

Managed competition: The policy context

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Abstract

In order to maintain universal access to medically effective care for all, costs must be contained at both the system-wide and micro levels. The managed competition model offers a framework within which increased efficiency could be pursued without sacrificing the goal of universal access and without impairing health outcomes and social cohesion. It would do this by removing structural impediments to rational decision-making and allocating to markets and governments the functions they perform best.

Introduction

George Palmer has contributed extensively to the education of health economists and to the development of health economics in Australia over several decades. His particular contribution has been to the development and application of casemix as a measure (or a proxy measure) of the output of Australian hospitals. From where we stand, it takes an effort of mind to think back to the time before diagnosis related groups (DRG) when it could be said, in the standard text on hospital economics, that ‘... there appears to be no agreement, either on a conceptual or merely definitional level, among those who have most intensively studied the economics of hospitals, on what the most appropriate measure of output is, or should be’ (Berki 1972, p 44).

If the output of acute hospitals cannot be described, let alone measured, what can an economist contribute to policy relating to the largest and most important single component of the health care system? In short, very little of practical use. And while capacity to measure and improve technical efficiency within acute hospitals does not amount to a comprehensive solution to the problems of the health system, it is a sizeable, and indeed essential, component of any such solution.

Casemix – an aside

My interest in casemix has always been in its applications as a policy tool rather than in the intricacies of its conceptualisation and formulation. Before moving on to my main subject, I would like to digress to raise what I regard as the most interesting question related to casemix in this context. Over the past few years we have had, in this country, a natural experiment which was never designed as such and which has not undergone serious analysis by health economists or policy analysts in the public sector. Between 1992–93 and 1994–95, two States, Victoria and South Australia, under pressure to undertake budgetary retrenchment, cut their allocations to public hospitals (quite severely in the case of Victoria). At the same time – largely to minimise the impact on the supply of hospital services to their populations – these two States implemented case payment based on DRG-adjusted inpatient episodes in place of much of the previous block grants based on historic cost. Two other large States in which the budgetary imperatives were absent, New South Wales and Queensland, continued to fund public hospitals as they had done previously. The outcomes of these different policies on public hospital inpatient activity and costs are illustrated in the following table, which is derived from Australian Institute of Health and Welfare statistics of public hospital separations and unpublished tabulations of State expenditures on public hospital services produced by the Commonwealth Grants Commission (1998), in the course of its 1998 update of general revenue grant relativities.

Table 1: Selected public hospital statistics – percentage increases, 1991–92 to 1995–96

| | Separations per capita | Cost ^a per separation | Cost ^a per capita |
|-----------------|---------------------------|-------------------------------------|---------------------------------|
| New South Wales | 18.6 | 2.8 | 18.6 |
| Queensland | – 5.5 | 5.2 | 11.1 |
| Victoria | 19.3 | – 23.7 | – 9.0 |
| South Australia | 13.4 | – 11.1 | 0.8 |
| Australia | 12.0 | – 1.8 | 6.7 |

a. Gross expenditures on public hospitals (Commonwealth Grants Commission definition).

These contrasts between the two pairs of States are not quite so stark as the figures suggest, as part of the increase in separations involved some reclassification of activities and an increase in the proportion of one-day stays. Statistics of Victorian *weighted* separations suggest that the increase in per capita separations would be roughly halved, that is, reduced to about 10% over the period. Even so, a substantial difference remains: an independent report estimated an increased throughput of 9% and reduction in total costs of 7% in 1993–94 (Health Solutions Pty Ltd 1994, p 188). This is not to be read

as support for the budgetary policy of the Victorian Government: indeed, subsequent experience has shown that the scale of the expenditure cuts has caused serious problems in the public hospital system. However, in the absence of case payment, the consequences for hospitals and their patients would have been more severe.

On the other hand, persistent difficulties are reported from the States which have not implemented case payment but have responded to growing waiting lists in the traditional manner, by increasing public hospital grants. The full significance of the natural experiment can only be judged by more comprehensive analysis of outputs and outcomes, which I commend to other health economists.

The foregoing discussion is not such a digression from the subject of managed competition as it might seem. In the first place, organisations undertaking any serious budget-holding function (such as health maintenance organisations – HMOs) essentially depend for their cost-reducing capacity, and hence their financial viability, on cost savings from hospital services being available to fund other alternative (usually cheaper) modes of care. This requires that:

- hospital and other services used by an individual are paid out of the same budget, that is, by the same payer
- there is a price for the hospital episode which (more or less) corresponds to its cost. Most of the discussion of case payment is confined to the impact of case payments on the recipients, that is, the providers, with little attention being given to the role of prices in determining the behaviour of purchasers.

Consequently, regardless of the extent to which case payment can contribute to the increased efficiency of hospitals operating under traditional arrangements, its introduction is a necessary condition for the successful functioning of managed competition or any other system based on intermediaries marketing comprehensive service packages to health care consumers.

The objectives of health policy

It is the more ambitious subject of the nature of comprehensive prescriptions for the health care system as a whole that constitutes the subject of my paper today. Although the familiar subject of managed competition is in the title, it is not my purpose to recapitulate in any detail the model which I have put forward (see Scotton 1999 for the most recent description of the model). Rather, it is to set it, the present arrangements – and by inference other proposals which have been advanced – in the context of broad policy objectives for the Australian health care system as a whole.

There are various causes of differences in prescriptions for health system ‘reform’. They range from different perceptions of how the existing system works (or doesn’t) to inconsistent ideological starting points and outright conflicts of material interest. At the same time, there is a greater measure of agreement about the public policy goals and objectives than there is about their specific policy implications.

It has become necessary these days to state one's position in the economic spectrum. I am of the extra-welfarist persuasion: that is to say, I believe health services have special characteristics which distinguish them for the purposes of public policy analysis from the general run of goods and services.¹ In particular, I believe that the goals of health service systems should include not only the maximisation of utility in the strict microeconomic sense, but also population health and equitable access to services, based on medical need. The existence of multiple goals is one of the reasons for the complexity of health policy issues – with regard to both problems and solutions. This is the more so, in that although the goals are conceptually different, they are in practice closely interconnected. The equity and health goals are linked by the fact that, from a utilitarian perspective, population health status will be raised more by directing preventive and personal health services to the disadvantaged than to those in a position to provide for themselves. The link is strengthened by the strong inverse relationship between socioeconomic status and levels of health.

Let us look a little more closely at the three goals and their policy implications with regard to government intervention in the form of regulation and funding.

1. *Efficiency* means the optimal allocation of resources, to and within the health care sector, to maximise utilities based on individual preferences. It is maximised by the operation of free markets, with few exceptions, the grounds for government intervention being limited to the existence of externalities, anti-competitive structures and practices and information deficiencies.
2. The acceptance of better *health* as an independent goal of policy is a more powerful justification for public intervention, in the form of discrimination in favour of services and delivery modes which have higher returns in terms of health improvement per unit of resources used. The advance of medical knowledge and techniques has given a great impetus to public interventions in pursuit of this goal, well beyond the range of externalities in the strict economic sense.
3. The *equity* objective relates to the special status of health care as a component of a decent standard of living in a humane society with a developed economy. It can be expressed at various levels, of which perhaps the most conservative is the proposition that no person's access to medically effective health services should be limited by inability to pay or should result in financial hardship. The exclusion of health services, to a greater or lesser extent, from the reward system which governs access to most other goods and services is a feature of all developed countries and many others at a lesser level of development.

In examining the implications of the above, I start with the central proposition that the *equity objective* is, and always has been, the primary rationale for government funding of the health care system. Over time, as the effectiveness and the cost of personal health services have increased enormously, the demand for and supply of public funding has steadily risen, to the point that about 68% of all current health expenditures are met from government sources – a figure which ranks Australia toward the lower end of the

OECD range. In light of the inverse relationship between health status and socioeconomic status, rising real costs of state-of-the-art health care, growing inequality of incomes and the increasing proportion of the population in the upper age groups, there is no reason to believe that the enormous need for cross-subsidisation will become any less. Nor is it possible that the requisite degree of cross-subsidisation would be forthcoming from any conceivable set of private arrangements based on the voluntary choices of individuals.

The fact is that government has to remain in the cross-subsidisation business in a very big way, or the access of the less healthy and the poor to health services will be seriously curtailed. The risk is not confined to a small and easily identifiable group of very poor and/or chronically ill. The concept of medical indigence has largely fallen into disuse since the almost universal prevalence of national health programs, but the level of income at which the occurrence of major health problems would cause serious financial difficulties is well above the poverty line, and those at risk form a large (and perhaps growing) proportion of the population. The case for universal coverage under a national program in which the cross-subsidisation is undertaken by government agencies funded through the budget is as compelling as it was 25 years ago.

In fact, the increasing inequality of incomes and wealth, and reduction in employment security which have resulted from globalisation and microeconomic reform have, if anything, increased both the need for universal health coverage and the voting public's valuation of the security which it offers. Quite apart from the valuation individuals place on security from the costs, universal coverage has an immense social value, at a stage in our history when many other institutions which have performed this function in the past are felt to have gone or to be under threat. It may be noted that none of the other industrialised countries exploring health system reform have contemplated reducing the universal or near-universal coverage of their national programs, which they regard as an essential expression of the principle of 'solidarity'. Social cohesion may have little bearing on short-term gross domestic product growth, but its erosion could generate very large long-term costs. In this context there is no doubt that Medicare and the other universal components of our health system are increasingly important elements in our social cement. Moreover, unlike many of the protectionist arrangements which have been dismantled, they do not inherently impose additional costs on the economy.

This is where the *efficiency objectives* come into the picture. The consequence of government intervention on the demand side – originally in the form of direct service provision, selective cash benefits and subsidies and other encouragement to private health insurance, and later through the establishment of universal publicly funded benefit programs – was a massive increase in the effective demand for health services. This necessarily undermined whatever capacity the health care market might have had for equilibrium in the absence of these interventions. The impetus for rapid expenditure growth did not come solely from the demand side, but was also powered by rapid advances in new medical knowledge and technology, which provided treatments which were far more effective in clinical terms than their predecessors and, especially in the

case of conditions for which no curative treatments had existed, on balance more expensive also.

In this respect, Australia's experience over the past half century has paralleled that of other developed countries. For a while, up to the early 1970s, rates of economic growth in OECD countries were such that rises in health care costs absorbed a quite tolerable portion of the incremental gross domestic product. However, as growth rates declined, the opportunity costs of increased use of health services rose sharply. Governments in most countries – with the notable exception of the United States – moved to contain them directly through budget and capacity ceilings and price controls and, subsequently, through attempts to limit access to services in a selective manner, hopefully related to the effectiveness of particular services in improving health outcomes.

These measures were substantially successful, in Australia and most other countries. The graphs of the percentage of gross domestic product devoted to health care show a pronounced discontinuity in the 1975–85 period. It was the very existence of a universal, publicly run program that provided the means by which financial constraints could be imposed. The notable exception to the trend was the United States, where the absence of a national program meant that there was no machinery through which budget ceilings could be imposed. However, the inexorable increase in the cost of state-of-the-art health care has continued through the years since, with continuing pressures being placed on health providers through growing stringency in current and capital budgets, with the emergence of waiting lists and other symptoms of explicit rationing of services. One senses a growing sense of malaise about health care systems in many countries, although the differences in their institutional arrangements mean that the stresses are manifested in various ways.

In fact, global budget ceilings and capacity limitations are blunt weapons, consistent only in a loose sense with allocative efficiency. While they are a necessary tool for constraining the resources allocated to health care, hopefully to a level approximating the point at which marginal social benefits are equal to marginal social costs, they are relatively ineffective in improving the efficiency with which health care resources are actually used. In fact, over time, the increasing complexity of medical practice and health care organisation has diminished the capacity of government agencies to make efficient allocation decisions.

As a result, among OECD countries there has been a growing advocacy – to some extent carrying over into implementation – of reforms involving a greater use of market and quasi-market relationships and incentives, in order to introduce a degree of self-regulating capacity within health care systems (Hurst 1991; Enthoven 1993; van de Ven et al. 1994; Chernichovsky 1995; van de Ven 1996). This advocacy, and the corresponding reforms, are all framed in the context of universal national programs offering a guaranteed package of care, in general financed publicly through taxation or earmarked social security contributions. In his description of what he terms the

‘emerging paradigm’, Chernichovsky (1995, p 347) distinguishes three conceptually different key system functions:

- (i) financing of care (including responsibility for the legislative and regulatory framework, that is, the ‘rules of the game’)
- (ii) organisation and management of care consumption (OMCC), defined as that part of consumption (that is, the socially guaranteed package) funded from the public program, and
- (iii) provision of care.

In Chernichovsky’s terms, the ‘emerging paradigm’ involves the separation of the government from the functions of OMCC and provision. In addition, he envisages that the second and third functions would generally be undertaken by different organisations, except to the extent that vertically integrated HMO-type organisations were viable.

The central question considered in this paper is whether and to what extent a model of this kind would have advantages in the Australian context.

The state of Medicare

After a period in which it occupied a central position in our national political debate and election platforms, the broad issues of health care financing and organisation are now in a sort of twilight zone. The turning point was the rejection in 1993 by the electorate of the radical proposals to dismantle Medicare which were incorporated in the *Fightback!* program. Since then, the Coalition parties have promised to maintain Medicare, effectively neutralising it as an election issue, while the emphasis on controlling budget outlays at the federal and State levels has fostered a creeping privatisation largely lacking serious rationale or observable benefits. The Commonwealth Government carefully circumscribed the terms of reference of the Industry Commission’s inquiry into private health insurance, and its subsequent extension by way of the income tax rebates of huge subsidies to private health insurers bore no resemblance to the Commission’s recommendations and was implemented with a minimum of debate. The current atmosphere is one in which serious discussion of big issues is not welcomed.

In the ideas market, Medicare has been regularly attacked by market economists and by spokespersons for people with material interests in the private health system. Many of their attacks are designed to promote the proposition that Medicare is in a state of crisis and can no longer be ‘afforded’ – a proposition at odds with the Australian record of maintaining total health expenditures at about the average level of non-United States OECD countries. The policy implications of this view are that efficiency gains in the health sector be achieved by abolishing universal entitlements and replacing them by means-tested subsidies for the poor and medical savings accounts for the rest of the population. Such programs would be rewarding to those in better health and economic circumstances and to many (especially the larger and more entrepreneurial) providers and insurers, but singularly disadvantageous to people in neither of these categories.²

At the other end of the policy spectrum we find a tenacious attachment to the detail of the present Medicare arrangements, the main rationale for which is the (not totally unjustified) fear that in the present political climate any changes are more likely than not to be for the worse with respect to the universality of coverage and income-related financing, which are its key features. However much this may be justified as a short-term tactic, it has little to contribute to long-term strategy.

These polar positions leave a large vacant policy domain in between. In the first place, Medicare is not in 'crisis', in the sense that any real meaning can be attached to that emotive term. The basic structure of Medicare is highly resilient and in terms of the ultimate outcome measure 'how does the average sick person get on?' the Australian health system probably does as well, in both absolute and value for money terms, as that of any other developed country. On the other hand, there are signs that Medicare is under growing stress, evidenced by more difficult access to publicly provided services and erosion of private health insurance coverage. These are the manifestations of longer run problems, for which no short-term or simple fixes are available.

Mounting concern about health system performance is not peculiar to Australia. Our situation is no more than the local manifestation of the effects of secular growth in the real cost of state-of-the-art health care resulting from continuing advances in medical science and techniques. This experience is shared by all developed countries, which alone have the luxury of committing themselves to the objective of providing state-of-the-art care to their entire populations. Given the constraints which apply to economic growth in developed economies, increments of real health care expenditure come at increasing opportunity cost, with consequent pressure to find economies, that is, to increase the efficiency with which health care resources are used. In other words, *efficiency* must now be accorded a higher priority in health systems than ever before: the overriding goal may now be re-expressed as universal access to medically effective health care *at least cost*. It is pertinent to note that this qualification relates to *total* health costs, and is independent of the private and public sector shares. Hence any solution must also address efficiency in both sectors.

The intrinsic difficulties in finding efficiencies in the health system are compounded in Australia by:

- the almost unique division of responsibility for health service funding between federal and State governments
- the multiplicity of separate programs, of which Medicare is only one, through which public sector health services are funded
- the lack of articulation and of comparability of incentive systems between public and private sector funders and providers.

The consequences are:

- distortion of consumer choices and provider allocation decision-making
- impediments to efficient substitution between higher and lower cost modalities of care funded under different programs

- the generation of opportunities for cost-shifting between different payers, which are availed of on a wide scale, at considerable direct and indirect cost.

The implications of this diagnosis, if accepted, are that an overall strategy for the health system would include not only general market-oriented reforms designed to transmit better incentives to all participants in the system (funders, providers and, as far as possible, consumers) but also significant restructuring of existing program and funding arrangements, to encourage productive substitution and minimise cost-shifting. This would involve substantial dismantling of the existing regulatory systems, rationalisation of the roles of Commonwealth and State governments and, to the extent consistent with other objectives, promotion of genuine competition within and between public and private sector participants.

In considering what this means for Medicare, it is important to distinguish the *essential* elements of Medicare and those which are products of the circumstances of the time at which the program was implemented. Like its successor, the original Medibank was designed and implemented with *equity* as its predominant rationale. The two core features of Medicare, by which the goal of access to health care for all members of our society is secured, are universal coverage and income-related financing. These are quintessentially public functions, which are deliverable only by governments through the exercise of legislative and taxation powers.

However, there are other aspects of Medicare – and of the health system as a whole – to which the same considerations do not apply. In principle at least, there are other areas (at the industry or firm level) in which market tools could contribute to economic efficiency (both technical and allocative) in much the same way as for the production and distribution of other goods and services.

In the past, the use of market tools in the health field has been impeded by several factors:

- inherited traditions of extending public assistance to poor and disadvantaged people through the direct provision of services
- the need to control or offset deeply rooted anti-competitive norms and institutions in the health field
- lack of workable output/outcome measures and information systems which could support efficient price signals.

Governments have traditionally intervened extensively, by anti-competitive regulation and by the establishment of (sometimes monopoly) public providers, to secure the public objectives set out above, and to protect consumers and payers (including themselves) from exploitation of monopoly power. However, in recent decades the situation has changed radically with respect to the relative capacity of government (through regulation, public provision and centralised allocation decisions) and more decentralised, market-oriented approaches to improve system efficiency. The driving factors have been as follows.

- The increasing complexity of medical knowledge and technology, with consequent diversification of skills, professional structures and organisational arrangements – which make the effectiveness of centralised allocation of resources ('control of the commanding heights') increasingly ineffective as a management strategy. Market tools provide an alternative means of achieving efficiency through the decentralisation of allocation decisions.
- Technical progress which has greatly improved the prospects of establishing workable markets in health services, namely:
 - the development of casemix tools, especially in the high-expenditure area of acute hospital care, as measures of output to which prices can be applied
 - advances in information technology which have not only made possible, but also offer prospects of, huge decreases in unit costs of processing the vast amounts of information necessary to establish complex databases required for efficient payment and risk-mediation systems.
- Changing public attitudes to the exercise of government power over many areas of economic activity constitute an environment in which the balance of relative effectiveness between public regulation and market tools has shifted decisively in the direction of the latter.

This is the context in which the managed competition program is proposed, that is, as a means of continuing to achieve the social and equity objectives which Medibank/Medicare was designed – *in the circumstance of the present time, that is, 30 years later* – while delivering improved efficiency at the microeconomic level. Whether that is interpreted as reform or abandonment of Medicare is basically a matter of semantics. Candidly, I can envisage no other reform which has any promise of achieving these objectives, and I would not be advocating radical amendment of the system if there were a feasible incremental alternative.

What might managed competition achieve?

As previously indicated, it is not the function of this paper to describe the managed competition model, other than in the broadest terms. In fact, it should be stressed that the model set out in Scotton (1995, 1999) is put forward as an example of a *possible* plan, designed to examine the feasibility of the concept and to promote discussion of health system reform issues, rather than as a developed program. In addition, some of its specifics are influenced by the need to effect a workable transition from the present arrangements, and could be amended as those needs disappear.

The extensive structural changes in my model are largely configured around the establishment of agencies, which I have termed 'budget-holders'. These organisations would take over from governments the OMCC function described by Chernichovsky and would occupy the central place in the health system. They would be the means whereby many of interactions now characterised by regulation, public monopoly and

hierarchy – the consequences of which have been graphically described by Paterson (1996) – would be replaced by informed contractual relationships in a broadly competitive market.

Within the framework of universal entitlement and global public funding, the model is designed to achieve a number of quite specific and identifiable goals – notably the elimination of cost-shifting between major participants and the inhibition of other manifestations of moral hazard, and the promotion of efficient resource allocation decisions at all levels of the system by the diffusion of rational financial incentives. Cost-shifting would be eliminated by the aggregation of existing programs into a single program, involving a single budget-holder having total financial responsibility for all the costs incurred by all persons enrolled with it. Moral hazard in the form of ‘cream skimming’ would be minimised by funding budget-holders through risk-adjusted capitation payments. (Scotton 1995, pp 94–5). The combined effect of these features would be to give an overwhelming focus to the goal of efficiency, which would be reflected in the contractual conditions offered for service provision. In this respect, the bargaining strength of purchasers of services would be enhanced, since budget-holders would be in a much stronger position than individual consumers in need of care.

At the level of the secondary (consumer) market in services, budget-holders would be constrained from ‘skimping’ or other forms of exploitation by the need to compete for market shares. As will be explained in the following section, consumers would have – if not the theoretical sovereignty promised under pure competition – a highly effective choice between alternative packages, which they would generally be better able to evaluate than the services of different health care providers.

While the model would significantly reduce the role of governments, the functions which they would need to retain are central to the managed competition model. The first of these is the basic funding of the national program. The Commonwealth Government would retain responsibility for cross-subsidisation by raising the great bulk of program revenue through the budget and disbursing it in the form of risk-adjusted capitation payments to the budget-holders. In addition, it would retain functions related to ensuring the broad outcomes of the program: setting overall policy parameters; maintaining the (competitive) rules of the game; managing the risk-rating process, and ensuring the access of all eligible persons, with special emphasis on the disadvantaged, to the benefits of the program.

Continuity with the present arrangements would also require a public sector presence in the budget-holding function, to ensure that people who did not contract with a private budget-holder would automatically be enrolled with a public budget-holder, that is, protected in a manner analogous to the present Medicare. In the model I have put forward, this would basically be undertaken by regional public budget-holders whose supervision, within the context of Commonwealth law, would appropriately be the responsibility of the relevant State governments. The relative shares of public and private coverage might change over time, but would be an issue of relatively small public policy interest – as distinct from its present undue prominence in public debate. The suggested

model also involves State governments retaining responsibility for the operation of publicly provided health services. Control of the scale and location of publicly provided health services would remain an important policy parameter, although the dependence of agencies providing personal health services on payments from budget-holders would limit State governments' discretion in the exercise of this function.

Consumer interests

While reforms directed to increased efficiency are most often thought of in terms of their impact on participants involved on the supply side – that is, on providers and funders of services – it needs to be remembered that the end of economic activity is the welfare of consumers. In fact, the managed competition model has the potential to benefit consumers in a number of ways, in addition to the obvious corollary of increased efficiency, in the form of an increase in the volume of health and/or other services which can be purchased from their incomes.

However, this does not mean that patients would have an increased say in their medical treatment. This issue was addressed by Paterson (1996) when he commented on the abysmal lack of access of medical consumers to information, and about deficiencies in communication between providers of care in respect of the same patient. The remedy he advocated was the empowerment of consumers through access to their medical records, on the grounds that consumers, thus armed, would be in a position to bargain effectively with providers, without the need for intermediaries in most cases. The case for unification of medical records and for better access to them by patients is worthy of support on many grounds, but for many, empowerment would be more effectively achieved by OMCC agencies acting on their behalf than by an enhanced bargaining capacity as an individual. In any case, the right to information would enhance the capacity of consumers, individually and collectively, to bargain with budget-holders.

In fact, Paterson (1996, p 38) goes some way toward this view, in that he argues in favour of the application of 'co-ordinated care' (a euphemism for managed care?) in the case of large multi-program users of the system. In another context he expresses the view that 'Innovation on the "aggregator" side offers extraordinary potential for dynamic evolution of a new health industry structure' (p 39). In my view, this is precisely what managed competition is about. It is clear that many features of the present system are inimical to the development of 'aggregators' able to offer packages of health services in a competitive market. Their establishment and subsequent evolution can only occur in a different program structure, designed so as to be conducive to their development.

Chernichovsky's case for the OMCC function to be delegated to a number of competitive intermediaries rests substantially on the empowerment of consumers through their public entitlements being packaged in a variety of forms tailored to their needs, rather than set out in legislation inevitably involving arbitrary decisions about which particular types of services are to be included in public entitlements. Protracted debates in the Netherlands, New Zealand and Oregon have highlighted the difficulties involved in central decision-making of this kind, and the limited results achieved from

prolonged search. The fact is that almost every possible medical intervention may be justified in some set of circumstances. The rationale for these – or for non-medical substitutes for services defined as ‘medical’ – is often capable of being set down in professionally certified protocols, but often case-by-case decisions are needed. Good decision-making in these circumstances cannot be legislated for, nor is it appropriate for centrally based officials to have the powers required for the exercise of wide discretion.

In my suggested managed competition model, this advantage does not result simply from its greater market-driven responsiveness to the diverse needs of individuals. It is powerfully reinforced by the risk-rated capitation formula, calculated from the differential expected costs of enrolled individuals. The effect of this formula would be to give greater weight to the care needs of people in poorer states of health and with lower income than would the outcome of an unregulated market. In the managed competition model, spending power – in the form of risk-rated capitation revenue – is weighted in accordance with health care needs. There would be no more ‘healthy singles’ tables, for which low-risk capitation payments would yield slim pickings. On the contrary, if the risk-adjustment formulas are accurate, budget-holders’ offerings would be designed to attract high users, and the result may well be the development of specialist (sub-budget-holder) organisations geared to meet the needs of various high-risk or high-need sub-populations.

On the subject of consumer welfare, it is necessary to address the issue of managed care, of which a caricature of the United States system has been advanced in order to resist any suggestion that individual doctors might be subject to some external constraint on their use of publicly funded resources as inputs to treatment. From the opposite point of view, managed care means no more than the planned use of resources available from constrained budgets to achieve the best outcomes, and is likely to be applied – on grounds of cost-effectiveness – to cases of serious and long-term illness involving large and preferably avoidable expenditure. It is highly desirable that managed care regimes should be undertaken in accordance with protocols and guidelines incorporating expert medical opinion, based on the best evidence, and be under the control of medically qualified people, with the aim of maximising clinical effectiveness rather than minimising costs. In some cases, such as the management of many long-term chronic conditions, managed care regimes involving regular supervision and intervention at the community level may result in improved health outcomes *and* cost reduction, through the avoidance of acute episodes requiring costly inpatient treatment.

The fact is that freedom of choice costs money, without necessarily delivering better health outcomes. In fact, to the extent that multiple choice combined with fee-for-service remuneration facilitates polypharmacy, failure to coordinate medical records, excessive testing and over-treatment, it may be negatively correlated with health outcomes. There is no need to apologise for the proposition that competitive pressures applying to budget-holders operating in the framework of managed competition would almost certainly result in limitation of access to uncontracted providers and the selective application of managed care in most basic plans.

At the same time, the flexibility of the model allows for a market-based solution. It would be consistent with my managed competition model to allow consumers who place a high value on freedom of choice to contract out of such restrictions. Under the model, private budget-holders would be able to offer packages giving wider choice of provider – that is, to a greater or lesser extent offering exemption from the application of managed care – but with the proviso that they be priced so as to preclude any cross-subsidisation from more basic tables. Since it would be expected that these higher tables would be subject to adverse selection, the additional premiums required might be very high indeed.

Providers

Unlike a financing system such as Medicare, the managed competition model is designed to effect profound changes to the supply side of the health system. The incentives to efficiency – and to evolutionary structural change conducive to further efficiency – would be primarily effected through the operation of the primary remuneration formula of risk-adjusted capitation, from government to budget-holders. The pressure to spread risk by sharing it with providers would be very strong – if United States experience is any guide, the adjustment process (at least in large urban locations, in which the great majority of the population lives) could be quite rapid. Aspects of the expected results include larger scale, more integrated organisation of providers, with the following features.

- *Fee-for-service* would decline as a component of remuneration. The form of remuneration would be determined by contracts between budget-holders and providers/sub-budget-holders, and (unlike the present arrangements) could vary according to individual circumstances. Given the incentives to diffuse risk, it is probable that mixed systems of remuneration would emerge, incorporating fee-for-service, capitation and other elements such as revenue or profit-sharing. There need be no uniformity: different doctors could be paid in different ways.
- *Managed care would apply to a growing proportion of patients.* Managed care has been much maligned. However, on a broad view, it could be defined simply as a process designed to secure the rational use of resources – for example, by the use of treatment protocols based on the best evidence to guide medical decision-making – in order to achieve the best available health outcomes.

Managed care has the potential for substantial savings in some cases – especially those involving patients with serious and/or long-term illnesses involving potentially high-cost treatments. On the other hand, it also involves significant administrative costs. Its application should therefore be selective, in accordance with a mixture of clinical and economic criteria. However, even with the benefit of protocols to guide allocation, the determination by any sort of bureaucratic process of who would or would not fall into categories requiring managed care would be greatly complicated by changes in health status – many individuals cannot be classified into high-cost/low-cost categories on a long or medium-term basis. It can be expected that the most efficient application of

managed care would be by budget-holders using flexible criteria, motivated by a direct pecuniary interest in making it work.

It is here that the role of the medical profession is crucial. Its political stance should be to ensure that it is in charge of the process of defining protocols and making the clinical decisions for which its members are uniquely qualified, rather than defending the right of individual doctors to be unaccountable for their use of resources.

- *Primary care resources would be redistributed more evenly* between metropolitan and country populations. The operation of the adjusted capitation formula would tend to bring this about automatically in the case of primary care, since the per-provider revenue available would be a function of the population–provider ratio, rather than the number of services per provider. Disparities in populations served would lead to a redistribution of notional general practice incomes between metropolitan and non-metropolitan general practitioners, and the resulting disparities would strengthen the incentives on general practitioners to move to non-metropolitan locations. The issues regarding specialist care are somewhat different, but the capitation formula might promote some diffusion of out-of-hospital specialist services to larger non-metropolitan centres.
- *Public hospitals would have the opportunity to maintain their status* (along with general practice) as a key of the Australian health system. Universal access to public treatment in public hospitals is an essential aspect of the universal system – they should not decline to the status of last resort for the desperate. The managed competition model I have proposed mandates free access to public hospitals as a universal entitlement of all packages offered by budget-holders: to do less would be to seriously abridge the rights now enjoyed and appreciated by Medicare beneficiaries.

This would by no means amount to a monopoly for public hospitals. They would depend for the bulk of their income on contractual payments by public and private budget-holders, which might be expected to take the form of DRG-related case payments. This would be the case for the treatment of private as well as public patients, which would enable public hospitals to compete actively for private patients, within pricing constraints which ensured that their prices fully covered their costs.

Provider restructuring

In recent years in California the need to bid for and secure contracts with budget-holders for a share of capitation revenues has led to profound restructuring among service providers, in directions which theory would predict. Coalitions of hospitals and multi-specialty medical groups – under the aegis of one or the other party – have been formed, for the purpose of offering broad-spectrum service coverage of defined populations. Two developments are noteworthy. Firstly, these organisations have not been tightly structured like the classical staff model HMO (‘vertical integration’), but tied together by internal contracting based around shared information systems (‘virtual

integration') (Robinson & Casalino 1996). Secondly, they have proceeded to the next step of offering their services directly to funders (that is, large employers), thereby cutting out the third-party intermediaries or, to put it another way, they have moved to take over or internalise the budget-holding function, in the same way as the classical HMOs.

There is no reason, under the managed competition model, why the risk-pooling function should be reserved to specialist financial intermediaries such as the present health insurance funds. Indeed, diversity in budget-holding – subject only to obvious prudential requirements – should be positively encouraged. The relative concentration of Australians in a few large metropolitan conurbations provides scope for the entry of one or perhaps more HMO type organisations, of which the local beginnings can perhaps be seen in the growth and diversification of Health Care of Australia. In the context of managed competition, their entry could inspire unaccustomed strong competition from the more entrepreneurial of the established insurers. There is no framework other than the managed competition model in which the market can be expected to deliver such beneficial outcomes in the health care system.

General practice

In a health financing system incorporating efficient incentives, general practice would be enhanced, through expansion of (and payment for) gatekeeper and public health functions in respect of defined populations. Responsibility for a range of own, referred and ancillary services provided to defined populations would require the enrolment of patients with a specific practice, with the corollary of some degree of restriction on coverage of services obtained from or through other providers. This would, of course, contribute to that continuity and coordination of service provision advocated as especially conducive to good patient care.

Contacting arrangements of this kind between primary care providers and budget-holders would be conducive to larger practice size, in order to spread risks, to encourage some degree of sub-specialisation and employment of paramedical personnel, and to take advantage of economies of scale in purchasing and administration. Trends of this kind have been observed among fund-holding general practices under the British National Health Service. This would not necessarily mean, nor would it be desirable, that small-scale and even solo practices would disappear. Advances in information technology have made it possible for small practices to share information, financial risks and purchasing costs without structural integration. This is a function which might be taken on by the emerging divisions of general practice, and which could become their principal *raison d'être*.

Ancillary health and support services

The present system of fee-for-service remuneration results in disincentives to the use of ancillary personnel in private medical practice and lack of access to nursing and paramedical services on the part of many patients who would benefit from it. Population-based reimbursement of providers, such as could be expected to become more prevalent under managed competition as budget-holders seek to share their risks, would encourage the substitution of lower cost alternatives to doctors' own time, both within medical practices and by contracted-out or bought-in services in circumstances in which the outcomes were judged to justify the costs.

Conclusion

With modern health technologies, there is no way in which any society can afford to provide all the health services which individuals and/or their medical advisers might – without being subject to financial or other constraints – wish to have. Limits have to be set, either by imposing financial costs on consumers (which the well-to-do are better placed than poorer people to pay) or by rationing the volume and type of services which are publicly provided or subsidised, for which the incidence of costs depends on the criteria governing the provision of services. In fact, the transfer of costs to patients is of limited efficacy in reducing consumption. To the extent that it does work, it has negative consequences for equity and health goals, not to mention wider aspects of social welfare (Rice 1997, pp 412–21).

As long as the goal of universal access to all medically effective care is maintained, the basic problem presented by the increasing real cost of state-of-the-art health care cannot be solved or avoided. The only feasible strategy is one of containment, by increasing efficiency, both at the system-wide and micro levels. It is at this point that one can join the advocates of freer markets. Provided that it is possible to establish a market which meets sufficient of the microeconomic criteria to be regarded as workable, efficiency will be maximised by allowing allocation decisions to be made by many individual producers reacting to market signals.

The managed competition model offers a framework within which the objective of increased efficiency could be pursued without sacrificing the goal of universal access and without impairing health outcomes and social cohesion, which the abandonment of this access would involve. It would do this by removing the present multitude of structural impediments to rational decision-making and allocating to markets and governments the functions which they perform best.

Endnotes

1. The policy implications of the special characteristics of health care have a long tradition in economics, dating from Arrow's classic (1963) article. For those interested in this debate, a recent exchange between economists of the welfarist and extra-welfarist persuasions appears in a series entitled 'Assessing markets: Model and practice' in *Journal of Health Politics, Policy and Law*, vol 22, no 2 (April 1997) pp 383–508.
2. I exempt from this generalisation a serious proposal advanced in the recent discussion paper on 'transferable Medicare entitlements' issued by the Australian Private Hospitals Association (1998). It incorporates cost calculations which are indicative for the managed competition model, and which indicate that the budgetary cost of the model would be about the same as present government outlays, *when the cost of the private hospital subsidy is taken into account*. However, the implications of cashing out Medicare entitlements are significantly different from entitlements to coverage by organisations operating within a managed competition framework.

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