New Zealand's health care reforms

Until the election the battle is over image

The possibility that some hospital managers will receive pay bonuses for column inches of good press coverage and penalties for negative news is just one example of a preoccupation with image in New Zealand's recently restructured health service. The term "hospital," with its negative connotations of sickness, has been dropped from new corporate titles in favour of names which provide a more upbeat vision. In one city, ambulances will no longer speed to the emergency department—it has been transformed into "Quick Help."

The government needs positive images of the reorganisation. The plan to restructure was announced two years ago but, with curious political timing, did not take effect until July this year—a few months before the general election in November. In the interim there has been strong professional and political opposition. The minister who masterminded the new structure resigned from the health portfolio this year, saying that he was not a street fighter. His replacement is regarded as a shrewd politician who will be better able to sell the package of reforms.

The reorganisation seeks to address some basic problems. For example, access to health care is unequal. Primary care is not free. Users pay on a fee for service basis and the government provides a range of subsidies. For some people the cost of visits to general practitioners and drugs is a substantial barrier to care. Waiting time for elective surgery depends on where people live and whether they have private health insurance. The previous health system did not meet the needs of the Maori population. Funding of care was fragmented, encouraging cost shifting. Cost containment was difficult, and public health activities lost out to the more immediate demands of acute services.

The government's solution to these problems promotes consumer choice through competition, integration of primary and secondary care, more businesslike management, and individual responsibility for health and health care. It limits central government expenditure and targets assistance to those least able to provide for themselves.

A policy document released in 1991 explains the new health service. As in Britain purchasing and providing care are separated, but unlike in Britain this separation extends to ministerial level (a new minister has been appointed to oversee public hospitals). Funding for primary care, secondary care, and support services for disability is controlled by four regional health authorities. These authorities purchase care from public, private, and voluntary providers, who compete for contracts. Original proposals to make purchasers subject to competition—by allowing dissatisfied consumers to transfer their entitlement to government funding to private health care plans—have been dropped.

People in higher income groups must pay a fee for hospital services that in the past were free. Public hospitals may generate income from private patients; previously this was not possible. New ways of funding primary care, including general practitioner budget holding, are encouraged. Population based services are funded separately through a new Public Health Commission. A national committee advises the government on the core health and disability support services that regional health authorities must purchase. These core services are defined as those to which everyone should have access on affordable terms and without unreasonable waiting time. Public consultation on policy is still required but public participation in management of the health service has ended. The reforms abolish elected boards—all board members of new organisations are appointed.

Enthusiasm exists for the high profile of population based health care and the new opportunities for health promotion and health protection. Substantial support for the changes also exists among those who are keen to develop more innovative ways of delivering primary care. Several pilot schemes are underway. But the proposals to change the funding of primary care have also generated intense opposition from those doctors who fear loss of independence and...
control over the fees that patients pay. Fierce disagreement within the General Practitioners' Association over whether doctors should sign contracts with the new authorities resulted in the resignation of the association's chairman and executive and the election of a more conservatively inclined group. The government retreated on the issue and agreed to continue present arrangements for those who oppose contracts.

Concerns in the public hospital sector centre on the commercialisation of the health service. The secrecy now surrounding management decisions has been heavily criticised as inappropriate for a publicly funded service. Fees for hospital care were introduced earlier than other changes and provided fuel for those concerned about possible privatisation. The strong negative public reaction led the government to abandon the inpatient fees, although charges for outpatient services remain. The full potential of the restructuring will remain untested for the next few months. The problem for the government is that, with no additional money for extra services, any substantial change in the provision of services is also likely to be controversial. The disadvantages of change will get immediate (pre-election) publicity: any gains are likely to become apparent only in the long term (after the election). This may partly explain the current preoccupation with image—the appearance of change is important to justify the costs of the restructuring, but real change, which might upset powerful interest groups, will be avoided until after the election. We do not yet know whether the image will reflect reality.

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# Faecal incontinence

*Childbirth is responsible for most cases*

Continent and defaecation require functional integration of the pelvic floor musculature and its striated, voluntary sphincter muscles; of the involuntary muscle of the internal anal sphincter; and of the smooth muscle in the colon and anorectum. Faecal incontinence has many causes. It may arise from local pathology, such as perineal supppuration and trauma, or as part of the loss of control of bodily and mental function associated with frontal lobe lesions and dementia. Even in otherwise healthy subjects diarrhoea may overwhelm the sphincter mechanism.

In a syndrome analogous to stress urinary incontinence, faecal incontinence may develop insidiously in otherwise healthy women; this syndrome, the most frequent cause of incontinence, is due to denervation of the musculature of the pelvic floor sphincter. Although urinary and faecal incontinence often occur independently, they have common predisposing factors, especially female gender and difficult or multiple labours; their prevalence also increases with age.

In healthy people there is a zone of pressure in the anal canal near the anal sphincter ring, which is due largely to the tonic contraction of the internal anal sphincter muscle and only slightly to the tonic contraction of the sphincter muscle. Reflex contraction of the external anal sphincter, however, is important in maintaining continence during transient increases in intra-abdominal pressure, as in coughing, laughing, or sneezing. The external anal sphincter can also, of course, contract under voluntary control.

Generally, faecal incontinence does not develop after division of the internal anal sphincter, although leakage of mucus and problems with controlling flatus may develop. Conversely, continence may sometimes be preserved in patients with a normal internal anal sphincter but with severe weakness of their external anal sphincter and puborectalis muscles, provided that faecal consistency is also normal. Avoiding damage to the internal anal sphincter is therefore important in patients in whom the external anal sphincter and puborectalis muscles are weakened by denervation, since such damage—which may occur, for example, during an anal stretch procedure—may lead to a worsening of the incontinence. The essential abnormality in patients with anorectal incontinence is that the pressure in the rectum exceeds the pressure in the anal canal long enough for faeces to enter the anal canal and thus to pass through the sphincter zone. In addition, incontinent patients have difficulty distinguishing flatus and stool, evidence of a sensory abnormality in the anal canal.

The pudendal nerves that innervate the external anal sphincter and perirectal striated sphincter muscles, and the direct pelvic branches of the sacral nerve roots (S3-S5) that innervate the puborectalis and intramural component of the perirectal striated sphincter muscles are easily damaged during childbirth. This probably results from stretch injury during elongation of the birth canal and from direct trauma during the passage of the fetal head. Nerve damage is more likely to occur when the fetal head is large, the second stage of labour is long, and forceps are applied, especially if a high forceps delivery is required and if there is a long trial of labour. Even a normal vaginal delivery is associated with electrophysiological evidence of damage to the pudendal nerves, which may last for up to three months after delivery. Subsequent vaginal deliveries may further damage the pudendal nerves, although damage is rarely severe enough for faecal or urinary incontinence to follow childbirth as an immediate complication. Serial measurements of the pudendal nerve terminal motor latency have provided support for the additional hypothesis that progressive pudendal nerve damage occurring in idiopathic anorectal incontinence results from recurrent stretch injury during perineal descent induced by straining at stool.

Faecal incontinence presenting soon after delivery is frequently associated with a tear of the external anal sphincter muscle. Unfortunately, despite immediate surgical repair incontinence often persists or recurs after a few months or more. This sphincter tear is evidence of an extreme form of obstetric injury to the pelvic floor and to its innervation, and the poor result of simple surgical repair to the visible tear is due to unrecognised injury to the innervations both of the external anal sphincter and of the puborectalis muscles.