Introducing competition in the public delivery of health care services

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Introduction

I will spend most of today's address sketching out a model for an efficient and effective health care system. It is a model that can be applied in a range of contexts. It can, for example, accommodate different choices about the degree of social financing of health services and about the degree of government involvement in providing those services. It is also open-ended and flexible in the sense of allowing for a gradualist, step-by-step approach to reform be taken while allowing for continuing structural reforms.

The model I will describe is primarily built around the idea of increasing reliance on the market mechanism in achieving health care outcomes. It achieves this by clearly delineating the different functional roles involved in the health system, creating arm's length relationships between players of the different roles and ensuring that those roles are played out in a competitive market wherever possible. In doing this, it aims provide the incentives needed to ensure:

- greater efficiency in service provision;
- more responsiveness to consumer needs and preferences; and
- an enhanced ability to meet the equity objective of ensuring that people have access to a high quality health service regardless of their ability to pay.

The model therefore follows the same basic philosophy as that increasingly applied over the past two decades to the reform of industries in a range of key sectors including energy supply, telecommunications and transport. Where reform in those sectors has been well-conceived and properly implemented, the benefits in terms of price, quality and output have usually exceeded the expectations of even reform advocates. Given the challenges facing health care in all our countries, the application of these reform tools to the sector is becoming crucial.

The context for reform

The context for health care reform in most Western countries is one in which there is an urgent need to respond to exponentially increasing demands on existing health systems, declining health care affordability and declining satisfaction among populations with the performance of existing systems. Two major factors are driving these problems, and they have become evident throughout the Western world. They are doubtless less immediate concerns in many developing countries, though there too they will increasingly become important.

The first of these issues is technological: new discoveries in diagnostics and treatment are massively increasing the range and number of possible interventions. In contrast to most areas, however, these advances are not reducing overall health care costs. While early diagnosis and treatment, and less invasive procedures may greatly reduce the costs of treating many maladies, the effect is largely swamped by demand for newly feasible treatment options. These often require sophisticated new diagnostic equipment, more complex surgical instruments and/or expensive drugs. In addition, there are costs associated with the fact that new discoveries can render existing treatments obsolete overnight. Thus, the rapid rate of technological progress is creating ever greater pressures on resources as the range of possible treatments expands.

The second pressure comes from the rapid aging of populations that is occurring in all developed countries. Populations are aging both because birthrates are falling and because the average lifespan is being extended. In fact, an ageing population applies two distinct pressures to the healthcare system. On the one hand, the demands of the elderly on health care systems are much greater than those of the young – for example, a 75 year old's health care costs will on average be three times those of a 25 year old. Thus, a rapid ageing of the population will significantly increase the demand for more complex health services.

On the other hand, an aging population increases the "dependency ratio"; that is, the ratio of the number of people outside the labour force to those inside it. In a predominantly tax-funded healthcare system, such as Australia's, this means that a declining proportion of the population is contributing to the costs of healthcare, even as those costs are rising rapidly.

Evident symptoms of these stresses include:

- rising waiting times for surgery, as growth in demand outstrips supply growth and queuing is increasingly used to ration demand;
- Governments increasingly responding to "supplier generated" demand by resorting to supply restrictions;
- diminishing subsidy levels in areas where governments seek to manage demand through requiring "co-payments" from users, and, increasingly;
- limits on the availability of new drugs, as the government struggles to control the costs of its underwriting of the supply of pharmaceuticals.

To these pressures for reform can be added a third: that of the increasing dissatisfaction of consumers who are better educated and more demanding with a system that limits their choices and is structured in many ways for the benefit of service providers, rather than consumers. This can only increase as reforms in many other industries empower consumers

and make them more accustomed to, and comfortable with, making consumption choices in complex areas such as health care.

A reform blueprint

An effective reform process requires that a complete and internally consistent blueprint be articulated from the outset. An explicit blueprint can act as a catalyst for reform as well as a map of the implementation process. Clearly establishing long-run objectives and the steps toward achieving them is essential so that directional consistency across the major agents of change – governments, primary, secondary and tertiary service providers – can be assured. Integration among the different service providers is essential if a comprehensive and co-ordinated system is to be achieved, and this integration requires the clear definition of common goals, so that the various players can clarify their roles in achieving these overarching goals. This directional consistence among players is obviously crucial to ensuring that better care is delivered to consumers, costs are minimised and the affordability of the system is maintained.

An articulated blueprint clarifies long term directions and so provides a basis for proactive planning. In particular, the improved transparency in planning direction that this implies leads to greater certainty for private sector players, thus facilitating their involvement in the system and maximising potential private investment.

Performance dimensions for a reformed health care system

Before embarking on the design or redesign of a health care system, one must have a clear picture of the outcomes that are being sought. A health care system can be evaluated in relation to five key performance dimensions that reflect the expectations and values of the community in this area. They are access, equity, efficiency, quality and accountability. I will briefly explain what each of these implies in turn.

- **Access** means that a wide range of services is made available near where people live, so that all members of the community have physical access to the treatments they require.

- **Equity** means that the system accurately reflects social choices about the minimum acceptable levels of service quality that will be made available to all members of the community, regardless of their ability to pay.

- **Efficiency** has three elements. Technical efficiency means that individual services are provided at the lowest achievable cost and that service provision is sufficiently integrated or co-ordinated to ensure that system-wide costs are also minimised. Allocative efficiency means that resources are devoted to providing the services that people value most highly. Dynamic efficiency means that an optimal long-run path is taken, as the nature and distribution services, as well as the means of producing them, varies in line with demand, technology and other learning.

- **Quality** means that there is a high level of confidence that objectives for service quality are met throughout the system.

- **Accountability** means that service providers and system managers are held responsible for the quality of services provided and for performance outcomes of system elements for which they are responsible.

The reform model: description and analysis

At the outset, I described the reform model in terms of the principle of maximising reliance on market forces and the need to ensure enhanced competition by clearly defining and separating the major roles, encouraging participation by the private sector and ensuring that the regulatory framework was reformed and developed so as to support competitive outcomes and service provision that was responsive to consumer needs and preferences. I will now describe the key aspects of this model in slightly more detail and analyse how it can be expected to improve performance, equity and quality. I will then talk briefly about transitional issues before finishing by answering some of the main criticisms that have been raised in respect of this model

Clarifying different roles in health care provision

A basic precondition for achieving effective pro-competitive reform is a clear understanding of the different roles or functions that are implicit in the health care system and a critical analysis of what roles are best able to be played by governments and by different kinds of public and private sector players. In fact, this role clarity is generally absent, largely as a result of the fact that Governments have to date simultaneously undertaken most of these different roles, in Australia as in many other countries. At present in Australia, Government is simultaneously funder, regulator, monitor, purchaser, owner of assets and also the major provider of services (although these roles are shared between federal and state governments). What are each of these roles?

1. Funder

Clearly, this is the ultimate provider of the money for purchasing health services. It is a role which government assumes to a large degree in virtually all countries, largely in pursuit of equity objectives, though also in recognition of the "public good" aspects of health care. The importance of this distinction, in defining the role of the funder is to separate it from that of the purchaser. The role of funder involves the supply of the resources that drive the system, but does not include the role of choosing what services will be purchased. Of course, the distinction between these roles can be unclear to the extent that government often takes on both, and often does so through the same agencies with little attempt to provide an arm's length separation.

2. Purchaser

The purchaser role involves determining what services will be purchased and in what quantities. It also includes the question of what providers will be engaged to provide those services and on what terms. While governments have often undertaken this role, I will argue that there is no impediment to the role being undertaken by private players. More importantly, as the purchaser role is arguably the one in which the potential benefits of competition are greatest, reform requires that the role must either be taken up by the private sector or, if maintained in the public sector, put at arm's length from government in its role as funder.

3. Provider

Providers are those who deliver the range of health services to the public. This description obviously embraces a very wide range, from individual medical practitioners through to major teaching hospitals that provide training and research as well as supplying a wide range of sophisticated medical and surgical procedures.

4. Regulator

The regulatory function involves ensuring the quality of service provision and of conduct generally by setting and enforcing minimum qualification standards on the different kinds of providers and specifying appropriate rules of ethical and professional conduct. Clearly, a major concern in relation to this role is "regulatory purity", or ensuring that the regulator takes a consistent approach to all service providers. This requires that there is a distance between the role of regulator – which is necessarily a role largely or wholly reserved to government – and the roles of purchaser and provider. From a probity, and ultimately an efficiency, viewpoint the government needs to avoid being a "self-regulator".

5. Monitor

Effective monitoring of outcomes is essential to the long-term evolution of the system, allowing stresses to be identified and resources to be reallocated or structural problems treated. Again, the importance of ensuring a clear separation of this role from those of purchaser and provider is evident.

The role of competition in health care

I will now turn to the question of how competition principles can be applied to health care and how related aspects of system design must be reformed in such a way as to support the ability of competition to achieve the desired outcomes. Firstly, it must be recognised that health care is an industry and that the benefits that competition is generally expected to bring – those of encouraging efficiency, reducing prices, responding to consumer demands and favouring innovation - are crucial here as elsewhere.

Resources spent on health care are necessarily diverted from other uses – uses that are similarly vital to achieving the basic responsibilities of government, such as education, infrastructure development or housing. Therefore, technical or allocative inefficiency in the provision of health services mean either a reduction in the quantity of services that can be provided for a given cost, or a reduction in the funds available to provide other public services. By contrast, the "efficiency dividend" from introducing competition increases the quantity of services able to be provided, whether within the healthcare area or in terms of freeing funds for other uses.

Consumer empowerment is also a powerful argument for pro-competitive reform. More than in virtually any other sector, regulation of health care provision, including professional self-regulation, has robbed consumers of sovereignty. Introducing competition means providing consumers with greater freedom to choose between different services and different service delivery mechanisms. By separating purchasing from funding and regulation it will encourage increased incentives for technical advances and allocative and dynamic efficiency improvements, yielding a much greater degree of responsiveness to consumer preferences. Self-regulatory practices that have developed essentially to serve the interests of service providers will be broken down by competitive pressures. As responsiveness to consumers increasingly becomes the norm throughout the economy, demands for reform in this direction in the health sector will continue to rise, eventually becoming irresistible.

In Australia, as elsewhere where the role of governments as purchasers, providers and regulators has been extensive, recognition of health care as an industry represents a major change in perspective. It is one which is recent and still partial. However, it is clear that health sector reform in a number of countries in which government has historically had the central role has embraced this general direction. These include the Netherlands, Belgium, Austria and the United Kingdom.

One point to make at the outset concerns the relative roles of public and private sectors in the provision of health services. Western governments have historically taken on a high degree of responsibility for health care in pursuit of equity objectives and public goods arguments. This has been reflected in most countries in government taking a dominant position in relation to all of the roles that I have just outlined. However, this is neither inevitable nor, I will argue, is it desirable. Obtaining the benefits of pro-competitive reform requires that arms length relationships be created between different agencies of government that are undertaking different roles, but it also requires a clear-sighted analysis of the effects of greater private involvement in different parts of the system. I am convinced that the outcome of this analysis must be a greatly increased private involvement in health care, vis-à-vis the current starting points in most Western countries.

Competition must be introduced at two levels: there must be competition between providers and competition between purchasers. I will look at each of these in turn, sketching out how competition would work and how competition will improve outcomes by addressing existing problems.

1. Provider competition

Provider competition ensures that technical efficiency is achieved in the provision of individual services or groups of services. It does this by giving providers incentives to reduce the price of services, to increase the quality of services and to better tailor services to

consumer needs. Only by making attractive offers in these terms will they obtain contracts from the purchaser to supply services.

The introduction of provider competition therefore takes an important first step toward achieving consumer sovereignty by eliminating substantially the power of providers to determine what services they provide. Under traditional models, governments have made block allocations for the purchase of a generically defined range of services – for example mental health services, or aged care services. Within these "global" allocations, the choices as to what mix and quantity of services to provide has been left to the service providers themselves. This inevitably means that their incentives to minimise costs by improving operational efficiency are very much blunted. Similarly, they have limited incentives to respond to the preferences of the populations they serve, particularly where doing so may inconvenience the service providers by, for example, changing the mix of skills needed to provide services, or the locations at which they are provided.

Establishing a competitive market for service provision fundamentally changes this dynamic. A first step, taken in recent years in parts of Australia, is the move to a "case-mix" system of funding. This bases funding on an average cost of treating a specific complaint, and thereby provides incentives for adopting the most effective mix of treatments and for providing individual treatments as economically as possible. However, it remains a process in which the government as purchaser sets prices, largely based on historical experience, while providers "succeed" merely by meeting these largely arbitrary benchmarks – in the sense of being able to generate a surplus at the set price levels. Thus, it fails to provide strong dynamic incentives for improved performance and innovation.

By contrast, a fully competitive provider market requires continuous improvement, flexibility and innovation by virtue of the purchaser's ability to confer or withhold contracts. Providers must compete in terms of the price and quality of their services in order to remain in the market. Instead of competing in terms of a pre-determined benchmark, they are bidding competitively against other potential providers of the same services.

2. Purchaser competition

Purchaser competition is essential in ensuring the efficient provision of an integrated range of services across the system – that is, that allocative efficiency is achieved. Allocative efficiency includes ensuring that the range and quality of services provided conforms to the preferences of consumers, as purchasers are required to compete for the business of health consumers by providing an attractive value package in the marketplace. Purchasing reform is probably even more important than provider competition to achieving improved quality and affordability in the provision of health services. However, it is likely that purchasing reform will need to be conducted in stages, with the first step being the distancing of purchasing from the central government. That is, the government would revert to its primary roles of funder and regulator, while purchasing was devolved to locally based agencies.

In the first instance, these agencies would have a geographical monopoly, being the purchasers of all services for populations within a defined area. Competition at this stage is limited to the "benchmarking" type, with the central Government, as funding agency, monitoring the performance of the different purchaser bodies and providing a framework of incentives for improved performance. Over time, the degree of competition can be increased by allowing competition between purchasers across geographical areas. That is, purchasers would need to compete for customers in order to survive and prosper, rather than having a

defined, geographically determined "captive market". Notably, at this stage, the decision as to whether solely to contract services or to manage (i.e. provide) them directly can be left to the discretion of the individual purchasers, as the competition between them effectively prevents any manipulation of market prices to which such relationships might otherwise give rise.

As I have mentioned, a key element of the competitive purchasing model is to ensure separation of the purchasing function from the funding function. This does not imply that purchasers must necessarily be private sector bodies – though there would be likely to be a number of benefits associated with the introduction of private sector expertise to this area. It does, however, mean that any public sector agencies operating as competitive purchasers would need to be established at a clear distance from the government in its role as funder. The possibility of not-for-profit private sector bodies becoming involved as purchasers also exists, with many already being closely involved in many aspects of health care provision.

Ensuring this arms-length relationship between funder and purchaser is essential if purchaser accountability, or value adding purchasing is to result. The distancing of the purchasing function from government, together with the creation of a market for purchasing agents, means that purchasers become accountable to their customers for purchasing choices. Thus, "political" purchasing choices – where considerations beyond those of efficiency and effectiveness intervene – should be minimised and the quality of purchasing decisions improved.

An important benefit of purchaser competition is its ability to improve the level of integration in the provision of services. Co-ordination of care is clearly vital to ensure efficiency and effectiveness. The key reform in this dimension is the move away from a separate funding of the different types of service provision to one of payments to competitive purchasers according to the number of customers they enroll, with a single funding allocation covering provision of all service types. Because the purchaser is responsible for all of its customers' health needs, it has incentives to provide continuity of care. The possibility of vertical integration between primary, secondary and tertiary service providers can also facilitate improved continuity.

Key benefits of a competitive model

I have briefly described how competition can be implemented in the provider and purchaser roles, and indicated some of the key benefits that such a move would bring in relation to the dynamics of each specific area. I would like to add to that briefly by highlighting the expected benefits of the move to a market-based model in terms of the broad outcomes of performance, equity and quality.

Cost

In performance terms, the most fundamental requirement of a sustainable health care model is obviously long-run affordability, combined with the maintenance and improvement of service quality standards in line with consumer expectations. A competitive model maximises affordability by providing strong incentives for both technical and allocative efficiency, as I have described. In doing so, it avoids the imposition of arbitrary or ad hoc rationing decisions

that would otherwise flow from stresses on affordability in a centrally directed model, due to the practical impossibility of providing effective co-ordination and appropriate incentives throughout the system.

The reallocation of roles among system players also implies an optimal transfer of risks. To the extent that private organisations enter the provider market, operational risks are removed from governments and accrue to those best placed to control and manage them. In addition, adoption of the competitive purchasing aspects of the model, in which corporatised Health Improvement Agencies (HIAs) compete to act as purchasing agents for consumers, will allow the risks associated with purchasing to be shifted to these corporatised entities. In the longer term, these risks may be shifted further from government by means of a privatisation of some or all HIAs.

Quality

Several elements of the competitive model contribute to improving quality. Firstly, purchasers will necessarily compete on the basis of quality as well as price, with the resultant major increase in competitive pressure necessarily driving up quality levels. HIAs will also contribute to quality by making more informed purchasing decisions, based on evidence of improved health outcomes.

Secondly, the reforms will enhance quality by improving responsiveness to consumer preferences. Systems in which the choice of what is provided rests to a large extent with the providers themselves are poorly placed to deliver this responsiveness. In the reform model, by contrast, purchasers can ensure provider responsiveness and accountability, through their ability to grant or withhold contracts, while purchasers themselves must satisfy consumer expectations in order to retain their custom, as consumers would be able to choose between purchasers. One aspect of this is likely to be pressure on purchasers to provide better information to consumers on alternatives for meeting their health needs. Thus, consumers will themselves become better equipped to make health choices than at present.

Greater responsiveness to consumer needs should also be favoured in the dynamic sense. Specific articulation of the range of services to be purchased is the first element of this. Because purchasers will makes specific choices among services to be provided, rather than leaving providers to implicitly decide what to provide, greater responsiveness to changes in service needs due to technological change, changes in population characteristics, etc. can be expected. In addition, the use of funding methodologies based on the size of the populations being served will provide better incentives for investments in health promotion and disease prevention as cost-effective means of achieving improved health outcomes.

Equity

Equity of access is a fundamental performance dimension for any health care system, although ideas of equity and means of achieving these outcomes can vary widely. Reform models that emphasise the role of competition, and thus necessarily presuppose increasing private sector participation in health care, are often criticised as risking reductions in access levels. However, it is demonstrable that a properly designed model can maintain and indeed improve effective access levels. One key element is to ensure that the purchasers of services do not have the right to refuse anyone membership, thus preventing attempts to deny coverage

to higher risk/higher cost groups. Funding contracts with purchasers should also specify the range of services to be purchased, to ensure that a wide range of needs are met, while monitoring of the demographic and socio-economic composition of purchasers' customer base can be used. It is also possible to treat this problem directly by providing different per capita funding levels to reflect the expected costs of providing services to different demographic groups.

Finally, the competitive model is also consistent with a range of different approaches, allowing different reform paths to be followed. Further reforms could involve, for example, the role of the HIAs evolving to include that of health insurer. A move to a voucher based system of health coverage can also be accommodated, or a move away from taxation-based funding. The model's flexibility also allows it to deal with the particular problems posed by sparsely populated rural areas. For example, the application of competitive purchasing to geographically based HIAs in such areas could lead to the number of HIA customers falling below an efficiency minimum. This can be circumvented by instead providing a time limited local monopoly to such HIAs, with regular tendering of the HIA contract (say five yearly) being used as the mechanism for ensuring price and service quality outcomes.

Getting from here to there: staged implementation

The adoption of the fully competitive model of health care provision I have outlined represents a very major change from the "starting point" that exists in most countries. It involves all of the players in the system adapting to very different roles and environments and therefore implies some significant transitional risks. In addition, there are transitional risks associated with the shift from one system, with its own logic and controls, to another. Thus, careful attention must be given to the process of implementing reform. The reform path must depend significantly on the starting point. However, I would like to sketch out some of the key steps and considerations that are of general relevance.

1. Create competitive conditions in the provider market

The first steps in a reform process must be to create the conditions for effective competition among providers. This has several elements that must be pursued simultaneously. Entry restrictions, other than those dictated by the need to assure service quality, must be removed. Funding arrangements must be reviewed and redesigned as necessary to ensure that they support the development of a competitive and efficient market in service provision. Similarly, close attention will be needed to the regulatory framework, to ensure that it supports and encourages competition. The starting point in many countries is one in which professional regulation has been left in the hands of the professions themselves, in the name of professional independence. This has an unsurprising tendency to lead to a proliferation of anti-competitive provisions, often masquerading under the guise of "ethical" or "professional conduct" rules. A careful reconsideration of the degree to which this notion of "professional independence" can be reconciled with the development of a competitive market is therefore essential.

2. Establish a clearly defined purchasing function

The value of a competitive provider market is obviously dependent on there being a clear separation of the roles of purchaser and provider. The former must have clear incentives to exploit the competitive nature of the provider market to obtain the best price and quality combination for services purchased, something that is compromised to the extent that purchasers and providers belong to the same organisation. A key part of this is the role of the purchaser in ensuring that a co-ordinated "basket" of services is purchased and that resources are not wasted through unnecessary duplication and under-utilisation of provider services.

Thus, the creation of dedicated purchasing arrangements should follow as closely as possible the establishment of competitive markets for provision. A necessary accompaniment to the establishment of dedicated purchasers is the clear enunciation by Government (via its role as funder) of broad health policy and the specification of health goals that are to be achieved through the purchasing function. This may be a significant challenge in itself, as these policies and goals are often partly implicit and may lack internal consistency.

3. Establish a single funding stream for purchasers

A key element in preparing the ground for fully competitive purchasing arrangements is to move away from the provision of multiple funding streams, which involve judgements by funders about the cost of providing different services and toward single, population based (though age and demography adjusted) allocations. This gives purchasers the option and incentive to seek major productivity gains in achieving outcomes in different areas, as their funding is made completely fungible and thus able to be applied to other outcome areas. In addition, the allocation of funds on a simple adjusted population based provides clear accountability for performance among purchasers, as outcomes are measured against a common resource base.

4. Establish a competitive purchasing market

Competition in the purchasing market is necessarily dependent on the establishment and sound functioning of a clearly defined purchaser role. Therefore it must be a longer-term aspect of the model's development. Establishing competitive purchasing would involve removing the geographical monopolies that would initially be given to providers and allowing individuals to choose between different purchasing agents based on their preferences among differing packages of services, their perceptions of service quality in different areas, and locational convenience factors.

An additional set of regulatory challenges necessarily arises in this stage of the reform. Government must ensure equity is maintained by providing access to a purchaser for all citizens. Thus, it would be necessary to deny purchasers the right to refuse an applicant for membership. A "default" option, perhaps of membership of the purchasing body that was geographically closest, would also be necessary for consumers who were unable to choose between purchasers. Finally, the purchasing function is clearly one that is capable of being privatised, with incentive for going down this path including the removal of additional risk factors from government and the provision of the clearest possible separation between the funder and purchaser roles.

Answering some common criticisms

As the reform model represents a major change from the way in which health care is currently delivered, it is unsurprising that it has given rise to a large number of criticisms and concerns. I would like briefly to raise and discuss some of the more important of these criticisms as a way of better conveying some of the important details of the reform model. The criticisms can be loosely grouped under three headings: The first are those related to fear of a loss of government control of, or accountability for, the system. Second are concerns about potential efficiency problems of the proposed model. Third are concerns about the implications for equity and access.

The aspect of the reforms which is central to all of these concerns is the much greater level of private sector involvement that competition must inevitably bring with it. It is received wisdom that to achieve the objectives of public health care requires a high level of government involvement. However, underlying my rebuttal of these criticisms is the view that the important roles for government are to ensure that health care providers are engaged under stringent and robust contractual arrangements and that these agreements pertain to a well-planned and sensible range of accessible, high quality services. Ultimately, provided the government continues to take full responsibility for its core roles of funding, regulating and monitoring of health care, there is no requirement that it perform the functions of provider and purchaser.

Indeed, not only is it unnecessary for government to dominate these roles, but it is largely counter-productive for the delivery of the benefits of competition. Without significant private sector involvement, competition essentially consists of different public sector providers competing against each other. While organisational and incentive structures can be designed to mobilise competition in this circumstance, it remains fundamentally limited: The government, as the "shareholder" has little incentive to see significant movement in market outcomes between the different providers or purchasers as it will ultimately unbalance system design and require a rebuilding of new organisations, with attendant transitional costs.

Accountability related concerns

Loss of control

If government is to retain responsibility for the outcomes of the health system, as it inevitably must, it clearly cannot afford to give away any substantial measure of control over the system. Will this not be inevitable once it has handed the tasks of providing and purchasing services, in substantial part, to private sector operators?

In fact, the major determinants of the degree of control the government can exercise over a private institution are the contractual and regulatory arrangements that are in place. Examples can be adduced from other policy areas in which Government's initial attempts to enter contractual arrangements with private firms have been less than successful. However, the health sector is one in which the starting point sees governments as the major player, being most experienced providers of the widest range of services. In this context, there must be grounds for believing in their ability to formulate, implement, monitor and manage effective, value adding contracts.

Additional safeguards also exist via the ability to establish flexible contracts with regular performance monitoring and, as I have mentioned, through the adoption of legislative frameworks that provide powers to intervene in cases in which public objectives are substantially unmet. Finally, it should also be apparent that the private sector has a long term interest in ensuring that public objectives are met, as this is the foundation on which its ability to continue to participate in, and earn profits from, the sector depends.

Overseas ownership

Concerns regarding the likelihood of parts of the health care system passing into foreign hands are twofold. Firstly, there is the concern that foreign ownership will necessarily entail a reduced degree of control over health outcomes. This is little more than a variant of the "loss of control" issue I have just discussed, with the additional element that, for many, a loss of control to foreign interests is considered of even greater concern. The response is also similar: that the mechanisms by which control is and must be exercised are those of contractual relations and the regulatory framework.

However, a second concern relating to foreign ownership is a financial one: that the result of selling off public assets to foreign concerns will entail a significant financial loss in the longer term, with revenues lost to foreign shareholders being greater than the sale price of the assets. In considering this issue, a number of factors need to be weighed. Firstly, it is clearly possible to underprice assets when sold. Avoiding this requires a sound asset sales procedure, involving transparency and open market bidding through auction or tender arrangements and clear delineation of the future rights and responsibilities of the purchaser.

Secondly, there are positive and negative aspects to asset ownership. As I have argued at several points already, privatising can yield major benefits to the government by transferring investment and operational risks to other players. This is almost certainly an optimal shift in circumstances where those players – i.e. providers – have the ability to control and manage the risks.

Finally, a concern is sometimes expressed that foreign purchasers will fail to reinvest in health care provision, preferring instead to repatriate profits to shareholders. In our experience, this has not been borne out in practice. Moreover, it is clear that the need to reinvest is created by the need to meet the contractual obligations into which private players will be entering with government and purchasers. Again, if those contracts are well specified, sufficient reinvestment will necessarily result.

Efficiency related concerns

Increasing costs due to the requirements of managing private involvement

Evidently, there are significant costs involved in establishing, monitoring and managing the relationships between government and private players in the system. These include the costs of planning, developing and negotiating contracts, monitoring of compliance, the likely greater cost of private financing and transition costs, particularly for staff. Some have argued

that the size of these costs is likely to be so large as to overwhelm any likely cost savings from achieving greater competition.

Answering this question must, essentially, be done on a case by case basis. The likely costs of moving toward a competitive system with significant private involvement in particular areas need to be assessed and weighed against the potential savings. However, the experience of reform in many industries has been that the benefits of competition have been much greater than most observers had expected prior to reform and it is certainly possible that this will prove to be the case in the health area. In addition, there must be a clear understanding of what costs can be attributed to private involvement and what costs relate to other goals. For example, enhanced monitoring procedures are equally likely to yield significant management benefits if applied to services provided by public agents. In this respect, it is not reasonable to ascribe all such costs to the fact of privatisation.

Reduced integration

It is often argued that a competitive system with significant private involvement will tend to cause fragmentation in service delivery, militate against the effective integration of services that is essential to the delivery of an efficient network of health care. It is true that competition (and not privatisation per se), by its very nature, tends to lead in this direction. It is equally true, as I have argued throughout this paper, that competition is essential to provide incentives for efficiency and responsiveness to consumer preferences. Moreover, providers and purchasers will have incentives to achieve more effective integration in order to succeed in a more competitive environment.

Thus, the health care system must and will find, and operate on, an appropriate point on a continuum between integration and competition. This brings us back to the crucial roles of contracting and the regulatory framework in providing incentives for integration without seriously undermining the competitive incentives that are fundamental to improving the performance of the system.

Reduced quality

It is also commonly argued that pressure to maximise profits will cause private providers to cut corners and reduce levels of service quality. At a theoretical level, this argument clearly holds little weight: It would be a very short-sighted approach for a provider to take in the context of a contestable market and the need to regularly have contracts renewed by a given set of purchasers. Moreover, even considering the short-term, well specified contracts would severely limit the opportunity for any reduction in service quality by setting out in detail the quality of services required to be provided and including financial disincentives for failures to meet those standards.

The argument also fails to pass muster on practical grounds. The reality is that there are already numerous private providers of services in Australia's health care system, albeit that in terms of hospitals per se they belong largely to the charitable sector. Nonetheless, there are similar incentives operating on these groups, as they will seek to generate a surplus on such operations, which will very often be used to fund other works, rather than being retained within the hospital sector itself. More broadly, the range of non-medical services that has been "contracted out" to profit-seeking private providers has grown rapidly in recent years,

and the results in general have been very significant reductions in service costs combined with the maintenance of satisfactory levels of service quality.

Moving toward US-style "managed care"

A specific version of the argument that these reforms will compromise quality points to the (often exaggerated) failings of the US model of "managed care" using Health Maintenance Organisations (HMOs). The concern is essentially that decisions about treatment are taken from the hands of the medical practitioner and placed with the insurance company, which exercises choices based on a purely economic rationing, with insufficient regard for the individual.

However, the model I have outlined differs crucially in having a greater reliance on competition and market mechanisms and in relying on a better flow of information. The trained judgement of a health profession in the individual case will always be fundamental, but better information sharing and improved co-ordination of care can improve those judgements and the treatments that result.

More information sharing with patients is an essential response to their greater knowledge and their expectation of having more input into the making of medical choices concerning them. Information sharing among providers increases both knowledge of best practices and provider co-ordination and thus contributes to better patient care.

Private provider failure

The involvement of private providers necessarily raises the question of what is the outcome if they do not perform according to contracted standards or they are unable to meet contractual obligations within budget and are bankrupted.

The response to this question is also necessarily contractual in nature. While it is always possible for the government to step in to underwrite the operations of a private agency, to do so would necessarily be to undermine important incentives and endanger the benefits of the system. A more feasible alternative is to ensure that contracts include "step-in" clauses that would enable government (or the relevant purchaser body) power to appoint a receiver where significant service related non-compliance occurred or financial problems became apparent. This could, in turn, lead to the appointment of a competitive provider to take over the responsibilities of the failing provider.

It must also be recognised that the problem of non–performance is not limited to private providers. In fact, the less transparent and explicit nature of the obligations between government as funder, purchaser and provider mean that these instances of non-performance are less visible and, as a result, likely to go unrecognised and/or unrectified for longer periods. In this sense, the more open system being advocated can also provide improved safeguards against these non-performance problems.

Equity and access related concerns

Limited access

a. Diversion of funds from service provision to profit

It is frequently argued that the involvement of profit-seeking private entrepreneurs in the system will necessarily reduce access, as funds otherwise available for service provision are diverted to profits and less profitable customers – usually assumed to be those with least capacity to pay - are squeezed from the system as profit maximisation is pursued. A variant of this argument is that the adoption of a system would necessarily push the system in the direction of the US health care system.

For some, these arguments are largely ideologically based: the provision of "essential services", such as health care is seen to be somehow incompatible with the profit motive – notwithstanding that other "essential services", such as housing, are everywhere provided by private profit-seekers. To the extent that profits are seen to divert funds from potentially higher levels of service provision, three related facts must be borne in mind:

- Firstly, that public capital, like private capital, has an opportunity cost. It is not a free good, but must be either raised in the market place (incurring interest costs), it must be diverted from other public uses, or it must be diverted from its most productive private use via the tax system. Whichever is the case, publicly provided capital has costs that must also be weighed.

- Secondly, the return to private capital includes a premium which rewards the assumption of various kinds of operational risks associated with service provision. By contracting service provision to private players, the government has removed these risks from its own account, thus eliminating the associated costs. To the extent that private players are better able to control these risks, there should be a nett benefit in this shift.

- Thirdly, the creation of competitive markets through competitive provision and purchasing, which largely depends on private sector involvement, will provide efficiency gains of much greater magnitude than the profits likely to be earned by private providers. There is ample evidence already of the importance of these gains, even in contexts where only limited and partial competition has been introduced.

So, the efficiency gains from increasing private involvement in the sector must provide the potential to increase access to services, by maintaining and improving the long-run affordability of the system. That is, if the quantum of services able to be delivered rises, the potential to provide more services to a wider range of people is necessarily created.

b. Failure to ensure a minimum level of universal access

Whether that potential is realised becomes a regulatory and contractual issue. As I have already suggested, a requirement that purchaser bodies cannot refuse membership applications, combined with clear definition by government of the range of services required to be purchased, could be employed to guarantee a high level of access. How much "universal access" is to be provided is a fundamental policy choice to be made. Arguably, government driven systems such as Australia's and Britain's have functioned on the implicit assumption that all services will be equally available to all people, regardless of ability – or

willingness – to pay. However, as I have argued, this model is increasingly unsustainable, as the costs of such a policy become impossible to meet and consumers demand the right to purchase additional services for themselves, in this area as in any other. Thus, we must recognise that "universal service" must relate to a defined range of services.

That said, I would emphasise that comparisons that are sometimes made between the reform model I have proposed and the US health care system disregard the fundamental difference that Australia's health care is largely taxpayer financed, unlike that in the United States. The reform blueprint has been developed on the assumption that this will continue to be the case (although it is also flexible enough to embrace other funding options). This fundamental difference in the basis of the two systems would therefore be undisturbed by these reforms, and criticism of the performance of Health Management Organisations (HMOs) in the US context, cannot be directly applied to these proposals.

There will be a loss of altruistic spirit among medical staff

Many expect that there will be a decline in the amount of "pro bono publico" work that medical staff and others will be prepared to undertake in a profit based system. In fact, experience suggests that reforms to date that have lead to a closer matching of remuneration and specific services performed have already lead to this outcome. This is intuitively understandable, as there is a clearer relationship between a unit of additional work and additional remuneration, making immediately apparent the private cost of performing such unpaid labour. However, these reforms have been undertaken in order to better align incentives and to reward productivity and control costs. All of these goals are, as I have argued, crucial to restoring the long-run affordability of the system and maintaining its quality.

Against this, such a decline in work performed for altruistic motives may be seen as a necessary cost of moving toward a more sustainable system. If so, another perspective also presents itself. That is, why should doctors be expected to provide a significant proportion of their services without payment? This is not an expectation generally held of service providers and it is certainly arguable that such demands should be unnecessary in any efficiently run system – that such a system should not require voluntary labour in order to operate successfully.

Loss of commitment to research and training

An issue quite closely related to the possible loss of altruistic behaviour in a more competitive environment is the question of the impact on research and training. Many fear that private, competitive, service providers will reduce their commitment to this function which, while vital to the longer term health – and efficiency - of the system, is seen as likely to be neglected as an unprofitable "non-core" activity. Again, the answer to this concern must lie in the contractual arrangements that are established.

In existing systems, there are often no clear budget allocations for teaching and research functions and, accordingly, little control and accountability for what is delivered. These functions are often delivered in part as a matter of institutional prestige. However, such a system is not adequate to ensure that the quantity and direction of teaching in research is sufficient for the long-term needs of the system. Under the model I have proposed, explicit

purchasing choices regarding teaching and research can be made and incorporated into purchasing and supply contracts – and are in practice much more likely to be made. In this sense, the delivery of adequate and appropriate teaching and research should in fact be better served under the reform model.

Conclusion

In sum, I think the message from this discussion of criticisms of the reform model I am advocating is that there will certainly be many and significant changes in the operation of the system and its underlying dynamics, but that it can ensure the preservation of the social values that underlay public health provision, while putting such provision on a sufficiently sound financial footing to preserve its viability – and hence its ability to continue to serve those values. While there is no perfect way of ensuring equity and sustainability in providing affordable and comprehensive service to all, given rapidly rising costs, this model provides much better performance against these objectives than either current public health provision systems or any alternatives yet articulated.

Finally, I would like to highlight briefly some of the key messages that may be of particular importance in the context of health provision in developing countries. I cannot claim to be expert in development matters, but I would suggest that the following issues might be worthy of special attention:

1. Ensuring the development of competitive provider markets

Professional groups have historically been loud in their demands for "independence" and have been successful in attaining and retaining a large element of "self-regulation". As I have pointed out, this has often been among the most important impediments to the development of competition. It is also very difficult to wind back extensive collegial and self-regulatory structures that have become seen in many cases as "traditional" institutions and have garnered a high degree of respectability about them. Closely related to this is the often extreme lack of transparency in the development and implementation of these self-regulatory standards.

Thus, for developing countries I think a key challenge will be to be vigilant in monitoring and controlling the development of these systems, ensuring that professional training structures do not limit the supply of service providers and that ethical rules are not used as a convenient means of forming cartel like arrangements and restricting competition, while reducing consumer responsiveness. Acting as early as possible, rather than taking a remedial approach as has been necessary in Western countries, will ensure that these largely self-interest based distortions do not unnecessarily obstruct the development of efficient service provision markets.

2. Choosing between different service provision possibilities

One underlying theme of my address has been that, even in the richest countries, the demand for health care services outstrips our ability to supply them and that this imbalance will continue to grow. This means that conscious, rationally based choices have to be made about what to provide and how to provide it.

These problems are, of course, much more pressing in developing countries. To that extent, a system that best supports the making of these choices on sound policy grounds is invaluable. The model I have outlined shows how providing clearly defined and explicit objectives, and freedom for responsible agencies to meet them as efficiently and effectively as possible, within a well specified framework of incentives, can be achieved. Informed choices can be made as to whether to devote additional resources to, say, public health and prevention measures, vaccination programmes, or mobile health care services.

As well as providing for effective and efficient provision, the open and transparent nature of the system should also enhance public confidence. This in itself could have a significant effect on satisfaction with the health care system.

3. Mobilising necessary capital resources

Governments looking at the merits of private sector involvement in health, as in a range of other industries, have focused in part on the possibility of mobilising large amounts of capital without exceeding prudent financial constraints. This is a particularly important consideration where large initial investments or major reinvestments are required.

For developing countries, the possibility of participating in the development of health care can be a means of mobilising significant amounts of private capital – both domestic and foreign – and thus freeing scarce public capital funds for other, competing, infrastructure priorities. Similarly, it can be a means of mobilising significant quantities of skilled labour from foreign sources to supplement scarce local supply and of facilitating technological transfers.

4. Contractual and regulatory sophistication

A recurring theme, particularly in the remarks on common criticisms I have just made, has been the necessity for sophisticated contractual and regulatory arrangements to underpin moves to a competitive system. It is certainly true that poor contracting can mean that most or even all of the potential benefits of introducing competition can be lost. Similarly, sound regulatory structures are essential both for the monitoring and management of contractual obligations and for the ability to move to remedy deficiencies.

Hence, moves down the path that I have advocated must as a matter of highest priority, be accompanied by a public investment in the skills and resources needed to develop the necessary sophistication. Only when there is confidence that such an underpinning is in place can the steps toward competition be taken with confidence.

5. Maximising affordability

Finally, and at some risk of repetition, the main driver of these reforms in Western countries has been to restore affordability to the system. The reform proposal I have presented is, in my view, the most powerful tool for maximising the affordability of health provision. In this respect, its basic insights have at least as great a relevance in a developing country context as in the West.