Submission

ASMS | TOI MATA HAUORA

Submission to the
Productivity Commission's Inquiry into

Enhancing Productivity and Value in Public Services

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ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
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INTRODUCTION

Time and resources have not allowed for this submission to cover all matters on which the Association of Salaried Medical Specialists (ASMS) has a view. It concentrates on some specific issues that affect our members (and, consequently, New Zealand's health system), including an analysis of payment-for-performance schemes involving doctors undertaken as part of an earlier report. The issues covered are:

- Strengths and weaknesses of the current health system
- Contestability of service providers, and patient 'choice'
- Integrating services
- Increased involvement of the private sector
- New commissioning arrangements: the NHS experience
- Payment for performance
- Risks of financial incentives
- Personal health budgets.

We have also commented on three matters not in the inquiry report but which we consider critical to improving outcomes and value in health service delivery;

- evidence-based policy development and evaluation;
- distributive clinical leadership; and
- health funding.

BACKGROUND

1.1 The Association of Salaried Medical Specialists (ASMS) is a union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent more than 4,000 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are in fact members.

1.2 Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

1.3 The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

1.4 The ASMS is an affiliate of the New Zealand Council of Trade Unions.

EVIDENCE-BASED POLICY DEVELOPMENT AND EVALUATION

> *Effective decision-making requires good advice, and that depends on informed use of evidence both in developing policy and in evaluating its effect once implemented. In this way the value of government's performance to the benefit of citizens is maximized.*
>
> Sir Peter Gluckman, Prime Minister's Chief Science Advisor, 2013[1]

Peter Gluckman's report to the Prime Minister on *The role of evidence in policy formation and implementation* drew attention to a 'growing recognition of the critical need to be more rigorous both in the employment of evidence for the development of policy, and in the assessment of its implementation'.

There are numerous examples of health policies being developed and implemented without a firm evidence base and without a built-in evaluation plan. The latest example of this is the current proposal by Capital & Coast, Hutt Valley and Wairarapa District Health Boards (DHBs) to merge and possibly privatise their public hospital laboratories.[2] The New Zealand 'health reforms' of the 1990s which attempted to introduce a market-oriented approach to health service delivery, including new purchasing and contracting arrangements, are also a good example.[3]

The terms of reference for the Commission raise questions as to whether the direction of its inquiry derives from firm evidence or whether it reflects a predetermined political agenda.

The terms of reference include the common-sense observation: 'Government agencies need to know what actually drives poor outcomes and what concrete actions can prevent or alleviate harm.' A logical and valuable focus for this inquiry would therefore be to identify the factors that drive poor outcomes, which would help agencies to make decisions to improve services. However, the terms of reference imply the cause (or at least a major cause) of poor outcomes has already been determined: 'There are significant gains to be made by challenging and improving the way in which social sector agencies identify need and purchase services.'

With regard to the health sector, assuming the 'gains' in question are improved health outcomes for patients and more value for money, the ASMS is unaware of any evidence to support that premise. We agree, however, that significant gains can be made in identifying and addressing *un*met need and health inequalities.

Any recommendations to introduce new purchasing or contracting approaches must be based on robust evidence that they would produce better patient outcomes and value for money than the current model. The evidence should take into account the risks of unintended consequences, the suitability to New Zealand conditions, and recognition that in complex adaptive systems such as

health, what works in one particular service area may not work in another. Any new approach must also include a built-in plan for ongoing assessment and open scrutiny.

STRENGTHS AND WEAKNESS OF THE CURRENT HEALTH SYSTEM

New Zealand's public health system compares well internationally and features some important assets, including:

- A largely single-payer funding system (through general taxation), which enables cohesiveness and continuity, and relative fairness, as well as avoiding the administrative costs associated with privately funded systems. [4] [5] [6]
- A health workforce with standards of practice second to none.
- A district health board model which provides a framework for the integration of services.[7]
- An ability to institute changes and best models of practice more rapidly and effectively than most other larger countries.

No one is suggesting we cannot do considerably better, however. Indeed, it is widely accepted we need to improve the value of the health dollar if we are to meet the challenges facing our health system. These challenges are not unique to New Zealand: increasing health service demand from a growing and aging population, rising public expectations, and the impact of technological advances.

In addition, there are well-documented inequities in access to, and delivery of, health services in New Zealand[8] [9] and specialists are reporting increasing incidence of unmet need, despite ever-increasing workloads. They also report many examples of potential service improvements which are being frustrated by barriers that prevent them from bringing about change.

Our examination of the key issues pertaining to this inquiry has led us to conclude the current funding and purchasing arrangements lack transparency, both nationally through the Population Based Funding Formula and locally through the DHB 'purchasing arms'.[10] Those shortcomings, along with a lack of good data, especially in relation to unmet need and quality of services, means there is poor accountability.[11] [12] [13] In addition, purchasing and funding arrangements seem overly complex (and costly) for a population of 4.5 million, involving about 10,000 contracts annually between service providers and either the Ministry of Health or DHBs.[14] Introducing new arrangements involving more contestability, more provider diversity and payment for performance would exacerbate the current weaknesses.

The following sections comment on specific issues.

CONTESTABILITY OF SERVICE PROVIDERS, AND PATIENT 'CHOICE'

The attempt to introduce a competitive market-oriented approach to New Zealand health services in the 'reforms', which were announced in 1991, came into force in 1993 and were abandoned from 1996, provide valuable lessons on the costly pitfalls of such an approach, especially in a country of this size.[15]

The market model was meant to give patients choice and also be more efficient and effective (though no evidence was provided at the time to support the policy), but it had the opposite effect. The cost of running the new purchasers of services, the Regional Health Authorities, grew by 40% over two years. Contract negotiations dragged on for months into each new financial year, consuming expensive management time. Access to primary care and hospital services deteriorated, waiting lists grew and Crown Health Enterprises, far from making a profit, clocked up substantial debts and required government bail-outs.[16] [17]

The European Health Care Management Association investigated the proposition that market mechanisms increase productivity and found little evidence to support it. They did, however, find evidence that market mechanisms increase costs.[18]

The problem with a market approach in health care at any level, according to one World Bank study, is that the characteristics of health care reflect 'market failure conditions', including:

- There are too few providers to enable competition, creating effective monopolies.
- It is prohibitively expensive for new providers to enter the market and difficult for existing providers to pull out.
- There is insufficient standardisation of quality. Where there is also inadequate monitoring and transparency, quality and safety are at risk.
- Generally, there is a wide knowledge gap between the patient and the service provider, so the patient is highly dependent on the provider for decisions about healthcare treatment. Demand for health services is often uneven and uncertain, raising the need for risk-pooling to spread the financial risk associated with health interventions. (Commissioning organisations - especially those covering 100,000 people or fewer - are likely to struggle if they are responsible and carry the risk for commissioning the entire spectrum of health care for their populations.[19])
- A patient suffering pain or with a life-threatening illness is less likely to 'choose' not to have treatment than a customer for other more optional goods and services.[20]

Market-oriented health system reforms are often promoted as ‘quasi markets’ that are not so much about maximising profits but more to do with attempting to improve efficiency and effectiveness, usually by introducing patient choice between service providers to drive ‘public competition’.

However, the full and unfettered availability of services to allow patients to choose any provider would require a surplus of capacity among public sector providers, thus diminishing effective use of resources, increasing service costs and creating new pressures to increase budgets. A service that offers patient choice also requires high quality information systems. In addition, the tension between centrally fixed budgets and provider competition is that where one provider gains, others will lose out on revenue while the system itself cannot expand to the additional capacity required to offer genuine choice or render problems of quality or inadequate capacity in individual providers. [21]

In New Zealand, these arguments are brought into even sharper focus owing to our small population and shortages of general practitioners and medical specialists, many of whom are approaching retirement age.[22] Virtually all medical specialties, including general practice, are on New Zealand Immigration’s skills shortage lists.[23] With clinical resources spread thinly across much of the country, there is no capacity, both in terms of the clinical workforce and existing information systems, to offer any real choice. Fragmentation of purchasing and providing services would create duplication of effort and lead to reduced economies of scale, which is the opposite direction of current government policy.

> *New Zealand’s small and geographically dispersed population means that opportunities for contestable provision at secondary and tertiary level will be more limited, particularly outside Auckland, with only a single purchaser and a single hospital provider within a geographical area for many services. Using competition to drive improvement may also be difficult at primary care level in low-income, rural areas*.
>
> Treasury, 2014[24]

Fragmentation also results in barriers to the dissemination of best practice in the health sector. Treasury recently described an example of this when an unnamed DHB refused to share a ‘very good’ business case with other DHBs, arguing that it was part of their intellectual property. As Treasury pointed out, questions are often raised by DHBs about what a good business case looks like, and to date there are limited examples of health sector business cases prepared under the Treasury’s Better Business Case format. The sharing of this business case would have been of great benefit to other DHB services.

Rather than fragmenting services by attempting to pit one against another, collaboration and cooperation through initiatives such as clinical networks are critical to maintaining safe and viable services. Improving integration, both within health and across health and the wider social sector, has

been identified by the Ministry of Health as one of four key areas to focus on to better equip the New Zealand health and disability system for the future.[25]

INTEGRATING SERVICES

Integrated health services are considered a solution to the challenge of maintaining the accessibility and integrity of health care around the world. One common aim is to achieve better economies of scale and therefore greater value for money. However, researchers have struggled to find high quality, empirical studies providing evidence on how integrating health services can improve cost-efficiency of service delivery. There is no universal definition or concept of integration, and a lack of standardised, validated tools that have been systematically used to evaluate integration outcomes. This makes measuring and comparing the impact of integration on systems, providers and at patient level challenging.[26] [27] [28]

The literature does not contain a one-size-fits-all model or process for successful integration, nor is there a firm empirical foundation for specific integration strategies and processes.[29]

Moreover, because of the complexities of health systems and the multiple contextual factors that have to be weighed up, integration of health services has proved an elusive goal for many policy makers around the world. As one commentator put it, there is an online graveyard of policies and programmes that, over the years, sought to bring about integrated health care. New Zealand's Ministerial Review Group, in discussing primary and hospital integration, observed that despite 'significant investment' from most of the major OECD countries, no jurisdiction has discovered the ideal model for integration.[30] [31]

One recent study which provides a summary of published reviews on the economic impact of integrated care approaches (and found the evidence inconclusive), questions whether 'integration' should be considered an intervention or whether it should instead be interpreted and evaluated as a complex strategy that involves multiple changes at multiple levels.[32]

The literature is clear that organisational integration does not necessarily lead to integrated care at the patient level (which is necessary when the aim is to improve patient health outcomes).[33]

A study of the experience of mergers and integrated care in Quebec concluded: 'Policy-makers and health care organisation executives often believe that organisational integration leads to, or even equates with, integrated care. This assumption doesn't hold true in practice.' The study found that merging organisations could not facilitate integrated care unless they were desired by all players and involved all players in an appropriate way to deal with service problems, otherwise they triggered conflicts and mistrust. [34]

Empirical studies in Sweden and Britain show that conflict of values, mistrust and opposition from various stakeholders are chronic features of top-down forced mergers, particularly when they are seen as simply attempts to cut costs.[35] [36]

Another major study, which draws lessons from seven international case studies on integration, found that while there were potentially some advantages in having a unified organisation – for example, single budgets and clear lines of accountability – the evidence from the case studies indicated a great deal of time and effort is required to merge organisations, and they were more vulnerable to 'top down' interference, which was identified as a barrier to integration. The study, echoing other international studies, suggests integrated care is possible only if it comes from the 'bottom up' through the development of specific 'micro-level' interventions by a small number of providers. 'Organisational integration then comes as a consequence rather than a cause, and may not occur at all.'[37]

Where integration does appear to have produced benefits (in terms of quality of care and patient satisfaction, rather than any economic effects), it has tended to involve programmes initiated by clinicians and often focused on particular patients groups or specialties, such as through clinical networks. Big is seldom better, and imposed decisions rarely bring cooperation among potential partners.

Intuitively, integrating services ought to improve economies of scale and cost-effectiveness, but it may not necessarily be cost saving if, for example, improving quality and safety and maintaining good access to services in the face of increasing demand are taken into account.

Further, research shows that attempts to achieve economies of scale and greater cost-efficiency through a top-down directive can be counter-productive, especially when the real aim is actually to cut costs.

Canterbury DHB's incremental moves to better integrate hospital and community services over the past six years or so is, according to one analysis, one of 'a small stock of examples' where integration appears to have resulted in some measurable positive changes.[38] More services are now provided in the community, and acute admission rates have dropped while average length of stay and readmission rates for both elective and acute surgery have also dropped. Moves to better integrate services, however, 'have not demonstrated that it is possible substantially to shrink the hospital'. Further, 'amid the welter of initiatives that Canterbury has taken, it is impossible to unpack their individual impact… [and] there is very limited cost/benefits analysis available for the various programmes'.

Notably, the process at Canterbury involved a number of different initiatives developed and implemented 'from within, by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli…' Clinical leadership was 'not focused on just a few heroic individuals in formal leadership roles,' but was shared and distributed as a collective responsibility.

Lack of transparency on some financial details raise questions as to the cost-effectiveness of the Cantebury model.

What is clear from the literature, however, is that organisational ‘integration’ involves upfront costs. It is a ‘marathon’, rather than a sprint (in fact it is commonly viewed as a continuing process); and it is challenging to implement, even when it is a ‘bottom up’ process, let alone when it is an imposed directive.

INCREASED INVOLVEMENT OF THE PRIVATE SECTOR

There is little robust evidence available on the cost-effectiveness of private health services compared with public services, due in part to variations in the services provided, the way data are collected and measured, and a lack of openness due to commercial sensitivity of some basic information.

Lack of transparency has been identified as a major problem in attempting to evaluate private health service providers as well as public-private partnerships (PPPs[1]) in health services, including joint ventures that may involve organisational mergers or integration.[39]

The available evidence, however, does not support private provision over public provision. And if organisational integration of health services has proved difficult regardless of whether it is in the private or public sector, attempts to integrate public and private health organisations, adding an extra layer of parallel for-profit requirements, can significantly complicate the process.[40] [41]

> *Public-private partnership projects (especially those with integration of clinical services) will fail in most countries unless there is buy-in by the clinicians, and by the wider political environment. This issue is still more emphasised when transforming an existing state facility into a private sector one, and if the public and private sector … staff management practices differ significantly.*
>
> Report to the European Union, February 2014[42]

A catalogue of safety, quality and financial issues arose following the establishment of a joint venture between the multinational Serco and the laboratories of two NHS hospitals, Guy's and St Thomas's (GSTS) in London in 2009. A GSTS performance review in 2010 noted an increase in clinical incidents, 'some of which could have had serious consequences for patients' and remained of 'some concern'. In 2011, however, the not-for-profit research group Corporate Watch detailed 400 clinical incidents.

Clinical failures were matched by a slide in finances. GSTS accounts show it lost £5.9 million in 2011 owing to higher than expected laboratory costs.

In May 2013 senior managers admitted they had underestimated the challenges of running the service and acknowledged clinicians' frustrations. A report by the Care Quality Commission the following month said GSTS was not compliant with the regulation to ensure staff were properly trained and supervised.[43]

In New Zealand, safety and quality issues arose soon after the private company Labtests (owned by Healthscope, one of the bidders for the Capital & Coast, Hutt Valley and Wairarapa DHBs' services),

1 Public-Private Partnership (PPP) refers to forms of cooperation between public authorities and the world of business, which aim to ensure the funding, construction, renovation, management or maintenance of an infrastructure or the provision of a service.

took over community laboratory services in August 2009 from another private provider, Diagnostic Medlab Ltd, which had a long-established relationship with the DHB. Within weeks the Health and Disability Commissioner was receiving complaints 'thick and fast' about Labtests' services, indicating he was concerned about public safety. [44] Labtests was evidently unable to cope and ended up shifting the high-cost, unprofitable anatomic pathology back to the DHB, while keeping the highly mechanised, high-volume, high-profit work.

A similar creaming of low-cost profitable work has occurred in Northland, with the DHB being left responsible for high-cost anatomical pathology.

In the Auckland case, one private company was taking over from another (and involved a long and expensive legal battle costing the Auckland DHB millions of dollars). The case provides another example of an under-estimation of the task of taking over a complex service, and recognising the importance of engagement with clinicians on the ground, even without the additional challenges of attempting to integrate with another organisation. It also highlights the extent of the fallout that can occur when staff are suddenly expected to switch allegiances to another organisation, which would occur in a contestable provider environment.[45]

Similar issues arose in the MidCentral DHB's organisational integration of laboratory services, where 'Cultural differences in staff from the community and hospital laboratories were very difficult to manage in a combined workforce. Years were required to build up a shared culture.'[46]

There is a dearth of good quality evidence on the cost-effectiveness of public-private partnerships (PPPs). However, an independent 'expert panel' set up by the European Commission to provide advice on effective ways of investing in health, reviewed a range of PPP models internationally and found no evidence they were any more cost-effective than the traditional forms of publicly funded and provided health care.[47]

On the contrary, 'various reports show that PPPs have been more expensive in the long term'. The panel's analysis points out that while PPPs may offer a private financial source to accelerate investment, PPPs do not eliminate a public budget fiscal constraint. Eventually the state has to pay, and this can be at a higher cost for taxpayers because generally the public sector can borrow more cheaply than the private sector.

The expert panel suggested that in order to compare the cost-effectiveness of projects procured via PPPs and those procured via conventional regimes, answers to a number of basic questions were needed:

- Will the cost of borrowing be lower?
- Will the total cost of construction and/or management of the facility be lower, when compared to traditional public procurement (assuming the same functions)?

- Will functions improve at the same or lower cost, compared to traditional public procurement?
- Will health service productivity be higher, for example measured as cost per hospital episode or physician visit?
- Will cost-effectiveness in terms of cost in relation to health outcome be improved?

NEW COMMISSIONING ARRANGEMENTS

The terms of reference direct the Productivity Commission to examine 'emerging new commissioning arrangements both internationally and in New Zealand'. That and the statement 'New Zealand can benefit from the experience of countries such as the UK' suggest the recently introduced commissioning arrangements in Britain's NHS will feature in this inquiry.

Assuming that to be the case, the ASMS agrees New Zealand can indeed benefit from the UK's experience – by avoiding making the same expensive mistake.

The development of commissioning in the NHS in England over the last 20 years has been described in one report as 'something of a saga of great expectations and disappointing results'. Despite experiments with a number of different organisational forms and structures (GP fundholding, total purchasing, primary care groups, primary care trusts and practice-based commissioning to name a few) and substantial investment in commissioning arrangements, research has shown marginal benefits at best.[48]

Commissioning forms part of the NHS 'internal' or 'quasi' market policies which aim to promote competition among providers in the hope of decreasing cost and improving efficiency and quality. A large-scale literature search on the effectiveness of these policies show they have not been proven to bring about the beneficial outcomes that classical economic theory predicts of markets, including provider responsiveness to patients and purchasers; large-scale cost reduction; and innovation in service provision. Evidence on the impact on quality of care is mixed, and while there have been some some signs of improved access for patients and increased provider efficiency, confounding factors (such as simultaneous increases in funding and pressure from enforced targets), along with weak monitoring strategies, make attribution to market policies alone doubtful.[49]

With the introduction of the highly controversial Health and Social Care Act (2012), the commissioning landscape was radically changed, without any evidence that the new arrangements – which open the way for much greater private company involvement – will perform any better than the previous model. There are indications it could be significantly dearer to run.

There are now 211 Clinical Commissioning Groups (CCGs) across England, responsible for £65 billion of the £95 billion NHS commissioning budget (the money to procure health services).

Each CCG, composed primarily of GPs, has a fixed budget to buy services for all the patients in their area. NHS-run services now have to compete with private companies for NHS funding to provide these services. Because most GPs do not have the time or skills to plan or buy health services, much of this work is provided by 17 Commissioning Support Units (CSUs). These not only manage things like human resources, pay roll issues, and patient involvement, but also play an important role in

service design and commissioning. Significantly, CSUs are due to be privatised by 2016, when they will compete among themselves to provide services to CCGs.

There are similarities in these arrangements with those of the attempted New Zealand market reforms of the 1990s, when Regional Health Authorities (RHAs) were set up as the purchasing agencies which could contract for services from competing public and private service providers. The NHS changes in England have gone further, however, since unlike New Zealand's RHAs, which were government organisations, many of the GP practices – and therefore many of the CCGs – are now run by private companies.

In addition, in a scheme worth £5 billion, NHS England has commissioned private companies to advise CCGs on aspects of their work including handling patient data, negotiating hospital contracts, and outsourcing services to the private sector. The companies will compete against or form partnerships with the 17 CSUs, which alone employ nearly 9,000 staff, designing health services and providing back office IT, procurement and payroll services to CCGs. [50]

The complexity of this restructured system is seen as a likely magnet for competition lawyers and transaction costs are estimated at 30p of every £1 spent.[51] [52]

PAYMENT FOR PERFORMANCE

> *Pay for performance may mark a naive understanding of the complexity of human motivation.*
>
> Don Berwick[53]

Reviews of the literature and methodological issues raise as many questions as answers on the subject of payment for performance for doctors. On the other hand, a number of studies identify significant risk factors.

Two decades ago American author and educationist Alfie Kohn noted: '[It] is difficult to overstate the extent to which most managers and the people who advise them believe in the redemptive powers of rewards.' He described how the acceptance of 'pay for performance' schemes were so ingrained in management practice that it was very difficult even to begin to challenge the concept, let alone describe alternatives, even though there was little hard evidence to support claims for the effectiveness of such schemes.[54]

Two years later, in 1995, prominent American health administrator Don Berwick stated in a trenchant editorial 'The Toxicity of Pay for Performance':

> *The best answer I have yet found regarding merit pay for doctors or any group of workers; namely, 'Stop it'. Merit pay, 'pay for performance' and their close relatives are destructive of what we need most in our health care industry — teamwork, continuous improvement, innovation, learning, pride, joy, mutual respect, and a focus of all our energies on meeting the needs of those who come to us for help.*[55]

Nevertheless, 'pay for performance' (P4P) schemes and their close relatives have become increasingly common, mostly in the private health sector and primary health services, and especially in the United States. Despite being the subject of numerous studies, however, their effectiveness remains as uncertain today as it was in the 1990s.

A major review of the literature and methodological issues, published in 2000, identified significant shortcomings in the research up until then. [56]

First was the question of robustness:

> *The effects of financial incentives have usually been described from observational studies: simple data collection, time series, opinion polls, prospective studies, intervention studies without a control group, models, literature reviews, but seldom from randomised controlled trials. …Of the many studies published on the impact of financial incentives on physicians and patient behaviour, few met the basic criteria proposed by*

> *the Cochrane group on professional practice. Furthermore, the results presented were often preliminary over a short follow-up period. Few studies used the same methodology to assess the impact of the same incentive, which limited the external validity of their conclusions.*

Second were the confounding factors:

> *Different results for the same incentive were found, depending on the type of health professional, institution or patient treated. With regard to the type of patients being treated in their practice, physicians reacted to incentives differently depending on: number and type of diseases, whether they are acute or chronic, whether diagnostic or therapeutic procedures are performed, patient sex and ability to pay. Other factors affecting physicians' responses to incentives were demographic and organisational: age, sex, experience, qualification; individual versus group practice, size of the hospital department or group practice, number of different institutions where the physician practised, level of local competition, volume of activity.*

Third were the risks that go with financial incentives, the major one identified being the potential 'conflict of interest between the physicians and the patient.'

As George Bernard Shaw put it: 'That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair…'

The problem, according to Shaw, was that the profit motive and encouragement of doctors to become entrepreneurial create the wrong incentives for good medical practice.[57] At a national level such incentives have also proved costly, as apparent in the United States.

Lastly are questions on the transferability of incentive programmes from country to country:

> *The possibility of using financial incentives, and the type of incentives used, is directly dependent on the structure and financing mechanisms of a health care system – the socioeconomic and cultural context. Thus, both the experiments made with financial incentives in one country and the results obtained may not be reproduced straightforwardly in another country unless major structure reforms are undertaken.*

Since that literature review a number of studies have indicated improvements in service performance through the implementation of financial incentive schemes, as outlined in the following examples.

In 2009 a literature review of physicians' remuneration models found evidence that P4P increases the quality of care, but with caveats:

> *…it is important to note that the framework for assessing quality benchmarks can impact how physicians report on quality criteria. For instance, in the P4P frameworks in the United Kingdom, physicians can purposely increase their quality score by selectively excluding patients in their practice.*[58]

In 2006 a financial incentive scheme was introduced in a large American hospital to encourage doctors to use health information technologies (including a new electronic medical record system and electronic radiology ordering system), and to adopt other, department-specific quality and safety measures. The scheme, which cost more than $6 million in its first year, offered rewards of up to $5,000 annually for physicians who met set goals. A report on the scheme showed that it led to increased use of these technologies and to other quality and safety improvements (though they are not specified).[59]

A study assessing the effect of financial incentives on the care for diabetes patients in GP practices in the United Kingdom between 2000/1 and 2006/7 indicates improvements in the recorded quality of care in the first year of incentives (2004/5). While these improvements included some measures of disease control, most captured only documentation of recommended aspects of clinical assessment, not patient management or outcomes of care. Improvements in subsequent years were more modest. [60]

A 2012 study on 30-day in-hospital mortality among patients admitted for pneumonia, heart failure, or acute myocardial infarction to 24 hospitals in Britain's NHS found modest reductions in mortality rates after the introduction of a P4P scheme, which included a range of quality improvement activities.[61] Bonuses totalling about $10 million were paid to hospitals during the 18-month period of the study. These bonuses were then allocated internally to clinical teams based on their performance. Importantly, the bonuses could not be taken as personal income but would be invested in improved clinical care. In addition, quality improvement strategies included the use of specialist nurses and the development of new or improved data collection systems linked to regular feedback about performance to clinical teams, and staff from all participating hospitals met to share problems and learning.

In contrast to the findings of this study, an earlier version of the scheme, implemented in the United States, found little evidence of an effect on hospital performance outcomes. The researchers of the NHS study said this reinforced a lesson learned from other studies that the details of incentive schemes and the context in which they are introduced may have an important bearing on their outcome. That said, they concluded: 'We cannot be certain from these results what caused the reduced mortality associated with the introduction of financial incentives for hospitals in England…'

Other recent studies have found no positive effects from financial incentive schemes.

A major study published in 2011 on the effects of financial incentives for GPs on the quality of care and outcomes among British patients with hypertension found no benefits for patients.[62] The study involved nearly 500,000 patients over seven years, from 2000 to 2007. A P4P scheme was introduced in April 2004 linking a portion of GPs' payments to measures of health care quality. The researchers looked at various measures, including blood pressures over time, rates of blood pressure monitoring, and hypertension outcomes as well as illnesses. Even after allowing for variations, their analysis showed no identifiable impact on incidence of strokes, heart attacks, renal failure, heart failure or death, either in patients who started treatment before 2001 or in those who started treatment around the time when pay-for-performance targets were launched.

The researchers commented:

> *Effective alternative approaches to improving quality of primary care for hypertension exist, such as case management or co-management of hypertension and other chronic conditions with allied health professionals such as nurses and pharmacists. Furthermore, evidence from studies of educational interventions suggests that fewer, simpler messages are more likely to achieve behaviour change than more complex, diffuse messages. Perhaps the resources devoted to pay for performance for hypertension would be better spent on implementing these interventions more widely.* [63]

Another study, published in 2010, involved a network of publicly-funded primary care clinics in the United States. Physicians in six of 11 clinics were given a financial incentive twice the size of the current Centres for Medicare and Medicaid Services' incentive for achieving group targets in preventive care that included cervical cancer screening, mammography, and paediatric immunisation. They also received productivity incentives. Six years of performance indicators were compared between 'incentivised' and 'non-incentivised' clinics. The study found 'there were no clinically significant differences between clinics that had incentives and those that did not'. [64]

A working paper published by Rand in 2009 used data from published performance reports of physician medical groups contracting with a large network health maintenance organisation (HMO) to compare clinical quality before and after the implementation of P4P, relative to a control group. The authors considered the effect of P4P on both rewarded and unrewarded dimensions of quality. They could not find evidence that a large P4P initiative resulted in any major improvement in quality.[65]

For the most part, however, research on the effects of financial incentives on doctors over recent years is inconclusive.

> *Although there is great interest in moving to episode-based payment and performance measurement, the proposed applications remain largely conceptual. Only a handful of real-world experiments have been completed or are in the early stages of implementation.*
>
> Health Affairs 2009 [66]

> *Little formal evaluation of hospital P4P has occurred, and most of the eight published studies have methodological flaws… There is a need for more systematic evaluation of hospital P4P to understand its effect and whether the benefits of investing in P4P outweigh the associated costs.*
>
> American Journal of Medical Quality 2009 [67]

> *Despite the popularity of these [financial incentive] schemes, there is currently little rigorous evidence of their success in improving the quality of primary health care, or of whether such an approach is cost-effective relative to other ways to improve the quality of care… Implementation should proceed with caution and incentive schemes should be carefully designed and evaluated.*
>
> Cochrane Library 2011 [68]

> *It's not yet clear, however, whether incentive schemes, particularly those aimed at improving the processes of care, will result in improved patient outcomes and so justify the cost of implementing them…. Although the framework produced rapid changes in behaviour, particularly with respect to improvements in processes, the system is costly. Total annual expenditure on the scheme is around £1bn, and the relation between some of its performance targets and population health improvements has been questioned. Evidence is also emerging that setting targets for some areas may have reduced performance in other areas of the service. Overall, the health outcomes may not have been sufficient to justify the substantial opportunity cost of the system.*
>
> British Medical Journal 2010 [69]

A paper summarising evidence about P4P effects, obtained from studies published between January 1990 and July 2009, found 'the effectiveness of P4P programmes implemented to date is highly variable' and 'the scientific quality of current evidence is still poor'.

> *P4P introduces one type of financial incentive, but does not act in isolation. Other interventions are often simultaneously introduced alongside a P4P programme, which*

might lead to an overestimation of effects...Current P4P studies only provide some pieces of this more complex puzzle.

BMC Health Services Research 2010 [70]

An unpublished paper on a Waitemata DHB pilot programme for selected elective surgery services, which included individual financial incentives for privately contracted doctors, was inconclusive on whether incentive-based contracts contributed to improvements in operating theatre performance. It observed that their 'effect on other [operating theatre] staff, on opportunity costs, and on long-term efficiency are unknown'.[71]

A later published paper on the Waitemata DHB pilot echoed other studies' findings that because the pilot introduced many changes simultaneously, 'It is unknown which of these factors contribute the most to the process and cost improvements; that is, which can be considered intrinsic to the model and which confounders.' [72]

Further, the claims of 'cost improvements' in the above study were questioned on the grounds that 'apples and oranges' comparisons were being made with the standard model of care. The latter, for example, include training responsibilities for future surgeons and anaesthetists, which can significantly increase the average length of time of operations (and therefore costs), whereas the pilot excluded training responsibilities.[73] [74]

An overview of reviews that evaluate the impact of financial incentives on health professional behaviour and patient outcomes, published by the Cochrane Library in July 2011, concluded:

Financial incentives may be effective in changing healthcare professional practice. The evidence has serious methodological limitations and is also very limited in its completeness and generalisability. We found no evidence from reviews that examined the effect of financial incentives on patient outcomes.[75]

An editorial examining the evidence on the effects of financial incentives, published in the *BMJ Quality & Safety Journal* in 2005, says the evidence suggests 'incentives do not induce the rational and predictable response that some observers would have us believe', and offers some insights as to the reasons why.

Firstly, the size of an incentive does not have a linear relationship with its impact. Indeed, there is some evidence that doctors may have a target income – perhaps a fixed sense of financial worth – above which they are no longer motivated to respond. Secondly, it also appears that the economic component of what appears to be a financially based incentive scheme is not what motivates professionals. In a local improvement project in the UK, much vaunted as a 'successful' example of incentivising quality improvements, the costs to some of the participating general

practices of implementing more effective systems of chronic disease management were greater than the resulting financial rewards. This did not seem to dampen the enthusiasm of those involved. Similarly, in a study conducted in Ireland, incentives to change prescribing behaviour were just as effective in dispensing practices (where there is a countervailing incentive to dispense expensive drugs) as in non-dispensing practices. These examples indicate that something more than personal financial gain is driving professional behaviour.[76]

In summary, the question whether explicit financial incentives improve health service cost effectiveness or quality remains largely unanswered, despite their use over many years. As the authors of one literature review concluded: 'Perhaps they [financial incentives] should be treated analogously to experimental therapies and only be used within the context of rigorous evaluations to determine their impact on health care quality and resource use.'[77]

RISKS OF FINANCIAL INCENTIVES

While the effects of financial incentives – negative or positive – remain unclear, there is good evidence of the risks associated with such incentives, the major one identified being the potential conflict of interest between the physician and the patient, which can lead to unintended consequences. At a national level such incentives have also proved to be extremely costly, as evident in the United States, the most expensive health system in the world which also has arguably the most entrepreneurial medical system in the world.

Conflicts of interest can have various negative effects.

Compromising quality

The quality of care to the patient can be compromised.[78]

A study of a large P4P initiative in the United States shows that, rather than encouraging providers to shift resources toward quality improvement more generally, P4P may instead only persuade providers to focus on narrow, incentivised areas. [79]

This result casts doubt on the promise of P4P as a transformative mechanism for improving the general quality of the healthcare system, and suggests caution in moving ahead with P4P and in interpreting the results of future studies.[80]

A 2008 Ministry of Health-commissioned review of major joint orthopaedic services and cataract extraction acknowledged a similar issue.

> *As often is the case, success can have its unintended consequences. For example … the increase in service level for specific conditions has created different inequities as some people, with other conditions and higher levels of need, remain untreated; firstly as a direct consequence of the focus on treating joint replacement or cataract patients and, secondly, through a more general effect of 'crowding out' other services drawing on the same limited hospital resources, eg specialist time or physical facilities.*[81]

The review also noted the service imbalances described above 'have generated deep concern from many clinicians that this undermines their ethical responsibilities and the principles of fairness which are core to elective care'.

In the case of Waitemata's pilot study, service outcomes focused mainly on throughput (of hip and knee replacement surgery cases) and failed to adequately measure quality and effectiveness of care. Key post-operative outcomes were not measured, such as joint function, quality of life, GP consultations, disability rating and complications not requiring hospitalisation.

A study of the pilot (the main author of which was involved in developing and promoting the pilot as part of a business case for government funding for a new elective surgery centre) claimed in its title that the pilot improved quality of care. This was argued on the basis that patients in the pilot were less likely to receive community physiotherapy and occupational therapy than standard care cases, though the study conceded 'there has been no examination of the reasons for the difference'. Generally, patients who have hip or knee replacement surgery benefit from post-operative physiotherapy, so if patients having surgery at the pilot site had not been accessing these services in the community they may actually have had worse outcomes in terms of mobility.[82,83]

Further, patient discharge data for hip and knee replacements at the DHB show a marked drop in the number of complex cases during the year of the pilot study. Other high-level elective surgery data also suggest the 'package of care' introduced through the pilot contributed to a growing inequity in the provision of services between orthopaedics (ie, the musculoskeletal system) and other surgical departments.[84]

'Cherry picking' and 'lemon dropping'

'Cherry picking' can occur when the service processes are open to 'gaming'. One questionable assumption underlying financial incentive schemes is that measurements of doctors' performance reflects their overall performance and not, for example, their patients' characteristics or their ability to 'game' the system.[85]

Researchers have identified a potential for financial incentive schemes to not only discriminate patients based on the complexity of their medical needs but also on their overall health status, which could increase health care disparities.

> *P4P and public reporting might induce individual physicians and medical groups to avoid patients whom they perceive as being likely to lower their quality scores, particularly if quality measures are not adequately adjusted for the patients' overall health status and perhaps for racial or socioeconomic characteristics as well.*[86]

While P4P schemes generally focus on improving quality, the same argument applies to financial incentive schemes that aim to increase productivity, as illustrated in the United Kingdom's NHS.

In order to increase patient volumes and reduce elective orthopaedic surgery waiting times in Britain, financial incentives were introduced in the form of competition between NHS hospitals and private-sector owned Independent Sector Treatment Centres (ISTCs) – sometimes referred to as 'surgicentres'.

However, studies have shown the policy has led to ISTCs 'cherry picking' low-risk patients while NHS hospitals are treating increasing number of patients who have a higher anaesthetic risk (through a

practice described as ‘lemon dropping’) and are likely to stay longer in the hospital in the post-operative period.[87] [88]

A paper on the Waitemata DHB pilot study highlights the risks of ‘cherry picking’:

> *A potential unintended outcome of the [‘package of care’] is that it may encourage clinicians to increase throughput of less complex cases at the expense of more complex cases, such that population health outcomes could be adversely affected. This criticism could equally be levelled at the design of the national target as this requires an increase in the number of elective surgeries, without any weighting for complexity. Any initiative designed to meet the target is therefore likely to encourage the prioritisation of less complex cases. However, financial incentives have the potential to be especially powerful in stimulating this type of unintended – and undesirable – effect. At both DHB and the national level, the average complexity, and range of cases performed publicly should be carefully monitored to ensure this does not occur.*[89]

In fact evidence of ‘cherry picking’ is provided in an earlier published paper which found the pilot included few patients aged 80 and over compared with the DHB’s orthopaedic patients not in the pilot. A further report, which included interviews with DHB staff involved in delivering elective services, found most interviewees believed the pilot ‘was greatly enhanced by the selection of cases’.[90] [91]

Compromising medical training responsibilities

The ‘apprenticeship’ model of training resident medical officers (RMOs) – the next generation of medical specialists – is a core responsibility of New Zealand’s public hospitals. This training and supervision requires medical specialists’ time and often means medical procedures take longer to perform procedures not involving RMOs. For example, the median operation duration of a supervised trainee in 22 studies was 34% longer than the surgeon. [92] [93]

As mentioned earlier, the exclusion of training responsibilities from the Waitemata DHB elective surgery pilot was seen as a ‘savings’ factor.

The exclusion of training from public hospitals, however, is clearly not an option. Waitemata DHB has attempted to resolve the issue in part by developing a new programme involving simulation training and training ‘outside surgical lists’. No evaluation has been published on the ‘package of care’ but anecdotal evidence from ASMS members indicates at least some RMOs believe they are not getting enough surgical time to gain the skills they need.

The Waitemata pilot illustrates the tension that can be created when financial incentives for medical specialists cut across their training responsibilities. Time is money, especially when the aim of

financial incentives is to improve 'productivity' or value for money (assuming that to mean doing more for less without compromising quality).

The same tension has arisen with attempts to introduce training responsibilities into the private sector. A recent Australian study estimates the additional operating time required to accommodate the needs of trainee surgeons would cost at least $1.2 million per trainee per year to cover private surgeons' lost opportunity costs and private hospitals' lost case payments. The study concludes that it is unlikely surgeons or hospitals will be prepared to absorb these costs.[94]

An unintended consequence of contracting out non-acute publicly funded services to the private sector has been reduced opportunity for training of RMOs and other health professionals.[95] Since England's NHS cataract services have been reorganised into the largely privately provided 'fast-track' model of surgery, for example, 'surgical registrars and senior house officers have had decreased opportunity to perform cataract extractions'.[96]

Costs

The question as to whether any productivity gains would be sufficient to outweigh the additional costs to pay for financial incentives is repeatedly raised in the literature.

> *There is currently little rigorous evidence about whether financial incentives do improve the quality of primary health care, or of whether such an approach is cost-effective relative to other ways of improving the quality of care.*
>
> Fierce Healthcare 2011 [97]

> *Little formal evaluation of hospital P4P has occurred, and most of the eight published studies have methodological flaws… There is a need for more systematic evaluation of hospital P4P to understand its effect and whether the benefits of investing in P4P outweigh the associated costs.*
>
> American Journal of Medical Quality 2009 [98]

> *Despite the popularity of these [financial incentive] schemes, there is currently little rigorous evidence … of whether such an approach is cost-effective relative to other ways to improve the quality of care….*
>
> Cochrane Library 2011 [99]

> *Overall, the health outcomes [of the incentive scheme] may not have been sufficient to justify the substantial opportunity cost of the system.*
>
> British Medical Journal 2010 [100]

And with regard to the Waitemata DHB elective surgery pilot:

> *…The key point of interest for the budget-constrained DHB is whether any productivity gains will be sufficient to outweigh the additional payments made as a result of the clinical contracts on an ongoing basis.*
>
> *Health Policy 2012*[101]

While it appears no evaluation of the cost-effectiveness of the Waitemata 'package of care' model has been undertaken, there is evidence that the cost of the model was increasing from an early stage.[102]

Divisiveness

The introduction of financial incentives in selected orthopaedic surgery services at Waitemata DHB quickly created deep divisions among the clinical workforce.[103, 104]

As a qualitative study for the pilot programme stated:

> *Opinions [expressed in staff interviews] were polarised on the issue of the new model of care …, in particular the financial incentives for surgeons and anaesthetists. Few participants were unconcerned about this issue, and most either strongly supported or strongly opposed it.*[105]

The divisions were due in part because the scheme was seen to be unfair and in part because of philosophical differences. Anaesthetists eventually rejected the incentive arrangement, despite strong pressure from senior management to stay with the scheme, and came to an agreement to work in the 'package of care' model as salaried employees.

The divisiveness that harmed staff relations and no doubt morale at the DHB has been a feature of some other financial incentive schemes.

> *The ineffective implementation of such schemes has led to many studies which have illustrated how such PRP [performance-related pay] or 'merit' schemes are divisive and counter-productive and have introduced bias and discrimination.… In 1994, Alimo-Metcalfe concluded that PRP tended to divide the workforce, create disaffected staff, encourage adversarial relations and kill the desire to take risks, experiment and collaborate.*[106]
>
> *Where there is doubt about the fairness… performance related pay may be divisive and demotivating.*[107]

Particular problems emerge with financial incentive schemes when they apply to the performance of individuals.

Prominent American academic and author W. Edwards Deming described how performance at work is a function of many variables, including the employee, the employee's co-workers, the job, the equipment, the materials, the customer, management and supervision, and the working environment. Thus it is the system, not the individual, which has the biggest impact on performance variance, making fair evaluations of employee performance 'inherently impossible'.[108 109 110]

Edward Lawler, Director of the Centre for Effective Organisations at the University of Southern California, stated that 'It does not make sense to combine a structure that calls for teams with a reward structure that rewards individual performance excellence.'[111]

But aside from the matter of fairness of financial incentives, it is clear from other research that many health service workers believe that performance incentives are wrong and, for some, insulting.[112]

A study of financial incentives in Britain's NHS found, 'A significant minority of participants believed that it was wrong for them to receive incentives to improve their performance. They did the best they could for their patients and were motivated by the vocation of their work. For some it was even insulting to be offered cash to improve performance, whether the offer was individual or team based. Moreover, those sites that opted for a personal cash bonus did not seem to perform better than those that chose to put their "winnings" into an improvement fund.'[113]

This point is especially relevant to Waitemata.

The introduction of financial incentives implies the DHB's poor elective surgery rates have nothing to do with the DHB leadership's evident failure to address increasing acute admissions and, in some areas, staff shortages, but everything to do with a notion that staff are not sufficiently dedicated to their patients and that that dedication can be bought.

There was no indication that the DHB's relatively low elective intervention rates might have been due to staff needing more incentive to work harder. On the contrary, the indications are of staff under high-workload pressure.

Final note

Since the Waitemata DHB 'package of care' model was implemented, elective surgery volumes have increased, but so too have they at other DHBs, which do not offer financial incentives. Waitemata DHB's elective orthopaedic surgery volumes overall, on a per-population basis, are higher than some DHBs but lower than others.

PERSONAL HEALTH BUDGETS

A recent research scan by the Health Foundation in Britain found that evidence on the impact of personal health budgets is extremely weak, with no conclusive proof that they improve health outcomes or save money.[114] There is, however, limited evidence that they foster a greater sense of empowerment. The report included 60 studies, most of which were from the United States, the Netherlands, and Germany but only included literature in English.

In the Netherlands, since 1997 people with disabilities and those who are chronically ill have been able to choose between receiving care in kind through standard providers or holding a personal budget to purchase care that they choose. A paper examining the Dutch literature shows the personal health budgets have been popular but costly, with many people using the programme as a way of paying for their previously received informal, and often unpaid, care. Indeed the Dutch Ministry of Health has argued that it has become unsustainable and access to personal health budgets has recently become much more restricted.[115]

While there have been high patient satisfaction levels with personal budget holding in the Netherlands, there has been no evaluation to examine whether budget holders are getting a comparable level of care from the reduced levels of funding (the value of the personal budget is 25% lower than the equivalent costs of care in kind, on the grounds that there will be fewer overheads); or indeed whether some of the costs are being displaced to elsewhere in the system. Further, research has shown most find the rules complicated and a third found administering the budget and its paperwork difficult. Consequently, there is evidence that parents of young budget holders are better educated, and that budget holders (or their parents) tend to have a higher income and be better able to manage complicated regulations, raising questions about equity of access. The complexity is also a reason why specialised agencies see this as an area of potential growth, which will lead to further cost increases, and there have been reported problems with fraud. [116] [117] [118]

In the Netherlands, it was found that the programme did not stimulate the market as anticipated, and there are longer-term concerns that the programme is driving down the wages of service providers, affecting the nature and quality of provision.[119]

In England, a series of pilots on personal budgets were introduced in 2005 and scaled country-wide in 2012. Evaluations in 2008 and 2012 are inconclusive about outcomes.[120] A more recently published study found there is no evidence, nationally or internationally, to confirm that personal health budgets have improved health outcomes. And there is no evidence to suggest the NHS will save money in the longer run as a consequence of introducing personal health budgets.[121]

Aside from the issues of cost, equity, quality and outcomes, researchers have raised many practical questions about personal health budgets. Among them:

- Does choice lead to confusion rather than clarity?
- What information and support enables people to make an informed choice?
- How do you commission a range of services to ensure that choice is meaningful?
- How do health professionals feel about taking on board patients' preferences, which may not be their own?
- What happens if people choose badly?
- Who should make decisions when a person lacks the capacity to make them for themselves?[122]

In addition:

- What if a personal health budget (PHB) becomes insufficient to cover an individual's healthcare needs, as set out in their care plan? Will he or she have to pay the excess?
- What happens if a service or equipment purchased from a PHB is unsatisfactory or doesn't work? Will the budget holder's budget be topped up to address this?
- Will service users be fully aware of what holding a PHB might involve? For example, the responsibilities of being an employer?
- Will PHBs prove more expensive for the health system than other ways of organising care? For example, the cost of equipment or services bought by an individual may be higher than the same goods or services purchased in bulk by public providers.
- Organising a PHB will involve members of the local health team in assessment, care planning, financial planning, and the monitoring of spending for each PHB holder. Who within the health team has the time or the training to do this, and how much will it cost?[123]

DISTRIBUTIVE CLINICAL LEADERSHIP

> *If progressive policies are to succeed in complex arenas, then moving from hierarchical and command-and-control modes of operating to more lateral network models is a prerequisite... There can be few areas where this is more true than in… improving health.* [124]
>
> Health Development Agency, NHS (2004)

> *Health care that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical.* [125]
>
> In Good Hands (2009)

Many of the attempts around the world to develop more cost-effective ways of delivering health care have been based on traditional rational planning. However, there is growing recognition that complex adaptive systems such as health services do not respond well to rational planning approaches because they neglect many aspects of complexity. Solutions to complex problems require, among many other things, a deeper understanding of unique local conditions, the inter-related and changing relationships of the many parts, and recognition of elements of ambiguity and uncertainty in health care. Big changes can occur from small interventions in complex systems, through inclusive, evolving, non-linear processes.

A proven way of applying complex solutions to complex challenges has been the introduction of a 'clinical leadership' approach to hospital service planning and delivery. Put simply, this is where multi-disciplinary teams of clinicians, usually led by a senior doctor, are supported to use their experience and expertise to improve the quality and effectiveness of the service they deliver. Clinicians, especially senior doctors, know the strengths and weaknesses of their services better than anyone. They, more than anyone, can identify the potential improvements, including the many small changes that can lead to significant gains in quality and efficiency.

The idea of distributive clinical leadership has rapidly been gaining currency internationally and, where it has been allowed to sufficiently develop, has proved successful in improving the value of the health dollar where other approaches have failed.[126] [127] [128]

The importance of distributive clinical leadership has been recognised in two documents: *Time for Quality*[129] and *In Good Hands*. The first is an agreement between the ASMS and the DHBs, and the second is the government's policy advice to DHBs on clinical leadership.

Research on clinical leadership indicates the most effective use of resources occurs when clinical leadership is embedded at every level of the system, not just in formal leadership positions. This is a key aspect of clinical leadership emphasised in *In Good Hands*:

> *Clinical leadership must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board).*
>
> *In Good Hands* (2009)

The commitment to clinical engagement espoused in these two documents is reflected in the report of the Ministerial Review Group (MRG) of 2009, which made several recommendations to secure the development of a strong clinical leadership in DHBs. Clinical leadership has also been identified in the literature as an effective way of achieving better engagement across primary and secondary care services, based on a partnership approach.[130]

Despite virtual universal support for clinical leadership, its implementation and development around the country has been, at best, patchy. Entrenched senior medical workforce shortages and some negative aspects of DHB culture are the major barriers to the development of clinical leadership.

The inquiry's aim of gaining better health outcomes and improved value for money would be far more likely to achieve success by focusing on ways to eliminate the barriers to implementing proven policy approaches such as that of clinical leadership, rather than the focus on purchasing services, where the evidence for improvement is lacking.

HEALTH FUNDING

The Association notes that the inquiry explicitly excludes 'a review of the level of public funds allocated to specific social services…' However, we submit that inadequate funding can have a significant impact on the ability of social services to provide efficient and effective services and the ability to improve service outcomes.

Health funding trends are frequently described as 'unsustainable', yet Vote Health's operating budget has been falling in real terms and as a proportion of GDP over recent years. Health funding is also often portrayed as a cost to society without acknowledging the benefits. The value of recognising health funding as an investment that produces social and economic benefits rather than as a drain on government coffers is reinforced in recent literature.[131]

A major European study, for example, shows government investment in health services achieves significant benefits to a country's economy through the creation of jobs and income. The study, covering 25 European Union countries from 1995 to 2010, evaluated the economic effects of different types of government spending by estimating 'fiscal multipliers' (the extra income generated in the economy for each $1 dollar of government spending).[132]

It found that the multiplier for total government spending was 1.61, ranging from -9.8 for defence to 4.3 for health. These differences appear to be explained by varying degrees of absorption of government spending into the domestic economy. Defence was linked to significantly greater trade deficits whereas health and education had no effect on trade deficits.

The study's authors say there is a widespread consensus that investment in health and education contribute to economic growth in the long term, by creating a healthier, better educated, and therefore a more productive labour force. The study shows that in addition to their long-term benefits, such investments may actually have short-term, positive growth effects.

CONCLUSION

Effective decision-making depends on informed use of evidence both in developing policy and in evaluating its effect once implemented. The available evidence does not support the premise that health outcomes and value for money would improve by changing the current way public health services are purchased. The evidence does, however, indicate significant risks in some of the purchasing models and strategies discussed - directly or indirectly - in the inquiry report, including 'contestability', quasi-market approaches, public-private partnerships, personal health budgets, 'payment for performance' and NHS-style commissioning.

Since the failure of the market-oriented 'health reforms' of the 1990s, successive governments have recognised the benefits of collaboration in delivering efficient and effective health services. The performance of our health system now compares well with other developed countries and is better placed to meet the challenges facing modern health systems today than most of these countries. The evidence indicates there are further gains to be made in further developing and refining collaborative models of health service delivery. Veering down the path of disproven or unproven contrary directions would undermine the making of these gains.

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