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A LAW & ECONOMICS CRITIQUE OF THE HEALTH AND DISABILITY SERVICES ACT 1993

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The provision of health and disability services was reformed by the Health and Disability Services Act 1993. This Act attempted to control the cost of health and disability care and promote efficiency in health markets through the introduction of competitive pressures. The vehicle for these competivie pressures was to separate the purchasing and provision of publicly-funded health and disability services. Although the state would continue to fund health and disability services, provision was subject to competition. The concept of public provision no longer exists; the most efficient providers would be chosen, be they Crown-owned or private.

However, the reformed system retains elements of the old sytem which adversely impact on the ability of the reforms to achieve their objectives. The public purchasers enjoy monopsony purchasing power, and many of the former public hospitals, now Crown Health Enterprises, enjoy monopoly power for many health and disability services. In addition, the reforms fail to completely address many of the causes of market failure in the provision of health and disability services. The problems of excess consumption, due to moral hazard and information asymmetries, continue under the reforms. The provision of some (secondary and tertiary) health and disability services may not be suited to competitive processes; attempts to do so are likely to result in a sub-optimal utilisation of those resources.

An important consideration for any public health system in New Zealand is the extent to which it addresses the health needs of all New Zealanders, especially Maori. Historically, Maori have enjoyed a health status significantly lower than pakeha. The greater flexibility in the Act, both for providers and purchasers, allows public funds to be targeted more effectively to the health needs of Maori.

The Health and Disability Services Act 1993 represents an imperfect attempt at health reform, but is an improvement over the previous system.

The text of this paper (excluding contents page, footnotes and bibliography) comprises approximately 16,000 words.

I INTRODUCTION

The provision of publicly-funded health and disability services in New Zealand was substantially reformed by the enactment of the Health and Disability Services Act 1993. This Act attempted to address the problems identified with the old system—visibly manifested in lengthy waiting lists—by injecting competitive pressures into the health system.

The keystone of these reforms was the separation of the purchasing and provision roles. Public hospitals in the old sense, at least in theory, had ceased to exist. Purchasers would choose from among competing providers to maximise the use of their resources, and thus provide the people of New Zeland with the best health and disability care available within the funding provided. Although the Act effected significant changes to public health, it did not necessarily entail a lessening of the commitment to publicly funded health and disability services.

Despite the intentions of the Act, the reforms are limited in the extent to which a competitive health care market is created. Problems caused by monopsonist purchasers, and monopolist providers, remain in many instances. The reforms are also subject to many of the evils which afflict health care markets. Finally, the provision of some health or disability services may not be amenable to market governance.

However, the provision of health care in a society inevitably represents a compromise between various objectives. The reformed health system, despite its defects, represents an improvement on that which went before. Purchasers and providers are now better able to utilise limited health resources.

II SOME ECONOMIC CONCEPTS

A Overview

Law and Economics is a technique which uses economic tools to analyse legal structures and processes. Economics in this sense, is not limited to money. Economics deals the use of resources, namely, "the science of rational choice in a world ... in which resources are limited

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in relation to human wants."[1] This quest is based on the assumption, which is not necessarily unchallenged, that people are rational maximisers of self-interest. People act rationally when they conform to the model of rational choice, whether or not they are conscious of doing so.[2] Maximising self-interest may include concern for others, so-called altruistic benefits. This model "implies that people respond to incentives — that if a person's surroundings change in such a way that he [sic] could increase his [sic] by altering his [sic] behaviour, he [sic] will do so."[3]

From this, economists derive the following three basic rules:[4]

1) LAW OF DEMAND — There is an inverse relation between price charged and quantity demanded. As price rises, demand will fall. As the relative cost of a good or service rises, the rational utility maximising person will practice substitution of relatively cheaper products.

   Related to the Law of Demand is the concept of elasticity of demand. Elasticity compares the percentage change in the price of a good or service with the percentage change in quantity demanded of that good or service. Where the two percentages are the same, there is said to be *unitary* elasticity of demand. Where the percentage change in quantity demanded is greater than the percentage change in price, demand is said to be *elastic*. If the percentage change is quantity demanded is less than the percentage change in price, demand is said to be *inelastic*. Essentially, the greater the price elasticity of demand, the greater the effect on quantity demanded by a change in price.

   Economists also apply this analysis to goods or services without explicit 'prices.' These goods or services are accorded non-pecuniary "shadow prices."[5]

2) ALTERNATIVE PRICE — To an economist, the cost of a good is the price that the resources consumed in producing that good would command in their next best use (also called the "opportunity cost"). This is the lowest price

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[1] R Posner *Economic Analysis of Law* (4 ed, Little Brown & Co., Boston, 1992) 3.
[2] Although it has been suggested that rational utility maximising individuals exist only within the confines of post-graduate economics programmes. Regardless, it is the underlying assumption on which most economic modelling is based.
[3] Above n 1, 4.
[4] The following discussion is summarised from Posner, above n 1, pp 4-12.
[5] Posner gives an example that the punishment meted out to convicted criminals is the 'price' of that offence. The relative 'price' of criminal activity may encourage the criminal to substitute other relatively less expensive activities. See Posner, above n 1, p 5.

that a rational utility maximising supplier will sell the good for. A corollary of this is that cost only occurs when someone else is denied the use of a resource. A resource which can be consumed without that consumption denying anyone else the ability to consume that same good is said to be costless.[6]

An important concept in the context of health care are "sunk" costs. "Sunk" costs are costs which are incurred prior to a transaction, and do not affect decisions relating to price or quantity. This is based on an assumption that rational utility maximising individuals are forward-looking in their behaviour.[7]

In a competitive market, the opportunity cost of a good will be both the maximum and the minimum price of a good. This point is known as the equilibrium. This point is arrived at by analysis of a supplier's marginal cost curve. At equilibrium, the marginal cost of producing an extra unit of a good is equal to price.

3) RESOURCES IN MOST VALUABLE USE — In a market system, resources will tend to be used for the most valuable use:[8]

> By a process of voluntary exchange, resources are shifted to those uses in which the value to consumers, as measured by their willingness to pay, is highest. When resources are being used where their value is highest, we may say that they are being employed efficiently.

This of course assumes the existence of a market, and that the good is a marketable commodity. One should also note that demand = willingness to pay = ability to pay. Such an analysis may sit uneasily in the context of health care.

Related to this is the Coase Theorem. Put simply, the Coase Theorem states that in a market where transaction costs are zero, the initial allocation of a property right will not affect its ultimate use. Resources will be traded until occupied in their most valuable use.[9]

B Efficiency

Efficiency describes the allocation of resources which maximises value. Efficiency is an objective in that it maximises the use of scarce

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[6]The most common example of a costless good is air.
[7]Posner cites the example of a white elephant which cost $1000 to build, but will sell for only $10. After the white elephant is completed, the costs are 'sunk.' The rational seller will sell the elephant for $10, for she will now lose only $990, rather than $1000. See Posner, above n 1, p 7.
[8]Above n 1, p 11.
[9]Above n 1, p 8.

resources. There are two measures of efficiency which are commonly used in law and economics:

(a) PARETO EFFICIENCY — A transaction is Pareto superior if it makes no-one worse off, and makes at least one person better off. In the context of voluntary exchanges, both parties are assumed to benefit from the transaction.[10]

Pareto superiority is difficult to apply in practice because most, if not all, transactions have effects on third parties, which effects are normally difficult to quantify in their entirety. A more workable measure is that of Kaldor-Hicks (below).

(b) KALDOR-HICKS EFFICIENCY — Kaldor-Hicks efficiency is also termed "wealth maximisation." Under this test, an exchange is efficient if the beneficiaries of the exchange are able to compensate any third parties for their losses, while still retaining some benefit from the exchange.[11] Note that the requirement for compensation is only *hypothetical*; it is not necessary for the third parties to be compensated, only that the beneficiaries are able to do so.[12]

As Kaldor-Hicks is essentially a form of cost-benefit analysis, unlike Pareto efficiency, it can be used to assess the efficiency of non-voluntary exchanges. This is especially useful with respect to collective decision-making.[13] Kaldor-Hicks efficiency is the measure normally used in economics discourse, and is used in this paper.

C Normative vs. Positive Analysis

1 Normative Analysis

Normative economic analysis is typically prescriptive, and tends to ask whether individuals affected by a transaction will perceive themselves

[10]This is based on an assumption that a rational utility maximising person would not voluntarily enter an exchange from which they do not benefit. Thus the voluntary nature of the exchange is proof of its Pareto superiority. See M Trebilcock "Lawyers and Economic Consequences" (1993 New Zealand Law Conference) 331.

[11]Trebilcock, above n 10, p 331. Posner gives as an example a wood carving. The carving is possessed by A who values it at $5. B values the carving at $12. Therefore, an exchange at a price between $5-$12 will make both parties better off and will be Kaldor-Hicks efficient if the loss to third parties does not exceed $7 (the gains from the transaction): see Posner, above n 1, pp 13-14.

[12]Above n 1, 14.

[13]Although it remains practically difficult to assess the net impact of a collective decision.

as better off in terms of their own welfare.[14] The value of transactions is judged by the response to this question. Normative analysis favours efficient transactions, or least those which promote efficiency.

Normative analysis tends to be a little controversial, in that it is inclined to favour private systems of exchange and ordering over collective systems. Economically, this is based on the premise that parties to a voluntary private exchange benefit from the exchange.

2 *Positive Analysis*

Positive economic analysis is descriptive or predictive, rather than prescriptive.[15] Positive analysis tends to address the allocative and distributive effects of policy, in determining how people are likely to respond to the incentives and disincentives in a policy. Positive analysis uses economics tools to address such questions as the effectiveness of a policy:[16]

> [E]conomic agents, in all their various activities, respond to incentives. This proposition is central to the understanding the functioning of any pricing system, whether it involves explicit (grocery store) prices, or implicit (penalties for different crimes) prices. To the neo-classical economist, the legal system is simply an institutional arrangement for prescribing, and setting implicit prices for, certain activities, within some over-arching consequentialist objective.

III HEALTH SYSTEM PRE-1993

Prior to the enactment of the Health and Disability Services Act 1993, the provision of health and disability services in New Zealand was dominated by a public health system, run as Area Health Boards. The private provision of secondary and tertiary health services was largely limited to non-acute procedures.[17] Private provision of primary care was much more widespread. However, general practitioners and pharmaceuticals were heavily subsidised by the public sector.[18]

Funding for these services came from a variety of sources. The government funded 100% of public hospital charges and about 25% of private hospital charges through subsidies. Consumers picked up

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[14] Trebilcock, above n 10, p 331.
[15] Trebilcock, above n 10, p 326.
[16] Trebilcock, above n 10, p 329.
[17] P Borren & A Maynard *Searching for the Holy Grail in the Antipodes* (Centre for Health Economics, York, 1993) 1.
[18] *Choices for Health Care: Report of the Health Benefits Review* (Health Benefits Review, Wellington, 1986) 15-17.

about 50% of private hospital charges, with the balance divided more or less equally between A.C.C. and private insurance companies.[19]

The government's Green and White Paper in 1991 highlighted eight major problems with the present public system:[20]

(a) PUBLIC HOSPITAL WAITING TIMES ARE TOO LONG[21]—Waiting lists for secondary and tertiary health care were widely regarded as too long. There were lengthy delays for "urgent" surgery, and routine surgical procedures were often continually delayed for a lack of resources.

Among the main causes of these delays was Area Health Boards' proclivity to cut services in the face of funding cuts, rather than make efficiency gains. This approach was sustainable due to the Area Health Boards' monopolisation of the provision of secondary and tertiary health and disability services.

The situation was compounded by a lack of clarity regarding what health and disability services should be publicly funded. The Green and White paper stated that among the responses to this problem should be the creation of a list of core services. Such a list would "define the 'ceiling' on the Government's obligations to assist people's access to health care,"[22] and enable funders and consumers of health and disability services to determine what services should be provided.

(b) CONFLICT IN THE ROLES OF AREA HEALTH BOARDS[23]—The dual role of Area Health Boards—purchasing and providing services—was perceived as a source of inefficiency. Area Health Boards used public funds for the maximum use of their resources, rather than maximising the use of the available public funding.

(c) CONSTRAINTS ON AREA HEALTH BOARDS[24]—Statutory controls on Area Health Boards were unnecessarily restrictive on the use of resources. Added to this was a lack of quality control and

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[19] Above n 17, 1-2; *re*. D Muthumala & C. McKendry *Health expenditure trends in New Zealand 1980-1991* (Department of Health, Wellington, 1991) for figures.
[20] S Upton *Your Health and the Public Health* (Department of Health, Wellington, 1991).
[21] Above n 20, 11-13.
[22] Above n 20, 13.
[23] Above n 20, 13.
[24] Above n 20, 13-14.

accountability mechanisms. These conditions led to a sub-optimal utilisation of the Area health Boards' resources.

(d) FUNDING OF THE SYSTEM IS FRAGMENTED—Fragmentation of funding sources for different health and disability services led to inefficiencies and cost-shifting. Secondary and teritary health and disability services were funded by the 26 Area Health Boards. These Boards were partly elected by their communities, but were fiscally responsible to the Minister of Health. Primary health and disability services and pharmaceuticals were funded directly by the Department of Health entirely on a demand-driven basis. Fuding for all health and disability services was also provided by the Accident Compensation Corporation for injuries sustained as the result of a 'personal injury by accident.' Procedures were duplicated and patients "shunted between systems with no guarantee of proper, managed, personal care."[25] Alternatively, cost-shifting among providers was widely practiced by providers to minimise their costs, rather than providing the best treatment to patients.

(e) PROBLEMS OF ACCESS TO SERVICES[26]—The Green and White paper identified geographical and economic disparities in access to health and disability services. People in low incomes experienced economic barriers to utilisation of primary health and disability services; people in small communities and more remote areas faced geographical barriers to the utilisation of secondary health and disability services.

(f) LITTLE ASSISTANCE FOR DOCTORS IN MAKING CHOICES[27]—Varying subsidies for primary care failed to encourage physicians to choose the most cost-effective treatment for patients. User co-payments[28] were limited to small areas of primary care and non-existent for secondary care; consequently, patients were not encouraged to minimise the cost of treatment: "the financial

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[25]Above n 20, 14

[26]Above n 20, 15-16.

[27]Above n 20, 16-17.

[28] Co-payments are the proportion of the cost of medical treatment borne by the patient. For instance, if a GP charges $40 for a consultation, and the state provided $25 for the cost of a consultation for a dependant child, the cost borne by the patient for the consultation would be $15. The cost to the patient of this care is therefore, $15.

incentives are perverse, encouraging the use of high-cost "free" hospital services at the expense of alternatives."[29]

(g) LACK OF CONSUMER CONTROL[30]—Publicly funded and delivered health and disability services offered little opportunity for consumer control over treatment received. Communities had little control over the determination of health needs and the purchasing of services. Of particular concern was the lack of services designed to meet the special needs of Maori, women and other communities.

(h) FAIRNESS[31]—Fairness is an important consideration for any health system in New Zealand—"The system must treat people fairly. it must guarantee all New Zealanders reasonable access to an adequate and affordable range, level and quality of services."[32] The system contained discrepancies in funding of services and access to treatment. These discrepancies were demographic, geographic and economic.

IV HEALTH AND DISABILITY SERVICES ACT 1993

The Health and Disability Services Act 1993 ('the Act') was enacted to address the concerns raised in *Your Health and the Public Health.* The Long Title to the Act states that its purpose is to

(a) Secure for the people of New Zealand—

(i) The best health; and

(ii) The best care or support for those in need of services; and

(iii) The greatest independence for people with disabilities—

that is reasonably achievable within the amount of funding provided; and

(b) Facilitate access to personal health services and to disability services; and

(c) Achieve appropriate standards of health services and disability services.

The core of these reforms is the division between purchasers and providers of health and disability services. Publicly-funded health and disability services are provided under the Act by the Crown entering *funding agreements* with *purchasers* of health and disability services. Purchasers then enter *purchase agreements* with *providers* of health and

[29] Above n 20, 17.
[30] Above n 20, 17-18
[31] Above n 20, 18-19.

disability services for the actual supply of health and disability services, public or personal.

It should be noted that while Parliament has reformed the provision of publicly-funded health and disability services, the commitment to the public funding of some level of health and disability services remains. Although the Act does not necessarily entail a change to the public/private funding mix for health and disability services in New Zealand, the potential exists for publicly-funded health and disability services to be purchased from a wider range of providers than prior to the Act.

A *Funding of health and disability services*

Public funding for health and disability services is provided to purchasers by funding agreements entered into by the Crown and a purchaser pursuant to section 21 of the Act. The funding agreement defines the persons for whom the health and disability services are to be provided. The specificity of the health and disability services to be provided varies with the contract.

In entering funding agreements, the Crown must give notice to the purchaser of its objectives pursuant to section 8 of the Act. The Crown's determination of its objectives under this section is subject to subsection (3). Subsection (3) sets out what the Crown aims to achieve in relation to the publicly-funded provision of health and disability services in New Zealand, *viz.* the best health and disability care and services achievable within the available funding.

Section 8 requires the Crown to specify its objectives in relation to the health status of the persons covered by a funding agreement and the health and disability services to be purchased for them; access to health and disability services; and "the special needs of Maori and other particular communities or people...."[33] When entering a funding agreement with the Public Health Commission, the Crown must specify its public health objectives.[34]

B *Purchasers of health and disability services*

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[32]Above n 20, 18.
[33]Health and Disability Services Act 1993, s 8(1).
[34]Health and Disability Services Act 1993, s 8(2).

A "purchaser" of health and disability services under the Act is defined in section 20 as the Public Health Commission, a regional health authority or any other person whom the Minister has declared to be a purchaser.[35]

1 *Public Health Commission*

The Public Health Commission ('PHC')was established as a body corporate by section 27 of the Act. This body was endowed with several disparate functions. The PHC was responsible for monitoring public health and identifying needs; providing advice to the Minister on public health matters; and procuring, directly or vicariously, public health services.[36] The PHC was unique in that it combined health policy advice and health and disability services provision roles.

However, purchase of health and disability services by the PHC was limited to *public* health services.[37] Public health services in the Act are defined as "goods, services, or facilities provided for the purpose of improving or protecting *public* health."[38] These services are distinguished from *personal* health services, which are "health services provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are provided for some other purpose."[39] The provision of health services to individuals with the intent of thereby improving that individual's health therefore falls outside the powers of the PHC. Public health services are more properly regarded as services which, although accruing a benefit to an individual, are not capable of being discretely purchased and enjoyed by an individual, but must be purchased for the benefit of a larger group. An example would be an environmental health policy.

The PHC has since been abolished. Its policy functions have been assumed by the Ministry of Health, its advice functions by the Core Services Committee, and the purchasing functions by the Regional Health Authorities.

2 *Regional Health Authorities*

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[35]Health and Disability Services Act 1993, s 20.
[36]Health and Disability Services Act 1993, s 28.
[37]Health and Disability Services Act 1993, s 28(1)(c).
[38]Health and Disability Services Act 1993, s 2. *Emphasis added.*
[39]Health and Disability Services Act 1993, s 2.

Regional health authorities ('RHAs') are established under section 32 of the Act. RHAs are responsible for monitoring the personal health needs of people within their regions and purchasing health and disability services to meet those needs.[40] The persons for whom a RHA must purchase health and disability services are defined in the funding agreements entered into by a purchaser and the Crown.[41] A RHA's responsibilities for the purchasing of health and disability services are defined geographically. Presently, four RHAs have been established under the Act: the Northern, Midland, Central and Southern RHAs.

Section 10 of the Act establishes four objectives for RHAs:

(a) To promote the personal health of people; and
(b) To promote the care or support for those in need of personal health or disability services; and
(c) To promote the independence of people with disabilities; and
(d) To meet the Crown's objectives notified to it under section 8 of this Act—

in accordance with, and to the extent enabled by, its funding agreement.

The purchasing of health and disability services by a RHA is subject to the objective of obtaining the best health and disability care within available funding.[42] In purchasing health and disability services, the RHA should maximise its available resources. To do so, it should purchase resources from the most efficient provider. The is no logical imperative for the RHA to purchase health and disability services from a Crown Health Enterprise (a former public hospital) if an alternative provider can provide the services more efficiently.

3 *Other purchasers*

The definition of purchaser in section 20 of the Act enables other persons (natural or legal) to be gazetted as purchasers by the Minister. Under this provision, the Crown may enable other bodies to act as purchasers of publicly-funded health and disability services. These purchasers are not subject to the restrictions on the PHC or the RHAs.[43] These bodies—for instance, a regional health plan—may be

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[40] Health and Disability Services Act 1993, s 33.

[41] Health and Disability Services Act 1993, s 21.

[42] Section 10(d) requires the RHA to endeavour to meet the Crown's objectives as notified under section 8(1). The Crown's determination of its objectives under section 8(1) is subject to subsection (3) of that section. Therefore, the aim to secure the best health and disability care and services within the available funding is impliedly part of the objectives of the RHA.

[43] The PHC's purchasing ability is limited to the purchase of public health services: Health and Disability Services Act 1993, s 28(1)(c). A RHA's purchasing is limited to the purchase of personal

able to compete with the PHC and RHAs for the purchase of health and disability services. Although at present, no other purchasers have been gazetted by the Minister, their existence may assist to address the problems of monopsony purchasers identified below.[44]

C Providers of Health and Disability Services

Purchasers of health and disability services under the Act may enter purchase agreements for the provision of health and disability services with "any person."[45] Purchasers are therefore unrestricted in their choice of provider. Both the PHC and RHAs have the objective of providing the best health and disability care and services within the available funds. Therefore, a purchaser should enter a purchase agreement with the most efficient provider of the health or disability services.

Providers enter into agreements with purchasers for the provision of specific health and/or disability services.

D Crown Health Enterprises

Under the Act, the former public hospitals have been formed into 23 Crown Health Enterprises ('CHEs'). Although the health reforms have retained a commitment to the public *funding* of health and disability services, this does not necessarily entail the continued public *provision* of health and disability services. Indeed, if a CHE cannot fulfil its obligation to be "as successful and efficient as comparable businesses that are not owned by the Crown,"[46] the RHA will contract with another, more efficient, provider.

The objectives of CHEs under the Act are to provide health and/or disability services, and, by providing services pursuant to a purchase agreement, to assist in meeting the Crown's objectives under section 8, "while operating as a successful and efficient business."[47] In addition, CHEs must—

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health services for the persons defined in the funding agreement with the Crown. Normally, this is a geographical restriction.

[44] See para VI(A)(4).

[45] Health and Disability Services Act 1993, s 22(1).

[46] Health and Disability Services Act 1993, s 11(2)(d).

[47] Health and Disability Services Act 1993, s 11(1).

(a) "exhibit a sense of social responsibility by having regard to the interests of the community in which it operates;"[48] and

(b) uphold generally accepted ethical standards;[49] and

(c) be good employers;[50] and

(d) operate as successfully and efficiently "as comparable businesses that are not owned by the Crown."[51]

The dominating objective of a CHE is to operate as a successful and efficient business, and to do so at least as effectively as comparable private businesses. The concept of a 'public' hospital is now arguably defunct. CHEs are little more than providers of secondary and tertiary health and disability services that are owned by the Crown. In regards to the purchasing of publicly-funded health and disability services, a CHE should not be treated differently from any other provider, publicly or privately owned.

However, although public hospitals have metamorphosised into commercial entities, some constraints remain. CHEs are incorporated under the Companies Act 1955,[52] and all voting shares in a CHE are held by the Minister of Finance and the Minister for Crown Health Enterprises.[53] The Crown is presently unable to dispose of its voting shares in a CHE. For this reason, the achievement of the objective to operate as successfully and efficiently as business not owned by the Crown may be impeded.

Agency costs are incurred when an enterprise is managed by agents, rather than by the owners. Agency costs arise for two main reasons. Firstly, employment contracts are necessarily incomplete: contracts cannot cover every possible action of the agent.[54] Secondly, individuals are assumed to be utility maximisers. The utility of the agent will often not conform to the utility of the owners.[55] For instance, an agents utility is maximised through remuneration; the owners utility is maximised through increases in profit or the value of the firm.

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[48] Health and Disability Services Act 1993, s 11(2)(a).
[49] Health and Disability Services Act 1993, s 11(2)(b).
[50] Health and Disability Services Act 1993, s 11(2)(c).
[51] Health and Disability Services Act 1993, s 11(2)(d).
[52] Health and Disability Services Act 1993, s 37(1)(a).
[53] Health and Disability Services Act 1993, ss 2 & 38(1).
[54] B Klein "Contracting Costs and Residual Claims" (1983) *Journal of Law & Economics* 367.
[55] E Fama & M Jensen "Separation of Ownership and Control" (1983) *Journal of Law & Economics* 301.

The principal internal device for minimising agency costs is to develop remuneration packages which attempt to align the interests of the agent with those of the principal. These often take the form of performance related pay or stock options. While the latter is not available to CHEs, performance related pay is used. Twenty percent of a CHE CEO's salary is 'at risk,' and a further twenty to thrity percent of the salary is available for achieving improvements in the performance of the CHE.[56]

The principal external control of agency costs—takeovers—are however not available to CHEs due to the inalienability of shares. Increasing agency costs will adversely affect the value of the firm, which will be reflected in the share price. If the share price falls below the value of the firms assets, the firm may be subject to a takeover. The former inefficient management would be replaced. The threat of takeovers, and loss of remuneration and standing, is an incentive on agents to maintain the value of the firm.[57]

V COMPETITION UNDER THE ACT

The Health and Disability Services Act 1993 aims to deliver the best health and disability care that is achievable within the funding available. The efficient allocation of health and disability resources under the Act requires competition—both among providers and purchasers. In the absence of a competitive market for health and disability services resources will not be allocated efficiently, and the health reforms will have failed—at least in part—to fulfil their objectives.

A *Meaning of Competition*

Competition may loosely be defined as a contest among sellers of a good or service for access to buyers. Although competition often relates to price, it may include other characteristics of a product, such as technological quality, access and speed of delivery.[58] Competition promotes an efficient allocation of resources:[59]

> Whether based on price and/or other attributes, effective competition has at least three benefits. First, it forces sellers to provide the combination of price and other attributes that best meets the needs of

[56] P Troughton *The Creation of New Zealand's Crown Health Enterprises* (Crown Health Enterprise Establishment Unit, Wellington, 1993) 16.
[57] Above n 55.
[58] D Dranove "The Case for Competitive Reform in Health Care" in R Arnold, R Rich & W White (eds) *Competitive Approaches to Health Care Reform* (Urban Institute Press, Washington D.C., 1993), 69.
[59] Above n 58, 70.

consumers. Second, it forces sellers to find the most efficient way to deliver their goods and services. Third it provides powerful incentives for innovation.

1 *Perfect Competition*

Competition in its purest sense is termed 'perfect competition.' Under perfect competition, market price is equal to both marginal revenue and average revenue.[60]

Several conditions exist for perfect competition. First, firms must be 'price takers,' that is, there must be a sufficient number of buyers and sellers in the market that no single participant is able to influence the market price. Secondly, the products must be homogenous. Homogeneity means that two or more competing products are the same in the eyes of a consumer.[61] Because products are homogenous, if one firm increases its price, it will lose the entirety of its market share to its competitors. Thirdly, there must be no information asymmetries. Aysmmetries of information are imbalances or incompleteness in information possessed by the parties to a transaction. Information asymmetries preclude perfect competition because parties make decisions based on incomplete knowledge. Finally, entry to the market must be free. Barriers to entry will also preclude perfect competition. If entry to the market is free, new suppliers will enter the market if market price is above equilibrium price. This will drive the market price down to equilibrium price. However, if there are financial, technological or regulatory barriers to entry, new suppliers may be unable to enter the market and the market price will remain above equilibrium.

2 *Monopoly*

Monopoly lies at the other extreme to perfect competition. A monopolist is the sole producer of a homogenous product for which there are no substitutes and many buyers.[62]

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[60] Marginal revenue is the change in total revenue resulting from the production of an extra unit of production.

[61] Differentiation in the characteristics of a product precludes a true comparability between the products. For instance, one might speak of the labour market in a society. However, within this market are many smaller markets, eg. The market for lawyers.

[62] The existence of substitutes will affect the price elasticity of demand for a product. As price rises, consumers will substitute other, less expensive goods. A true monopolist can raise price with greater impunity, as there are no substitutes for consumers to switch to. (An example of a substitute would be margarine for butter.) With many buyers, no single buyer will be able to exert an countervailing influence on price.

Under perfect competition, market price is equal to marginal revenue and average revenue. However, under a monopoly, market price is determined by marginal revenue and marginal cost. A producer will increase output as long as marginal revenue is greater than marginal cost. Beyond this, the marginal cost of producing an extra unit of production is greater than the extra revenue derived therefrom. Market price corresponds to the equation of the marginal cost and marginal revenue curves. The difference between average cost and market price represents monopoly profits.

Monopoly inhibits an efficient allocation of resources in a market. Monopoly results in a lower production of a product than in a competitive market. Monopoly also results in a 'deadweight loss' to society:[63]

> [T]he monopoly price causes some consumers to substitute other products, products that the higher price makes more attractive. The substitution involves a loss in value. This can be seen most easily by assuming that for each use of the monopolised product there is a substitute product that is identical to the monopolised product but simply costs more to produce, and hence is priced higher than the monopolised product would be priced if it were priced at its competitive price, but lower than the monopoly price. The effect of monopoly is then to make some consumers satisfy their demands by switching to goods that cost society more to produce than the monopolised good. The added cost is a waste to society.

3 *Monopsony*

Monopsony is the obverse of monopoly: a market in which there is a single buyer.

4 *Monopolistic Competition*

Both perfect competition and monopoly are relatively rare. More usual is a market operating under monopolistic competition. Monopolistic competition is a middle ground between perfect competition and monopoly. Under monopolistic competition, "a large number of firms [produce] similar but not identical products. The introduction of product differentiation gives firms an element of monopoly power in that each firm ... can influence price."[64] However, the other features of perfect competition remain. The absence of barriers to entry will prevent firms enjoying monopoly profits.

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[63] Above n 1, p 277.

Instead of a single market with one, or many, seller(s), under monopolistic competition there is a series of closely related markets within which sellers enjoy elements of monopoly power:[65]

> Monopolistic competition, then, concerns itself not only with the problem of an *individual* equilibrium (the ordinary theory of monopoly), but also with that of a *group* equilibrium (the adjustment of economic forces within a group of competing monopolists, ordinarily regarded merely as a group of competitors).

Monopolistic competition is more descriptive of the market for most health and disability services.

B *Competition among providers under the Act*

Competition among providers in the health system varies depending on the health and disability services in question.

Competition among providers of primary health and disability services may be feasible. Primary health care is subsidised by RHAs, but varying portions of the cost of care are borne by the patients/consumers. In many areas of New Zealand, a competitive market among GPs may exist. If a GP prices their services above the competitive price, patients may choose another GP. Although the conditions for perfect competition are not satisfied even with respect to health and disability services provided by a GP, a GP is not in the position of a monopsonist.[66]

However, the existence of competitive markets for secondary and tertiary health and disability services is much more problematic. The Crown Health Enterprise Establishment Unit advised that a "clinically viable stand-alone CHE required a population catchment area of about 35,000."[67] A considerably larger catchment area is required if several hospitals are able to operate successfully in an area. Without competition, the health care market will not reach a point of competitive equilibrium. However, one might argue that due the high entry costs into the health care market, because of the high capital cost of modern

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[64] D Pearce (ed) *Macmillan Dictionary of Modern Economics* (4 ed, Macmillan Press Ltd, London, 1992), 289.

[65] E Chamberlain *The Theory of Monopolistic Competition* (8 ed, Harvard University Press, Cambridge, 1962), 69.

[66] Although this will vary depending on geographical location. Although feasible in a urban location, it may be less so in a rural location. If however a rural GP is enjoying super-normal profits, these may be sufficient to attract other GPs who will compete for market share. Competition will reduce price to a competitive price.

[67] Dr P Troughton *The Creation of New Zealand's Crown Health Enterprises* (Department of the Prime Minister and Cabinet, Wellington, 1992), 12.

health facilities, and as a result of a small, dispersed population, in many instances, CHEs may enjoy a position analogous to a natural monopoly. While a competitive market may develop in Auckland, it is unlikely to develop in Southland. The cost of choosing another provider may exceed the cost of the monopoly provider.

However, discrepancies exist between different services. Although a competitive market may exist in some areas for general surgery, this may not be the case for more specialised services, such as fertility treatments.

The risk of monopoly profits may be offset by the government's monopsony power. However, this will result in a position of bilateral monopoly, rather than a efficient market.[68]

C Competition among purchasers under the Act

1 Regional Health Authorities

With the exception of primary health and disability care, the patient is not normally the purchaser of the services. The RHAs are the principal purchasers of secondary and tertiary health and disability services in New Zealand. Presently, all acute and most non-acute surgery is provided by the state.[69] Under the health reforms, purchasers (ie. the RHAs) enjoy relative monopsony power. Providers of secondary and tertiary health services who are not willing to accept the RHAs' prices for given services will only be able to operate in the private market. Although the private sector is growing, it would not be able to absorb all medical professionals.

2 Crown Health Enterprises

The situation is more acute for CHEs. There are essentially only three sources of funding - the government, an insurer, or the patient. In practice however, CHEs are funded almost exclusively by RHAs. At present, insurance companies will only refund insured patients for government charges in a CHE. Patients treated privately in a CHE therefore have to bear the full cost of such treatment. However, the cost of most secondary and tertiary health care is potentially ruinous; which

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[68] M Parkin *Microeconomics* (Addison-Wesley Publishing Co, New York, 1990), 417.

[69] In 1980, the state sector accounted for 88% of health expenditure; by 1992 it accounted for only 79%. There are some user part-charges for publicly-funded health and disability services: see para VIII(A)(2).

is why risk adverse consumers purchase insurance. A rational consumer is not going to pay for treatment at a CHE, when they would be covered by insurance at a private hospital. With respect to a CHE, the RHA is in the position of a monopsonist. The CHE has little choice than to accept the price determined by the purchaser.

However, this situation is changing. CHEs have not yet begun treating patients privately. Once the government has established protocols for the treatment of private patients in CHEs, most insurance companies have indicated that the normal policy schedules for reimbursement of treatment costs will apply.[70]

3 *Health Plans*

The government's Green and White Paper, *Your Health and the Public Health* contemplated the establishment of health care plans, who would purchase publicly-funded health and disability services for their members instead of RHAs. This possibility remains live, as s 20(c) allows the Minister to *Gazette* "any person" as a purchaser for the purposes of the Act.[71] Once Gazetted as a purchaser, a health plan could enter a funding agreement with the Crown under s 21(2) of the Act, and then enter purchase agreements with providers under s 22(2) of the Act.

Members of the public would be able to transfer their entitlement for government funding from the RHA to the health plan, who would then purchase health care on their behalf.[72] Health care plans were envisaged ass options for communities, large medical practices or even for large firms as a replacement for health insurance.[73] One of the complaints against the previous health system was its lack of responsiveness to Maori health care needs; health care plans offered an option for publicly-funded health and disability care tailored to the needs of Maori:[74]

> Iwi authorities and other Maori organisations will be able to establish health care plans concentrating on Maori health needs, addressing Maori concerns about how health services are delivered. This will

[70] Telephone conversations with AETNA, Blue Cross Ltd, EBS Health Care, Southern Cross and Unimed Medical Care Society: 3 August 1995. Southern Cross was alone in indicating that they would not reimburse policy holders for private treatment in a 'public' hospital.

[71] Health and Disability Services Act 1993, s 20(c).

[72] Above n 20, p 61.

[73] Above n 20, p 61.

[74] Above n 20, p 61.

offer Maori a vehicle for taking greater control over the resources used for health services for Maori.

The establishment of health care plans may help to offset the monopsony power of RHAs. Competition among buyers may develop, albeit within restricted areas of the country and/or for particular health and disability services. However, health care plans drew considerable criticism at Select Committee stage, and as yet, no alternative purchasers have been *Gazetted* under s 20(c).

VI PATIENTS UNDER THE ACT

A *Uncertain Demand*

Demand for health care is uncertain. The value of treatment required is uncertain, as is also the type of treatment required. Under the Health and Disability Services Act 1993, the Regional Health Authorities make decisions on the health needs and preferences of their communities, and purchase health services to meet those needs.[75] A consumer's access to health care is not dependant on their demand, but on a RHA's priorities. Even if Regional Health Authorities are successfully able to anticipate the health needs of their communities, this will not necessarily mean that a particular consumer's health care demand is met.

B *Consumers vs. Purchasers*

One of the government's complaints with the former health system was a lack of consumer control.[76] A consumer receiving government-funded health care has no more control over the delivery of health care or their choice of provider than a consumer under the previous system. The consumer is not the purchaser. If choice is desired, private health insurance remains essential. A provider's funding is not dependant on its ability to provide services which attract patients, but to provide a service which meets a RHA's criteria. Under the health reforms, the government, not the patient, is the key player in the health market. The individual consumer must accept the choices made by the RHA, or purchase private health insurance.

VII MARKET FAILURE IN THE HEALTH REFORMS

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[75]Health and Disability Services Act 1993, s 33(1)(b).
[76]Above n 20.

Where health services are provided under a market system, rational, risk adverse consumers will defray the future cost of health care through insurance. In the US, the great majority of insurance premiums are paid by employers. Access to health care is therefore largely dependant on employment. The unemployed, either permanently or temporarily, are often left with inadequate coverage. Although the US spends 12.5% of GNP on health care, 14% of the population, 35 million people, have no health insurance coverage, and a further 65 million have inadequate coverage.[77] The cost to employers, the main purchasers of health insurance, is becoming prohibitive. By 1990, health care represented 7.1% of total labour costs, and 107.9% of net company profits.[78]

However, although the market undeniably provides health care to those consumers who can pay, many are left without access to health care, and the market itself does not provide health care efficiently:[79]

> In order for an efficient, market-based health care system to work, several conditions are essential. First decisions must be made by the consumers. Second, the consumers must know the value and cost of the goods they are contemplating purchasing. Third, the consumers must pay the full cost and receive the full value of the goods they choose to buy. All three conditions are absent from the current market for health care services.

A Moral Hazard

1 Moral hazard and market failure

Moral hazard, which can also been termed 'cost-unconscious demand,'[80] arises because "the parties making decisions about the utilisation of health care services are not the parties who bear the economic risk of those decisions."[81] Health care is paid for either, as in the United States, by the employer, or through private health insurance taken by the consumer. In both cases, at the point of consumption, health care is effectively a 'free' good.[82] There is

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[77]"Health Care Reform -- A Symposium" (1992) 26 *Akron Law Review* 135, 139.
[78]*Health Care Financing Review* 13 (1991) 83.
[79]R Blank "Regulatory Rationing: A Solution to Health Care Resource Allocation" (1992) 140 *University of Pennsylvannia Law Review* 1573, 1587.
[80]A McGuire, P Fenn & K Mayhew "The Economics of Health Care" in A McGuire, P Fenn & K Mayhew *Providing Health Care: the Economics of Alternative Systems of Finance and Delivery* (Oxford University Press, New York, 1991) 14.
[81]C Dunlay & P Pavarini "Managed Competition Theory as a basis for Health Care Reform" (1993) 27 *Akron Law Review* 141, 143.
[82]Above n 80, 14.

therefore no incentive for consumers to be cost-conscious in their selection of health services.

Demand for health care, and its supply, is therefore higher than would be the case in a perfectly functioning market, as the benefit of health care to the consumer will always exceed the cost of care (the opportunity cost). However, moral hazard results in an inefficient use of resources. Although the benefit to the patient exceeds the opportunity cost of treatment, the cost to society of the use of resources for the provision of health care is greater than the benefit from health care.[83]

It has also been suggested that the cost-unconsciousness of patient demand for health care diminishes the incentives to avoid ill-health; therefore the incidence of ill-health increases.[84] When health and disability care is a 'free food' at the point of consumption, the economic consequences of ill-health are reduced. The cost of ill-health therefore becomes relatively less viz à viz the benefit of activities which may adversely affect health; or preventative measures to protect health become relatively more costly.

2 *Moral hazard and the Act*

(a) SECONDARY AND TERTIARY CARE—The problem of moral hazard continues to exist under the Act. The majority of health and disability services are funded either by the government through the RHAs or by health insurance companies. Co-payments exist for some publicly-funded health and disability services, but costs are capped.[85] Among health insurers there is a trend towards lower levels of co-payments, with increasing numbers of policies offering the option of 100% reimbursement of medical expenses.[86]

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[83] C Donaldson & K Gerard *Economics of Health Care Financing: The Visible Hand* (Macmillan Press Ltd, London, 1993), 31.

[84] Above n 83, p 31.

[85] Levels of co-payments are determined by the patients income. Low-income patients have Community Service Cards, which entitle them to lower levels of co-payments. Co-payments exist for outpatient services, and some referral services. Although CHEs may charge inpatients co-payments, most do not. If a patient is admitted to a hospital after referral from a GP, no charges apply. Even if co-payments are charged, the amount any one patient must pay is capped—after a certain number of treatments, no more charges are levied.

[86] For instance, Southern Cross Healthcare offer a range of insurance policies. Formerly these offered reimbursement levels of 80-100% and varied in the maximum amount repayable. Although these options remain, Southern Cross has modified even its base policies to offer the option of full reimbursement. Regularcare, the base plan, requires a co-payment of 20%. Now, Southern Cross

In most cases, government-funded health care remains effectively a 'free' good at point of consumption by the consumer.[87] There is a lingering feeling in New Zealand—having contributed to the funding of the health system through taxation—to regard health and disability services, as and when required, as a right. The prospect of non-discerning consumers maximising consumption—even when the opportunity cost of that care to society exceeds the benefits of care—without regard to minimising cost remains.

However, with regard to publicly-funded health and disability services, several devices exist which militate against excessive consumption of health and disability services by patients. The first is the gatekeeper role to secondary and tertiary services provided by GPs and other primary providers.[88] The second, and perhaps most important, are the fiscal constraints under which the health system is presently working. Regardless of the cause, demand for secondary and tertiary health and disability services presently outstrips the resources available. Waiting lists exist even for 'urgent' surgery, and waiting lists for non-acute surgery often grow inexorably longer.

This last factor is a result of public funding. The patient/consumer is not the funder of health care. Although under an insurance market, the patient is not the funder, providers of health care are reimbursed for treatment provided to a patient based on actual consumption. Under the Act, funding is provided by the RHAs and is independent of patient demand and/or consumption.

(b) PRIMARY CARE—Under the Act, most patients must pay co-payments for primary health and disability services. Th existence of co-payments should decrease the elements of consumer moral hazard as health care is no longer a free good at the point of consumption.

There appears to be a price elasticity for health care of about -0.1 to -0.2. This means that for every 10 percent increase in

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have introduced a RegularcarePlus policy. This offers the same levels of cover, but reimburses 100% of expenses incurred.

[87] Even when health and disability services are not free goods, levels of co-payments are low.

[88] To receive specialist publicly-funded treatment, a patient must be referred by a primary care provider.

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the cost of health care, consumption will decrease by 1 to 2 percent.[89] The RAND Corporation's Health Insurance Experiment of 1974 has provided some concrete evidence.[90] Almost 7800 people were involved in the experiment, which used 14 different health plans with differing levels and types of co-payments. By 1987, results indicated that people enrolled in the free plan incurred outpatient expenses 37-67% higher than people enrolled in plans with co-payments.[91]

The effect of co-payments on health, rather than consumption of health and disability services, is more problematic. Other studies of the RAND experiment indicate that the effect of co-payments on the consumption of health and disability services was greater among lower income groups.[92] These studies have also indicated that, among low-income patients, co-payments, in addition to curbing unnecessary consumption of health and disability services, may reduce necessary consumption of health and disability services.[93] The overall effects of co-payments on health is indeterminate, and perhaps negligible.[94]

Although likely to have some effect on the consumption of health and disability services, co-payments do not appear to significantly affect health status. Due to the inelasticity of demand for health care, co-payments, in and of themselves, are a blunt instrument for addressing consumers' moral hazard. Co-payments under the Act may be defended as a revenue measure, or as an equity device to make those on higher incomes to contribute more to the cost of their care. However,

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[89] Above n 78, p 90.

[90] Above n 78, p 89; see J Newhouse & C Phelps *On having your cake and eating tit too: econometric problems in estimating the demand for health services* (Rand Corporation, Santa Monica, 1974).

[91] Above n 78, pp 89-90; see G Goldberg, A Leibowitz, W Manning, J Newhouse & W Rogers "A controlled trial of the effect of a prepaid group practice on use of services" (1984) 310 *New England Journal of Medicine* 1505. The 37% figure resulted from the plan with a co-payment rate of 25%; the 67% figure resulted from the plan with a co-payment rate of 95%. Thus, even with a reasonably low co-payment rate, significant differences in consumption were recorded.

[92] Above n 78, pp 90-91. One other possibility may be that these groups consult physicians less frequently, but with a greater number of complaints each visit. Thus, the consumption of health and disability services may change very little, although the cost to the patient is lessened. Delays in seeking treatment for single complaints may also have a deleterious effect on these persons' health status.

[93] Above n 78, p 91.

[94] Above n 78, pp 91-92.

they are unlikely to significantly affect the consumption of health and disability services.

B Information Asymmetry

1 Information asymmetry and market failure

A perfect market presumes the existence of a fully-informed consumer: the consumer is the best judge of their own welfare. In health care, this presumption cannot be sustained. The individual consumer does not possess the information to rationally decide the treatment they require, or, to a great extent, judge the quality of the care they receive:[95]

> The individual patient's choice is heavily conditioned and constrained by the providers of health care.... The specialised knowledge required for the dispensation of health care, in conjunction with the emotional and often urgent nature of medical decisions, undercuts the patient's ability to be a rational shopper. It is unrealistic to expect consumers to become sophisticated, cost effective purchasers of health care, in part because of the steep learning curve in shopping for value in health care.

Information asymmetries incorporate elements of moral hazard. The treatment prescribed, and the provider, may not be the most efficient choice, either for the consumer, or for society as a whole. For instance, physicians may advise treatment which maximises their profits, rather than the treatment which minimises cost to the consumer.[96] Similarly, "the economic incentive for physicians on a fee for service basis is actually to provide more services and, thus receive more payment, rather than to make careful cost-benefit analyses in choosing the service to be provided."[97] Additionally, demand for health care is inelastic; the tendency is for consumers to equate 'more' health care with 'better' health care.[98] When, as is often the case, health care is a 'free' good, there is nothing to militate against increased consumption of health services. Patients/consumers have no incentive to oppose this inclination as the cost of extra treatment is borne by the funder (the government of an insurer), not the patient.

As a result of consumer inability to assess the requirements for health care, the doctor is placed in the position of an agent in advising the

[95]Above n 79, 1587.
[96]This is frequently the case in the US, due to the cost-unconscious nature of consumer demand. There is no incentive for the consumer to seek a cost-minimising treatment, as they do not bear the cost. Physicians may therefore choose a profit-maximising treatment in the certainty that the cost will be borne by the insurer.
[97]Above n 80, 143.
[98]Above n 34, 8.

patient on their requirements.[99] The doctor is required to be a perfect agent: "doctors objectively supply information to the patient, who can then make a decision which maximises utility."[100]

2 *Information asymmetry under the Act*

Information asymmetries preventing consumers from becoming cost effective purchasers of health and disability care is endemic to health markets generally, and not to any particular method of delivery.

However, the degree to which information asymmetries lead to an over-utilisation of health and disability services varies by the method of remuneration of doctors:

(a) FEES—There is a perception that doctors remunerated by fees will over-utilise services:[101]

> The conventional wisdom is that this encourages the use of services on the recommendation of their doctors, thus inflating health care costs with possibly little or no effect on health itself. [This demand for healthcare] is the amount of demand, induced by doctors, which exists beyond what would have occurred in a market in which consumers are fully informed.

This perception is only equivocally supported by research. Although research has indicated increased levels of consumption where doctors are remunerated by fees,[102] explanations independent of the method of remuneration have been offered for these results.[103]

Primary providers are largely remunerated by fees in New Zealand. However, one could argue that the existence of patient co-payments for most health and disability services will mitigate the incentives on doctors to over-utilise health and disability services.

(b) CAPITATION—Capitation is a method of health care funding which prospectively allocates a provider a certain level of

[99] The special relationship of doctor and patient is recognised elsewhere by the law. For instance, a doctor bears fiduciary duties to the patient.

[100] Above n 93, p 43.

[101] Above n 79, p 103.

[102] Above n 78, p 104.

[103] If doctors' fees are above the competitive price, there will be an incentive to over-provide services. If however, the market price is below the competitive price (due to regulation or monopsony), there will be an incentive to under-provide. Alternatively, economists have explained the results as increased consumption resulting from greater availability of doctors, and consequent falling fees and associated non-monetary costs. Thus increased consumption is the inevitable consumer response to reductions in the cost of health care. See above n 78, pp 104-105.

funding for each patient. The income doctors receive is not dependent on the amount of services offered. Rather, the cap on income encourages doctors to minimise the cost of health care.[104] Evidence to support this is, however, scarce.[105] Evidence from the United Kingdom shows that GPs remunerated by a capitation payment are more likely to refer a patient to a public hospital than those receiving payments through fees.[106] However, it cannot be conclusively shown that these differences are due, solely or mainly, to the different methods of payment.

RHAs are encouraged to control "demand-driven expenditure" for primary health and disability services.[107] The suggested vehicle for achieving this is capitation contracts with IPAs.[108] Although RHAs will still contract with IPAs on a fee-for-service basis, capitation is preferred.[109] The capitation framework established by the Midland RHA payed doctors a formula-based figure for each patient considered to be a regular patient of the practice.[110] Commentators in New Zealand have recognised the risks of capitation—namely, over-utilisation of services by patients and under-servicing of patients by doctors.[111] However, the effect of capitation in reducing supplier-induced demand, and that of co-payments in addressing moral hazard, may reduce the over-utilisation of health and disability services. Although there is a risk that patients will be under-serviced, in a competitive market,[112] if a patient feels that this is occurring, it is possible to transfer to another GP. This will cause a loss of income to the former

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[104] Above n 78, p 110.
[105] Above n 80, p 11.
[106] Treatment at a public hospital being funded separately from the GP's funding. This is therefore an exercise in cost-shifting by physicians seeking to minimise their own costs.
[107] Minister of Health *1994/1995 Policy Guidelines for Regional Health Authorities* (1 March 1994).
[108] "An IPA is a partnership, association, or corporation that delivers or arranges for the delivery of health services by entering into service arrangements with the licensed health professionals who belong to the IPA": L Freyer *Contracts between RHAs and IPAs* (Unpublished seminar paper, LAWS 534: Law & Medicine, Victoria University of Wellington, 24 July 1995), 3.
[109] See Freyer, above n 109, p 6.
[110] Above n 109, p 6.
[111] Above n 109, pp 7-8.
[112] It has already been suggested that a competitive market for primary health and disability care may exist in New Zealand: see para IV(B).

provider. Therefore, the incentive to keep patients—and thus funding—may reduce the incentive to under-service.

C *Non-price Competition*

1 *Non-price competition and market failure*

Due to the price-unconscious nature of demand, price is often not the dominant factor in consumers' choice of providers. Consumers instead base their decisions on factors such as available services, the quality of the medical professionals,[113] of little therapeutic merit.

2 *Non-price competition under the Act*

Non-price competition under the health reforms is to some extent alleviated because consumers are not purchasers. The purchasers of publicly-funded health and disability services are the RHAs and the PHC. These purchasers *will* have price and quality as the primary factors in their choice of provider. However, price is not a dominant factor in an individual's choice of provider. Indeed, an individual consumer may have little or no choice of provider; the provider is determined by the RHA.

D *Adverse Selection*

1 *Adverse selection and market failure*

Adverse selection results from information asymmetries in the health market. Buyers of health insurance generally have a better idea of their risk than sellers. Therefore, "in a competitive market, if the insurance companies have no idea of individual risk status, a premium could be set reflecting the general health risks of the insured population."[114] Under this system, all insured people pay identical premiums. However, people with lower risks of health care may opt out of this market, as they perceive the price of health insurance to be too high. This raises the risk status of the remaining insured persons, increasing insurance premiums. This may prompt more people to opt out, starting the cycle again.[115]

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[113] Above n 79, 144.
[114] Above n 83, p 35.
[115] Above n 83, p 35.

While the cost of insuring the shrinking pool increases, large numbers of lower-risk consumers require health care. Insurance companies will tailor policies for these groups.[116] To attract these groups, insurers will practise risk selection and market fragmentation.[117] Risk selection refers to insurers' attempts to minimise their risk by designing premiums and benefits to attract healthy people, rather than unhealthy people; for instance, not providing cover for pre-existing conditions. Or, insurers may practise market fragmentation and design policies to appeal to certain groups; for instance policies aimed at retirees. However, adverse selection can operate on the demand side too, as consumers may conceal information from the insurer so that their premiums do not reflect the true risks of requiring care.

Market failure occurs because people may be left uninsured as a result of risk selection and market fragmentation. Low-risk people may be left without insurance coverage because they consider the price of insurance too high. Insurers, who would be willing to sell insurance at lower premiums, do not do so because of a lack of *ex ante* information on the consumer's risk status.[118] The second group are high-risk consumers without the financial resources to pay the cost of insurance premiums for their risk status. Although this is not strictly a problem of market failure, the market functions in a socially unacceptable manner:[119]

> For the high-risk group, the market does not fail. Quite simply, their financial resources cannot cover the cost of insurance. As Evans (1984) points out, these people 'cannot afford Mercedes Benz's either, but that is no failure of the automobile market'. Despite this, it is this aspect of adverse selection which presents the more serious social problem.

2 *Adverse selection under the Act*

Adverse selection by providers is relieved under the health reforms due to the universal nature of coverage. However, as contributions to health care costs are proportionately equal among all consumers, high risk patients will pay a lower than actuarially fair contribution, while low risk patients will pay a higher than actuarially fair contribution. By this it is meant that an individual's contribution to the cost of health care will not reflect their risk of need for such care. As public funding for

[116] Above n 83, p 35.
[117] Above n 79, 143-144.
[118] Above n 83, p 36.
[119] Above n 83, p 36.

health and disability services comes from tax revenues, people with equivalent incomes make equivalent contributions to the cost of health care, regardless of their comparative health care needs. For instance, two people earning $40,000 per annum, one 30 years of age and the second 70, both contribute equivalent sums towards the cost of their health and disability care. However, the health care needs of the 70 year old are likely to be much greater than those of the 30 year old.

Such a situation can be justified on equity grounds. Firstly, regardless of contributions, all consumers enjoy access to adequate health care. Secondly, although consumers pay comparatively less than their actuarial share later in life, this is offset by their greater contributions earlier in life. Therefore, greater contributions when young are a form of insurance, or forward contract for the provision of health and disability services later in life.

E *Externalities*

1 *Externalities and market failure*

Externalities are "spillovers from other people's production or consumption of commodities which affect an individual in either a positive or negative way, but which are out of the individual's locus of control. Individuals may gain utility from the provision of health services to others:[120]

> This occurs because individuals appear to care about other people's health. If such 'caring externalities' do exist then there appears to be a philanthropic case for at least some charitable (i.e. public in the widest sense) provision of health care. Individuals care about the health status of others and will therefore seek to provide care for them as an altruistic act.

Conversely, the denial of health and disability services to other individuals may adversely affect welfare. Since the end of the Second World War, New Zealand has had a tradition of providing equal access to health services for all.[121] A situation such as that in the United States, with large numbers of people without or with inadequate health care, would not be generally acceptable in New Zealand. Given that such a concern exists, there are essentially two ways to fulfil this desire. The first is transfer payments to individuals, but individuals

[120]Above n 78, 10-11.
[121]Above n 17, 19.

may spend the money on other goods, and still require care later. The second, and preferable, alternative, is to provide health care directly.[122]

2 *Externalities under the Act*

The social utility of consumption of health care by others is very neatly satisfied under the health reforms. However, one may argue whether it is necessary for the government to fund health care largely through tax to afford cover to a minority of society. Arguably, the constraints on consumer choice created under such a system, and the resulting absence of competition among providers, is a cost greater than the benefit to society of the social utility of provision to others.

VIII TRANSACTION COST ECONOMICS

A *Transaction Cost Economics*

The theory behind the Act, and behind other efforts in reform overseas, has been to control costs and rationalise the provision of health and disability services by injecting competitive pressures into the health markets to encourage efficiency:[123]

> The purchasing function would be enhanced if health providers (such as specialists and hospitals) had to compete for contracts offered by funders. The threat that funding might move to alternative suppliers should provide a powerful incentive for providers to seek improvements in quality efficiency, cost-control and other activities. Moreover, contracting between purchasers and competitive providers should lead to prices moving more closely into line with genuine costs.

This is correct, but only if there is a competitive market for health and disability services. Although this may be true of some health markets, it cannot be said of all. [124] The provision of health and disability services—especially secondary and tertiary services—often involves high degrees of asset specificity, uncertainties in the demand for services, and frequent transactions. These factors may lead to a conclusion that market governance will not provide the most efficient use of resources.

Transaction cost economics maintains that market governance structures (ie. Contracting) are not suitable for all transactions.

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[122] Above n 78, 11.

[123] MacFarlan & Maitland "Reforming health care" (1995) 192 *OECD Observer* 23, 25.

[124] It had already been noted in this paper that competitive markets for primary health and disability services may be possible in many locations: see para VI(B).

Different governance structures are appropriate for different transactions.

Transactions may be organised in a variety of modes. At one end of the spectrum lies market governance; at the other, vertical integration. Transactions are rarely costless, and transaction costs vary between different modes of organisation and transactions. The mode of economic organisation should therefore aim to minimise transaction costs:[125]

> Pre-given technologically separable units are posited. Exchange between these units must be organised and regulated. These activities involve real resource (transaction) costs, to a greater or lesser extent, in much the same way that friction exists in the physical world. It follows that if we assume economising behaviour, economic institutions (or 'governance structures' in the transaction cost jargon) will evolve to minimise the costs of organising resource allocation.

Under some circumstances, vertical integration, rather than external contracting, may be the preferred solution. For instance, in the health sector, the transaction costs of providing health and disability services may be minimised by internal governance, rather than by external contracting.

1 *Explanation of Transaction Costs*

In 1937, Ronald Coase posited that if the market can allocate resources effectively, then there is no reason why "resource allocation be planned/directed within firms."[126] The solution was the existence of transaction costs, namely "that there is a cost of using the price mechanism."[127] Transaction costs are the "costs of running the system."[128] Alternately, "[t]ransaction costs are the economic equivalent of friction in physical systems."[129]

Transaction costs are of two types, *ex ante* costs, and *ex post* costs. *Ex ante* transaction costs are the "costs of drafting, negotiating and safeguarding an agreement."[130] The largest cost when negotiating an agreement will often be information; the information costs may, in the context of the health sector, be considerable. Each of the four RHAs

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[125] Above n 1, 3.
[126] M Dietrich *Transaction Cost Economics and Beyond* (Routledge, London, 1994) 15.
[127] R Coase "The nature of the firm" (1937) 4 *Economica* 386, 390.
[128] K Arrow "The organisation of economic activity: Issues pertinent to the choice of market versus nonmarket allocation" in *The Analysis and Evaluation of Public Expenditure: The PPB System* (U.S. Government Printing Office, Washington D.C., 1969) Vol 1: U.S. Joint Economic Committee, 91st Congress, 1st Session, p 48.
[129] O Williamson *The Economic Institutions of Capitalism* (The Free Press, New York, 1985) 19.

must purchase health and disability services for the people within its district. Before doing so, they must determine the health and disability care requirements of those people. The resulting contract may be complex and comprehensive; or it may be more general. Contracting parties will want to safeguard the contract. This may effect the nature of the organisation: "Faced with the prospect that autonomous traders will experience contracting difficulties, the parties may substitute internal organisation for the market."[131]

Ex post transaction costs are more varied:[132]

> These include (1) the maladaptation costs incurred when transactions drift out of alignment in relation to ... the "shifting contract curve", (2) the haggling costs incurred if bilateral efforts are made to correct ex post misalignments, (3) the setup and running costs associated with the governance structures (often not the courts) to which disputes are referred, and (4) the bonding costs of effecting secure commitments.

Williamson gives as an example a contract in which the desired result is y, but in which the contract stipulates x.[133] The costs of shifting from x to y, and will include, *inter alia*, self-interested bargaining to maximise the share of the benefits of the shift.

2 *Fundamental Assumptions of Transaction Cost Economics*

An analysis of economic organisation under transaction cost economics rests on three pillars: (1) bounded rationality, (2) opportunism and (3) asset specificity.[134] In the absence of these three factors, contracting would present no problems:[135]

> If bounded rationality, opportunism and asset specificity are not all present, transaction costs will not exist, according to Williamson. Consider the case of global rationality: in such a situation it would be possible to costlessly construct completely specified contracts at the outset, long-term contracting is possible. In the absence of opportunism, any gaps that exist in contracts, because of bounded rationality, will not pose execution hazards because neither party will attempt to gain advantage over the other: short-term, sequential contracting is possible. When asset specificity does not exist, there is no need to have continuing economic relationships, hence markets will be fully contestable. These examples indicate the bounds of the orthodox analysis of markets. Outside of these bounds institutional arrangements to manage resource allocation are more complex.

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[130] Above n 129, 20.
[131] Above n 129, 20.
[132] Above n 129, 21.
[133] Above n 129, 21.
[134] Above n 129, 30.
[135] Above n 126, 21.

(a) BOUNDED RATIONALITY—Neoclassical economics regards people as rational, wealth-maximising individuals.[136] Transaction cost economics challenges this, asserting that people have bounded rationality; that is, people are "*intendedly* rational, but only *limitedly* so."[137] Bounded rationality exists because individuals are limited in their ability to acquire and process—often complex—information. As a result, "[c]omprehensive contracting is not a realistic organisational alternative when provision for bounded rationality is made."[138] Given bounded rationality, contracts are necessarily incomplete; the degree of incompleteness increases with the complexity of the contract. Utility maximising outcomes are inhibited because the decision-makers are able only to imperfectly determine these outcomes.

The effects of bounded rationality may be reduced—or economised—by the choice of decision processes or governance structures; transaction cost economics uses the latter. Transaction costs resulting from bounded rationality need to be considered to determine the most efficient governance structure: "*Ceteris paribus*, modes that make large demands against cognitive competence are relatively disfavoured."[139]

(b) OPPORTUNISM—Williamson describes opportunism as "self-seeking with guile."[140] In insurance markets, opportunism is often described as adverse selection (*ex ante* opportunism) and moral hazard (*ex post* opportunism):[141]

> [Adverse selection] is a consequence of the inability of insurers to distinguish between risks and the unwillingness of poor risks candidly to disclose their true risk condition. Failure of insureds to behave in a fully responsible way and take appropriate risk-mitigating actions gives rise to *ex post* execution problems.

Often, opportunism refers to practises calculated to obtain an advantage, often through "the incomplete or distorted disclosure of information."[142] As a result, information asymmetries are caused, complicating decision making. Parties act on

[136] Above n 129, 45.
[137] Above n 129, 45.
[138] Above n 129, 46.
[139] Above n 129, p 46.
[140] Above n 129, p 47.
[141] Above n 129, p 47.
[142] Above n 129, p 47.

incomplete or inaccurate information; the outcome is not necessarily a joint utility maximising one, but one which maximises the utility of the opportunistic party. In addition to the obvious difficulties posed by *ex ante* opportunism, *ex post* opportunism complicates the resolution of contractual uncertainties: "[W]ere it not for opportunism.... [u]nanticipated events could be dealt with by general rules, whereby the parties agree to bound by actions of a joint profit-maximising kind."[143]

Williamson's response is to devise *ex ante* safeguards to protect against *ex post* opportunism:[144]

> Rather than to reply to opportunism in kind, therefore, the wise prince is one who seeks both to give and to receive "credible commitments."[145] Incentives may be realigned, and/or superior governance structures within which to organise transactions may be devised.

Opportunism creates problems because it creates uncertainty in the resolution of contractual uncertainties.

(c) ASSET SPECIFICITY—Asset specificity refers to the degree to which the value of an asset is related to a particular transaction. Specificity is not limited to physical assets—such as plant—but can include human and dedicated assets.[146] Asset specificity and its ramifications can be conveniently summarised thus:[147]

> (1) asset specificity refers to durable investments that are undertaken in support of particular transactions, the opportunity cost of which investments is much lower in best alternative uses or by alternative users should the original transaction be prematurely terminated, and (2) the specific identity of the parties to a transaction plainly matters in these circumstances, which is to say that the continuity of the relationship is valued, whence (3) contractual and

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[143] Above n 129, p 48. Williamson suggests a clause such as the following, inserted into the initial agreement: "I agree candidly to disclose all relevant information and thereafter to propose and cooperate in joint profit-maximising courses of action during the contract execution interval, the benefits of which gains will be divided without dispute according to the sharing ration provided." (p 47)

However, Dietrich correctly observes that, even in the absence of opportunism, a joint profit-maximising outcome may not be achieved, due to bounded rationality: "[G]iven bounded rationality, and in particular informational complexity, there is no reason to assume that individual perceptions and objectives will allow the definition of a unique maximising strategy. Similarly it is claimed that only fair returns will be demanded. But how can objectively fair returns be defined when bounded rationality exists? In the second question the general clause refers to the disclosure of all relevant information and maximising behaviour. Once again: where is bounded rationality?" (Dietrich, above n 126, pp 24-25.)

[144] Above n 129, pp 48-49.

[145] Credible commitments usually arise in relation to irreversible, specialised investments, and are reciprocal acts designed to safeguard a relationship.

[146] Above n 129, p 55.

[147] Above n 129, p 55.

> organisational safeguards arise in support of transactions of this kind, which safeguards are unneeded (would be the source of avoidable costs) for transactions of the more familiar neo-classical (nonspecific) variety.

In any transaction, general or specific assets may be available for use. The use of specific assets will usually be more efficient. Alternatively, other transaction may require specific assets. Reduced fungibility of assets will create problems of asset specificity in contracting. Although the use of specific assets may allow cost savings, "specialised assets cannot be redeployed without sacrifice of productive value if contracts should be interrupted or prematurely terminated."[148] These problems do not arise with general purpose assets; the fungibility of these assets allows them to be redeployed with little or no loss of productive value. Parties to a contract therefore face a tradeoff: "Do the prospective cost savings afforded by the special purpose technology justify the strategic hazards that arise as a consequence of their nonsalvagable character?"[149] This trade-off varies according to governance structure; transaction cost economics therefore seeks to determine the governance structure which will minimise the cost of this trade-off.

The presence of asset specificity in a transaction commits parties to an agreement, "the object being to avoid the sacrifice of valued transaction-specific economies."[150] The contracting party is committed to the ongoing relationship because of the economies realised by the use of transaction-specific assets; the contracted party is committed to the ongoing relationship because of the need to recover the cost of those assets. Put another way, parties become 'locked-it' to the transaction. Transaction cost economics asserts that governance structures for such transactions should reflect this.

3 *Governance Structures*

Given bounded rationality, opportunism and asset specificity, different modes of organisation are appropriate for different transactions. Which mode of governance is appropriate is influenced by three factors: (1)

[148] Above n 129, p 54.
[149] Above n 129, p 54.
[150] Above n 129, p 76.

asset specificity, (2) uncertainty and (3) frequency. As the presence of these factors increase, the mode of governance tends more towards vertical integration, and away from market governance.

(a) Asset Specificity—see para 2(c) above.

(b) UNCERTAINTY—Uncertainty arises because of bounded rationality and opportunism: "[U]ncertainty is assumed to be present in sufficient degree to pose an adaptive, sequential decision problem. The occasion to make successive adaptations arises because of the impossibility (or costliness) of enumerating all possible contingencies and/or stipulating appropriate adaptations in advance."[151]

The effect of uncertainty varies with the nature of transactions. Uncertainty poses few problems for nonspecific transactions; alternative trading arrangements may easily be made. However,[152]

> [w]henever assets are specific in nontrivial degree, increasing the degree of uncertainty makes it more imperative that the parties devise a machinery to "work things out"—since contractual gaps will be larger and the occasions for sequential adaptations will increase in number and importance as the degree of uncertainty increases.

When combined with asset specificity, uncertainty affects the appropriate governance structure for a transaction. Where asset specificity is present, parties have an interest in the continuity of the relationship. In this situation, the governance structure should facilitate the resolution of uncertainties in the execution of the contract; otherwise, their resolution may be extremely costly.

(c) FREQUENCY—Specialised governance structures minimise the transaction costs of nonstandard transactions, but cost. These costs can most easily be offset by large, recurring transactions. As specialised governance structures necessarily invovle a trade-off between transaction costs and production costs, the frequency of transactions is a relevant consideration.

4 *Vertical Integration*

Asset specificity remains the main influence on the choice of governance structure. As the degree of specificity increases, non-

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[151] Above n 129, p 79.
[152] Above n 129, p 60.

market governance structures become more effective. One of the main benefits of markets is their ability to aggregate demand from many purchasers, thus being able to realise economies of scale. However, as assets become more specific to a transaction, the ability to aggregate diminishes; economies of scale are no longer as pressing.

Governance costs are also important. When assets specificity is present, resolution of uncertainties in the contract is more easily and less costly under non-market governance structures, rather than by costly and time-consuming re-contracting.

The degree of asset specificity impacts on two costs—governance costs and production costs:

(a) PRODUCTION COSTS—As asset specificity increases, the difference between the cost of production within the firm compared to the market diminishes, due to the decreasing ability to realise economies of scale.

(b) GOVERNANCE COSTS—Governance costs is a function of two costs—the costs of bureaucratic control, against which is set the cost of market governance. As asset specificity increases, bureaucratic controls become less costly, and market governance relatively more costly.

The object is to minimise both governance and production costs combined.[153] While the costs of internal provision exceed the cost of market provision, market governance will be favoured.

Essentially, internal production is favoured when asset specificity is substantial. Under these conditions, aggregation benefits are negligible and the lock-in effects of the transaction are costly under market governance.[154]

B IVF Case Study

1 Overview

In May 1995, the Northern RHA, North Health, awarded the contract for publicly funded In-Vitro Fertilisation treatment to a private clinic, Fertility Associates. Previously these services had been provided by the Fertility Clinic at National Women's Hospital. The purchase of public health services at a private clinic at the expense of a 'public'

[153] Above n 129, p 93.

provider aroused considerable comment in Auckland. Despite the intent of the health reforms, there appeared to be a persistent public perception that CHEs would get RHA contracts.

The RHA contract represented approximately 85% of the funding for the Fertility Clinic at National Women's; the remaining 15% comes from a contract with the Midland RHA. The loss of this funding will probably be fatal to the survival of the Fertility Clinic; it is highly unlikely that this funding will be able to be recouped from private patients, of which they as yet have none.

It is perhaps salient to note that National Women's did not object to the awarding of the RHA contract to Fertility Associates as such, but to the manner in which the contracting process was conducted.[155] Broadly, National Women's felt that the RHA had insufficient information to adequately compare the tenders, and that insufficient concern was given to ancillary issues, namely the University of Auckland Medical School's training arrangements.

With respect to the former, while it was conceded that in a purely commercial environment, a failure to supply information could only disadvantage the tenderer, it was felt that the instant situation was different. The RHA was dealing with public money, and therefore should have attempted to remedy the information deficit.

2 *University of Auckland*

The contract for the provision of publicly-funded IVF services made no allowance for training. Presently, the University of Auckland has training agreements with the CHE. Once IVF services are transferred to Fertility Associates, these arrangements will be effectively frustrated.

The CHE found it difficult to remove training expenditure from their budgets, a difficulty Fertility Associates did not face - a factor undoubtedly contributing to the attractiveness of Fertility Associates' tender. However, there is no reason why funding for treatment and training should not be separate. What must be remembered however, is that training—at least with respect to IVF treatment—cannot occur in isolation to treatment. Effectively, training will occur in the clinic with the RHA contract. In this case, it may have been more sensible to

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[154] Above n 129, p 94.
[155] Interview with Dr Guy Gudex, National Women's, 13 July 1995.

include the RHA's the training budget could have been included in the tender.

On the other hand, Fertility Associates pointed out that while it may be possible to make arrangements for training with the University now they have the contract, they felt that this should not be an issue for the RHA when awarding the treatment contract. The training arrangements were between National Women's and the University. If, because it failed to win the contract from the RHA, the CHE is no longer able to fulfil its training obligations to the University, that is a matter for resolution between those parties. It is not a matter properly within the concern of the RHA. One may still retort, that if the training budget will effectively, and necessarily, follow the RHA contract, then the funding for training could have been included in the original tender.

3 *Concerns for the Future*

Of perhaps more concern, is the effect of this tender round on the future provision of IVF services in Auckland. The Northern RHA awarded the IVF contract to the most efficient provider. However, when the IVF contract expires in three years, the RHA may face some difficulties.

National Women's and Fertility Associates tendered for the RHA contract. The other fertility clinic in Auckland, Artemis Associates, did not—it was too small. 85% of the funding for the Fertility Clinic at National Women's came from the Northern RHA. Without this funding, the clinic will probably close. The balance, 15%, comes from the Midlands RHA, and is itself up for tender within the next 12 months.

Entry costs for IVF treatment are extremely high. It is unlikely that another provider will enter the market to tender for another three year contract. Therefore, if the clinic at National Women's closes, in three years time, there will probably be only one tenderer—Fertility Associates. If this is the case, the purchase of IVF services will not be efficient. A pre-condition of an efficient market is competition; without National Women's there will be no competition.

The RHA faces something of a problem. While competition exists *ex ante* the 1995 contract, there is unlikely to be *ex post* competition.

For the Act to function, and for health and disability resources to be expended most efficiently, the RHA must address this problem.

4 *Transaction Cost Analysis*

The IVF contract provides a good example of the problems which transaction cost economics attempts to address. In some cases, notably where there is a high degree of asset specificity, uncertainty and frequency, market provision may not be the most efficient mode of provision.

Ex post competition for IVF services is inhibited by the small size of the market and the high entry costs. The market for IVF treatment is relatively small; the RHA contract for $4 million over three years represents a significant market share. Insurance companies do not cover the costs of IVF treatment; treatment is either funded by the RHA or entirely by the patient. IVF treatment is technologically intensive. Both the equipment and the personnel required to provide treatment are highly specialised and expensive. These create high technological barriers to entry into the IVF market. This may be offset if the market for IVF treatment is national, rather than regional.

Three solutions are open to the RHA to address this problem:

1. The RHA could use its monopsony power against the monopoly power of the supplier. To determine the market price for IVF treatment, the RHA could have reference to prices in other regions (or countries). The price set would then correspond more closely to a competitive price.

If one adopts Williamson's arguments, the degree of asset specificity involved in IVF treatment could favour vertical integration. The best alternative use of IVF resources is much less than their value in the IVF market. The use of non-specific assets is not possible; therefore, in order to realise the benefits of specific assets, governance structures which minimise transaction costs should be adopted.

2. Many of the present problems stem from the term of the contract. The three year term, at the level and cost of services provided for, is insufficient to realise the cost of the assets required for treatment. Both tenderers in 1995 were already IVF treatment, so neither enjoyed incumbancy advantages against the other. However, the incumbancy advantages of Infertility Associates in 1998—having

already invested in the specific assets—will make it much more difficult for alternative providers to compete.

A solution to this would be a contract for a term sufficient to realise the cost of the assets. The Commerce Commission has stated that long term contracts for health and disability services are not necessarily inconsistent with the Commerce Act 1986:

> A long term contract in the health sector may not by itself raise competitive concerns under the Act. However, it is likely to raise concerns where there is a monopsony purchaser, a monopoly provider, or the barriers to entry to the relevant markets are high and there are potential or existing providers with the ability to contest the relevant markets. In these circumstances, consideration should be given to the issues raised in this decision, and whether a proposed contract could be negotiated for a shorter term.[156]

Vertical integration of the provision of IVF treatment is not possible, as RHAs are unable to provide services directly.

3. Although the RHA is unable to provide IVF treatment directly, it could deal with the physical assets required for treatment. The assets could be leased to the provider, or the contract could provide that the provider should sell the assets to the successful tenderer. However this assumes several things, perhaps without adequate grounds: (1) The former provider wishes to sell the assets to the successful tenderer. In this case study, were Fertility Associates to lose the RHA contract in three years, they would want to retain the equipment for their private practice. (2) The successful tenderer wishes to purchase the assets. In the case study, the successful tenderer, Fertility Associates, already possesses the assets required for treatment. (3) There are no problems valuing the assets.

C Mental Health Case Study

1 The Commerce Commission Decision

In April 1995, the Midland RHA (Midland Health) contracted with the Hamilton CHE, Health Waikato Ltd, for the provision of mental health services. The contract was a period of 10 years, and covered the provision of:[157]

(i) forensic mental health services;
(ii) intensive patient care and acute/intensive care services;
(iii) rehabilitation services; and

[156] New Zealand Commerce Commission *Midland Regional Health Authority/Health Waikato Ltd—Decision No. 275* (Wellington, 1995) pp 95-96.
[157] Above n 156, 1.

(iv) other health or disability services, if any, to be provided at the facility.

Health Waikato demanded a 10 year contract to recover the costs of a new facility built for the provision of mental health services (the facilities agreement). An application was made by the parties to the Commerce Commission to determine if these agreements breached s 27 of the Commerce Act 1986. Section 27 prohibits contractual arrangements which would "have the purpose or effect, or likely effect, of substantially lessening competition in a market."

The Commission in its report highlighted several barriers to entry into the mental health services market, or the expansion of a providers existing market share. Among these was a recognition that economies of scale made it unlikely that more than one facility of the type contracted fro would be provided in the Midland Health region in the ten year period.[158] They also noted the high entry costs incurred constructing a suitable facility, and the high exit costs from the market. High exit costs exist because the productive value of the facilities in the best alternative use is much less than the cost of the facilities. The Commission recognised that "[w]ithout a guaranteed capital recovery stream, such as that intended in the applicants proposal, a potential entrant would need to consider the likelihood of the facility being redundant before the capital cost is fully repaid."[159]

The Commission determined that a 10 year contract for access to the facility to be built by Health Waikato would lessen competition for the provision of in-patient mental health care in the Midland Health region; indeed, with minor exceptions, alternative providers are unlikely to enter the market for the duration of the contract.[160] The Commission also found that competition for the provision of publicly-funded mental health services would be lessened. Although the contract for services is separate from the agreement on the facility, the lock-in effects of the facilities agreement is such as to make it likely that for the duration of the facilities agreement, Midland Health would contract with Health Waikato for the provision of mental health services.[161] These effects are strengthened by Health Waikato's gate-keeper role: Health Waikato staff assess patients requiring mental health services, determine their

[158] Above n 156, pp 49-50.
[159] Above n 156, p 52.
[160] Above n 156, p 64.
[161] Above n 156, p 66.

treatment and refer them to a provider. It is not cynical of the Commission to suggest that under these conditions it is unlikely that Health Waikato would refer patients to alternative providers.[162]

If the agreements between Midland Health and Health Waikato were not permitted to proceed, the Commission found that mental health services would probably be provided by a single provider. The Commission noted that the facilities agreement could proceed if amended. As it stood, Health Waikato would not permit any other provider access to its facilities. The Commission was prepared to consider the retention of the facilities agreement, provided open access was available for other providers. The RHA could then contract with the most efficient provider, who would make use of Health Waikato's facilities.[163] Health Waikato was prepared to accept a shorter term contract, provided the costs of the facility were recovered over this time; the ten year contract represented the RHA's preferred level of annual expenditure.[164]

2 *Transaction Cost Analysis*

The Mental Health case study represents an unsuccessful attempt to address the problems of asset specificity. The Commission noted that the high degree of asset specificity, and the less valuable best alternative use. The provision of mental health services also involves frequent transactions over the period of the contract. Uncertainty is also present in that services are demand-driven, both in the level and content of treatment provided. It seems a good example of where non-market governance should be used, as both parties have and interest in the continuing relationship, and the costs of re-contracting would be considerable.

However, the Commerce Act prohibits anti-competitive practices. The arrangements were uncompetitive, especially if one regards the scope of the mental health markets involved as the Midland Health region—as did the Commission. However, in the absence of these arrangements, market governance would result in a less efficient provision of mental health services. In determining the price for services, providers would need either to consider the cost of the assets or use non-specific assets.

[162] Above n 156, p 67.
[163] Above n 156, p 74.
[164] Above n 156, p 75.

Either option is less efficient; the first because the cost of the services is higher, and the second because the quality of the services may be lower due to the use of non-specific assets. Market governance may result in a sub-optimal utilisation of mental health resources.

IX MAORI AND HEALTH AND DISABILITY CARE

A *The Treaty and Maori Health Needs*

While the Health and Disability Services Act 1993 provides for the public funding of health and disability services for all New Zealanders, Parliament has recognised the special health needs of Maori. The Crown, when notifying purchasers of its intentions under s 8, must consider the special needs of Maori.

Article 2 of the Treaty of Waitangi confirms to the Maori the "unqualified exercise of their chieftainship over their ... treasures."[165] The Crown has conceded that Maori regard health as a taonga, but rejects any claim that Maori health is therefore "a special claim on New Zealanders as a whole, over and above the responsibility of the Crown to secure the health of all citizens...."[166] In the mind of the Crown, its obligations under the Treaty are fulfilled by the presence of s 8, and a direction to include reference to the special needs of Maori in the statements of intent of purchasers and Crown-owned providers.[167]

However, the Crown's views are not shared by all Maori. Some would argue that the Crown's obligations extend further. Milroy and Mikaere have argued that, prior to the arrival of pakeha, Maori enjoyed a health status comparable with the best nations of the world.[168] The status of Maori as tangata whenua, the status of health as a taonga, and the guarantee of te tino rangatiratanga in the Treaty, means that "Maori are entitled to have their standard of health restored to a level

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[165] Translation of the Maori text by I H Kawharu in M Chen & G Palmer *Public Law in New Zealand* (Oxford University Press, Auckland, 1993), 300. The word translated 'treasure'—taonga—"refers to all dimensions of a tribal group's estate, material and non-material—heirlooms and wahi tapu, ancestral lore and whakapapa, etc." (p 301)

[166] Department of Health *Whaia te ora mo te iwi: Strive for the good health of the people* (Department of Health, Wellington, 1992), 23.

[167] Above n 166, p 23.

[168] S Milroy & A Mikaere "Maori and the Health Reforms: Promises, Promises" (1994) 16 *NZULR* 175, 175.

comparable to that of the healthiest peoples of the world. They are also entitled, absolutely, to have control over that restoration process."[169]

The meaning or content of te tino rangatiratanga, and its full implications, remains unsettled; as does the meaning and content of kawanatanga.[170] An attempt to define these terms is beyond the scope of this paper, and perhaps unnecessary. What remains to be addressed is whether the structure of the Act is able adequately—and efficiently—to address the very real health concerns of Maori.

B *Impediments to Access to Health and Disability Services*

The objective of the Act is not the efficient allocation of health and disability care resources as such, but the most efficient provision of health and disability services to all New Zealanders. In funding health and disability care, the Crown has recognised the special needs of Maori. An efficient utilisation of New Zealand's health and disability care resources which failed to address the needs of Maori would not meet the objectives of the Act. Without doubt, requiring the provision of health and disability services to all New Zealanders may result in a less efficient allocation of resources than may otherwise be possible. Likewise, consideration of the special needs of Maori may also result in similar costs. However, the demands of allocative efficiency must, within the New Zealand context, be tempered by the over-arching objectives of the Act.

Maori access to health and disability care is impeded for several reasons. Principal amongst these is that Maori—especially women—may feel that health and disability services are not provided in a culturally appropriate way. Milroy and Mikaere cite several examples. For instance, "[t]here are particular aspects of women's health which it would be considered inappropriate to raise with a man, regardless of whether or not he is a GP."[171] Cultural inhibitions may inhibit Maori women to question providers about their treatment. Public health

[169] Above n 168, p 193.
[170] 'Kawanatanga' is the power granted the Crown in the Maori version of the Treaty. Professor Kawharu translates it as 'government.' The English text of the Treaty uses the word 'Sovereignty;' whatever the precise meaning of kawanatanga, it is certain that to the Maori signatories of the Treaty, it connoted something less than Diceyan concepts of sovereignty.
[171] Above n 168, p 183.

campaigns, such as anti-smoking campaigns, have reduced effectiveness within Maori communities.[172]

Much of this, it is argued stems from the services oriented nature of the Act, which is at odds with the people oriented nature of Maori health needs.[173] Purchasers and providers focus on the provision of health and disability services, to the relative detriment of the concern for the special needs of Maori. Maori health needs become a secondary priority.[174]

Physical barriers to treatment also exist for Maori. The greater proportion of Maori in rural areas or lower socio-economic areas, where access to health and disability services is more limited, should not be overlooked.

C Health Plans and Maori

Although the Crown and purchasers are concerned that health and disability services be provided in a way culturally appropriate to Maori, this is not a complete solution. The physical barriers to treatment are likely to continue under the Act. Milroy and Mikaere are correct when they suggest that the purchase of services by RHAs is unlikely to address the needs of Maori communities. An RHA contract for cardiology services for instance, may provide the level of care to address Maori health needs, but not necessarily eliminate the physical barriers to treatment. Some concerns will only be addressed by a greater involvement of Maori as providers of health and disability services:[175]

> *If* iwi are properly funded in the critical establishment phases, ***and if*** the problem of the cost of increased administration for the small, new provider which is inherent in the system can be overcome, then there may be a growth in the number of health services provided by Maori for Maori. Many of the problems arising from differing cultural values may then be overcome. More Maori may be encouraged to train in the health professions if they can see that they might be able to work in an environment that is comfortable for them and is of immediate benefit to their whanau.

A better response, one which is able to target Maori health more effectively and efficiently than RHAs are Health Care Plans. Maori

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[172] Above n 168, p 185; this is in reference to a report, J Broughton & M Lawrence *Nga Wahine Maori me te Kai Paipa* (1993), which indicated that while most Maori women associated smoking with a health risk to themselves, they did not perceive a connection between smoking and Sudden Infant Death Syndrome.
[173] Above n 168, p 189.
[174] Above n 168, p 189.
[175] Above n 168, pp 190-191.

health care plans were contemplated by the government when developing the reforms.[176]

The definition of purchaser in s 20 of the Act allows the Minister of Health to *Gazette* "any person" as a provider.[177] Health Care Plans are alternative purchasers of publicly-funded health and disability services. People who did not wish health and disability services to be funded for them by the RHA, could move to a Health Care Plan; their slice of the pie of the public health budget would be transferred to this plan. The health care plan would then purchase health and disability services for their members from public funds.[178]

Health care plans dedicated to the purchase of health and disability services for Maori would be able to more adequately address the needs of Maori than RHAs:[179]

> Health care plans offer the following advantages for Maori:
> - 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;
>
> ....
> - the opportunity to recognise the complex social and economic factors that affect Maori health and to support Maori development through managing resources.

Health care plans—as has already been noted—may help to address the monopsony power of RHAs. Dedicated Maori health care plans may also be far more effective in achieving the greatest level of health and disability care for Maori "that is reasonably achievable within the amount of funding provided."

X ALTERNATIVE SYSTEMS OF DELIVERY

A Belgium

1 Structure of the System

A health care system which provides universal and adequate cover efficiently remains elusive. A market-based health system, even if the

[176]Above n 20, pp 69-73.
[177] Health and Disability Services Act 1993, s 20(c).
[178] Above n 20, p 62.
[179] Above n 20, pp 70-71.

causes of market failure can be addressed, may produce an efficient but undesirable outcome:[180]

> An efficient allocation is consistent with a fraction of the population disenfranchised from economic activities and left cold and hungry and diseased. And the competitive market mechanism -- even when fully functioning -- can under a large class of circumstances be guaranteed to bring about precisely that.

A dysfunctional market-based system, such as the United States, does not allocate health care resources efficiently and leaves large numbers of people without health care. The pre-reform health system in New Zealand was also neither efficient, nor did it effectively provide health services to large numbers of people.[181] However, it must be possible to find some middle ground.

The Belgian model provides an interesting proposal. Belgium possesses a health system guaranteeing access to health care, using both public and private resources. Although Belgium spends only 7.5% of GNP on health care, versus 12.5% in the United States, all Belgians enjoy access to health care.

The system is funded through a system of compulsory health sickness and invalidity insurance. Belgians can choose between five private and one public insurers.[182] For those who cannot afford insurance, the state pays both the premiums and the patient deductibles.[183] Adverse selection is avoided as the public insurer may not refuse membership to an applicant.[184]

Unlike private health insurance in the United States or New Zealand, premiums are not calculated actuarially, but stated as a percentage of income, namely 6.35%, and pensioners contribute 2.55% of their pension.[185] The 'moral hazard' arising from pre-paying for health care is largely mitigated by patients contributing 25% of their incurred medical costs.

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[180] P Dasgupta "Positive freedom, markets and the welfare state" (1986) 2 *Oxford Review of Economic Policy* 25, 29.

[181] For instances, waiting lists resulting from provision shortages could result in patients dying before treatment was available.

[182] D Maragas "Belgian Health Care" (1992) 26 *Akron Law Review* 215.

[183] Above n 182, 215.

[184] The public insurer has not been inundated with large numbers of high-risk patients. 99% of Belgians belong to the five private insurers.

[185] Above n 182, 217.

Universal coverage of Belgians may in part be due to monopsonistic purchasers establishing fee schedules at nationwide "conferences."[186] Such schedules contain costs, but may also result in inefficiencies. Most health professionals in Belgium are happy with this system however, and those who wish to may opt-out of the fee schedule.[187]

2 *Lessons for New Zealand*

The Belgian model provides some possible answers to market-based and government health services. The causes of market-failure are largely addressed by the system. 'Moral hazard' is avoided by the use of consumer contributions at the point of consumption. Similarly, although informational asymmetries are endemic to health care, a consumers may be disinclined to regard 'more' as 'better' if forced to undertake a cost-benefit analysis. The asymmetry may be compensated for if consumers demand cost-benefit information from their physician, and a physicians profit-maximising tendencies in treatment may be mitigated by the consumers demand for cost-minimisation. Consumer contributions will also encourage consumers to consider price when choosing a provider.

The Belgian model affords much more choice to consumers. Provider's revenue is dependant on the demand from the actual consumer. Incentives will therefore exist for providers to provide the health services demanded by the actual consumers, and will provide services to meet consumer demand, rather that a government agency's perception of the community's needs.

However, the primary device for cost-containment in this system is the monopsony power of the insurers exercised in national "conferences." The cost of these inefficiencies may be acceptable, if the system delivers better health care to more people than the alternatives.

Reform of New Zealand's health system along these lines would go a long way to creating a market in which consumers, rather than the government, are the players, while still providing health care for all members of society.

B *Oregon*

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[186]Above n 182, 222.
[187]Above n 182, 224.

1 The Oregon 'List'

A major reform of the provision of health and disability services through Medicaid in Oregon was effected with the passage of the Oregon Basic Health Services Act 1989 (OBSHA). The OBSHA provided universal coverage for health care, provided that the services required were accorded a sufficiently high priority on a list of health and disability services.[188] Initially, the list of services was drawn up through extensive consultation with communities and practitioners, and[189] services were prioritized according to the perceived benefits conferred:[190]

> The ratio of costs to benefits , expressed as cost per year of life saved or cost per quality-adjusted year of life saved, become the cost effectiveness measure. Alternatives programs or services are then ranked, from the lowest value of cost-per-effectiveness ratio to the highest, and selected from the top until available resources are exhausted. The point on the priority list at which available resources are exhausted, or at which society is no longer willing to pay the price for the benefits achieved, becomes society's cutoff level of permissible cost-per-unit effectiveness.

However, this resulted in some anomalies. For instance, plastic surgery was covered by the list, but prostate surgery was not.[191]

Oregon's list was revised. Conditions and treatments were assigned to one of 17 categories, and new priorities determined by three criteria: "(1) the category's perceived value to the individual, (2) its value to society, and (3) the "necessity" of the category."[192] Final priorities were determined by the responsible committee reassigning treatments to another category, if they felt it was appropriate.[193] Virtually all services in categories 1 to 9, and many in categories 10 to 13, were deemed "essential health care."[194]

The Oregon plan, while it may reduce the level of services previously provided under Medicaid, provides 100% coverage for the poor. When faced with funding constraints, expenditure will be reduced by

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188 D Hadom "Setting health care priorities in Oregon: cost-effectiveness meets the Rule of Rescue" (1991) 265 *Journal of the American Medical Association* 2218,2218.
189 C Dougherty "Setting health care priorities: Oregon's next steps: supplement" (1991) 21 *The Hastings Center Report* S1, 7.
190 Above n 188, p 2218.
191 Interview with Wendy Edgar, Core Services Committee, 28 September 1995.
192 Above n 188, p 2219.
193 Above n 188, p 2220.
194 Above n 188, p 2220.

removing coverage for treatments, rather than removing people from treatment.[195]

One of the benefits of the Oregon plan is the transparency of the rationing process. Rationing decisions have been largely removed from the hands of doctors. The death of a 7 year old boy in 1987 from acute lymphocytic leukemia, because several months earlier the Oregon legislature had decided to stop funding soft tissue transplants, drew widespread publicity and criticism.[196] The legislature's decision's defenders argued that "[t]here is only so much money. If you balance a bone marrow transplant for one boy against prenatal care for hundreds of poor, pregnant women, you come out in favour of poor, pregnant women."[197] Whatever the merits of this argument, the decision to stop funding for soft-tissue transplants was made with little input from anyone outside the legislature. Although Oregon's list is less flexible, this is outweighed by its explicitness. Rationing decisions are public, subject to public input, and thereafter to public scrutiny. As rationing is inevitable, transparency and public confidence in the rationing of publicly funded health and disability services are important considerations.

2 *The Oregon List and a 'Core' of Health Services*

Section 6 of the Act provides of the establishment of a National Advisory Committee on Core Health and Disability Support Services. This committee is required to advise the Minister of Health on "[t]he kinds, and relative priorities, of personal health services and disability services that should, in the committee's opinion be publicly funded."[198]

The Oregon reforms are an obvious example for the rationing of publicly-funded health and disability services. It is however, an example that was not followed by the Core Services Committee, for several reasons.[199] While the list funded services on the basis of their priority, there was still no guarantee of access for an individual.[200] Any list of core services would either be so broad that there would be no guarantee of access, or so narrow that treatments which should be

[195] N Daniels "Is the Oregon rationing plan fair?" (1991) 265 *Journal of the American Medical Association* 2232, 2232.
[196] J Dixon & H Welch "Priority setting: lessons from Oregon" (1991) 337 *The Lancet* 891, 892.
[197] Above n 177, p 892.
[198] Health and Disability Services Act 1993, s 6(1)(a).
[199] Core Services Committee *The Core Debater* (Issue 3 — October 1994).

available would be excluded.[201] A negative list, listing services which would not be provided, was also rejected, largely because it was unworkable.

The alternative developed by the Core Services Committee was to examine the provision of health and disability services on an individual basis, and attempt to determine who should be provided with this service, rather than attempt a global list of services which should or should not be provided.[202] For instance, the Committee may decide that no-one should be provided with certain health and disability services from public funds, and recommend universal access for other services.

This is a more pragmatic, and flexible approach than the Oregon list. Transparency is, to a great extent, preserved. Although the public do not have access to a list of publicly-funded health and disability services, the rationing criteria will be available for public scrutiny (in the Committee's report to Parliament). The Committee has developed a set of criteria for prioritising patient need for elective procedures, rather than ranking services.[203] A patient is awarded a score out of 100, made up as follows:

1. Pain—40%
2. Functional Activity—20%
3. Movement and deformity—20%
4. Other factors—20% (This includes factors such as the ability to work and other social considerations.)

The criteria represent a balance between medical and what might be termed social priorities (such as the utility of treatment). Although these criteria fall short of defining a core of services to be publicly funded, the rationing process is exposed to public scrutiny.

While the compilation of a list addresses the extent of publicly-funded health and disability services, it largely fails to address market failure. The fundamental structure of the Act, even were a list to exist, would remain unaltered. A list would represent little more than a direction to RHAs on what services should be purchased for their members.

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[200] Above n 191.
[201] Above n 191.
[202] Above n 191.

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XI CONCLUSION

The provision of health and disability services in a society inevitably represents a compromise between competing objectives. The single-mined pursuit of efficiency in the allocation of health resources results in socially unacceptable results. Demands for efficiency must, within the New Zealand context be tempered by the demands for universal coverage and equity.

The structure of the health system established under the Act is not perfect. The market for health and disability services in New Zealand, as in most countries in the world, is subject to defects. The RHAs are monopsonists, the CHEs are often in the position of a monopolist, marekt failure persists under the reforms. Health and disability services which are not amendable to competitive tendering are subjected to it nevetheless.

New Zealand, in failing to completely perfect the provision of health and disability services, is in good company. The level of funding devoted to health care, and the level of benefits received, are certainly respectable by world standards.

Many of the problems remaining in the Health and Disability Services Act 1993 are unlikley to be addressed further—they result from basic human nature, and its resulting limitations, and limited resources available for health and disability care. Were human nature different, and were resources unlimited, then it may be possible to provide the level of health and disability services which people expect.

Whatever the defects of the reformed health system, it represents a better and more rational solution to the maximisation of limited health resources than that which it followed.

[203] Above n 191.

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