Purchaser/Provider and Managed Competition: Importing Chaos?

Andrew Street
Research Fellow

April, 1994
ISSN 1038-9547
ISBN 1 875677 321
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The Co-ordinator
Centre for Health Program Evaluation
PO Box 477
West Heidelberg Vic 3081, Australia
Telephone + 61 3 9496 4433/Facsimile + 61 3 9496 4424
E-mail CHPE@BusEco.monash.edu.au
The Health Economics Unit of the CHPE receives core funding from the National Health and Medical Research Council and Monash University.

The Program Evaluation Unit of the CHPE is supported by The University of Melbourne.

Both units obtain supplementary funding through national competitive grants and contract research.

The research described in this paper is made possible through the support of these bodies.

### AUTHOR ACKNOWLEDGMENTS

I gratefully acknowledge Professor Richard Scotton and Dr Terri Jackson for helpful comments on earlier drafts of this paper, and Chris Altis, Joseph Cagliarini, Dr Vivian Lin, Peter Nagel, Gianfranco Spinoso and Sabrina Stow from the Victorian Department of Health and Community Services with whom I had fruitful preliminary discussion of the issues. The views expressed and any errors are the sole responsibility of the author.
A purchaser/provider separation and managed competition have been recommended as options for reform of Australia’s health system. This paper presents the theoretical basis and supposed advantages of each model. The introduction of the purchaser/provider separation in the United Kingdom and New Zealand is described, as are the proposals for implementation of managed competition in the United States and The Netherlands. The potential for either model to deliver its promised benefits is critically evaluated in the light of existing evidence. It is concluded that neither model can command unqualified support, and that alternative policy options might merit consideration before importing solutions from overseas.
Introduction

A purchaser/provider separation and managed competition have been suggested by a variety of commentators as reform options aimed at correcting some of the structural inadequacies of Australia's health care system (National Health Strategy 1991, 1993; Gilbert, Viney & Katz 1993; Victorian Liberal National Coalition 1992; Scotton 1991, 1992, 1993). To some extent purchaser/provider and managed competition share similar themes and may be easily confused, not least because they originate from the same person. Alain Enthoven first formulated his ideas about managed competition in the 1970s in the context of the United States' health system (Enthoven 1978). Subsequently refined, these ideas are a central part of the reform package recently launched by the Clinton administration (Enthoven 1993; United States, The White House 1993). In 1985 Enthoven produced a paper addressing the future of the National Health Service in the United Kingdom (UK), which became the blueprint for the reforms introduced in 1989 (Enthoven 1985). He was also instrumental in providing direction to the Dutch who began a re-evaluation of their health system in 1987 (Enthoven 1988).

However, despite their common origin the concepts are distinct. A purchaser/provider separation is designed to use contractual arrangements to introduce competitive elements into what remains essentially a publicly managed health system. The reforms which have been implemented in the UK, and which are presently being introduced in New Zealand (NZ), aim to distinguish responsibility for demand (purchasing) from that of supply (provision) where these roles have not previously been separated. In contrast, the reforms being discussed in the Netherlands and the United States (US), are not intended to create these distinctions because they already exist. Rather, under managed competition the aim is to reform the market for health insurance, by subjecting insurers to a regulatory framework designed to minimise risk selection and to transform insurers into purchasers of services. Van de Ven (1993) characterises the difference between the two structures by arguing that purchaser/provider aims to form a health care market, by separating demand from supply, whereas managed competition aims at reforming the existing market, by focusing especially on purchaser (insurer) behaviour. While the main thrust of purchaser/provider is towards promoting competition among providers, under managed competition it is competition among purchasers which is of prime concern.
This paper has two main sections. The first section focuses on the purchaser/provider model, describing its rationale and main features. The reasons for the introduction and experience of the model in the UK and NZ are then explored. The theoretical merit of a purchaser/provider separation is then evaluated with respect to four main issues: priority setting, consumer representation, effective contractual arrangements, and waiting lists. The section concludes with a consideration of the value of a purchaser/provider separation in Australia.

The second section of the paper addresses managed competition. The model is described, together with an outline of the proposals for its introduction in the US and the Netherlands. The suggestion that managed competition might be a suitable reform option in Australia is then evaluated.

The purchaser/provider separation

The purchaser/provider model aims to introduce market incentives into publicly managed systems. To achieve this, the model assigns managerial responsibility for the functions of demand and supply to distinct institutions. The production of services becomes the sole concern of provider bodies such as hospitals, nursing homes and community health centres, which no longer hold a budget and decide how it should be spent. Rather, providers depend for their revenue on contracts from purchasers. However, purchasers are not consumers or patients, but purchasing authorities established to buy (but not produce) health services. Purchasing authorities are commissioned to secure improvements in health for defined (usually resident) populations, and do so by assessing their population's health care needs, determining the most cost-effective means of meeting these needs, and contracting with providers to supply the services required.

Fundamental to the purchaser/provider separation is the process of competitive tendering, or contracting, designed to encourage competition among providers. Having estimated which and how many services are needed, the purchasing authority invites providers to submit tenders for contracts to supply them. These contracts specify the type and amount of care to be supplied, the quality of the service, and the contractual period. Once awarded, providers are able to focus on the technical aspects of provision, aiming to fulfil their contractual obligations at lowest cost. The merit of competitive tendering rests on its ability to force providers to continually seek to improve the efficiency of their productive processes. The more efficient will win more contracts by being able to submit lower bids than their competitors. They will also be able to expand into new areas of business where previously they may have been constrained from exploiting spare capacity.

With the pursuit of technical efficiency (i.e. how best to produce specified services) the concern of providers, responsibility for allocative efficiency (i.e. which services are best provided) is the preserve of purchasing authorities. Purchasing authorities are well placed to alter the mix of services available by acting in the interests of their populations and wielding their collective buying power. Released from the influence of providers, purchasing authorities are able to substitute care across traditional service boundaries, ensure that services are received in their most appropriate settings, and contract for cost effective forms of provision. Further, given their commission to
secure measurable health improvements it is in their interest to ensure a greater co-ordination of care for individual users.

Central government need not play a major part in the day to day running of the health system. After establishing regulatory functions, and allocating population weighted budgets to purchasing authorities, the market can be left to itself, with the central government restricting itself to the financial and performance audit of purchasers. The audit of providers can be left to the purchasing authorities with whom they have entered into contractual agreements. In practice, however, it is unlikely that the internal market would be allowed to be completely unregulated. Government departments may issue guidelines and directives to purchasing authorities to achieve a degree of consistency in purchasing decisions, and to ensure that the health system contributes to national, and not merely local, objectives and priorities.

**Internal markets: purchaser/provider in the United Kingdom and New Zealand**

*Background*

The UK and NZ were among the first countries to develop national health systems paid for through general taxation and allowing free or subsidised access to health services for all citizens. These public health systems were subject to considerable bureaucratic regulation, national directives passing down a single chain of administration and limiting local autonomy. Funding followed a similar route to managers.

In the UK, a population based formula was used to determine the annual cash-limited budgets allocated to Regional Health Authorities (RHAs). Some of these funds were used to provide services at regional level, with the greater proportion allocated to District Health Authorities (DHAs) within the region who were directly responsible for service provision in their locality. A similar funding basis was developed in NZ, where fourteen Area Health Boards (AHBs) were established in 1983, charged with responsibility for hospital and community health services.

In both NZ and the UK, hospitals, nursing homes and other institutions were paid on an historical basis, with minimal adjustment made for changes in workload. This method of financing did not encourage providers to increase workload. If anything, the reverse was true: hospitals, for example, had an incentive to limit the number of patients treated and thereby build up waiting lists so as to acquire extra funds to deal with the resulting problem. Managers of cash limited budgets had incentives to behave strategically rather than economically in the face of budget reductions imposed by governments seeking to increase efficiency. Instead of assessing productivity, managers cut service levels or engaged in cost-shifting to the primary care budget or the community, and employed political means to secure increased funding, by targeting high profile services for cuts (New Zealand Treasury 1990).
Moreover, in both the UK and NZ, consumers had limited ability to ensure that the health system responded to their needs and preferences. Universal access and zero or minimal direct patient charging entailed rationing by other means. Consumers faced limited choices in where they received treatment and the type of services available, and often faced delays in receiving the care they required, as exemplified by waiting lists. Consumer health councils were restricted more to reactive functions, providing advice on complaints procedures, rather than to proactive activities, having little direct influence on decision-making. The health system was geared more to satisfying the interests of managers and providers than to identifying and responding to the needs and wishes of patients (Enthoven 1985).

**Recent Reforms**

Purchaser/provider arrangements in Britain were introduced by the 1989 White Paper ‘Working for Patients’ which contained more far-reaching proposals than any previous suggestions regarding reorganisation of the National Health Service (United Kingdom Department of Health 1989). DHAs are now no longer responsible for administering the provision of care within their locality. Instead, they concentrate on assessing the needs of their resident population and contracting with hospitals and other providers for the health services required to satisfy these needs. Funds are allocated according to a capitation formula, ostensibly adjusted for the health of the population, although the adjusters and their weights remain under review (Sheldon, Smith & Bevan 1993). The reforms allowed hospitals the option of removing themselves from administration by the DHA, giving them greater flexibility in financial and personnel matters. Hospitals choosing not to become self-governing remain under DHA control on a contractual basis, as ‘directly managed units’ (DMUs). The DHA can purchase services from self-governing hospitals, DMUs (whether in the DHA or not), private hospitals, and any other provider it wishes to contract with.

Under the proposals canvassed in NZ in 1991, four RHAs were introduced to act as purchasing authorities (New Zealand Ministry of Health 1991). Unlike in the UK, where DHAs are responsible only for the purchase of hospital and some community services, RHAs in New Zealand are to purchase a much wider range of health services, including health promotion and disease prevention services which can be delivered to individuals. (Population focussed public health activities are the responsibility of a newly established Public Health Commission). Existing AHBs are now charged with overseeing services provided by both Crown Health Enterprises (CHEs), which run large hospitals and other major health services, and Community Trusts, which provide local services. As in the UK, relations between RHAs and provider units are mediated through contractual arrangements.

**The value of a purchaser/provider separation**
A number of claims have been made about the benefits which a purchaser/provider separation might be expected to yield. These claims are reviewed in this section. First the claim that priority setting will be made explicit is evaluated. The second argument addressed is that consumer representation will be enhanced, with purchasers acting as an effective counterweight to the power presently exercised by providers in the health system. Third, it is argued that competitive tendering will force providers to continually improve their productive processes. The value of contractual arrangements and the potential for effective competition through contractual arrangements is addressed. Finally, it is suggested that a purchaser/provider separation will enhance the pursuit of both technical and allocative efficiency. This claim is considered in relation to the effect purchaser/provider might be expected to have on reducing waiting lists.

**Priority setting**

Under the purchaser/provider model priority setting is an inherent feature of the needs assessment and resource allocation process. Decisions are less dependent on the demands of providers than they have been in the past, and more attention can be given to local opinion or the cost effectiveness of services. However, it remains unclear how priority setting should be conducted. Evidence suggests that, to date, DHAs in the UK have been unwilling to make explicit purchasing decisions or to set priorities (Ham 1993). It has been claimed that DHAs have resorted to crisis management with 'the urgent' taking precedence over 'the desirable' (Klein & Redmayne 1992). This experience may reflect information deficiencies and transitional difficulties associated with the shift to a new structure of organisation, which may not persist in the longer term.

Nevertheless, eliciting public preferences is a complex task and their use in decision making is not uncontroversial. In Oregon an ambitious attempt was made to incorporate public values in the process of deciding how to prioritise services to be made available to Medicaid beneficiaries. However, it was concluded that `citizen participation is a politically and legally flawed strategy' and all survey results and judgements about quality of life were eliminated before Federal approval was granted to the project (Fox & Leichter 1993). The desire for managerial autonomy and consumer input should be balanced against the risk that the consequent decisions, often based on the views of the majority or most articulate, may be unjust. There is a danger that the instruction for purchasing authorities to engage in community consultation will become a smokescreen for politicians wishing to avoid responsibility for difficult choices which are inevitable when resources are scarce.

In an attempt to ensure consistent priority setting, in NZ RHAs are to purchase all `core' services to which all New Zealanders are guaranteed access. Thus, instead of deciding which particular services to buy, the function of the RHA is restricted to determining how many services are required and which providers to purchase them from. The complex task of deciding which services to include in the core has not yet been completed. Indeed, the National Committee established to undertake the exercise has rejected the idea of producing a detailed priority list of services, arguing that core services might better be defined simply as those which have been
provided by the public system in the past (New Zealand National Advisory Committee on Core Health and Disability Support Services 1992).

Experience from the UK and NZ suggests that it is unlikely that the problems of priority setting will be resolved by independent non-elected bodies. Although it may valuable to have purchasing authorities promoting discussion of the issues, the questions of resource allocation cannot be avoided under a purchaser/provider separation any more than under other forms of health system organisation.

Consumer representation
It has been suggested that a purchaser/provider separation would allow consumers a greater role in the health care system (National Health Strategy 1993). The assertion that consumers will be better represented by decentralised bodies seems to rest on the assumption that decisions made as close to the consumer as possible are the most likely to reflect consumer preferences regardless of whether formal accountability mechanisms are in place, although no evidence has been produced to support this (Harris & Wood 1993). In the UK, DHAs are required to seek the views of their population and improve the quality of information available about health services (National Health Service Management Executive 1991). However, commentators have complained that the decision-making process has been obscure and subject to only limited external review (Dixon & Welch 1991).

To overcome this problem it has been proposed that consumers and communities should be represented in the decisions made by both purchasers and providers, influencing the provision of information, targeting of resources, and contractual specifications (National Health Strategy 1993). However, the extent to which community input actually influences decision making cannot be guaranteed even if provision were made for appointments to the respective boards of management. It is not clear who consumer representatives should be, whose views they would actually represent, what accountability they would have to their constituency, and how much weight would be given to their advice. It is difficult to envisage how statutory requirements can be framed to ensure adequate consumer representation because they do not redress the fundamental problem. Consumers do not actively choose to be represented by these bodies, and, short of going to live in another district, they cannot seek representation by another purchaser if dissatisfied with the service they have received. Thus, ultimately, consumers have no effective sanction over purchaser behaviour. Given that consumers cannot easily vote with their feet, there are few incentives for purchasing authorities to be innovative or responsive to consumer preferences (Van de Ven 1993).

Contracts and competition
The mainstay of the purchaser/provider separation is the contracting process. Contracts are the mechanism through which the influence of purchasers is wielded, with the benefits of a purchaser/provider separation resting on the competitive forces which contracting unleashes. However, a number of commentators have argued that the anticipated advantages of competitive tendering may not be as significant as advocates of the model maintain.
First, the contracting process is likely to entail high transaction costs. Competitive tendering quite plainly introduces an adversarial element into the health system. In the UK, a number of hospitals are in formal dispute with DHAs over their contracts, and the Audit Commission has reported that the tendering processes have been subject to uncertainty with some contracts remaining unsigned until well into the financial year (United Kingdom Audit Commission 1993).

Moreover, especially when there are large sunk costs associated with providing a service, the bidding process may be inefficient (Harris & Wood 1993). In order to make a realistic bid, a provider may have to invest in assets which cannot be readily convertible for other uses. If the provider fails to win the tender such resources will be lost to the system. Further, if a specialty fails to win its tender, shared hospital overheads will be spread over fewer specialties. This may compromise the efficiency of remaining activities resulting in a ‘spiral of decline’ in which other specialties fail to win their contracts (Akehurst, Brazier & Normand 1988).

As yet, there is little evidence from the UK or NZ either supporting or refuting these claims. The internal market in NZ has been introduced too recently for its effects to be known, while in the UK, DHAs have been unable to fully exploit their new bargaining positions, partly because the government has insisted on a transitional period before the internal market becomes fully effective. Consequently, the contracting process has amounted to a formalising of existing arrangements rather than a system of competitive bidding.

Second, it has been argued that quality may be a casualty of competitive tendering (Shiell 1992). Even if contracts included some quality specifications, providers may be able to skimp on non-verifiable aspects of care, especially if purchasers have a limited ability to scrutinise providers to ensure that contracts are fulfilled. Quantitative details such as price and volume are easier to measure than qualitative issues. Most contracts in the UK have included quality conditions as minimum acceptable standards, rather than the promotion of high quality care. The threat to quality is not, of course, peculiar to purchaser/provider arrangements, but may be more pertinent if providers, struggling to compete, believe that quality is worth sacrificing to win or retain contracts. Purchasers may be able to overcome this if, as an alternative to price competition, they were to set prospective prices and to ask providers to bid for contracts on the basis of quality. This would put the onus on providers to demonstrate quality, reducing the need for purchasers to monitor it directly and continuously.

A third potential problem with the contracting process is that it is likely to jeopardise access to particular health care providers. This has already happened in the UK. Although hospitals are obliged to admit all accident and emergency patients, they do not have to accept for other forms of treatment patients who are resident in DHAs with which the hospital has no contract. Although provision may be made for the hospital to bill the DHA retrospectively on a one-off basis there have been cases where the DHA has not agreed that emergency treatment was necessary and has been reluctant to pay. In their turn hospitals have been unwilling to accept further patients from the defaulting DHA. Caught in the middle of the billing argument it is not clear who is
responsible for the patient. Clear criteria are required to adjudicate between providers and purchasing authorities when no contract exists between them. But even with such criteria the basic problem remains. With contracts being the mechanism by which resources are allocated, referral patterns and patient choice are likely to be limited in the internal market. Those who wish to use providers, institutions or services which their DHA has not contracted for will find their access to them compromised.

Finally, the efficiency of the contracting process depends upon the presence of effective competition. It is competition which will drive providers to continually strive for improvements in their service delivery, so that they do not lose business to other agencies. It has been shown that hospital prices are lower in more competitive markets (Melnick, Zwanziger, Bamezai et al. 1992). However, this competitive edge may be blunt for a number of reasons. Competition may not be realised in sparsely populated areas where existing providers enjoy a natural monopoly (Kronick, Goodman, Wennberg et al. 1993). Particularly in rural areas it may not be possible for the purchasing authority to transport patients further afield. Rather than reflecting the cost of production, prices offered by rural hospitals may be set slightly below the amount that the purchaser would be willing to pay to transfer patients elsewhere, with hospitals reaping monopoly profits.

Even where more than one provider exists, the advantages of competition may be short lived if one of the local competitors is forced out of business. The threat of potential entrants may not be enough to ensure that monopoly practice does not occur. In an industry with high barriers to entry, including large capital costs and problems in doctor recruitment, the threat of competition may not be a significant deterrent to monopoly behaviour. Competition may be lacking even without the existence of monopoly. If providers engage in collusive behaviour they may be able to obtain higher prices than they would in a competitive setting. If prices do not reflect the costs of production, hospitals will gain from higher profits, but social welfare may not increase.

Efficiency and waiting lists
The most commonly cited indicators of the performance of public health systems are waiting lists. Two explanations may be offered for their existence. The first explanation, frequently heard by providers to pressure governments for more money, is that the health system has insufficient resources to respond immediately to the demands of all those requiring care. If those waiting are patients for whom the expected benefit of treatment is less than it is for patients presently being treated, the system is nevertheless making efficient use of its available resources. Waiting lists could be eliminated only by allocating more resources to the health system. Whether it would be desirable to spend more on health depends on the value derived from the present (non-health) use of the resources.

The alternative explanation for waiting lists is that the system is inefficient, perhaps both technically and allocatively. The system is technically inefficient if it would be possible to treat more patients with the resources available. Waiting lists might be reduced by eliminating waste
and duplication, improving work practices and productivity, or negating the political incentives to
maintain lists. Allocative inefficiency exists when the resources could be put to better use by
treating patients other than those presently receiving treatment. In other words, the benefit being
derived by patients presently using the resources is less than the benefit that would be realised if
those waiting for treatment were treated instead. Of course, it would require an enormous
research effort to ascertain the extent to which waiting lists represented allocative inefficiency, but
given that no clear rationale exists for assignment of patients to lists, it is likely that it exists.

The purchaser/provider separation has not solved the critical problem of waiting lists in the UK. In
fact, it was recently reported that the number waiting for hospital treatment has risen to more than
one million for the first time in the National Health Service's history. By responding to the
government's target to ensure that no patient has to wait more than two years for treatment, DHAs
have simply spread the burden onto other patients. The result has been that for those waiting less
than two years the average wait has increased and more people have been added to the list.
Meeting the government target cannot be hailed as a victory for efficiency. It has merely been an
exercise in the re-prioritisation of patients.

Not only has purchaser/provider failed to date, it is unlikely ever to solve the waiting list problem in
the UK. The reason is, quite simply, that the contracting process cannot introduce the economic
incentives required to address the issue. For providers to have an incentive to treat patients, they
must be paid according to the work they perform. Of course, contracts are supposed to do this,
and indeed they do - but only up to a point. The fundamental incentive in the contracting process
is the fulfilment of contractual obligations: once the contract has been fulfilled, providers have no
incentive to do further work.

This would not matter if purchasers could accurately predict demand for each service their
population might require so that the work contracted for amounted to the work required. But, at
bottom, contracts are simply more localised versions of global budgets. Given that in the past
DHAs were unable to accurately estimate something as crude as the number of in-patients to be
treated each year, it is unlikely that they will be able to predict the numbers requiring particular
treatments. There is no reason to believe that simply by more accurately specifying the product
the problems associated with global budgets will disappear. If anything the estimation will be
subject to even greater error, if only because small samples (those having a particular treatment)
are subject to greater variation than large ones (all in-patients).

Purchasing authorities could allow for inaccurate needs assessment by paying providers on a cost
per case basis should the contract be fulfilled earlier than expected. In fact, DHAs in the UK have
been advised to adopt such a strategy. However, the advice can offer no solution to the problem,
and the financial position it entails cannot be sustained even in the short term. DHAs will attempt
to allocate resources according to their best estimates of future service requirements, and
moreover, will want to pay for as many services up front (i.e. in the contract) so that the provider
supplies as many services as possible during the contractual period. However, the more
resources tied up in contracts, the less available for paying for care provided on a cost per case
basis for underestimated demand. DHAs themselves have limited funds - at some point they will be unable to pay for additional cases, and providers will stop treating patients. The inevitable result is that the most efficient providers - those who fulfil their contracts soonest - will be penalised for their performance. Just as under global budgeting, hospitals will reduce services and close wards if funds are not forthcoming.

Such behaviour is no less common under purchaser/provider than when global budgets were operating in the National Health Service. A number of hospitals have been told to discontinue performing routine procedures because their local DHA has run out of funds to pay for them (Fletcher 1993). Four months into the financial year Redbridge and Waltham Forest Health Authority told three hospitals to halt treatment for non-urgent patients to avoid over-running the agreed contracts. Similar instructions were issued to two other hospitals by Camden and Islington Health Authority. The purchaser/provider separation will inevitably fail to eliminate waiting lists because the fundamental incentive is to fulfil contracts rather than to treat patients.

**Purchaser/Provider in Australia**

The preceding discussion suggests that the introduction of a purchaser/provider separation cannot be expected to be an unambiguous success. Although in theory freeing decision making from provider influence, there is little reason to believe that purchasers will be able to resolve the questions of priority setting. Indeed, not to subject decision making to due political process may lead to some unpalatable results. Similarly, it is not clear whether a purchaser can ever be adequately responsive to constituents who have neither chosen it as a representative nor are able to seek alternative representation. The benefits of contractual arrangements remain unproven and may not justify the administrative and, perhaps qualitative, costs of the exercise. Competitive tendering may exist in name alone if the conditions for competition do not obtain or if providers are able to engage in anti-competitive behaviour. Finally, while the model is advocated on the grounds that it promotes technical and allocative efficiency, the claim seems far from being realised in practice, as demonstrated by the failure to reduce waiting lists in the UK. It is argued, moreover, that purchaser/provider arrangements are unlikely to provide a remedy for those on waiting lists because incentives are related to contracts rather than patients.

There are three further constraints to realising the supposed advantages of the model in Australia. First, the main benefits that purchasing authorities aim to achieve cannot be realised if purchaser/provider arrangements are confined to the health sector under the jurisdiction of state governments. Many of the suggested benefits arise because of the ability of purchasers to shift resources across existing service boundaries, to substitute more effective care provided in less traditional settings, and to ensure that patients receive appropriate continuity of care. But the possibility of changing the mix of service delivery is severely limited if purchasers are able to buy only those services for which the states have prime responsibility. Unless all services under the auspices of the states and the Commonwealth are subject to the arrangements, few benefits will be realised. These considerations did not arise in the UK or NZ, where there are unitary governments and a single hierarchy of health administration.
The second reason pertains to the drive to efficiency among providers which competitive tendering is supposed to promote. Victoria has already introduced casemix funding for acute hospital services. Casemix funding differs from purchaser/provider in one major respect. Under casemix funding, the funder - the state government - sets the prices it is prepared to pay for acute health services. Providers then submit bills (in effect) after supplying them. Under purchaser/provider arrangements, the purchaser aims to determine both the price and volume of services prospectively. Given the costs associated with assessing needs, inviting tenders, awarding contracts, and monitoring performance, this amounts to an extraordinary effort for little gain. Many of the efficiencies which purchaser/provider promises will also be advanced under casemix funding and other output based funding mechanisms, without necessitating a complete disruption of the whole health system. For example, in Stockholm county in Sweden it has been reported that, within a year of the introduction of casemix funding, `not only productivity but also the total volume of hospital production of care has grown rapidly, and waiting lists for surgery have almost disappeared' (Diderichsen 1993). It is expected that, despite a 4% budget cut to the Victorian public health sector, the incentives to increase throughput will significantly reduce waiting lists within a year of the implementation of the new funding arrangements (Victorian Department of Health and Community Services 1993).

Neither the UK nor NZ had an adequate method for classifying health services when their reforms were introduced. In the UK, unable to define the products which are to be contracted for, most purchasers to date have defined contracts crudely on a `block' basis, usually at specialty level. Belatedly, work has begun on designing Health Resource Groups (HRGs), as a classification system of hospital services similar to Diagnosis Related Groups (DRGs), with the hope that these will form the basis of increased contractual specification (Wiley 1992). It is arguable that, because of the lack of product definition, the UK and NZ had little choice but to embark on a contractual approach to reforming their health systems. It is possible that, had they had HRGs, the purchaser/provider model could have been avoided, and that when HRGs are developed a financing system based on casemix may replace contractual arrangements.

The third limitation of the purchaser/provider separation is that it addresses the public health sector only. Many problems facing the public health system cannot be adequately addressed without reference to the private sector, which is involved in both the provision and financing of health services. The future of Australia’s private health sector has long been the subject of much media and political debate. A proposal which considers the dual nature of the Australian health system would merit attention. Managed competition has been offered as the means of integrating the traditionally separate public and private health sectors.

Managed competition
Although christened later, managed competition was born in the 1970s when Alain Enthoven presented his ideas for a reorganisation of the health insurance market in the United States (Enthoven 1978). Enthoven observed that the relationship between individual consumers, health insurers, and health care providers inevitably led to market failure. When health insurers pay for care, consumers have no financial incentives to constrain their demand when using services (moral hazard). Nor do health care providers have an incentive to keep their fees down, knowing that their bills will be passed on to the insurer. Faced with increasing costs insurers have found it easier to rein in demand rather than to control providers. Those whom the insurer expects to be high users of services, such as the aged or those with previous medical histories, face higher premiums or co-payments. As a result the cost of insurance becomes increasingly prohibitive, constraining access to care. Thus, the insurance market fosters inefficiency and thwarts equity. Enthoven developed the rules of managed competition in response to these market failures.

The fundamental idea behind Enthoven's model is that insurers are subjected to constraints designed to ensure that they engage in price competition. In contrast to purchaser/provider separation, where it is the price of particular services in contracts that is of relevance, under managed competition the price in question is that of an annual package of care, i.e. the insurance premium. Insurers which offer lower premiums attract more policy holders and therefore earn more money, while those with higher premiums lose business. In order to reduce premiums insurers have to control the cost of services. How insurers control these costs is left to their discretion. They may do so by entering into contracts with providers, as under a purchaser/provider system, or by paying providers capitated sums for care requirements over fixed periods, or by adopting a fee schedule for reimbursement of individual services. The details of how insurers pay providers is not an important feature of Enthoven's proposal. What is crucial is that it is the sole responsibility of insurers to control the costs of providers.

Enthoven proposes a set of tools designed to ensure that the incentives to control costs are in place. Firstly, premiums paid directly by those joining the health plan would not be the main source of revenue for the insurer. Insurers would be required to set a standard premiums for anyone who wanted to join the plan. In other words, premiums should not be related to the expected costs that an individual might incur. Maximum limits would also be placed on co-payments and deductibles similar to the current Australian pharmaceutical 'safety-net'. Standard premiums are aimed at preventing insurers from engaging in preferred risk selection, in which insurance is offered to those with low expected costs while those with high expected costs are discouraged from taking out a policy, usually by setting high premiums but sometimes more subtly (Newhouse 1982).

Second, insurers would have to offer standardised benefit packages for a comprehensive range of health services, and accept responsibility for all the costs of their covered population. This would ensure that cost shifting to the public system or the primary and community health sectors did not occur. Supplementary coverage for extra benefits such as choice of ward could also be offered for which people would pay an additional premium.
Third, Enthoven argued that there should be open enrolment, with insurers obliged to cover anyone who wishes to take out a policy with them. Finally, he suggests the need for continual ‘management’ of the insurance market to prevent insurers from overcoming existing rules. This role would be undertaken by ‘sponsors’, which ensure that cost control is focussed on the behaviour of providers rather than on patient selection or the restriction of access to services.

Sponsors would be able to wield this influence because insurers depend on them for the greater proportion of their revenue. Only a fraction of income is derived from out of pocket premiums paid directly by policy holders. The majority of funds are allocated by sponsors in the form of risk adjusted capitated payments to account for individual differences in expected health care costs of the insurer’s policy holders. Risk rating is important for two main reasons. The first is to ensure equitable access to health insurance: without risk rating insurers have an incentive to engage in preferred risk selection. The second is to ensure fair payments to insurers: unless payments are risk adjusted, insurers may be competitively disadvantaged if they cover a higher proportion of people with above average expected costs than other insurers. Insurers should neither be rewarded nor penalised for attracting certain types of policy holder.

Sponsors may be government bodies or large employers. If desired, sponsors could play a more extensive role than clearing house for payments to insurers, by actively representing consumers in the insurance market, wielding the combined buying power of their members to negotiate favourable insurance deals on their behalf. These different approaches to the role of the sponsor are revealed in the proposals for the introduction of managed competition in the Netherlands and the US, which are the subject of the next section.
Managed competition in the Netherlands and the United States

The Netherlands
The Dutch have been exploring managed (or what they call `regulated') competition since the Dekker proposals were tabled in 1987 (Ministry of Welfare, Health, and Cultural Affairs 1988). At present, access to the majority of health services is guaranteed under a two tiered insurance system, with everyone below a certain income covered by Sickness Funds and the remainder having the option of taking out private insurance. The structure of this insurance market has created the imperfections which managed competition aims to address. There have been few incentives for Sickness Funds and private insurers to control costs or improve their service to policy holders because of the limited competitive pressure on them. This is partly because Sickness Funds cover those below a certain income and private insurers only those above, and partly because most Sickness Funds enjoy regional monopolies.

The Dekker proposals advocated that the two tiered system be abolished (Ministry of Welfare, Health, and Cultural Affairs 1988). A single national, universal system was proposed in which Sickness Funds and private insurers would compete with one another for all policy holders, subject to the conditions advocated by Enthoven which restrict competition to the price of the flat rate premium for basic coverage, and prevent product differentiation and preferred risk selection. The government, acting as the `sponsor', would prevent product differentiation by defining a standard comprehensive package of care which forms the basic cover for all policy-holders, although insurers would be able to offer supplementary cover for services not included in the basic package.

The government would minimise the incentive to engage in favourable risk selection by putting a ceiling on the flat rate premium paid directly by policy-holders to insurers. The greater proportion of the insurance premium would come from income related payments made by employers and employees into a central pool. These payments would then be allocated to insurers according to their number of policy holders, with adjustments made to reflect the predicted risk each policy-holder has of incurring medical expenses during the given insurance period (Van Vliet & Van de Ven 1992).

The Dutch proposals of 1987 have received broad political support, and few changes have been made to the central recommendations, even though different governments have since presided over the process. Full implementation of the reforms is not expected until 1995, and even this date may be overly ambitious. Nevertheless, some changes have been introduced (Van de Ven 1993). Most of these effect Sickness Funds, and can be seen as preparing the way for their role in the reformed system. Sickness Funds now receive capitation payments which are partially risk-adjusted, they are able to selectively contract with providers, and (along with private insurers) are able to negotiate lower fees. The insurance market is being made more competitive, with Funds allowed to expand beyond their traditional geographical catchment areas, and open entry into their markets allowed. Regulations governing providers have also been loosened. General
practitioners are now able to open practices wherever they wish, private day surgeries are allowed, and Sickness Funds can own medical facilities.

The United States
The Dutch are introducing managed competition to improve a health system which has long offered virtually universal access. In contrast, universal coverage has never been a feature of the US health system, with the majority of citizens relying on the cover offered under various insurance schemes. The elderly and those in poverty are covered under the government programs, Medicare and Medicaid, while others take out private insurance either as individuals or as part of their employment package. However, there are now more than 30 million Americans without health insurance and a similar number are under-insured. Added to this inequity in coverage, the system is inefficient. The US devotes a greater proportion of its Gross Domestic Product (GDP) to the health system than does any other country, but the return on this investment is not reflected in comparatively better outcomes as measured by the more common indicators of health. Insurers have exercised little control over hospital and medical bills, and there are no constraints on global expenditure. The Clinton administration expects that, without reform, the US will be spending 20% of its GDP on health care by the year 2000 (United States, The White House 1993).

The proposed path to reform resembles that taken by the Dutch. Under Clinton's Health Security Act all American citizens will receive a health security card entitling them to a comprehensive package of benefits. Insurers will have to accept all those who wish to hold a policy with them. Moreover, they will be unable to raise premiums or withdraw cover from individuals who require care. The reforms are designed with the primary aim of introducing price competition to the insurance market, so that there is a greater incentive to control costs and increase quality. In addition, global expenditure is to be capped by limiting the rate of growth in premiums.

There is one major feature distinguishing the Dutch and US proposals. In the US, individuals will not deal directly with insurers when seeking a policy. Instead they will be actively represented by sponsors, either large employers or Regional Health Alliances created by state governments, which will organise a variety of health policies and negotiate premiums with insurers on behalf of their members. Those selecting the same policy will pay the same premium, irrespective of their expected health care costs, and the insurer will not be able to refuse to cover anyone who wishes to hold a policy with them. Sponsors will adjust the payments to the insurer offering the policy according to the collective risk among the individuals enrolled. All health policies negotiated by sponsors will require sanction by state governments to ensure that they fulfil basic conditions relating to the range of services covered and national quality standards. Policies will differ in the supplementary benefits offered, the restrictions placed on which providers may be used, and the cost-sharing arrangements with the policy holder.

These arrangements are intended to ensure that consumers have a choice of options, and that they will be conscious of cost in their selection of insurance policy and use of services. The
Clinton administration believes its proposed reforms will increase the efficiency and quality of the US health system, while also restraining expenditure, maintaining choice, and, perhaps most importantly, guaranteeing universal access. For Clinton's vision to be realised, the proposal must first be accepted by Congress and the Senate, as well as surviving the lobby groups which have long dominated US policy making. Subject to its overcoming these impediments, the administration expects the plan to come into effect from 1995, with full implementation by 1997.

Managed competition in Australia

Scotton has argued that managed competition might be introduced to Australia without compromising the benefits presently available under Medicare and other public programs (Scotton 1991, 1992, 1993). He proposes that the private sector should operate within a national health system, rather than outside it, as at present. Medicare beneficiaries should be given the option of having their care requirements administered by private budget holders. These would be regulated by the Commonwealth and subject to Enthoven's conditions for managed competition including standardisation of benefit plans, open enrolment, and limits on co-payments and deductibles.

In contrast to the existing health insurance market in Australia and to prevent cost-shifting to the public sector, private funds would be obliged to cover all services available under Medicare and other public programs, and would be liable for the full cost of service use. To overcome the present incentives to engage in favourable risk selection, the income of private budget holders would flow directly from the Commonwealth, through the Health Insurance Commission, according to a risk-adjusted formula similar to that being devised in the Netherlands.

Scotton envisages the Commonwealth having prime responsibility for raising revenue for health services. State and territory governments would be responsible for public providers and for public (area) budget holders, which cover everyone not electing to join private budget holders. As with their private counterparts, public budget holders would receive capitation payments determined according to the characteristics of their covered population. This revenue constraint would force them to contract with efficient service providers. To facilitate this, public and private budget holders would be free to contract for health services from both public and private providers.

It is hypothesised that, without sacrificing universal coverage or access, managed competition would increase consumer choice, promote allocative efficiency via incentives to substitute cost-effective services, and advance technical efficiency because competitive pressure would encourage private and public budget holders to seek ways to reduce the costs generated by service providers. The risk adjusted capitation payments and regulatory constraints on their behaviour would prevent them from controlling costs by restricting access, cost shifting or denying coverage.

Given that managed competition has yet to be tried in practice it is difficult to evaluate these claims. The benefits of the model hinge on the ability of governments (or other sponsors) to ensure that there are no incentives for insurers to engage in non-price competition. Critics may
argue that this hope can never be fully realised. However, one of the main advantages of the model is that it can be adapted to deal with problems as and when they arise. Enthoven recognises that insurers are likely to circumvent the basic rules of managed competition but views these rules not as constraints established once and for all, but as a set of tools with which to periodically interfere with the market if it is working imperfectly. He argues that under managed competition sponsors will be `continuously structuring and adjusting the market to overcome attempts to avoid price competition' (Enthoven 1993). For example, if there is evidence of risk selection, the sponsor can refine the capitation formula. Similarly, the sponsor can raise the standards of care guaranteed in the insurance policy or introduce penalty clauses to ensure that quality is not compromised.

However, despite the interactive nature of the model, it remains unclear whether managed competition can deliver the benefits it promises. First, it is not apparent that budget holders will successfully control costs under managed competition. Much depends on the arrangements that insurers have with providers. Enthoven is a strong advocate of `managed care' arrangements such as those offered by Health Maintenance Organisations (HMOs) or Preferred Provider Organisations (PPOs) in which the patient's choice of doctor is limited but the consumer faces lower up-front or out-of-pocket expenses. Scotton has also suggested the development of managed care arrangements in Australia (Scotton 1991, 1992).

Aside from the likely resistance from Australia's medical profession to these arrangements, evidence from the US that HMOs and PPOs have restrained costs is not incontrovertible, with commentators suggesting that if they have succeeded in reducing costs it may have been at the expense of quality or by engaging in favourable risk selection (United States General Accounting Office 1988; Hellinger 1987; Newhouse, Manning, Keeler et al. 1989; Epstein & Cumella 1988). Others argue that, despite temporary cost reductions, managed care organisations have failed to deliver significant cost savings or to slow the rate of cost inflation (Freund 1989; Relman 1993). Further, given the diversity in institutional arrangements of HMOs and PPOs extrapolation from past experience to a future of managed competition in the US, let alone elsewhere, is difficult. Reviewing the evidence, Langwell concluded that `the effectiveness of managed care in constraining the rise in health care costs has yet to be demonstrated when provided to a large proportion of the population' (Langwell 1990).

Scotton argues that, were managed competition to be introduced in Australia, it should be in tandem with explicit methods of cost control, such as casemix funding (Scotton 1991, 1993). However, if independent cost control mechanisms are available, would not managed competition prove an unnecessary partner? Scotton does not believe so, asserting that `private health plans would be in a better position than monopoly government agencies to adopt innovative utilisation review and second opinion programs, and to contract with subscribers and providers for low cost regimes of care' (Scotton 1991) and that `budget holding intermediaries would be better placed to determine relative needs and to implement the rationing function effectively and equitably' (Scotton 1992). However, the evidence to support these contentions is weak. Historically health funds in Australia have failed to demonstrate their superiority over government agencies in either
cost or quality control. Nor can it be contended that government bodies are incapable of augmenting change, given, for example, the introduction of casemix funding in Victoria and a variety of quality assurance measures including the accreditation program by the Australian Council on Healthcare Standards and the patient satisfaction surveys being piloted in a number of states. Scotton's assertion of the merit of managed competition for these purposes must remain an open question.

A further reason why managed competition may fail to deliver its promises relates to the competition that can be expected among private budget holders. Without adequate competition, the likelihood that they will be responsive to consumers will be reduced. Even in areas of high population density, competition may be limited. Private budget holders will have incentives to engage in co-operative or collusive arrangements so as to benefit from economies of scale in bargaining with providers. Already, in anticipation of the full implementation of the Dutch reforms many Sickness Funds have merged and private insurers and Sickness Funds are also forging links before the legal separation of their markets is ended (Schut 1992). This could lead to a reduction in choice of insurer and insurance policy, and places less pressure on budget holders to consider their customers because they are less likely to lose them. Even if competition presently exists, it is not clear how, given the incentives for insurers - and providers - to consolidate, managed competition can be prevented from turning into oligopolistic regulation. There is little reason to believe that an oligopolistic insurance market will offer a greater diversity of policy options or prove more innovative than if arrangements were handled by public agencies.

Finally, in both the Netherlands and the US it is recognised that the radical overhaul which managed competition entails will not take place without difficulty. In the Netherlands, despite broad political support, the reforms are being introduced cautiously and over an extended time period. In the US, Clinton's reform package could not have been presented if there was not a general perception that the health system was in crisis, and even now the proposal faces strong political challenges before it becomes policy. A recommendation that Australia follow the Netherlands and the US cannot be made without consideration of the political process it must undergo before acceptance. Its passage may fail to gather the momentum it has generated overseas for two main reasons. First, although the future of the private health sector has been the subject of considerable debate, the scale of the problem in Australia is not obvious. A number of commentators argue that resolution of the issue is not necessarily an immediate concern which suggests that political efforts might be better directed elsewhere (Richardson 1993; Editorial 1993).

Second, in both the US and the Netherlands, almost exclusive reliance is placed on the insurance market to facilitate access to health services. Consequently, the political imperative to structure the insurance market correctly is very important. In Australia, this requirement is diluted by the existence of Medicare, which both dampens pressure from the electorate to reform the private health sector, and suggests that the advantages of managed competition will be of a lesser order of magnitude than expected in the Netherlands and the US.
Moreover, these advantages are unproven. As Aaron and Schwartz (1993) point out `the benefits its advocates assert ... are expressions of faith, not experience'. Coupled with uncertainty about the benefits of the model, its introduction is unlikely to be costless, given the probability that the private sector would accept managed competition only as a last resort. Politically, as well as economically, there may be little to gain by forcing managed competition upon the Australian health care system.

**Conclusion**

A purchaser/provider split and managed competition are radical reform strategies entailing substantial structural change to the present health system. Neither can expect unqualified support. It is not clear that the purported advantages of a purchaser/provider split are sufficient for the option to merit further consideration in Australia. Experience from overseas suggests that the ability of the model to improve consumer representation, enhance efficiency, and reduce waiting lists is limited. The model can be expected to perform less successfully in Australia where the division of responsibilities between states and Commonwealth may hinder purchasing authorities in their attempts to re-allocate resources across existing service boundaries.

Moreover, many of the benefits of the model may be achieved through alternative arrangements, the most obvious option being the introduction of output based funding mechanisms. For example, the introduction of casemix funding for acute hospital services is likely to contribute to the pursuit of technical efficiency as well as reversing many of the perverse incentives of the existing financial arrangements in the public hospital sector. Unlike a purchaser/provider separation, casemix funding may also be expected to contribute to a reduction in the number of patients waiting for treatment.

The introduction of output based payment for other health services or episodes of care may be an appropriate policy option for application across the health sector (Duckett & Jackson 1993). Revision of funding arrangements would not necessitate wholesale structural change, nor would it preclude other targeted initiatives such as reform of capital allocations, improved discharge planning, and a reassessment of state and Commonwealth responsibilities.

The elimination of waiting lists as promised under casemix funding would also reduce the political imperative to address the problems facing the private health sector, at least in the short term. However, if the trend in the decline of the proportion of the population with health insurance continues, at some point the public sector may be unable to cope with an increase in demand. But even if this point is reached in the near future, the increased demand on the public system could be addressed by a rise in the Medicare levy, rather than the introduction of managed competition.

Present enthusiasm for a purchaser/provider separation and managed competition relies more on assertion about their potential than experience of their success. Where evidence is available, mainly of purchaser/provider arrangements in the UK, it does not justify unequivocal support for the reform option. Given uncertainty about their benefits, it would be unwise to advocate either
model without first considering other initiatives tailored to address the particular problems Australia faces. If, as is likely, these problems are peculiar to the Australian health system, it may be that the solutions turn out to be specifically Australian rather than imports from overseas.


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