Reforming Health Care – Privatisation, Deregulation and Competition

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Mr Samuel presents this paper in two capacities. Part 1 is presented in his capacity as President of the National Competition council. Part 2 is presented in his capacity as Chairman of the Inner and Eastern Health Care Network (Vic).

INTRODUCTION

The health sector is experiencing an unprecedented period of change. Increasing demand and a contracting funding base will increasingly strain the public health system. This means optimising resource use is imperative if the health care sector is to continue to meet the needs of the Australian community.

The National Competition Policy (NCP) can aid the achievement of this objective. The NCP's competitive neutrality and legislation review agendas can help to ensure that the health care system is efficient, accessible and of the highest possible quality.

Today I intend to develop this theme. First, in my capacity of President of the National Competition Council, I will expand on the implications and benefits arising from the application of the NCP to the health care sector. Second, in my capacity as Chairman of the Inner and Eastern Health Care Network in Victoria, I intend to present a vision for the future of health care in Australia.

Undoubtedly, there are many challenges facing the health care sector, which will not go away simply by ignoring them. Instead, by taking up the challenge and engaging in the debate, the Australian health care sector will find itself presented with new opportunities capable of taking it into the new millennium.

PART I - NCP AND THE HEALTH SECTOR

(i) What is the National Competition Policy?

The National Competition Policy (NCP) provides an agreed blueprint for promoting the better use of competition to improve the performance of both the pubic and private sectors. NCP is about improving competitiveness and providing the conditions for more sustainable economic and employment growth.

In 1995 the Commonwealth, State and Territory governments signed an integrated set of agreements containing general reform principles and specific reform commitments which form the National Competition Policy (NCP). The key elements of NCP are to:

- extend the reach of the anti-competitive conduct laws of the Trade Practices Act to virtually all public and private sector businesses;

- improve the performance of essential infrastructure through implementing reform packages in the electricity, gas, water and road transport industries;

- review, and where appropriate, reform all laws which restrict competition, and ensure any new restrictions provide a net community benefit; and

- improve the performance of government businesses through structural reform, introducing competitive neutrality so that government businesses do not enjoy unfair advantages or disadvantages when competing with private businesses, and considering the use of prices oversight.

The NCP package puts a national umbrella over a number of reforms which governments were already in the process of developing or implementing. The adoption of a co-ordinated approach to reform on a national basis recognises the growing reality of Australia as a single market, rather than a series of markets delineated by State borders. A national framework also seeks to overcome the inconsistencies that can arise from a more piecemeal approach. In the past, a state-by-state approach in rail led to not only different gauges but also different technical and safety standards. A national approach also allows each State to capitalise on what the others are doing, removing the need for each State to individually reinvent the wheel.

While governments decided to adopt a national focus for competition policy, most of the implementation is happening on an individual government level, with each government in control of how the policies are implemented in their jurisdiction. By agreeing to the NCP they have put a framework around the development of their policies to support keeping the national issues in mind.

The Second Reading Speech accompanying the Competition Policy Reform Bill 1995 identifies the business activities of the health sector as included in the coverage of the

NCP. The legislation review and competitive neutrality reform agendas are relevant for the health sector. Each are addressed in turn in the following sections.

It should also be noted that professions, including health professionals, were previously exempt from the prohibition on anti-competitive behaviour contained in the *Trade Practices Act* (TPA). This protection was removed with the extension of the TPA in 1996. As the Australian Competition and Consumer Commission (ACCC) is responsible for administering the TPA, it is not addressed in this paper.

(ii) Legislation Review

What is legislation review?

Governments have agreed to review and – where the restrictions are not in the public interest – reform laws which restrict competition. The legislation review agenda also entails mechanisms to vet new or amending regulation to ensure that they do not unduly restrict competition.

The guiding principle for reviews is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.[1]

The NCP provides a framework and statement of policy principles for the review of legislation.[2] Appropriately, it also provides the flexibility necessary for governments to conduct reviews which take into account those issues which are most relevant in each particular instance through public benefit considerations – including economic, social, ethical and environmental issues.[3]

Legislation review and the health care sector

The Commonwealth, States and Territories have scheduled a range of health sector related legislation for review. The majority of which relates to health practitioners, but other areas of interest include Medicare arrangements, private health insurance and pharmacy regulation.

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1 Clause 5(1), Competition Principles Agreement.

2 Clause 5(1) and clause 5(9), Competition Principles Agreement.

3 Clause 1(3), Competition Principles Agreement.

States and Territories have scheduled a wide range of health practitioner legislation for review over the period to 2000. These include reviews of medical practitioners, nurses, chiropractors, psychologists, dentists, dental hygienists and technicians, physiotherapists, optometrists, podiatrists, chiropodists and pharmacists.

Broadly speaking, legislation can restrict competition for professional services in two ways. First, it can restrict who is able to enter a market and second, it can restrict how participants already in the market are able to operate. These types of constraints affect pricing policies, business income and management decision making.

From a competition policy viewpoint, certain aspects of professions regulation may well be justified. For example, in the market for medical services the availability of subsidised health care, and the fact that doctors both advise patients of the need for treatment and supply the service, mean that some form of regulation may be necessary to ensure doctors do not over-service their patients. The information problems consumers face in selecting a practitioner of suitable capability may also justify regulation of entry into a profession through appropriate accreditation standards and reservation of professional title.

However, there remains a significant body of anti-competitive provisions, such as licensing, fee setting, advertising restriction and ownership restrictions, which should be reviewed and, where appropriate, reformed.

Thus, the review program has potentially important implications for health professionals by removing unnecessary red tape, and by allowing health professionals to operate in more innovative ways in existing markets or in providing access to new services.

A recent example of this is the development of the new “nurse practitioner” classification in New South Wales. Nurse practitioners will have the authority to seek some diagnostic radiology and pathology testing and limited drug prescribing rights. This new classification will provide community access to another level of health services and may go some way to relieving some of the problems associated with doctor shortages in rural and regional New South Wales. Several other states are examining the model.

The Queensland Government review of health practitioners presented an innovative model for regulating health professionals. The Queensland Health Practitioner Registration Acts Draft Policy Paper proposed the adoption of the Ontario model for regulating professions. It proposed a reasoned minimalist approach to regulation based on a risk management assessment on a profession by profession basis while ensuring access to and standards of health care.

Given the complexities associated with health policy both within and between the Commonwealth and state governments, the application of the legislation review principles to the health sector has not been without its difficulties. Two such issues identified by the Council relate to the provision of Medicare provider numbers and the recent Commonwealth review of private health insurance.

In 1996 the Commonwealth passed legislation which limits the Medicare provider numbers available annually to new doctors, thus restricting entry to new doctors. In the Council's view the Commonwealth is yet to provide evidence of a substantive public benefit in support of this legislative restriction as required under the Competition Principles Agreement.

In 1997 the Commonwealth conducted a review of parts of the *National Health Act 1953* and the *Health Insurance Act 1973* relating to private health insurance. The Council is concerned that the review may not have investigated all restrictions on health funds. In particular, that the review's terms of reference explicitly prevented the review body (the Industry Commission) from examining the Commonwealth's policy of retaining Medicare, bulk billing and community rating. Despite this, the Industry Commission reported that community rating is perhaps the main regulatory influence on product and price competition among health funds.

Legislation review and the health care sector - where to from here?

An important forthcoming health review, is the national review of pharmacy and pharmacist regulation. A national review is a sensible approach given the inter-related nature of the Commonwealth and state legislation in this area and shows the flexibility of NCP to allow the most appropriate review vehicle to be harnessed in each circumstance. The Council is looking forward to a robust examination of the issues by the pharmacy review group.

Many state reviews of health practitioners have been completed or are underway. The Council will receive updates on progress from governments in the lead up to its forthcoming assessment of progress with implementing NCP.

The application of the legislation review principles to the health sector will be an ongoing area of interest to the Council through to its last assessment of progress in mid-2001. The Council will continue to work with governments to ensure that, where it is required, regulation continues to be appropriate and effective. And that the NCP program helps to provide the community with, and access to, a wide of range of health practitioners and services.

(iii) Competitive Neutrality

What is competitive neutrality?

Government businesses consume a significant amount of the country's resources to provide a vast array of services to both households and the private sector. Consequently, the performance of public sector businesses has a major impact on the wellbeing of the economy and the community.

In the late 1980s there was widespread evidence that government businesses were performing poorly. Many studies and reviews identified poor capital and labour productivity, inappropriate management practices, poor quality goods and services, inappropriate pricing practices and poor financial performance.

Since that time improving the performance of government businesses has been an ongoing focus for all Australian governments and, notwithstanding problems with some individual businesses, governments' efforts are yielding real gains for the community. For example, prices for the outputs of government trading enterprises fell substantially between 1991-92 and 1995-96, and payments to governments doubled, due partly to competition reforms. More recent evidence shows that these trends are continuing. In the five years to 1996-97, the sharpest price reductions occurred in electricity (24 per cent), port services (23 per cent), telecommunications (23 per cent) and air traffic services (40 per cent). Lower prices help consumers and business people, and more money in the governments' coffers obviously makes it easier for them to keep taxes down or to fund additional social services if they so choose. However, while some significant gains have been made there is still much to be done.

A mechanism for improving government business performance recommended by the Hilmer Report (1993) and included in the National Competition Policy (NCP) is the principle of competitive neutrality. Competitive neutrality under the NCP, involves removing any net competitive advantage arising from government ownership, where government businesses face actual or potential competition from the private sector. This allows the two sectors to compete on an equal footing and encourages efficient operation of public enterprises. The underlying aim is to ensure that the community's resources are allocated to those activities that can achieve the most with them.

In signing the NCP, governments agreed to apply competitive neutrality to two types of business activity:

- Government Business Enterprises (GBEs) which are those activities identified by the ABS as Government Trading Enterprises or Government Financial Enterprises; and

- those undertaken by government departments as part of their wider functions.

Under the NCP, GBEs should be corporatised where appropriate. As part of this, GBEs need to introduce:

- full Commonwealth, State and Territory taxes or tax equivalent systems;

- debt guarantee fees directed towards offsetting the competitive advantages provided by government guarantees; and

- those regulations to which private sector businesses are normally subject, such as those relating to the protection of the environment, and planning and approval processes, on an equivalent basis to private sector competitors.

Where corporatisation is not appropriate, governments have agreed to apply competitive neutrality principles through introducing the above three reforms, and action to ensure that prices fully reflect production costs.

While the presumption in drawing up the NCP was that competitive neutrality principles would be applied wherever appropriate, clause 3(6) of the Competition Principles Agreement suggests that if a clear net cost to the community can be shown then competitive neutrality should not be applied. Competitive neutrality under the NCP is designed to complement, rather than override, pre-existing government objectives such as an accessible, high quality and efficient health care sector.

Competitive neutrality and the health care sector

An appropriate application of competitive neutrality principles can assist public health care agencies to get more from their available resources in a number of ways.

Firstly, competitive neutrality increases transparency which promotes greater accountability and better resources allocation. For example, full cost pricing ensures that hospitals are aware of the true cost of their in-house business activities and thus whether or not they are getting value for money.

Competitive neutrality also enables hospital businesses to focus on maximising their commercial return. For example, the corporatisation model suggested by the NCP involves the introduction of clear business objectives, management independence and accountability, independent performance monitoring, and an effective system of rewards and sanctions. In addition, competitive neutrality provides hospitals purchasing these services with an opportunity to clarify their non-commercial objectives and evaluate the effectiveness with which these objectives are achieved.

Where a hospital decides to allow external and in-house businesses to compete, application of competitive neutrality principles enables the hospital to objectively identify the most cost effective means of securing the desired outcome. Selecting the most efficient provider, be they public or private, facilitates cost savings which could then be channelled into other areas such as increasing the number of available beds, reducing waiting list, or upgrading equipment and facilities.

Introducing competitive neutrality to health care is still in its early stages in most jurisdictions. To date, progress has included:

- identification of significant health sector businesses;
- determination of the most appropriate means of introducing competitive neutrality (corporatisation, commercialisation, full cost pricing etc);
- evaluation of the relative costs and benefits of introducing competitive neutrality; and

- where appropriate, a reform timetable and implementation.

Jurisdictions have however, varied in terms of the breadth of their reform agendas and the amount of progress achieved.

In Victoria, public hospitals have identified over 300 clinical and non-clinical activities which were to have competitive neutrality principles by 1 July 1998. This involved the introduction of full cost attribution and evaluation of the most appropriate ongoing structural arrangements for providing the service.

Full cost attribution is also being applied to health care activities in NSW. For example, the NSW Department of Health, the Medical Board and the Cancer Council of NSW, all of which have annual turnover of more than $2 million, were to apply full cost pricing principles, where appropriate, from 1 July 1998.

Health care reform in South Australia has included corporatising Medvet Science, a business activity of the South Australian Health Commission. Commercial reforms are also being considered for another Health Commission business, the Institute of Medical and Veterinary Science.

In Tasmania reforms such as full cost pricing and competitive tendering are being considered and, where appropriate, applied to a range of activities including laundry and cleaning services, corporate services, radiography and psychogeriatric nursing.

The ACT has undertaken a large number of contestability and benchmarking studies of both clinical and non-clinical activities. Competitive tendering has been introduced to some non-clinical activities.

Applying competitive neutrality principles to the treatment of private patients in public hospitals is being considered by a number of jurisdictions. An independent cost benefit assessment commissioned by Queensland Health recently noted that the introduction of full cost attribution could:

- improve the overall efficiency of the private health insurance market;

- remove the price distortion between public and private providers; and

- subject to certain constraints, improve service quality in the medium to longer term and lower health premiums in the longer term.

However, these benefits would have to be weighed against greater outlays by insurance firms, higher premiums and increased pressure on public health services. Resolution of this issue would require consultation between the States and the Commonwealth given joint Commonwealth/State funding arrangements and the importance of avoiding inter-jurisdictional distortions in the demand for services.

The role of competitive neutrality complaints

As part of their NCP commitments all jurisdictions have introduced arrangements for responding to complaints regarding contravention of competitive neutrality principles by significant government businesses. Complaints mechanisms play an important role in ensuring the effectiveness of existing competitive neutrality reform initiatives. Further, in jurisdictions were the scope of the complaints mechanism includes activities not already subject to competitive neutrality policy, complaints can identify new areas requiring attention.

While complaints mechanisms have only been in operation for a short time, there have already been a number of allegations of non-compliance by health sector businesses. For example, NSW has received complaints regarding the manufacture and sale of artificial eyes by Sydney Eye Hospital and Sydney Hospital's inspection, monitoring, and consulting services with respect to hazardous materials in the work place. Victoria has received and responded to complaints regarding hospital prosthetic departments, ambulance services and hospital laundry services.

Competitive neutrality and the health sector – where to from here?

Increasing demand and a contracting funding base as the population ages will increasingly strain the public health system. Long waiting lists and rising costs as the number of treatable conditions increases means optimising resource use is imperative if the health care sector is to continue to meet the needs of the Australian community.

Governments and health care agencies are considering a range of options to assist the public the health care sector achieve more with its available resources. For example, hospitals may decide to use spare capacity to provide services (such as pathology services) to the private sector. Where this occurs it is important that hospitals recover at least the marginal cost of the business activity.

Another option which is already reaping rewards is increasing the role of the private sector in service provision. For example, in Tasmania a privately run ambulance service for non-urgent patients promises to reduce the delays (which in the past have been up to six hours) and provide a 20 per cent saving to private hospitals, workers compensation insurers and the Motor Accidents Insurance Board. Further, the resulting ease in the caseload of the State's public ambulance service's will facilitate a reduction in response times to urgent cases.

While the Council supports private sector involvement and efforts to better harness the benefits of greater competition, the NCP does not require the introduction of measures such as privatisation, purchaser/provider splits or competitive tendering. However, where governments decide to introduce reforms that see public businesses engage in actual or potential competition with private sector providers (such as competitive tendering or where consumers are funded directly), competitive neutrality is essential if the benefits from these reforms are to be fully realised.

PART II – A VISION FOR THE FUTURE OF THE HEALTH SECTOR

Why should health be managed (or at least considered) as a business.

No one in this room today can doubt that the health industry is at a significant cross-road. One way will take it into a challenging future. The other could spell disaster. The road that we, as a society choose to follow, will be up to each of us in this room today. As tax payers, as well as members of the health care industry, we will play a part in how public health and hospital services are provided.

Society has seen many changes in the past few years about how Government supplies public services to its constituent population. There has been a healthy move towards introducing market forces and private initiatives into public utilities and capital construction, for example.

It is a mistake to think that health care is some sort of special exception rather than what it really is: a business or industry. The service this business or industry produces is health care.

And as with any other industry, the chief concerns within this business or industry are like any other: what should we produce and how can we produce this most efficiently and effectively - given our biggest problem, which is scarcity of resources.

There are only a finite number of resources with which to meet infinite needs and wants of our customers. Demand is outstripping our supply so, like any business, the health industry must make some decisions about how to allocate its resources to maximise its returns. In this case, the returns are maximising health care products to provide the greatest benefit to society as a whole. This greatest benefit also will be one that appropriately reflects society's needs and priorities.

So how will it allocate these resources? As we search for the best allocation mechanism, we must bear in mind all the time that putting resources into meeting the needs of one part of society will automatically mean other parts of society will not get resources.

In the public sector there are significant opportunity costs associated with dedicating a resource to the production of one good rather than another. Spending more on health care, for example, diminishes the amount of funds that governments can devote to education, defence, road maintenance, etc. All of these uses are undoubtedly for society's good. So, to try and maximise the overall benefit to society, these resources must be distributed carefully among competing demands.

Today, health care expenditure makes up 8.5 per cent of GDP. Health is one of Australia's largest industries, employing about seven per cent of the labour force. This is big business, by any measure, and this growing sector is consuming a large amount of our attention and tax-based resource.

So it should worry you, as tax payers, that to date the distribution of resources into public health has been undertaken in a highly arbitrary way. Governments have traditionally

determined how much of our taxes are allocated to the provision of health care services, using their own estimation of what is an appropriate allocation of funds – always considering the government of the day's political agenda. To date, the optimal amount of public health care funding has never been based upon any scientific assessment of the population's needs or required health outcomes.

Theoretically, I could argue that a more market orientated approach would at least ensure that the amount spent on health care services would reflect and respond to the demands of the market, that is, to the government's constituent population. But let's be realistic. In the short term it is unlikely that allocation of money to health care in Australia will ever be completely trusted to a market mechanism. So we are still looking for the best mechanism for allocating tax payers' money.

Whatever mechanism is finally chosen for allocating public resources, operational efficiency is also a vital consideration. As a tax payer I want my taxes to be used as well as is possible, minimising wastage and duplication. Each resource allocated to the provision of health care services should be utilised to maximum efficiency, so we can maximise the quantity, quality and range of goods and services that we are able to produce for the tax dollar.

Already public health providers are facing major decisions: rising costs need to be contained to be able to provide a comprehensive, accessible and enduring system of care. As the population ages, costs will become prohibitive and if there are no mechanisms for resource allocation and prioritisation in place, rationing will be undertaken in an arbitrary way.

This rationing will not be based on health and quality of life factors. We can see early examples of this rationing today in the escalating public waiting lists for elective surgery.

These imperatives of allocative and operational efficiency are of course not limited to the public sector. All businesses want to allocate their resources to maximum benefit - and to maximum efficiency. Despite innate differences between health care as a commodity from, say, cars or clothing, the fundamental principles that guide effective production and provision are the same.

Health's imperative for allocative reform is urgent. With each passing year the current health care system becomes less affordable.

We all accept that the population is ageing and that this trend is expected to continue well into the next century. Population forecasts for the period till 2016 demonstrate a significantly higher increase for the older population, than the population as a whole. In fact, from 1996 to 2021, the over 65 population is expected to nearly double to over four million, with an increase of a further two million people in the next 30 years.

Now, on one side, this is increasing the demand for services. On the other it is decreasing society's ability to pay for these services. The taxation base from which our current system is funded is shrinking. The percentage of the population within the labour force,

from which income tax is sourced, is growing relatively smaller while at the same time the welfare population it is required to support is increasing at a rapid rate.

At the same time there is an increasing number of treatable conditions. Advancements in research and development mean that every day we discover new methods and treatments which assist recovery from conditions which were previously incurable. Even though there are many chronic diseases for which as yet no cure exists, we are able to keep people living healthier and longer.

The bad news is that these advancements in research and development require new equipment and pharmaceuticals. Every clinical breakthrough brings significant costs associated with the overnight obsolescence of previous treatments.

Expectations of our society also play a tremendous role in determining the total amount that any democratic country chooses to expend on health care services. These expectations of health care services, as a general rule, are increasing.

Expectations are based on two key factors: experience and information. As people lead healthier and longer lives, their experience of ill-health is reduced and the incidence of disease and disability becomes increasingly unacceptable. This means there is a rise in expectations upon health care institutions to prevent mortality and morbidity. Similarly, as medical information becomes more freely available to the general public through publications, media, films, television and the Internet, the gap in knowledge between patient and physician narrows somewhat.

All these factors are present today but, not only are we living in an economic environment of rising costs, we are also experiencing shrinking revenues. Pressures are being felt from the Asian currency crisis, reduced tariff protection and accumulated debt. In this environment, it is difficult for the Government to fund an adequate and acceptable level of service, let alone new or improved infrastructure.

Additionally there are constitutional limitations on the capacity of Australian States and Territories to raise additional taxation revenue with which to undertake these initiatives.

In the face of these mounting cost pressures, demand for public services is continuing to increase. Since the introduction of Medicare, the percentage of the Australian population with private insurance has more than halved (dropping from 68 per cent in 1982 to a mere 31.9 in June 1997). While this is happening, the percentage of Australians relying on the public system has grown considerably from 71 per cent in 1982/3 to 82 per cent in 1995/6.

Despite major government initiatives to encourage people to take up private health cover, these trends have not been reversed and the public sector is increasingly unable to cope with its workload. It is no surprise that Governments are looking for alternative ways to deliver health care.

The Value of Competition

But even if the current near-crisis situation did not exist – and there were no cost pressures driving the system towards increased competition and private sector involvement - the National Competition Policy would still abolish barriers to entry into the arena of public health provision.

This is because it is not of fundamental importance whether services are provided or purchased by the public or private sector. The ultimate role of the government in health care is to ensure the appropriate funding of health care, equitable and adequate access to health care services and the regulation and monitoring of the standard of these services. It is the quality and availability of the services that is important not the identity of the provider and/or purchaser of that service.

So what are we to do? We commonly hear the argument that health care is far too important a commodity to be left to the whims of market forces, yet is it too important to leave solely to the Government? In the words of the vice Chancellor of the Murdoch University in Perth, Steven Schwartz,

"Food and clothing are also necessities of life, but we don't have a food-care levy"

We don't place the responsibility of determining the quantity and range of food to be provided onto the shoulders of the government. So we cannot afford to allow these same decisions relating to health care delivery to remain the sole responsibility of governments. If we are to meet the challenge of optimal allocation and operational efficiency we must begin to run the health care system in a business-oriented way.

A commonly used argument to differentiate health care from a normal good or service is the idea that consumers of health care services lack the knowledge to be able to determine what services are best for them. This may well be the case - but, remember, we don't necessarily let the people with this requisite knowledge determine these services now.

Working on such a principle, we should be leaving problems of determining service types, ranges and quantities to those better informed, such as medical practitioners - not to government institutions.

Today's consumer has a reduced power of choice and access to services because of the lack of a true market for health care services – and hence market signals to provide information. Market forces and fair competition can only improve consumer choice.

Competition has much to give Australia's health sector. Competition ensures that, in order to win, competing parties strive for excellence, in areas in which they are to be judged or evaluated against one another. Introducing competition into the provision of health care services should drive agents within the market to innovative heights in three key areas:

- access to services - or quantity of services provided
- quality of services, and
- cost - or price.

Australia has actively, albeit in an ad hoc fashion, encouraged competition into the public sector. Health care is not exempt from this process.

To quote the Assistant Director of the Infrastructure & Investment Unit in the Victorian Department of Health, Lynton Ulrich, who has had first hand experience in trying to foster increased private involvement and competition in the Victorian health care market:

"the introduction of competition into the sphere of public health provision is by no means based on the premise that the private sector is necessarily better. It is based on the fact, and is a trend which can be observed across many nations in the Western world, that the introduction of private funding, expertise and competitive principles will improve quality of services, operational efficiencies, innovations (technical and practical) and increase value for taxpayer's dollar."

The process of introducing competition is outlined within the National Competition Policy. Competitive neutrality for public bodies means foregoing competitive advantages bestowed upon them by sheer virtue of their public ownership.

Competition in terms of the provision of health care services means that services will ultimately be provided by accountable organisations through explicit contracts with government departments, irrespective of whether these agents are public, private charitable organisations or private-for-profit organisations.

Another advantage for the Government and therefore society is that the introduction of true competition means explicit service contracts will be necessary and this means the service required must be clearly defined from the outset - something that is missing in today's system.

A level playing field between all players in public health care provision, whether it be public-public, public-private or private-private, and which abolishes all barriers to entry, requires a clear and shared understanding of product types, quality and quantities to be supplied. If private providers are going to successfully contract with government for the provision of health services, and by successfully I mean with only positive effects to access to and quality of services, items to be purchased must be clearly defined.

True competition will also mean that the roles of purchaser of services and provider of these services will have to be clearly separated. We will no longer be able to rely on the current cosmetic purchaser/provider split. Purchasing will need to be undertaken at a price set (and agreed to) by the market. Preferential pricing or, in other words, rewarding the inefficient, will disappear.

As acknowledged by the Victorian Minister for Health and Aged Care, Rob Knowles at the AIC Conference in 1997

"policy making and the regulatory function should be separated."

The system today requires role clarity. The introduction of competition may assist in tidying up the edges, redrawing the lines and redefining roles more clearly.

Definition of the product and quantities to be purchased will mean explicit decisions about what will - and will not - be provided. This will lead to a system of logical prioritisation and sensible rationing. Definitions of minimum service quality for contractual purposes will lead to a more Evidence/Outcome/Quality based approach to health care provision. Costs will become more reflective of end results rather than just inputs.

Business performance has moved towards the measurement of outcomes. Health care should be no different. Funding of health care should be based on outcomes or results. At the very minimum designated outputs such as goods and services should be purchased from departments and service providers rather than what is still occasionally found in parts of Australia today, a system of funding inputs such as salaries and operating expenses.

Traditionally in health, it has been very difficult to measure outcomes. Even in Victoria under casemix- a system in which funding more clearly reflects the work undertaken rather than based on historical budgets - funding is very much about units of care provided and the resources required to produce those units - not about results of care. Introducing quality requirements into service provision contracts will lead to an increase in quality and more stringent quality control.

Thus competition is a highly appropriate vehicle for simultaneously achieving a system which is cost effective, which upholds, and even raises, quality standards and which accurately reflects both resource and opportunity costs.

Increasing involvement of private sector – not necessarily the enemy (in defence of informed debate!)

There are five modern myths which are promoted against allowing private sector involvement in public health, that is, opening the gates of the health sector to true competition.

The first is that increased private sector involvement through competition will lead to reduced access. This is not logical. If services are provided on a contractual basis, the government who is the purchaser, selects the breadth and quantum of services to be provided. So, irrespective of whether the provider is a public or private entity, to receive payment, this provider must provide that range of services at the prescribed standard of quality or better.

As experience shows with Latrobe Regional Hospital in Victoria, the private operator has a contractual obligation to provide treatments to all patients regardless of a patient's health insurance status, a patient's financial status, a patient's place of residence or whether the patient intends or elects to be treated as a public or private patient.

At the same time the government does not underwrite or guarantee a minimum service throughput base, so there are additional advantages to government in this case of having shifted demand risk to the private sector.

The second myth suggests that privatisation will lead to reduced quality . In fact, it is far more likely that the opposite of this statement would be true.

As stated before, under a contractual arrangement for the provision of health care services, the government has the opportunity to specify standards of care. These can be set at the levels we are accustomed to today, or in fact, higher. The specification of such standards may also increase the level of quality monitoring from what we are accustomed to in today's largely public system.

Another point of note in terms of service quality is the fact that in what we deem to be a public system today, there are a number of private, albeit charitable, organisations who have been providing quality public health care services for a good many years. St Vincent's Hospital has always been entirely comparable with the best public hospitals in terms of patient satisfaction, despite its private ownership.

The next myth says that privatisation will lead to increased costs to the tax payer . It is true that a system based on contractual agreements, and the processes of competitive neutrality and market testing, has its associated costs. However, it is also true that these costs are up-front and singular. They are off-set against gains in the long run from improved efficiency, increased quality at the least possible cost.

The fourth myth is that privatisation means that our health system will become like that of the USA .The failures of the US system has been promoted by the media so that the American health care system has become an anathema for most Australians. The critics say that a large percentage of the American population do not have access to adequate and sufficient health care services.

People then assume that the associate reduced or inadequate access is due to the free market system operating in the United States. This system links profit motives, private providers and the managed care system with scarce, restrictive and expensive services. However, the real reason that the entire American population does not enjoy as 'immediate' and equitable access to high quality services as in Australia, has nothing to do with who is providing the health care services nor with how the supply-side is structured. It has everything to do with the population's level, and mechanism, of insurance.

Even if Australia set up an exact replica of the American system with health management organisations and private providers, there would remain a clear distinction between the two systems, because Australia has in place a system called Medicare - a system of

taxation based universal insurance, not dependent on income levels, ensuring access to emergency medical services for all Australians.

Even if Australia were to completely privatise the provision of public health services, as long as the private providers were engaged under the constraints of the Medicare/Australian Health Care Agreements as are today's public and private providers - there would be no change to the level of access enjoyed by Australians today, irrespective of their means or situations of employment.

Finally, the last myth suggests privatisation would result in a change in focus from people to dollars. Under a system of contractual service provision, private or public providers would need to supply the services required of them by their contract. Their opportunity to cream skim and specialise in performing only the most lucrative procedures is removed if their service contract is sufficiently specific.

Such specification could also have external benefits. The specifications of what will be provided means explicit acknowledgement of what will not be provided. Rationing or prioritisation can be undertaken on a far more demand driven manner than in today's system - with perhaps a more balanced distribution of resources across acute and elective services.

Where to from here?

The new model that I see needs to develop must demonstrate the following features:

- firstly, it must show sufficiency of and improved integration, that is, co-ordinated care and scope for appropriate service substitution
- secondly, optimisation of risk transfer. This means deferral of some risk and potential future financial liability from the shoulders of government to the private sector
- thirdly, maintenance of and continuous improvement in the quality of care
- fourthly, heightened competition to provide incentives for increased efficiency and quality at least cost
- next, role clarity, that is a clear division of function between purchasers, providers and regulatory parties
- sixthly, regulatory purity and improved regulation. Again clear division of function and an increased focus upon - and requirement – for monitoring qualitative measures or service standards as well as the traditional quantitative factors such as bed numbers and outpatient visits

- next, long run affordability must be ensured. The system must be shaped in such a way to ensure that it is able to cope with changes in population and financial trends

- next, minimisation of market failure risk. Demand, supply and patient satisfaction must be closely monitored; and safety net arrangements (such as the devolution of overflow) must be established, should a contractor fail in meeting their service obligations

- and finally, structural flexibility must be ensured to enable ongoing reform.

So how could we evolve along a path such as this?

There is no doubt we have to reduced or remove barriers to entry into public health care provision. This will result in increased private sector involvement in both financing and provision of services.

There will have to be an increased level of genuine competition between government providers - just as well as competition between private entities and between private and public entities.

The final logical point of this competition is, of course, the complete private provision of services, system-wide. Again, I must stress, it is not who provides the service that is important it is unencumbered access to, the quality and the efficiency of the services provided.

In the meantime, we can see the introduction of local, purchasing agencies. That is agencies purchasing services on behalf of their population.

The introduction or maintenance of an appropriate, population weighted, resource allocation formula is integral to this. This allocation formula must encourage rational purchasing such as a geographic division and must be on a fair and equitable basis ie. allocating per capita.

Another "must" is the introduction of full competition between purchasing agencies - the promotion of sophisticated purchasing systems and methodologies - along with the introduction of consumer choice. Let the consumers entrust their health entitlements to those who they see as the most fit to provide them with the services they want/need.

Finally, we will see increased private involvement in the public health care sector culminating in privatisation of the purchasing agencies I mentioned before.

No matter what happens, it is clear things must change. And the solution is the introduction of market forces and fair competition. As Steven Schwartz from the Murdoch University said:

"We have tried government controls and they have failed; it is time to make the market save the health system."