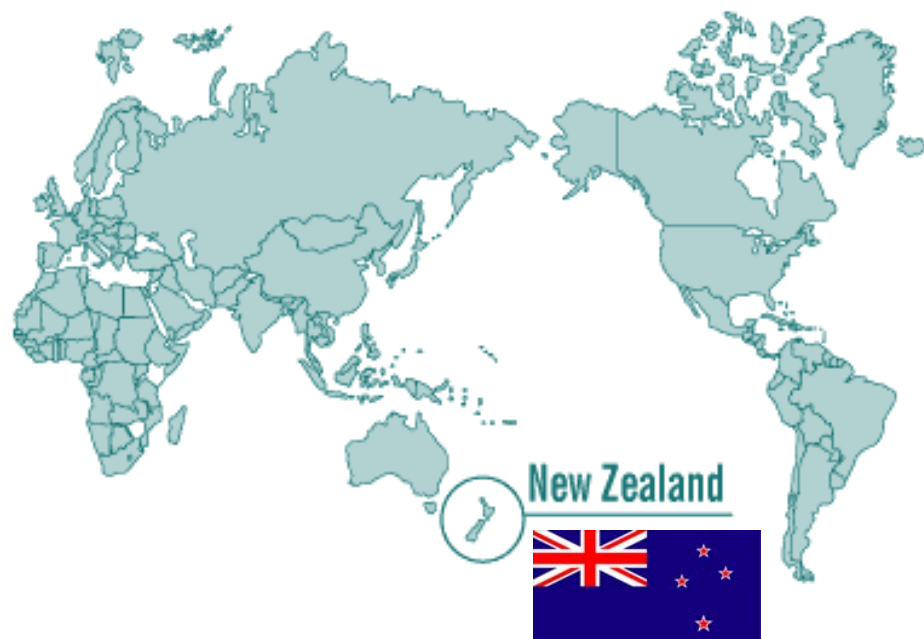


New Zealand's *failed experiment* with managed competition & commercialization of public hospitals (1993-6): *Possible lessons for other countries?*

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New Zealand (*background*)

- 4 million people (+ 40 million sheep!)
- Tax-funded, universal access
Public Health System
~ 8% of GDP, 21% of govt spending
- ~ 23 public hospitals
- Private providers (family doctors,
dentists, pharmacists, specialists etc)
- + Private Health Insurance
(mainly as 'top up' ~ 25% of pop)

Problems in 1980s & early 90s^{*}

- **long waiting lists** (for elective services): 67,000 people in 1991
- **public hospitals regarded as inefficient**: private hospitals ~ 30% cheaper to run

WHY?

- lack of cost data to facilitate good management
 - poor incentives for hospital managers, *eg.* fixed wage contracts
 - conflicting roles of government as both **funder & provider** of services
 - lack of incentives to 'contract out' work (*ie.* do 100% themselves)
- **lack of choice** for healthcare consumers

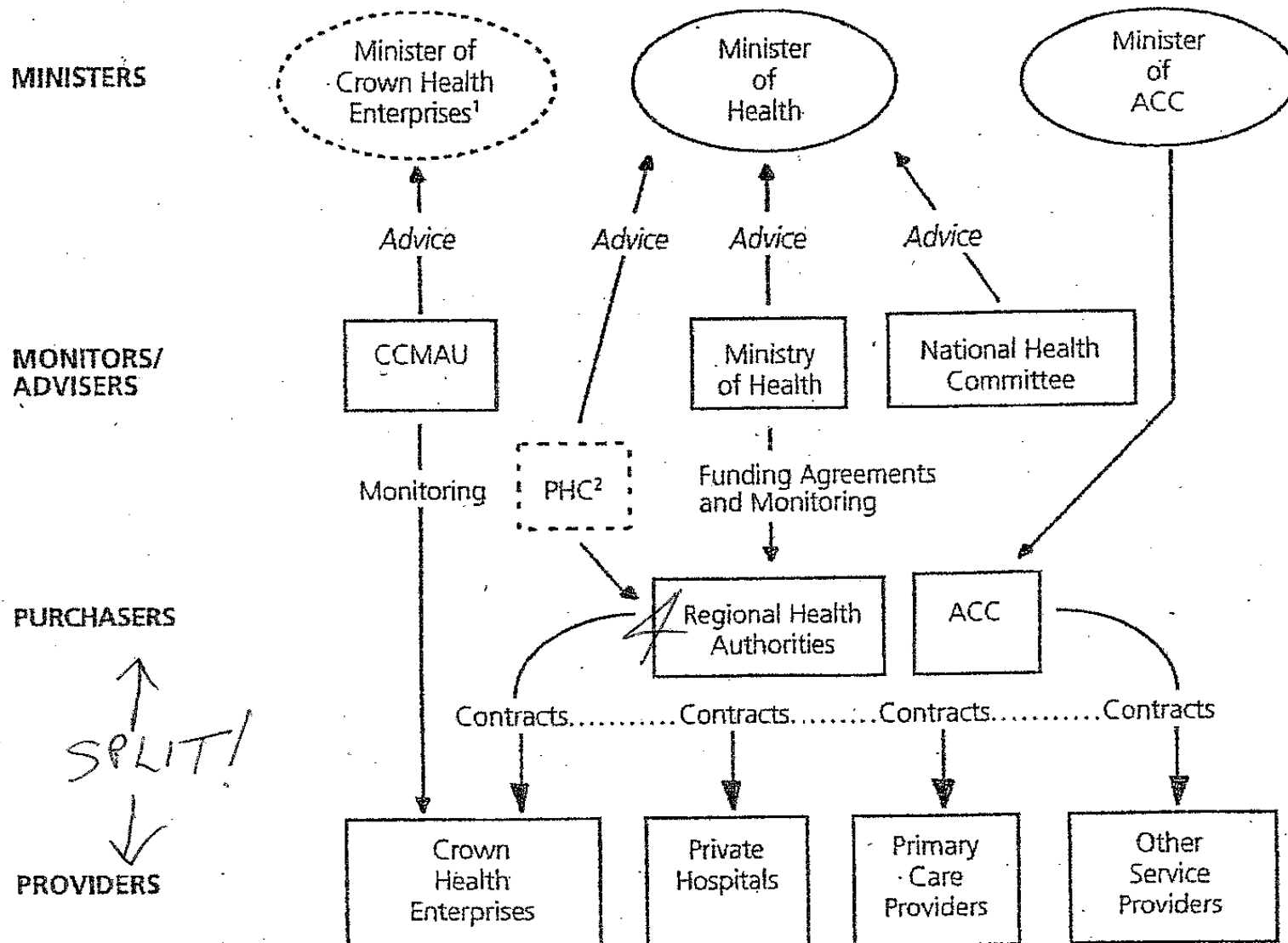
^{*} References available.

Solutions (1993-6)

(Proposed in 1991 'Green & White Paper', S. Upton: *Your Health & the Public Health*)

1. **Competitive Funding**: Private insurers in direct competition with govt funder/purchaser. (proposed but not implemented because of anticipated adverse selection problems ...)
 2. **"Purchaser-Provider Split"** ("quasi-markets", "managed competition", "corporatization")
... inspired by reforms from UK, Netherlands, Sweden
 - 23 public hospitals to be renamed as **"Crown Health Enterprises"** (CHEs)
→ **semi-autonomous 'firms'**: to be **socially responsible AND** also operate as **successful businesses**, generating return on capital & run by managers from 'business sector' (eg. from outside health sector) → challenge to clinical freedom ...
 - **"user charges"** for hospital care (+ "Community Services Cards")
 - (*in theory*) CHEs monopoly power to be eroded → **CHEs to compete for public funds** against each other and also the small private sector (expected to expand)
- (+3. **PHARMAC** (Pharmaceutical Management Agency) established in 1993)

Figure 8.1 The Structure of the Reformed Public Health System, 1993-1996



Source: T. Ashton (1999) "The health reforms: to market and back?", Chap 8 in J. Boston (ed), *Redesigning the Welfare State: Problems, Policies and Prospects*, Oxford University Press.

Outcomes?

According to Treasury (1996):

“The health reforms have yet to yield the original expectations. By a range of measures ... the pace of performance seems, if anything, to have been weakened since the reforms.”

- poor financial performance: large deficits for 21 of the 23 CHEs (public hospitals) (wage & input price inflation, CEO bonuses; but maybe higher quality?)
- high turnover of hospital CEOs: 15 resigned (over 3 years: 1993-6)
- still technical inefficiency (but hard to measure)
- ↑ waiting lists: from 67,000 to 94,000 (→ Booking & Points Systems)
- ↑ total hospital costs: ↑ by \$1b, 1993-96
- ↑ transactions costs (*eg.* contracting)
- more accountability?
- ↑ consumer choice (although greater reliance on private insurance)
- ↓ sector morale (“reform fatigue”)

What went wrong?

- **barriers to entry** for private hospitals (limited “contestability”):
high fixed costs; limited information; poor credibility
difficult logistics → the 23 CHEs effectively had local monopoly each
legislative constraints on CHEs entering private markets
- **barriers to exit**:
govt. bail-outs, as reluctant to let CHEs go bankrupt ...
legislative measures to require provision
→ CHEs couldn’t drop unprofitable services
- RHAs (purchasers) **too risk averse** → reluctant to buy from other (private) providers:
too risky, too costly to transact
- inherent **conflict in objectives**: business orientation vs. social responsibility
- **power of doctors** to control hospitals? (in conflict with managers & corporatization ethos)

*Did corporatization fail because: (1) It's fundamentally inappropriate in health sector?
OR (2) The managed competition model was 'too managed'
(not enough freedom, as in conventional markets)?*

The current NZ set-up?

Since 1996: Public hospitals “reconstituted as not-for-profit organisations, but still required to practise sound financial management and accountability and to cover all costs, including cost of capital”

Movement away from competition between hospitals and business orientation

Since 2000: Re-organised into **21** “*District Health Boards*” (DHBs)

- ★ locally elected & government-appointed (including Maori representatives)
- ★ DHBs own local hospitals (vertical integration again)
- ★ population-based funding formula (but what weights?)

Why so many organisations?? (ie. 21 DHBs)

National consistency versus local representation

Duplication, *eg.* administration costs