Quasi-markets and Pseudo-contracts in the New Zealand Public Health System^

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1. Introduction

The public health system was one of the last parts of the public sector to be remodelled. Such restructuring drew on essential elements of the New Public Management.[1] The abolition of the area health boards in 1993, the splitting of the purchasing and providing functions, and the introduction of more business-like practices into public hospitals were all aimed at introducing market-like incentives and disciplines into the health system. The intention was to establish what has become known internationally as a "quasi-market": that is, a market in which government agencies undertake the purchasing function on behalf of consumers by placing contracts with providers for the delivery of health services. Central to these structural changes was the notion that a contestable contracting process would encourage providers to produce more efficiently.

The New Zealand Public Health and Disability Act, which rejects much of the model adopted over the last 7 years, was passed in December 2000. The Act abolishes the Health Funding Authority and once again combines the purchase and provider roles of publicly-owned services under District Health Boards (DHBs). This paper examines the nature of the quasi-market for health care and the way in which it, and the contracts and pseudo-contracts within it, have performed in practice. We look at the shifts that occurred over time and consider reasons why the quasi-market did not perform as well as might have been expected.

2. The nature of the quasi-market

In quasi-markets, as in traditional markets, the roles of purchasing and providing services are undertaken by separate organisations which negotiate to buy (or sell) an agreed type of service for a given price. However, quasi-markets differ from traditional markets in a number of important ways. The practices of the people and organisations within them are therefore also very different.

In the health sector, the government remains the dominant funder of most health services, including all of those services for which the roles of purchaser and provider were separated under the 1993 reforms. This means that consumer

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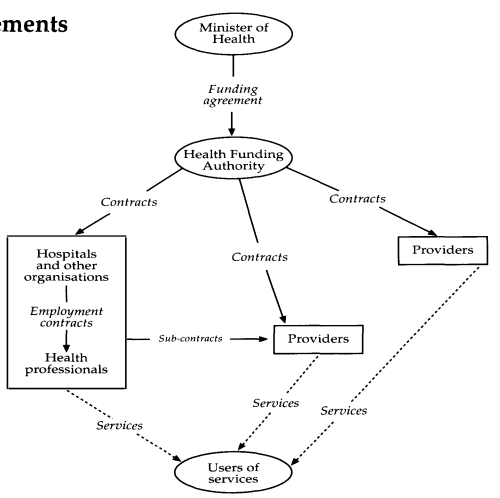
1 See the seminal work of D Osborne and T Gaebler, *Reinventing Government* (New York : Addison Wesley) 1992 and the extensive discussion in C Harlow and R Rawlings, *Law and Administration* (2 ed) Butterworths 1997 esp p 131.

purchasing power is not expressed in money terms because the price of these services at the point of use is zero (or near zero). The choices of consumers are not constrained by incomes but instead by the allocative decisions made on their behalf by the purchasing authority. Decisions about the level and regional distribution of funds are likewise made centrally by the cabinet, the minister and the Ministry of Health rather than by market forces.

On the supply side, public and private providers compete with each other to win contracts with purchasers for public funds. However, unlike conventional markets, many private health sector providers are not-for-profit organisations. Moreover, providers are likely to have more information about the costs of production and about the quality of their services than the purchaser. This opens up the potential for providers to act opportunistically (for example, by cross-subsidising some services, by over-pricing others or by engaging in some form of inefficient production) especially for those services where there are significant barriers to entry and competition is minimal. One other important feature on the supply-side is that, while managers are responsible for negotiating contracts and for managing budgets, the health professionals who are diagnosing and treating patients make most of the real resource decisions.[2]

All of these features mean that, instead of a one-to-one relationship between a buyer and a seller, the quasi-market for health services is characterised by a cascading series of relationships, each of which is governed by its own set of rules and by different forms of agreement (Figure 1). This in turn means that the incentives in a quasi-market are somewhat different from those in a conventional market. In particular, the incentives that are assumed to flow from these more-market type arrangements are one step removed from both the people who are actually providing the service and from those who are using the service – that is the doctors and other health professionals and their patients.

Figure 1: Cascading agreements



2 The National Health Committee (previously the National Advisory Committee on Core Health and Disability Support Services) and the Health Funding Authority

3. Reasons why the quasi-market did not perform as expected

By 1996 it was clear that the expected efficiency gains from the new structure were somewhat less than expected. This comment applies most particularly to the Crown Health Enterprises which were the primary target of the quasi-market structure. In its 1996 briefing to the incoming Minister of Crown Health Enterprises, the Crown Company Monitoring and Advisory Unit reported that:

> The health reforms have yet to yield the original expectations. By a range of measures (eg. average length of stay, personnel costs, bed numbers) the pace of performance seems, if anything, to have weakened since the advent of the reforms.[3]

There are many possible explanations for the lack of expected efficiency gains in public hospitals, including that expectations for improved efficiency from the quasi-market structure were simply overly optimistic. Three other possible explanations are discussed here. These are weak budget constraints, the fact that doctors, rather than managers, make the real resource decisions and the absence of competitive pressures.

(a) Weak budget constraints

The Crown's interest in the CHEs/HHSs[4] has been vested in two shareholding ministers – the Minister of Finance and the Minister of Health (or the Minister of Crown Health Enterprises prior to December 1996) — who hold an equal number of shares. While the offices of ministers may be (and frequently are) transferred to another person, transfer of any shares or of any associated voting rights has been prohibited.[5] This means that, unlike similar companies in the private sector, ownership of CHEs/HHSs has not been subject to the threat of takeover as is the case in contestable capital markets.[6]

The CHEs/HHSs also do not bear the risk of insolvency which is normally present in a commercial environment. If the shareholding ministers had allowed a public hospital to go out of business, this would have severely compromised access to services, albeit temporarily. A willingness on the part of the government to fund CHE deficits indicates that this is also considered politically undesirable. Some of the accumulated debts of the CHEs were written off by the government. In addition, until 1998, many of the CHEs/HHSs (*e.g.*, 18 out of 23 in 1997) had "letters of comfort" signed by the Minister of Health which effectively underwrote any loans raised by these CHEs/HHSs in the private market.

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have both attempted to develop more explicit methods for setting service priorities. While this has resulted in some marginal changes in funding allocations, the majority of health funds continue to follow historical patterns of resource allocation.

3 Crown Company Monitoring and Advisory Unit (1996) *Crown Health Enterprises: Briefing to the Incoming Minister.* Wellington, p 21.

4 Crown Health Enterprises, and (post 1996) Hospital Health Services respectively. Both refer to public hospitals.

5 Section 38, Health and Disability Services Act 1993.

6 B M H Sharp, (1994) *Health Policy, Quasi-markets, and Purchaser-Provider Contracts.* Paper presented to New Zealand Association of Economists.

The budget constraint faced by the CHEs/HHSs was therefore very weak, at least until 1998 when the letters of comfort were withdrawn. In the absence of a tight budget constraint, any pressure on directors to satisfy the objectives of the shareholders appeared to stem almost solely from the threat of the replacement of directors and/or CHE managers.

(b) Doctors as decision-makers

A key part of the 1993 reforms was the commercialisation of publicly-owned hospitals. The State Sector Act 1988 had already replaced the system of shared management by the hospital manager, medical superintendent and principal nurse with general management. After 1993 further devolution of responsibilities occurred. The CHEs were constituted as legal entities with independent boards and their CEOs were empowered to negotiate contracts with purchasers, to set wages rates, and to buy and sell capital without ministerial approval.

CEOs were provided with personal incentives to perform, including large bonus payments (some of which were paid out in spite of poor financial performance of the organisations for which they were responsible). However, because it is doctors rather than CEOs or managers who make the real resource decisions, efficiency gains depend crucially on the ability of managers to encourage efficient resource use by doctors.[7] While considerable attention was paid to the development of incentive-based contracts for those at the higher levels of the management hierarchy, the incentives facing those who were actually providing the services were largely ignored.

Unlike managers, hospital doctors have a dual role to play as agents of their patients and as employees of the hospital. This limits the extent to which managers might influence the behaviour of doctors. The situation is complicated still further by the fact that managers do not have the information required to assess whether or not a doctor is providing services in an efficient manner. Therefore, even if appropriate incentive-based contracts could be developed, the manager has limited ability to monitor the performance of doctors.

In the USA, the techniques of managed care are commonly applied. Most of these are designed to encourage treatment practices which reflect some norm. Techniques include the requirement for second opinions and other forms of peer review, and the use of protocols and clinical guidelines. The major difficulty with these types of techniques is that, because they are designed to encourage more efficient use of resources, they have the potential to undermine the doctor-patient relationship and the ethical standards upon which this relationship is based.[8]

There are other reasons why managers may face difficulties in influencing the behaviour of doctors working in public hospitals. Many specialists spend part of their time working in private practice where fee rates are significantly higher than in the public sector. As Vaithianathan has noted, this begs the question of

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7 R Vaithianathan, "The Failure of Corporatisation: Public Hospitals in New Zealand", (1999) *Agenda*, 6(4): 325-338.

8 See for example, J Little, "Managed Care Contracts of Adhesion: Terminating the Doctor-patient Relationship", (1997) 49 *Rutgers L R* 1397.

why many doctors continue to work in the public sector at all.[9] It may be that the work in public hospitals is more professionally rewarding because most acute work is carried out in this setting. Whatever the reason, the practice incorporates perverse incentives because waiting lists for public hospitals provide a useful source of private patients.

Another problem was that the language and practices of the more market-like approach to health care and the commercialisation of hospitals was alien to many doctors. In the absence of any sense of ownership or buy-in, managers are likely to find it difficult to assert their authority over doctors because other incentives predominate. One example occurred in 1995 when the management of Capital Coast Health was awarded a contract to supply a number of elective surgical procedures to patients from a neighbouring CHE.[10] The contract had to be cancelled when surgeons refused to perform the procedures on the grounds that it was unethical for these patients to queue-jump ahead of those on Capital Coast's own waiting lists. Another example occurred in Southland when an ophthalmologist from Australia was employed on a short-term basis to perform cataract surgery. Again the contract had to be cancelled when local doctors refused to provide the necessary follow-up treatment to these patients.

(c) Absence of competitive pressures

Studies undertaken in the USA following the introduction of competitive contracting processes in that country have shown repeatedly that the number of bidders for contracts for health services is usually very small, and that the vast majority of contracts are placed with incumbent providers.[11] This applies even for those services where the barriers to entry appear to be minimal.

The studies also indicate that the entry of new providers into the market is usually confined primarily to those introducing new services. This certainly appears to have been the case in New Zealand. In a study of the markets for seven elective surgical procedures provided in CHEs, Ashton and Press (1997) found that, while there were no pure monopolies, the degree of market concentration was high.[12] Moreover, there were few significant shifts in the pattern of service provision across CHEs in the two years following the health reforms. There were also very few contracts let to private providers for these services. In contrast, where there has been new money — such as for services for Maori and for mental health services — many new providers have entered the market.

Some health services obviously enjoy a natural monopoly. This applies particularly to highly specialised services or to services where there are high

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9 R Vaithianathan, "The Failure of Corporatisation: Public Hospitals in New Zealand", (1999) *Agenda*, 6(4): 325-338.

10 Ibid.

11 C Propper, (1992) Quasi-markets and Quality, *Studies in Decentralisation and Quasi-Markets 09*, School for Advanced Urban Studies and Department of Economics, University of Bristol.

12 T Ashton and D Press, " Market Concentration in Secondary Health Services Under a Purchaser-Provider Split: the New Zealand Experience", (1997) *Health Economics*, 6: 43-56.

sunk costs. Where there is a single purchaser as in the case of the HFA, sunk costs effectively become transaction specific, there being no alternative purchaser for these services. Thus providers are unlikely to invest in assets such as staff training, building and large items of equipment unless they are assured that the contract will be renewed in subsequent years.[13] This creates a barrier to entry for potential competitors.[14]

Even if providers do enjoy a monopoly, it may be argued that incentives to perform still exist as long as there is *potential* competition — *i.e.* services are contestable — or if there is some potential for some non-core services to be shifted to alternative providers. One early example was the decision of the Northern Regional Health Authority[15] to place the contract for fertility services with a private provider rather than with the incumbent provider — Auckland Healthcare. While this contract represented only a tiny percentage of total turnover for Auckland Healthcare, it no doubt sent a shock-wave through the CHE, thereby providing the necessary incentive for improving efficiency in other services.

The potential for the HFA to shift marginal contracts to alternative providers is, however, inevitably constrained by the government's desire to secure continuity of supply of essential services through public-ownership. Removing even small contracts at the margins may undermine the financial viability of an organisation. The provision of marginal services may also secure important economies of scope, especially where these services utilise common support services. In such a situation, contracting with alternative providers may simply add to total costs because the average cost of other services increase.

There are other reasons why effective competition may be limited and why contracts are likely to be placed with incumbent providers. First, New Zealand's small population base means that for particular services, the market is often simply too small to support more than one provider. Importantly, even for services where the entry costs are relatively low, a minimum throughput may be desirable in order to secure some minimum standard of safety. Second, patients often prefer incumbent providers. Seeing a doctor or living in a particular rest home is a very personal experience. Once a relationship with a provider has been established, people may be unwilling to shift to an alternative provider, even though the alternative provider may be offering what appears from the outside to be a higher quality of service. Third, purchasers may place high value on variables such as loyalty, reputation and the existence of a track record. Thus, while a service may be contestable in theory (because there are no economic barriers to entry or exit), this may not be the case in practice. Fourth, contestable contracting can be a costly process for both purchasers and providers. As we shall discuss in greater detail below, these factors help to explain why, after a flurry of initial activity, the RHAs very soon began to focus their attention on developing longer term contractual relationships with incumbent providers rather than opening up contracts to some form of contestable bidding process.

13 J A Roberts, "Managing Markets", (1993) *Journal of Public Health Medicine*, 15(4): 305-310.

14 See n 19.

15 Regional Health Authorities were later combined to form a national Health Funding Authority.

A final point to note is that competition is a means of producing efficient outcomes rather than an end in itself. Contestable processes such as those undertaken by the Waikato RHA in relation to residential long term geriatric facilities (discussed below) aim at eliminating the most inefficient providers and consequently eliminate the excess capacity necessary for competition itself. This in turn reinforces the position of incumbents and creates new regulatory challenges to ensure that the remaining incumbents maintain efficient practices and pricing. In this sense at least, given the sunk costs involved in many parts of the health industry, related barriers to entry and restrictions on the supply side, competitive or quasi-competitive markets could only be a temporary technique to achieve efficiency.

4. Contracts and the New Public Management: the promise

If creating an efficient quasi-market was the aim, the contract or negotiated agreement was the central mechanism by which it was to be achieved. The use of contracts was intended to reflect the market by imposing both private sector disciplines and private law on the relationship between funders and providers. This distinction between *discipline* and *law* is important.

In terms of market discipline, the contract was meant to provide a regulatory or administrative technique by which to specify and monitor the performance of both public and private actors. It was a device to ascertain *what* health services were being delivered and at what cost. In this sense it does not matter whether the relationship is legally a contractual one and susceptible to contractual remedies. This is evidenced by the range of agreements (loosely referred to as "contracts") throughout the public sector which translate what were formerly ministerial,[16] purely bureaucratic, grant or conditional grant or legislative arrangements into pseudo-contractual ones. In legal terms many of these relationships could never be enforceable contracts because the parties do not have separate legal identity. They are simply agreements between different parts of the executive government which is a single legal personality. According to

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[16] See, for example, purchasing agreements which are an administrative instrument without statutory or contractual basis and which cannot be used to derogate from statutory measures for accountability and governance. An example of the confusion that can arise about the status of such instruments involved the Tourism Board which is a separate legal entity. The Tourism Board was set up by statute in order to ensure more private sector input in the marketing of tourism. It enjoyed some measure of independence having statutory functions, the power to initiate its own programmes, and the protection that directors could only be removed for cause. The Minister was to have responsibility through an annual statement of performance criteria, and the statutory ability to give general policy directions. A problem arose when the Minister disagreed with the Board's strategies on matters that went beyond the scope of a policy direction. Using the "purchase agreement" the Minister sought to maximise his bargaining power (in order to accord his policies priority) by drip-feeding funds. The "purchasing agreement" requires detailed reporting of the quality, quantity, timeliness and cost of outputs at a much greater level of detail than required by the estimates. It has no statutory basis. As a purely administrative instrument it cannot supplant or substitute for the statutory measures of accountability and governance.

some academic commentators, the advantages of such arrangements do not depend on their having legal force, the gains being primarily a matter of administrative technique.[17] Such commentators envisaged that contractual mechanisms would allow for more flexible, responsive, and non-bureaucratic responses to citizens' needs. As well as promoting efficiency, contract was said to offer the possibility of greater transparency and participation by citizens in service specification and provision and in the goals of public spending. Such processes could consequentially provide safeguards against bureaucratic capture. The contractual paradigm has been used as a powerful metaphor for a new form of governance which:

> ....captures the idea that all of the participants in a particular context – government agencies together with a wide variety of non-governmental actors – negotiate over policy and its implementation.[18]

Thus, the "metaphorical" or "symbolic" promise of contracts is a powerful one. Contracts were intended to represent both "voice" and "choice", to allow greater participation at the policy end of the political process than was possible under command and control forms of governance, and indeed under traditional public law notions.

In addition to whatever discipline and symbolic promise "contracts" contribute to the administrative process, many of these agreements *do* have legal status and give rise to legal obligations and other consequences. They may, for example, attract the application of the Commerce Act where agreements are anti-competitive (for example, because their long-term nature presents too great a barrier to entry)[19] and the supervision of the "ordinary" law of contract. An explicit premise of deregulation in New Zealand was that any necessary regulation could and would be provided by private law.[20] That is, there would be no direct government intervention, that what regulation there was would be "light-handed", and that in general the public sector would be subject to the same rules as the private sector. Proponents of the state sector reforms generally,

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17 See C Harlow and R Rawlings, *Law and Administration* (2 ed) Butterworths 1997. But see C Flood criticising the lack of legal enforceability under the UK model in "Accountability of Health Services Purchasers", (1997) 20 *Dalhousie Law Journal* 470 and K Barker, "NHS Contracts, Restitution and the Internal Market", (1993) 56 *Mod LR* 832.

18 J Freeman, "The Private Role in Public Governance" (2000) 75 *NYULR* 543, 549.

19 See J McLean, "Contracting in the Privatised and Corporatised Environment" (1996) 7 *PLR* 223, 228, and D Goddard, "Long-term Contracts: A Law and Economics Perspective" [1997] *NZLR* 423, 455 for criticisms of the application of the Commerce Act 1986 to long term health contracts.

20 This view is consistent with a Diceyan preference for ordinary law of the ordinary courts to control both public and private bodies. It ignores the debate among contract lawyers about whether there is in fact one such ordinary law which provides the abstract principles by which all contracts should be judged — see for example M Friedman, *Contract Law in America* The University of Wisconsin Press, Madison 1965, 20. For criticism of Friedman's approach see C Wonnell "The Abstract Character of Contract Law", (1990) 22 *Connecticut Law Review* 437 and Posner positing that some of the special rules are merely defensible

and in relation to health particularly, argued that the private law of contract, tort, and equity would provide sufficient remedies. As with the quasi-market, the expectations surrounding contracts — both legal and symbolic — may have been overly optimistic.

5. Health contracting in practice

In the health context, restructuring was intended to capture both the technical and legal advantages of contracting. The New Zealand health system has more fully embraced the contractual model as a means of *legal* as well as *regulatory* accountability than in the United Kingdom where, for example, disputes over National Health Service purchasing agreements are subject to political rather than legal resolution. In New Zealand such agreements can be and have been litigated in the ordinary courts. The New Zealand example raises starkly the issue whether contract methodology should be regarded merely as a form of bureaucratic technique or whether the full range of private law disciplines should also apply. This in turn raises the prospect of the New Zealand health system providing examples of the "private model of public law" in practice. That is the view that privatised or contracted out activities should not be subject to public law standards but to private law standards (which may themselves sometimes incorporate public law concerns).[21]

From the outset, there were a number of sceptics about the use of contracting in the health sector.[22] They considered that the optimistic picture painted (mainly by economists) of contractual participation represented something of an idealised caricature of the process. Many contractual forms of participation are of dubious quality. As we have already noted, the opportunities for citizens to participate is particularly limited in the health sector, where doctors and patients are both one step removed from the contractual process. Moreover, in the case of the HFA monopsony purchaser, it was suggested that the "contract" is primarily a distributional device. Accordingly, behind the private form is often a pure exercise of public power.[23] Such power will often be unsusceptible to either public or private remedies.

"concretizations" of more abstract principles (R Posner, *Economic Analysis of Law* 121, 122 (3d ed 1986)).

21 See C Harlow and R Rawlings, *Law and Administration* (2 ed) Butterworths 1997, esp 42, 207; D Oliver, *Common Values and the Public-Private Divide*, Butterworths 1999, esp 12. Harlow and Rawlings dislike the "juridification" of the contractual process (209) but at the same time distrust the tendency to deny formal legal recognition to "pseudo-contracts" on the basis that it may lead to a separate "public law of contract" (210, 215, 250).

22 See generally by way of example, Legal Research Foundation, *Contracting in the Health Sector* Seminar papers (1994) and especially on this point D Stephenson, "The Contracting Process – Building New Relationships in Health Care – Commentary" 59, 60, and T Ashton, "Voice and Exit in New Zealand's Health Care Sector – Commentary" 43-46.

23 M Aronson, "A Public Lawyer's Responses to Privatisation and Outsourcing" in M Taggart (ed.), *The Province of Administrative Law*, Hart Publishing 1998, 40, 55-56.

Of those critics who conceded that contracts *could* deliver more flexibility and responsiveness, some thought this a mixed blessing. Opportunities for flexibility bring with them opportunities for arbitrary use of power — both in terms of contractual obligations and price which might result in widely differing prices and levels of services throughout the country. On a more fundamental constitutional level, commentators, such as Daintith, have suggested that the ability to vary contractual terms would be the equivalent to the suspension of the law which is prohibited in other regulatory settings.[24]

Other critics had concerns about the expected efficiency gains. They suggested that the government agent would be forced into contractual competitive mode whether or not the particular case demanded it, and whether transaction costs outweighed any possible advantages of such a method.[25]

Not surprisingly given these sometimes diametrically opposed concerns, the examples from practice bear out some but not all of these early criticisms. The picture is a complex one and crucially depends on the type of relationship the contract seeks to regulate. Where the "contract" has been most successful is as a regulatory technique for managing relationships rather than enforcing compliance. From early on sensible measures were taken to reduce transaction costs – though sometimes at the cost of promised flexibility. Parties have not been forced strictly into contractual mode, but this too has had a cost in terms of contestibility. The contractual device has been embedded in (often dense) regulatory settings. Significantly, the system as it has worked in practice has combined various subsidy schemes with contractual and mixed contractual-subsidy arrangements. Again this in turn has had costs in terms of the ability of providers to "negotiate over policy" and (in a sometimes perverse way) on the ability of purchasers to enforce compliance. The almost uniformly unsuccessful litigation in the area points to over-inflated expectations around the "contractual promise". On the whole the courts have given more weight to public function rather than contractual legal form.

We take three types of contract to illustrate some of these effects. The first illustrates where we think contractual technique has been most successful. The second illustrates the limits of participation under the contractual paradigm and the effects of the broader regulatory environment and the third indicates the significance, or otherwise, of instrument choice.

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24 T Daintith, "The Executive Power Today" in J Jowell and D Oliver (eds) *The Changing Constitution*, OUP Oxford 2 ed 1993, 200 states that it is a "fundamental principle of the constitution that the government cannot otherwise than through parliamentary legislation, exercise regulatory power, that is to say, alter the existing legal rights of its subjects". Contractual mechanisms enable governments to escape the constraints affecting the exercise of formal powers of legal regulation. Similar concerns in the United States context find expression in the over-delegation doctrine.

25 P Howden-Chapman, "Doing the Splits: Contracting Issues in the New Zealand Health Service", (1993) *Health Policy*, 24: 273-289.

(a) Government as Purchaser: The simple case

The Health Funding Authority purchases health services from both public and private providers. The most straightforward kind of contract is for public health programmes (*i.e.* health promotion, health protection and preventative programmes) which are provided for the public at large. Most contracts entered into under the budget allocated to the public health sector are in this category. Importantly, that budget almost exclusively funds non-profit provider organisations.[26] This is crucial because it means that in large part the funder's and providers' objectives are aligned. It is more of a co-operative partnership than a competitive contract. In many cases the providers are monopolies, and the contracts are rarely put out to competitive tender.[27] Indeed in one case the purchasers have had to *establish* monopolies (as in the creation of agencies to provide needle exchange programmes).[28] There is then, little by way of a market or competition. Complex tendering processes are not economically justifiable under this scenario and have been sensibly put aside.[29] (We shall say more about competitive tendering later.)

What does the existence of a contract mean in this context? As a result of early problems of individual contracts drawn by law firms running to 300 pages, all health contracts are now selected from a range of standard form templates administered by bureaucrats in Dunedin. Regional managers are responsible for specifications but do not have the power to derogate from standard contractual terms and the contract price is set globally and is not negotiable. Nevertheless the specification process has been useful in aligning expectations of performance. (We use those terms advisedly – we do not know whether such expectations have actually been delivered.[30]) The annual or 6 monthly reporting requirements provide reliable indicators of problematic cases. Contracts are seldom not renewed – but if need be the threat of going to competitive tender has been effective.

Apart from the more onerous reporting requirements on providers and increased specification of expected performance by government agents, there has been little change to the old system of bureaucratic management even as the new process has evolved. The contracts themselves are scarcely ever referred

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26 For example, the Heart Foundation, AIDS Foundation.

27 A contract in Southland was recently awarded to a group of health protection officers who formed their own company in competition with the public monopoly.

28 A policy co-ordination role is usually performed by the HFA. However, the policy-maker/ provider split has resulted in regulatory slippage in relation to needle exchange programmes. It is still a criminal offence to possess and distribute needles – even for the prevention of infectious disease (s 12A(2) Misuse of Drugs Act 1975). As such, any contractual agreement relating to such matters would be unenforceable.

29 The Public Health Operating Group, Public Health Contracting First Principles Document specifies that "Flexible processes are to be adopted for purchasing public health services...depending on the merits of the particular case. Services ought not to be made contestable where there is no good reason, or legal requirement, to do so." (The Commerce Act governs the health sector.)

30 Anecdotal accounts suggest that much of the effort has been expended in reaching agreement, and monitoring — especially by way of external audit — has been extremely weak.

to by either party and would have very little normative value, if the parties were to do so. Like many long-term or relational contracts, they are seldom used as the basis of a compliance regime but rather as a device by which to manage relationships. Continuity of relationship may be a key indicator of quality of service in some parts of this sector.[31] These matters are unlikely to get to court — either by way of public or private law challenge.

In this simple variety of case, we would suggest that the contractual legal form of regulation has in itself made very little difference and that the real gains have been in terms of regulatory technique. The old grant system could have been used to similar effect. That is, money could have been given to such agencies (technically an act of state), the Crown determining conditions, audit and reporting arrangements appropriate to the grantee, with very little difference in effect or accountability. The real gains have been in terms of aligning expectations and establishing co-operative relationships. As practice has evolved, the contractual mechanisms have been sensibly adapted for efficient ends, and transaction costs reduced as much as possible.

(b) Contracts for the benefit of third party individuals

(i) Multi-Party Contracting in Quasi-Markets

More difficult have been the contractual negotiations for the delivery of services to specified qualifying individuals such as rest home patients. A dominant technique of the New Public Management has been for government purchasers to act on behalf of consumers in selecting providers in competitive quasi-markets. This has met with a predictable range of complex problems.

The cases have been broadly of two kinds. The first set of cases has attacked tendering processes,[32] and the second category focuses on processes more broadly defined. They are both attempts to improve transparency and represent different responses to the problems arising from imperfect information and the potential incompleteness of contracts. As we shall see, the legal responses have different consequences in terms of flexibility. Tendering doctrine tends to restrict flexibility and the ability of the parties to adapt and change contractual specifications; while "heads of agreement" "good faith bargaining" clauses and the like, are attempts to design a framework within which the inevitable adaptations will occur without too great a risk to either party.

Under the old law, no contractual obligations were thought to arise out of a call for tender. The law is now clear that representations made in the tender specifications and even expectations arising out of a course of conduct may create binding obligations to act fairly. This "two contract" contract approach favours

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31 See, for further examples, T Ashton, "Contracting for Health Services in New Zealand: A Transaction Cost Analysis", (1998) 46 *Soc Sci Med* no 3 357-367.

32 For a more detailed discussion of the cases see McLean, "Contracting in the Privatised and Corporatised Environment" (1996) 7 *PLR* 223, 225-227. For more recent authority which attempts to contain the trend towards greater procedural protection see *Fullers Cruises Northland Ltd v Auckland Regional Council* Unreported High Court Auckland 4 June 1999 CP 438/96, Paterson J.

transparency and fair competition. It provides a safeguard against abuse of position, especially given the monopsony situation which exists in health – a matter to which we shall return in considering the *Roussel* case.[33] But the requirements of fairness and competition are at odds with flexibility. The doctrine effectively discourages parties from negotiating about specifications let alone about the goals of public spending. It tends to force the purchaser to specify in advance its requirements. Such requirements cannot be refined or altered later in the process without risking legal challenge. The legal doctrine promotes transparency at the pre-contractual stage and at the same time militates against flexibility.[34]

Such procedural niceties also attract significant transaction costs.[35] Contractual damages are an inappropriate remedy for procedural misconduct in many instances. Tender bids are often speculative, loss leading, and made in order to establish a tender history. "Expectations" giving rise to damages are often more constructed than real in this setting. While this can be avoided in part by contractual boilerplate provisions such as "the highest or any tender shall not necessarily be accepted",[36] the public law remedy of an entitlement to a rehearing may be more appropriate.[37] Or indeed, it may be that where government contracts are concerned, a reliance measure of damages (including loss of foregone opportunities) may be a more appropriate remedy.[38]

The second category of litigation has focused on processes more broadly defined. The cases tend to arise out of statutory obligations to consult, an emerging common law "legitimate expectation" of consultation, and self-imposed contractual terms under heads of agreement requiring "bargaining in good faith".[39] In one case the Bill of Rights Act guarantee of natural justice has also been (unsuccessfully) invoked.[40] These could be viewed as examples of public law preoccupations with process intersecting with or informing traditionally private law concerns. They raise questions about whether a contractual term imposing an "obligation to negotiate in good faith" will be

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33 *Roussel UCLAF Australia Pty Ltd v Pharmaceutical Management Agency Ltd* (Unreported Privy Council, 30 July 1998).

34 See, for example, the *Report of the Controller and Auditor-General* B. 29 [99d], 47 on the Health Funding Authority contract for a specialist sexual health service. The problem could have been avoided by consultation prior to the call for tenders (as indeed required by s 34 Health and Disability Act 1993).

35 This has prompted the Auditor-General to suggest that purchasing guidelines should be revisited.

36 See eg, *Gregory v Rangitikei District Council* [1995] 1 *NZLR* 469.

37 Thanks to Mike Taggart for this point.

38 For a compelling analysis, see G Hadfield, "Of Sovereignty and Contract: Damages for Breach of Contract by Government", (1999) 8 *Southern California Interdisciplinary Law Journal* 467.

39 See eg, *Mercury Energy Ltd v Electricity Corporation of New Zealand* (Unreported, High Court Auckland, CL20/92, Temm J) and *New Zealand Licensed Rest Homes et al v Midland Regional Health Authority* (Unreported, High Court Hamilton, Hammond J, 15 June 1999); Unreported New Zealand Court of Appeal 128 (17 July 2000) Henry J.

40 *NZ Private Hospitals Association v Northern Regional Health Authority* (Unreported, High Court Auckland, CP 440/94, Blanchard J, 7 December 1994).

enforceable.[41] Processes have become more transparent, but the quality of contractual participation has fallen far short of a meeting of minds.[42] Much of what has been achieved in terms of greater participation at the pre-contractual phase, was not due to the contractual form alone, but was equally due to the statutory duty to consult. The cases tend to conflate discussion of the different causes of action.

The case of *New Zealand Licensed Rest Homes v Midland Regional Health Authority*[43] is an example. In that case the plaintiff providers alleged breach of contractual undertakings to develop a transparent method of negotiation and to contract in good faith[44] and of the statutory obligation to consult.[45] These procedural arguments (both from public and private law) were focussed on the pre-contractual phase.[46]

In the *Licensed Rest Homes* case, the purchaser was moving from an historic cost system to an efficient pricing model. Replacing scheduled fees for service based on historical cost with efficient pricing models providing a fair rate of return was problematic and highly contested. The high volume of negotiations carried associated transaction costs. These transaction costs were compounded by controversial valuation practices and inadequate industry standards and benchmarks. These difficulties were further complicated by the fact that a fair rate of return was being assessed for both charitable and profit motivated suppliers operating in the same market.

The standard terms and conditions of the contract were made the subject of industry representations. Several efficient providers were selected on which to base the new pricing model. These were meant to generate the information base on which the parties were to agree about pricing. The plaintiff providers were seeking to force the re-negotiation or continuation of negotiations on specific aspects of the funding model.[47]

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41 For example, in *New Zealand Licensed Rest Homes et al v Midland Regional Health Authority* (Unreported, High Court Hamilton, 15 June 1999), Hammond J said "There is nothing intrinsically objectionable in the subject matter of a "promise" being an undertaking to follow a particular procedure. Much of public law, to take a simple example, is founded on the premise that certain procedural matters are binding, even on government" (p 40).

42 For example, in a leading case of *Wellington International Airport Ltd v Air New Zealand* [1993] 1 NZLR 671, 674, consultation was defined as more than notification, but something short of negotiation or consensus:

> "If the party having the power to make a decision after consultation holds meetings with the parties it is required to consult, provides those parties with relevant information and with such further information as they request, enters the meetings with an open mind, takes due notice of what is said, and waits until they have had their say before making a decision, then the decision is properly described as having been made after consultation."

43 Unreported, High Court Hamilton, Hammond J, 15 June 1999; Unreported New Zealand Court of Appeal 128 (17 July 2000) Henry J.

44 Based on their 1995/1996 agreements.

45 Section 34 Health and Disability Act 1993.

46 The final terms of the various contracts were not at issue.

47 The rate of return mutually advocated in the working group meetings was between

Each claim was unsuccessful both in the High Court and Court of Appeal — disappointing some public lawyers' hopes that contracting would radically improve participation in the traditionally non-reviewable "policy" areas such as the determination of pricing formulae. While there was conflicting evidence as to whether the Midland RHA was negotiating to a budget, the Court placed weight on the fact that the matter involved a public body distributing fixed monies. It was clearly essential to the background of the case that Midland had received a budget allocation from central government based on historic cost – from which base it was hoping to improve efficiency. The High Court Judge was direct: the purchaser was not an unconstrained negotiating party, but instead was "perched uncomfortably between central government and the ultimate consumers".[48] Government, he said, was "not going to surrender the field".[49] However "expert" the contesting opinions about the most suitable pricing formulae might be, they would always be subject to political and other adjustments.[50] Behind the private law form is a pure exercise of public power.

Whatever the quality of contractual and other participation for the plaintiff providers, they are not always good proxies for patients. Consumers and citizens did not seem to be consulted at all on this model. As a result of the negotiations, some rest homes were paid an increase on former years, and funding of the remainder of the services was rationed – prompting Hammond J to remark that:[51]

> Essentially this was achieved by leaving more elderly people in their homes who may previously have been admitted to residential care. The lesson is salutary: it is the public who suffer when the contractors in this sector fall out.

These difficulties may be most acute during the period of transition and undoubtedly the new system has seen an increase in the transparency and defensibility of the pricing process. Moreover, relatively speaking, the transaction costs have not been as high for rest homes as for some other services. Rest homes as a whole have tended to co-operate, negotiating many contractual provisions through umbrella groups.[52] Moreover, information systems in relation to rest homes were relatively advanced, due to the informal contractual arrangements already in place prior to the reforms.[53] However, the transaction costs associated with these procedures and this litigation should not be underestimated. It may be that over-heated expectations of providers who anticipate a real meeting of minds, have added to these costs. In other words, contract as "symbol" has been

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13.2% and 14.5%. In the final report on which individual contractual negotiations were to be based, it was set at 10.95%. The Court of Appeal said that the earlier understandings did not give rise to a contract in any legal sense.

48 At p. 32.

49 Ibid.

50 On what basis, for example should the government fund small less efficient rest homes that service remote rural regions?

51 At p .17.

52 This also led to a certain degree of confusion in the Midland case itself, as to whether plaintiffs were arguing on the basis of individual contractual expectations, or on the basis of the broader statutory obligation to consult.

53 See further, T Ashton, "Contracting for Health Services in New Zealand: A Transaction Cost Analysis", (1998) 46 *Soc Sci Med* no 3 357-367.

taken far too seriously. This degree of transparency could have been achieved as a matter of administrative process through a "statutory duty to consult" without adopting the contractual *legal* framework.

(ii) Contract as Subsidy Arrangement

Over half the elderly receiving residential rest home care in the *Midland* case were publicly funded. In many contracts in the health sector, payments for a service take the form of a subsidy means tested to the patient but paid directly to the contractor or provider – often in conjunction with part-charges paid by the patient. These arrangements straddle the public/private divide even more precariously.

There are a number of regulatory elements in this setting: the registration of the rest home, the grading of the services it provides, the conditions under which patients will be subsidised, and the medical and financial needs of patients. These involve a number of complex legal relationships, and a number of different mechanisms which specify quality of care.[54]

In *Director-General of Social Welfare v De Morgan*[55] the government paid a subsidy to certain qualifying patients in residential rest homes by way of a "contractual price for service" agreed with the rest home. The problem was that while termed a contract between the government and the Rest Home ("Rest Home Subsidy Scheme, Agreement with Participating Rest Homes") it also was in the nature of a grant for social welfare assistance. The service price reflected both elements. It was determined by a (non-statutory) schedule based on the dependency and care needs of different categories of patient, and on the difference between what the patient could pay and the service price. It was funded out of the Social Welfare budget. When the Goods and Services Tax was increased from 10% to 12.5% the government attempted to take advantage of a statutory exemption for public authorities "where the consideration for supply of goods or services is in the nature of a grant or subsidy". In the result, the rest home was made to absorb the difference.

While it might be viewed as a subsidy by the government, it did not have that character in the mind of the rest home operator. For the provider's part, the contract had a much more commercial flavour. In the High Court, the matter was seen from the provider's perspective, there being:

> no logical reason why the altruism of one contracting party should pass a tax burden onto the other contracting party, unless that other party is the beneficiary of a charity.

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54 Problematic, for example, is the question of how much information (particularly of a medical nature) about an individual and her eligibility for subsidy should be passed to the funder so that it may verify payments (see *Hobson v Harding* (1995) 1 HRNZ 342). Note also the debate about whether rules or standards achieve the most effective regulation — see J Braithwaite and V Braithwaite, "The Politics of Legalism: Rules versus Standards in Nursing Home Regulation", (1995) *Social and Legal Studies* 4, 307-341.

55 Unreported, Court of Appeal, CA 26/96 Richardson J.

The Court of Appeal, however, allowed the government as purchaser to take advantage of the (government's) intended purpose of the arrangement – to make a welfare payment to patients. The contractual form of agreement was treated as largely irrelevant in this interpretation of the statutory language. The government was not treated like an ordinary commercial party, but rather as the state actor in pursuit of its welfare programme.

There can be little doubt that again the patients – both subsidised and unsubsidised – were the losers under this scenario. A subsidised patient would not under New Zealand law be privy to the contract and therefore not be able to enforce the agreed standard of care. For there to be contractual privity the contract must not be simply to the benefit of a third party but must also evidence intent to confer enforceable rights on that party. Moreover, at least half the patients in the particular rest home paid the full contract price – and were subject to an increase to take account of GST (presumably cross-subsidising the rest). Political accountabilities were obscured – the exemption effectively facilitating a covert benefit cut. Perhaps understandably, the Court of Appeal did not address any of these broader structural concerns.

The subsidy system remains a matter of core government policy and will be properly subject to change. At the same time many residential homes depend on subsidies to remain financially viable. The question is whether adding contracts to this tension has helped any. From the 1960s until the mid-1980s subsidy arrangements in this area were extremely discretionary. Many institutions (as well as patients) depended on ad hoc social security payments. As in *De Morgan*, payments generally took the form of a top-up of the difference between the social security benefit and the fees of a particular rest home – with no upper limit. Of the latter Justice Chambers recently remarked "it is scarcely possible to imagine a broader discretion to pay money".[56] Sometimes (as was apparent in a recent case[57]) these payments were made even in cases where the rest home was not properly registered under the relevant statute. A reluctance to enforce what regulation existed is perhaps understandable given the potential effect on very vulnerable individuals and their families. Moreover, given the degree of reliance in this setting, the public law of legitimate expectation may impose procedural and perhaps even substantive impediments to enforcement in this setting – irrespective of or in addition to the existence of any "contract".[58]

Clearly there were efficiency gains to be made to the subsidy system. In the later 1980s attempts were made to regularise the basis of these payments. Legislation was introduced to provide the basis of a new support subsidy for

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56 *Bettina Rest Home v Attorney-General* (Unreported High Court Auckland 118/95 20 December 1999, C/A 23/00 21 June 2000).

57 *Bettina Rest Home v Attorney-General* (Unreported High Court Auckland 118/95 20 December 1999)

58 See recently, *R v North East Devon Health Authority, ex parte Coughlan* (CA) 2000 WLR 622 in which a decision to close a nursing home was found to be unfair despite a lawful process, because it was an unjustified breach of a promise to a severely disabled individual that she should have a home for life there. The decision was also thought to be contrary to art 8 of the European Convention on Human Rights. Cf. *R v Secretary of State for Education and Employment, ex parte Begbie* [2000] 1 WLR 1115.

disabled people[59], and a funding programme was put in place which provided for maximum rates of subsidy according to the grading of the particular rest homes. At the same time a policy of separating elderly from younger intellectually disabled patients was introduced. In 1993 the then RHAs took over the administration of this subsidy system from the Crown.

The payments continued to be in the nature of a grant overlaid either by standard form contracts or s 51 notices. The former are fairly uncontroversial in terms of their legal status. It is common in the private sector to use standard form contracts or contracts of adhesion – especially to limit transaction costs, to stabilise the incidence of doing business and to reduce the need for contingency funds. Whether special rules should apply to such contracts in order to mitigate the potential for abuse of power is not a question we can enter here.[60] The opportunities for negotiation and participation in such agreements, however, are obviously very limited. Except for increased flexibility (for the purchaser) and decreased transparency (for the provider) a standard form contract differs little from the old regulatory form of standardised agreement which had previously been used in the rest home area.

The s 51 notice is more controversial in terms of its legal status. Section 51 of the Health and Disability Act 1993, requires the purchaser to give notice (publicly or individually) of terms and conditions. Acceptance of the subsidy payment is deemed by statute to be acceptance of those terms and conditions. Such terms and conditions can be changed on notice by the authority.

Does such an arrangement produce a contract? The objection that such a statutorily imposed form of agreement is not a legal contract has been successfully taken in the English Courts.[61] The English Court of Appeal found that there was no contract. Among other reasons given, the Court stated (at 128):

> Contract is essentially an agreement that is freely entered into on terms that are freely negotiated. If there is a statutory obligation to enter into a form of agreement the terms of which are laid down, at any rate in their most important respects, there is no contract.

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59 Initially the subsidy was only available to charitable institutions.

60 For an analysis of the arguments see T. Rakoff, "Contracts of Adhesion: An Essay in Reconstruction", (1983) 96 *Harv L Rev* 1174. For example, Llewelyn proposed a private law solution, Leff proposed a broad programme of legislation coupled with administrative enforcement; Slawson proposed that form terms ought to subjected to a form of judicial review, Kessler analysed the large scale corporation as a social enterprise and Rakoff suggested that contrary to the ordinary law of contract, form terms ought to be considered presumptively although not absolutely enforceable.

61 The controversy arose out of *W v Essex County Council* [1998] 3 All ER 111 which involved a written agreement between a local authority and foster parents about the conditions of the fostering arrangement. In breach of the agreement, the local authority failed to disclose that the foster child to be placed in their care had been accused of sexual offending, and thereby deprived them of the option to refuse to foster him. The child subsequently abused the foster parents' own children.

Whatever objections can be made to this reasoning,[62] such arguments would be harder to make in New Zealand since the amendment in 1998 to add s 51(1)(b) which allows the Authority to enforce the terms and conditions "as if it were a deed". Presumably this amendment was intended to overcome any objections to its contractual force (including objections going to lack of consideration).

For our purposes the point is that the only real element of choice available to the provider is whether or not to participate in the scheme. As such it is in substance and form closer to a conditional grant than a contract. The lesson from *De Morgan,* too, may be that for some purposes, the Court of Appeal may well treat it as such.[63]

In the case of rest home subsidies, such efficiency gains as were made did not depend on adoption of the contractual form but rather on the laying down of rules of whatever legal form. The regulatory effect and benefits could also have been achieved by writing the rules in a legislative form – probably as a form of regulation. Indeed, that would have been more transparent. What efficiency gains were made by the regularising of such arrangements, were probably of a one-off nature.

Indeed, on the contrary, at least as far as the few reported cases are concerned, the existence of the contractual overlay tended to disguise the otherwise highly regulated nature of the setting and to excite litigious expectations – especially where changes in government policy affected the financial status quo of the provider.[64] Once again the litigation was unsuccessful.

(c) Regulatory form over economic function

While the forgoing examples show how regulatory substance tended to prevail over contractual form, government has also at times had the benefit of legal form over economic function. We have already discussed how the imposition by the courts of procedural safeguards in the tendering cases provides a safeguard against the government's abusing its monopsony position. In *Roussel UCLAF Australia Pty Ltd v Pharmaceutical Management Agency Ltd*[65] a judicial review challenge to the procedures of the monopsony purchaser of pharmaceuticals was unsuccessful where, if tendering processes had been adopted in making the purchasing decision, a contractual challenge may well have been successful.

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62 As Brian Coote notes in "Common Forms, Consideration, and Contract Doctrine", (1999) 14 *JCL* 116, importantly the local authority was neither obliged to enter into the agreement with them or to supply them with foster children on demand. Similarly, the intending foster parents were under no obligation to put themselves forward. The only "obligation" in a real sense was in relation to the form of the agreement and the fact that its terms were not freely negotiated. Finding "no contract" in this instance raises doubt about a range of other common form contracts, contracts of adhesion generally and indeed about objective theories of contract. For the classical contract theorist, it is a heresy. On any reading, it is a departure from the ordinary law of contract.

63 It may well be that the law of legitimate expectation, for example, adds a further procedural gloss to notice provisions.

64 Changes to the maximum levels were grandfathered so as to limit the effect on individual patients.

65 (Unreported Privy Council, 30 July 1998).

Again there were elements of the transaction that looked "private". Pharmac is an incorporated company with a purely public function. Its directors are responsible for determining the level of subsidies paid out of public funds to the manufacturers of pre-approved pharmaceuticals. Pharmaceutical companies, in effect, compete with each other for Pharmac subsidisation of their products – there being a close correlation between level of subsidy and volume of prescriptions written and filled. On advice, the directors resolved to reduce the level of subsidy on the antibiotic Rulide by more than half its former level. It was more than 7 months before the same classification took effect for its main competitor.

There was a series of judicial review challenges in this controversy. The point that was eventually considered by the Privy Council was whether Pharmac had acted unreasonably by failing to consider Rulide along with competing antibiotics as a group before proposing the new reference price. Considering one antibiotic without considering its competitor, it was argued, gave rise to procedural unfairness. The case raised the question whether some overriding principle of fairness required equals to be considered equally in these kinds of cases and compelled the decision-maker to avoid conferring on another a competitive advantage. The Court of Appeal and Judicial Committee rejected the view that judicial review notions of fairness had developed so far (notwithstanding the spirited dissent by Thomas J in the Court of Appeal). Indeed, that would have been a large step for the Courts to take in developing the law of judicial review. Judicial review has never been good at assessing competing claims of licensees and of other applicants for limited resources.[66] Quasi-markets like real markets do not ensure equality. And Courts are unwilling to impose too great a procedural burden on administrators. The Courts in these cases do, however, appear to have underplayed the potential for the government proxy purchaser to abuse its economic position.

The case, of course, represents only what minimum standard of process the Courts were willing to enforce on Pharmac. Subsidy processes could and should where practical be made more fair as a matter of administrative design regardless of whether a contractual legal form is used.

6. Lessons for the future

Our analysis suggests that, since the introduction of the quasi-market for health services in 1993, there has been a steady shift away from the concept of a competitive (or contestable) market towards more collaborative arrangements between service providers.[67] There has also been a shift in purchaser/provider

66 See, most recently, *Fleetwing Farms Ltd v Marlborough District Council* [1997] 3 NZLR 257 in which the Court refused to alter the order in which competing appeals about resource consents for similar activities were heard in the Environment Court. But see the off-hand remark in *Fiordland Venison Ltd v Minister of Agriculture and Fisheries* [1988] 2 NZLR 342, 344: "The evidence before the Court did not disclose, however, how it came about that some applications were dealt with before others, nor did Fiordland attempt to mount a case of breach of natural justice in that regard."

67 This was and contrary to what some academic commentators had predicted. See for example, C Flood, (1999) "Contracting for Health Care in the Public Sector"

relationships and in the style of contracts. Contracts have become less complex with standard form templates replacing individualised contracts. The average duration of contract has lengthened and, while there is still work to be done in terms of ascertaining national benchmarks both in terms of service and price, national pricing schedules have replaced negotiated prices for many services. Purchaser-provider relationships have drawn closer and transaction costs have been reduced, albeit at some cost in terms of flexibility and participation.

The abolition of the Health Funding Authority and the merging of the roles of purchaser and provider for publicly-owned health services seem to signal a firm rejection of a contractual model for health services as a means of improving efficiency. The New Zealand Public Health and Disability Act also decidedly rejects as inadequate the ability of the contractual mode to give effect to either "voice" or "choice" and proposes instead that local district health boards will be the primary vehicle for public participation.

The explanatory note to the Bill states that it replaces the "current commercial and competitive model with a cooperative and collaborative approach".[68] Our analysis of the present system suggests that, in recent years, the quasi-market for health services has not operated in practice in a particularly commercial or un-collaborative way. Despite being clothed in the language of the market, contracts have often been used as a means of managing relationships rather than enforcing compliance, and competitive pressures have often been weak. Contracts have worked best as a matter of technique in specifying outputs or outcomes and in quantifying costs.

It is unclear what mechanisms will be used for allocating health resources to providers following the establishment of 21 District Health Boards. At present some large HHSs are completing arduous negotiations over 5 year contracts – 4 years of which are still to be performed. It is uncertain what status those agreements will have under the new regime – for example, as agreements with central government or as administrative guidance. Some mechanism or mechanisms will be necessary for managing relationships, improving service quality and strengthening accountability. However, our analysis suggests that for some services at least, effective management does not depend exclusively on the contractual legal form and that other regulatory methods may be equally effective (including the involvement of the Controller and Auditor General). Different legal mechanisms may well be appropriate for different services.

The potential role of competition among providers under the new system is also not clear. The explanatory note to the Bill (unusually) raises as a concern the prospect of hospitals favouring themselves over external providers.[69] This

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Canadian Business Law Journal 180 who suggested that selective contracting here was likely to be a transitional arrangement on the road to some form of managed competition contracting. Her comments about the arrangements leading to a form of managed care may yet be borne out. In a different context, the United Kingdom has abandoned compulsory competitive tendering at local authority level – see for example P Vincent-Jones "Responsive Law and Governance in Public Services Provision: A Future for the Local Contracting State", (1998) 61 *MLR* 362.

68 Explanatory note to Bill 48-1.

69 Not only does this appear to be possible, but groups of DHBs may also be able to act in anti-competitive ways. Section 44(1)(b) of the Commerce Act 1986 currently

seems to indicate that funding for some services should be contestable. While opening up services to competitive tendering can be very costly, some form of selective contracting by DHBs may be effective for those services where barriers to entry are minimal, especially in relation to new monies.

It may be a truism that regulatory fit depends on context. But in a sector which has been restructured so many times and so radically in the past two decades, lessons learnt from practical experience are easily forgotten. While we were among the critics of the 1993 reforms who suggested that the blanket use of contracts across the whole of the sector was likely to be costly and inappropriate, by the same token, we do not think that blanket regulation is appropriate. Decisions about appropriate regulatory techniques should be made on a service-by-service basis and be reviewed over time as those relationships evolve. As a country we can ill afford change without the careful evaluation of the present system and continuity where it has worked well. Much of that work is still to be done.

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provides that nothing in Part II of the Act dealing with restrictive trade practices or behavioural prohibitions applies to arrangements between interconnected bodies. Section 2(7A) essentially deems parts of the Crown to be not interconnected, with the effect that parts of the Crown presently have to observe the prohibitions in the Act when structuring their dealings between each other. Clause 97 of the NZPHD Bill amends section 2(7) and (7A) to ensure that "transferors" within the meaning of the Health Sector (Transfers) Act are treated as interconnected, and therefore exempt from the Commerce Act under 44(1)(b).Transferors include the Crown, a public health organisation (DHBs, Pharmac, NZBS, and RHMU), a subsidiary of a public health organisation, Health Benefits Limited, and a Crown Entity in which a public health organisation holds an interest.