Hay, 1989:19).

This was illustrated by the Wellington Committee on the Colonial Hospital in 1854 in their expressions of concern.

> This 'erroneous' thing, this state hospital, 'this peculiar principle', ... had to go... 'Purely charitable institutions' paid for out of revenue and conducted by the Government tended to lessen the self reliance of the people, and 'to foster a dependence on the public hurtful to the public morals'...public hospitals should

> be conducted as they were in England; it would 'teach the people how to take care of themselves' (cited in Sutch, 1966:47).

The committee did agree, however, that the hospital should not be closed "until some other sufficient system be established" (ibid).

Hospitals in the provinces were funded by private subscriptions, fees from patients, and grants from provincial governments. It was hoped that with local control of the hospitals being granted to the provinces, voluntary subscriptions would increase (Hay, 1989:20). However this did not happen. New Zealanders did not generally have the wealth that was available in Britain. The majority of the settlers were working class.

Though New Zealand was being advertised in Britain as having no workhouses (Sutch, 1966:47), (Hay, 1989:20), reflections of the English workhouse mentality were still evident amongst policy makers in the 1860s. In 1862 the Christchurch Provincial Government opened a hospital and lunatic asylum along the lines of the English model. The hospital was to be maintained by public subscription and the patients were to be charged fees of thirty shillings per week. However sufficient subscriptions were not forthcoming and the patients were too poor to pay the fees. The hospital was soon taken over by the Provincial Government in 1864 (Sutch, 1966:49).

In Auckland in 1868 the Provincial Council, in its efforts to boost funds to provide for the sick and the poor, passed the Sick and Destitute Act. The objective was to provide funds for the "maintenance of destitute persons, the sick and lunatic, and neglected and orphaned children"[29] (Sutch 1966:51). The fund was to be financed by a tax of ten shillings per year on all non-Maori

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[29] Again this Act has the notion of the 'deserving poor' as in the English Poor Law 1834.

males[30]. However, as is general with such poll-type taxes, it merely succeeded in increasing the burden on the already heavily burdened poor. The taxes proved impossible to collect and the Act was repealed in 1870 (Tennant, 1989:16).

Benevolent societies were beginning in the larger settlements to provide care for those whose needs were not being met by the minimal State-subsidised services. Thus there was already a growing distinction developing between the public and private provision of care (Fraser, 1984:56). Hay noted:

> [t]here emerged an embryonic State sector which had a specific target population and which fostered an early, but important, distinction between public and private care (Hay, 1989:21).

By the 1870s an additional fourteen hospitals, mainly private, had been established in the Otago and West Coast goldfields to deal with the accidents and sickness of the miners. A similar expansion during the 1870s meant that New Zealand had thirty-seven hospitals by 1882. The majority of admissions to the hospitals were male with some hospitals such as Charleston, Coromandel and Ross admitting no females at all (Dow, 1991:49).

Fraser (1984) summed up the hospital system that existed by the end of the provincial period.

> There was...the nucleus of a hospital system, though the resources required to operate them were not fully assured, coming as they did from a variety of sources. Self-help, and assessments of economic need, based on the then pervasive logic of 'benevolence', which was buttressed by notions of discipline and the deserving poor, rather than explicit ideas about social equality or universalism, were the keys to the forms of medical care which developed in the early decades of the colony (p.56).

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[30] According to Tennant (1989:16) this is one of the first welfare taxes in New Zealand. It was essentially a poll tax, collected from the people in Auckland to help pay for local services.

By the end of the provincial period local control of hospitals was established but funding was a real concern. Provincial governments made grants to the hospitals and these were to be augmented by fees from patients and in some places public subscriptions. However patients were not always able to pay their fees and consequently hospitals were usually insufficiently resourced (Sutch, 1966:84).

Central funding, provincial control

Following the Abolition of Provinces Act in October 1875 the responsibilty for hospitals again came under the umbrella of central government, from 1 November 1876. The hospitals were run by their locally elected boards but central government became the primary source of finance (New Zealand Department of Health, 1969). Hay explained: "the Government provided most of the finance for hospitals, but had very little say in their functioning" (Hay,1989:22). This separation of funding and control set the direction for hospital administration. Initially funding for hospitals was set by the 1876 Financial Arrangements Act which created a provincial district land fund from the revenues resulting from the sale, leasing, letting, or other disposal of local Crown waste lands. If insufficient funds were available the Colonial Treasurer was empowered to advance monies from the consolidated fund (Hay, 1989:22).

In an attempt to reduce the government's financial responsibility for hospitals, Liberal John Ballance, proposed in 1878 that hospitals should be subsidised pound for pound by Government for money collected from local body funds and subscriptions. However this met with mixed success due to the contemporary economic circumstances. Many local bodies were unable to raise sufficient funds during a time of depression and the government had to provide further assistance (op cit, p.23).

During the years 1878 - 1885 the government made several attempts to pass legislation which would reduce its financial liability for hospitals and encourage voluntary charity and subscriptions[31]. None were successful. Central government had to retain the financial responsibility but control remained with the locally elected boards.

An attempt to introduce national insurance

In 1882 a new government was elected and Atkinson the Colonial Treasurer, argued for a national insurance scheme to fund health and welfare provisions. The scheme was intended to ensure that people would receive support during times of sickness and hardship. It was to provide for people in times of accident, widowhood, orphanhood, old age, and ill health (New Zealand Department of Health, 1974), (Royal Commission of Inquiry, 1972), (Sutch, 1966:86), (Hay, 1989:24). Atkinson believed that compulsory co-operative thrift was the only remedy against pauperism (Sutch, 1966:86).

His proposal marked the first effort made in New Zealand to provide for all citizens in times of sickness and poverty. However "general reaction to the scheme was both sceptical and hostile" (Hay, 1989:25). The scheme was resoundly rejected by government members. Those who claimed to be concerned with public morals argued that it would:

> sap the independence of persons relieved and jeopardise Christian concern for one's brothers (New Zealand Department of Health, 1974:36).

and

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[31] For a fuller discussion on these bills see Hay, (1989:22-4).

> encourage idleness, and thriftlessness, undermine the self-reliance of the people, and break up families (Royal Commission of Inquiry, 1972:41).

Sir George Grey condemned it with the following:

> I say it is a blow at Christianity itself. It is a blow at the family. It is an attempt to make every single individual a part of a great communistic society (NZPD,1882:Vol 42,194).

Grey and his supporters, believing strongly in the principles of individual and family responsibility for welfare, engaged Christianity as the cornerstone of these values and beliefs. The ideal of 'the family' as provider of welfare did not, however, take into account the reality which prevailed.

Atkinson in his support for increased state intervention in health care and support for those experiencing hardship, argued that the precedent had been set. The State had already intervened in areas such as railways, telegraph, Post Office Savings Bank, and education. It was entirely appropriate for the State to promote "certain ends that we desire" (NZPD,1882:Vol 42,188), (Hay, 1989:26).

Rejected by members of Government, even though he held the position of Colonial Treasurer, Atkinson's proposal nevertheless reflected and stimulated a growing readiness for change in attitudes towards state provision for social services generally and, in terms of this thesis, health services in particular. He was the first senior political figure in New Zealand to express such a concern.

An attempt to rationalise hospital care

The concern of most in authority, however, was with the efficiency of the hospitals, not with the sick and infirm who were not able to afford treatment. Grabham, Inspector of Hospitals in the early 1880s, believed that the efficiency of hospitals was impaired by the admission of chronic and incurable patients. He argued that by providing beds for the incurable, old and feeble, whom he described as "worthless persons", the hospitals were unable to cater for those sick who would respond to treatment and could be returned to the community[32] (AJHR,1885:Vol H-18,2). Many hospitals responded by introducing by-laws banning the admission of incurable patients (Dow, 1991:50).

However by the latter years of the nineteenth century, with the continuing depression and the aging of the settler population, there was a growing trend within hospitals, especially in the goldmining districts, towards providing residential care for the old, the chronically ill, the terminally ill and the feeble-minded. Hospital care was often provided free due to the desperate circumstances of the particular patients (Oliver, 1988). Succeeding Inspectors of Hospitals urged the Government to establish separate homes for the elderly and the incurable[33].

Grabham pointed out in a memorandum in March 1885:

> the provision of free hospital treatment by the Central Government is pauperising the population to an alarming extent, and taking away inducements to thrift (cited in Dow, 1991:52).

McGregor, Grabham's successor, expressed similar concerns in his first report. He was also concerned about the effect state involvement would have on those providing charity.

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[32] Note the similar arguments used currently to justify removing the elderly and the severely disabled from hospitals to the community.

[33] See AJHR,1900:Vol H-22,1; AJHR,1907:Vol H-22,2,11.

> It is a matter of grave concern that, in some districts at least, it [the Hospitals and Charitable Institutions Act] threatens to dry up the springs of voluntary charity (AJHR,1887:Vol 2,H-19,1).

McGregor, like his predecessor, believed that state intervention represented a retrograde step from the British laissez-faire system, an abandonment of one's duties to provide for oneself and one's family, and an encouragement of the procreation of the degenerate - people whom he felt would eventually cause society itself to degenerate (AJHR,1898:Vol H-22,1-7).

The establishment of Hospital Boards

Government's increasing concern for its fast growing expenditure on hospitals (it had increased to seventy-five per cent of running costs by 1885), prompted the Hospitals and Charitable Institutions Act in 1885. This Act decreed that the majority of money for the hospitals be raised locally with Government only providing a reasonable proportion of the overall expenditure. Local hospital and charitable aid boards were established in each district (originally twelve but soon increased to twenty-eight). They were to control and administer health services and charitable aid in their areas. (Statutes of NZ, 1885), (Burgess, 1984:6-7), (Hay, 1989:28).

The 1885 Act laid the foundations for the administration of hospitals for the next one hundred years. Hospitals were to be supported through Government taxes and local body rates. Fraser (1984) suggests that the Act "though it underscored the involvement of the State, was meant to provide a tactic for controlling the financial involvement of the State in medical care" (p.57). Local financial responsibility and management were to be enforced and private charity was to be encouraged. Fraser suggested further:

> While the state was clearly involved in subsidising the funding of medical care, it was also true that local ratepayers were unable to escape from assuming a responsibility for this increasingly expensive commodity (op cit, p.58).

The government believed the use of locally-raised money would encourage careful administration of hospitals and charitable aid. Oliver (1977) suggested:

> From one point of view local rates were a form of public finance; from the central government's point of view they were rather a form of compulsory benevolence, encouraged by the prospect of a central subsidy pegged to the level of local contributions both voluntary and levied. Thus both the legislators and administrators hoped, local boards spending chiefly their own money, would be induced to limit their own outlay to the deserving (Oliver, 1977:6 cited in Fraser, 1984:57-8).

The 1885 Hospital and Charitable Institutions Act remained the basis for the administration of health services and charitable aid in this country for the next 50 years. The Hospital Boards it established remained in place for the next 100 years.

Increasing use of hospitals

An unintended consequence of the Act was the increased acceptability of hospitals as places to receive medical treatment. With their increasing financial responsibility for the maintenance of hospitals, ratepayers' attitudes towards hospital care changed. Where hospitals had been perceived as service providers for the poor and destitute, many came to believe that if they had to pay for the facilities through taxes and rates they should also have access to them.

Condliffe (1959) suggested the 1885 Act "took a long step towards the public provision of hospital service and poor relief as a right of citizenship" (Condliffe cited in Hay, 1989:29).

During the late 1880s and 1890s the aging of the population, increasing urbanisation, and advances in medical technology and anaesthesia, encouraged the attitude that hospitals were desirable places in which to receive medical treatment. Advances in medical technology and anaesthesia often meant that treatments were only available in hospitals. They ceased to be places just for the poor. (Hay, 1989:31).

Maori Health

Following the building of the first hospitals to accommodate Maori afflicted by European-introduced diseases, little concern was shown for the declining Maori health status during the remainder of the nineteenth century. Durie suggested "some saw the demise of the Maori as inevitable if not desirable, and action must have seemed pointless" (Durie, 1994:38). An extract in the *New Zealand Herald* of 17 August 1874 expressed a commonly held opinion:

> That the native race is dying out in New Zealand there is, of course, no doubt...The fact cannot be disguised that the natives are gradually passing away; and even if no cause should arise to accelerate their decease, the rate at which they are now disappearing points to their extinction in an exceedingly brief period (cited in Maclean, 1964:189).

While estimates of the Maori population in the nineteenth century were remarkably unreliable, there is little doubt that a severe decline had occurred. A census taken in 1857-8 based on an actual headcount, suggested a Maori population of 56,049, about one third of the accepted population in 1800 (Durie, 1994:31). By the year 1896 it had decreased to 39,854 (Pool, 1991:76).

Durie maintained Maori were biologically and socially ill-prepared for the changes that colonisation brought to their lifestyles.

> If death did not occur through epidemics or muskets, then it was hastened by lifestyles which disturbed the balance between tapu and noa and severed the nurturing links between Maori and their lands (Durie, 1994:30).

According to Binney, Bassett and Olssen (1993) some efforts to improve Maori health were made. In the 1880s Pope, Inspector of Native Schools, worked with Maori children in the schools encouraging more hygenic habits. In 1884 he published a school reader Te Ora mo te Maori (Health for the Maori).

Towards the end of the nineteenth century Maori dissatisfaction with their position in the affairs of the nation was being transferred into political action. A Maori Parliament, Paremata Maori, was established in 1892[34], and the Young Maori Party emerged in 1897. Health education was one of the members' first concerns. Within Maori communities attempts were made to reform health practices. There was a move to return to the old practices of clean water, adequate sanitation, ventilated houses, and effective drainage.

These hygenic practices and the Maori's gradually increasing immunity to contagious diseases, led to increased health status for Maori by the early years of the twentieth century.

In 1899 a newly formed Maori newspaper, *Te Pipiwharauroa* contributed to improved Maori health status by publishing many articles on health for its Maori-reading audience.

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[34] Paremata Maori was not recognised by the Government. It drafted legislation of its own and persuaded one of the four Maori members of Parliament to present it as a Bill in the House of Representatives. It was not well received and resulted in an evacuation of the debating chamber.

Following the establishment of the Department of Public Health in 1900 and the appointment of the first Maori medical officer Maui Pomare, western scientific medical principles were applied to the plight of the Maori. Durie stated:

> [a]lthough the 1900-1930 phase witnessed a new level of Maori participation involving tribal leaders and recent Maori graduates, control was increasingly directed from the centre, so that eventually the Department of Health assumed full responsibility and health professionals (medical officers and district nurses) displaced community leaders (Durie, 1994:42).

In the early decades of the twentieth century Maori were actively involved in the delivery of health services. Following the passing of the Maori Councils Act 1900, 19 elected Maori Councils were established. They were authorised by the Department of Public Health to enforce sanitary regulations relating to houses, meeting houses, and water supplies. They were regarded by Maui Pomare to be "appropriate vehicles for health promotion, disease prevention and data collection" (op cit, p.44). They provided a much-needed infrastructure for the work of the Department amongst the Maori people.

As Durie suggested the Maori Councils, "for all their apparent autonomy, were in effect simply expected to deliver government programmes without introducing their own policy perspectives" (ibid). This was exemplified in the passing of the Tohunga Suppression Act in 1907[35], a clear message by Government that health care would be firmly based on Western concepts and methods.

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[35] Maclean suggests the Act was passed to prevent the exploiting of the Maori by the many charlatans posing as Tohangas, who claimed to have supernatural powers for treating disease (Maclean, 1964:194). Belgrave, however, describes the Act as "draconian legislation" designed to promote the practice of western medicine and to prevent the practice of Maori medicine (Belgrave 1991:16).

The monopolistic power of the medical profession

In the early years of colonisation there was no national system of licensing providers of medical care. Providers included chemists and nurses as well as doctors. All three diagnosed illnesses and prescribed treatments, and doctors and chemists dispensed medicines for their clients. Chemists were the first to provide an established form of apprenticeship in New Zealand. Very few dentists had any training and nurses and midwives had none. Medical qualifications had to be obtained in countries overseas (Hay, 1989:35).

During the 1870s the various providers of health care were more clearly differentiated. From 1868 doctors were required to be registered. In 1875 New Zealand's first medical school was established at the University of Otago and in 1887 the Otago Medical Association merged with similar organisations in other parts of New Zealand to form the New Zealand branch of the British Medical Association. The Association assumed responsibility for the standardisation of medical practice and for the control of economic activity within medicine (ibid).

With the development of the medical school and their own professional association, the status and power of the medical profession became institutionalised. Doctors were now able to exercise control over the numbers and quality of the candidates entering the medical school and the curriculum that they were taught. Doctors defined medicine and its practice in New Zealand. They influenced the beliefs and practises of the people about health and illness and the appropriate methods and places of treatment. With their professionalisation doctors were able successfully to eliminate competition and create a medical monopoly. Medicine became an exclusive and protected profession.

The specialisation of knowledge and doctors' 'scientific' approach to medicine led to the practice of individualised, curative medicine. This concentrated attention on the individual rather than the social and environmental causes of disease.

Hay suggested that with the backing of the New Zealand Medical Association:

> [t]he medical profession had emerged as a potentially powerful element within New Zealand society...In their unity, members of the medical profession had taken considerable control of the nature of competition within their market and had also found a means by which they could alter the nature of demand (Hay, 1989:39).

The dominance of the medical profession was rarely questioned. As Belgrave suggested: "[b]ecause of their training, their professional status and their commitment to science, doctors saw themselves as having the authority to direct and control all others within the health economy" (Belgrave, 1991:8). Belgrave explained doctors maintained their dominant position through political advantage: "[d]octors used their superior political and economic clout to control professions that threatened their position" (op cit, p.9). Other health professionals such as nurses and midwives became subject to medical supervision and direction.

Nurses and Midwives

Nurses and midwives during the early years of colonisation, were mainly married women providing an informal but essential service to people in their own homes (Belgrave, 1991:11). The few women employed in hospitals were employed as domestics. Burgess (1984) suggested that nursing care in hospitals up until the 1880s had been largely carried out by male attendants and some older women previously employed as domestics (p.4).

In the 1880s trained nurses from British hospitals began arriving to work in the country's hospitals. By 1883 Wellington Hospital had set up its own training scheme for nurses and this was soon followed by other large hospitals. In 1901 the Nurses Registration Act was passed giving recognition to nurses as a professional body.

Nurses' hospital training was heavily influenced by the medical profession and oriented towards doctor-directed treatments with the nurses responsible to the patient's doctor rather than the patients themselves. Hospital training emphasised the nurses' subservient relationship and attitudes of discipline and obedience were seen to be important aspects of their training.

Doctors decided what information was appropriate for nurses and they maintained control over nurses' access to scientific knowledge ensuring that nurses' knowledge remained inferior to theirs (Belgrave, 1991:21).

With registration came further opportunities for nurses to extend their boundaries of involvement in the health system. In the following two decades, in addition to hospital care, nurses became involved in occupational health, school health, Maori health, health education, military health, public health, and district nursing.

In 1904 the Midwives Registration Act entered the statute books despite opposition from the medical profession. This Act allowed for those practising as midwives to register, and it provided for the training of midwives. Again the medical profession maintained control over the training of midwives ensuring the dominance of the medical profession. Belgrave maintained that, because of their small numbers:

> [t]rained midwives were prepared to accept subordination to the economic and professional demands of medical practitioners for the sake of their own precarious professional status (Belgrave, 1991:24).

The 1904 Act marked a transition from midwives working as independent practitioners, to them working under the jurisdiction of doctors. As Belgrave suggested medical hegemony prevented midwives from working in competition with doctors. They were now expected to work alongside doctors in a supportive role. The doctors were responsible for the deliveries and the midwives for the ante- and post-natal care of mothers and babies (Belgrave, 1991:23).

Establishing the Department of Health

The concerns of public health, as distinct from personal health, in the nineteenth century were those of conserving and improving the population's health by controlling the environment to prevent the spread of disease. Public health requires a population-based approach rather than the individualised approach of personal health care services. The state became involved in the provision of public health services due to the fear of epidemic disease.

In line with the ideology of individual and family responsibility for health care, and because of the individualised nature of medical care in this country, there was no recognition given in the early years of colonisation to social or environmental causes of disease. There were no laws governing sanitation, street cleaning, drainage or sewage, or the notification of infectious diseases until the threat of smallpox became a reality in 1872.

The Public Health Act of 1872, was prompted by the discovery of isolated cases of smallpox in Wellington and Auckland, and the insanitary conditions developing in Otago due to the rapidly increased population following the discovery of gold there. The Act provided for the setting up

of provincial boards of health, responsible for sanitation in their areas and to which infectious diseases were to be notified (Maclean, 1964:12).

Following the abolition of the provinces, a further Public Health Act was passed in 1876 replacing the provincial boards of health with a central board of health. Except in Otago, neither Act was well administered. According to Maclean the central board of health proved to be:

> a singularly ineffective body...It continued in existence for 24 years, but beyond making occasional decisions on matters of quarantine it met infrequently, and failed to initiate any public health policy (ibid)

The outbreak of Bubonic Plague in Australia, and the threat of it spreading to New Zealand, prompted the Public Health Act 1900. This Act "marks a turning point in the history of public health, as by it the Department of Public Health was set up" (Maclean, 1964:15) The Department was given very extensive and effective powers, giving it control over local authorities. It was to operate under the jurisdiction of a newly appointed Minister of Public Health (Statutes of NZ, 1900:103), (Maclean, 1964:14-15), (Sutch, 1966), (Burgess, 1984).

In 1910 the Public Health Department and the Hospitals Department merged but the Mental Hospitals Department remained separate for another forty years. In 1911 the Maori health services also came under the jurisdiction of the new department.

With the outbreak of the influenza pandemic in 1918 the existing public health provisions proved inadequate (AJHR,1919:Vol H-31,1), (New Zealand Department of Health, 1974:30), (Hay, 1989:59). The Act of 1900 was too restrictive and unclear as to the powers and responsibilities of the various agencies and officers of the Department. The Department was very under-staffed due to officers being in full-time military service and others succumbing to the disease. The

disease spread rapidly, killing 5,471 people in less than two months(Maclean, 1964:387)[36]. Death rates among Maori were seven times greater than among Pakeha (Binney et al, 1993:332). Links were drawn between poverty, dirt and disease and many old buildings were demolished on the orders of the Influenza Epidemic Commission (set up in 1918 following the outbreak of the disease) (Maclean, 1964:22).

Following an inquiry by the Commission a new Public Health Act reforming the administration of public health was passed in 1920. In addition to its mandatory powers, the revamped Health Department[37] assumed advisory and supervisory roles in all areas of health needs not just 'public health' (New Zealand Department of Health, 1974).

In 1920 the new Department of Health assumed responsibility for the newly formed school dental service and the training of dental nurses. In 1921 the School Medical Service also came under the jurisdiction of the Department (Burgess, 1984:12).

The Department of Health remained responsible for the administration and regulation of both personal and public health for the next 73 years. It provided succeeding governments with policy advice and was responsible for the implementation of health policy changes.

Increasing demand for government-funded health care

During the early years of the twentieth century increasing acceptance of hospitals as suitable places for medical treatment, and changing economic and political circumstances, encouraged

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[36] Binney et al (1993:332) suggest there were 8,000 deaths in under 2 months.

[37] The Department was renamed the Department of Health and the Minister of Public Health became the Minister of Health under the Act (Maclean 1964:436).

growing expectations among the people for increased state involvement in the provision of health care.

Even as early as 1912 Valentine, Inspector General of Hospitals, reported:

> There is a tendency on the part of all classes of the community to take advantage of our hospitals, and this tendency is rapidly growing. There is no longer the repugnance, either on account of fear, ignorance, or pride, to enter a public hospital that was so noticeable a decade or so ago. We seldom hear nowadays of 'butchershops' or 'experiments'; nor, on the other hand, do we notice that independence or pride that prevented many a sick person from seeking relief in a public institution through fear of being considered by his neighbours as 'on the rates' (AJHR, 1975:Vol H23,39).

With the outbreak of the first world war in 1914, the Government encouraged enlistment by promising free maternity care and free health care in hospitals to wives and dependants of enlisting servicemen regardless of their ability to pay. The policy was outlined in the Public Health Department's annual report of 1918:

> With a view to assisting the dependants of those at the front it was decided that the Department should afford free maternity treatment at the St. Helen's Maternity Hospitals to the wives of soldiers on active service. The Department also pays the fees charged by the Hospital Boards for treatment in hospital of the wives and children of all men on active service outside New Zealand. Free treatment at the Department's expense is also given to the brothers and sisters, and parents of such men if they are solely dependent upon the soldiers in question (AJHR,1918:Vol H-31,8).

With a disproportionate number of the very young, the old and the ill represented in the remaining population, and fewer doctors in the community to treat them, hospitals became accepted places for free health care. Returning ill and wounded servicemen were likewise eligible for free health care (Hay, 1989:48). The stigma that had been attached to hospitals was

fast disappearing. No longer were hospitals regarded as places of last resort but as places of hope offering effective health care.

By the 1930s several key factors had played an important part in changing the public's perceptions of health care services and the appropriate role for the Government in providing them. Free hospital and maternity care for servicemen and their dependants following the outbreak of the first world war; increased state involvement in health services following the influenza pandemic; the extreme poverty that resulted from the effects of the great Depression leading to the inability of many to afford health care; and the advances in medical technology that had transformed public hospitals. Much of the new technology could only be afforded by, and operated in, large institutions. Hospitals therefore became acceptable places for treatment. As Hay suggested: "[h]ospitals were fast becoming essential, egalitarian, and de-stigmatised" (Hay, 1989:49).

The public believed that more doctors and greater use of high cost, hospital-based technologies would improve health. However due to the high rates of unemployment and the extreme poverty experienced by a large portion of the population as a result of the Depression, individuals were unable to afford to pay for health care or the premiums required to belong to the friendly societies. Pressure was mounting for increased State involvement in the provision of health and welfare services.

By 1930 New Zealand lagged behind the rest of the developed world in providing contributory health and welfare schemes (Hanson, 1980:14), (Hay, 1989:64).

Both the Government and the Labour Party, representing the interests of the working class, were aware that changes to the health system were inevitable (Fraser, 1984:61), (Hay, 1989:63-4). The Government and other interested parties such as the New Zealand Branch of the British Medical Association (BMA) and the Hospital Boards Association favoured compulsory, contributory insurance schemes with those on low incomes being eligible for free health services (Hay, 1989:82). The Labour Party supported a universal, comprehensive, non-contributory policy (Hanson, 1980:35). The 1935 general election was contested on this and other aspects of welfare.

Labour had been advocating free medical care and the nationalisation of medical services since 1916 (J. Campbell cited in Hanson, 1980:32). By 1926 this had expanded to include other aspects of the health services and by 1935 Labour's election policy promised universal, free health care.

The health service was to be as free and universal as education, and Labour claimed that the Government should take responsibility for ensuring it was available to every citizen. Prevention rather than cure was to be the emphasis of the new health system.

In the 1935 general election Labour received the mandate of the people with an overwhelming majority. Decades of growing expectations that the state should provide health care as a right of citizenship contributed to the election of the first Labour Government in 1935.

The 1938 Social Security Act

The 1938 Social Security Act culminated the shift from the nineteenth century attitude of individual responsibility for health and welfare, to an expectation that the Government should take responsibility for ensuring adequate provision of health and welfare services.

In July 1936 the newly elected Labour Government set up a parliamentary committee, the National Health Insurance Investigation Committee, chaired by Dr D G McMillan, a medical doctor turned politician, to investigate the provision of medical and other treatment services (Hay, 1989:96). The recommendations of the committee formed the basis of the health policy contained in the 1938 Social Security Act (op cit, p.103).

The Social Security Act embodying the first Labour Government's health and welfare policies entered the statute books in August 1938, to come into force on 1 April 1939. The general election in September 1938 confirmed for Labour that they had the mandate of the people to proceed with their policies. The proposed Social Security Act was a major aspect of their election manifesto and they were returned to power with an even greater majority than in 1935 (Hay, 1989:111-2).

The benefits of the Social Security Act were to be financed from general revenue and a social security tax of one shilling in the pound (five cents in the dollar). It was the intention that citizens should "contribute according to their means and receive benefits according to their needs" (Caucus Committee on Health and Superannuation cited in Hanson, 1980:78).

The Government recognised the value of a healthy people for the country as a whole. According to McMillan:

> Health has great value, and it is sound economy that considerable sums should be spent for its preservation (NZPD,1938:Vol 255,90).

McMillan recognised too that many people, especially Maori, were receiving virtually no health care at all, particularly dental care.

In its recognition of the link between poverty and ill-health, Labour increased employment opportunities, legislated for improved standards and state-provided housing, provided free milk and apples to all school and kindergarten children (Sutch, 1966:186), and established permanent health camps for deprived and sickly children.

In the years immediately following the passage of the Social Security Act the Government implemented free hospital and outpatient services, pharmaceuticals, x-rays, physiotherapy, district nursing services, domestic assistance, laboratory diagnostic services, artificial limbs, hearing aids, and contact lenses, and for children under sixteen dental benefits (Hanson, 1980:125), (Hay, 1989:129). With the continuing growth and expansion of the health services, more and more use was being made of services that had hitherto been beyond the reach of many (AJHR,1947:Vol H-31,29). Costs to the succeeding governments for the provision of these free health services soared[38].

The Government intended a capitation scheme for general practitioner provided primary health care, encouraging doctors to practise preventive health care as well as curative health care, but the medical profession refused to co-operate with the Government.

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[38] For details on the extra costs see AJHR1944:Vol H-31,6-8; 1945:Vol H-31,10; 1946:Vol H-31,22-3; 1948:Vol H-31,36-7.

The power and influence of the medical profession prevented the Government from realising its intentions of providing comprehensive, universal, free health care.

The doctors' dissent

The New Zealand branch of the British Medical Association (BMA) led by the formidable Dr Jamieson, was totally opposed to a universal scheme (Hay, 1989:86,106). Members believed a universal scheme would mean state control and would seriously and unnecessarily interfere with private enterprise medicine (op cit, p.94). They argued that a free, universal scheme would contravene principles "fundamental to the practice of medicine" (op cit, p.107)

According to Burdon (1965):

> the doctors submitted a statement condemning the Government's scheme as being unwarranted, misdirected, unsound in method, of no advantage over the existing system of treating disease, discouraging to individual initiative, contrary to principles of liberty, and likely to have an adverse effect on the standard of medical work (cited in Hay, 1989:109-10).

The BMA proposed instead a four-tier scheme whereby patients would be means-tested and the state would only be responsible for the poorest. They argued that the doctor-patient relationship would be threatened by a universal scheme and that would lead to a deterioration in the quality of practice (Sutch, 1966:245), (Hay, 1989:101).

On 13 August 1938, the day following the presentation of the Social Security Bill to Parliament, the BMA confirmed in a letter to Minister of Health, Peter Fraser, that it would not co-operate with the Government (Hay, 1989:111).

The Government needed the cooperation of the medical profession to implement its policy. The power and influence of the profession prevented the Government from realising its health policy objectives.

Eventually in 1941, after much wrangling[39], and despite various threats by the Government, the strength of the medical profession prevailed and the Government was forced to capitulate on the critical issue of general practitioners continuing a private financial arrangement with patients. The 1941 Social Security Amendment Act provided doctors with a general medical benefit and as well allowed doctors to charge their patients a fee for service.

The market character of medicine was confirmed and curative rather than preventive medicine firmly re-established, continuing the serious flaws with access which the 1938 legislation was designed to resolve.

By reifying the doctor-patient relationship and claiming that it requires a direct financial exchange between the two parties to protect its special nature, Jamieson as leader of the BMA, was able to prevent the Government from realising its policy objectives. The Government's capitulation marked a true victory to the power and influence of the medical profession. Although Government-subsidised medical care was universally available, the doctors had succeeded in retaining their position as private enterprise practitioners, controlling the ways that medical care was to be provided. By subsidising general practitioner care, the State enhanced the ability of the public to avail themselves of medical care and at the same time preserved "the private, profit-making production of that care" (Hay, 1989:122).

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[39] For a detailed account of the debate between the BMA and the Government see Lovell-Smith (1966), Hanson (1980), Hay (1989).

With the passing of the 1941 Social Security Amendment Act open-ended, demand-driven, state-subsidised primary care was established.

Private hospitals and private health insurance

Private hospitals had long been an important part of the health system. They provided choice for those who could afford to pay the fees and an opportunity for doctors to provide secondary care outside the public system. According to Hay it had not been the intention of the first Labour Government to dismantle private hospitals (Hay, 1989:132-3).

The dual private-public hospital system continued despite the 1938 Social Security Act providing for free health care in the public hospitals. The Act entitled private hospitals to the same Government subsidy as the public hospitals, 6 shillings (60 cents) per patient per day, irrespective of the treatment received (op cit, p.133).

Following its election in 1949, the National Government sought to displace the costs of health provision to the public sector by bolstering the private sector. It supported the development of the private system in the belief that private organisations could provide beds required by the community at less cost to the taxpayer than could the State. A requirement of the 1957 Hospitals Act was for the Minister of Health to provide "private sector encouragement" (op cit, p.126). By 1984 licensed private hospitals provided approximately 20 per cent of total hospital beds (Fraser, 1984:63).

A further factor encouraging the development of private hospitals was the development and growth of private health insurance.

In 1961 a group of surgeons formed the Southern Cross Medical Care Society. The introduction of medical insurance spread the cost of private health care across all those insured. Along with surgeons being assured of patients able to pay their bills, those who could afford the annual premiums were able to enjoy the benefits of private hospitals and specialists of their choice. In addition they were reimbursed eighty per cent of the costs of these and general practitioner charges. Membership grew rapidly from 1,000 members in 1964 to 700,000 in 1981 (Ward and Asher, 1984:99). The National Government encouraged the development of medical insurance in 1967 by making the annual premiums tax-deductable.

The use of private hospitals by the insured was further encouraged when public hospitals began rationing services by developing waiting lists for non-urgent surgery. Fougere (1984) described it as "a class biased redistribution of waiting times"(p.82). Those able to afford the health insurance premiums have been able to exit the public hospital system and receive their care from surgeons and physicians of their choice in private hospitals. Those too poor, too sick, or too old are unable to enjoy the benefits of private health insurance. They have no option but to endure the long waits for appointments and surgery in public hospitals.

Private hospitals and private insurance have relieved pressure on the public system by providing the insured with alternative, immediately available, health services. Fougere suggested this is indicated by the "relative underprovision of public services" in those medical specialties and regions where private provision is available (ibid).

The 1972 Accident Compensation Act

In the early 1970s concern over inadequate compensation for workers led to a more far-reaching social insurance scheme covering all New Zealanders for accidental injury. This scheme

served to strengthen the private provision of health care by making funds available for the increased demand that eventuated.

In 1972 the Accident Compensation Act entered the statute books following the report of the Royal Commission for Personal Injury. Originally the Act covered workers' injuries only but after a change of Government the Act was amended to provide universal entitlement to all New Zealanders and visitors to New Zealand (Duncan, 1993:14).

In addition to monetary compensation, the Act granted free medical and hospital, often private hospital, care to victims of accidents. The Act was funded by contributions from employers, the self-employed, and motor registration as well as government. Implementation of the Act had the effect of giving accident-related injury and illness preference over non-accident disease and illness. Accident victims could receive free medical care from either public or private health care providers (Hanson, 1980:139-41), (Hay, 1989:175-7).

Some doctors again expressed their concerns that the Act pointed the way to nationalisation of the medical profession. They disagreed with the universality of the Act and with patients not bearing some direct costs for their treatments. This they claimed could endanger the traditional doctor-patient relationship. However, in comparison with the doctors' reaction to the 1938 Social Security Act, their reaction to the 1972 ACC Act was minimal. This was due to a notable difference between the two Acts. Under the Social Security Act the original proposal was for government to determine the fee that doctors would be paid, whereas under the ACC Act doctors were to determine the fee. The fees were expected to be "reasonable" (Hay, 1989:177).

Market related medical care was strengthened by the Act as it encouraged people with accident-related injuries to take advantage of the free health care services and consequently increased numbers of doctor visits per year. Hanson suggested that by giving accident victims 80% of their pre-accident income "the Act enhanced the capacity of the public to consume, and therefore contributed to the preservation of existing social arrangements for goods and services production" (Hanson, 1980:179). At the same time the Act provided for communal responsibility for accident costs[40].

The third Labour Government's attempts to restructure the health system

In the early 1970s, increasing demands for health care coupled with deterioration in the country's economic performance reduced the availability of government funds, bringing pressures on the health system. Waiting lists were growing and patients requiring GP services were required to absorb more and more of the costs.

At its instigation in 1941, the General Medical Services Benefit (GMS) represented at least three quarters and often all of the standard fee. But the GMS remained unchanged until 1972 and through inflation slowly decreased as a proportion of the standard fee. In 1972 the GMS was increased to about one half of the general practitioner's charge to the patient (Ward and Asher, 1984:98), (Hay, 1989:160).

In 1974 the newly elected Labour Government, concerned that health services were becoming inaccessible for many people, especially beneficiaries and those on low incomes, produced a

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[40] April 1992 marked the first major changes to the Act. The Amendment to the ACC Act included a shift in funding from employers to employees and a loss of lump sum payments for "no fault" compensation. It signified a move away from communal responsibility for all accident victims.The generous social insurance scheme introduced 20 years earlier proved unacceptable (the Government argued unsustainable) for a government attempting to limit its liability for health and welfare spending. The 1992 amendment resulted in a diminished compensatory scheme significantly disadvantaging those sustaining serious disabilities from accidental injury.

white paper, A Health Service for New Zealand, outlining the Government's intentions to restructure the health system. The underlying principle of the restructuring was that health should be a right for all and not depend on an individual's economic circumstances (New Zealand Department of Health, 1974), (Hay, 1989:170). The paper marked a return to the first Labour Government's philosophy of health care being the right of all New Zealanders, a social service rather than a marketable product (New Zealand Department of Health, 1974:84).

Emphasis in the paper was on community responsibility for health care and preventative health care services. Included in the recommendations was the replacing of the fee-for-service system of payment for general practitioners with a contractual arrangement between doctors and the proposed 14 Regional Health Authorities. The Regional Health Authorities were to replace the hospital boards and be responsible for the co-ordination of all health services in their regions (Ward and Asher, 1984:98)

The paper was resisted strongly by doctors and others, especially private health care providers, who were benefitting from the existing system. The recommendations were finally rejected[41] along with the Labour Government in the 1975 general election, (Ward and Asher, 1984:98), (Hay, 1989:171).

As in 1938 the power and influence of the medical profession, this time supported by other private enterprise providers, proved to be a formidable force in its campaign against the Government's intentions of providing a universal, attainable and equitable health service.

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[41] Rejected but not completely forgotten as can be seen with the introduction of 14 area health boards in the 1983 Area Health Boards Act, and Upton using the idea of regional health authorities in his 1991 health policy.

The return of National

Growing concern and debate on issues related to the health system prompted the incoming National Government to set up in 1976 the Special Advisory Committee on Health Services Organisation (SACHSO). This was followed in December 1979 by an Advisory Committee on Hospital Board Funding (Fraser, 1984:64).

The SACHSO recommendations became the basis of the 1983 Area Health Boards Act replacing the 27 formally autonomous, elected Hospital Boards established by the Hospitals and Charitable Institutions Act 1885, with 14 Area Health Boards. Under the terms of the 1983 Act, the elected Area Health Boards were to become responsible for the overall planning and coordination of personal and public health services in their areas, displacing the district offices of the Department of Health (Ward and Asher, 1984:98-9), (Hay, 1989:171). There were marked similarities between the structures of the Area Health Boards and their responsibilities and those of the third Labour Government's Regional Health Authorities.

The Advisory Committee on Hospital Board Funding, after reviewing the current system of financing public hospitals, recommended funding should be made on the basis of a population based formula. This formula calculates funding on the basis of age, sex, mortality and fertility ratios, and takes into account factors such as patient flow between boards and into the private sector, and the costs involved in teaching medical and nursing students, and running long term care institutions for the intellectually handicapped (Ward and Asher, 1984:99), (Hay, 1989:171-3). Population-based funding marked a major turning point in New Zealand health policy. It effectively capped hospital budgets signalling an end to the open-ended funding which had been in existence since the 1938 Social Security Act (Blank, 1994:124).

The new funding formula became effective from 1 April 1983 (Hay, 1989:172) but National did not have the opportunity to implement the Area Health Boards Act as it was defeated in the general elections of 1984. Helen Clark, the third Minister of Health for the fourth Labour Government oversaw the formation of the 14 Area Health Boards by 1989.

The fourth Labour Government

As mentioned in Chapter one the election of the fourth Labour Government in July 1984 set in motion a "remarkable wave" of public sector reform reflecting an ideological shift to the right (Boston, 1991:1).

Roger Douglas, Minister of Finance for the fourth Labour Government, was a free market enthusiast. He believed that the country could no longer afford to, and should not attempt to protect people from poverty and alienation but should encourage people to look after themselves by investing in private enterprise schemes. Under Douglas's influence the country was plunged into social and economic restructuring according to free market principles[42].

Three different Ministers of Health were appointed during Labour's two term period in office. Each of the three Ministers instigated enquiries with a view to reforming the health care system. In 1986, under Minister of Health Michael Bassett, Claudia Scott chaired the Health Benefits Review committee producing a report Choices for Health Care in December 1986. The committee was concerned mainly with primary health care. The terms of reference required the committee to

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[42] See Easton's The Making of Rogernomics (1989) for a detailed discussion of the restructuring.

> recommend how the health benefits system might contribute as effectively as possible to the Government's broad social and economic goals of equity and efficiency (Health Benefits Review Committee, 1986:2).

The committee recommended a funder-provider split in the health system. It set out various options for the role of the state in health provision but recommended that the state remain as dominant funder and that competition be introduced among providers of health care in the public, private and voluntary sectors.

Following this report Bassett appointed Alan Gibbs[43] to lead a committee enquiring into Health services. Unshackling the Hospitals, also known as the 'Gibbs' Report'[44], further promoted the idea of a funder-provider split in the provision of health services and competition between providers. The Report recommended that regional health authorities be established as purchasers, Area Health Boards be retained as providers of health care, and modified competition be introduced between hospitals.

After much deliberation David Caygill, appointed Minister of Health after the general election in 1987, published Labour's proposals for reforming the health services Health: A Prescription for Change. The most significant aspect of the changes was that Area Health Boards were to become responsible for the provision and funding of primary care. The changes were to take place following the local body elections in 1989 (Martin,1991:280).

Before Caygill's proposals could be implemented he was replaced as Minister of Health in January 1989 by Helen Clark who published her proposals for the health service in December

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[43] Auckland businessman and member of the New Zealand Business Roundtable.

[44] See Hospital and Related Services Taskforce, Unshackling the Hospitals (1988).

1989, A New Relationship: Introducing the New Interface Between the Government and the Public Health Sector.

Clark's proposals, focussing on the relationship between the Area Health Boards and central government, were implemented. In line with the 1988 State Sector Act and the 1989 Public Finance Act[45], chairpersons of the boards were to negotiate contracts with the Minister of Health and were thus to become "accountable" to the Minister for the boards' outputs. Also in line with the State Sector Act, Clark introduced private sector management practices into the Area Health Boards to improve the "efficiency, effectiveness and public accountabiliy" of boards (Martin,1991:281-282).

In addition Clark defined health goals and targets for the next ten years which were "designed to improve the health status of New Zealanders by focusing on the broader determinants of health such as alcohol and tobacco consumption, and motor vehicle accidents" (Bowie and Shirley, 1994:302).

In September 1990 Clark offered GPs the opportunity of entering into contracts with the Government for the provision of primary health services. In return for increased GMS benefits and a higher practice nurse subsidy the GPs would have to agree to keep within an agreed scale of patient charges. Only 5% of GPs representing 5.9% of the population took up the contract scheme. They were from low income urban areas and rural areas (Matheson and Hoskins, 1992:35-6). The scheme was resisted by the majority of GPs on the grounds that "it limited the freedom of GPs to charge for their services" (Bowie and Shirley, 1994:303). The scheme was formally abolished by the National Government in March 1991.

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[45] See Boston, J et al Reshaping the State (1991) for a discussion of these Acts and their implications for New Zealand's Public Sector.

According to Treasury (1990) benefits from the Labour Government's initiatives were beginning to emerge.

> Boards were beginning to operate in a more disciplined, business-like manner and some evidence was produced to suggest that, collectively, these inititiatives reaped benefits...throughput of surgical patients in public hospitals increased by 10 per cent between 1987 and 1990, while the average length of stay in hospital fell significantly (cited in Bowie and Shirley, 1994:303)

Despite these obvious gains in efficiency and effectiveness that were beginning to emerge, the reformed health system of the late 1980s was not given the time needed for a true evaluation of its viability.

Following the December 1990 general election and despite its promises to the contrary, the incoming National Government released its intentions to reverse "without public consultation, the way in which New Zealand's public health system had been organised for decades" (op cit, p.318).

The 1990 National Government

Between 1938 and 1990 both Labour and National Governments supported the essential principles of the 1938 Social Security Act and its 1941 Amendment. Both supported free hospital and related services and government-subsidised primary care. All attempts by both parties to reform the system in the 1970s and 1980s included retaining a predominantly government funded health system. This bipartisan agreement seemed about to continue into the 1990s for, in their 1990 Election Manifesto, National claimed as did Labour, that they would

retain Area Health Boards. National stated Area Health Boards would be expected to effectively represent both taxpayers and consumers (National Party, 1990:8).

However in July 1991 only seven months after their election victory, the National Government's Minister of Health Simon Upton, released his Government's health policy setting out the Government's intentions to fundamentally restructure the health system.

By 1990 New Zealand's health care system, strongly influenced by the local-central relationship governing hospitals, the power and influence of the medical profession, and the increasing expectations that government subsidised health care services should be available as of right, contained many structural anomalies. There was no central planning for health service provision. Area Health Boards continued to provide services themselves rather than purchase them from other providers where it would have been more efficient to do so. Large amounts of capital were caught up in non-health related investments and Area Health Boards had conflicting roles. They were both answerable to their communities who had elected them, and to the Government for the fulfillment of the terms of their contracts within the margins of a capped budget. The system was fragmented between primary and secondary care, accident related and non-accident related care, and continuing care and acute care.

In their attempt to grapple with these problems, the fourth Labour Government introduced changes to increase the efficiency and effectiveness of the Area Health Boards. The National Government however, was not prepared to allow time to see if the changes would have the desired effect. Instead it claimed the system was unsustainable and structurally flawed, and designed a policy that would completely restructure the health system.

Chapter 5

THE POLICY AND THE IMPLEMENTATION STRATEGY

Introduction

The National Government's statement of health policy Your Health and the Public Health, was released on 1 July 1991 as part of the Government's 1991 annual budget.

During its implementation the substantive content of the policy underwent change. In this chapter I discuss the nature of the 1991 policy, the factors influencing the policy decisions, and the strategy the Government intended to follow for its implementation. Following chapters will describe and analyse the changes that have taken place during the implementation process.

National aimed to limit its financial responsibility for health care whilst still retaining a publicly funded system which would guarantee affordable access "to an acceptable level of health care" (Upton, 1991:1). As mentioned in Chapter 1 this was to be achieved by establishing a competitive market within the health environment and by targeting government assistance only to those on low incomes and to high users of health services. What was not stated clearly was that universal free secondary health services and subsidised primary health services, established with the introduction of the 1938 Social Security Act, would no longer be the right of every New Zealand citizen. Middle and high income earners would have to pay a higher proportion of their health care costs.

The Government believed introducing competition between both purchasers and providers of health services would result in a more efficient and effective health system thus controlling overall health spending. This would require a radical restructuring of the existing health system.

The justification for the Government's plans to radically restructure the health system and shift financial responsibility onto individuals and families, was that its health spending had increased between 1980 and 1991 by 27 per cent more than the increase in consumer prices over that period (op cit, pp.7-8). According to Bowie (1992:458), Bowie and Shirley (1994:311), and Easton (1994:221), these figures are fallacious. Easton argued:

> [t]he mistake arose in a Treasury paper which deflated the nominal spending with the wrong price index, failed to compare apples with apples, and then used a judicious choice of period to maximise the size of the error (ibid).

Likewise Bowie and Shirley argued that Upton's claim of such a substantial increase in health expenditure "is patently incorrect" (1994:311).

> First, the two amounts $1.1 billion and $3.8 billion [the figures used to determine the increase] are not comparable since in the latter period the Department had to pay a number of new levies including superannuation contribution, fringe benefit tax, rent on premises, and GST. Second, no allowance appears to have been made for either the population increase or population ageing that took place over that period. Third, the consumer price index adjustment is arithmetically incorrect; it is unclear how the 27 per cent was derived. Further the consumer price index is an invalid measure of the prices which the Department of Health experienced. Health providers, such as hospitals, do not have the same spending pattern as households. A producer price index would have been a more appropriate deflator (ibid).

They suggested further that health expenditure (in real terms) "may have even dropped over the period if measured on a per capita basis" (ibid). According to McKendry and

Muthumala (1993:22) the Government reduced its share of total health spending from 88 per cent in 1980 to 78.9 per cent in 1992[46]. This amounted to 7.3 per cent of its GDP compared with an average of 7.6 per cent for OECD countries.

Financial calculations, or miscalculations, aside the policy is a response to what the Government perceived to be a "structurally flawed" system, existing "[a]gainst a background of continuing fiscal crisis" (op cit, p.8). The problems within the system perceived by the Government were listed as: deterioration of hospital buildings; ageing equipment; too long waiting lists; fragmentation of funding; problems of access to services especially for those on low incomes; conflict in the roles of Area Health Boards; politicisation of the decision-making process - the ability of interest groups and public campaigns to resist change; too much money tied up in staffing and running large institutions; and public health strategies which frequently fell victim to Area Health Board cost-saving drives (Upton, 1991:8-9).

According to health economist Toni Ashton (1993) the Government's response to the problems:

> is based upon an ideological commitment to competitive markets rather [than] upon any clear empirical evidence that the changes will achieve greater value for money, thereby improving the health status of New Zealanders (Ashton, 1993(a):62).

Ashton suggested the ideology underpinning the policy includes: "a general belief in the superiority of markets over governments, of competition over cooperation, and of self-

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[46] The 12% and 21.1% respective differences were financed by individuals and private insurance.

reliance over community responsibility" (op cit, p.59). The values and attitudes and the approach of the Government represents a commitment to monetarist ideology.

The policy strongly reflects the Treasury advice to the Government following its election in December 1990. Except for the separation of personal health and population based public health, and an explicit definition of a core of services to which everyone was to be entitled, all the other policy initiatives were advocated by Treasury[47].

This influence was reflected in the Terms of Reference for the Health Services Taskforce set up by Upton to advise the Government on a New Zealand solution to the problems it perceived in the health system.

The Taskforce

Following its success in the 1991 general election, National set up the Ministerial Committee on the Funding and Provision of Health Services, otherwise known as the Health Services Taskforce.

The Taskforce was composed of five members, two businessmen and three medical professionals (none then currently practising medicine), and chaired by Roderick Carr, Chief Manager, Retail Finance Services, and General Manager of BNZ Life Insurance Ltd (Upton, 1991:141-2).

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[47] See Treasury's Briefing to the Incoming Government 1990 pp.118-128.

The Taskforce was required to "analyse all the reports and research already done on health sector problems and solutions" and "to advise the Government on how to achieve a New Zealand solution" (op cit, p.10). It was to work alongside the Change Team on Targeting Social Assistance and the Ministerial Working Party reviewing the Accident Compensation Corporation and was answerable to the Minister of Health (op cit, p.139).

The Terms of Reference for the Taskforce reflected Treasury's recommendations to the Government. While Taskforce members clearly accepted the Government's ideological position, the Terms of Reference were so circumscribed they had little freedom in which to manoeuvre. The direction in which the Government intended to move was clearly defined in the Terms of Reference. It included objectives of:

- targeting services to those least able to make provision for themselves;
- providing choices between purchasers and providers of services;
- establishing competition between purchasers and providers of services;
- fostering individual responsibility for health; and
- ensuring that public health services are used to limit the Government's financial exposure as principal funder of health services (op cit, pp.137-138).

As Ashton suggested, within the Terms of Reference "[t]here was an implicit acceptance of the ability of competition to improve efficiency, and of the general applicability of competitive market theories to the funding and provision of health services" (1992(b):152).

The Taskforce presented various briefings and papers to the Government but did not make a final report. Its recommendations formed the basis of the Government's 1991 health

policy, released as part of the Government's annual budget. In Upton's words: "[t]he Government considered its [the Taskforce's] advice and recommendations before identifying key issues and formulating its own strategy" (op cit, p.10). The Green and White Paper, he claimed, "outlines the Government's diagnosis of the system and its strategy for the future delivery of health care in New Zealand" (ibid).

Cabinet Papers obtained under the Official Information Act reveal the Taskforce's recommendations mirrored those of Treasury but included the separation of personal and public health services, and the inclusion of a specific core. The Taskforce also recommended to Government a staged process of change rather than the radical restructuring with immediate implementation, preferred by the Government[48].

By not producing a final report which could be available for public discussion, the Taskforce confirmed the public's and health professionals' concerns that its work was not consultative but a private matter between itself and the Government. Members of the Taskforce were obviously aware of these accusations. Following the demise of the Taskforce, Carr suggested: "[d]uring the six months the task force worked, there were many accusations that the whole process was being conducted behind closed doors without consultation" (Carr, 1991:39).

The substantive content of the policy

While the stated primary objective of the policy was "to secure, for everyone, access to an acceptable level of health care" (Upton, 1991:1), the emphasis in the policy was on

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[48] See Cabinet Papers (91) 81, 18 June 1991, and Cabinet Paper (91) M24/6, June 1991.

increasing efficiency and containing costs. Upton and the National Government were ideologically committed to introducing market principles into the health environment, believing a more efficient and effective system would result. According to Upton these principles could not be satisfactorily introduced into the existing "structurally flawed" (op cit, p.9) health system, a system which was "centralised, rigid and unresponsive to change" (op cit, p.19).

The resulting policy outlining the necessary changes to establish a more "flexible system" (ibid), can be summarised as follows:

- separating the roles of purchaser and provider of health care services and creating a market situation by introducing competition between both purchasers and providers.
- establishing four Regional Health Authorities (RHAs) as purchasers of health services.
- Health Care Plans (HCPs) being established to provide an alternative approach to health care delivery from that offered by the Regional Health Authorities.
- disestablishing the 14 Area Health Boards.
- establishing larger public hospitals on more business-like lines as Crown Health Enterprises (CHEs).
- appointing a Minister of Crown Health Enterprises to represent the Crown's interest as the owner of public hospitals and associated services.
- smaller hospitals being taken over by their communities and established as community trusts.
- Government explicitly defining the core health services that RHAs and HCPs must make available to every New Zealander.

- integrating the funding and purchasing of primary and secondary health services and accident and sickness-related services.
- introducing hospital part-charges for both in-patient and out-patient services.
- targeting services to low-income people and high users of health care services.
- funding, purchasing and provision of public health services being separated out from personal health services by establishing a separate public health structure.(op cit, pp.3-5).

In August 1992 disability support services were added to the brief for the restructuring but as mentioned previously they will not be dealt with in this thesis.

The policy is based on certain basic principles, and these will be treated individually. They comprise the purchaser-provider split; introducing competition at both the purchaser and provider levels; integrating primary and secondary care; integrating accident and sickness-related care; defining an explicit core of services to which everyone will be entitled; separating personal and public health services; and targeting Government assistance to those on low incomes.

The purchaser-provider split

The purchaser-provider split is the fundamental element of the policy. It separates the roles of purchaser and provider, and provides the framework for establishing competition at both of these levels. However it goes further than Upton claims. It is in reality a funder purchaser provider division with a new element, the purchaser, being placed between the previously existing funder (Government) and providers. It breaks the linkage between

Government and health care providers by putting the purchasers - RHAs, PHC and HCPs - in between.

The Government is the funder of the health services. It collects taxes from tax-payers and apportions a capped sum to vote health. The RHAs and the Public Health Commission (PHC), as the Government's agents, were to be the purchasers of health services. They would be responsible for ensuring that all their clients have affordable access to core services. They would purchase these from the providers, the CHEs, community trusts, doctors, midwives, physiotherapists, etc. Alternative HCPs could both purchase and provide health care services.

In separating the purchaser and provider roles, the Government accepted the recommendations of both the Health Benefits Review and the Gibbs Report[49] but goes further by introducing competition between purchasers, and targeted assistance (Scott, 1993:18). Also, instead of retaining Area Health Boards as Treasury, The Health Benefits Review Committee and Gibbs intended, National's policy required their disestablishment and the creation of the new agencies, the RHAs, the PHC and the CHEs.

According to Upton the purchaser and provider roles within Area Health Boards were conflicting roles. He suggested they "hamper the quest for better value for money in the health system, and make it impossible to reward the most effective health care providers" (Upton, 1991:21), because Area Health Boards would inevitably provide services themselves rather than contract out to other more efficient providers (ibid). He suggested this conflict between the roles made it difficult for the boards "to carry out either role

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[49] See Health Benefits Review Committee Choices for Health Care (1986) Chapter 8, and Report of the Hospital and Related Services Taskforce Unshackling the Hospitals (1988) Chapter 5.

effectively. This leads to other problems which are more visible to the public, such as long waiting times for hospital care and lack of responsiveness to individuals' needs" (op cit, p.23).

When discussing the purchaser-provider split in early policy-related speeches and press releases, Upton tended to conflate the terms 'purchaser-provider split' and 'funder-provider split' implying that the interests of the funder and the purchasers are identical[50]. In the policy itself he clearly refers to the 'purchaser-provider split' and discusses the different roles of purchasers and providers (Upton, 1991:21), but in his policy-related speeches and press releases he uses the terms funder and purchaser interchangeably.

In his speeches Upton reflected different motivations for the split depending on who he was addressing. In a speech to the Wellington Clinical School, 7 August 1991, Upton claimed the split was motivated by "the desire to integrate primary and secondary care, and the need to bring practitioners along with that decision". GPs, he maintained, "would not willingly come under the area health board umbrella because of concerns that they are hospital dominated" (ibid). He claimed that GPs would more readily enter into contracts with RHAs (despite them being agents of the Government) (ibid).

In the same address he explained "[f]under/provider separation has become standard fare in the public sector [and] is very much in line with how the Government now operates under the [1989] Public Finance Act" (ibid). He explained this further in his President's Lecture to the Christchurch School of Medicine, 11 September 1991: "[t]he Public Finance Act

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[50] The different interests of the funder and the purchasers will be dealt with in the following section on the RHAs.

requires a radical rethink of the way government does business. No longer is the focus on inputs. The concern is now with outputs and prices for those outputs".

Applying the logic of the Public Finance Act to the health sector the Government becomes responsible for funding access to services. The RHAs and the PHC, as the Government's purchasing agents, "will ensure provision of those services" and the providers "will decide how services are to be delivered" (ibid). The Minister of Health "will have no hand at all in dictating exactly how these outputs are to be produced" (Upton, Glen Garlick Oration, Melbourne, 18 June 1992).

Because the premise of the Public Finance Act is that there is potential conflict between the roles of funder and provider, different ministers of the crown were to be responsible for the different roles. The Minister of Health would be responsible for funding access to health services and a newly appointed Minister of Crown Health Enterprises would be responsible for the ownership role of the public providers of secondary health services, the CHEs (ibid).

Upton claimed that the separation of the purchaser and provider roles would enable competition to take place both between purchasers of health care services and providers of health care services. The two levels of competition, he contended would increase efficiency and therefore lead to controlled costs in the health system.

The separation of the funder, purchaser and provider roles also allows the Government to "step back from day-to-day health management decisions" (op cit, p.9). In line with the 1989 Public Finance Act, these become the responsibilities of the purchasers and providers.

Separating the roles of the purchasers and providers is described by Bowie and Shirley (1994:312) as the "linchpin" of the policy. The split, they maintained, was intended to "stimulate a more competitive environment" (op cit, p.313) at the purchaser level and induce "enhanced accountability in the monitoring of resource flows" (ibid). It was also intended to "facilitate the co-ordination of primary and secondary care" (ibid).

Howden-Chapman and Ashton (1994) suggested the rationale for the purchaser-provider split "is based on the potential gains from specialisation of these roles...[t]he assumption is that the increased explicitness of this process will lead not only to greater accountability but also to more flexibility and consumer responsiveness" (p.71). Purchasers will be able to concentrate on obtaining "the most appropriate quality care at the best price" (ibid) while providers can concentrate on increasing the efficiency and quality of their services so as to gain an increased market share of contracts.

However Borren and Maynard (1993) suggest the purchaser-provider split will lead to:

> increases in the cost of management and administration. Previously non-existent purchasing authorities are to be established. A considerable increase in the cost of middle management and management systems within public hospitals will need to take place, as hospitals attempt to improve efficiency and estimate average cost of procedures (p.24).

The Government argued that expected efficiency gains from the effects of the purchaser-provider split would offset the costs of setting up a new tier of bureaucracy and the transaction costs involved in contracting for services. Transaction costs include: the ongoing costs of designing, negotiating, and enforcing contracts (op cit, p.75). But as Bowie and Shirley suggest "the degree of competition is likely to remain limited for many

services, given the size and dispersion of New Zealand's population and the problems associated in achieving economies of scale" (Bowie and Shirley, 1994:313).

Mooney and Salmond (1994) also expressed their concern about the high transaction costs involved in operating the purchaser-provider split. Their other concern was for the issues of "consultation, partnership and altruism" (p.181) which they claim are excluded from the approach. "The purchaser/provider split", they claimed "is ideologically driven and does not appear to reflect the underlying values of New Zealand society" (ibid).

Regional Health Authorities

According to Upton the RHAs were to be the "spearhead" of the reforms (Upton, speech to the RHA Seminar, Auckland, 28 May 1992). They would be required to purchase core health services, as determined by the Government, for all the people in their region keeping in mind the Crown's objectives. The Crown's objectives were to be set out in the annual Policy Guidelines for Regional Health Authorities. The RHAs would also be subcontracted by the Public Health Commision to purchase some public health services on its behalf (Minister of Health, 1992a:2).

Four RHAs were to be established as independent crown agencies. They would be overseen by a board of directors appointed by the Minister of Health. Under the terms of the policy RHAs would be responsible for monitoring the need for health services in their communities, and for purchasing primary, secondary and accident-related personal health care services for their members.

The Government, as dominant funder of health care services, would provide each RHA with a population-based share of the health budget. The RHAs would also receive funding from the PHC for the public health services for which they contract, and funding from the Accident Compensation Corporation to fund accident related health care (op cit, pp.56-57).

To ensure that purchasers would be responsible for "managing total health care services for the people in their regions" (Upton, 1991:42), RHAs were to offer their clients supplementary or gap insurance. This would cover services not included in the core, and the refunding of user part-charges. While recognising the risk that gap insurance posed for the Government "it will undercut the discipline imposed on people's choices by part charges[51] " (Upton's speech to the Wellington Clinical School, 7 August 1991), Upton preferred that such insurance be available from the RHAs rather than from multiple funders by which he meant insurance companies (ibid).

The RHAs would have dual roles. Upton claimed at different times to different audiences that RHAs would be both agents of the Government and agents of the people.

In a speech to the Healthcare Reform Conference, 13 September 1991, Upton stated that the RHAs would be the Government's purchasing agents, and in the Green and White Paper (p.63) he referred to RHAs as Government agencies. In contrast, in an address to Area Health Board Commissioners, 30 January 1992, he claimed that RHAs "will be the champions of the people...No one else. They will have no conflicting loyalties". He reaffirmed this in an address to the RHA Seminar, 28 May 1992. "New Zealanders will grow to recognise the importance of the RHAs as their agent in the health system". Again

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[51] See the later section in this chapter on user part-charges and Upton's belief that they would influence health professionals' and users' decision-making.

in his Glen Garlick Oration, 18 June 1992, he stated that the RHAs would be "[a]n agent entirely on the side of the individual user".

For Upton there was no conflict of interest in these dual roles. He maintained for RHAs there would not be "the conflict of interest that dogged area health boards - because of their dual roles" (Address to the Healthcare Reform Conference Auckland, 13 September 1991). The conflicting dual roles of Area Health Boards, he claimed, were the purchaser and provider roles. Area Health Boards were accountable to the communities who elected them, and yet were not always able to provide the most appropriate care because of the incentives to provide services themselves rather than contract out for services (Upton, 1991:13).

Yet there is very real conflict existing between the dual roles of the RHAs. Loraine Hawkins, Chief Advisor Strategic Policy in the Ministry of Health[52], acknowleged this conflict:

> RHAs have responsibilities both to taxpayers and service users, and so are caught in the middle of this tension. They are expected to act as agents of the users of health services in their dealings with providers. Indeed, part of the rationale for the purchaser/provider split was to create agencies that were able to focus purely on consumer interests, without the conflicting pressures of provider management. But RHAs are also required to meet taxpayer interests by achieving defined objectives within a global budget constraint...Conflict between taxpayer and consumer interests is inevitable. Consumer expectations are rising, and rapid technological advancement is expanding the range and quality of health services that could be offered (Hawkins, 1995:8).

The RHAs as agents of the Government (and therefore according to Hawkins agents of the taxpayers), would need to be mindful of the Government's concern to limit its financial

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[52] Loraine Hawkins was a member of the Health Services Taskforce secretariat in 1991.

obligation (Upton, 1991:64), but as agents of the people they would need to strive to ensure access to the services people want or believe they are entitled to. To assume there is no conflict of interest is to assume that the Government's and the people's concerns for the purchasing and provision of health care services are identical. They are not.

The evidence is clear that RHAs would be primarily agents of the government. Members of the RHA boards would be appointed by the Government and work according to guidelines determined by the government. They would not be elected by the people, and therefore not answerable to the people, as were Area Health Boards. The Government could use various kinds of sanctions and incentives to ensure the RHAs would act in accordance with its directives. As discussed below the only sanction clients of the RHAs could use would be to opt out and enrol with one of the alternative HCPs.

The performance of the RHAs would be monitored by the Government "to ensure they have contracted to provide a comprehensive range, level and quality of services and to ensure they consult with the communities they serve" (Upton, 1991:34). But the National Government recognised too that as monopoly purchasers the RHAs "may not be as receptive as they should be to consumers who want different services, or to funding innovative health service providers" (op cit, p.63). Therefore within the policy National allowed for the development of alternative HCPs to provide competition at the purchaser level. According to Upton, alternative HCPs would allow consumers "the ultimate sanction against RHAs which fail to respond to their concerns: the ability to take their custom elsewhere" (op cit, p.62).

Health Care Plans

Health Care Plans were to be non-government organisations responsible for managing the total health care needs of their clients. They would be obliged "to offer all their clients affordable access to the same range of services as RHAs" (op cit, p.61). This compulsory range of services, 'core health services'[53], would be specified by the Minister of Health. In addition to the core services HCPs would be able to offer their clients supplementary health care services.

HCPs were to be both general and specific, offering the same services as RHAs and yet offering them with a specific focus, for example a Maori or female orientation. Upton suggested: "[h]ealth care plans can specialise in the care requirements of particular groups, such as women, families with young children, Maori and so on " (op cit, p.65), or they could be offered for specific industries or unions.

Upton suggested that women, Maori and other "particular groups" may find their health needs met more specifically through Health Care Plans (op cit, p.61).

He claimed the concept of HCPs was introduced to provide choice for individuals and to provide competition at the purchaser level encouraging RHAs "to work harder to purchase more and better services with the money available" (op cit, p.66). They would therefore provide an incentive for the RHAs to act in accordance with the Government's directives.

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[53] See the discussion of 'core health services' below.

To protect the clients of HCPs and to contain overall health costs, "Health Care Plans will operate within limits set by regulation" (op cit, p.69) and each plan would have to be approved by Government (ibid). To receive approval:

> plans will have to demonstrate that they offer cover for all core services, that they have sound cost-control strategies, and that they are able to manage the risk involved in their operations (op cit, p.69).

HCPs were to be available to everyone, irrespective of income or health status. Each person would be able "to take their entitlement to Government funding with them," (op cit, p.66) and use this to pay the fees of the HCP of their choice. People who are likely to have higher health care costs would receive a larger Government subsidy to take with them to the HCP of their choice (op cit, p.67). Upton believed that this would prevent HCPs from 'cream-skimming', taking on only low risk clients.

People would be able to move back to their RHA or from one HCP to another. A time limit was to be determined for this (ibid).

Upton suggested in a speech to the Healthcare Reform Conference, 13 September 1991, "one of the most exciting prospects is the establishment of Maori health care plans...Maori", he claimed, "have a great deal to gain from the establishment of their own health care plans. They will be able to offer culturally appropriate health services, allowing for particular health priorities."

In the same speech Upton suggested the opportunities that he saw for general practitioners (GPs) with the introduction of alternative HCPs. He suggested that he "would expect to see GPs playing a central role in the establishment and running of health care plans, as both

promoters and providers". GPs would be able to opt out of contracting with RHAs and yet still be able to offer their clients government funded services.

Unlike RHAs, HCPs would be able to own their own health care facilities. They therefore would be able to provide some services themselves and contract with other providers for other services for their clients. For example they would likely contract with CHEs for major trauma services. As for RHAs, HCPs would be able to contract with a wide range of providers but these would need to be "properly qualified health professionals" (op cit, p.67).

Upton suggested that HCPs would not be implemented until RHAs, CHEs and community trusts were fully established (op cit, p.61) and he envisaged a phasing in of HCPs "to allow plans and reinsurers to develop experience at managing the risks involved in underwriting health care cover" (op cit, p.72).

HCPS were envisaged by the Taskforce as a means to reduce the Government's fiscal risk both by providing competition at the purchaser level and by shifting financial responsibility onto a section of the population. In its Report to the Prime Ministerial Committee (April 1991) the Taskforce advised:

> [t]he Government would assist low income people to pay their premiums. High income people would pay their own premiums. This would permit sizable fiscal savings to be made (p.6).

The Taskforce cites the Change Team on Targeting's[54] estimate of these savings to be in excess of $1 billion per annum (op cit, p.33).

Upton went one step further in the Green and White Paper, suggesting that if in the future the majority elected to enrol with HCPs, financing of health care could move from being a tax based system to an insurance one. "RHAs and health care plans could be given the task of collecting premiums from their clients directly" (Upton, 1991:98).

Many opponents of the health policy have argued that HCPs are merely one stage on the way to privatisation. Helen Clark as Labour's spokesperson for health argued with reference to Upton's above comment:

> The Government's agenda is clear, radical, and destructive of the public health service. It is simply ingenuous, if not downright duplicitous, of Mr Upton to claim that he is keeping a public health system. If he is allowed to complete this agenda, there will be nothing public about our health system - except that the public use it! (Address to National Nursing Workshop, Wellington, 29 February 1992).

Crown Health Enterprises

Most larger public hospitals and related services, especially those in larger centres, would be established as Crown Health Enterprises. They would be owned by the Government on behalf of the community and would be the responsibility of a new Ministerial portfolio headed by the Minister of Crown Health Enterprises (Upton, 1991:21).

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[54] The Change Team on Targeting was a Taskforce set up at the same time as the Health Services Taskforce to investigate an integrated approach to the targeting of social assistance.

Each of the CHEs would be under the jurisdiction of a board appointed by the Government. The boards in turn would appoint managers to run the CHEs (op cit, p.35). Upton argued that appointing managers rather than health professionals to run the CHEs, and establishing CHEs on a "business-like basis":

> will allow managers to get on with the job of running hospitals and other services efficiently, and will allow health professionals to work in a better-organised, more professional environment (ibid).

CHEs, as publicly owned providers of secondary health care services, were to compete with other providers to contract with the RHAs "to provide services of acceptable quality and cost, and to be accountable for successful performance of contracts in a socially responsible, ethical manner" (Malcolm and Barnett, 1994a:86). CHEs would be responsible to their boards and ultimately the Minister of Crown Health Enterprises to operate as efficient businesses, and to the RHAs for fulfilling the terms of their contracts.

As mentioned above, from midnight on the night the health policy was released Area Health Boards were disestablished and replaced by Government appointed commissioners. This marked the final severance of the linkage the Government had with local elected health boards. The commissioners were to manage Area Health Board services in their transition to Crown Health Enterprises.

Upton argued in the policy that the larger public hospitals would be established as Crown Health Enterprises because "running large hospitals and other major health services requires all the skills involved in running a large business as well as the talents and skills of health professionals" (Upton, 1991:34-5).

However the need for public hospitals to be run on a more business-like basis stems from the central role they play in the new contracting chain through their provision of the great majority of secondary health services. The National Interim Provider Board (NIPB) (the agency responsible for establishing the provider agencies) contended, "to meet the challenge of the new environment" (NIPB, 1992:10) and to be competitively viable and fair to their competitors, CHEs needed to be set up according to a "profit-making businesslike model" (op cit, p.11). This would ensure they would have "neither competitive disadvantage nor advantage over other organisations" (op cit, p.13).

The profit-making businesslike model would provide "direct incentives to keep the institution[s] efficient, flexible and innovative" (ibid). The Board maintained these are necessary qualities in a competitive market.

For Upton too "[p]rofit is the means to a better health system" (Address to the first National Conference of Religious and Welfare (non-profit) Rest Homes, 3 July 1992). In this address he explained why he believed CHEs should be profit-driven:

> Dividends not only secure a commitment to stay in business: they are a way of putting pressure on managers to use the assets of the business properly. And this is why the Government is going to make CHEs pay a dividend.
>
> Requiring a rate of return from CHEs is the best way of guaranteeing that they make optimum use of their assets. It enables the Government - on behalf of the taxpayer - to put some pressure on decision-makers.

The dividends paid by CHEs, he explained, "will be ploughed back into the health system" (ibid), but they will not necessarily be invested into the CHEs themselves.

Katherine O'Regan, associate Minister of Health, reiterated Upton's belief in an address she gave on behalf of Upton to the New Zealand Institute of Health Management, 24 November 1992. O'Regan declared:

> [r]eturn on assets will be the index of success in the proper use by CHEs of their assets - it is a powerful way of ensuring the best possible access of New Zealanders to health and disability services.

The CHEs would be monitored by the Minister of Crown Health Enterprises to ensure they are being managed wisely, making prudent investment decisions, and returning a profit on their investments (Upton, 1991:35).

CHEs would not be responsible to their communities as were the Area Health Boards. Their concerns would not be with outcomes (improved health status of their communities) but with outputs (particular services) and the efficiency they could generate in producing outputs so as to increase their share of the market. This use of jargon serves to obfuscate the shifts in accountability and lines of responsibility implicit in the policy.

By retaining ownership of the CHEs the Government can ensure that essential services are provided even when these are not competitively attractive for the CHEs. Government as owner can direct the CHEs to provide essential services to ensure access to them is available for members of the RHA communities (Arnold, 1992:4)[55].

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[55] Simon Arnold was a member of the Health Reforms Directorate, the implementation agency responsible for establishing RHAs and the policy on contracting between RHAs and providers.

Integration of primary and secondary health care

Primary care is provided by general medical practitioners (GPs), nurse practitioners, practice nurses, district nurses, independent midwives, pharmacists, and a number of not-for-profit organisations such as the Plunket Society. Primary care providers are the first and sometimes the only point of contact clients have with the health system. Secondary care is provided by hospitals, both public and private and medical specialists.

Upton and the National government believed that integrating the funding and purchasing of primary and secondary health care services would overcome the fragmentation that currently existed between the services.

In the existing health system, funding for health care services was the responsibility of various agencies: the Department of Health, the Accident Rehabilitation and Compensation Insurance Corporation, private insurers, patient part-charges, Area Health Boards, and sometimes the Department of Social Welfare. As Upton stated, cost-shifting between agencies and programmes was a common feature, as were breakdowns in communication and the sharing of information (Upton, 1991:42-3).

Upton claimed this fragmentation of funding and cost-shifting resulted in "considerable fiscal risk" for the government (op cit, p.43). The integration of funding therefore was pursued to limit the Government's financial liability.

This was evident in an address Upton gave to the Healthcare Reform Conference, 13 September 1991: "fragmentation is exactly what the Government has set out to cure.

Eliminating fragmentation is one of the Government's two major goals in reforming the health system"[56].

The integration of funding through RHAs and HCPs, Upton believed, would be essential to achieve integration of health care service provision and to reduce the opportunities for cost-shifting (address to the Wellington Branch of the Public Health Association, 18 February 1992).

Upton contended that by integrating the purchasing of primary and secondary care the health system would become more cost-effective, consumer-responsive, fair and efficient. He claimed:

> [i]ntegrating primary and secondary care will encourage co-operation between GPs and hospitals, and better-managed and more personal care of people. It will also mean that the total health care needs of people will be managed by one agency (op cit, pp.37-8).

GPs play a key role in providing primary health care services. As mentioned above, they are often the first point of call for people experiencing health problems and they act as gatekeepers to secondary health care services, and to many pharmaceutical and diagnostic services. As Upton suggested in his Nordmeyer Memorial Lecture to the Wellington Clinical School, 7 August 1991, successful integration of primary and secondary care would require the co-operation of GPs.

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[56] In this particular speech he claimed the other goal to be "to provide access to services for those on low incomes".

RHAs would require GPs to enter into remunerative contracts with them, so as to limit the level of spending for primary care, and to ensure that RHA clients would have access to government subsidised primary health care services. In the policy Upton suggested:

> As RHAs will have capped budgets, they will need to find ways to contain the level of primary care spending. If they do not, there is a risk that demand will lead them to over-spend their budget or reduce the funding available for other services (Upton, 1991:48).

In devolving the responsibility for funding primary care, the Government is also devolving responsibility for containing costs, while still providing a sufficient primary health care service as determined in the 'core'. In other words the Government is intending that the RHAs should do what they, the Government, could not do, that is, contain the costs of primary care spending.

Under the terms of the policy, to offer government subsidised services to their clients, primary care providers would need to competitively contract with the RHAs or HCPs. Upton suggested that RHAs could enter into a variety of "creative contracting" (op cit, p.50) arrangements with primary care providers to achieve their goals.

Upton intended that primary health care would not be so heavily influenced by GPs but would involve a more multi-disciplinary approach. He argued that the current subsidy system of payment did not allow this development (op cit, p.46).

Fully integrated health care would require the elimination of fragmentation not only between primary and secondary care but also between accident related and non-accident related care.

Integrating accident and sickness-related care

Within the policy Upton claimed that the Government intended to integrate the funding for accident-related health services with other health services funding "so that people receive the same treatment whether they suffer an accident or an illness" (op cit, p.41). The Government's intention, I believe, was to integrate the purchasing of accident and sickness-related health services. The funding for accident-related services would continue to come from Accident Compensation levies (ibid), and RHAs would assume responsibility for purchasing accident-related services on behalf of the Accident Rehabilitation and Compensation Insurance Corporatiom (ACC).

By Government aligning the purchasing of accident-related health services with other health services, Upton claimed, access to treatment would be provided on a fairer basis than was currently the case. "[T]he incentive to shift costs on to the accident compensation scheme by classifying illness as accident" would be removed (op cit, p.42).

Cost-shifting was not the only disadvantage in the existing system. There were "serious inequities in the treatment and access to care between people whose health problems are caused by accident and those caused by illness" (op cit, p.56). Accident-related care was given priority as it often meant returning people to the workforce earlier and therefore terminating the ACC compensatory payments. Those receiving non-accident-related care were not entitled to compensatory payments.

The integration of the purchasing of accident-related services and sickness-related services was an important part of the Government's intentions for RHAs and HCPs to manage the total health care of their clients.

Core Health Services

Core health services were to be the range of services everyone would be entitled to as an adequate minimum level of health care (op cit, p.76). Upton explained: "Core Health Services are the health services to which we believe everyone should have access, on affordable terms and without unreasonable waiting time" (op cit, p.75).

Both RHAs and alternative HCPs would be required to ensure that all their clients have access to these services "no matter where they live or what their circumstances" (op cit, p.151). The core would be the basic package of services on which RHAs and HCPs would compete for clients.

Upton advised: "the Government has an obligation to assist people to obtain the core services" (op cit, p.75). Core health services would not necessarily be made available free of charge. However the charges must be "affordable" to everyone (op cit, p.76).

According to Upton:

> [t]he Government believes we must define more explicitly what are to be included in core health services for New Zealand. This explicit list will make clear what services Regional Health Authorities (RHAs) and other health care plans are obliged to offer to all their clients. It will be used to protect the level of health services and hold RHAs and health care plans accountable (op cit, p.75).

With a clear definition of the core, RHAs and HCPs "will not be able to cut important services or neglect low-profile services" (op cit, p.77).

Upton intended the list of core health services would "reflect the community's priorities" (op cit, p.75). To ascertain these priorities a Government appointed committee, a National Advisory Committee on Core Health Services, would be appointed to engage "in a process of public consultation about the core" (ibid). The committee would then advise the Minister of Health on which services should be included in the core and the Minister of Health would be responsible for the final decision.

> The list of core health services would be specified in general legislation...[and] would be enforced either through the general courts' system or a specialist tribunal established by legislation (op cit, p.86).

According to Upton, defining a core of services to which everyone is entitled is to make explicit the Government's rationing of health care services. Upton explained in a speech to the NZ Institute of Health Management, 27 November 1991:

> Defining core services will formalise what doctors and others have been doing for years - rationing health care...The advantages of defining the core more explicitly are that rationing will no longer be done on an ad hoc basis by those ill-equipped to do it. And the public will have a better idea of what its people are entitled to.

Where historically rationing of health care services in this country has been done by queueing or denial of care, Upton claimed:

> [d]efining a set of "core health services" more explicitly will help to ensure that the services the public believe to be the most important will be provided. It will also acknowledge more honestly that there are limits to the health services we can afford (Upton, 1991:80).

The Government intended that people would be able to purchase health services not included in the core but they would be required either to pay for them themselves or make provision for them through private insurance (op cit, p.76).

Upton suggested in his Green and White Paper that the core could be listed as a positive or a negative list. A positive list would specify those services to which people would be assured access. A negative list would specify the services which would be excluded from Government funding, people would be entitled to all the rest (op cit, pp.81-2).

Initially the Government sought public comment on how core health services should be defined[57]. People were asked to comment on: "what combination of the following approaches should be used:

- a negative list;
- a general positive list, with obligations to provide all services on the list, using treatments of cost-effectiveness;
- a detailed priority-ranked list (op cit, pp.87-8).

Making rationing explicit by defining a core and enforcing its provision, would replace the existing system of rationing, which involved fixed budgets, user part-charges, and waiting lists. This system has resulted in considerable regional variation in access to services and people's uncertainty as to their entitlement.

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[57] This was one of the two 'green' aspects of the Green and White Paper. As mentioned in Chapter 1 the other aspect was how core services should be funded.

To guarantee affordable access to an explicit core of services the Government would need to overcome existing problems of extensive waiting lists leading to prolonged waiting times, and geographical variations in access to services. This would require the Government to either increase its expenditure for health services or decrease the numbers of publicly funded core services.

According to Upton an explicit list would provide accountability measures for the competing purchasers of health services and certainty of entitlement for clients of RHAs and HCPs.

Public Health

Upton defined public health as "the science and art of preventing disease, prolonging life, and promoting health through organised efforts of society" (Press release, 3 August 1992). Public health strategies are population-based strategies, they include health protection, health promotion and disease prevention. They are targeted at whole populations rather than individuals and families. According to Upton, public health strategies are essentially long-term investments in better health for all New Zealanders (Upton, 1991:105).

An important element of the policy was the separating of the funding, purchasing and providing of population based public health services from personal health services. This was to involve establishing a separate public health structure which would include "a Public Health Commission (PHC) to co-ordinate and contract for the provision of public health services, and a Public Health Agency (PHA) to provide regionally-based public health services" (ibid). The PHA would have three regional branches.

Within the new public health structure the purchaser and provider roles would be separated in line with the rest of the policy. The separation of the purchaser and provider roles Upton claimed, "will encourage high-quality and efficient provision of services, and make sure that advice on policy, regulations and priorities for spending is not dominated by the special interests of providers" (Upton, 1991:110).

The PHC, the purchaser of public health services, would be responsible to a ministerial Advisory Board appointed by, and responsible to, the Minister of Health. Upton summarised its far-reaching responsibilities:

> The Commission will manage the total budget for public health activities. It will advise the Government on public health priorities, taking into account national needs and particular regional requirements. It will develop public health programmes and fund them. It will advise the Government on regulations to best serve the public health, and promulgate these regulations. It will also advise the Government, RHAs and health care plans on personal health care services required to meet public health objectives, for example, immunisation (op cit, p.111).

The PHC as purchaser of public health services would contract with the Public Health Agency as principal provider of regional public health services, and various national bodies such as the National Heart Foundation and the Cancer Society, for nationally focussed public health services.

The PHA with its three regional branches would be "the major publicly-owned provider of public health services"(op cit, p.112). It would be accountable to the PHC for the delivery of contracted services, and be overseen by a board appointed by the Minister of Health (ibid).

He maintained the improved co-ordination and planning of services in the new separate structure would be able to provide "a rapid response to epidemics, natural disasters and major environmental accidents" (op cit, p.113).

In a press release (3 August 1992) Upton claimed that it was necessary to separate the funding for public health services from personal health services because RHAs (and HCPs) may lack strong incentives to invest in strategies that show no short term gain. He argued a specifically defined budget could not be diverted to short-term needs.

Within the policy, effective and efficient public health services are presented as a means to reduce the Government's fiscal risk: "The Government, as principal funder of health services, has an interest in effective public health activities because they reduce publicly-funded treatment costs" (Upton, 1991:107).

User part-charges

User part-charges are those charges made to the patient at the point of delivery of health care services.

User part-charges have long been part of the New Zealand health care system. Following the 1938 Social Security Act they formed that part of the general practioner fee that was not covered by the General Medical Services Benefit and was therefore payable by the patient. In 1984 user part-charges for pharmaceuticals were introduced by the fourth Labour Government.

In the 1991 health policy Upton "rationalised" user part-charges to include general practitioner visits, hospital inpatient and outpatient services, laboratory tests and higher charges for pharmaceuticals (op cit, pp. 53-4). The "rationalising" or extending of user part-charges to secondary health services was intended to "discourage cost-shifting between primary and secondary care budgets" (op cit, p.54). Upton argued that people had been using hospital services which were free at point of contact but ultimately more expensive for the taxpayer, rather than GP services which entailed a user part-charge (ibid).

In addition to discouraging cost-shifting, Upton suggested that user part-charges were introduced to make both users and providers conscious of the actual costs of the various health care services. His Government believed this would reduce the overall demand for services.

> There is overwhelming evidence that user charges play a vital role in encouraging consumers to consider the costs of health services, and economise on their use. This is particularly true of services which people decide to use themselves, for instance GP visits (Upton, 1991:94).

In an address to the Association of Salaried Medical Specialists, 1 November 1991, Upton reiterated:

> part-charges look like a useful way of restraining expenditure on health services. They encourage sensible use of services by signalling to patients and their agents the cost of the services and products under consideration.

In an address to the New Zealand Institute of Health Management, 27 November 1991 Upton made the point that the extension of part-charges was not fiscally driven. He claimed

that part-charges were being extended to encourage integration between primary and secondary services:

> The point of charging is not to raise revenue...[c]harging is about integration, so that people will have the services they need delivered in the most appropriate and cost-effective setting. And about sending out a price signal to doctors and patients about the resource consequences of their decisions.

Yet in a press release three months later, on 3 February 1992, Upton pointed out the financial advantages of user part-charges for Area Health Boards. Using very "conservative estimates" he suggested that existing Area Health Boards could expect to realise net returns in excess of $35 million[58].

In an address to the New Zealand Medical Association General Assembly, 15 April 1992, Upton set out five arguments in support of user part-charges. They would:

- encourage careful resource use
- facilitate the integration of primary and secondary care
- allow a redistribution from higher income to lower income families, and, at the same time, giving the Government some small fiscal gain
- provide a safety valve that guarantees the freedom of practitioners to set their fees and safeguards the Government's fiscal exposure
- facilitate risk-sharing between the Government and providers.

The argument against user part-charges, that they would compromise access to health care services, Upton believed could be managed by "setting charges at reasonable levels and by

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[58] By 2 July 1992 this estimate was reduced to $20 million (Upton media statement 2 July 1992).

limiting people's liabilities" (ibid). This would be achieved by applying a limit on the charges each individual or family would have to pay in any one year.

Upton also recognised in the Green and White Paper "raising the level of user charges too high will increase demand for gap insurance" (Upton, 1991:95). This was something the policy sought to avoid, as increasing gap insurance would ultimately lead to increased health costs for the Government.

To ensure people could take advantage of the limits set on user part-charges, exemption cards were to be issued to users of hospital in-patient and out-patient services, and a separate card for those obtaining pharmaceuticals. Charges for families were to be limited to five out-patient visits and ten nights in hospital per year and the limit on pharmaceuticals was to be placed at fifteen items in any one year (Upton press release, 19 September 1991).

An interim regime of user part-charges for all except National Superannuitants, was to be introduced on 1 February 1992. Superannuitants were to join the scheme on 1 April 1992.

The interim regime was to remain in place until the RHAs and alternative HCPs were established. Then they were to become responsible for setting user part-charges for their clients (Upton, 1991:55).

By extending the use of user part-charges the Government intended to reduce the overall demand for health services, and reduce the Government's fiscal risk by shifting some of the financial responsibility for health services onto individuals.

Targeting

Targeting involves the granting of social assistance to those deemed to be in the greatest need. With this policy targeting would be achieved by means-testing, to determine those entitled to social assistance (Boston, 1994:2).

A targeted approach was part of the Government's strategy to limit its financial liability for health care provision. It was part of the Government's "grand vision" for the reform of social assistance in all areas of social policy[59]

Upton claimed the health system must treat people fairly (Upton, 1991:18). He stated the system must "guarantee all New Zealanders reasonable access to an adequate and affordable range, level and quality of services" (ibid). To achieve this, National moved away from a universal approach to health care, towards a targeted approach. Jenny Shipley, as Minister of Social Welfare in 1991, also advocated a targeted approach to social assistance. She claimed that targeting social policies would provide the cheapest and most cost-effective way of directing public funds to those in greatest need (Shipley, 1991:17-18,44).

In his speech to the New Zealand Health Employers Management Skills Course, 4 July 1991, Upton declared: "[t]he big change [in the policy] is the move from universal to targeted provision".

Targeting was to be achieved by defining three income-related groups. Group one included those in receipt of income-tested benefits and those on low incomes. Group two included

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[59] For a discussion of the "grand vision" see Jonathon Boston "Grand Designs and Unpleasant Realities: The Fate of the National Government's Proposals for the Integrated Targeting of Social Assistance" (1994).

recipients of partly abated family support. Group three was the rest, those on 'higher' incomes[60]. Those in groups one and two would be offered 'Community Services Cards' which showed their level of entitlement to assistance for services such as health care. Those entitled to Community Services Cards were required to present the cards at point of service to prove their eligibility for subsidised care.

Targeting of social assistance to those on low incomes and the chronically ill[61] meant that middle and higher income earners would have to pay for access to both primary and secondary core services. This was part of the Government's stated intentions for individuals to take responsibility for their own health care (Upton, 1991:137).

For Upton, limiting the Government's financial liability required a shift in people's expectations of the role of Government. In an address to the New Zealand Institute of Health Management, 27 November 1991, he contended:

> New Zealanders, and especially middle-class New Zealanders, will have to change their mind-set about health, about entitlement, about cradle to grave care. They will have to progress from the attitude of, I've paid my taxes, now I'm entitled to free limitless health care.

Yet he went on to explain that changed expectations were not only necessary because the Government was short of revenue, but targeting health care results in a more efficient health system! For Upton cost shifting to individuals would result in a more efficient system for the Government.

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[60] Higher' was defined ungenerously as $17,280 for a single person with no dependants, and $32,393 for a couple with 2 dependent children.

[61] People were deemed 'chronically ill' if they had consulted their GP six times within the preceding six months.

The move from a universal to a targeted approach for health care required a shift in thinking Upton described as a culture change, and he claimed the Government "has a key responsibility in its leadership role to help people make the change" (ibid).

> We have to bring about a culture change in the way we see our responsibilities and the responsibilities of the State...We must nurture the view that the State is there to help those who cannot help themselves, not to blithely hand out your money to me...you and I can look after ourselves most of the time in most circumstances (ibid).

The targeting of government assistance for health care only to those on low incomes, is part of a hegemonic change[62] the National Government intended imposing on the people of New Zealand. The Government intended limiting its financial liability for health care by shifting the costs onto the middle and high income earners.

Strategy for Implementation

To ensure effective implementation of the policy, the Government outlined a strategy for implementation, and timetable for change. Implementation was to commence immediately denying health professionals or the public the opportunity to delay or prevent implementation of the policy initiatives.

Implementation of the policy was to be one of the Government's top priorities over the following two years (Upton, 1991:127).

An important part of the implementation strategy was to appoint implementers sympathetic to the intentions and objectives of the policy. Many of the implementers were to be drawn

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[62] As used by Gramsci, see Hoare and Nowell Smith (1971:xiv).

from the private sector. New agencies were to be created to implement the policy rather than using the Department of Health which had historically been responsible for the implementation of health policy changes.

The Department of Health was to be renamed the Ministry of Health and it was to be responsible for ensuring "that the current health system continue[d] to function while the reforms [were] being implemented" (Upton, 1991:123).

The implementation strategy was to be initiated immediately. The same night the policy was released, commissioners were appointed to take over existing Area Health Boards and manage their transition to CHEs. According to Upton the Government considered this "necessary to ensure continuity of services and minimal disruption to the public at a time of significant change" (op cit, pp.127-128).

The appointed commissioners were to help ensure the smooth implementation of the reforms. They would also provide access to board records and staff for the National Interim Provider Board which would have the primary responsibility for managing the process of changing the organisational form of hospitals (Upton, media statement, 30 July 1991).

Upton recognised the threat to implementation if elected Area Health Board members were expected to manage the transition. It would place board members

> in the unenviable position of having to respond to the communities which elected them while also having to follow Government directives on reform. Divided responsibilities cannot secure the continuity of health services during the transition, or facilitate the implementation of the reforms, no matter how well-intentioned people are (Upton, 1991:128).

By immediately disestablishing the publicly elected Area Health Boards the Government would prevent likely opposition to its policy intentions from those who were in a position to compromise the implementation process.

The two key implementation agencies were to be the National Interim Provider Board (NIPB), responsible for establishing the provider agencies, especially the CHEs, and the Health Reforms Directorate (HRD) responsible for establishing the RHAs. They would both be located in the Prime Minister's Department.

As mentioned in Chapter 1, within the Green and White paper Upton included a timeframe for implementation. The timeframe set out his expectations for the implementation of the various stages of the restructuring. His intention was to ensure the restructured health system would be operational by 1 July 1993, just two years after publication of the policy. This was a far more ambitious timeframe than other countries implementing similar reforms had set out to achieve[63].

Speed was to be an important element in the implementation of this policy designed to radically restructure the existing health care system which had built up over a period of one hundred and fifty years.

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[63] See Chapter 6 for an account of the delayed implementation of recent health policies in the Netherlands and the United Kingdom.

The policy goals

The goals of the policy are not clearly articulated. On the first page of the policy statement Upton claimed: "[w]e must be quite clear about the goals we set ourselves and realistic about what can in fact be achieved" (1991:1). Yet he did not state the goals but gave only the primary objective of the "reform process". This is "to secure, for everyone, access to an acceptable level of health care" (ibid).

Confusingly, in his speeches and press releases Upton spoke of different goals, objectives and aims according to who he was addressing. For example when addressing the Salvation Army Executive in Wellington, 22 August 1991 he spoke of three goals of the health reforms: "the integration of primary and secondary health care; the integration of sickness and accident [care]; and the assistance of people on low incomes to get the health care they need." These goals show a concern both for a more integrated health system, and for those on low incomes. This is the section of the population from where the Salvation Army draw their clientele.

When giving the President's Lecture to the Christchurch School of Medicine three weeks later Upton spoke of the aim of the policy as "global management of patient care...that puts maintenance of wellness and returning the patient to health, first" (11 September 1991). Five months later in an address to the Wellington branch of the Public Health Association, he was stating the Government's main objectives to be: to ensure access to an agreed core of services; better value for the health dollar; and control of the Government's financial liability. Later in the speech he refered to a fourth objective: "to better integrate service provision" (18 February 1992).

The lack of clarity successfully clouds the Government's unstated objective to control health spending, and will make it difficult to evaluate the success of the policy in the future.

Conclusion

Rather than a statement of health policy, the Green and White Paper is concerned with reducing the Government's fiscal risk and gaining control over spending on health. It was to be achieved by setting up a managed market in the health system, sharing risk with providers, and targeting publicly funded health care services only to those on low incomes and high users of health services. The policy is based on the monetarist principle that a competitive health care market would result in a more economically efficient and effective system and would therefore limit the Government's financial responsibilty.

Chapter 6

INTERNATIONAL COMPARATIVE CHAPTER

Introduction

This chapter compares New Zealand's 1991 health policy, its implementation and its implications for health care, with recent health policy changes in the United Kingdom and the Netherlands, and with intending and existing policy practices in the United States. Comparative analysis is helpful in illustrating the problems that are common to these different systems and the similarities and variations in policy responses.

New Zealand's 1991 health policy did not develop in a vacuum but was influenced by recent health policy changes in countries such as the United Kingdom and the Netherlands, and by existing policy practices in the United States.

New Zealand is one of eighteen of the twenty-four member countries of the Organisation for Economic Co-operation and Development (OECD) which are currently either planning or implementing health reforms (Upton, 1991:7). From these eighteen countries I selected the United Kingdom and the Netherlands because, despite their very differently structured health systems, there are clear similarities between them and New Zealand in the problems they have identified and the strategies they are employing to achieve their policy objectives. In particular each country is making greater use of market forces to contain their spending on health.

I selected the United States because the United Kingdom, the Netherlands and New Zealand are all moving towards a more market approach in their health systems, adopting strategies currently in use in the American health system. New Zealand, in particular, intended creating competition between purchasers and adopting a managed care approach to primary health care, both of which have been important parts of the health care system in the United States for some years.

I intend to demonstrate the similarities and differences between New Zealand's and the other countries' policy changes and will contend that New Zealand's policy changes are more extensive and were to be implemented with more speed.

The chapter will examine health systems in each of the countries prior to the introduction of recent health policies. It will focus on key elements in the new policies, discussing the similarities and differences between New Zealand's and the other countries' policies and the way they are being implemented.

Similar strategies for similar problems

Each of the eighteen OECD countries implementing health policy changes is, according to Upton, "grappling with the problem of ever-increasing demand for health services as a result of an ageing population, new technologies and higher consumer expectations" (op cit, p.7). Consequently containing costs for health services has become a common goal.

In the United Kingdom, the Netherlands and New Zealand a key element of the new health policies has involved introducing a market system of regulated competition into the health

system to control overall health care costs. In the United States where market forces have been an integral part of the health care system since the late 1970s (Raffel and Raffel, 1987), increasing health care costs have led to a move to provide regulations to manage the health care market.

The New Zealand Government, like the governments in the United Kingdom and the Netherlands, and the Clinton administration in the United States, proposes to control escalating health costs while at the same time ensuring that all citizens have access to an 'acceptable' level of health care (Upton, 1991:1). New Zealand, the United Kingdom and the Netherlands are all in the process of implementing policies to achieve these aims and President Clinton in the United States proposed changes that would have had similar effect.

Flynn (1993:65) suggested the drive by many countries to control and reduce government expenditure in health and other welfare areas results from the economic crisis of the 1970s and the subsequent recession which led to a fiscal crisis in western welfare states.

The preferred solutions for each of the countries for dealing with their very similar problems reflect a 'top-down' approach to policy implementation. The governments have each enacted legislation to completely restructure their health care systems without public or health professional consultation (Ham et al, 1990:11-6), (Lay, 1991:21). They have then attempted to impose the policy changes on their populations.

In the United Kingdom, the Netherlands and New Zealand the health policies have been an integral part of an overall rationalising of social and economic policies. In the 1980s each of

these three countries embarked on similar economic and social policies. According to Flynn the United Kingdom and the Netherlands embarked on:

> complete reassessments of government functions, reorganisation of state services, privatisation measures, deregulation, decentralisation and retrenchment across the entire range of welfare (Flynn, 1993:69).

New Zealand embarked on similar policies under the fourth Labour Government, the restructuring being continued by the current National Government.

The United Kingdom

The United Kingdom spends less than most other western countries on health care, in 1990 about 6% of GDP (Ham et al, 1990:15), (Lay, 1991:21). About 86% of total health spending is publicly funded through general taxation, the remainder comes primarily from user part charges (Ashton et al, 1991:12), (Lay, 1991:21). According to Ashton et al only about 10% of the population have private health insurance. As in New Zealand, surgical waiting lists are long and in some areas clients are required to wait several days before getting an appointment to see a GP or practice nurse.

The health system existing in the United Kingdom prior to the recent policy changes was organised as follows: Fourteen Regional Health Authorities (RHAs) were allocated funds according to a population-based formula. They were responsible for planning and resource allocation in their regions and for monitoring the performance of the District Health Authorities (DHAs) and the Family Health Services Authorities (FHSAs). The RHAs in turn redistributed funds to the DHAs who were responsible for purchasing health services for the people in their areas and managing hospitals and units (Ham, 1993:162-3). Both the members and the

chairpersons of the RHAs and DHAs were appointed by the Secretary of State for Health, and they were financially accountable to Parliament through the Secretary of State for Health. The RHAs and the DHAs were in practice agencies of the Government (Flynn, 1993:71).

Secondary health care services in the United Kingdom were predominantly publicly provided by the National Health Service (NHS) through public hospitals. Many of the hospitals had a separate wing for private patients (Lay, 1991:21).

In 1988, in response to widespread concerns that the public health services were under-funded, Prime Minister Margaret Thatcher convened a small committee of senior ministers to review the NHS. The review was internal with no public consultation or input from interested provider groups (Ham et al, 1990:11-6), (Lay, 1991:21).

In 1989 the committee released its white paper, Working for Patients. The central aims of the paper are:

> to extend patient choice, to delegate responsibility to those who are best placed to respond to patient's needs and wishes, and to secure the best value for money (Department of Health and Social Security, 1989:102).

The Government intended to "build further on the strengths of the NHS, while tackling its weaknesses" (ibid).

The paper concentrated on strengthening management in the formerly medically-dominated health sector, and on changes to the delivery of services rather than funding. The existing method of funding, predominantly from taxes, was to continue with no extensions of user charges. Universality was to continue with access to health services based on need, not ability to

pay. The only change in financing was tax relief on private health insurance premiums for those over sixty (Department of Health and Social Security, 1989), (Lay, 1991:23), (Ham et al, 1990:15-8), (Ham, 1993).

The reforms to be introduced in April 1991 were concerned with creating an environment for managed competition within the health services. A competitive environment, it was believed, would increase efficiency and control spending. This was to be achieved by separating the roles of purchaser and provider at District Health Authority level, and introducing competition between providers of health services by selectively contracting for provision of health services. Managed competition, the committee believed, would ensure the underlying principles of the NHS would not be undermined (Ham et al, 1990:18), (Ham, 1993).

Family Health Services Authorities were to become responsible for assessing the needs of their communities for primary health services, and for purchasing the necessary services. These services include those provided by general practitioners, dentists, pharmacists and opticians, all independent practitioners outside the NHS (Ham, 1993:166).

GPs were to be encouraged to become more responsive to their patients by being remunerated on a capitation basis. Larger general practitioner practices would be encouraged to become 'budget holding' practices, responsible for primary and some specified secondary health services. Budget holding practices would be remunerated on the number of patients enrolled with their practices and the services the GPs were contracting for. The GPs would in turn contract with hospitals and other providers for the provision of specific services (Ham et al, 1990:18).

Hospitals could opt out of health authority control and become self-governing Trusts but still remain within the NHS. As self-governing NHS Trusts they would be able to:

> determine their own management structures, to employ their own staff and set their own terms and conditions of service, to acquire, own and sell their own assets, to retain surpluses, and to borrow money subject to annual limits (Ham, 1993:168).

This would grant the Trusts more autonomy and the government hoped that this would lead to increased choice for patients and improved quality of care (Flynn, 1993:79), (Ham, 1993:168).

The government would remain the dominant funder of health care services. The purchasers would include District Health Authorities, budget holding GPs, and private health insurers. They would be responsible for purchasing health services on behalf of their communities from public, private and voluntary providers. The Secretary of State for Health would retain ultimate responsibility for both the purchasing and the providing of health care services (Ham, 1993:168-9).

Hospitals would enter into service contracts with purchasers but would be reimbursed for services already provided. This method of reimbursement was intended to create an incentive for hospitals to attract patients (Department of Health and Social Security, 1989:34-5), (Ham et al, 1990:18), (Lay, 1991:23).

DHAs would be responsible to ensure that all their patients have "guaranteed local access" to "core" services. "Core" services were to include all those personal and public health services to which patients need guaranteed local access. They would not be defined explicitly but

categorised in general terms (Department of Health and Social Security, 1989:34). DHAs would contract with hospitals and other providers for the provision of some or all of these services.

Two other important ideas central to the white paper were: doctors should be made more accountable for their performance, and management within the NHS should be strengthened. Medical audits would be used more extensively in general practice and in hospitals, and hospital doctors would become more involved in resource and service management. Management in the NHS would be strengthened by the establishment of a new Policy Board and the reconstitution of the NHS Management Board as a Management Executive, and by re-establishing health authorities along the lines of boards of directors. As much decision-making as possible would be delegated to the local level but this would be matched by accountability upwards. Local managers would be accountable to the centre for the implementation of the Government's objectives (Department of Health and Social Security, 1989), (Ham et al, 1990:18-9).

The Government intended phasing in the policy changes over a period of three years from the release of the paper in 1989, but public reaction to the restructuring resulted in delays. The implementation of the restructuring was not commenced until April 1991 (Lay, 1991:23). By 1995 Alan Langlands chief executive of the NHS executive was able to claim: "the concept of a managed health service is firmly established; resources are now allocated to populations, not instituitions; [and] the separation of the purchaser and provider functions is complete" (Langlands, 1995:128). Also by 1995, despite "widespread opposition and/or scepticism even amongst GPs" (Colin-Thome, 1995:135), GP fundholding covered 35% of the registered population (ibid). Fundholding involves fundholders taking responsibility for a defined range of services but does not include the budget for GP services (ibid).

The United Kingdom continues to commit a smaller share of GDP to health than most other countries, 7.4% in 1996 (Shipley, 1996(a):4), but Langlands claims: "[i]n terms of health outcomes, the UK's performance appears to be comparable to that in other countries" (Langlands, 1995:129).

The Netherlands

Historically the Netherlands has followed a social insurance model[64] of funding health care supplemented by private insurance premiums paid by higher income groups, significant direct payments and government subsidies. All citizens in the Netherlands are required to belong to a health insurance scheme (Ashton et al, 1991:13), (Flynn, 1993:69). Compulsory social insurance covered the whole population for serious and prolonged disability and sickness, and those on low incomes and those on social security benefits were covered for other health risks. Those on higher incomes were required to take out private health insurance or pay directly for services for other health risks (Ham et al, 1990:37).

As in other western countries, in the 1980s the Netherlands experienced rapidly rising costs for health care. By 1990 health care was accounting for 9.5% of GNP[65] (van Londen, 1992:228). As in the United Kingdom and New Zealand, surgical waiting lists are used as a means of rationing services[66]. Both public and private services are available to everyone. According to Rosenblum (1993) "[t]reatment is determined by medical need and place in line, not ability to pay".

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[64] Employers and employees below a specific income level pay compulsory social insurance through non-profit sick funds. Those above that income level are required to have private insurance.

[65] According to van Londen current government policy is aimed at reducing overall health expenditure to 8.5% of GNP by 2005.

[66] Ham et al (1990:47) claim there are no waiting lists for treatment in the Netherlands but van Londen describes waiting lists as "the normal procedure of rationing" (van Londen 1992:228).

Health care services are provided by mainly private practitioners and private non-profit institutions, though there are some public hospitals (Lay, 1991:26).

> GPs are paid by capitation by the sick funds and on a fee-for-service basis by private insurers. There is a high degree of regulation, including controls over fees and charges set by providers for both public and private patients (Ashton et al, 1991:14).

According to Ham et al (1990:39) a striking feature of the health care system in the Netherlands is the predominance of hospital services. This is due no doubt not only to the expectations of the people that services will be available as required, but also to the previous method of funding hospitals. Prior to 1983 hospitals were financed according to the number of beds occupied, providing an incentive to fill beds. In 1983 prospective budgets were introduced for hospitals providing hospitals with an incentive "to keep expenditure within negotiated limits" (Ham et al, 1990:40).

Public health services and community health services are financed from general taxation (op cit, p.39).

Control of overall health spending has proved difficult for the government in the Netherlands as responsibility for the planning, finance and provision of health services is carried by separate, quasi-autonomous institutions located at national, regional and local levels (Flynn, 1993:70). From the mid 1970s, in an attempt to maintain some control, government introduced restrictions on "the number of hospital beds and new hospital building[s]; restrictions on the use of health care technology; fixed budgets for hospitals; and limits on doctors' fees" (Ham et al, 1990:39). These measures, and the government's annual public expenditure plan setting out its intentions for health spending, had only partial success in controlling overall health care expenditure.

In 1986-7 a major review of the health system was undertaken by a committee chaired by Dr Wisse Dekker. According to Ham et al the stimulus behind the review was:

> concern about the limited effectiveness of government planning and regulation on health services; the lack of incentives for insurers and providers to use resources efficiently; and inequities in access to health care between different groups in the population (Ham, 1990:44).

The resulting report Willingness to Change, or the Dekker Report, as it became known, proposed reduction in government regulation and the introduction of market principles to increase efficiency. It proposed introducing greater competition between insurers who funded health care and between providers of health services whilst at the same time maintaining control over total expenditure (Ham et al, 1990:44-5), (Ashton et al, 1991:14). It also recommended a substantial reduction in the number of hospital beds. This involved closing some hospitals (Flynn, 1993:77).

The most fundamental feature of the reform was the merging of the sick funds and the private health insurers and the introduction of a compulsory basic insurance for everyone covering essential health and social services (op cit, p.77). These include visits to general practitioners and hospital consultants, hospital treatment and some social services complimentary to health services. Additional health services could be covered under a separate insurance arrangement. The services to be included in the basic package were to be determined by government and included in legislation. To avoid risk selection insurers would be obliged to accept all patients (Ham et al, 1990:44).

Almost 90% of the premium for the basic package would be collected by the Government on an income-related basis and paid into a Central Insurance Fund. The Central Insurance Fund would distribute the money to insurance companies selected by individuals on a risk-related capitation basis. Individuals would then pay the remaining portion of the premium to their chosen insurance company at a flat rate. This portion of the premium plus supplementary insurance would provide the opportunity for competitive prices between insurance companies (Ham et al, 1990:44-5), (Ashton et al, 1991:14-5), (Lay, 1991:28), (Flynn, 1993:77).

To encourage competition between providers, insurers would be free to contract selectively with providers of services. The Dekker Committee believed that "selective contracting would stimulate competition between providers and would create powerful incentives for efficiency" (Ham et al, 1990:45). Reduction in health costs brought about by the introduction of competition between purchasers and providers would reduce the need for government regulation (Lay, 1991:29).

The Dutch Government responded positively to the Dekker proposals for reform, and introduced legislation to implement the main recommendations. However, according to Flynn:

> the government acknowledged that, because health care could not be driven and determined solely by market forces, it must retain its powers to intervene in price and budget negotiations. Central government has maintained its right to control costs by defining the content of the basic insurance package, by deciding the level of income-related premiums, and by fixing expenditure ceilings on new developments (Flynn, 1993:77-78).

The Dekker Report's proposals were to be implemented in stages with the restructuring finally complete by 1990. However, according to Ashton et al "the proposals were not well understood and were followed by a period of rather confused debate" (Ashton,1991:51). The completion

date for implementation was put forward to 1992 and, in 1989 following the election of a new government, the completion date was put forward yet again to 1995 (op cit, pp.51-2).

According to Okma (1995) interest groups and critics, especially larger employers and the central organisation of private insurance companies, "have been very vocal and very effective in their opposition" (p.98). This has led to a slowing down of the implementation process. "Some argue that the whole process has come to a halt" (ibid). Okma claims there is a real commitment amongst those in power to reduce public funding of health services "through new cost control measures" and a "general acknowledgement of the need to shift responsibility from the government to other groups such as the consumers, other insurance agencies and the providers of care" (op cit, p.100). By 1996 the Netherlands spending on health care had reduced to 8.8% of GDP (Shipley, 1996:4).

The United States

The United States health care system is based on a free market model and according to Ham et al is "a paradox of excess and deprivation" (1990:60). The United States spends significantly more on health care than any other country and its health spending is increasing faster than any other major industrialised country. In 1990 health spending accounted for 12.5% of GDP (Blank, 1994:111), and in 1995 14.1% (Shipley, 1996(a):4).

The United States' health care system is mainly privately funded with government offering targeted insurance coverage through its Medicare programme for the elderly and certain disabled groups, and through the Medicaid programme for low income families. Most Americans obtain their health insurance through their employers but many, Lay (1991:9)

suggests 12%, Ashton et al, (1991:7) and Ham et al, (1990:61) suggest 15% or 37 million, are without any insurance and millions more have only limited coverage. The uninsured are still able to obtain treatment from hospitals, that theoretically are not permitted to turn anyone away, but they remain responsible for financing their own care.

The majority of Americans are insured through their jobs, their employers purchasing insurance from one of the large insurance plans. In recent years, due to the escalating costs of insurance, many of the larger employers are carrying the risk of their employees' medical costs themselves. The escalating costs of insurance places small employers at a real disadvantage and employees are often compelled to make provisions for themselves.

Health care provision in the United States is dominated by the private sector. Private hospitals and doctors in the private sector provide the majority of care. Most private hospitals are not-for-profit organisations[67]. Only about one quarter of hospitals are State or local government owned (Lay, 1991:8).

Most health services are provided on a fee-for-service basis. Those with insurance are reimbursed by their insurance company (or employers) according to the terms of their agreements. The prices paid for services provided to Medicare patients are determined by Federal Government according to a fixed schedule without regard to medical complications or differences in the quality of care[68] (Annis, 1993:2)[69]. For Medicare clients hospital care is paid from pay-roll taxes, doctors' fees are paid from general taxation and an annual premium is paid

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[67] Any surplus revenue earned must be retained in the organisation (Ashton et al, 1991:7).

[68] The fixed fee schedule in hospitals is known as Diagnostic Related Groups (DRGs). The hospital gets paid the same regardless of the treatment patients receive.

[69] Dr Annis is a past president of the American Medical Association.

by the client. Health service costs for Medicaid clients are funded from a state-federal programme (Lay, 1991:8-9).

In recent years cost sharing has been introduced to make consumers more aware of the costs of services and to deter overuse. Cost sharing can take the form of individuals sharing the cost of their insurance premiums or it "can be applied at the time of use through co-payments, deductibles, or payments for services not covered by insurance plans" (Ham et al, 1990:63).

Lay suggested that reliance on fee-for-service medicine encourages doctors and hospitals to treat people in the most expensive ways and has therefore proved to be the real cause of inflation in the United States health system (1991:9).

Managed care

In an attempt to control the rapidly escalating costs of health care, alternative ways of funding and providing services have been developed. Health maintenance organisations (HMOs) are one form of the new managed care systems which act as both insurers and providers of health care. In return for an annual fee, sometimes paid by the employer and sometimes paid directly by the client, clients are provided with access to a comprehensive set of health services.

Services may be provided through the HMOs' own clinics and hospitals in which doctors are salaried (a staff model), or the HMO can act as an insurer and contract with a large group practice (a group model) or with a number of practices (a network model) or a variety of practitioners on a fee-for-service basis (an independent practice association (IPA) model) (Ham et al, 1990:66), (Ashton et al, 1991:9), (Lay, 1991: 12).

It is claimed that the prospective or pre-paid method of funding HMOs provides an incentive to utilise resources cost effectively and encourages the practice of preventive health care and ambulatory care to reduce the need for expensive hospitalisation. HMOs also promote the integration of primary and secondary care[70]. However Annis (1993) claims that numerous studies confirm:

> managed care doesn't work. A study by the Congressional Budget Office, for example, found that most types of managed care realize little or no savings. Even though some types of HMOs are able to reduce hospital use, those savings are offset by increased use of the HMOs' other services. Furthermore, managed care is management-heavy, imposing an extra layer of costs (p.3).

By 1988 over 29 million people were enrolled with over 700 HMOs (Stoline and Weiner, 1988 cited in Ham et al, 1990:66), but increasing price competition, and tighter federal government controls of Medicare, resulted in substantial financial losses. This has resulted in a decrease in the growth of HMOs and the development of a modified form of insurance-based, fee-for-service health finance. The new structures, known as preferred provider organisations (PPOs), negotiate fee-for-service discounts with specified providers in return for guaranteeing them a volume of work. This results in lower premiums for clients making the new organisations economically competitive with the HMOs (Lay, 1991:10).

Oregon Basic Health Services Act 1990

In the state of Oregon Medicaid has been extended to all families below the federal poverty level to provide everyone with a basic level of health care. Employers must provide insurance cover for all their employees above the federal poverty level, and an all-payers' high-risk pool was

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[70] See Arnould et al (1993) for a comprehensive discussion of managed care organisations in the United States.

established "to cover those with pre-existing conditions who are unable to get private insurance coverage" (Ashton et al, 1991:8).

To "guarantee universal access to a comprehensive range of basic health care services and paramedical services" (Lay, 1991:11), a prioritised list of conditions and treatments has been developed. The prioritised list takes into account the cost of treatments, the likely improvement to a person's quality of life, and how many years that improvement will probably last (Lay, 1991:12). Of the 696 medical interventions on the list Medicaid clients are entitled to the top 565 (*Economist*, 23 April 1994:35). In compiling the list the public were consulted via public hearings, community meetings and telephone surveys. The Oregon Basic Health Services Act legislating for the changes came into effect 1 February 1994 (ibid).

The Clinton Plan:

In the late 1960s and 1970s both federal and state governments sought to control escalating health costs by regulatory policies. However with the changed political climate of the 1980s under the Reagan administration, market forces were promoted in the belief that competition would promote greater efficiency and lead to more effective control on health spending. Nevertheless, despite a free market climate health costs continued to escalate (Ham et al, 1990:67-8).

High levels of health spending have not improved the health status of Americans. Their infant mortality rates and overall life expectancy rates are less than the OECD average (Ham et al, 1990:72). High levels of spending have led to excessive opportunities for those that can afford them and extreme deprivation for those who cannot.

In his election mandate, President Clinton promised to reform America's health care system, to give everybody access to a basic level of health care. Following his election he appointed his wife Hillary to head a taskforce to fully investigate the ills of the present system and to devise a new policy entitling all Americans, through compulsory insurance, to a "core benefits package" (Arnett, 1993:30). The Clinton Plan that evolved from this investigation is a policy of more government intervention to regulate and control the health insurance and health care markets.

It involved establishing new structures to ensure more federal government control, and encouraging (some suggest forcing) people to join the managed care organisations to reduce the costs of primary and secondary care (Matthews and Hering, 1993:6). A global budget[71] would be introduced to control the extent of health spending. (op cit, p.10).

In 1993 President Clinton's policy was one of six major health care bills being debated in the United States. The bills varied by degree of government involvement in providing health care. They ranged from Republican Jim McDermott's proposal for a universal, tax-financed government insurance system, to Senator Phil Gramm's proposal which would make individuals responsible for their own health care and provide Government assistance only for very low-income people, to help them buy health insurance policies (*The Washington Post National Weekly Edition, 8-14* November, 1993:13)

President Clinton's plan with its increased government intervention was closer to McDermott's proposal.

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[71] The term was introduced to mean a cap on spending.

Against a background of rapidly escalating costs, the Clinton Administration was unsuccessful in having its plan accepted by Congress. The Republicans, concerned with reducing the country's deficit, argued for greater individual responsibility for health insurance and a reduction in the level of services provided by Medicare and Medicaid (Neubauer, 1995:15).

At this stage it is not possible to talk of a timetable for implementation as health policy in the United States is still in the formation stage.

The comparison with New Zealand

The United Kingdom, the Netherlands and the United States, as well as New Zealand, have identified similar needs to control escalating health costs while at the same time meeting the increasing demands for health services. Despite their very different organisational and financial structures the United Kingdom, the Netherlands and New Zealand are using similar instrument tools to achieve their policy objectives. New Zealand's 1991 health policy reflects influences from each of the aforementioned countries.

For both the United Kingdom and New Zealand the proposed policy changes represent a reversal of many long-established policies and practices. For all actors in the health systems they require a complete alteration of assumptions and work practices.

A fundamental element of the policy changes in each of the countries is the separation of the purchaser and provider roles.

Purchaser-provider split

New Zealand, like the United Kingdom and the Netherlands, has adopted market principles, believing that increased competition will increase efficiency and effectiveness and lead to reduced costs in the health system. In New Zealand, as in the Netherlands, a managed market environment was to be achieved by creating competition between both purchasers and providers of health care. In the Netherlands there was already an established split between purchasers and providers and the recent policy changes involved reforming the health insurance system to increase competition between insurers (Flynn, 1993:77). In contrast, to create competition at the purchaser level in New Zealand, the National Government abandoned previous structures and established new agencies to be responsible for purchasing the total health care needs of their clients. These purchasing agencies create a new level of management in the health system. In the United Kingdom competition is being established between providers only.

Yet in the United States where competition already exists between both purchasers and providers of health care services, and market principles have been an integral part of the health environment since the late 1970s, efficiency and effectiveness have not been achieved. Health care costs in the United States have increased faster than any other major industrialised country and life expectancy is lower and infant mortality rates are higher. Increased competition is no guarantee of reduced health care costs or of the increased health status of a population.

According to Upton the separation of the purchaser and provider roles is fundamental to creating a competitive market. In his policy the separation goes right back to ministerial level. A separate portfolio has been established with a new minister of the crown taking responsibility for the Crown Health Enterprises, the publicly owned health service providers.

In the United Kingdom the separation of the purchaser and provider roles only applies below the District Health Authority (DHA) level. The DHAs are responsible both as purchasers of health care services and for providers within the National Health Service (NHS). The same minister of the crown remains ultimately responsible for both the purchaser and provider roles. This is similar to what the Area Health Boards in New Zealand were doing in the late 1980s under Labour Health Minister Helen Clark. Area Health Boards were responsible for public hospitals and for providing community health services and public health services for their communities - but not for GP or private specialist services.

In the Netherlands the roles of purchaser and provider are separate but neither are the responsibility of the government, though government does maintain some control through regulations. The purchasers are the insurance companies each competing to purchase health services for their clients. This same situation has long existed in the United States. In New Zealand a market was to be created between purchasers by providing for the development of alternative Health Care Plans to compete with the Regional Health Authorities as purchasers of health care services.

Greater competition between providers has been encouraged in the Netherlands, the United Kingdom and New Zealand by requiring the purchasers to contract competitively with providers. Despite evidence to the contrary from the United States, Upton believes, as do policy designers in the United Kingdom and the Netherlands, that, by competitively competing for contracts, providers of health care services will become more efficient and effective, leading to lower overall health costs.

In the Netherlands and in New Zealand purchasers are encouraged by their capped budgets to contract prospectively with providers. In the United Kingdom, though GPs are mainly remunerated prospectively on a capitation basis, hospitals are reimbursed for services already provided.

To further pursue the principle of market forces, in New Zealand larger public hospitals were to become Crown Health Enterprises and be run as successful businesses in a way not envisioned elsewhere. Unlike the hospitals in the other countries the CHEs are required "to make a return on assets" (Upton, 1991:35). Smaller hospitals would be offered to their communities to be run as community trusts. In the United Kingdom hospitals now have the choice of becoming more autonomous as self-governing hospitals but they will still remain within the NHS. They are not required to return a profit but to contract with District Health Authorities to provide specific health services. In the Netherlands and the United States hospitals are mainly private not-for-profit organisations.

Integration of primary and secondary care

New Zealand's policy provided for integrated funding and purchasing of primary and secondary care. The Government believed it would eliminate much of the existing cost-shifting and lead to decreased fiscal risk for the Government. Integrated funding and purchasing of both primary and secondary health care services is established practice in both the Netherlands and the United States. In contrast in the United Kingdom, secondary services are purchased by the District Health Authorities and primary services by the Family Health Services Authorities, though fundholding GPs can hold budgets for some specific secondary services.

Despite evidence from the United States[72], in the United Kingdom, the Netherlands and New Zealand HMO-type managed care organisations were to be promoted to encourage further integration of primary and secondary services and to reduce the need for secondary services. Each government believes this will ultimately lead to reduced health costs.

Core Health Services

An essential element of New Zealand's policy is the explicit definition of a core of health services to which everyone would be entitled. For Upton the core forms the basic package of health services on which purchasers could compete for clients (Upton, 1991:75). Each of the countries examined aimed to provide all their citizens with access to core or essential health services.

According to the Dekker report in the Netherlands, and New Zealand's 1991 health policy, the core would be determined by the government. In New Zealand it would be explicitly defined following annual advice from the National Advisory Committee on Core Health and Disability Support Services on which services should be universally available. In contrast, core services in the United Kingdom and the Netherlands would not be explicitly defined but determined in general terms. In the United Kingdom core services would be broadly categorised under five headings[73]. It would be the responsibility of the DHAs to contract with individual hospitals to ensure that the services are available universally.

The Clinton plan intended that a "basic core benefits package" would be universally available. The services to be included in the core would be determined by a newly established National Health Board (Arnett, 1993:30).

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[72] See Annis (1993:3) regarding HMOs not being more efficient than other forms of health care.

[73] Though Ham (1993:254-5) suggests the NHS will move towards a more explicit list. He gives the example of the North East Thames health region drawing up a list of health services for which people would not be placed on waiting lists.

The state of Oregon has already implemented an explicit core to ensure that everyone has access to a basic minimum level of health care.

According to Upton, in New Zealand core services would be "accessable" and "affordable" not necessarily free (Upton, 1991:75). In contrast, core services in the United Kingdom are provided free at point of delivery and in the Netherlands most core services are free, except for some user part-charges for GP services which were introduced with the policy changes.

User part-charges

In line with the National Government's intention to shift responsibility for health and welfare back onto individuals, New Zealand's health policy extends the use of part-charges for core services. These include: general practitioner visits, hospital in-patient and out-patient services, laboratory tests and higher charges for pharmaceuticals. Upton claimed the extension of user part-charges is necessary to ensure every New Zealander has access to core services. To ensure the part-charges would not be prohibitive for those on benefits and low incomes, a targeting regime was introduced.

In the United Kingdom there was to be no extension of user part-charges and in the Netherlands as mentioned above they were only extended for some GP services. In the United States user part-charges are dependent on the particular insurance coverage an individual has.

The funding of health care provision

In both New Zealand and the United Kingdom the funding of health services is to remain predominantly tax-based. In contrast, the Netherlands will retain its insurance based funding of health care, but there will be radical changes to its organisation.

In the United Kingdom, the Netherlands and New Zealand health expenditure is to be controlled by global budgets. Likewise in the United States, President Clinton planned introducing a global budget to contain health costs. But there has been much opposition in the United States to this move as Americans believe that rationing of services will be an inevitable result[74].

Increased managerial control

In the search for increased efficiency and reduced health costs, in each of the countries there has been an extension of managerial authority, especially in the hospitals. Strengthened management challenges and restricts medical autonomy by ensuring that clinical practice is exercised within the bounds of management control. Historically doctors have had a dominant role in the making and implementing of health policy in each of the countries, but under recent policy changes the power and dominance of the medical profession is under threat.

Reliance on the perspective and skills of managerialism extends management's control over health professionals and resources and marks a significant change from conventional hospital organisation. Accounting and economic discourses displace other values and meanings and lead to health services being defined narrowly in terms of their resource implications[75]. Where

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[74] Rationing of health care in the United States already exists in terms of the large number of people uninsured and the even larger number under-insured.

[75] The management of patients in hospitals is determined according to clinical pathways which standardise the costs of treatment procedures.

previously health professionals working in hospitals were concerned with health outcomes, the desired end states of their treatments, they are now to be concerned with health outputs, the numbers of particular surgical or medical procedures to be undertaken.

As Flynn (1993:76) suggested, this marked shift towards managerialism begs the questions: "[w]hose interests are represented by the managers of funding, purchasing and providing agencies?" and "[w]ill managers become a new elite rather than merely a countervailing influence in health policy making?"

Public Health

New Zealand's is the only policy which separates out the funding, purchasing and provision of public health services from personal health services. In each of the other countries public health remains an integral part of the total health system.

With the introduction of private Health Care Plans, the New Zealand Government could not be confident that public health services would be adequately provided by the competing purchasers as there is no short-term gain to be made from them.

In the Netherlands public health services and community health services together are funded from general taxation rather than social or private insurance funds. But the funding and provision of these two are not separated.

Implementation

New Zealand's 1991 health policy provided for a radical restructuring of its health care system, both in terms of the structures used to provide health services and the manner in which health services are managed and provided. To ensure its successful implementation, the policy provides for the abolishing of existing institutions and for establishing new structures to implement the policy objectives.

In contrast recent policies in the United Kingdom and the Netherlands build on the strengths of their existing structures to implement policy objectives. In its White Paper the Department of Health and Social Security in the United Kingdom claimed it will "build further on the strengths of the NHS, while tackling its weaknesses" (1991:102). The roles of the Regional Health Authorities and District Health Authorities have been refashioned to accommodate the shift in focus to a managed market environment.

In the Netherlands and the United Kingdom public discontent over the proposed changes to the health systems was recognised by the governments as valid. Amendments were made and implementation slowed down. In contrast New Zealand's National Government immediately began implementing its 1991 policy, the same night it was released. There was no opportunity for consideration to be given to any concerns expressed by the public or the health professionals[76]. In comparison with the other countries, New Zealand's timetable for implementation was much shorter. Discussing the brief timetable in light of their review of recent and intending health reforms in the United Kingdom, the Netherlands, the United States, Canada and Germany, Health Boards New Zealand[77] stated:

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[76] However GPs were able to refuse to co-operate with the Regional Health Authorities by not entering into remunerative contracts with them, see chapter 9.

[77] Health Boards New Zealand was a committee elected from, and representing the Area Health Boards.

> [h]asty decisions made on the basis of imperfect analysis could destroy those elements of the New Zealand system which other countries are seeking to emulate while failing to secure improvements in those areas where the system is weak (Ashton et al, 1991:52).

However, the National Government was determined that its health policy would be implemented according to the strategy set out in the Green and White Paper.

In the United States the legislative process is much slower than in any of the other countries and consequently any new policy will take several years before it is implemented. This allows time for public and professional debate and input into the policy process.

Conclusion

There are clear similarities between the problems identified by New Zealand's National Government and the governments in the United Kingdom and the Netherlands. Each of the government's has emphasised cost containment in the delivery of health services rather than promotion of health status in their recent health policies.

There are clear similarities too between the solutions put forward by each of the three governments. Efficiency is expected to improve as a result of creating or strengthening competition in the health environment, and by applying managerial solutions to existing problems. Increased efficiency is expected to lead to reduced health costs resulting in decreased government financial responsibility.

As Flynn suggested when discussing the recent health policy changes in the Netherlands and the United Kingdom, similarities in the two policies "undoubtedly reflect the influence of new right

precepts in both countries' governments" (Flynn, 1993:80). New Zealand's 1991 health policy also reflects the principles of new right or monetarist ideology. Health care becomes a commodity to be competed for between purchasers and between providers in the new health care market.

In adopting this approach New Zealand, the United Kingdom and the Netherlands are disregarding the United States' experience where free market principles have led to rapidly increasing health care costs and poorer health status. While not emulating the United States' health care system the three countries are adopting elements such as managed care, competition between providers, and, in the Netherlands and New Zealand, between purchasers too.

New Zealand's policy differs from those of the other countries in several important facets. The two most outstanding differences are the speed with which the New Zealand Government intended implementing the policy, and the profound nature of the changes. Rather than improving the existing system it establishes new agencies with different accountabilities. Other important differences are: decreasing the Government's financial responsibility for health care by shifting the responsibility back onto individuals, especially middle and high income earners; the purchaser-provider split extending right back to the cabinet table with different cabinet ministers being responsible for the purchasing and the providing of health care services; the explicit definition of a core[78] ; and a separate structure for the purchasing and providing of public health services.

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[78] As stated previously this is a similar undertaking to that established by the 1990 Oregon Basic Health Services Act.

Whilst acknowledging the international influences on New Zealand's 1991 health policy, I conclude that New Zealand's policy is more far-reaching and its proposed implementation more tightly controlled, especially by the use of speed.

Chapter 7

CORE HEALTH SERVICES

Introduction:

For Upton and the National Government an explicit definition of core health services was a crucial element of the health policy. An explicitly defined core would make transparent the Government's commitment to publicly funded services, and would make clear to individuals their entitlement to publicly subsidised health services. The core would be the "acceptable level of health care" (Upton 1991:1) to which everyone was to have access.

Yet within seven months of its appointment, the National Advisory Committee on Core Health Services (CSC), responsible for representing to Government the community's views on which services should be included in the core, made the decision not to proceed with defining the core as set out in the policy.

This chapter will analyse: why an explicitly defined core was crucial to the policy; why the core as envisaged in the policy was not defined; the CSC's decision to change its focus; the nature of the confusions surrounding the debate that ensued; and the implications of the CSC's decision for health care.

An explicit core of health services was crucial to the commercial nature of the health policy. It would allow commodification of health care services within the new competitive health environment. It would provide: a set of services on which RHAs and HCPs could compete for

clients; the minimal level of services which RHAs and HCPs would be obliged to purchase for their clients; and the basis of the contracts between purchasers and providers. It was also crucial for limiting the growth of medical expenditure.

Blank (1994) suggested that the definition of core health services was "perhaps the most critical aspect of the health reforms in the long run, because it will serve to bring the debate over health care funding into clear focus" (p.101). It would specify the Government's commitment to a publicly funded health system by making clear both the services that Government would fund and those that Government would not.

Why an explicitly defined core was crucial to the policy

For Upton the explicit definition of a core of services to which everyone would be entitled to affordable[79] access was a crucial element of the restructuring of the purchasing and provision of health services. In Health Reforms Submissions, a report from the Health Reforms Group, Upton claimed: "[t]he question of core health services, and the related question how we define our list of core services, is a crucial part of the health reforms...[p]robably the most important concept in the new health system." (1991:1-2).

In his Nordmeyer Memorial Lecture to the Wellington Clinical School, 7 August 1991, Upton stated:

> [a] crucial element of the new system will be the definition of what are core services - those health services to which all individuals will be ensured access, as opposed to those services they can be left to purchase for themselves. In the past, access to health services has been variable. The new system will guarantee reasonable access to an agreed range of services, which will now include

[79] Core services would not necessarily be free for everyone at point of delivery.

> primary care. People will no longer suffer - or benefit - from randomness of delivery.

An explicitly defined core, Upton further believed, would be necessary for contracting between purchasers and providers.

> I fail to see how you can strike contracts for the provision of a comprehensive list of services if you don't have some idea of what core servies are (Upton, address to the Bioethics Research Centre, 15 August 1991).

Defining core health services, Upton contended, would result in "better value for scarce resources and seek to limit the growth of medical expenditure" (Upton, 1991:75). A defined core, he claimed, would acknowledge more honestly those limits (op cit, p.80).

He suggested a defined core would become the floor of our health system, defining the minimum range, level and quality of services to which everyone should be entitled. At the same time it would also be the ceiling, "limiting the Government's obligation to help people with access to health care" (speech to the Bioethics Research Centre, University of Otago, 15 August 1991). Upton explained that burgeoning advances in medical technology had led to increasing expectations about what the Government should provide. A ceiling on government spending would mean people would be aware of which services government would be funding, and which services they would need to purchase for themselves, either by directly paying for them or by investing in supplementary insurance. By restricting the extent of the core it could act as both a cost saving mechanism for the Government, and at the same time it would give people a clear indication of the services for which they could expect to receive Government funding.

A specific core would make explicit the rationing of health services which, in the past, took place informally through waiting lists and denial of care (Upton, 1991:80). Upton suggested: "[d]efining core services will formalise what doctors and others have been doing for years - rationing health care" (Upton, address to the NZ Institute of Health Management, 27 November 1991).

A defined core would make explicit which services were to be purchased by the RHAs for every member of their communities. In a press release of 13 March 1992 the Minister declared identifying a core essential in the light of the Government's decision to establish four RHAs. It was also crucial to the development of Health Care Plans. For both RHAs and HCPs the definition of a core would provide the minimal level of services they would be obliged to offer their clients, and they would be required to ensure that all clients would receive guaranteed access to those services. Upton stated an explicit list "will be used to protect the level of health services and hold RHAs and HCPs accountable" (Upton, 1991:75).

The list of core health services "would be specified in general legislation, which would also specify penalties for RHAs or Health Care Plans which failed to provide core health services" (op cit, p.86).

Speaking to the National Party's Glenfield branch, 16 October 1992, Upton pointed out what he believed to be the unfairness in the current rationing of health services:

> our priorities haven't been arrived at by any systematic process. It is usually an historic accident or a squeaky wheel that has led to a particular emphasis in expenditure (p.2).

To illustrate Upton discussed the variations in accessibility to publicly funded services such as cardiac revascularisation and cataract surgery within the various Area Health Board regions (ibid).

A clearly defined core, whether positive, negative or a priority list[80], would overcome regional variations in services available. RHAs, and HCPs would have to ensure that core services were accessible and affordable to everyone irrespective of geographical location or other limiting factors (Upton, 1991:7).

Upton discussed core services as those "the Government has an obligation to assist people to obtain" (Upton, 1991:75), and referred to them in the policy and in his speeches and press releases as "publicly funded" services (ibid). However in the same policy statement he introduced a targeted approach to publicly funded services, and extended part-charges requiring high income earners to pay full charges for some services expected to be included in the core[81]. Upton stated that RHAs and HCPs would be obliged to ensure that their clients have affordable access to core health services (op cit, p.61), but the Government determined the income level at which people would be expected to pay for their own services and determined the level of user part-charges.

When discussing access to core services Upton was referring to people's ability to obtain services. This was not just a financial matter but included the availability of services, recognising the regional variations in services offered, and the times people would have to wait to receive services. Upton recognised that the long waiting lists which existed in 1991[82], especially for

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[80] See Upton, 1991:81-86 for a discussion of positive, negative and priority list approaches in the definition of core services.

[81] For example GP services.

[82] They are much longer in 1996.

elective surgery, denied people access to services to which they should be entitled, but he did not recognise that the extension of user part-charges and the targeted approach to publicly funded services would reduce access for many people.

For Upton and the Natonal Government an explicitly defined core was crucial to establishing a competitive health market. It would provide a set of services on which purchasers could compete for clients, and providers could compete for contracts, and it would provide an accountability measure for purchasers. By specifying core services in legislation Upton believed the Government would be introducing a transparency into the health system which would enable both the people and the Government to hold purchasers accountable.

A defined core would also make explicit the Government's commitment to funding health services, and it would make clear to individuals the services for which they could expect to have affordable access. In the new commercial environment the core would in effect be a contract between the Government and the people.

The National Advisory Committee on Core Health Services

In March 1992, as stated in the Green and White Paper (p.87), the Minister of Health appointed the National Advisory Committee on Core Health Services. The committee was to assist the Government in defining the core services to which all citizens should have access "on affordable terms and without unreasonable waiting time" (op cit, p.75), "no matter where they live or what their circumstances" (op cit, p.151). In August 1992 disability support services were added to the committee's brief and the committee was renamed the National Advisory Committee on Core Health and Disability Support Services, still to be known as the CSC.

The committee, under the leadership of well-known broadcaster Sharon Crosbie, also included three medical academics, a dean of a law faculty who specialised in medico-legal ethics, and a Red Cross official (Upton, press release, 13 March 1992).

According to its Terms of Reference, the basic goal of the Government in setting up the committee was:

> to receive independent advice on what health and disability support services the Government should ensure are purchased with due respect to its limited fiscal means, in order that people have access to effective services on fair terms (CSC, 1992:5).

The committee was required to:

> consult with the public, and with health professionals and other relevant professionals about the services currently provided and their distribution, and seek views on which services the Government should ensure are purchased and on any desired changes in the distribution of services or their terms of access (ibid).

Following consultation the committee was to:

> recommend annually to the Minister of Health which core health and disability support services should be purchased, how they should be distributed and the terms of access[83] on which they should be available (ibid).

Consultation with the public was to take place "through public meetings, submissions, surveys, and any other processes it thinks appropriate" (Upton, speech to the Bioethics Research Centre,

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[83] The CSC was to be concerned with access in terms of availability of services, and which services should be included in the core. Upton had already determined that all core services would not be publicly funded for everyone but targeted to those on low incomes and high users of health services. Middle and high income earners would be required to pay user part-charges or full charges for some services.

Dunedin, 15 August 1991). The committee was not temporary but an on-going body advising the Government on an annual basis (ibid)[84].

Abandoning the core

Within its first seven months the CSC abandoned the notion of an explicitly defined core according to the policy intentions. Members of the committee considered that Upton had set an impossible task and they as government appointed implementers made the decision to redirect their focus.

In its first report, Core Services 1993/94, the committee stated "there is very little merit in drawing up a detailed list of services in some sort of priority order" (CSC, 1992:63). Instead the committee suggested that those services currently publicly-funded[85] should be regarded as the core (ibid). Yet in his foreword to the report Upton expressed his gratitude to members of the committee (and members of the community) for their contribution "to this first step in *explicitly defining* core health and disability support services" (op cit, p.4) (my emphasis). Upton's comment suggested he still believed the committee would work towards explicitly defining the core. But according to Sharon Crosbie in her foreword to the report, the committee was concerned with modifying access to existing services (op cit, p.6) rather than defining the core as required by Upton in the policy.

In direct contrast to Upton's claims that existing services were unfairly rationed, the committee claimed the health and disability support services currently being provided:

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[84] See Terms of Reference for the committee (National Advisory Committee on Core Health and Disability Support Services, 1992:5).

[85] The CSC, as did Upton, continued to refer to core services as publicly funded services when in fact extensive part-charges and in some cases full charges had been introduced for services, many of which reasonably could be assumed to be included in any definition of core.

> are the product of decades of reasonably commonsense and principled decisionmaking. By and large, the current core reflects fairly accurately the values and priorities of several past generations of New Zealanders (CSC, 1992:63).

In its publication The Best of Health 2, the committee claimed that its decision not to adopt a list approach was supported by the public. A list approach, similar to the Oregon one, "could give us a system that is more unfair than the one we have already" (CSC, 1993(b):14) because individual circumstances would not be taken into account. The committee maintained that decisions about core services should be decided not on which services should be included in the core and therefore accessible to all, but on individuals' particular circumstances, "a particular service to a particular person at a particular time" (op cit, p.17). The emphasis, the committee asserted, should not be on which services should be publicly funded but whether and when a service should be publicly funded (ibid).

In The Core Debater, the committee's first newsletter published two years after the committee was established, the decision not to define the core was explained thus:

> One of the first things the committee did decide was that the core could not simply be a list of services, treatments or conditions that would or would not receive public funding. Very early on we decided that that approach just wouldn't work - it would be *impossible to implement* because it would either have to be so broad as to be meaningless, or so rigid as to be inflexible and unfair (CSC, 1994a:1) (my emphasis).

In its third annual report, Core Services For 1995/96, the Core Services committee again explicitly rejected the notion of a simple list. It suggested:

> A `simple list' of core services is not an appropriate way to describe people's eligibility or access to publicly funded disability support and health services. Such an approach does not have the capacity to tailor services to the needs of individuals and communities (CSC, 1994(c):7).

This was further reinforced in the third issue of the committee's newsletter, The Core Debater, the CSC stated explicitly:

> the Committee has dispensed with the notion that first appeared in the Green & White Paper, that New Zealanders' health and disability support services could be identified by the use of a simple list detailing either the services people were entitled to, or conversely, the services they were excluded from (CSC, 1994(d):1).

In its position as a Government appointed committee the CSC decided that this crucial element of the health policy was impossible to implement according to the policy intentions. I accept the committee was set an impossible task. Health services are not like other commodities in the market place. However, rather than returning to the Government and asking for further direction, the committee proceeded to redirect its focus so that individuals' circumstances, both clinical and social, would be taken into account when deciding entitlement. Thus rather than the committee defining general entitlements, it became a committee concerned with rationing access at the indiviual level.

The refocusing of the committee

The committee shifted its focus from representing to Government the views of the people on which services should make up the core, to one of determining the circumstances when specific services should be included. Thus it became concerned with modifying access to existing services on behalf of the Government. Its focus moved from the broader allocative decisions and concentrated instead on the allocation of services at the individual level. No longer were services to be the focus for Government funding as was claimed in the policy (Upton, 1991:50). Rather funding was to be rationed according to the particular circumstances of each individual.

Four questions were proposed as a framework for deciding the circumstances in which services should be publicly funded . These were:

- what are the benefits?
- is it value for money?
- is it fair?
- is it consistent with the community's values and priorities? (CSC, 1993(b):17).

Recognising "that New Zealand is made up of many different communities, with different perceptions, priorities, and expectations" (CSC, 1994(c):12) the final question changed to: is it consistent with the communities' values and priorities?

In addition the committee recommended to the Government health gain priority areas such as mental health services, children's health services and Maori health services, which should receive special emphasis by the RHAs when making their purchasing decisions and allocating resources (Minister of Health, 1994(a):6).

With the release of the committee's second report, Core Services for 1994/95, to the new Minister of Health, Bill Birch, in August 1993, the appropriate role of the committee as determined by the Minister of Health, had changed. The new Minister of Health, recognised the appropriate role of the committee to be "advising [Government] on the appropriate access to services" (Foreword to the National Advisory Committee on Core Services, 1993:3).

Policy guidelines for the RHAs

Each year the Ministry of Health, after consultation with the CSC (and the Public Health Commission before it was disbanded in July 1995), determines the services the RHAs are obliged to purchase on behalf of their clients. They are known as service obligations and are described in very general terms in the annual Policy Guidelines for the RHAs (and, until July 1995, the PHC). The Policy Guidelines are released annually to guide the RHAs in the development of their Purchase Plans and Statements of Intent. These with the Purchase Plans "form the basis for negotiating the Funding Agreement between the Minister of Health and each RHA" (Minister of Health, 1994(a):3).

In the 1994/95 Policy Guidelines for Regional Health Authorities, the service obligations are described as primary care (general); pregnancy and childbirth services; secondary and tertiary medical services; secondary and tertiary surgical services (op cit, p.35). The level of description, according to the guidelines:

> is intended to be detailed enough to satisfy consumers' need to know their cover in general terms, but be broad enough to allow the RHAs sufficient flexibility to purchase services in ways that meet the particular needs of the population as a whole or specific communities. The level of description in the service obligations also recognises the financial constraints on RHAs and the requirement that RHAs manage financial risk. Except in a limited number of areas, therefore, the service obligations describe which services are to be purchased but not the way they should be purchased (op cit, p.7).

The service obligations are described in such general terms that regional variations in access can continue, and the lack of specificity makes it difficult for the public to hold their RHAs accountable. The transparency and accountability Upton intended to introduce with an explicit core are not realised with the policy guidelines.

According to the Policy Guidelines the RHAs will be monitored by the Ministry of Health to ensure they are purchasing service obligations. This will be done by "checking the purchasing agreements between RHAs and providers, routine reporting on performance indicators, and, if necessary, special audits" (op cit, p.30). But the purchase agreements too are couched in general terms allowing the RHAs autonomy in their purchasing decisions.

Jenny Shipley, appointed Minister of Health following the general election in November 1993, continued to discuss a defined core. In an interview, 15 August 1994, she acknowledged Upton's understanding of a defined core but for her the service guidelines would be the means for defining the core.

> The most likely way in which the core service[s] will be defined is through the service obligations that the Government defines in the Policy Guidelines on an annual basis...Over time I believe that the Crown will become more specific about what it is seeking to purchase in its service obligations.

She continued, "the core is unlikely to be a list of services simply defined as being either in or out". Shipley offered no clarity as to what she meant by defining the core but her statement suggests the service obligations would become more specific regarding circumstances when particular services would be publicly funded.

Despite the CSC's clear statements that an explicit core would not be determined using a simple list approach, real confusion surrounds the issue. Wendy Edgar, programme director for the CSC, both in an interview with me, and in an article published in Health Manager[86] where she was acting as spokesperson for the committee, appeared confused with the issue and with the term 'explicit definition' of a core.

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[86] See Edgar, W., "Priority setting and the Core Services Committee" Health Manager Vol2 (2), June 1995.

In the interview Edgar claimed "explicitly defining the core in a limited timeframe was simply not workable" when the committee had not in fact been given a timeframe. Upton had stated clearly that he expected "[a] highly detailed and explicit Oregon-style core might take several years depending on the level of detail the Government wished to achieve" (Upton, 1991:87). Edgar continued:

> defining a core is absolutely not impossible, but is not possible simply and quickly without it generating mass unfairness....it would not have given any guarantee of access (interview, 4 October 1994).

She suggested, that the committee could have developed a list using a "top-down approach" but "it would never have happened". She then clearly stated that there would be "overt rationing", which implies an explicit definition, but qualified it by saying "Jo Public will not know to what s/he is entitled". She followed this with a statement that the committee is going to "define quite explicitly" some key areas. For Edgar and the committee defining explicitly seems to mean making explicit statements about the circumstances when a person will be able to expect to receive a core service, and the time that s/he will have to wait for that service. But the public will be unaware of which particular services they are entitled to expect affordable access to.

In her journal article "Priority Setting and the Core Services Committee" (1995), Edgar claimed "a clear list of core services...is neither fair nor workable" (p.4). She illustrated how the committee had shifted its focus and now concentrates its work on defining the circumstances in which government funded services should be available. She suggested the committee had concentrated its attention on:

> making clear when services should be publicly funded - that is, under what circumstances services would be beneficial, who should receive the services first, and how long they should have to wait (ibid).

To date the committee has applied these criteria to 18 health and disability services[87]. The criteria serve to limit the Government's financial responsibility for providing particular services. For example coronary revascularisation will not be offered to all individuals who have severe narrowing of their coronary arteries. To be eligible for this surgery individuals will need to have clearly defined clinical and social circumstances according to the CSC's guidelines[88], and if all these circumstances do not apply angioplasty may be offered or pharmaceutical symptomatic relief. Both treatments cost considerably less than coronary revascularisation and have lesser remedial results.

With this approach the committee focuses on the most effective way of using resources within service areas (cardiac surgery), not on the most effective way of resourcing between service areas, for example between cardiac surgery and orthopaedic surgery or urology services. But Edgar claimed:

> [t]he work provides essential building blocks to allow us to determine [in the future], in an objective and "uncaptured" way, the wider question of the amount of funding likely to be needed for particular services and the most effective balancing of resources between services or treatment areas (op cit, p.6)

Eventually "[c]lear statements will be published about services or circumstances which have priority, and those which are unlikely to be funded publicly" (ibid) and these will be available for public discussion. "Priorities *can* be established for publicly funded health and disability services" she suggested. "That task is challenging but possible". But she continued: "[t]here is a strong

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[87] In Oregon those responsible for identifying the priority list identified over 2000 health services.

[88] See CSC's Fourth Annual Report September 1995 pp.48-9 for the pilot priority criteria.

risk of 'gaming'[89] the system (by both professionals and patients) when there is an explicit definition of what will be publicly funded" therefore "[m]andating a list of services is not sensible" (op cit, p.11).

The confusion surrounding Edgar's statements serves to obscure individual entitlements and preserve covert rationing.

The rhetoric used serves to obfuscate the committee's actual shift in focus, and leads to confusion and contradictions within the debate. There is no clear understanding of what is meant by defining the core. For Upton defining the core involved the development of an explicit list of health services, either positive or negative. For the CSC and Shipley, the meaning is not clear but their use of the word defining implies a refining of those services already provided . Refining involves providing guidelines for determining the circumstances when people should have access to currently provided publicly funded services, but the public are unaware of the extent of those services.

In her attempts to explain the change of focus of the committee Edgar described it as inevitable. She claimed, as do Bottom-Up theorists, that experience gained through the actual implementation of a policy will always result in changes being made to the policy: "the reality of making the blueprint work inevitably resulted in tweaking and slight changes in direction" (Edgar, interview, 4 October 1994). For Edgar the shift in focus is described as "tweaking and slight changes in direction" whereas it is in fact a significant shift from explicitly defining a core according to the values of the communities, to developing a strategy for reducing the Government's financial responsibility for the provision of health care services. This was

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[89] For Edgar 'gaming' means creatively diagnosing a patient's condition to ensure that the treatment will be publicly funded.

principally achieved by Upton with the introduction of targeting and the extension of user part charges. But the CSC, through its refocusing, defines many people as not eligible for publicly funded services on clinical and social terms. For example an unemployed, elderly smoker with no dependants and with particular clinical criteria would not be offered coronary revascularisation.

Gleisner and Paterson (1995) criticised the shift in focus of the CSC :

> [it] falls far short of clarifying an entitlement package; it is inadequate as a principle of justice, it provides no basis for choosing; it begs the question about values and none of the priorities carry a price tag (p.8).

Finally accepting the impossibility of determining the core using a list approach, Upton claimed when interviewed 18 November 1994:

> it was never Government policy to have an explicit core...Personally I have never supported an explicit core. I think it is impossible and I think that very rapidly became the view of people looking at it. If you look at the instructions the Government gave the CSC when it set it up, it ruled out an explicit list. They were never asked to do that and they never did.

Upton's blatant change of position now that he is no longer the Minister of Health, calls into question his commitment to, and support for the policy. With hindsight, realising the impossibility of implementing this aspect of the policy, Upton totally rejects it disclaiming his earlier support.

George Salmond, Director of the Wellington based Health Research Centre and former Director General of Health, believes that the shift in focus of the CSC was inevitable (interview, 3

October 1994). The committee, he believed, was given an impossible task. He explained this in a radio interview:

> [t]hose of us who knew anything about these issues recognised that right from the beginning that [defining the core] was not going to be a possibility. No country in the world has been able to precisely define core services, because it is a constantly moving target (Salmon, National Radio interview with Kim Hill, September 20 1994).

In an address to the Whitireia Community Polytechnic, 19 August 1992, Salmond argued an explicit core was not practical:

> [i]nternational experience from Oregon and elsewhere suggests that explicit definition requires the making of explicit political value judgements which are controversial and difficult and which few politicians are either willing or able to make. In the short and probably in the longer term the explicit definition of core services is not a practical proposition (p.12).

Salmond, from his experience of twenty years in public health and as Director General of Health where he grappled with rationing, access and equity issues and advised various Ministers of Health, suggested with Mooney that the role of the CSC needed rethinking. They contended that the CSC should provide expertise "on how to plan rather than laying down what is to be provided or not provided" and further "they should focus on efficiency" (Mooney and Salmond, 1994:181).

> The very reason for trying to establish a core is the result of the recognition - the explicit recognition - that there are limits to the amount of resources that the government is prepared to spend on health care (op cit, p.180).

They suggested that the committee could become involved with assessing from an efficiency stance new and existing technology (op cit, p.181).

According to Robert Howell[90] the concept of core services is a private enterprise notion introduced by Government to reduce or limit its fiscal responsibility. Howell advised the notion is used in private enterprise "when deciding the purpose and strategies of companies. Rather than invest in a wide range of products and services...companies decide to limit their focus to a core business and 'stick to their knitting'" (Howell, 1994:12).

When adapting this concept for the health system Howell suggested:

> it is assumed that some basic health needs and services can be defined and included in the core, and less basic needs and services can be left to other non-publicly funded agencies. If this is not adequately carried out, then either government expenditure on health services will not be controlled and reduced, or publicly funded services will be so reduced that there will be in effect a move to privatisation (ibid).

According to Blank (1994) and Borren and Maynard (1991) an explicit core showing the extent of the Government's commitment to funding health services would increase the gap between low-income people who require greater amounts of health care, and those who can afford either to pay for the services themselves or purchase private health insurance ((Blank, 1994:107), (Borren and Maynard, 1991:19).

In competing for clients, health insurance companies would offer increasing services and the consequent burgeoning of privately provided health services would lead to ever increasing health costs preventing the Government from containing overall health costs as was intended by National in the health policy. It would also mean that many health care services would be

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[90] Robert Howell is a Teaching Fellow at the Department of Management Systems, Faculty of Business, Massey University.

unavailable for low-income people unable to afford private health insurance or to pay for the procedures themselves. As Blank suggested this would raise critical political, ethical, and clinical issues (Blank, 1994:101).

Claudia Scott[91] was concerned with the "role and activities" (Scott, 1995:2) of the CSC. She perceived them as somewhat problematical. She was concerned about the committee's current focus on practice guidelines, protocols and priority areas.

> Priority areas merely identify particular groups or services. They do not make effective linkages between the attributes of individuals receiving services, the characteristics of the services, and the health outcomes attributable to such services. They do not provide guidance as to where the best value for money can be obtained from marginal health care dollars. Moreover it appears that the funder's requirements for RHAs to give attention to priority areas is subject to the availability of resources (ibid).

Scott argued that the CSC's "inability to clarify the core...has reduced opportunities for promoting efficiency and equity of access" (ibid). For Scott an explicitly defined core was essential to realise the Government's intentions.

> The nature of the public entitlement and a clarification of the regulatory environment in which competition in funding, purchasing and providing will take place, is imperative if the policy clarity, transparency and accountability which inspired the reforms is to become a reality (op cit, p.3).

She argued further, "[g]iven fiscal constraints, this search for the nature of the public entitlement must be effectively linked to the budget constraint" (ibid). She believed the task of explicitly defining the core was not impossible but was beyond the scope of an advisory committee such

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[91] Claudia Scott is Professor of Public Policy at Victoria University. She was chairperson of the Health Benefits Review in 1986 and was an adviser to the Health Services Taskforce in 1991.

as the CSC, "and must be seen as the single most important task of the Ministry of Health - as key adviser to the Government on health policy" (ibid).

Scott contended the costs of the delay in determining the public entitlement or core, are "substantial in terms of lost opportunities for full realisation of those public policy goals inspired by the reforms" (ibid).

By appointing the CSC charged with representing the communities' views on what should be included in the core, the National Government was implying that rationing of health services in this country would be open and carried out according to the views of the citizens. However it did not recognise that there is no unanimity of views amongst the various communities nor did it address the prior question of how much New Zealanders are prepared to spend on health care in relation to other tax-funded goods and services. This is, and must remain, a political decision taken by the Government. As Philippa Howden-Chapman (1991) suggested: "in any social service area, where there are limited recources, broad allocative decisions are inevitably political" (p.3).

A national committee such as the Core Services Committee, whose mandate included advising the Minister of Health on which health care services should be publicly funded, leads to a simplification of the issue ignoring the various dimensions of rationing.

Rudolf Klein writing in the British Medical Journal suggested four dimensions of rationing:

- decisions about the allocation of resources to population groups - the young, the elderly, women, the disabled, the mentally ill, etc

- decisions about specific forms of treatment, especially, but not exclusively, treatment that may require new investment - heart and liver transplants, new immunisation programmes, etc, and also decisions about the extent to which a service should meet the need within a population
- decisions on the priority for treatment of particular patients within an existing service - who should be treated first
- decisions about how much to invest in particular patients where a decision to treat has been made (Klein, cited by Alistair Scott in the NZMA Newsletter, 22 July 1992).

This typology illustrates both the micro and macro nature of rationing decisions. The micro decisions usually are made by health professionals, and the macro decisions are the responsibility of governments. The macro decisions, being political, will always be contentious and to some extent arbitrary, suggested Alistair Scott, then chairperson of the New Zealand Medical Association, (ibid). He contended that this is why there should be community debate and review about the health services that are publicly funded.

As Klein suggested "there are no ready-made techniques for determining choices among competing priorities in health care" (ibid). Oregon's attempt to define a core, for example, does not offer a model for acceptance by other countries.

The CSC's focus has shifted from being concerned with rationing at the macro level, the first and second of Klein's categories, to rationing at the micro level, the third and fourth categories.

As Jacqueline Cumming suggested, "[t]he original concept of a core has not been implemented" (1994:41). The government appointed CSC has redirected its focus from explicitly defining the acceptable level of health care to which everyone was to have access, to determining the circumstances when government funded services should be available. Upton's notion of an explicitly defined core forming the basis of contracts between the government and the people, as well as between purchasers and providers, proved to be unworkable and has been abandoned.

Implications

The failure to define a specific core changes the fundamental nature of much of Upton's health reforms.

By not defining a specific core of services, contracts between RHAs and providers, especially CHEs, will need to be in general terms rather than for specific services as intended by Upton. Contracts were to be let for services rather than to providers. Lack of a specific core will reduce the contestable nature of the contracts and will therefore not lead to increased efficiency, the determinant for introducing competition into the health environment.

Clients of RHAs will not have a clear indication of the health services to which they can expect to receive government funding. There will not be any floor guaranteeing a minimal level of services to which people are entitled affordable access, or a ceiling on government's obligations and health spending.

Rationing has become a central task for the RHAs[92]. Rather than being explicit, rationing will continue in terms of waiting lists and denial of care. This will encourage the use of private health insurance for those who can afford it, leading to the further development of a two tier system of health care. Those on low incomes will remain at the mercy of the RHAs and the providers the RHAs contract with, receiving only those services made available to them, and they will be subject to waiting lists. In contrast those with private health insurance will enjoy a greater range of options and will not be required to wait for the health care services they require. The increased use of private health insurance will increase overall health care costs.

The Government's recent moves towards introducing managed care[93] will allow the RHAs to devolve responsibility for rationing to the Managed Care Organisations (MCOs) resulting in even less accountability to their clients.

With the changing agenda of the Core Services Committee, the values and preferences of the people served by the health system will not be reflected in the services offered as intended by Upton (Upton, 1991:75). Instead doctors and MCOs will continue to take responsibility for rationing services at the individual level taking into account the CSC's guidelines for the specific services for which they have been developed.

Without a specific core, monitoring and accountability of RHAs will be difficult. Geographical variations in access will continue and clients and the government will not have any measures by which to hold RHAs accountable. It will be difficult too for RHAs to monitor and hold accountable providers they have contracted with, if they have not contracted for the delivery of specific services.

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[92] See Gleisner and Paterson (1995)"Rationing - the Role of Regional Health Authorities".

[93] See the following chapter for an explanation of managed care and managed care organisations.

By not defining a core the government's level of commitment to a publicly funded health system is not explicit. There is no transparency about the government's commitment, and the original objectives of the National Government's 1991 health policy can not be realised.

The CSC's decision not to explicitly define a core as envisaged in the policy means rationing of health services will remain covert enabling the Government to restrict health spending without the general public being aware. RHAs and MCOs will be able to cut services when necessary to remain within their capped budgets.

In December 1995 the Health and Disability Services Amendment Act was passed renaming the committee and excluding the word 'core' from its title. The committee was renamed the National Advisory Committee on Health and Disability but it was to be known in the shortened form: the National Health Committee (National Health Committee, 1996(a):1). According to the committee:

> [t]he change of name brings an increase in the Committee's role and resources. From now on, it has the additional function of advising the Government on the kinds, and relative priorities of public health services that should, in the Committee's opinion, be publicly funded (ibid).

Lynette Jones, chairperson of the committee suggested this extension of the committee's role was:

> a clear endorsement of the leadership role the Committee has taken since March 1992 in providing the Government with sound evidence-based advice on how to make publicly funded health services more effective, more cost-effective and fairer - through being more consistently practised (ibid).

Removing the word 'core' from the title serves to highlight the refocusing of the committee and is the final demise of any notion of an overt and specific set of services to which everyone should have affordable access.

Conclusion

The decision not to proceed with a list approach was made by members of the CSC within the first few months of their endeavour. Members of the CSC are not street level bureaucrats using their discretionary power to adapt the policy to their own ends. They are Government appointed implementers sympathetic to the policy intentions. They therefore do not fit with a Top-Down explanation of why this aspect of the policy was not implemented. Nor do they fit with a Bottom-Up explanation. They are not members of provider agencies having to accommodate policy initiatives and developments. The committee was made up of academics and lay people, none of whom are active health practitioners (Upton, press release, 16 March 1992).

During the process of implementation the committee discovered that Upton's contention that health care services could be codified and commodified as other goods and services, proved to be unworkable. The social and clinical circumstances of individuals needed to be taken into account when considering access to services. A list approach would have disregarded these factors.

The concept of an explicitly defined core using a list approach was important to the ideological thrust of the health reforms but the concept was poorly thought through resulting in changes being made to the policy during the implementation process.

With the abandonment of the notion of an explicitly defined core, the acceptable level of services to which everyone was to have access, the public remain unaware of the government funded and government subsidised services to which they are entitled. The RHAs are able to withhold and withdraw services to remain within their capped budgets, and regional variations in access continue.

Chapter 8

HEALTH CARE PLANS

Introduction

Establishing private Health Care Plans (HCPs) was a crucial element of the National Government's 1991 health policy. HCPs were to create competition at the purchaser level, provide choice of purchaser for the users of the health system, and thus provide a vital check on RHAs.

Their inclusion in the policy was influenced by the recommendations of Treasury who believed the introduction of competition at the purchaser level would result in overall reduced health care costs (Treasury, 1990:124-5). HCPs were ideologically crucial to the policy rather than functionally crucial for health service provision or improving health status. They were a crucial part of the market ideology driving the policy and a possible step on the way to privatisation of the health system.

This chapter will discuss: why HCPs were a crucial part of the policy; the factors influencing their non-implementation; the Government's decision not to implement HCPs and yet only a year later allowing for them in the legislation; and the Government's current endeavours to introduce Managed Care Organisations.

Why HCPs were crucial to the policy

HCPs were an integral part of the policy design. They were crucial if competition was to be established at the purchaser level. Because RHAs would be responsible only for people in their regions, they would not compete with each other. Alternative purchasers needed to be introduced. The inclusion of HCPs in turn necessitated other aspects of the policy design. It required a specific core[94] being identified so that purchasers would be competing on the same basic package of services. It also required separating out the budget for public health services from personal health services as HCPs would have no incentive to provide public health services which are targeted at whole populations and show no short term gains.

The concept of Health Care Plans was first mooted by Treasury in its Briefing to the Incoming Government 1990. It recommended individuals being able to use their share of tax-funded entitlement, targeted according to income, to purchase private health insurance. Contestable funding, it contended, would decrease the Government's fiscal risk (pp.124-6).

Following this recommendation the Health Services Taskforce was required by Upton in its Terms of Reference to establish alternative purchasers of health care services.

In its Report to the Prime Ministerial Committee from the Taskforce on the Funding and Provision of Health Services (April 1991) the Taskforce set out its "favoured option" for reform which included alternative purchasers or "pre-paid health plans" (PPPs) (p.5). It recommended:

> [t]he ideal models the Taskforce has in mind for PPPs are organisations like health maintenance organisations(HMOs), and preferred provider organisations

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[94] But as discussed in the previous chapter this was not the only reason, or the main reason, for defining a core.

> (PPOs[95]). These types of organisations are characterised by tough, well structured contracts with health care providers to contain the costs of care, and by use of "managed care" systems - which involves managing the total health care of their clients to achieve the best outcomes with available resources (op cit, p.6).

Patricia Danzon and Susan Begg[96], in their report Options for health care in New Zealand, (1991) commissioned by the New Zealand Business Roundtable also recommended establishing alternative purchasers. The report preceded the release of National's policy but only became available to members of the public following a request under the Official Information Act.

Danzon and Begg recommended establishing competing private insurers as one step on the way to complete privatisation of the health system. Like Treasury, they suggested that individuals should be able to opt out of public insurance (RHAs) taking their 'premium', derived from tax funding, with them to enrol with a private insurer of their choice. Eventually premiums would be paid directly to HCPs rather than via tax funding (Danzon and Begg, 1991:53-7), thus moving further towards privatisation.

Like Treasury Danzon and Begg contended that the threat of competition for a monopoly public insurer would result in greater efficiencies than could be realised should RHAs operate as monopoly purchasers, and that HCPs would provide individuals with choice of public or private purchasers (ibid).

> Introducing private competition in the insurance function, by allowing consumers to choose between public and private insurers for their basic coverage, could be expected to yield significant efficiency gains. Competition

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[95] See Chapter 6 for a discussion of HMOs and PPOs in the American Health System.

[96] Danzon is an American economist specialising in private insurance, and Begg is from CS First Boston, supporters of, and consultants for, privatisation of government assets but with little expertise in the health sector (Easton, 1994:225).

> among insurers would assure greater satisfaction of diverse preferences (although limited by the extent to which the government defines the minimum package that must be offered); greater stimulus and efficiency in controlling moral hazard[97]; and greater incentives for production efficiencies by providers (op cit, p.55).

Lack of competition at the purchaser level, they argued, would provide a relatively weak incentive for purchaser performance, which would result in also weakening the incentives for performance at the provider level (op cit, p.83).

Influenced by Treasury's recommendations and supported by Danzon and Begg's suggestions, the National Government, acting on the advice of the Health Services Taskforce, included HCPs in its 1991 health policy.

Upton's arguments for adopting HCPs can be divided into three main themes. 1. HCPs would create competition for RHAs; 2. they would provide choice at the purchaser level for those wanting an alternative approach to health care; and 3. they would provide a vital check on the performance of RHAs.

1. Competition

Fundamental to the 1991 policy was the separation of the purchaser and provider roles enabling competition to be established at the two levels, between purchasers and between providers. Establishing HCPs was essential for the creation of competition between purchasers.

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[97] Moral hazard is posited to exist when clients, who do not pay directly for their health services, use them too frequently thus increasing overall costs.

Concordant with Danzon and Begg, Upton maintained that competition at the purchaser level would increase competition at the provider level too, as purchasers would have to ensure that they were contracting with the most efficient providers. This would inevitably increase efficiency in the health system overall and lead to reduced health costs.

For Upton HCPs were a crucial aspect of the health policy:

> on balance we are better to go for contestability than monopoly. I believe health care plans are an integral part of the new health system. I see no sense in dismissing them out of hand at this stage, and encourage those who are presented with argument to that effect to consider very carefully what sort of health system would result from such a decision (Upton, address to the NZ Coalition of Service Industries, 25 March 1992).

Establishing HCPs as competitive insurers was supported by C S First Boston in its National Interim Provider Board report, commissioned May 1992, Structural, Organisational and Legislative Issues Relating to the Reform of Public Health Care Providers. In discussing potential impediments to the development of efficient, market-driven health care providers, C S First Boston stated:

> In our view, major sustained gains from the reform of the health system are unlikely unless competition between health plans as proposed by the Government is allowed to develop. With monopoly public purchasers, consumers are constrained from using their insurance purchase decisions to express preferences regarding the type of coverage offered and the ability of health plans to control costs. Monopoly health plans are therefore unlikely to have consistently strong incentives to act as prudent purchasers in contracting for services on behalf of consumers (C S First Boston, 1992:9)

According to C S First Boston the establishment of alternative HCPs was essential to provide robust incentives for RHAs to be efficient purchasers of core health services (op

cit, p.101). The considerable monopsony power, that would otherwise be enjoyed by the RHAs, would not guarantee prudent contracting on behalf of their clients, undermining the gains from establishing competition between providers (op cit, p.133).

Competition at the purchaser level, C S First Boston claimed, would achieve the following:

- greater satisfaction of diverse preferences...The ability of consumers to choose different health plans provides incentives for health plans to meet the preferences of individuals in terms of insurance policy options and to provide such insurance at minimum cost.
- competition provides incentives for health plans to apply pressure on providers to improve quality or minimise costs. This pressure reinforces the potential gains from competition at the provider level.
- competing health plans provide greater stimulus and efficiency in controlling moral hazard. This applies to the prevention of illness as well as to the use of medical care (op cit, p.134).

For C S First Boston, as for Upton, competition at the purchasing level was essential to establish an efficient market-driven health care service.

The National Interim Provider Board accepted the recommendations of C S First Boston and advised in its May 1992 report to the Department of the Prime Minister and Cabinet:

> When the provision of health services is separated from the purchasing of health services it is essential both of these are established in businesslike structures that are subject to competition or the prospect of it. Competition is the only way of ensuring, on a continuing basis, constant innovation and best value at optimum quality for every health dollar.
>
> Once the initial reforms have settled down we are convinced that providers of health care will perform better if there is more than one purchaser (NIPB, 1992:8).

2. Choice

When introducing the concept of HCPs, Upton claimed the over-riding goal for the National Government's reform of the health system was "to make sure it delivers the services people want, at an affordable cost" (Upton, 1991:62) Choice of health care services in the past has been available only to those who could afford to pay the costs of alternative health care services or to buy private health insurance.

The development of alternative HCPs, claimed Upton, was intended to offer choice to all users, not just those who could afford to buy supplementary insurance, or those in a relatively good state of health (ibid). In the past people with chronic conditions such as diabetes were unable to purchase private health insurance. Upton intended that suitably adjusted tax-funded entitlements for the elderly and for people with chronic conditions, would be provided by the Government to prevent cream-skimming[98] by the HCPs (op cit, p.67). All users of the health system would have choice, not just healthy, low-risk clients who could afford to pay more. HCPs, he claimed, were explicitly about choice for people and real control over the way in which public funds would be directed.

Aware that not all health professionals would want to contract with RHAs to provide government-subsidised services, Upton suggested when speaking to the Health Care Reform Conference, 13 September 1991, that HCPs would also offer choice to providers of health care services. They would be able to enter into contracts with specific HCPs or run them themselves.

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[98] Cream-skimming refers to insurers only taking on low risk clients, leaving high risk clients to the RHAs.

Upton, and National, went beyond the rationale of economic ideology with the claim that HCPs are especially appropriate for Maori.

He claimed they would offer Maori and other groups the opportunity to take responsibility for their own health (Upton, press release, 5 August 1991). They would provide the opportunity for Maori to receive culturally appropriate health care services which would take into account their specific needs and priorities. In an address to the Healthcare Reform Conference, 13 September 1991, he recognised that Maori had been failed by the existing health care system and again suggested that Maori would be able to establish their own culturally appropriate HCPs allowing for their particular health priorities.

In the Green and White paper he claimed HCPs are "[p]ositive incentives [that] must be given to Maori as individuals and as members of whanau, hapu, iwi and other community groups to take responsibility for their own health" (Upton, 1991:70).

They were to offer Maori the following advantages:

- the opportunity for delivering health services in a culturally appropriate way, thus removing some of the barriers that impede Maori from using existing services;
- the opportunity for Maori to specify their own health priorities and requirements for the style of practice, and reflect these in the contracts for health services negotiated with providers;
- scope to encourage new and innovative providers to deliver health services;
- the opportunity to negotiate access to providers at an agreed price, so that Maori as individuals and members of a collective group are aware of health costs and the need to take greater responsibility for their health;
- in the longer term, the ability to reduce overall cost of health care by encouraging preventive health measures;

- the opportunity to recognise the complex social and economic factors that affect Maori health and to support Maori development through managing resources (Upton, 1991:70-71).

Winston Peters, Maori himself, and then a member of the National Government, supported the concept of HCPs for Maori. He descibed HCPs as:

> [a] bold, innovative and proactive idea which may actually bring about positive outcomes [for Maori]. Maori as any other group in New Zealand, may be able to opt out of the mainstream health system and access or join their own, or any other, health care plan. Whereas in the past Maori consumers have had to accept a 'system' or lump it, consumers of health services can now opt out and choose a scheme which better meets their needs (Peters cited in Durie, 1994:158-9).

Upton suggested too that HCPs could "specialise in the care requirements of particular groups, such as women, [and] families with young children" (Upton, 1991:65). He suggested in a press release on 1 March 1992 that to deny the possibility of HCPs, "is to tell groups within the population that there is only one way to provide health care". To not establish HCPs, he contended, would be to deny people choice.

3. HCPs as a vital check on RHAs

In an address to the NZ Coalition of Service Industries, 25 March 1992, Upton contended the development of HCPs would ensure that RHAs are kept alert to the needs of their communities:

> there remains the real risk that four bodies with a geographical monopoly will go to sleep. That they will fail to reflect the diversity of their populations, and settle on a restricted range of delivery mechanisms.

Monopoly purchasers, Upton suggested, would assume "that there is only one unique way of purchasing access to health care. In a pluralistic society that is hard to maintain" (ibid).

In the Green and White Paper he stated an important aspect of HCPs was that they were "to keep RHAs up to the mark" (Upton, 1991:62). HCPs, he contended, would allow consumers "the ultimate sanctions against RHAs which fail to respond to their concerns: the ability to take their custom elsewhere" (ibid).

The mere presence of HCPs, Upton claimed in his address to the NZ Coalition of Service Industries, 25 March 1992, would be sufficient to control the way RHAs perform.

> It will be the users of health services who will exercise control over RHAs' behaviour, by the threat of selecting an alternative purchaser. They won't actually have to switch purchasers to exert that influence, either (ibid).

Thus being able to take their tax-funded entitlement to an alternative purchaser would provide users with the ultimate sanction over RHAs.

> The existence of health care plans not only gives users leverage over the performance of their RHA, it allows them the final sanction - the choice to redirect public funds to a more responsive purchaser, one they believe will offer the style of care they need (ibid).

Without HCPs "[t]he only controls over these four monolithic agencies would be bureaucratic/administrative controls, and there is a reasonable doubt whether the Government would be able to enforce contracts adequately this way" (ibid).

The notion of HCPs as a vital check on RHAs was supported by Alan Jones, policy adviser to the Prime Minister 1990-1993. He maintained, HCPs were originally intended "to keep RHAs honest" and to compel them to be efficient and accountable (interview, 14 July 1993). "RHAs will be continually confronted with the risk of losing their client base and that will keep their performance up to scratch" (ibid).

This was reiterated by David Smyth , Director of the Health Reforms Directorate (HRD) and previous deputy secretary of Treasury. Smyth explained that HCPs were intended to be "essentially a regulation of an insurance market" (interview, 15 July 1993). They were to serve as a regulating device for the competing insurers, the RHAs.

Non-implementation of HCPs

In a complete turn around, on 20 June 1992 Upton stated in parliament that the Government had decided not to proceed with HCPs. He explained the decision not to proceed, in terms of the difficulty Government was having in determining an adequate risk-rating formula to protect against cream-skimming by HCPs. The risk-rating formula was to determine the level of entitlement to Government funding that individuals would be granted towards their HCP premiums. The information required to work out a formula, Upton claimed, was just not available (NZPD,1992:Vol 528,10776).

In a press release of 26 June 1992 Upton refuted his previous arguments for the establishment of HCPs. Commenting on C S First Boston's recently tabled report, Upton claimed that the report "seriously underestimated the risks of a number of proposals it enthuses over". He continued:

> For example, the importance of competitive insurers is highly questionable. It is for that reason the Government decided to defer the consideration of health care plans.

This statement contradicted the basis of National's policy. It marked a major turning point for Upton and the National Government. It indicated the Government was beginning to realise that it had not done its homework. Influenced by Treasury and Danzon and Begg, the Government had included the concept of HCPs in its policy but had not worked out the details of how they were to be implemented or the implications for health care.

In a press release on 20 August 1992 he announced: "in view of the difficulties that have become apparent over the last year work on health care plans has stopped". Yet (in an obvious reluctance to abandon totally the concept) he went on to suggest that Maori and other groups "may well want to explore this option. I believe any Government must be prepared to acknowledge that there are different ways of doing things and be prepared to allow innovative solutions not of its own design".

The Health and Disability Services Bill released on the same day allowed for the establishment of alternative purchasers.

Eight months later Upton explained the Government's decision not to proceed with HCPs was made in response to the Labour Party's direct opposition to them and their intention to abandon them should they become the Government.

> I have always had it in mind that whatever is put in place must be able to be used by any mainstream New Zealand Government. That is why the Government has not proceeded with health-care plans (Upton, NZPD,1993:Vol 534,14623).

Newly appointed Minister of Health Bill Birch stated quite categorically on the 31 March 1993: "[i]t is not the intention of the Government to implement alternative health-care plans" (Birch, NZPD,1993:Vol 534,14508).

But when questioned by the Labour Party as to why there was still provision for them in the Health and Disability Services Bill he declared that the clause permitting their establishment would not be removed from the Bill because it would be unfair to Maori who may want to establish a plan of their own (ibid)!

Two days earlier in a press release Birch had stated:

> I am not in the business of promoting alternative health care plans, but some groups including Maori, have said they may be appropriate for them. And the legislation should not pre-empt that opportunity where there is a community demand for it.

The resulting legislation, the Health and Disability Services Act 1993, allows for the establishment of alternative purchasers of health care services merely by the Minister of Health giving notice in the *Gazette* (Health and Disability Services Act, 1993:10).

Political and professional opposition to HCPs

Labour's spokesperson for health, Helen Clark, was firmly opposed to HCPs. She had made it clear that she believed that their development would be a step on the way to privatisation of the health system, "a fundamental strike at the heart of any attempt to run a public health system" (Clark, NZPD,1992:Vol 528,10778).

In an address to the New Zealand Nurses Association Nursing Workshop, 29 February 1992, she claimed establishing HCPs "delivers the terminal blow to the public health system". She argued further:

> [o]nce an exodus from the RHAs is allowed to begin, they will cease to be comprehensive regional funders and planners. They, like the insurance companies, will fund and plan only for the clients who elect to have them purchase on their behalf. No one anywhere will want or undertake the task of planning and co-ordinating for whole communities as the area health boards did. That function would disappear and the workings of a competitive market would take over. There is no public health system left at that point.

Clark suggested HCPs were a fundamental part of the Government's agenda to privatise the health care system, more fundamental than competition between providers. When the Government announced its intention to abandon the idea of HCPs she argued that this decision called into question the nature of the whole reform (ibid). If HCPs were to be abandoned then why proceed with the health reforms?

Likewise, Alistair Scott, then chairperson of the New Zealand Medical Association and editor of the Association's newsletter, claimed the demise of HCPs marked a major policy shift for the National Government. Patients and providers would no longer have the choices that HCPs were to provide (Scott, NZMA Newsletter, 12 August 1992:1-2). Scott also suggested that with RHAs no longer subject to competition, control of the overall system would be centralised in the Ministry of Health (op cit, p.3).

He set out three major negative implications for Government which he believed influenced the demise of HCPs.

> They would have made the planning of health care much more difficult, and the rationing of care noticeably less equitable. And, from a macroeconomic

> perspective, and given the government's economic objective to restrain the total spending on health care, capping health expenditure would be problematic (op cit, p.1).

The development of HCPs had the potential to undermine the public health system as we know it. If large numbers of people registered with HCPs rather than the RHAs it would inevitably mean less funding for public providers resulting in run-down public facilities. As Scott suggested it would also have meant that the Minister of Health would not have been able to control overall health spending or the way that the health services developed.

However without HCPs, Scott is concerned that the restructured "heavily centralised and monopolistic system" (op cit, p.2) would result in even less choice for patients. He suggested:

> the freedom of choice of patients may, without care, become as restricted in the entire service as it has been in the public hospital setting (ibid).

He intimated that RHAs would be free to purchase services they believe to be necessary irrespective of individuals' preferences. Unless their clients have supplementary insurance they would have no alternative but to accept the level and kinds of services that would be purchased on their behalf. Clients would have no sanctions, no representation, and therefore no control over their RHAs (ibid).

According to Wendy Edgar, programme co-ordinator for the National Advisory Committee for Core Health and Disability Services, HCPs were not implemented for two reasons. Firstly, determining a risk-rating formula proved too difficult especially for Maori with their "burden of morbidity and the ways they were potentially choosing to deliver services".

Edgar claimed that Maori "suddenly saw HCPs as being their tangible chance to have control of a significant amount of resource" (interview, 4 October 1994). Secondly she suggested Government did not proceed with HCPs because RHAs needed to be established first "to give them a chance to work" (ibid).

> ...bits of the original blueprint needed to be phased in progressively. Key things needed to be established first so the sector didn't haemorrhage. Services had to continue to be provided and some of the elements of the reforms that were to do with efficiency, rational provision, and so on meant that there needed to be fewer players to begin with (ibid).

She suggested further:

> Many of the boards of the RHAs were new at the game whereas the potential HCPs were largely based on health insurance companies who had significantly long experience in the field and had a considerable degree of expertise that the RHAs didn't have (ibid).

Edgar claimed that there should have been a more realistic time-frame for implementing the health reforms. With more time there would have been more clarity about the developing and phasing in of the various elements of the Green and White paper (ibid).

Edgar also claimed the Government had originally intended that private health insurance companies would be interested in developing HCPs. I believe the conditions for HCPs required by Government were too unattractive for the private sector. Currently nearly half of all New Zealanders are insured by the private sector for supplementary insurance but the private sector only pays out 3.5% of overall health costs (Scott, 1993:19). If private health insurance companies developed HCPs they would be obliged to ensure that all their clients had affordable access to all service obligations. To provide cover for all service obligations,

including the low use/high cost services such as major trauma and intensive care services, would possibly prove prohibitive for private insurers in a country with such low population levels.

Like Helen Clark, Lyndon Keene, spokesperson for the Coalition for Public Health, maintained the establishment of HCPs was an important part of the Government's agenda to privatise the health system. He claimed the Government's agenda was to introduce HCPs as competition for RHAs then to create incentives for people to join HCPs thus reducing the RHA's direct involvement in purchasing health care services. The next logical step, he maintained, would be for clients to pay their premiums directly to their HCPs rather than via taxes to Government and from Government to HCPs via RHAs. In this way the Government would be cut out of the whole process and we would have a de facto insurance scheme (Keene, interview, 6 October 1994). The source of Keene's concern was Upton's suggestion in the Green and White Paper:

> [i]f, in the future, the majority of people choose to enrol with health care plans, the Government will face the costs of first collecting revenue and then returning it to individuals or health care plans to pay the annual fees of plans. At this point, the Government may wish to consider another approach to financing health care to reduce these costs. RHAs and health care plans could be given the task of collecting premiums from their clients directly (Upton, 1991:98).

Keene too recognised the Government's difficulty in developing a risk-rated formula to determine each individual's entitlement to government funding towards their HCP premium. He believed this was the reason HCPs "fell apart" but claimed that work was still proceeding on the development of a formula.

George Salmond, director of the Health Services Research Centre and former Director General of Health, contended that in addition to the Government's inability to develop a risk-rated formula for the premiums, the demise of HCPs was inevitable following the Core Services Committee's decision not to explicitly define core health services. He explained this in an address to the Whitireia Community Polytechnic, 19 August 1992:

> [t]he introduction of health care plans is predicated upon explicit definition of the core services and on establishing some means of assessing individual entitlements to a government contribution towards the cost of health insurance. As neither of these requirements can be met health care plans have been abandoned. This removes the possibility of having competing purchasers operating in the public health market, makes RHAs monopolies and thus undermines the whole competitive strategy (pp.12-13).

Salmond's contention begs the question, which came first, the abandonment of HCPs or the dropping of an explicit core? According to Wendy Edgar the decision not to proceed with HCPs meant it was not necessary to explicitly define a core meantime. Salmond, however, suggests the opposite.

According to Upton when interviewed in 1994:

> an explicit core and health care plans were not linked in a formal sense...health care plans were not necessarily dependent on an explicit core but if you are going to require people to use public money for a particular purpose you have to be more explicit. You have the least guarantee if the State does things because the State says we do everything but of course it doesn't do everything. But it all mops up somehow.

Maori Reaction to the Abandonment of HCPs

Mason Durie (1994), voiced his concern at the Government's decision to abandon HCPs. He claimed "Iwi were particularly interested in the possibility of Iwi health care plans as alternatives to regional health authorities" (p.158). "Their appeal", he suggested, "was linked closely to the possibility that health care plans might fit comfortably with Iwi development" (ibid). While appreciating that HCPs were not directed solely at Maori, Durie suggested that "[a]mong the promulgated advantages for Iwi health care plans was the opportunity for partnership between Maori and the State in accordance with the Treaty of Waitangi" (ibid).

"Health care plans" he proposed, "were seen as having particular interest for special groups seeking more from a health care system than regional health authorities could be expected to provide" (op cit, p.159).

Maori concerns for the development of their own HCPs included a fear of unfair competition from the RHAs, the claim by Labour Minister Helen Clark that a Labour Government would not tolerate HCPs[99], and the realisation that major funding would be required from Iwi "to inject a measure of reality into Iwi plans. Without it, collapse of a health care plan would be difficult to avoid" (op cit, p.160). Because Maori are over-represented in the lower socio-economic group in society, the vast majority of funding for Maori HCPs would come from the risk-rated premiums allocated from taxes. Few would be able to afford additional premiums. Yet Maori have higher rates of morbidity and mortality than non-Maori resulting in higher health costs. Maori HCPs would therefore require

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[99] As reported in the *Dominion*, 7 April 1992.

additional funding for them to be able to offer their clients an adequate level of care, and for them to remain viable.

"The Task Force", Durie claimed, "had anticipated (though without any serious consultation) that Maori authorities would make substantial 'top-up' contributions which would supplement State funding" (op cit, p.159). Maori had not anticipated this. A further concern was:

> the linking of health care plans with what could amount to a private health service for which the State might assume progressively less responsibility. The last thing that was needed was a health care system which was less accessible than the mainstream service or which, for financial or management reasons, was forced into delivering a substandard level of care (op cit, p.159).

Upton's intentions in the policy were that Maori would not only take over the opportunities to provide more culturally appropriate care, but Maori also would be expected to take responsibility for their own health status (Upton, 1991:70) He did not take into account the socio-economic factors which affect Maori health status but over which they have no control[100].

Easton suggested that Upton's claim that Maori would benefit from the introduction of HCPs "is dishonest, offering the Maori what it must know to be undeliverable" (Easton, 1992:10). The difficulty, he maintained, comes about through no "rigorous definition of Maoriness, [and] no adequate information on the higher costs of Maori sickness" (ibid) (caused by the higher incidence of sickness amongst Maori).

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[100] See The Public Health Commission's 1993 publication Our Health Our Future (1993:55-71) for a discussion of the socio-economic factors, often beyond the control of individuals and groups, which affect health status.

For Easton the offer of Maori HCPs is a "perversion of the intellectual process" (op cit, p.9), words becoming "subservient to political needs" (ibid). "The section [in the Green and White Paper] is enthusiastic about the effects of the Maori taking over management of their health funding and delivery ... What the paper does not discuss is feasibility" (ibid).

Upton, when interviewed in November 1994, undeterred by the concerns of Maori, maintained Maori were the strongest supporters of HCPs.

> But they, I think quite wisely, came to the view that they weren't in a position to run them at least in the short run. But over time they may well...I mean you can see a very strong Maori reason why in time, growing out of notions of sovereignty, people will say [we] want to run our own health system.

He acknowledged further that the Government's decision to establish HCPs along the lines of competing insurers was influenced by Treasury. He explained: "[t]he notion of competition between purchasers was very much a Treasury reason" (ibid). With hindsight he stated that HCPs were not in fact crucial to the policy but were included to provide people with choice.

> The idea was that RHAs were take it or leave it monopolies...health care plans provided an alternative, a choice...the idea is still there. I wouldn't be at all surprised if in 5-10 years there was a political movement to do that [establish HCPs] and it can evolve out of what is there [the provision in the legislation] (interview, 18 November 1994).

The difficulty, he again stated, was in working out adequate risk-rated premiums:

> [i]n the short run it became very clear, we simply didn't have the ability to risk-rate people so that you could actually get a genuinely adequate sum of money for each person who enrolled. It just gets too complicated. There simply wasn't the information there. But that will almost certainly over time change (ibid)

Managed Care

With the appointment of Jenny Shipley as Minister of Health in November 1993, there was no further discussion of HCPs. Instead Shipley recommended the introduction of managed care. The concept was first introduced by the Health Services Taskforce in its April 1991 Report to the Prime Ministerial Committee. Managed care was to be the essence of the alternative purchasers the Taskforce recommended. Shipley then was introducing the substance of HCPs under a different name and with some different properties.

In an address to the New Zealand Medical Association Conference, 19 April 1994, she introduced the concept using Laurence Malcolm's definition:

> managed care is...a way of organising health services so that providers are able to make value-for-money decisions, within a given budget, to achieve the best possible outcomes for patients and consumers.

Shipley linked managed care with budget holding[101], whereas in a generic sense it co-ordinates the care of clients - an intended function of the RHAs and HCPs[102]. She suggested managed care "contrasts with "unmanaged care" in which there is no budget" (ibid). While claiming the Government "has no fixed view on how "managed care" should evolve" (ibid) she promoted it as an opportunity for GPs to pursue. Managed care was to include responsibility for both primary and secondary health services but the contracts would vary according to the levels of risk undertaken by the different managed care organisations (MCOs).

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[101] For a discussion of budget holding contracts see next chapter.

[102] See Upton (1991:47).

Over the following months the concept gained support, initially from the RHAs and later from GPs and community groups. Phil White, Central RHA, suggested to me in an interview (6 October 1994) that Central RHA envisaged managed care developing from the budget holding contracts then being entered into between the RHA and GPs. The Government's Policy Guidelines for the Regional Health Authorities 1996/97 supported and encouraged the development of managed care.

Shipley's Advancing Health in New Zealand (undated but the contents suggest early 1996) sets out the Government's intentions for the development of managed care. Under the guise of managed care the Government devolves to the RHAs the responsibility to shift financial risk for personal health care to private enterprise MCOs. Unlike HCPs, MCOs will not compete with the RHAs but with each other and other private and public providers. The RHAs will remain ultimately accountable to the Minister of Health for the clients of MCOs, so will be responsible to monitor the performance of the MCOs (pp.24-6). Like HCPs, MCOs would both provide services themselves and purchase services from other providers, for example purchase secondary services from CHEs or private hospitals. In return for carrying risk the MCOs would retain any surplus, giving them an incentive to reduce their costs.

In May 1996 the Ministry of Health and the four RHAs convened a conference in Wellington entitled Managed Care: Options for New Zealand. In her opening address Shipley announced that managed care is on the Government's agenda for publicly funded health services. She saw it as a challenge "to how we can manage the public's expectations

within the given resources". She suggested it had "enormous potential to help achieve outcomes in the Government's health gain priority areas".

John Marwick, senior professional advisor at the Ministry of Health, suggested in his conference paper, the degree of responsibility and risk passed on to the MCOs could vary from an indicative budget for pharmaceuticals for an enrolled population, to full financial risk for primary and secondary services.

Marwick suggested models for MCOs could include those in the United States (HMOs and PPOs), GP fundholders in the United Kingdom, and local government involvement in Finland. Though a GP focus was promoted, Marwick suggested other community groups such as Maori and rural groups or commercial organisations might be interested, or alliances between groups such as Maori and groups of GPs might be a possibility. Aware of the implications for health service delivery, he suggested "further development [could] lead to proposals which would radically alter our whole health system" (Marwick, paper to Managed Care: Options for New Zealand Conference, Wellington, May 1996).

Managed care is being encouraged for Maori. Karen Poutasi, Director-General of Health suggested in Co-ordinated Care for Maori - Issues for Development (1995), "this approach can increase responsiveness to Maori needs and empower Maori to take responsibility for their own health" (p.4). There is a high degree of congruence, she maintained, between the aims and aspirations of Maori and those promoting managed care.

Just as there were short term incentives for Maori to establish HCPs, there are short term incentives for Maori to establish MCOs either on their own or in partnership with GPs or IPAs.

However, the development of MCOs raises similar concerns to those relating to HCPs. Marwick listed the concerns as:

- 'under-servicing'
- 'cream-skimming'
- difficulties in strategic planning
- high administration costs
- cost-saving rather than raising quality (Marwick, paper to Managed Care: Options for New Zealand Conference, Wellington, May 1996).

The funding of MCOs was not discussed.

As mentioned above, the Government has devolved to the RHAs the responsibility to devolve risk and in the process overcome the very similar problems it encountered in attempting to establish HCPs. The problems encountered determining a risk-related premium for HCPs will be multiplied as MCOs will vary in size, extent of risk, and demographic details of their populations. Also the Government has not addressed the additional problems for MCOs undertaking the risk for Maori health care. Maori, with their higher rates of morbidity and lower health status, will require additional compensatory funding if health care is to be equitable. Despite not having resolved these dilemmas the Government and the RHAs are keen to proceed with negotiations and contracts.

Implications

Though HCPs are not to be implemented the Government's and the RHA's interest in establishing MCOs indicates the implementation of this aspect of the policy is not yet finished. Different from HCPs in some respects, most importantly MCOs will not be (at least initially) in competition with RHAs. Their introduction will result from changes made to the policy during the implementation process.

The implications of the non-implementation of HCPs for health care will differ according to whether or not MCOs are established. If MCOs are not established the four RHAs will continue to occupy monopoly positions in their own regions unchecked by the threat of 'exit'[103]. With no threat of competition from alternative purchasers there is no guarantee that the RHAs will remain answerable to their communities. Though they are both agents of the government and agents of the people, the RHAs' accountability is biased towards Government. The Boards of the RHAs are appointed by the Government and are accountable to the Government through their funding agreements which are legally binding documents[104]. They have no legal requirement to act on the concerns of their clients.

The Health and Disability Services Act requires them to consult with "appropriate" members of their communities only with regard to their specific purchasing intentions. According to the Act each RHA shall:

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[103] 'Exit' refers to people's ability to move outside the public system to purchase health care. See Fougere "Inequality and Ideology". Paper to Sociology Seminar, 19-20 August 1982. p.66.

[104] See Shipley, J., Policy Guidelines for Regional Health Authorities 1996/97 (p.9).

> in accordance with its statement of intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:
>
> (a) Individuals and organisations from the communities served by it who receive or provide health services or disability services:
>
> (b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities (Health and Disability Services Act, 1993, Section 34).

According to the Minister of Health, Jenny Shipley, consulting with the community means providing information to the public about intended changes before they take place. When discussing "management of change protocols" she advised that once RHAs have established a case for change, they must provide that information to the public, and then manage the change (Shipley, Media Release, 19 August 1994). The changes she was discussing were major changes such as withdrawal of services in particular areas, and closure of hospitals.

Upton claimed RHAs would be independent agencies of the people and the government but they are not immune from politics. Without the contestability that HCPs would have offered, RHAs will be subject to political pressure from whichever government is in power. Health spending will be extended or restricted through the annual contracts made between the RHAs and whichever political party is in power.

Without the competition that would have been provided by HCPs, RHAs will not have the incentive to contract with providers in the most prudent way. RHAs could become provider-captured by CHEs who, with only minimal provider contestibility in the secondary sector for elective surgery, would need to be kept on side to ensure that they, as sole providers of many core services, continue to provide those services that the RHAs would be obliged to purchase on behalf of their clients. Tony Cull, former chief executive officer

of the Waikato CHE suggested "pragmatism will take over from idealism. It is in fact already happening" (Address to Legal Research Foundation seminar, 6 July 1994).

Another consequence of the demise of HCPs will be increased private supplementary health insurance for those on higher incomes or those who receive a subsidy from their employers. This will result in even less 'voice'[105] from this section of the population and an increased gap between those on higher incomes and those on lower incomes. Low income people will have no alternative but to accept the services which the RHAs purchase on their behalf.

Developing managed care will not only allow the Government and RHAs to devolve financial risk, but it will allow the Government to devolve political risk. The MCOs will be able to make decisions about the availability of services that it would be politically untenable for the Government, or even the RHAs, to make.

MCOs, in their bid to remain within their budgets will be concerned with cost-saving rather than increasing choices for their clients. Where HCPs were to offer choice to individuals about the way their health care services would be purchased and provided, individuals will not have a choice as to whether their GPs become involved in MCOs and in many cases will not be able to opt out for alternative care[106].

The concerns about managed care expressed by Marwick, and the problem of determining funding, need to be satifactorily resolved or individuals will be further disadvantaged.

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[105] 'Voice' refers to people's ability to "push the state to improve provision and operation of public services" (Fougere, 1982:66).

[106] In many areas of the country there is a shortage of GPs.

As was repeatedly stated at the Managed Care Conference there have been no studies produced in any country that prove that managed care has improved the health status of its clients or decreased a country's overall health spending. The Government's determination to proceed with managed care despite the concerns expressed by its advisors in the Ministry of Health, suggests the Government is still commited to market ideology and the commodification of health care drawing the question: is managed care seen to be a step on the way to privatisation of the health system? MCOs could logically lead to privatisation. As MCOs increase in number and size the Government may consider it more convenient for MCOs and RHAs to collect premiums from their clients directly, just as Upton suggested for HCPs[107].

Conclusion

HCPs were designed to enhance the market nature of the restructured health system and reduce the Government's fiscal risk by devolving risk and responsibility for the provision of health services to the private sector. Upton's 1994 explanation confirms that the National Government, heavily influenced by Treasury in its policy directions, had not sufficiently explored the practical implications of introducing HCPs.

The decision by Government not to proceed with HCPs yet to allow for them in the legislation suggests the Government does not intend abandoning the concept entirely. It ensured that it can be reintroduced at a later time when the information necessary for working out a risk-rating formula is available, or the political climate more amenable.

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[107] See Upton (1991:98).

As with the core, the non-implementation of this aspect of the policy cannot be explained by either a Top-Down or a Bottom-Up approach. The decision not to proceed with HCPs was made by the Government following advice from the HRD (Smythe, interview, 15 July 1993). The HRD, the implementation agency responsible for policy issues and legislative and regulatory regimes for the new health system (Upton, 1991:132), recognised that the information was not available to determine an adequate risk rating formula to prevent cream-skimming (Smythe, interview, 15 July 1993). In addition, HCPs did not have the support of the Labour Party, should they become Government. HCPs, like the core, were crucial to the commercial nature of the policy but during the experience of implementation it became obvious to the Government that they were not acceptable to the Labour Party nor were they implementable. The Government was responsible for making the changes and it was not influenced by street level bureaucrats or grass roots actors.

However the Government's determination to achieve its unstated objective is illustrated by Shipley's attempts to introduce MCOs. While MCOs would not provide competition at the purchaser level or a vital check on RHAs, due to the financial incentive of retaining any savings made, it would be in their interests to restrict health spending and thereby contribute to the control of the Government's fiscal risk.

MCOs will not assist the realisation of the stated primary objective of the policy.While Shipley claimed managed care would achieve the best possible outcomes for patients, as in the United States, the in-built financial incentives will encourage MCOs to restrict services to stay within their budgets.

Chapter 9

GENERAL PRACTITIONER SERVICES

Introduction

One of the central aims of the health policy was to integrate the funding for all personal health services. Personal health services include both primary and secondary health services. General practitioners (GPs) play a key role in providing primary services. Upton argued that the co-operation of GPs was crucial to the successful integration of health services (address to the Institute of Health Management, 1 August 1991), and that the integration of primary and secondary services "is critical to achieving improvements in cost-effectiveness, fairness, consumer responsiveness and efficiency" (Upton, 1991:47). It was to be an important factor in achieving the unstated objective of the policy. GP co-operation was also crucial to ensure that Government subsidised services were accessible to all those entitled to them.

Under the terms of the policy RHAs were required to contract with providers for the provision of services. Contracting would involve GPs agreeing to provide primary medical services to an enrolled population for a capped sum. This would enable RHAs to control costs for the provision of primary health care services. However, historically GPs have resisted all attempts by Government to enter into contractual arrangements believing these would curtail their financial and clinical independence and interfere with the doctor-patient relationship. For the last fifty years GPs have enjoyed a demand driven, open ended system of remuneration from the Government, and have been free to charge their patients an additional fee for each service.

This chapter will examine why GP contracts were crucial for the successful integration of primary and secondary health services, the GPs' resistance to contracting with RHAs, the compromise that was reached between Government and the GPs, the subsequent arrangements between the RHAs and GPs, and the implications for the provision of primary health care services.

Why GP co-operation was crucial

GPs as key primary care providers were an essential element in Upton's more integrated approach to "managing total care for individuals and families" (Upton, 1991:41). They are often the first point of call for people experiencing health problems and act as gatekeepers to specialists, secondary health care services, and many pharmaceutical and diagnostic services. In their gatekeeping position, GPs generate an increasing primary care budget in terms of the pharmaceuticals, laboratory tests, diagnostic services, and treatment services they prescribe. Malcolm and Barnett, (1994(a)) suggested it had increased by more than 6% annually over the preceding decade (p.93).

In the new health system, where the RHAs would fund both primary and secondary health care services, GPs would have "a much more central role" (op cit, p.53). Their co-operation would be essential to ensure access for RHA clients to primary health care services, and crucial for controlling primary health care costs. Because RHAs would receive capped budgets any overspending on primary services would reduce funding available for other services (op cit, p.48).

The Government's decision not to proceed with HCPs has resulted in the funding for all personal health care services being channelled through the four RHAs. The RHAs are

responsible for ensuring that all their clients have access to core health services (or service obligations as they are now called). As GPs are important providers of many of the essential primary services, it was considered crucial for the RHAs that sufficient numbers of GPs across all geographical locations enter into contracts with them to provide these services. The Associate Minister of Health, Maurice Williamson, stated this clearly:

> Regional Health Authorities will be required to ensure access to core health services, which will include primary health care. Therefore the Regional Health Authority will have to secure the services of GPs. That is what is meant when we talk of contracts and negotiations between the two parties (Williamson, press release, 4 September 1991).

Because RHAs would receive a capped budget from Government, it would be imperative that they encourage doctors to move away from the current demand driven, fee-for-service method of payment which reimburses GPs for the services they have provided. Upton claimed that the open-ended funding arrangements that existed for GPs, and some other providers, exposed the Government to "considerable fiscal risk" (Upton 1991:43). He suggested:

> [w]e need to create an environment in which a variety of contractual and organisational approaches can be tried, in the interests of promoting greater responsiveness to the users of health services, and better value for money (op cit, p.50).

Under the terms of the policy GPs were a crucial element in the new health care market. Not only would RHAs need to enter into contracts with GPs, GPs would need to compete with each other for contracts with the RHAs to provide their clients with government subsidised primary services[108]. Government funding for subsidised services would only be available through the RHAs, and the competitive, contractual arrangements between purchasers and providers were

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[108] See Health Reforms Directorate, (1992:3).

an important element of the market environment designed to control spending on health services.

In the 1992 summary of the Government's policy guidelines to the RHAs, Directions for Health and Independence, Upton explained the function of the intended contracts:

> [c]ontracts will form the basis of the relationship between RHAs and providers of those services which are paid for, or subsidised, by the taxpayer. This is so that the understandings reached between the parties - what is to be provided, the amount of money which will be paid for the services(s) provided, the quality levels required, and other details - can be recorded. Contracts will allow the RHAs and providers to be more flexible and innovative in developing services that meet users' needs (p.5).

While recognising that doctors have resisted strongly any previous attempts by governments to control their methods of practice or the fees they charge their patients, Upton claimed that doctors would enter into contracts with RHAs more willingly (ibid). The devolving of responsibility to the RHAs to achieve what preceding National and Labour Governments had not been able to achieve - GP co-operation for the control of primary care spending - was an important element of the policy.

Upton anticipated that a capped budget with responsibility for purchasing both primary and secondary health care services would lead to the RHAs placing "increasing emphasis on primary and preventive care services, which would have the potential for reducing demand for more expensive secondary care services in the longer term" (op cit, p.48). The co-operation of GPs would be essential for this to eventuate as GPs are key providers of these services.

Another intended strategy in the Government's quest for efficiency, was the increasing use of day surgery and community-based care. Upton claimed that day stay surgery would result in

"[c]ost savings in the order of 50% per procedure[109] " (Upton, 1991:53). Both day stay surgery and community based care require communities and their GPs to take responsibility for providing services that until recently were provided by the public hospitals. For this to be successful, the RHAs would require the co-operation of GPs to provide the necessary support services to clients in their communities (ibid).

Upton described this co-operation of GPs with RHAs as "crucial" to the new policy (address to the Institute of Health Management, 1 August 1991), and for the successful integration of primary and secondary care (Nordmeyer Memorial Lecture at the Wellington Clinical School, 7 August 1991). In his attempt to gain the co-operation of GPs, Upton stressed the commercial nature of the contracting process inferring that it would fit well with private enterprise general practice.

> To carry the reform through, we need the services and cooperation of general practitioners; independent business people who have made it clear that that's how the majority of them want to remain ... What's proposed is a recognition that, to put it bluntly, we have a market economy. One in which many doctors and other health professionals are not employed by the Government and have no wish to be (ibid).

Again on the 13 September 1991 Upton reiterated to the Healthcare Reform Conference in Auckland, that the co-operation of GPs was fundamental to the successful integration of primary and secondary care, one of the Government's major goals of the health reforms, he claimed.

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[109] For a more detailed analysis see Tang, J., "What's New: Ambulatory Surgery", in Texas Medicine, Vol 80, January 1984.

Because RHA budgets would be capped, the Health Reforms Directorate (HRD) suggested that in their contract arrangements with GPs, RHAs would need to control spending on primary care services. It was likely therefore that "RHAs [would] want providers to accept greater responsibility for health services to their clients" (Health Reforms Directorate, 1992:3). This greater responsibility referred to by the HRD was fiscal responsibility. RHAs, suggested the HRD, would want GPs and other providers to share the fiscal responsibility for providing primary health care services by sharing the financial risk.

Within the policy Upton devolved responsibility to the RHAs to find ways "to contain the level of primary care spending" (Upton, 1991:48), but gave no clear directions for how RHAs were to contract with the GPs. "The legislation does not specify the new contract forms - that will be up to the RHAs and providers" (Upton, press release 20 August 1992). However, he did point out that "fee-for-service payment of doctors makes it difficult to control the overall costs of doctors' services" (op cit, p.49) whereas "[r]isk-sharing and budget-holding contracts...focus on directly encouraging doctors to be cost-conscious" (op cit, pp.49-50).

The contracts were to supersede the existing fee-for-service remunerative arrangements. Historically, remuneration for services already provided, has encouraged a treatment/curative focused method of practice. Upton's intentions that GPs enter into contracts with RHAs "for a specific range of services to groups of people" (Upton, press release 20 August 1992), would involve a shift in focus to preventive care, and, for those entering into budget holding and risk sharing contracts, cost control when prescribing pharmaceuticals, diagnostic testing, and other treatment services. It would also involve a culture shift for doctors in the way they practise. In the interests of economic viability they would be compelled to devolve responsibility for some treatment services to practice nurses and other health professionals. The doctor-patient

relationship, the cornerstone of general practice doctors claim, would need to expand to include other health professionals.

The doctors' dissent

In a direct mirroring of the medical profession's refusal to co-operate with the first Labour Government's 1938 Social Security Act, the profession has again resisted strongly the current National Government's attempt to persuade GPs to enter into remunerative contracts with RHAs.

The power of the medical profession in New Zealand has enabled the profession to resist all attempts by governments to exercise control over it. The profession has been able to maintain a position of strength ensuring that medical practice has remained essentially private enterprise. Since the passing of the 1941 amendment to the Social Security Act, doctors have been able to offer their patients government subsidised care, by receiving subsidies from the government on behalf of their patients. At the same time they have been free to charge a fee-for-service directly to their patients.

The New Zealand Medical Association (NZMA) Newsletter, edited by the current chairperson of the NZMA, illustrates clearly the doctors' resistance to the 1991 health policy and its requirement that GPs co-operate with RHAs, entering into remunerative contracts with them. The doctors argued that the policy was a threat to their professional independence and they must resist the Government's and RHAs' attempts to gain their co-operation.

Geoff Stephens writing in the NZMA's Newsletter of 22 April 1992, described the profession as "a body of professionals which has doggedly striven against all odds to maintain financial and clinical independence over the past 50 years".

Recognising the importance of general practitioner co-operation for the successful implementation of the 1991 health policy, and the power of the medical profession, Stephens suggested: "[i]t must be clear to every reader that if every GP refused to take a contract in 1993, there would be quite a hiccough in the transition [to the newly reformed health system]" (ibid).

Likewise Auckland ear, nose and throat surgeon Mr H.R.R. Glennie, suggested that concerted opposition by the NZMA would be effective in ensuring that 90% of the intended health reforms would never be implemented. He also claimed that with the support of the medical profession the intended health reforms could lead to a system which would be the envy of the western world (Letter to the editor, NZMA Journal, 11 November 1991).

Stephens voiced the central concern for doctors: "I am convinced that GPs are about to suffer their greatest ever loss of independence, and that they will not get it back" (NZMA Newsletter, 22 April 1992). He contended that under a contract scheme where GPs receive payment on behalf of their patients directly from RHAs, conditions would be attached to this money which would "carry the distinct possibility of very serious reductions in our professional independence" (ibid).

Alistair Scott, then editor of the newsletter, expressed a concern in November 1992 that RHAs would encourage midwives and practice nurses to enter primary care (they are already primary care providers) and consequently restrict the number of contracts let to GPs (Scott, NZMA

Newsletter, 25 November 1992:1). RHAs failing to contract with any GP, he contended, would result in restrictions on patient choice because patients of a GP not under contract to an RHA would not be able to receive subsidised care. However, a united profession, Scott believed "will be able to ensure that general practice stays much as it is" (op cit p.4).

In the NZMA's Newsletter 10 March 1993, Scott stated the concerns of the GP Action Group, a newly established group who were against all forms of contracts and wished to retain the status quo. They described the amended Health and Disability Services Bill as being:

> all about power and control, has the potential to fix fees, and is a threat to the independence of all GPs, to the doctor-patient relationship and to the quality of general practice (p.6).

This was supported by Scott:

> [n]o one can deny that the Health and Disability Services Bill as currently written poses a serious threat to the future of general practice, and indeed to the practice of medicine generally (ibid).

In April 1993 Scott expressed his real concern that, despite Upton's promises to the contrary, fees charged patients by their doctors would be controlled by the RHAs, thus making a further inroad into the independence of doctors.

> Simon Upton constantly reiterated that he had no intention to control fees. It was difficult to believe him because he had given such explicit instructions to the contrary in the "Policy Guidelines to the Regional Health Authorities", the instrument by which the RHAs are informed of the government's objectives (Scott, NZMA Newsletter, 14 April 1993:3).

Scott was not strictly correct for, within the Policy Guidelines, GPs, in contrast to other doctors and providers, were to be exempt from this principle. But for Scott this was no guarantee for the future.

> Despite documentary evidence to the contrary, Simon Upton persisted in saying that it was not his intention to do things that were (and still are) explicitly demanded by the guidelines (ibid).

To clarify the NZMA's stance on the health reforms the association presented the Ministers of Health and Crown Health Enterprises, and RHA officials with the five issues that the association believed required attention to make the Health and Disability Services Bill acceptable.

> 1. Health care for all in need - the Bill should include a statement re people's right to health care.
>
> 2. Arbitration, not confrontation - an independent appeal process is required if people want to challenge decisions made by the RHAs or the PHC
>
> 3. An ethical health service to protect the public - there must be a stipulation that purchasers observe the ethical codes of the relevant professions
>
> 4. A framework to enhance accountability - the Bill fails to provide a framework that will assist in ensuring that there is true accountability
>
> 5. Meaningful consultation - consultation with both the public and providers must occur in a way that satisfies the parties (op cit, p.7).

By the end of April 1993, with the Health and Disability Services Act due to become law on 1 July, and conscious of their obligation to ensure access to GP services, the four RHAs were concerned to enter into contract arrangements with GPs. A document distributed by the Central RHA reads: "Our prime objective over the next few months is to ensure that arrangements with each provider are in place from 1 July 1993" (cited in NZMA Newsletter, 28 April 1993).

With the majority of doctors still refusing to enter into contracts the RHAs decided to offer doctors an arrangement that they claimed would maintain the status quo. During the following

weeks representatives of the four RHAs and representatives of the NZMA and the New Zealand General Practitioners Association (NZGPA) held discussions "to try to achieve a national 'rollover' arrangement which would be acceptable to doctors" (Peter Faulkner, past chairperson of the NZMA, writing in the NZMA Newsletter 9 June 1993).

However, according to Faulkner "[t]he documents were not a clear roll-over, and were heavily biased to what the RHAs thought the new relationship should be" (ibid). During a teleconference of the NZMA executive on 19 May unanimous agreement was reached that "the profession faced a major threat to its independence" (ibid).

As in the 1930s a red letter[110] was sent out to all members and to non-member GPs "alerting them to the problem" (ibid). According to Scott writing in the same Newsletter, the preservation of the status quo was merely a pretense:

> the government['s] intention to control the profession administratively is apparent at every turn...[a]s we said in the recent Red Letter to members, the evidence is now there for all to see that, whatever other aims there may be, the Health reform is about destroying the independence of the medical profession in New Zealand.
>
> The profession must not let this happen. We must not accept it for ourselves, or for those who follow us in our profession, and we must not allow it for our patients.
>
> Strong and independent professions are a bulwark of liberty and freedom, and in medicine, an independent profession, free to work in partnership with patients, and with minimal government interference, is the ultimate guarantee of a quality service.
>
> The Regional Health Authorities may back down from their present confrontational stand. But if they do not, we must fight them (Scott, NZMA Newsletter, 9 June 1993:4).

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[110] The NZMA sends out red letters to alert members, and in this case also non-member GPs., to perceived crises effecting the profession.

In their arguments the doctors linked clinical and financial independence with quality GP services and the doctor-patient relationship. They implied any loss of financial or clinical independence would ultimately lead to a deterioration in quality of services. This served to obfuscate the doctors' real concern which was, as in the 1930s, a loss of financial independence. They wished to retain their current remuneration arrangements with Government, and the freedom to charge their patients additional fees for each service provided. They also wished to retain their clinical independence. They did not want the Government or the RHAs to determine the terms and conditions for the practice of their profession or for them to interfere in the doctor-patient relationship.

Jonathan Simon, previous honorary secretary of the Royal New Zealand College of General Practitioners, summarised the GPs' concerns as follows:

- the GMS [General Medical Services] benefit was regarded by GPs as a patient benefit and therefore sacrosanct
- they feared a loss of clinical freedom and autonomy
- a possible loss of income
- they did not believe there was a problem so why fix it?
- any contract should be between GPs and their patients not with RHAs (Simon, interview, 2 June 1996).

As mentioned above Upton's inability to sell the reforms to the health professions or the public led to his replacement as Minister of Health at the end of March 1993 by senior cabinet minister Bill Birch. The stalemate between the doctors and Upton was not the only problem for Upton in having his policy accepted and implemented, but it was an important feature. Birch was mooted in the media as the "salesman for the new public health system" (*Waikato Times*, 25 March 1993).

A new salesman for the health policy

In his first speech as Minister of Health, and consequently his first attempt to sell the health policy, Birch emphasised the importance of integrating GP funding with "the other health reforms" (Speech to the Rotary Club of Wellington, 29 March 1993). Referring to the very real concerns of doctors about contracting with RHAs, he suggested that contracting "had some doctors tangled up in their stethoscopes" (ibid). In a conciliatory but paternalistic manner he stated that he was concerned not to "rush" to shift doctors on to contracts but rather to "sit down and talk things through with doctors" (ibid).

Likewise in his address to the North Shore Doctors at North Shore Hospital, 26 April 1993, Birch again talked of doctors needing more time to make their decisions about "how they want to operate in the new system" but at the same time he stressed he was "keen for the development of contracts to proceed". He also stated his intention to re-evaluate the Health and Disability Services Bill against the New Zealand Medical Association's concerns for "clear objectives, clear accountabilities, and clear requirements for consultation". Whilst acknowledging "reorganising of the Bill at this late hour is no small task", he suggested "the understanding and perception of the legislation may be improved by such a move".

To the Royal New Zealand College of General Practioners in Auckland, 2 June 1993, he reiterated: "for those of you who want to take things more slowly,...[c]hange will not be forced on you". He advised "the current fee-for-service GMS will roll over" because he thought it reasonable "to provide some certainty during the transition period for those who are apprehensive about change". The roll-over provisions he suggested, are "designed to be nothing more or less than helpful".

In his address to the Taranaki/New Plymouth Branch of the New Zealand Medical Association, 16 June 1993, Birch reiterated these points and attempted to ameliorate the perennial concern of doctors:

> the RHAs understand the special and confidential nature of the relationship between doctors and their patients. There is no intention to interfere with that relationship.

Unsuccessful in resolving the conflict with the doctors, Birch negotiated a two year roll-over period of the current fee-for-service GMS in June 1993 .

Non-implementation

Eventually on the 16 June 1993, with no GPs entering into new contracts with the RHAs, a roll-over agreement of the current fee-for-service GMS, and other patient subsidies payable to GPs, was reached. Birch, Minister of Health at the time, viewed it as a temporary arrangement that would ease the transition until GPs eventually entered into contracts with the RHAs. He explained it thus:

> I believe the appropriate balance has been struck with a two year roll-over period of the current fee-for-service GMS for those of you who want to take things slowly (speech to the Hawkes Bay Branch NZMA, Napier, 23 June 1993).

The roll-over agreement involved GPs working under Section 51 notices issued by their RHAs. Section 51 notices entitled GPs to continue to claim and receive patient subsidies and other benefits for treatments already provided, according to the terms and conditions set out by the RHAs (Health and Disability Services Act 1993:Section 51). Graeme Edmond, chief executive, Midland Regional Health Authority, in a letter to GPs in the Midland region, advised the

conditions would continue "for a minimum of 24 months from 1 July 1993, and be ongoing thereafter subject to a six month notice period". He explained, "[b]y continuing to claim and receive patient subsidies or other benefits you are deemed to have accepted the terms and conditions set out in the notice" (Edmond, 23 June 1993).

Patients of GPs not entering into Section 51 arrangements were to be able to have their subsidies, where eligible, refunded directly from the RHAs (ibid)[111].

In his address to the South Auckland Division of the NZMA at Manurewa 3 September 1993, Birch noted that whilst the Section 51 arrangement provided for GPs to continue providing Government subsidised services to their clients, providers needed to be "mindful that open-ended payment arrangements put pressure on the RHAs". Whilst the stated objective of the policy, access to services, could be realised under the Section 51 arrangements, the unstated objective, to control fiscal risk, could not be achieved.

Though the Minister of Health referred to the agreement as a "roll-over" agreement and Midland Health referred to it as "a fair reflection of the status quo", Alistair Scott chairperson of the NZMA reported that the NZMA executive regarded the notices as "quite inadequate and that the profession faced a major threat to its independence" (NZMA Newsletter, 9 June 1993). Scott argued:

> [t]he Health and Disability Services Act destroys the administrative framework of the present public health system, and with it, the disciplinary and legal underpinning of the system.

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[111] Just as under the terms of the 1941 Social Security Amendment Act, whereby patients of GPs who refused to accept government subsidies, could obtain refunds for their subsidised entitlement from the Social Security Department (Hay, 1989:120-1).

> It pretends through Section 51 notices, to allow the preservation of the status quo, but the government intention to control the profession administratively is apparent at every turn (op cit, p.4).

With the passing of the Health and Disability Services Act, Part II of the Social Security Act and s.41(1) of the Medical Practitioners' Act were repealed, effectively reducing the powers of the Medical Profession's own Disciplinary Committee and granting disciplinary powers and administrative decision-making powers to the RHAs. Scott questions how the Minister can claim the status quo is being maintained "when the pillars that support it have been withdrawn" (Scott, NZMA Newsletter, 23 June 1993). Whilst the GPs had retained their financial independence, these aspects of the Act marked a partial loss of their clinical independence.

Scott claimed: "only a fragile semblance of what was there before can be maintained thereafter [following 1 July]". Even the roll-over arrangements, he suggested, represent a new environment "so far containing new threats - and no new opportunities" (op cit, p.6). He continued:

> There is at least the chance that they will preserve for a time the semblance of an independent profession, a semblance of due process and fairness, and an opportunity to see revealed the dangers of a system, with commercial ethics in an area of human endeavour in which quite other principles should rule, without being destroyed by it (ibid).

A year later Shipley, then Minister of Health, defended the use of Section 51 Notices, claiming that the Government recognised that the changes to contract based provision of health services would take time. Therefore, she said, Government supported the use of Section 51 notices seeing them as providing "a smooth transition and continuity over the initial period when the split between purchaser and provider was made" (address to the Independent Practice Association Conference, Wellington, 25 June 1994).

Independent Practitioner Associations (IPAs)

The RHAs inherited some capitation and some salaried contracts which GPs had had with the Department of Health for many years. Also the RHAs inherited some national pilot programmes that were set up by the Health Reforms Directorate and the Ministry of Health after the release of the 1991 policy. According to Dr Jim Primrose, Adviser General Practice with Midland Health (the Midland RHA), no GPs had entered into new remunerative contracts with the RHAs by 1 July 1993.

Because RHAs have capped budgets and had not been able to share or devolve any risk to GPs by 1 July 1993, the Government entered into a risk sharing arrangement with them for demand driven primary care expenditure for their initial year of operation. In their second year the RHAs created their own risk reserves to manage any possible over-expenditure in demand driven primary care services (Ministry of Health, undated but contents suggest 1995(a):121).

Early in the reform process GPs began grouping together to form Independent Practice Associations (IPAs). According to Tony Haycock, former Adviser General Practice for North Health (the Northern RHA), the development of IPAs was a kneejerk reaction by GPs to provide them with bargaining strength. They were concerned too that general practice in the new health environment would need a management component and by grouping together they could defray costs by collectively employing managers (interview, 24 September 1994). By the end of 1995 there were 40-45 IPAs throughout the country (Malcolm, 1995:7).

Malcolm contended:

> some IPAs, and probably the majority of the membership [of IPAs], appear to be just seeking the protection they might offer and are very unclear about the value of membership...Many GPs are fearful of 'putting their heads into the noose' of contracting with the possible risk of losing their present independence and clinical freedom (Malcolm, 1994:10).

The model for the IPAs was adapted from one used in the United States. It was recommended in a report commissioned by the Health Reforms Directorate and the New Zealand General Practitioners' Association[112]. It was concerned with how primary care might be organised within the restructured health system and was entitled Independent Practice Associations in New Zealand: Policy Issues (1992). The report recommended the development of IPAs - organisations of GPs and other health care providers - to contract with health care purchasers to provide specified health care to their clients (Auckland UniServices Limited, 1992:ii).

The report recommended that the contracts between the IPAs and the RHAs should involve both incentives and risk-sharing. The IPAs would receive capitated funding for the clients of their members, and individual members or practice groupings would enter into separate remunerative contracts with their IPA. These contracts between members and their IPA could take a variety of forms. They could include:

> (i) Salary
>
> (ii) Capitation
>
> (iii) Fee for Service
>
> (iv) Risk sharing contracts - contracts where GPs share the costs generated by their actions
>
> (v) Budget holding contracts - patients are registered and practices receive an allocation of the annual budget. All costs provided for in the contract are covered out of the budgets (op cit, p.54).

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[112] At that time the NZGPA was headed by Tom Marshall, a GP who accepted the inevitability of reform but was determined to influence its outcomes. He was later ousted by a group of GPs against all forms of contracting and determined to maintain the status quo.

Any savings made by the IPAs would be divided between members according to the terms of their contracts.

The Government and the RHAs have applauded the development of the IPAs as they present an opportunity for the RHAs to enter into group negotiations and possible contracts with the members rather than having to deal with GPs individually or practice based groupings. GPs form the membership of the vast majority of IPAs. The IPAs vary considerably in size with the largest, ProCare in central Auckland having 320 members (Malcolm 1995:7), Pegasus Medical Group in Christchurch having 195 members, and the Wellington based Central Independent Practitioners Organisation having approximately 180 GPs (Ministry of Health, 1995(a):123-124).

The resulting contracts between the IPAs and RHAs have acknowledged the GPs' position as gatekeepers. By June 1994 seven IPAs had entered into nominal budget holding contracts with RHAs for some referred services, most commonly for pharmaceuticals and laboratory tests (Shipley, address to Independent Practice Association Conference, 25 June 1994). None of the agreements involved GPs carrying risk for over expenditure of the budgets and in all cases the GP members of the IPAs still practised fee-for-service medicine[113].

Built into the nominal budget holding arrangements were incentives for GPs to change their prescribing habits and underspend their budgets. The savings realised would benefit GPs. With some agreements the GPs retain all the savings but in others the savings are shared between the GPs and the RHAs. The ratios differ between arrangements and between RHAs. In contrast to Upton's intentions in the policy and the original intentions for IPAs as outlined in Independent Practice Associations in New Zealand: Policy Issues, as at the end of 1995 no GPs or IPAs were

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[113] The fee-for-service subsidies are paid to GPs by Health Benefits Limited, an agency established in Christchurch in 1993 by the four RHAs.

carrying any financial risk (Ministry of Health, 1995(a):123), (Primrose, interview, 13 October 1995). The only control on GP driven primary health care spending was being achieved through contracting GPs attempting to stay within budget for pharmaceuticals and laboratory tests by changing their prescribing practices. Incentives, in the form of GP savings were being used to control fiscal risk.

In early 1996 a Tauranga based group of 45 doctors, Prime Health Limited, one of the early pilot programmes set up by the Ministry of Health and the Health Reforms Directorate, contracted with Midland Health to carry limited risk for pharmaceuticals and laboratory services for its clients. Prime Health entered into an agreement with Managed Care New Zealand, a subsidiary of Aetna Health (an American health insurance company) to share the financial risk. In line with the current interest in managed care, Prime Health's GPs are interested in eventually expanding their budget holding to include some secondary health services (Primrose, interview, 15 February 1995).

Central Health (the Central RHA) is also enthusiastic to encourage GPs to extend their budget holding contracts to include some secondary health services. Phil White, Adviser General Practice Central Health, regards budget holding as a step on the way to a more managed care approach. He envisages GP budget holding practices eventually becoming Managed Care Organisations (MCOs), holding budgets for a large variety of secondary services as well as for pharmaceuticals and diagnostic testing (interview, 6 October 1994)

Managed Care Organisations (MCOs)

The current move towards managed care and the development of managed care organisations promoted by Shipley and the RHAs is attracting interest from GPs and IPAs. Managed care will

give GPs the opportunity to manage budgets for their enrolled clients and retain any savings made. As mentioned in Chapter Eight the RHAs will hold the ultimate risk for the clients of MCOs.

According to Malcolm (1994) the possibility of holding budgets for both primary and secondary services in the new managed care environment offers GPs "a new strategy for shifting the power and dominance from the secondary to the primary sector" (p.9). Shipley believes this greater emphasis on primary care will ultimately result in reduced costs for secondary and tertiary services (Shipley, address to Independent Practice Association Conference, 25 June 1994).

Without an explicitly defined core, GPs as members of MCOs will be responsible for rationing services. The needs of each individual patient will have to be considered in a financial as well as a clinical sense. According to Graham Scott, Chairperson Central RHA, the good of the individual will be considered against the good of the organisation:

> [w]hen we give the clinician responsibility and accountability for the budget we pass on the job we have as an RHA to the clinician. When they have to care for the population, they will alter their decisions about using resources, to get the best value for the population from available resources. They manage the tension between the demand for services and the realities of a constrained budget. They have their eyes on the person set against a backdrop of the needs of others (Address to the Managed Care: Options for New Zealand conference, 4 May 1996).

Where GPs and IPAs become members of MCOs they will be responsible for purchasing both primary and secondary services including those from their local CHEs, private hospitals and medical specialists. This will involve a reversal of roles. CHEs and medical specialists will become accountable to the GP members of the MCOs. But if MCOs are developed along the lines of HMOs in the United States, medical insurance companies or CHEs may be the owners

of the MCOs and this will result in GPs being employed by the MCOs and being required to make clinical decisions in light of the directives of those managing them.

An important aspect of managed care is the management of the way health services are delivered. In MCOs in the United States and the United Kingdom this involves protocols and guidelines determining the circumstances when treatments and diagnostic tests may be offered to clients. Very often decisions on whether clients will be admitted to hospital or prescribed expensive diagnostic tests, must be referred to the managers of the organisation.

In the United States managed care organisations such as HMOs are not always owned by providers but are frequently owned and managed by medical insurance companies which employ providers to deliver health care services. In the United Kingdom fund-holding practices using managed care principles are composed of providers and managed by them or employed managers.

John Marwick, senior professional advisor in the Ministry of Health, advised at the Managed Care: Options for New Zealand conference in Wellington, May 1996:

> It's right to say that we are not talking about transplanting an American health system, but we are looking at areas of success and controversy so we can develop options that suit us in New Zealand.

Managed care and the development of MCOs is a deliberate attempt by Government and the RHAs to further control fiscal risk. While RHAs would ultimately hold the financial risk it would be in the interests of members of the MCOs to control spending on health services and realise savings. While being offered financial incentives, GP members of MCOs may lose some of their clinical independence if they are managed by generic managers or insurance companies.

The July 1996 RHA Maternity Scheme

In July 1996 the RHAs imposed their new maternity scheme on GPs, Obstetricians and Midwives despite determination by the doctors not to work within the scheme[114]. Remuneration was to be made on a budget holding basis under Section 51 agreements. A woman requiring maternity care would elect a Lead Maternity Carer (LMC) who would be given a budget from the RHA to cover the costs of her care and for funding any referrals which the woman may require. The LMCs therefore would hold the risk for providing maternity care and would in this way control health spending for maternity services which has doubled since 1991 despite the numbers of births remaining about the same (Shipley, press release 16 July 1996).

GPs strongly resisted the budget holding arrangements preferring a fee-for service agreement. Many have chosen to work outside the scheme charging their patients full fees and suggesting they claim refunds from their RHAs. The New Zealand Medical Association (NZMA) recommended that GPs refuse to accept payments under the scheme but continue to provide free care to their maternity patients in the interim, in the hope that the RHAs could be persuaded to rethink the scheme (Linehan, NZMA Newsletter, 12 July 1996:1).

Due to the determined opposition of the medical profession, and their concern for ensuring access to GP provided maternity services, the RHAs have shown some willingness to discuss possible amendments to the scheme. In early October a Joint Medical Maternity Working Party released an alternative maternity proposal based on fee-for-service remuneration. However the proposal did not have the acceptance of the RHAs or the College of Midwives, but talk is

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[114] See "Maternity services - still the hot issue" NZMA Newsletter, 28 June 1996.

continuing in an effort to produce an arrangement which will suit all parties - the RHAs, Midwives, Obstetricians and GPs. In the meantime Government funding for maternity services is only available through the Section 51 agreements.

Implications

The organisation and delivery of primary health care is undergoing significant change with important implications for clients, the delivery of health services and the medical profession.

The Section 51 agreements established in July 1991 between the RHAs and GPs have continued, despite the Government's and RHAs' intentions that they should be transitory arrangements until contracts could be agreed upon. According to the Ministry of Health the Section 51 agreements are not sustainable in the longer term:

> These arrangements have served to protect people's access to services during the transition, and have given the new agencies time to develop the skills they need to operate in the new system. They have, however, limited purchasers and providers in their moves to construct a more appropriate and efficient mix of services and so are not sustainable in the longer term (Ministry of Health, 1993(c):27).

In the 1994/95 Policy Guidelines for Regional Health Authorities the Minister of Health required RHAs to develop proposals to replace Section 51 Notices which were due to expire in January 1996 (p.22). However, as at the end of 1996 most GPs are still working under them. Though the Government had devolved responsibility to the RHAs to gain the co-operation of GPs, the current Minister of Health has continued to play a role in encouraging GPs to take responsiblity for controlling spending for primary care services.

Because the Section 51 maternity arrangements involve the LMCs holding budgets for the provision of maternity care, they are regarded by the RHAs as sustainable in economic terms, but if GPs continue to refuse to accept them, women may be denied access to GP services during pregnancy.

The development of IPAs is achieving some of what Upton had intended would result through GPs contracting with the RHAs, with the major exception that GPs are not sharing the financial risk with the RHAs. GP members of IPAs are becoming more accountable for the costs of the services they provide. They are monitoring each other through peer review and developing guidelines for prescribing pharmaceuticals and diagnostic tests.

The monitoring and accountability taking place in IPAs was initially accepted by GPs because it was seen as peer review but generic managers increasingly are managing IPAs and GPs are therefore becoming accountable to managers from outside their profession. GPs have lost some of their professional autonomy but have accepted this because of the financial incentives. These incentives have also served to break down the GPs' earlier resistance to contracting with the Government or its agents.

Managed care is regarded by many GPs and IPAs as an opportunity to assume control over the direction of health care, to have more money injected into general practice, to benefit financially, and to enhance the status of general practice. Other groups such as Maori are also keen to form MCOs , either on their own or in partnership with GPs or IPAs.

In the new managed care environment clients of MCOs would be required to enrol with a particular organisation and receive all their health care through that organisation rather than use various GPs and agencies for health care as is the current practice for many.

Because financial considerations would be a major consideration, clients may not always see their GP of choice. They may be referred to other health professionals such as practice nurses. This would be determined by practice guidelines. Also, referrals to medical specialists and hospitals, and the length of stay in hospital following treatment, would be at the discretion of those managing the organisation. GPs would lose the considerable financial and clinical autonomy they enjoyed before 1993.

The development of managed care would shift more of the responsibility for the purchasing and provision of health services to the private sector resulting in a clawing back of the public sector. As mentioned in Chapter 8 it would be an easy process at a later date for a Government to move to a private system of health care if this is its intention.

Conclusion

The process of implementation of this policy initiative was influenced by the requirements set out in the policy that GPs must contract with their RHAs to provide Government subsidised services to their clients. This would have required major changes to the way they practised their profession and GPs, with the backing of the medical profession, had sufficient power to resist co-operating with the policy intentions and to compel Government to make changes to the policy. In 1996, though the Government has imposed budget holding agreements on GPs (and other providers) for the provision of maternity services, GPs have continued to resist the arrangements in their attempts to again compel Government to make changes to their policy.

In 1993 the RHAs' ability to counteract the power of the medical profession was impeded by their lack of information and expertise necessary for negotiating with the doctors. The RHAs were newly established agencies with few members experienced in the health sector and with no blueprint for contracting with GPs. The policy design lacked detail, it provided only abstract ideas about contracting. According to Tony Haycock, GP adviser for North Health (the Northern RHA), in the early stages when some GPs came together to form IPAs and were willing to discuss possible arrangements with the RHAs, they became frustrated by the RHAs' lack of information and inability to enter into fruitful discussions (interview, 24 September 1994).

Upton, when interviewed in November 1994, showed no concern that GPs had not entered into risk-sharing contracts with the RHAs. He stated that a variety of different arrangements was how he had envisioned contracting. He reaffirmed the Government's devolving of the responsibility to the RHAs for how they would manage their budget: "the Government doesn't care, it's the outcomes Government is concerned about" (interview, 18 November 1994).

The diversity of arrangements which has eventuated between GPs and the RHAs has the potential to disperse the earlier strength and power displayed by a united profession. This is being tested by the current refusal of GPs to co-operate with the new maternity scheme. GPs and IPAs are now in competition with each other in a way not seen before in this country. Added to this, the intended development of managed care will overturn the historical relationships that existed between GPs and medical specialists resulting in a more divided profession.

The GPs' refusal to co-operate with the the RHAs and the Government in 1993 cannot adequately be explained in terms of a Bottom-Up approach. The doctors were not merely using their discretionary power to alter the policy while it was being implemented. The GPs, a pivotal group in the health system, with the strength and power of the medical profession behind them, rebelled against the policy by refusing to enter into contracts with the RHAs by July 1993. Their refusal caused the top to make changes to the policy to ensure access to government subsidised services for those entitled to them. Sabatier and Mazmanian's Top-Down approach suggests policies need to have the support of interest groups to ensure successful policy implementation, but GPs are more than just an interest group in relation to this policy. They play the key role in providing Government subsidised primary services.

The Government's attempt to devolve responsibility to the RHAs for gaining the co-operation of GPs could be explained from a Top-Down perspective but this approach is not adequate to explain the on-going process of implementation of this feature of the policy. The underlying assumption of the policy was that by changing the method of payment of subsidies to GPs, they would be forced into complying with the Government's intentions. However this does not take into account the history of the medical profession's determination not to enter into contractural arrangements with the Government or its agents, or the pivotal position enjoyed by the GPs. The content of the policy effected the implementation process and likewise, during implementation, changes were made to the policy.

The subsequent development of IPAs and the arrangements between GPs and the RHAs cannot be accounted for by either a Top-Down or a Bottom-Up approach. The formation of IPAs and IPOs was initiated by GPs and, though recent arrangements between GPs and the RHAs were

initiated by the RHAs, the GPs have generally resisted risk-sharing and have entered into arrangements where they can make financial gains.

The RHAs are faced with the dilemma of being obliged to both ensure access for their clients to GP services, and to control spending so as to stay within their capped budgets. Currently the RHAs are ensuring access to Government subsidised GP services, but not maternity services, by continuing with the Section 51 notices issued in July 1993. These were originally intended to be transitory arrangements expiring in January 1996, but in the absence of replacement contracts with GPs, the RHAs have been forced to continue with them. The RHAs are attempting to resolve their dilemma by seeking to encourage GPs to enter into Managed Care Organisations which would have financial incentives for GPs. The RHAs' attempt in July 1996 to impose budget holding arrangements on GPs and other providers for maternity service has resulted in GPs again refusing to co-operate, compelling the RHAs to negotiate further policy changes.

Chapter 10

THE NEW PUBLIC HEALTH STRUCTURE

Introduction

The separation of the purchasing and providing of public health services from personal health services was a fundamental element of the 1991 health policy. A Public Health Commission (PHC) was to be responsible for purchasing public health services, advising Government on policy, developing and promulgating regulations, and co-ordinating public health strategies. A Public Health Agency (PHA) was to be established as the major publicly-owned provider of regional public health services. Within the policy the PHC and the PHA were important for: maintaining the separation of the provision of public health services from personal health services; the separation of the purchaser and provider roles in the public health context; keeping a focus on public health; and reducing overall health costs in the future.

Early in the implementation process the Government decided not to proceed with establishing the PHA, resulting in changes to the way public health services would be provided. The PHC was implemented as planned but within seventeen months of the passing of the Health and Disability Services Act, legislating for the newly restructured health system, Minister of Health Jenny Shipley announced that it would be disbanded, its functions to be carried out from inside the Ministry of Health.

This chapter will look at why a separate public health structure was regarded by Upton as crucial to the policy, why the PHA and PHC were considered to be an important part of that

structure, the non-implementation of the PHA, the reasons given for it not being implemented, the implementation and then disbanding of the PHC, and the implications for the delivery of public health services in New Zealand.

The importance of, and difficulties with, a separate public health structure

According to Upton the Government's intention to establish a separate public health structure for the purchasing and provision of public health services "marks the importance the Government places on public health and health promotion activities" (Upton, address to the Health Promotion Forum Auckland, 24 October 1991). For Upton the importance of public health strategies was linked to the controlling of fiscal risk. "[P]ublic health services, if they are successful, will reduce the use of personal health services[115]" (ibid). He continued "[i]n the health arena, health promotion activities might be said to be the stitch in time that saves at least nine, and probably a great many more" (ibid).

The Government also saw a separate public health structure as better for public health. Upton explained the new separate structure for public health would "ensure a renewed focus on public health - which is crucial not only to the nation's health, but to making the best use of available resources" (ibid). He considered the structural reforms would guarantee protection of public health funding "protection of funding for population based services aimed at health protection, disease prevention and health promotion - something we have not been guaranteed in the past" (ibid). According to Upton, and research carried out by the Public Health Association of New

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[115] In the 1991 policy he had claimed "[t]he Government, as principal funder of health services, has an interest in effective public health activities because they reduce publicly-funded treatment costs" (Upton 1991:107).

Zealand[116], Area Health Boards, under mounting financial pressure, were unwilling to invest in long term public health strategies (ibid), (Public Health Association, 1994:4).

Upton maintained the new structure would overcome problems of "inadequate co-ordination, lack of national focus and lack of an identified responsibility for public health" (Upton, 1991:110), which would have resulted if RHAs and HCPs had been made responsible for planning and purchasing public health services (ibid).

A further though unspoken reason for a separate public health structure was that it was crucial in National's policy if alternative HCPs had been established. This was so for the provision of public health services would not have been an attractive proposition for alternative HCPs whose focus would have been on the personal services necessary for their own clients. Public health services do not give an immediate or short term return for the investment involved.

Also, as public health advocates would argue, there needs to be a community or national approach for public health strategies to be effective. As Geoff Ineson, then Regional Public Health Resource Manager, Wellington Area Health Board, noted, "[p]ublic health issues do not recognise district and regional boundaries" (Ineson, 1992:2). For example, outbreaks of contagious diseases or the importation of contaminated food could have an impact across several regions and would require a national and co-ordinated approach. This would not be possible if RHAs and HCPs were responsible only for the public health strategies affecting their clients.

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[116] The Public Health Association is composed of a wide spectrum of people working in the public health field. The association promotes knowledge through research, debate on topical health issues, and participates in the development and evaluation of public health policies.

In a paper submitted to the Public Health Commission Implementation Group (PHCIG)[117], Dr John McLeod, member of the Health Services Taskforce, explained why organisations other than Government may have only weak incentives to fund public health services:

> 1. the benefits of funding public health activities are diffuse and often accrue over long periods of time;
> 2. the benefits may not accrue to the funding organisation;
> 3 . the costs of failure can be passed on to others (eg, water pollution) (McLeod, 1991:5).

Individuals also have weak incentives to invest in these services since they cannot capture the full benefit themselves and cannot protect against under-investment by other individuals (ibid).

McLeod believed that if it is left to the market to provide public health services "it is likely that fewer public health programmes will be provided than is optimal owing to market failure. An element of public expenditure on public health programmes, therefore, is required" (ibid).

Just as for personal health services, the purchaser and provider roles in the new public health structure were separated, creating what was in fact a funder-purchaser-provider split - the Government as funder, the PHC as purchaser, and the PHA as provider. Unlike for personal health services, competition was not to be established at the purchaser level, and only limited competition would be established at the provider level. Providers would be able to compete for contracts with the PHC for providing national public health strategies, for example a national cervical screening programme. At the regional level the PHA would be a monopoly provider of regional public health services but it would be "permitted to contract out those of its public health functions which are well-defined and predictable, and thus able to be contracted out

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[117] The PHCIG was specifically concerned with advising the Minister of Health on the implementation of policy related to establishing the PHC.

efficiently" (Upton, 1991:112). It could therefore be argued that the PHA would have a purchaser as well as provider role.

Upton suggested this separation of roles would allow the Government's investments in public health "to be more transparent" (Upton, address to the Health Promotion Forum Auckland, 24 October 1991). However, the Government's decision to separate the funding, purchasing and provision of public health services from personal health services marks a contradiction to another of the essential elements of the 1991 health policy, integration. Integration, Upton argued, was necessary to address the many problems then being experienced in the health system (Upton, 1991:41). He sought to integrate the funding of primary and secondary services and the funding of accident-related care and non-accident related care, yet he created an artificial separation between the provision of public health services and personal health services.

Integration of the funding and provision of public health services and personal health services was introduced with the 1983 Area Health Board Act. Prior to the passing of this Act, the provision of personal health services was the responsibility of private practitioners and hospital boards, and provision of public health services was the responsibility of district offices of the Department of Health. However, public health nurses employed by the Department also provided some personal health services. These included immunisation, care of new born babies and their mothers, testing for hearing deficits, and investigation of sexual abuse complaints.

Chris Laurenson, then a public health consultant, suggested in an interview (17 November 1994) that the distinction created by Upton in the policy between public health services and personal health services, is an artificial separation. It is often impossible, he suggested, to separate public

and personal health services at the provider level[118]. For example, immunisation is both a public and a personal health issue, both a public and a private good. Immunisation programmes are public health strategies developed to eradicate particular diseases from the population, but the delivery of immunisation services to individuals and families is a personal health service (ibid).

Many public health workers, especially public health nurses, provide services at the interface of personal and public health, and, according to Laurenson, they were concerned that this artificial separation "may reduce the effectiveness of the public health function by requiring them to identify with only one aspect of the dichotomy" (Laurenson, 1992:12).

Bandaranayake[119] (1994) commented that it is often impossible to separate public health and personal health services at the point of delivery, "as many personal health providers will continue to play a key role in meeting public health goals...The reverse, is also true, as many public health staff provide personal services in areas with difficulties in service access...Consequently", he suggested, "the division between personal and public health services ignores the basic principles of public health service planning and delivery, which emphasise the importance of integration and co-operation" (p.135).

Upton too now recognises this separation is artificial. When interviewed in November 1994, Upton suggested that the proposal to establish the PHA was "probably a poorly developed bit of someone's thinking and quickly fell off the list". The PHA was not implemented he suggested, because "you didn't want to separate the provision of those things [public health services] from

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[118] A point recognised by Health Waikato's Community Health Division in its integrated approach to community health services - see below.

[119] Bandaranayake is a member of the Department of Public Health at the Wellington School of Medicine.

the provision of personal health care. Public/personal health provision is a problematic interface ... an artificial separation in lots of ways".

A separate public health structure was important in the new health system both to protect the public's health and to reduce future personal health costs. However, this separation of public and personal health services created an artificial distinction at the provider level and contradicted the Government's intention to integrate the planning, purchasing and provision of health services.

The Public Health Agency

The Health Services Taskforce recommended to government that the provider of public health services should be:

> a national business with regional offices which would be a Crown agency...because
>
> - it will promote national co-ordination of public health activities while allowing some regional diversity and links with other regional agencies;
> - the Crown agency form will promote an efficient approach to the provision of services;
> - it separates possible conflicting roles with the funding agency;
> - it allows minimal regional size requirements to be fulfilled;
> - it limits administrative complexity and costs (Cabinet Paper, PMR (91) 81:2-3).

The PHA would have three regional offices, according to Dr John McLeod, "[t]he northern and southern regions will have the same boundaries as the northern and southern Regional Health Authorities. The central region will cover the two lower Regional Health Authorities in the North Island" (McLeod, paper submitted to the PHCIG, 19 December 1991).

The PHA was to be headed by a board appointed by the Minister of Health "so that it can draw on a wide range of public health and business expertise from different sectors" (Upton, 1991:112) and it was to be accountable to the PHC for the delivery of contracted population-based services (ibid). Upton introduced the term "population-based services" and used it interchangeably with "public health services" throughout the Green and White Paper.

The PHA was to be the major publicly-owned provider of regional public health services.

> Its responsibilities will include the development of strategies to ensure that food and water supplies are safe and healthy, and that sewage, chemical and other waste products are disposed of safely. It will also administer public health legislation and regulations (op cit, p.111).

The PHA was to advise RHAs, HCPs and local authorities on public health issues. It was to have the capacity to respond in times of epidemics and to be responsible for food and drug recalls (op cit, p.112). It was also to be able to contract with other Government departments to carry out some of their regulatory functions. For example, it could monitor compliance with the Sale of Liquor Act on behalf of the Department of Justice, or monitor compliance with the health requirements of the Child Care Centre Regulations on behalf of the Ministry of Education (ibid).

In a paper submitted to the chairperson of the PHCIG, the Public Health Association of New Zealand strongly supported the establishment of the PHA "as a monopoly provider of certain key functions" (Public Health Association, January 1992) with its branches providing a regional focus on public health issues and strategies. It also supported the PHA contracting out services to other providers but remaining accountable to the PHC for the provision of those services.

The PHA, being concerned with the provision of population based health services, was to maintain a public health focus, important for conserving and improving the population's health status and reducing the future need for publicly-funded treatment costs. The PHA, therefore, was regarded as an important element in reducing future health costs. It was, however, to be a monopoly provider which was in conflict with the contestable nature of the rest of the policy and Upton's arguments that competition would provide a more efficient and effective health service.

Implementation of the proposal to establish the PHA was the responsibility of the National Interim Provider Board (NIPB). In the Green and White Paper Upton explicitly listed establishing the PHA as one of the NIPB's two functions (Upton, 1991:130). In the Terms of Reference for the NIPB, the Board was given the task of establishing providers for the restructured health system, including "[e]nsuring Public Health services are adequately and efficiently provided" (NIPB, 1992:71). As Gillian Durham[120] suggested, the brief was less specific than the Green and White Paper in terms of establishing the PHA. "The terms of reference were sufficiently broad to enable the National Interim Provider Board to reconsider whether the Public Health Agency was the best way to ensure adequate and efficient provision of public health services" (personal communication, 27 March 1995).

Non-implementation of the PHA

The first public indication that the Government was considering not establishing the PHA was Upton's statement to a Public Health Association meeting, 18 February 1992. He stated that the formation of the PHA was under question and that he would make a decision on whether it

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[120] Dr Gillian Durham was a member of the PHCIG, then Chief Executive Officer of the PHC, and, from 1 July 1995 she holds two titles: Director of Public Health and Deputy Director General Public Health.

would be established, on receipt of a report from Professor Skegg, chairperson of the PHCIG (Ineson, letter to the PHCIG, 20 February 1992).

In the same month Gillian Durham[121] had commented to the National Health Protection Advisory Committee that the NIPB was concerned "that setting up the PHA as a monopoly provider was in conflict with a contestable environment in which the market could lead to greater efficiencies" (cited in Laurenson, 1992:19-20).

Within the same week Professor David Skegg, chairperson of the PHCIG (and later chairperson of the Board of the PHC), stated in a meeting with the Waikato Area Health Board that he personally favoured Regional Health Authorities acting as agents of the PHC, contracting with Crown Health Enterprises to provide regional public health services (op cit, p.20).

In a memorandum to cabinet (21 April 1992) prepared by the PHCIG, it was recommended "that the Government should announce that it has decided not to establish a Public Health Agency for the time being" (p.9). Cabinet was advised that "many organisations and individuals have seriously questioned the need for a Public Health Agency" (op cit, p.7). Some of the concerns were:

- Although the Agency was to be a provider organisation it would have both purchaser and provider functions which could interfere with the contestability which the Government required.
- There was likely to be a severe shortage of contracting expertise in the health service, and the regional offices of the Agency would duplicate some of the purchasing functions of the RHAs requiring extra personnel.

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[121] Dr Gillian Durham was contracted by the NIPB "to direct a project to "unbundle" public health services and resources" [in both the Department of Health and Area Health Boards] (Cabinet paper (92) 64A:3-4).

- The Agency would likely be bureaucratic and costly to run if it were to be responsive to the communities living away from the three main offices of the Agency.
- The Agency would put a gulf between staff working in public health and personal health care in local communities. Separating public health staff into an Agency would interfere with the integrated approach that had been a positive feature of many Area Health Boards (op cit, pp.7-8).

The paper continued: "[t]he National Interim Provider Board (NIPB) and the PHCIG consider that the PHC should explore using the RHAs as its agents for purchasing public health services at a regional level" (op cit, p.8). It suggested further that public health staff currently employed by Area Health Boards could remain with the soon to be established CHEs, and the CHEs, along with other providers, could contract with the RHAs to provide public health services. It also suggested that the PHC could consider contracting with HCPs to purchase and/or provide public health services.

Both implementation agencies recognised the contradictions in this aspect of the policy and therefore recommended changes should be made to the policy. The NIPB was concerned with maintaining the purchaser-provider split and contestability within the public health environment, and the PHCIG recognised and wished to maintain the positive developments in recent years of an integrated approach to the delivery of personal and public health services.

At its meeting on 27 April 1992, less than one year after the release of its health policy, the National Cabinet made the decision not to establish a Public Health Agency meantime (CAB (92) 284). In a memorandum to the Cabinet Committee on the Implementation of Social Assistance Reforms, 27 May 1992, it was declared that the PHC could use RHAs as its agents for purchasing regional programmes. The RHAs would be able to purchase public health

services "from Crown Health Enterprises (CHEs), regional councils, private organisations, or voluntary agencies" (p.4).

This development completely contravened Upton's original intentions.

> Regional Health Authorities have not been made responsible for public health services because it is very difficult to make someone responsible for the health status of another person through a contract. And when budgets are under tight constraint the priority goes into services which provide immediate care for people (Upton, press release, 30 July 1991).

On 6 May 1992 in parliament, in answer to a question from the deputy leader of the opposition, Helen Clark, as to whether the Government was still considering establishing a separate Public Health Agency, Upton replied:

> I think I am correct in saying that we have not actually decided not to do that at this stage, but the weight of evidence would suggest that such a separate agency is not necessary and that we will be able to secure the delivery of public health initiatives through providers [CHEs?]. That is the ideal, whenever it can be achieved...The agency idea will be avoided if possible (NZPD,1992:Vol 524,8264).

As with HCPs the Government did not absolutely discount the idea of establishing the PHA, but it was to be "avoided if possible" (ibid). Whilst maintaining the funder-purchaser-provider split within the public health environment, the separation of public and personal health at the provider level was not to be implemented. The competitive CHEs were to be responsible for the provision of public health services.

Establishing a Public Health Agency, whilst having several positive aspects, would have contradicted three essential elements of the 1991 health policy. (1) Because the PHA was to

have a combination of purchaser and provider functions it would have been at variance with the fundamental element of the policy, the purchaser-provider split; (2) It would have blocked contestability within the provision of public health services by creating a monopoly situation for the services which it provided; and (3) it would have conflicted with Upton's quest for integration within the health system by creating an artificial separation between the provision of public health services and personal health services at the provider level.

The PHA was originally intended to be the majority provider of public health services but because its three regional offices would have been so geographically widely spread it would have had to purchase services at the local level in many instances.

By creating a monopoly situation in the provision of regional public health services, Upton departed from the market principles underlying the rest of his policy which he claimed would increase efficiency and effectiveness in the health system. A PHA, employing skilled public health workers (in a climate where these skills are scarce) and providing a nationally co-ordinated approach to the provision of public health services, would have precluded competition from alternative providers.

Tod Kreible, Group Director of Policy and Planning with the Public Health Commission in Wellington, and following July 1995 a member of the Public Health Group within the Ministry of Health, suggested (interview, 7 October 1994) that the development of a PHA would have improved the co-ordination within the public health sector by maintaining better communication and integration within public health. It would have allowed for better information flow between the purchaser and providers of public health services.

Kreible also suggested that it would have meant lower transaction costs within the sector as there would have been fewer contracts to negotiate, and the Agency would have been able to maintain a range of skills necessary for the provision of public health services at a national level.

He maintained that the decision not to establish a PHA was a commercial one. Rather than set up another bureaucracy to provide public health services, the NIPB elected that CHEs should continue with the responsibility for providing public health services.

Laurenson agrees with Kreible that the establishment of the PHA would have enhanced the communication and co-ordination within the public health sector. He suggested it would have been especially important for health protection officers, and would have provided a recognised national provider service. Currently there is no recognisable national public health service provider where the public can lay complaints regarding food and water problems. Different bodies are responsible for public health services in different parts of the country.

In its 1993 briefing to the incoming Minister of Health, the Ministry of Health recommended that the idea of an agency to provide public health services be revisited as an option for improving service delivery:

> This would ensure that public health services (including regulatory services) are provided on an integrated national basis. It would eliminate problems of potential conflict of interest for CHE staff who have dual accountabilities. It would also eliminate the risk of costs and programmes being shifted between personal and public health. (Ministry of Health, 1993(c):51).

This recommendation was made just four months after the 1993 Health and Disability Services Act, legislating for the restructured health system, entered the statute books.

Evaluating the new public health structure in 1994, Bandaranayake suggested:

> [t]he original recommendation of the task force... to establish a Public Health Agency to be the main service provider should not have been abandoned. Such an agency would have had a better chance of organising the provision of services at a regional level and beyond, while establishing precise contractural agreements built on appropriate area-specific service specifications... Consideration should now be given to establishing an agency (Bandaranayake, 1994:138).

The value of developing a PHA to provide an integrated approach to the purchasing and provision of public health services was also recognised by the Executive Council of the Public Health Association. In its December 1994 discussion paper[122] based on submissions from Public Health Association branches, and on a national survey of senior public health practitioners and managers in CHEs, one of its two recommendations was that "[r]egional and local public health services be purchased and/or provided via no more than 6 public health agencies". It suggested the benefits of this arrangement would be to:

- provide the elements of a national public health service;
- provide greater protection for public health resources, streamline administrative arrangements, increase accountability, and reduce transaction costs;
- encourage the development of a nationally co-ordinated and unified, efficient and effective public health service;
- make best use of the scarce public health expertise available;
- allow the flexible purchasing of community oriented public health services which can be integrated at local level;
- provide the more structured and secure environment needed to recruit, train, retain and develop a skilled and efficient public health workforce;
- provide more secure accountability through to the minister for regulatory services (ibid).

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[122] "Shackled by the Contracting Chain: A Review of the Purchase and Delivery of Public Health Services".

Following the decision not to implement the PHA, its intended functions have become fragmented causing confusion for both the providers and recipients of public health services.

From July 1993 to July 1995 the Northern, Central and Southern RHAs purchased public health services from local CHEs and other providers on behalf of the PHC. Midland RHA elected not to sub-contract on behalf of the PHC, so providers in the Midland area contracted directly with the PHC. Following the disestablishment of the PHC in July 1995, Midland RHA was required by the Ministry of Health to purchase public health services on its behalf.

In some areas CHEs have already opted out of providing public health services and the provision of these services has been consolidated in a neighbouring CHE . This has been the case in Wellington and Auckland where one CHE provides public health services for the whole area, in Wellington Hutt Valley Health CHE, and in Auckland Auckland Central CHE. Amalgamations are also underway in Canterbury and the Bay of Plenty. Kreible and Skegg suggest this indicates a move towards a PHA-type structure (Kreible, interview, 7 October 1994), (Skegg, interview, 15 March 1995).

Contrary to the Government's intentions set out in the Green and White Paper, in the Midland region Hamilton's CHE, Health Waikato, intended setting up its own wholly-owned subsidiary, Community Health Business (CHB). CHB was to provide all community based care, including both public and personal health care services (Alessi, 1994:19). These services were to be provided by a medical officer of health, health protection officers, public health nurses, district nurses, physiotherapists, occupational therapists and dieticians, across Health Waikato's geographical region. However it was decided in December 1994 by Health Waikato's Board that

for financial reasons CHB would not be established as a separate entity meantime, but would remain as a division within the CHE (Pam Wards[123], interview, 17 January 1995).

Health Waikato's Community Health Division differs from other public health providers throughout the country in that it integrates both public and personal health services at the client level. Rather than separate the two services as Upton intended in his policy, it seeks to provide an integrated approach to community health, one similar to that provided by the Area Health Boards (ibid). Alessi (1994) argued this approach is "consistent with the Green and White Paper goal of encouraging flexibility, efficiency and innovation in the delivery of health care to the community" (p.19).

Community Health Division's services are organised on a programme basis combining both public health and personal health services. The programmes include: rehabilitation services, immunisation programmes, etc. Prior to 1 July 1995 it contracted with both Midlands RHA and the PHC to provide the necessary funding for their particular components of the programmes (ibid).

Wards contended there was a tendency for Midland RHA and the PHC to double up in the services they wished to purchase for the area. "Midlands wants to buy what the PHC believes they should purchase". This is not a problem, she suggested, while Community Health Division remains the monopoly provider of public health services in the area. Community Health Division is able to make sure that doubling up does not take place at the provider level.

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[123] In January 1995 Pam Wards was Programme Implementation Manager,Community Health Division,Health Waikato.

Wards explained that it was "an economics argument" not to separate out the services of the public health workers: "I can't justify three people in Coromandel passing each other on the road, working with the same family for different reasons [both public health and personal health reasons]". She illustrated this with a scenario of sexual abuse of a child where there has been several other similar cases in a particular area in recent months. The child requires assessment and examination, the family requires assessment, and the school needs to be approached about its commitment to the *Keeping Ourselves Safe* programme. Wards argued that one community health worker can deal more effectively with all the initial stages of this referral rather than involving three (or more) different personnel (ibid).

Medical Officers of Health and Health Protection Officers are employed by CHEs, but at the same time they are under the jurisdiction of the Ministry of Health which issues them warrants to act as statutory officers. According to Wards this dual agency causes conflicts of interests for the health protection officers.

Hospital licensing, which was to be a function of the PHA, was maintained by the Ministry of Health as CHEs cannot be made responsible for their own licensing. To maintain this function the Ministry has opened branch offices in the regions.

The quest for efficiency through contracting and competition has resulted, according to the Public Health Association, in undermining the effectiveness of public health strategies. "The length of the purchasing 'chain' may involve up to five levels, with considerable financial and organisational transaction costs" (The Public Health Association of New Zealand, 1994:2). These additional costs, the increased overheads of those services provided by CHEs, the fragmentation of services, and the continued diverting of funds by CHEs to personal health

services have resulted in less effective public health strategies (op cit, p.4). The report also states: "public health resources, which were expected to be "ring fenced" have not been secure within CHEs...In our survey 29% of the respondents felt that resources for public health had declined since July 1993" (ibid).

The decision not to implement the PHA was made by the NIPB because it contradicted the fundamental policy call for the separation of the funder, purchaser and provider roles; as a monopoly provider it would have precluded competition at the provider level. Further it also conflicted with the integration of health services. To maintain the funder-purchaser-provider split and contestability at the provider level, the commercially oriented CHEs were made responsible for providing public health as well as personal health services. While this decision recognises the linkages between the provision of public health and personal health services, it fails to recognise the philosophical differences between public health workers' health and wellness perspective, and the CHEs' profit-oriented approach to the provision of treatment services for sickness and accident-related illness. It also means that the positive aspects of the PHA as a separate provider agency for public health services will not be realised. The PHA would have provided a nationally co-ordinated approach increasing communication and integration within public health. It would have been a recognised national provider service with lower transaction costs and it would have eliminated cost shifting between personal and public health.

Implementation and disbandoning of the PHC

Following the advice of the Health Services Taskforce[124], the PHC was to be established as a Crown Agency and located in the new Ministry of Health, but would operate as an independent

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[124] See Cabinet Paper PMR (91) 81 p 2.

entity with its own Ministerial Advisory Board appointed by, and responsible to, the Minister of Health. Its intended location was due to its policy advisory role, and to facilitate the sharing of information with those responsible for personal health services (Upton, 1991:110-1).

However, following advice from the PHCIG chaired by Professor David Skegg[125], the PHC was established as a stand alone entity "at arm's length from the Government" (Skegg, 1995:1) with its own budget, and answerable to its own Board. According to Skegg, Upton's suggestion that the PHC could be an independent entity within the Ministry of Health was just not workable. To be able to give the Minister of Health frank advice that was open to public scrutiny, the PHC would need to be established at arm's length from the Government (Skegg, interview, 17 June 1996).

This change led to further changes in the nature of the PHC. One of the PHC's major functions, that of "developing and promulgating regulations" (Upton, 1991:110) was transferred to the Ministry of Health "to keep the responsibility for coercive powers close to the Government" (Ministry of Health, 1993(c):49). But the PHC "act[ed] as the Ministry of Health's agent in purchasing (from CHEs and other service providers) some of the services needed to implement regulatory measures" (ibid). This transferring back to the PHC the responsibility for some of the regulatory function blurred the lines of accountability and caused much confusion for public health workers and members of the public.

According to people working inside both the PHC and the Ministry of Health (personal communications), this blurring of the lines of accountability and the separation of the policy making and regulation functions led to much ill-feeling between the two agencies, and "a lack of

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[125] Skegg was later appointed chairperson of the PHC Board.

integration of advice on personal and public health matters" (Bandaranayake, 1994:137). The Ministry of Health advised the incoming Government in 1993:

> [t]he transfer of resources for public health advice to the Public Health Commission from the Ministry of Health leaves the Ministry with a reduced analytical capacity for dealing with public health issues. This makes it difficult for the Ministry of Health to fulfill its responsibilities to provide strategic advice covering all health issues, and has resulted in gaps and overlaps which produce poorly integrated advice to the Ministry (Ministry of Health, 1993(c):50).

As well as the concerns expressed by the Ministry, the PHC was not popular with the Government, or the heads of some industries whose activities and products effect health status. Complying with its requirement under the 1993 Health and Disability Services Act "to monitor the state of public health and to identify public health needs" (Health and Disability Services Act, 1993 Section 28), the PHC released its first report in 1993 on the health status of New Zealanders. Using available statistics and research information, it described the health status of New Zealanders and explained: "something of the social and physical environment and other risk factors which affect health" (PHC, 1993:7).

To the dismay of some Government Ministers the report attributed low health status not just to people's lifestyle behaviours, but to the Government's recent economic and social policies which had resulted in increased unemployment, lower incomes for many families, and lower benefit payments. This was especially relevant to the low health status of Maori and Pacific Islanders who are over represented in the numbers of unemployed, under-employed, and beneficiaries.

The PHC was prolific in its policy advice to the Minister of Health but as a result of its advice on tobacco, alcohol and nutrition "[t]obacco and alcohol groups ... joined with sections of the food industry in lobbying Ministers to have the PHC muzzled" (Skegg, 1995:2).

Within seventeen months of the passing of the 1993 Health and Disability Services Act, legislating for the new health system, Shipley announced that the PHC would be disbanded. Most of its functions would be carried out from inside the Ministry of Health but RHAs would take over the purchasing of regional public health services (Shipley, media release, 13 December 1994).

Shipley explained the reasons for the disestablishment as structural. She recognised the split between the non-regulatory role of the PHC and the regulatory role of the Ministry of Health, was detrimental to the work being done in public health. Shipley maintained positioning public health inside the Ministry would result in "the most efficient and effective delivery of public health services" (ibid). She maintained in the debate leading up to the third reading of the Health and Disability Services Amendment Bill (the legislation disestablishing the PHC): "the members of the Public Health Commission ... have done a stunning job and it is no reflection on them that the Government has decided to abolish the function of the Public Health Commission" (Shipley, NZPD,1994:Vol 547, 6803).

She suggested further:

> many people agreed that it was probably appropriate for public health policy and personal health and disability policies all to be considered in the same place. That was the primary reason I as Minister of Health took the decision to introduce this amendment in the first place. It has been of great concern to me that if we are to get health gains in New Zealand, public health needs to be considered, promoted, and advanced in the same context as policy decisions are taken for personal health and disability support services (op cit, p.10494).

By abandoning the independent structure of the PHC and transferring many of its functions to the Ministry of Health, Shipley was effectively closing the door on independent policy advice

gained through wide consultation and scientific evidence (Skegg, 1995:1). Rather than being responsible to an independent board concerned for the health status of the population, the public health group within the Ministry would be directly responsible to the Minister of Health. The CSC was to become responsible for advising the Minister "on the kinds of public health *services* that should be publicly funded - not on the myriad of other factors that affect the public health" (ibid). Skegg continued:

> [a]nyone who has studied public health knows that, for key health determinants such as tobacco, nutrition, and poverty, the most important factors involve not health services but other areas of Government policy. Whereas the PHC had a duty to report on such matters affecting public health, they will lie outside the brief of the Core Services Committee (ibid).

No longer would there be an independent body evaluating the health implications of the Government's social policies, or planning and purchasing public health services. The separate public health structure which Upton claimed was crucial to the nation's health and to making the best use of available resources, was abandoned.

Thus the PHC was successfully implemented as planned in the 1991 policy. It carried out its functions according to the 1993 Health and Disability Services Act[126] yet it was disestablished in a very short time.

Upton recognised that effective public health strategies could produce greater and more cost effective improvements in health status than individualised personal health services and he was aware that, if competitive purchasers for personal health services had been established, a separate public health structure would have been necessary. My research indicates two factors

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[126] See the Health and Disability Services Act 1993, Section 28, pp.12-13

influenced the disestablishing of the PHC and the integration of its functions into the Ministry of Health. Firstly, the decision not to implement HCPs meant that RHAs, as monopoly Government purchasers, could be directed to purchase public health services, and secondly, the Government either did not appreciate the PHC's independent advice, or did not like it being open to public scrutiny. The Government did not want to acknowledge the consequences of its own social policies - increased unemployment, under employment and lowered benefit rates - which the PHC advised were causal factors in the lower health status of many New Zealanders.

For Upton and the National Government, public health strategies were about programmes to encourage healthy lifestyles, to ensure the provision of safe food and water, and to control epidemics of disease. The PHC went further in its analysis of the health status of New Zealanders and looked at the causes of unhealthly lifestyle behaviours, and linked causal factors with outcomes[127]. Its 21 published policy papers upset not only the Government but also commercial and vested interest groups[128].

By transferring the responsibility for public health to the Ministry of Health, the Government would be able to ensure that the advice it received was in keeping with its own policies and directions. However during the select committee debate on the Health and Disability Services amendment Bill, the Labour members of the committee refused to support the Bill unless the Government included the following seven principles:

1. the creation of a distinct identity for public health within the ministry.
2. a high profile be given to public health by the ministry.
3. funding and resources for public health be ring-fenced within the ministry...

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[127] See Public Health Commission (1993:55).

[128] See the editorial in the *Press*, 15 December 1994, and Skegg, Public Health in an Open Society in Otago Bioethics Report. July 1995, pp.1-2

> 4. a critical mass of staff with expertise in public health be located within the ministry...
>
> 5. any legislative change include a statutory obligation upon the ministry to promote and protect public health...
>
> 6. prior to any changes there will be full consultation with community health groups about the future development of public health in New Zealand...
>
> 7. there be a requirement for a direct line of reporting to the Minister of Health by the Director of Public Health (NZPD,1995:Vol 552,10496).

At the time the Government was a minority government and was forced to accept Labour's proposal. The principles were included and the Act entered the statute books following its third reading in December 1995.

This marked the final demise of the stand alone PHC answerable to its own independent board. Despite it being an essential part of the separate public health structure which Upton claimed was crucial both for the nation's health and for making the best use of resources, and it fulfilling its functions as set out in the 1993 Health and Disability Services Act, Shipley, as Minister of Health, made the decision to disestablish it.

Implications

Without the separate public health structure there will not be the transparency in the funding, planning, purchasing and provision of public health services wanted by Upton (1991:105). With the purchasing and provision of public health services becoming the responsibility of the RHAs and the CHEs, public health spending will be obscured by the fact that it will be funding joint services with personal health funding. This joint funding will mean that public health will remain in danger of losing its focus on promoting health to the more urgent need of funding treatment services.

The lines of accountability will be blurred due to the extended contracting chain which now exists and the lack of any recognisable national provider of public health services. The extended contracting chain also draws into question the commitment to efficient use of resources which Upton and the National Government were so keen to ensure. It will require increased administration costs and therefore less funding will be available for the purchase of public health services, and it will make it difficult to provide a rapid response to epidemics, natural disasters and major environmental accidents. It also makes effective monitoring and evaluation of public health strategies difficult.

The fragmentation in the provision of public health services which has arisen as a result of the PHA not being established, will continue to cause confusion for both providers and recipients of public health services. This fragmentation, and the commercial nature of the CHEs has resulted in diminished co-ordination between providers leading to a reduction in communication and the dissemination of information[129].

The medium and long term benefits realised through the public health strategies provided by the CHEs will accrue to the RHAs and the Government. There will be no immediate or short term gains for the CHEs who are required to operate as successful businesses.

Tod Kreible and David Skegg suggested that the consolidation that is going on in the provision of public health services in many CHE areas is a move towards public health agency type structures. "The difference is between having a PHA set up as a given structure and the evolving of what is essentially similar... We are moving that way with flexibility rather than having the agency thrust upon us" (Kreible, interview, 7 October 1994). But these new PHA type

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[129] For a further discussion of these points see "What's gone wrong with our Public Health?" in Consumer, Number 331, October 1994.

structures will be essentially different from the structure intended in the Green and White Paper. They would simply be departments within CHEs whose principle focus would continue to be on the provision of personal health services.

With the decision in December 1994 to abolish the PHC, there is little likelihood of a PHA being established, despite the Government's original decision not to proceed with its implementation "meantime" (CAB (92) 284).

Despite the provisions in the legislation for the Director of Public Health to be able to advise the Minister of Health directly on public health matters, there will be no more independent public health policy advice recognising the real causes of lowered health status. As David Skegg suggested:

> [i]n future Governments will make decisions that effect the public health without receiving open advice based on independent assessment of scientific evidence and on wide consultation (Skegg, 1995:2).

Skegg suggested further that New Zealanders will lose access "to information and advice about measures that could improve the health of the nation" (ibid).

Future programmes and policy advice to the Minister of Health will be couched in terms of individuals' responsibilities for their own health status. Health promotion programmes will be concerned with changing lifestyle behaviours rather than dealing with the principal determinants of lower health status.

According to Richard Hoskins, Manager Public Health at Midland RHA, Shipley's decision to establish the Public Health Group within the Ministry has resulted in the group becoming a

reactive rather than pro-active group. The Group's focus is on replying to Ministerial directives rather than taking a pro-active role developing new initiatives to increase the health status of New Zealanders (Richard Hoskins, Seminar at the University of Waikato, 6 June 1996).

The decision not to establish a PHA has resulted in the RHAs becoming responsible for the purchasing of regional public health services and the CHEs becoming the main providers of regional health services. Rather than protecting the public health budget, as has been suggested by the Public Health Association, public health finance will be able to be easily diverted to balance the budget for more urgent personal health services - the essential concern of the CHEs. This was the very reason the purchasing and provision of public health services was separated from personal health services.

Conclusion

The separate structure for public health was intended to protect public health funding and ensure that a public health focus was maintained. Failing to establish the PHA, and then disestablishing the PHC within a short time, suggests the Government's stated commitment to public health was not a concern for the health status of New Zealanders, but a concern with reducing its fiscal responsibility. Public health services which were seen to be important for reducing future publicly funded treatment costs would be purchased and provided alongside personal health services, but no longer would there be independent advice evaluating the effects on health status of the Government's own policies or of the products of the country's leading industries.

Neither a Top-Down nor a Bottom-Up approach is adequate to explain the non-implementation of the PHA or the disestablishment of the PHC. Both were decisions made at the top by Government. The decision not to establish the PHA was made by Government following advice

from the NIPB and the PHCIG. Skegg and his committee recognised that the PHA would have contravened two fundamental aspects of the policy. As a monopoly provider it would be in conflict with the principle of a contestable environment, and, though it would have been a predominantly provider organisation, it would have had both purchaser and provider functions. It would also have contravened the principle of integration which Upton had claimed was important for a more efficient and effective health system. As for the core and HCPs, this aspect of the policy was poorly thought through and resulted in changes being made to the policy during implementation.

For the same reason the process of implementation and then disestablishment of the PHC as a structure separate from those responsible for personal health services, cannot be accounted for by either a Top-Down or a Bottom-Up approach to implementation. Following advice from the PHCIG the PHC was established as a separate structure outside the Ministry of Health, contrary to the intentions set out in the Green and White Paper. But within a short time the new Minister of Health announced that it would be disestablished and its functions would be carried out from inside the Ministry. The disestablishment of the PHC, though prompted in part by representatives from the alcohol, tobacco and food industries, was a decision made at the top by the Minister of Health. It was not brought about by actors at the periphery changing the policy to suit their own ends.

Once the decision was made not to implement HCPs, the Minister of Health was able to regulate for the RHAs to purchase regional public health services. She then transferred the responsibility for public health to the Ministry of Health to ensure that the advice it received was in line with its own policies and directions. Working from within the Ministry, those concerned

with public health issues will now be answerable to the Minister of Health through the Director General of Health and the Director of Public Health, not to their own board.

To increase the health status of the population, especially for Maori and Pacific Islanders who experience higher rates of morbidity and shorter life expectancy than non-Maori, we need careful and independent analysis of the social and physical environment and other risk factors which affect health. With the responsibility for public health being merged into the Ministry of Health the future direction of public health priorities, programmes and research will now be politically determined and controlled.

Chapter 11

THE NEW HEALTH ENVIRONMENT

Introduction

The previous four chapters have sought to illustrate how important policy intentions can undergo change during the implementation process. Despite the ease with which the Government was able to introduce the health policy, and its carefully planned implementation strategy, the policy has not been implemented as planned.

This chapter will discuss the areas of the policy that were successfully implemented, the areas that were implemented but within a short time discarded, and those which were either abandoned or underwent substantial change during implementation. It will discuss the changed health environment which has eventuated as a result of the introduction of the policy, and will conclude by arguing that the substantive content of this policy influenced the implementation process, and likewise, the experience of implementation illuminated problems with the policy inducing the Government to make changes.

Upton and the National Government assumed that their policy would be implemented according to their intentions. They underestimated the difficulties involved in implementing a policy involving radical change to the structure of the health system and to the way health services are provided. They assumed health care could be treated as any other commodity, and failed to take sufficiently into account the social and political implications of the policy initiatives and the social and political context of the health environment.

Even where the Government was able to maintain tight control by appointing implementers sympathetic to the intentions and objectives of the policy, some fundamental aspects of the policy were not successfully implemented. However, the resulting health environment is markedly changed as a result of the Government's attempts to implement its 1991 health policy.

Implementation of the policy initiatives

In line with the implementation strategy contained in the policy, implementation of the policy initiatives began immediately. The same night the policy was announced Area Health Boards were disestablished and Government appointed commissioners took over their functions.

The National Interim Provider Board (NIPB) responsible for establishing the provider agencies, was appointed the following month under the leadership of Sir Ronald Trotter, chairperson of Fletcher Challenge and previous chairperson of the Business Roundtable. According to Easton (1994:226), Trotter had no background in health administration and was "a well known spokesperson for privatisation". The NIPB "was later headed by former Telecom chief executive officer (CEO), Peter Troughton, who was also a former Business Roundtable member" (Bowie and Shirley, 1994:315).

The Health Reforms Directorate (HRD) responsible for establishing the RHAs and developing policy for the establishment of HCPs, was appointed four months later under the leadership of David Smyth , previously deputy secretary of Treasury.

The implementation process was hierarchically integrated in that members of the early implementation groups went on to manage the next level of implementation. This comprised the Public Health Commission Implementation Group, the Regional Health Authority Establishment Committees, the Health Information Office and top level positions in the Ministry of Health and the newly appointed RHAs and CHEs.

The NIPB, the HRD and the Communications and Co-ordination Unit (CCU), responsible for co-ordination and public communication, were set up in the Department of the Prime Minister and Cabinet. Formerly the Health Department had been responsible for the implementation of health policies. The choice of implementers, the establishment of new agencies, and the location of the new agencies, indicated the strong political commitment of the Government to successful implementation of this policy.

The separation of the purchaser and provider roles of the Area Health Boards was achieved with the establishment of the RHAs and the PHC. These purchaser agencies were positioned between the Government as funder and the providers, essentially establishing a funder-purchaser-provider split. Hill (1993) suggests maintaining central control particularly over finance, and delegating implementation responsibility for unpopular changes to organisations for which the Government can deny responsiblity, is a recent innovation used by many countries to solve implementation problems[130].

Following the appointment of the Regional Health Authority Establishment Boards in April 1992, the Boards of the RHAs were appointed and the RHAs were established and in operation before 1 July 1993 as intended. Rather than being competitive purchasers for just personal

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[130] See Degeling (1993) for an account of this phenomenon in the restructuring of the Australian health system and Flynn (1993) for a discussion of it in both the United Kingdom and the Netherlands.

health services, the RHAs have become monopoly purchasers of both personal and regional public health services. The policy intention that RHAs offer their clients supplementary or gap insurance has not been implemented.

RHAs receive a capped budget from Government and their purchasing requirements are set out annually in the Policy Guidelines published by the Ministry of Health.

Similarly, CHEs were established following the creation of a new portfolio and the appointing of Paul East as Minister of Crown Health Enterprises. The NIPB was disbanded in October 1992 and replaced by the Crown Health Enterprise Establishment Unit (CHEEU) whose role was to establish and monitor the Crown Health Enterprises. The Crown Health Enterprises became independent crown agencies with the 1993 Health and Disability Services Act.

Though the CHEs were established successfully, their functions have undergone substantial change. They are responsible for providing both personal and regional public health services, and while they are still required to contract with the RHAs for the provision of services, there has been little competition established in the secondary sector. Rowling (1994) suggests:

> the reality is that many areas are non-contestable, particularly due to the specializations already adopted by many CHEs. There are also many low margin (and indeed in some cases, negative margin) services where there is no economic incentive for alternative providers to compete [131] (p.53).

Flood and Trebilcock (1994) echo Ashton (1992(a):155) when they suggest:

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[131] The example *par excellence* is major trauma services which require large amounts of both technical and human resources to be available on call for emergency situations.

> [b]ecause of the geographic spread and small size of the New Zealand population, in many areas and in respect of many services, there are no effective competitors to the encumbent public hospitals nor are effective competitors likely to emerge because of the economies of scale involved in the operation of an efficient hospital (p.20).

The requirement that CHEs operate as successful businesses making "a return on assets" (Upton 1991:35) was regarded early in the implementation process, as an impossible requirement. Malcolm and Barnett (1994(a)) cite a letter from the Crown Health Enterprises Chairs' Consultative Committee to the Ministers of Health, Crown Health Enterprises, and Treasury dated 17 December 1993:

> [t]he CHE group are of the view that this business of providing health is not a genuine commercial mode. We are not able to significantly influence the market, adjust prices or alter the nature of supply in order to capture markets in the way that other commercial organisations do. It is proper that it be seen in that light and that the objectives reflect the nature of this orientation rather than an expectation of yields according to commercial criteria (CHE Chairs' Consultative Committee cited in Malcolm and Barnett 1994(a):96)

The CEOs of the CHEs were seeking collaboration with RHAs rather than the 'master/servant' relationship which they claimed had evolved. The RHAs are dependent on the CHEs to provide core services or service obligations for their clients, and the CHEs are dependent on the RHAs for contracts to provide services.

However the contracting process between the CHEs and the RHAs is not one between equal parties. The CHEs are required to become more efficient and tender lower prices for services in order to gain contracts. At the same time they are required to return a profit. Yet any gains made by CHEs are captured by the RHAs who are then able to purchase more services, but not necessarily from the CHEs.

The PHC was successfully established but in December 1994 just seventeen months after the Health and Disability Services Act had entered the statute books, the Minister of Health Jenny Shipley announced that the PHC would be disbanded. Most of its functions were to be carried out from inside the Ministry of Health.

An interim regime for user part-charges was introduced in February 1992 as planned but in response to extensive public outcry, Birch announced soon after his appointment as Minister of Health in March 1993, an election year, in-patient charges for hospital services would be discontinued. Exemptions for mental health, maternity services and accident victims were made before the scheme was introduced.

Targeting was introduced on 1 February 1992 by the use of Community Services Cards. The original intention of dividing the population into three groups was soon changed to two groups and the high user cards were introduced but the qualifying criteria were soon changed. Also in response to public outcry the Government later re-introduced subsidised primary care for pre-school children of high income earners. The introduction of targeting marked the shift from a universal approach to the provision of health care services which New Zealanders had come to expect as right of citizenship, to people taking responsibility for their own health care.

Smaller hospitals were not established as community trusts as had been suggested in the policy. Establishing community trusts required community initiatives and these were not forthcoming.

As discussed in the four previous chapters the CSC was appointed as planned but within seven months the committee decided not to explicitly define a core according to the policy intentions; Health Care Plans were not established; the funding of primary and secondary services was

integrated but GPs resisted entering into remunerative risk-sharing contracts with the RHAs as the Government intended; and the PHA was not implemented.

Thus despite the Government's carefully planned implementation strategy, substantial changes have taken place to the policy during implementation.

The changed health environment

The health environment by 1996, though different from that proposed by Upton and the National Government in the 1991 policy, was markedly different to the health environment existing before the policy was introduced. Many of the changes that have eventuated, though different from the policy intentions, have taken place as a result of the introduction of the 1991 policy.

The health environment in 1991 was characterised by free hospital and related services provided by 14 Area Health Boards, and government-subsidised primary care. The Area Health Boards were funded by government on a population based formula to provide both personal and public health services. GPs and other primary care providers were funded separately by the Department of Health, and accident related care was funded by the Accident Compensation Corporation (ACC).

In the new health environment funding for public health services is separated from funding for personal health services. Funding for publicly provided primary and secondary services is integrated but accident related services are still funded from the Accident Rehabilitation and Compensation Insurance Corporation (ARCI), (previously ACC). In October 1995 the Government decided to separate them even further by making ARCI responsible for purchasing

accident related elective surgery, primary care, emergency transport, community and referred services and ancillary services. The RHAs remain responsible for purchasing accident related acute services and laboratory services[132].

Government subsidies for primary care services and outpatient services are targeted to those on low incomes and high users of health services, through the use of community cards and high user cards. Middle and high income earners are expected to take responsibility for most of their own health care costs. This shift from a universal to a targeted approach was an important element in the Government's determination to change people's expectations of the role of the state in the provision of health and welfare services.

Though hospital in-patient services are again free to all users, the extensive waiting lists for elective surgery which Upton claimed were one of the major problems with the previous health system, have continued to escalate[133] resulting in less access to elective surgery. Those on high incomes and those with private health insurance are able to use private hospital facilities but those on low incomes are obliged to endure the pain and inconvenience of waiting up to several years for elective surgery in the CHEs.

There has been a steady rise in health insurance premiums as insurance companies try "to recoup money paid for medical and surgical services" (Paul Regtien, spokesperson for Southern Cross Healthcare, cited in the *Waikato Times*, 25 September 1996). This has resulted in a reduction of the numbers of people insured, around 51% of the total population in 1991 and closer to 41% in 1996 (Coalition for Public Health, 1996:1), (*Waikato Times*, 25 September 1996). There has

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[132] See Shipley, J., Policy Guidelines for Regional Health Authorities 1996/97 (p.75).

[133] According to figures supplied by the CHEs and compiled by the Coalition for Public Health, surgical waiting lists increased from 62,000 in 1991 to 94,000 in 1996, an increase of 51.6% (Coalition for Public Health 1996:4). Shipley stated in a press release (19 September 1996) the figures for June 1996 were 94,057 having dropped from 95,470 in March 1996.

also been a reduction in the extent of cover people are seeking. According to James White, president of the New Zealand Health Insurance Association, more people are now opting "for hospital or surgical-only cover" (ibid). In total this means that more people are paying for their own health services. According to figures obtained from the Minister of Health, the private share of overall health spending, including private households, health insurance, and charities, has risen from 13% in 1985 to 22.3% in 1995, and the Government's contribution has decreased from 87% to 77.7%[134].

The system of CHEs contracting with the RHAs for the provision of specific numbers of services often means that CHEs have excess capacity in specific service areas because they have completed the numbers of services for their contracts and are not funded to do more, and yet waiting lists for those specific services continue to escalate. The excess capacity created by the limited contracts has been used as the justification for allowing private patients to be treated in public hospitals[135].

Responsibility for public health services being returned to the Ministry of Health following the disbanding of the PHC, has marked a return to pre-Area Health Board days when the Department of Health was responsible for public health services. The difference in the new climate is the extended contracting chain and the ring-fencing of funds. On behalf of the Ministry, the RHAs contract with the CHEs to provide regional public health services for their populations. With the centralisation of the provision of public health services in some areas, the CHEs are contracting out to other providers. The extra administrative layers are absorbing much needed money from the public health budget.

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[134] For further details see Muthmala, D., and P.S. Howard, Health Expenditure Trends in New Zealand 1980-1994.

[135] See Shipley, press release,14 November 1995.

Within the new health environment the Government has devolved responsibility for the day to day running of the health system but has retained control over health spending and the provision of services. However, this devolution has not been totally accepted by the media or the people. The current Minister of Health is frequently required by the news media to defend in public the outcomes of the Government's decisions. This is very often related to reduced access to health services. Government controls health spending by capping RHA budgets and the budget for public health, and controls how the money is spent through its funding agreements with the RHAs. As well the Government can intervene when it decides it is necessary and require individual CHEs to provide particular services (Health and Disability Services Act, 1993:Section 40).

The end of the local-central relationship governing hospitals

There has been a break with the local/central relationship established in the 1870s between the Government and the hospitals. The new structures have removed the linkage the Government had with locally elected boards and displaced the local domination of these boards. The four RHAs are responsible for larger populations than the earlier community based Hospital Boards and Area Health Boards, and the boards of the RHAs and CHEs are appointed by the Government not elected by their communities. As discussed above funding and control have been centralised in the new health environment but responsibility for how health services are delivered has been devolved to the RHAs.

With the boards of the RHAs being appointed rather than elected, and primarily accountable to Government, they have been able to make major decisions without the influence of their populations, and without the political consequences which would have resulted had those same

decisions been made by Government. The RHAs have been able to achieve what Governments have not been able to - closing hospitals, centralising services, and withdrawing services.

The hospital centred decisions of the Hospital Boards and Area Health Boards have been replaced by economic, managerial centered decisions, made the majority of time, by people not familiar with the health system nor the needs of the users of the health services. There has been a tendency to appoint generic managers[136] sympathetic to Upton's and the Government's beliefs that health care can be treated as any other commodity in the market place. When discussing the implications of one RHA decision with the Planning and Development Manager of that RHA, she explained to me "I don't have to understand how the services work, I only have to plan them"!

Competition, and the threat of competition between providers, has led to CHEs shedding many of their support services such as laundry, cleaning and catering services, and some patient services such as long term care of the sick elderly. The latter has resulted in many cases in a reduction in the level of care provided for these people. Where Hospital Boards and Area Health Boards provided hospital based care with qualified medical and nursing staff, many of the sick elderly are now in private institutions staffed by less qualified and unqualified carers.

The integration of funding for primary and secondary services has enabled RHAs to move money from hospital services to what they believe are more appropriate services. This has resulted in more day stay surgery, community based care, and primary care initiatives such as iwi contracts for the provision of primary care services. The hospital-centered focus of health care which existed before the 1991 policy was introduced has changed in the new health

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[136] See Brian Easton, (1995) "The Rise of the Generic Manager", pp.39-48.

environment. Hospitals are no longer owned or controlled by their local communities but are commercial enterprises controlled by the Minister of Crown Health Enterprises and their boards of directors.

The continuing power and influence of the medical profession

While the power and influence of the medical profession enabled the GPs to have their same conditions of remuneration rolled over in July 1993, and the GPs are attempting to do the same in 1996, the changed health environment has resulted in major changes to the way GPs practise their profession.

Many GPs have become members of IPAs and subsequently have entered into nominal budget holding contracts with the RHAs for pharmaceuticals and laboratory tests. This was something GPs would not have contemplated under the previous system. These contracts will result in some control over expenditure for the RHAs but there is no sharing of risk, except for the Prime Health group in Tauranga. If the GPs or IPAs overspend their contracts the RHAs will meet the shortfall. As discussed in Chapter 9, in contrast to risk sharing, with these agreements GPs stand to gain from savings they are able to make by changing their patterns of prescribing.

The development of IPAs, prompted by the GPs' perceived need to establish a collective approach, has subsequently been used by the RHAs as a focus for negotiations and has consequently reduced the RHAs' contracting costs. Without the formation of IPAs they would have had to negotiate contracts with individual doctors and group practices. Furthermore, several of the IPAs with budget holding agreements have themselves set in place monitoring and accountability measures for their own members thus alleviating the RHAs from having to institute similar measures.

These subsequent developments, though financially advantageous to GPs at this stage, may yet prove to be just as restrictive to their clinical and financial independence as they believed the RHAs threatened to be. While IPAs are managed and controlled by GPs this will be preferable for GPs to being controlled by Government agencies, but health insurance companies and generic managers have become involved in their management.

Some GPs are currently showing interest in developing MCOs. They perceive managed care as an opportunity to: provide a level of autonomy and clinical freedom; gain control over an allocated budget; and make savings from that budget. While MCOs would have the responsibility for rationing resources and services, the RHAs would retain the ultimate responsibility for ensuring that all their clients receive the health services set out in the annual policy guidelines. While there is still an on-going dialogue about managed care arrangements between the RHAs and interested parties, mainly doctors, doctors have demonstrated that they will only enter into arrangements which will benefit them and their patients. Yet, as Malcolm points out, there would be a potential conflict of goals in MCOs between GPs concerned for improving health outcomes for their patients, and managers for achieving profits (Malcolm, 1995:5). There would be the potential too for GPs to behave more like entrepreneurs concerned with economic incentives rather than their professional service ethos.

Already, with budget holding contracts for pharmaceuticals and laboratory tests, GPs are making treatment based decisions in the light of economic imperatives. In a managed care environment economic considerations would also effect referrals to medical specialists and hospitals, and patients' length of stay in hospital following treatment. The only advantages to patients in budget holding practices have been the reinvestment into services of some of the

savings from the contracts with the RHAs. However this has not been a uniform occurrence as some RHAs have precluded spending of savings on service initiatives which would financially benefit practices.

There does not appear to be any advantage to clients if their GPs become members of MCOs. The development of MCOs would require people to enrol with an organisation rather than use various GPs and other primary care providers as is often the practice. It may also limit access to GPs as clients may be referred to other health professionals, for example practice nurses, rather than to GPs of their choice.

The development of MCOs has the potential to further disperse the strength and unity of the medical profession. As members of MCOs, GPs would be in competition with each other and they would purchase services from hospitals and specialists, overturning historical relationships with other members of the medical profession. The changes which have taken place since the policy was introduced have succeeded in changing the primary care environment and changing the expectations of GPs. In an article in the *New Zealand Herald,* Jonathan Simon described these changes as a "cultural revolution"[137].

While the GPs, with the support of the medical profession, were able to refuse to co-operate with the RHAs and the Government in 1993, they have not been able to prevent the major changes which have taken place to the primary care environment. These changes referred to by Simon as a cultural revolution, have the potential to undermine the strength and influence of a previously united medical profession.

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[137] See "Doctors doing their bit" in *New Zealand Herald,* 22 October 1996, p.A13.

People's expectations not realised

People's growing expectations that the state should provide subsidised health care services by right of citizenship, (one of the factors driving the health system in earlier decades), have not been realised in the new health environment. Rather, the Government's overall intention was to change people's expectations of the Government's role in providing care in times of sickness and hardship, and to shift responsibility for health care back onto individuals and families. The Government only intended providing a safety net for those unable to support themselves[138].

Whilst the stated primary objective of the policy was to ensure access for everyone to an acceptable level of care, the Government did not intend extending access to publicly provided or subsidised health services, but rather intended restricting access by means of targeting and determining the services to be included in the acceptable level of health care.

Despite the changes to the policy which have taken place during implementation, the Government has succeeded in reducing access to publicly funded and subsidised health services through targeting, the refocusing of the Core Services Committee, escalating waiting lists for elective surgery, regional variations in access, and the centralisation of services. However, the Government has not been as successful in changing people's expectations of its role in providing health care services.

Conclusion

As Jane Kelsey (1995:216) suggested, there has been some innovation, increased flexibility and efficiency in some areas, mainly in the primary services area, but with no clear policy goals it will

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[138] See Bolger, Richardson and Birch (1990:11).

be difficult to evaluate the success of the policy even in five to ten years time. As Blank (1994:148-9) pointed out there is no indication of what the health system should look like in five to ten years, or what proportion of health spending the Government should be responsible for. While the process of implementation can be evaluated at this stage it will require a period of at least a further five years to adequately evaluate the Government's success in achieving its goals. As both Kelsey and Blank pointed out the policy did not include any clear statements about what the Government was aiming to achieve. Its only stated objective was "to secure, for everyone, access to an acceptable level of health care" (Upton, 1991:1). This objective does not provide a clear standard by which success can be evaluated. Hill (1993) suggests this use of simple goals rather than more complex long-term goals stating exactly what the Government intends to achieve, is a strategy Governments are currently using in policy making to avoid implementation problems, for example, unintended consequences of policy initiatives (Hill, 1993:7).

As already mentioned, the policy was not introduced in a vacuum, it was part of the National Government's programme to reduce the role of the state in social policy areas. Though termed "a Statement of Government Health Policy" its main concern is reducing the Government's fiscal risk, not increasing health status. It was introduced towards the end of a decade of massive social, political and economic upheaval. The Health Services Taskforce was one of six taskforces set up by the Government to "redesign the Welfare State so that those in genuine need receive appropriate help, and those who can afford to fend for themselves do not have assistance they could do without" (Bolger, Richardson and Birch 1990:11).

Despite the Labour Government's radical structural adjustment programme introduced in 1984, by the time National again became Government in 1990, the country's economy was in a state of

decline[139]. National, like Labour, was heavily influenced by members of the Roundtable and Treasury. The ideas of these neo-liberal economic theorists influenced the 1991 health policy in the same way they had influenced other recent social policy changes. In addition National appointed a number of these economic reformers to direct the implementation of their health policy and to be members of the boards of the RHAs and CHEs. The appointees lacked experience in the health professions or the management of health services, and assumed that their experiences in Treasury, Fletcher Challenge, Telecom, Forestcorp or Freightways, could be simply transferred to the health system. Economic necessity was the justification for the proposed radical policy changes.

Gone are the days when New Zealanders could expect to receive Government subsidised health care services by right of citizenship. Within an economic perspective, health care has become a commodity to be bought and sold in the market place. It is no longer regarded as a public good. Competition in the market, the reformers argued, would enhance efficiency and quality.

With no regard for the particular historical, demographic (small population size) and geographic factors (population spread thinly over large areas), and the particularities of the New Zealand situation, and with no blueprint to follow, the economic theorists attempted to impose their neo-liberal market model on the health environment. There was no consideration of the social costs of this approach. It was a theoretical approach experimentally applied and expected to succeed.

The National Government assumed that it could impose this radical policy, requiring major changes in the way health services are purchased and provided. It assumed that major changes could be brought about simply by changing the rules. In its concern to control health care costs,

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[139] See introduction to Jane Kelsey's The New Zealand Experiment a World Model for Structural Adjustment.

National did not take into account the social and political context of the health environment. An important part of National's approach involved what Easton (1994) referred to as the "blitzkrieg". Following Douglas's successful corporatisation - and later privatisation - of many State-Owned Enterprises, and the reform of local Government, the same strategies were employed[140] to restructure the health system. Easton (1994) suggested the approach was similar to the blitzkrieg in warfare.

> In each case the 'lightning strike' involved a policy goal radically different from the existing configuration, to be attained in a short period, following a surprise announcement and a very rapid implementation...each policy blitzkrieg was different in detail, but at its heart was the aim to transform profoundly some substantial aspect of the economic and social framework (p.215).

Easton contended speed was used to prevent effective resistance from interest groups.

Despite the Government's blitzkrieg approach and its carefully designed implementation strategy, the 1991 health policy has not been implemented according to the original policy intentions. The implementation of this policy demonstrates that policy making and implementation are not separate categories or phases in a linear sequence. The content of the policy influenced the implementation process and likewise the experience of implementation illuminated problems with the policy inducing the Government to make changes. The content of this policy and its implementation process were inextricably linked.

When implementing a radical policy such as this, both content and context need to be taken into account. It cannot be assumed that a carefully designed implementation strategy, and appointing implementers sympathetic to the policy intentions, will result in a successfully implemented

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[140] For an account of Douglas's strategy see Roger O Douglas Unfinished Business (1993:215-38).

policy. This research has demonstrated that poorly designed policy containing inadequate assumptions, contradictions and discrepancies, significantly influences implementation.

Sabatier and Mazmanian along with other Top-Down supporters assume that there is a conflict of interests between those who formulate policy and those who implement it. They assume that implementers or street level bureaucrats will alter policy during its implementation to suit their own ends. The implementation of this particular policy demonstrates that that assumption is not always legitimate. Implementers responsible for deciding not to implement some crucial areas of this policy - an explicitly defined core, health care plans, and the public health agency - had been involved in the policy making process and were supportive of the Government's policy initiatives. It was only when they attempted to implement the policy that they became aware that the ideology could not effectively be put into practice.

The ability of the medical profession in 1993 to coerce the Government into rolling over its same conditions for the remuneration of GPs, can not simply be explained in terms of street level bureaucrats having the discretion to alter policy to fit with their own intentions, as is the explanation offered by Top-Down supporters. Nor does it fit with a Bottom-Up explanation. This episode of resistance involved not individual GPs, but the medical profession as an organisation, and needs to be acknowledged as a political act demonstrating the power and influence enjoyed by this group. In 1996 the Government again attempted to overcome the doctors' resistance by imposing its new maternity scheme, but the doctors' have refused to co-operate and negotiations regarding possible amendements to the policy are continuing.

Neither Top-Down nor Bottom-Up approaches can adequately explain the implementation of this particular policy. Neither approach recognises that Governments can make changes to

policies during the implementation process to make them more implementable. The Top-Down approach assumes that changes made to policies during implementation have been brought about by street level bureaucrats or actors at the periphery adapting policies to suit themselves. They argue that these changes have come about through poorly planned implementation strategies or because the policy makers have not maintained strict enough control over the implementation process. Successful implementation for Top-Downers results from co-operation by implementers with the directives of the policy makers to achieve the policy objectives. The Bottom-Up approach assumes that implementation arises from the interaction of a policy with its setting. Policies will be adapted (transformed or subverted) by those at the periphery to suit the local context. For Bottom-Uppers this is inevitable. Successful implementation for them depends on the skills of individuals at the local level who can adapt policies to local conditions. As Matland (1995) suggests: "[t]he pivotal question is whether attention should be focused on fidelity to the designer's plan or on the general consequences of the implementation actions when determining success" (Matland, 1995:154).

Attempts at synthesising the two approaches are not useful either in analysing the process of implementation of this particular policy. As with the Bottom-Up approaches they start from a policy problem rather than a policy decision or statement, and assume input into policy making from those at the periphery - those actively concerned with the policy problem. Paul Sabatier's synthesis, his advocacy coalition framework, shifts attention from analysing policy implementation, to analysing policy change, and requires a time period of 10-20 years (Sabatier, 1986:38-44).

The debate between the Top-Down and Bottom-Up approaches centers around whether policy analysis should be prescriptive or descriptive. The Top Downers are concerned with specific

policies or programmes and the realisation of their objectives. In contrast Bottom-Uppers are less concerned with the implementation of a policy *per se* than with understanding actor interaction in a specific policy sector.

In my analysis of the implementation of the 1991 health policy I have been concerned with the factors which have influenced the process of implementation of the policy as it was taking place. My findings demonstrate that implementation analysis needs to recognise that policies continue to be developed as they are being implemented. Policy making and implementation are not separate categories in a linear sequence. Also the substantive content of policies significantly influences their implementation. Compliance with prescriptive frameworks and rules, such as Sabatier and Mazmanian's six conditions for successful implementation[141], cannot compensate for poorly designed policy. As Bardach (1980) suggested ""[g]ood" implementation cannot by itself offset the ill effect of "bad" policy any more than a more perfect compass and straight edge can help us square the circle" (p.141).

The only aspects of policy content Sabatier and Mazmanian are concerned with are: whether a policy has clear and consistent objectives, and an adequate causal theory about how to effectuate social change. They are not concerned with whether a policy is based on adequate assumptions about the environment it is pertinent to, or whether it contains contradictions in its design which will affect its implementability. For example the Government's intention to explicitly define a core using a list approach was not implementatble. Despite the Government appointing a committee solely concerned with identifying a core, within seven months the committee recognised that this aspect of the policy was not implementable.

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[141] See Chapter 2 p.27 for a discussion of the framework.

Likewise with HCPs, the Government appointed committee responsible for formulating the policy and guidelines for establishing HCPs, realised early in the implementation process that the formula for risk-rated premiums could not be worked out as the necessary information was not available. Also, after initially showing interest, Maori and the health insurance companies decided not to proceed with them.

As mentioned in the previous chapter neither a Top-Down nor a Bottom-Up approach can adequately explain the non-implementation of the PHA. The PHA, as envisaged in the policy, would have contradicted two fundamental elements of the policy. These contradictions influenced the appointed implementers in their advice to Government not to establish the PHA. As mentioned above, the ability of the medical profession to coerce the Government into rolling over its same conditions in July 1993 also can not adequately be accounted for by either side of the debate.

As Matland suggests, both approaches "contain kernels of truth relevant in any implementation situation" (Matland, 1995:171), but I suggest that neither is adequate to account for the implementation of all policies.

Though some crucial aspects of the policy were not implemented as planned, a significantly changed health environment exists as a result of the introduction of the policy. Despite the major changes that have taken place to the policy, the Government has achieved much of its (unstated) objective. The Government's intention to reduce its share of overall health expenditure by shifting responsibility onto individuals has been achieved. As stated above, the Government's contribution to overall health expenditure has decreased from 87% in 1985 to 77.7% in 1995. Individuals can no longer expect to receive Government subsidised health care services as of

right. The Government has also devolved responsibility for the day to day running of the health system to the RHAs, and the responsibility for ensuring spending on publicly provided health services remains within a capped budget.

The Government's intention to increase efficiency in the health system has resulted in the closing down of small hospitals, the withdrawing of services from some hospitals, the shifting of money for services from the secondary sector to the primary sector, and the eventual contracting with some GPs for pharmaceuticals and laboratory tests. These politically perilous actions were achieved by delegating responsibility for them to the newly established RHAs.

The separating of the purchaser and provider roles, establishing CHEs as stand alone businesses, and the introduction of budget holding with the intention of moving towards managed care organisations, will facilitate the move to privatisation of the health system if that is the Government's intention.

Securing access for everyone "to an acceptable level of health care" (Upton 1991:1) was the primary (and only) stated objective in the policy. Yet the targeting of publicly funded services, the increases in waiting lists, the CSC's guidelines determining when publicly funded services should be available, the closing of hospitals, and the withdrawing of some services from some hospitals has reduced rather than secured access for many people.

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