

FROM PUBLIC SECTOR TO PUBLIC ENTERPRISE: LESSONS FROM THE REORGANISATION OF NEW ZEALAND'S HEALTH SERVICES

ABSTRACT

The New Zealand economy over the last fifteen years has undergone a transformation from a highly interventionist and regulated economy to free market capitalism. The approach to liberalisation and commercialisation was at the time, known as Rogernomics¹, and was a consistent application of the free market doctrines seen in the United States at the time of the Reagan Presidency and in the United Kingdom under Thatcher. One of the objectives of the reform was the corporatisation of the state. The social welfare and health service sectors were, in particular, subjected to close scrutiny as the government attempted to reduce and rationalise its expenditure. Most health services had been financed and delivered in the public sector. The government's attempt to reduce expenditure in this sector and the same time increase the efficiency and effectiveness of health services delivery focussed on a form of managed competition. Indeed, the health system has been reorganised three times since 1984 and these changes in themselves provide important lessons. This paper considers the reorganisation of New Zealand's health services and considers the outcome in terms of costs, efficiency, effectiveness as well as health status indicators. In doing so, we hope to provide a number of lessons to economies in transition from socialism.

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¹ So-called after Roger Douglas, the first Treasurer of the Labour government which was elected in 1984.

Introduction

The 1980s were a time of the so-called “crisis of the welfare state” in many industrialised economies. Public deficits put pressure on governments to reduce their expenditure and a frequently targeted area for reduction was income transfers and social services including health. At the same time, there were increasing demands on the social services due to the aging of the population and the higher unemployment rates.

The move to reduce the size of government expenditure and welfare expenditure in particular was part of an overall philosophy of free market economics which emphasised small government including minimal government intervention in the economy, provision of incentives for production and employment and the exposure of traditional areas of public sector activity to competitive pressures to reduce price and increase output and efficiency. Many areas of the New Zealand economy were subjected to the reform process which started in 1984 and is still ongoing. The aim of this paper is to examine and describe the reorganisation of the New Zealand health system in the context of the wider economic reform and evaluate the outcome.

Background

Prior to the 1970s, New Zealand was an isolated, insular but reasonably prosperous welfare state. A comprehensive social security system based on universal entitlement was introduced by the first Labour government of New Zealand which was elected in 1935. In addition, the economy was highly regulated. The government owned and operated the postal services, the railways, the domestic and international airline and the television and radio broadcasters. There were at various times until the period of reform; rent control, interest rate controls, price and wage controls, price regulation on petrol, postal services and power, fertiliser subsidies, tax concessions on farm development such as fencing and scrub-cutting and on the value of new livestock and producer boards which had monopsony control over all agricultural produce. The country had a fortress mentality due to the existence of tariff barriers, import quotas, industry assistance and subsidies, prohibition on competing imports, capital controls and limitations on currency conversion for New Zealanders travelling overseas. New Zealand's mixed economy was described "as a market economy where

markets are seldom permitted to operate efficiently, together with a centrally-planned economy without a central plan" (McLean, 1978 quoted in Bollard *et al*, 1996).

An examination of economic performance in the period prior to reform in the early 1980s provides part of the explanation of the motivation for reform. New Zealand recorded one of the worst real GDP and per capital growth rate performances of any OECD period in the post-war period. The per capita GDP was 25 percent above the OECD average in 1950 and 25 percent below the OECD average in 1990 (Bollard *et al*, 1996). The inflation rate was considerably higher than that of its trading partners. Income support payments grew rapidly during the 1970s and 1980s as a result of increased unemployment and an increase in the entitlements of aged persons and single parents. The ratio of net public debt to GDP rose from 5 per cent to 32 per cent of GDP in the decade to 1984 and peaked at 52 percent in 1991-92. (Bollard *et al*, 1996).

Roger Douglas, the first Treasurer in the Labour Government elected in 1984 was responsible for initiating the reforms. For this reason, the reforms in the initial stages were known as Rogernomics and were similar to the supply-side economics of Thatcherism and Reaganomics. The economic reform consisted of market liberalisation as well changes in the use of macroeconomic policy for stabilisation purpose. The underlying ideology of the reform was a view that government intervention should be confined to market failure only, fiscal policy should not be used for short term demand management, the Reserve Bank should focus on enhancing the credibility of anti-inflationary policies, and employment and economic growth should be achieved through supply-side policies of increased efficiency, reduction in taxes, incentives and an appropriate economic climate for investment. Central to the view of microeconomic reform were the notions of contestability, incentive and monitoring issues, and public choice (Bollard *et. al*, 1996). Indeed, one of the important characteristics of the New Zealand reforms is the extent to which they have involved changes in the formal institutions and the rules made by the governments that influence incentives faced by individuals (Bates, 1997)

One of the objectives of the reform was the corporatisation of the state. The social welfare and health service sectors were, in particular, subjected to close scrutiny as the government attempted to reduce and rationalise its expenditure. The Labour Government under Prime Minister David Lange challenged the tradition of universal entitlement and put

greater emphasis on a targeted approach, in which state support and subsidy is concentrated on those with the greatest need.

Reform of the Health System

Major reforms of the public sector have rested on the ability to distinguish outputs from outcomes and to differentiate policy management from service delivery. Reforms of the New Zealand health system were similar to reforms occurring at the same time in the United Kingdom, the Netherlands and the United States. Scott (1993) suggests that health services reform has been a major preoccupation of most of the OECD countries. The idea was to move the health system away from a traditional public service mentality where there was an excessive focus on inputs, for example hospital bed day costs, to focusing on outcomes or objectives such as improvements in health status. The overall aims of the structural reforms of the public sector were accountability and greater efficiency.

Health services in New Zealand prior to 1984 were financed by taxation through a public health insurance system and delivered in the public sector. The private system was very small. The government's attempt to reduce expenditure in this sector and the same time increase the efficiency and effectiveness of health services delivery focussed on a form of managed competition. The health sector was corporatised: the delivery of health services is now undertaken by public enterprises.

Health systems in industrialised nations are characterised by two types of controls on health expenditure. The first type of control is demand control which is implemented through the use of copayments. Much of the control of health care expenditure in the United States emphasises the role of copayments. The second type of control is on the supply side and is evident in many countries including Germany, Australia the United Kingdom and New Zealand. Supply control entails limits on the number of doctors, bed numbers, facilities and the distribution of technology. This form of control tends to result in waiting lists and queuing.

Control over both the demand and the supply side of the market may not be effective unless there are sufficient market signals which provide appropriate incentives for suppliers and consumers to be accountable for the total health budget. Enthoven (1988) suggests that incentives for efficiency within a public health insurance system are weak. Within a public health insurance system, there is a complex set of perverse incentives

inherent in the traditional cost reimbursement for public hospitals; the tax supported fee-for-service medicine and third party intermediaries with little or no payment at the point of service.

A number of reforms have been used to strengthen the market signals in a traditional publicly funded and insured health system. The overriding objective of reforms in the health care sector is increased efficiency while maintaining equity of access to health care. Most reforms proposed for the achievement of these objectives are based around the notion of 'internal markets' or 'managed competition'. Enthoven (1988) developed the notion of 'managed competition' where the government (representing the demand side) is the funder and determines the equity and overall objectives, and the providers (on the supply side) compete on the basis of price, quality or volume for contracts to provide health services. An alternative structure is a three way split into a funder (the government), the purchaser (area health authority) and the provider (hospitals, community health centre etc.). The funder identifies sources of funds and allocates those funds to purchasers of services with an overall objective of improvement in the health status of the community. The purchaser acts as an agent for the funder to secure the required services, taking into account volume, price and quality. The providers compete with each other to provide a service also taking into account the volume, price and quality objectives. The providers are forced to evaluate both the services provided and the way in which they are provided.

The objectives of managed competition are accountability, transparency and value for money. In the short run, value for money should be evident in lower prices, higher quality and/or increased output. Improvements in productivity are an important component of competition. In the long run, competition should impact on market structure through changes in the size of institutions, degree of specialisation and entry and exit of firms (Propper and Söderlund, 1998).

The three stages of health reform 1984 to 1998

Stage I: Funder-Provider Split 1984 to 1993

The initial reform of the health system in New Zealand was consistent with other public service reform and was motivated by a desire to reduce government expenditure in particular and the size of the public sector in general. There were other problems with the

pre-1984 delivery of health services which were consistent with the public choice approach to reform. More specifically, there were disincentives to innovate in terms of the development of more integrated service delivery. Hospitals tended to dominate the health system in terms of both focus and funding. The global budgets of hospitals provided an incentive to defer maintenance of physical assets in order to provide more services. There were problems in terms of the monitoring quality and access and a lack of responsiveness and accountability to the needs of local communities. Many of these problems resulted from a funding mechanism based on pre-existing services rather than the needs of the local populations. After 1984, funding of regional health services, especially hospitals, was based on a resource allocation model which took into account the special needs of Maori and Pacific Islander populations. The first health reform in New Zealand was the replacement of the Hospital Boards with Area Health Boards. The Area Health Boards Act of 1984 permitted decentralisation of public health activities to 27 public hospital boards. The area health boards undertook both purchaser and provider roles.

Stage II: Funder-Purchaser-Provider Split 1993 to 1997

Many of the problems that motivated the changes to a funder-provider model still persisted after the introduction of that approach. The desired contestability was still absent. The absence was partially blamed on a lack of financial and management skills of the elected members of area health boards. Furthermore, it was felt that the commercial incentives to deliver a desired product at the lowest possible price were weak.

In 1990, the Labour government of Prime Minister David Lange lost government to the National Party. The new Prime Minister, Jim Bolger and his government appeared to have an even greater reformist zeal than the previous government. In 1991 a Green and White Paper² was tabled in Parliament. It outlined the application of competitive market theories to the funding and provision of health care, and suggested a threeway split of roles into funder, purchaser and provider. At the same time, the members of elected area health boards were replaced with appointed commissioners for public hospitals. The health boards were renamed Crown Health Enterprises (CHEs). Their role was to undertake service

provision on a contractual basis for the purchasers of services, the Regional Health Authorities (RHAs). Easton suggest that the "uncertainty of purpose of the reforms seems to suggest that they merely had the general aim of improving the health system. But more sinisterly they appeared to be a coherent plan to move towards the privatisation of the public health system - on the supply side via the conversion of providers into private businesses, and on the demand side via the conversion of public sector purchasing into private purchasing by user chargers and private insurance." (Easton, 1997, p. 156). As an example, the CHEs were expected to be run along the lines of best commercial practice and were expected to return a profit on their asset base by appropriate charging. The legislation that established the CHEs requires them to operate as successful and efficient business and to achieve or maintain the solvency of the enterprise. Both the RHAs and CHEs were run as commercial enterprises and for this reason, the managers were appointed to both organisations that had little or no expertise in the health sector.

Stage III: Coalition Agreement 1997

In 1996, the New Zealand voters had their first election under mixed member proportional voting (MMP). This system replaced the previous first past the post (FPP) voting system. The FPP supported a dominant two party system and as New Zealand has a unicameral parliamentary system, the party in power was able to pass legislation readily. As a result, the parliamentary system was not always responsive to the desires of the electorate. The outcome under the first MMP system was a coalition between the National and New Zealand First parties. Overall the MMP system led to greater representation by minority groups, especially Maori and women.

The Coalition Agreement on Health which was implemented in 1997 replaced the four RHAs with a single funder, known as the Health Funding Authority. The providers of services were the same as before. The funder's role is to set priorities, negotiate and manage contracts and monitor performance. The role of providers, in addition to providing services, is to take responsibility for quality, contribute to the work of the funder in allocative

² In the Westminster system, a Green Paper is a discussion paper and is followed by a White Paper, which is a policy statement. The Green and White paper was described as a statement of government health policy and represented a *fait accompli*.

decisions and become more involved with the funder, other providers and communities (Coalition Agreement on Health, 1997).

The Coalition Agreement on Health (1997, p.7) expressed the view that "relationships between people and organisations should be more collaborative and co-operative at all levels". This view was a response to an inherent weakness in the funder-purchaser-provider arrangements: there was tension between purchasers and providers, especially Maoris providers. Some of this tension was a function of managers who were inexperienced in the health sector and unresponsive or unsympathetic to the differences between health and other goods and services. There was a lack of shared vision between the purchasers and providers and the community and the clinicians were unsupportive of the reorganisation of health into a funder, purchaser, provider split. The competitive relationship between CHEs fostered secrecy. The costs of contracting and transacting were much higher than anyone had anticipated. Easton (1997) claims that the estimates of the costs of the reforms vary between 2 and 10 percent of one year's health budget. On top of the costs of the reforms, the estimates of the extent of cost reduction through efficiency gains were unrealistic. A cost reduction from efficiency gains of 30 percent was suggested at the time of the publication of the green and white paper (Easton, 1997). This estimate was later reduced to 5 percent efficiency gains. Moreover there was some concern that cost reduction was achieved by cost shifting rather than real gains in efficiency. The time frame in which it was believed that efficiency gains could be achieved was unrealistic. Such major adjustments in terms of health delivery and funding require a considerable change in the management and clinical culture. Changes in clinical culture in particular are important in any desire for cost containment in the health sector. Finally, there was a sense that there was lack of clear direction and a need for a nationally consistent purchasing policy.

The New Zealand health sector has now a funder -provider model of health funding and delivery. One of the disadvantages of the three-way split was that the costs of contracting become more explicit and highly visible as there is another layer of management (Ministry of Health, vol 1, 1996). But, the flexibility to respond to individual or community needs is not available under a formal contracting arrangement.

Evaluation

Health reforms do not necessarily yield net benefits to society. First competition is not necessary to reduce inefficiencies and competition may not increase efficiencies. In many areas of New Zealand, there is only one provider of services. Nonetheless efficiency improvements are still achievable. Second, the operation of the market requires that providers have both the incentives to compete with other providers, and the managerial independence to respond to competition by lowering prices and cutting costs appropriately (Propper and Söderlund, 1998). Cultural changes, which are necessary to refocus management behaviour, take time.

In the period prior to 1984, health services in New Zealand were funded and provided, with some exceptions, by a bilateral monopoly. The first reform did not change this structure significantly, but the second reform of a funder-purchaser-provider split did. One purchasing authority per region with monopsonistic power, and limited competition amongst providers replaced the bilateral monopoly of funding and providing. A single purchasing authority generates benefits from economies of scale and monopsony powers in assessing service options and negotiating contracts with providers (MacFarlan and Oxley, 1995). Under the latest health sector reform, there is one purchaser rather than four. This means that there are still benefits from economies of scale and monopsony power over providers. The disadvantage of one purchaser is that the organisation is further removed from health consumers and may become unaccountable. The advantage of one purchaser is that there is a greater likelihood of the development of an integrated, long-term view of health as well as the appropriate mix of public health care.

Another consideration of the costs and benefits of microeconomic reform in the health sector are the costs of monitoring and transacting. Evans (1990) cautions that competitive systems may lower the direct costs of providing a service, but the administrative and surveillance costs may be high. Propper and Söderlund (1998), for example note that any effect of competition in the NHS is also likely to be attenuated by the heavy management of the NHS internal market. This certainly seems to be the case with the reorganisation of health services in New Zealand. The costs of administering and monitoring the internal market were visible, explicit and seemingly high (2 to 10 percent of the total annual health budget as mentioned above).

There are significant problems in evaluating the effectiveness of health sector reform. Indeed, evaluation faces the same difficulties as the overall evaluation of the performance of the health sector. The factors that may be evaluated are changes in total expenditure, changes in quality, changes in throughput, changes in waiting lists, changes in health status or a mixture of all these factors. All of these factors are difficult to quantify. Total expenditure in real or nominal terms is a crude but readily available measure. Its value however is muddied by the fact that the total health budget usually increases in real terms regardless of the organisational structure. Moreover, changes in real health expenditure by the public sector have to be considered alongside increases in out-of-pocket payments by households and increases in the proportion of the population with private health insurance. Private out-of-pocket expenditure, private health insurance and contributions from charities accounted for 12 percent of total health expenditure in 1979/80 and 23 percent in 1994/95. The average annual increase between 1980 and 1995 in private expenditure on health was 15.5 percent. (Ministry of Health, 1996, vol. 2). Reductions in the real value of benefits combined with increased waiting lists for public hospital services have contributed to the growth in demand for private health insurance. The average yearly growth rate in private health insurance from 1980 to 1995 was 23.4 percent. The government subsidy for doctors' fees declined from 75 percent in 1938 to 25 percent in 1986 (Stephens, 1996). In 1996, subsidised fees of approximately 50 percent of doctors' fees were only available to those eligible for a Community Services Card. Non-card holders pay the full fee for a doctors consultation. The overwhelming evidence that private expenditure has increased at a much higher rate than public expenditure supports the view that the government was controlling public expenditure largely by cost shifting.

During most of period when there were four RHAs, waiting lists for surgical services increased and little progress was observable in changes in health status measures (Ministry of Health, 1997). Changes in health status may take a considerable time to respond to any changes. The literature in this area seems to indicate that economic prosperity and social equity are much more important determinants of health status than how much is spent on the health sector. (Marmot, 1993). A shift of resources into targeted areas such as mental health was achieved during the period of the RHAs.

Conclusions

It is apparent that many of the changes described above may have occurred without major structural reform. The same is true of the improvements in productivity of 1 to 2 percent (Easton, 1997). The overall message from the reform of the New Zealand health system was that there was too much reform both in terms of the number of reforms and the scale of the reform. Attempts at major health sector reform in both the United States and Great Britain indicate that major as opposed to incremental reform is unlikely to be successful. The reform in New Zealand was most of all undemocratic: there was little support for the changes both amongst the public and health professionals. Furthermore, the public in New Zealand is committed to a public health system. A change, which by stealth was pushing more expenditure responsibility and therefore more resources to the private sector, was consequently unpopular. Finally, any reform takes time to have an impact. New Zealanders have faced three major reforms in the period since 1984. Not only does such frequent change make evaluation of outcomes problematic; it also means the health professionals and the population as a whole is suffering from reform fatigue.

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