

Medicare: Policy Issues and Options

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ABSTRACT

By international standards Australia's health scheme, Medicare, is relatively efficient. Despite this, it is structurally unstable. The private health insurance and hospital industries operate at full cost and in competition with a public sector that is 'free' at the point delivery. Despite claims to the contrary this has not, to date, resulted in a decline in the size of the private hospital sector. However, over time, this must occur and a decision must be made about the desired balance between the public and private sectors. Theory and evidence indicate that the full privatisation and deregulation of health care is not a sensible option. Alternative options include the use of an ad hoc subsidy to prevent the decline of the private sector, a movement towards a largely government dominated industry, and the adoption of 'managed competition' to activate the 'internal market' in health care. In principle, the last of these options has the greatest potential for the achievement of allocative efficiency.

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1 Introduction

Health expenditures are very large. They exceed spending in either the mining or construction sectors or in agriculture and communications combined. Despite this, Australia's per capita health costs are not high by the standards of western countries.

Table 1
Health Spending 1991: Per Capita \$US and Percent of GDP

	\$US/ capita	H/GDP (%)		\$US/ capital	H/GDP (%)
Australia	1,407	8.6	Japan	1,307	6.8
Austria	1,448	8.4	Luxembourg	1,494	7.2
Belgium	1,377	7.9	Netherlands	1,360	8.3
Canada	1,915	10.0	New Zealand	1,047	7.6
Denmark	1,151	6.5	Norway	1305	7.6
Finland	1,426	8.9	Portugal	624	6.8
France	1,650	9.1	Spain	848	6.7
Germany	1,659	8.5	Sweden	1,443	8.6
Greece	404	5.2	Switzerland	1,713	7.9
Iceland	1,447	8.4	Turkey	142	4.6
Ireland	845	7.3	United Kingdom	1,043	6.6
Italy	1,408	8.3	United States	2,868	13.2
OECD average:				1,305	7.9
Source: Schieber & Greenwald (1993)					

International comparisons indicate that our health expenditure is in the middle of the range for OECD countries and almost exactly what would be predicted from its per capita GDP (see *Table 1*). By contrast with the United States, but in common with most OECD countries, Australia stabilised its health share of the GDP throughout the 1980s (see *Table 2*): the ratio has been comparatively stable since 1975.

Table 2
Total health expenditure and GDP (current prices) and rate of growth
1982-83 to 1992-93

	Total health expenditure		GDP		Total health expenditure as % of GDP
	Amount (\$m)	Growth rate (%)	Amount (\$m)	Growth rate (%)	
1982-83	13,239		171,774		7.7
1983-84	14,958	13.0	194,831	13.4	7.7
1984-85	16,546	10.6	216,257	11.0	7.7
1985-86	18,586	12.3	240,224	11.1	7.7
1986-87	21,115	13.6	264,521	10.1	8.0
1987-88	23,328	10.5	298,426	12.8	7.8
1988-89	26,154	12.1	339,723	13.8	7.7
1989-90	28,814	10.2	370,007	8.9	7.8
1990-91	31,132	8.0	379,902	2.7	8.2
1991-92(a)	32,758	5.2	388,071	2.2	8.4
1992-93(a)	34,338	4.8	401,698	3.5	8.5

Source: Australian Institute of Health and Welfare 1994

This does not mean that Australia's health care system is without short run and longer term problems. As a result, there has been a continual flow of suggestions for reform, the most recent originating from the previous Minister for Health, Senator Richardson (Commonwealth of Australia, 1993). Significantly, the option of privatising and relying upon a simple and largely unregulated market now appears to be off the political agenda. While proposals have been made for the more sophisticated use of 'managed competition' there is now a near consensus in western countries that governments have a responsibility for ensuring, if not providing, a high level of access to health services. In part, the rejection of the simple model arises from the special status given to health care which is revealed in both the political process and in direct surveys of population opinion. In part, the rejection is a recognition of market failure arising from the information asymmetry between patients and health care providers for all but the most trivial services. In the most exhaustive analysis of consumer demand to date, the authors of the US random control trial of health insurance (the 'Rand experiment') found no relationship between the services deferred by a patient copayment and the clinical benefits of the services as judged by an independent panel (Lohr, Brook, Camberg et al 1986). As a result of this and other evidence of the consumer's inability to evaluate complex services, many economists have rejected the conventional analysis and measurement of consumer welfare (Rice 1992) and the great majority of health economists accept that the patient's agent, the doctor, has some ability to manipulate demand (Feldman &

Morrisey 1990). The negative correlation found between health expenditures and the government share of total expenditures in western countries supports the belief that effective countervailing power to health care providers requires a large and powerful provider which, in practice, has been (but, in principle need not be) the government (OECD 1987).

2 Short-Run Problems

The most publicised short run issue is the relationship between public and private hospital use, private health insurance and queuing. In summary, the argument popularised by the health funds, private hospitals and the Australian Medical Association can be paraphrased as follows:

Withdrawal of the Commonwealth bed day subsidy for private hospitals in 1986 resulted in an increase in both private hospital fees and the private health insurance premiums required to insure against these costs. As documented by the Prices Surveillance Authority (1993), this and the large increase in private hospital costs have been responsible for a very significant increase in premiums for private health insurance. This, in turn has tipped the historical balance between the public and private hospital sectors.

Higher premiums plus the economic recession have led to less private health insurance. But as the best risk members are the first to leave, those retaining insurance have a worse risk profile which, in turn, forces a further increase in premiums and a further reduction in the number privately insured. This has resulted in an accelerating decline in insurance cover.

As private hospitals depend upon privately insured patients, their share of the workload has declined, placing further pressure upon public hospitals and this has resulted in rising queues as the public sector cannot cope with the increasing workload.

Present trends therefore jeopardise the existence of independent health insurance and with it the private hospital sector. Without the beds and dollars from the private sector, Medicare is not viable. Consequently, urgent measures are required to restore the position of private health insurance.

The argument is only partly true. Health insurance has declined, largely for the reasons given (Table 3). Private hospitals do rely upon private health insurance for 80 per cent of their revenue. However, they depend primarily upon supplementary insurance and this has declined much less than basic insurance. Despite this small decline, the private hospital shares of hospital admissions and expenditures have increased, not decreased, in the past 10 years. Between 1982/83 and 1992/93 the percentage of admissions to private hospitals rose from 23 to 29.6 per cent of all admissions and, even allowing for the rise in day surgery, this indicates strong growth.

Table 3

Percentage of Australians covered by the Basic Hospital Table only and the percentage of those covered by a Supplementary Hospital Table

Year (June)	Basic	Supplementary
1984	50.0	29.6
1985	47.7	31.2
1986	48.8	34.2
1987	48.3	38.4
1988	47.3	38.5
1989	45.5	38.4
1990	44.5	39.0
1991	43.7	38.7
1992	41.0	37.0
1993	39.4	36.1
(March) 1994	37.6	34.7

Source: Private Health Insurance Administration Council (1993)

The continuing decline in private insurance implies that this trend cannot be sustained indefinitely, and it is unlikely that the private sector would maintain its present share of the hospital market. Indeed between 1991-92 and 1992-93 private hospital admissions fell, albeit very marginally, from 30.2 to 29.6 per cent of the total. However, the private hospital industry could contract significantly before it was reduced to its 1982-83 share of the market.

As the proportion of admissions to private hospitals has risen, not fallen, it is untrue that waiting lists in the public hospitals are attributable to a contraction in the private hospital sector. Waiting lists are very largely attributable to strict budget caps on public hospitals and, to a lesser extent, a shortage in the supply of particular specialists. On the other hand, a reduction in the length of the public queue would be likely to accelerate the decline in private health insurance membership, and hence increase the demand for public hospital care.

3 Short-Run Solutions

The fact that the instability of Medicare originated with the withdrawal of a subsidy to private hospitals suggests the restoration of the subsidy as a solution to the decline in health insurance membership. Alternatively, and as advocated by the private health insurance funds and by the federal Liberal party, the subsidy could be directed towards private health insurance by making premiums tax deductible. The option could be supported by both an equity and efficiency argument. Private health insurance effectively competes against a public insurance system which is free at the point of service. Those who select private health insurance still contribute fully to the cost of the national scheme and are, in effect, paying for hospital care twice. A subsidy could therefore be viewed as equitable. As a subsidy would reduce the distortion in the relative marginal cost of private versus (free) public insurance, it could also be argued that it would lead to a partial

fulfilment of one of the necessary conditions for economic efficiency. The contentious issue here is whether or not another necessary condition is fulfilled, namely, the existence of competitive and efficient private health and health insurance sectors. As noted later, present regulations ensure that private health funds are not concerned with efficiency in Australia, and there is no evidence to suggest the superiority of private hospitals.

The option of reintroducing a subsidy has not, to date, been seriously considered, almost certainly because of its adverse effect upon the federal budget deficit. Indeed, the recent proposal by Senator Richardson sought, firstly, to induce high income earners to purchase private health insurance (or face a tax surcharge) and, secondly, to increase the attractiveness of private health insurance by requiring it to cover fully all hospital and private medical costs. These costs would have to be negotiated with hospitals and private doctors. The general consensus was that this latter proposal would not have the desired effect. Doctors and hospitals could be expected to resist the explicit attempt to reduce their fees and, in the absence of lower fees, private health insurance premiums would have to rise to cover the existing out-of-pocket expenditures. The result would be a reduction, not an increase, in private health insurance coverage.

A further reform which was briefly discussed and immediately rejected was the modification in the requirement for 'community rating' of the health fund contributions. Under community rating, there can be no difference in the premium between the young and healthy, and the elderly and sick; low risk members are thereby required to cross-subsidise high risk members. For this reason, as premiums have risen, the good risk members have been the first to leave the health funds, thus worsening the funds' risk profile and putting further pressure on premiums. The modification or elimination of community rating would allow the health funds to compete for healthier members but they would risk losing less healthy members as their premiums rose.

In the absence of further regulation, community rating would also disadvantage health funds with a poorer than average risk profile. To offset this, all health funds are required to contribute to a reinsurance pool against which they may charge the costs of the chronically ill and of their members over 65 years of age. By 1992/93, 44 percent of the funds' payments of \$2.5 billion to hospitals was via the reinsurance pool. While this reduces, (but does not remove) the incentive for the funds to 'risk skim', it also removes much of their incentive to contain costs as they are no longer responsible for the full costs.

In sum, the scope for budget neutral reforms to private insurance is limited to the point of being nonexistent. In part this is because voluntary health insurance is required to carry out social policy and redistribute income from the low to the high risk members. It is scarcely surprising that such a voluntary redistribution is resisted by the losers. More fundamentally, voluntary health insurance is competing against Medicare which provides benefits (albeit with greater limitations on access) at no additional cost above the unavoidable tax and levy contributions. However the insurance regulations are altered, private health insurance has to compete on a very uneven playing field.

In the absence of other satisfactory policies, the default option is to do nothing and to permit the further decline in private health insurance. This has been advocated most recently by the Caucus/ACTU Working Group on Health (1994) which argued that there is no evidence that 'a continued decline in [health insurance] participation rates will put significant pressure on Medicare' (p20). A more persuasive argument is that there is no urgency for change. In 1992/93 health insurance companies were in a strong financial position. Surpluses of \$214 million increased their reserves to a record level of \$1.2 billion (Private Health Insurance Administration Council, Financial Statement 1992-93). As noted above, private hospital use and expenditures are historically high. Most importantly, it is argued that it is possible to increase public hospital output (that is, increase the number of patients treated) at no additional cost, and in the short run enable public hospitals to accommodate any increase in patient numbers which might arise from a marginal decline in private insurance coverage.

4 The Introduction of Casemix-Based Funding

The use of case payment in Victorian hospitals is potentially the most important change in the health sector since the introduction of Medicare. Until 1993 Victoria, like the other states, negotiated annual global budgets with their hospitals. In the mid 1980s Victoria had adopted a system of 'health service agreements' under which hospital budgets were, in principle, related to the patient load. In practice, there were major discrepancies between the budgets, which remained attributable more to historical factors than to patient numbers (Duckett 1994). The main reason was the inability of the Health Departments to measure output. Typically, attempts to reduce hospital budgets were countered by the contention that each hospital had an atypical patient mix and that budget cuts would necessarily reduce the number of services that could be produced.

This informational impediment ended with the development of the Diagnosis Related Group (DRG) classification system which grouped admissions on the basis of diagnoses and according to resource costs. Depending upon the version of the classification, this has resulted in between 470 to 530 categories of admissions within each of which there is a similar cost of treatment. The addition of cost weights - dollars - to each DRG group converts the classification into a system of hospital payments (Scotton & Owens 1991). The DRG system was developed in the United States in the late 1960s and used to finance their Medicare system for the elderly from 1983. Australian research into DRGs commenced in 1988 with a five year, \$30 million Commonwealth 'Casemix Development Program' which was extended for a further five years in 1993. However there appeared to be little enthusiasm or sense of urgency for the use of DRGs for actual case payment until the election of the coalition government in Victoria in October 1992. This resulted in the introduction of DRG-based case payments eight months later on 1 July 1993.

In the six months to December 1993, the throughput of Victoria's hospitals increased by 5 percent, the waiting list for 'urgent' procedures declined by 70 per cent and the total number waiting 'longer than clinically desired' fell by 27 per cent (Duckett 1994). Over the same period the public hospital

budget was reduced by 5 per cent, implying a 10 per cent increase in productivity. The Victorian evidence is still incomplete. However, the evidence and experience to date represent strong endorsement of the economist's belief in the importance of appropriate incentives. This outcome is consistent with the results observed in the United States after the introduction of DRG-based funding for their Medicare program. The US experience also provides greater insight into the possible adverse effects of DRG-based case payments. These have not been as significant as forecast by critics of the system. For example, while there has been some 'gaming' of the system (for example, 'DRG-creep' - the reclassification of patients to more profitable categories), this has not been quantitatively very important (Russell 1989). Similarly, the evidence does not suggest significant demand-creation to offset the cost limits on DRG payments, nor quality deterioration ('quicker and sicker' hospital care) (Kahn, Rubenstein, Draper et al 1990).

5 Long-Term Problems

While there was greater scope for productivity gains in Victorian public hospitals than elsewhere in Australia, the Victorian experiment indicates that the introduction of DRG-based hospital payments should be the first priority in health policy. They have the potential to increase the productivity of the \$14 billion hospital industry which is the largest component of the health system. However, it does not ensure allocative efficiency between hospitals and other sectors, nor an appropriate control over the growth in total spending.

One of the reasons for concern over future trends is shown in *Table 4*. Despite the stability of the share of Australia's GDP spent on health care, real expenditure growth per person from 1980 to 1990 was almost identical to the US experience. Along with other OECD countries, Australia restricted health expenditures in the 1980s mainly through the use of budget caps in public hospitals and, to a lesser extent, through a reduction in the administered rebates and hence the total fees paid for certain services and procedures. These measures can achieve a relatively easy, one off, lowering of expenditures which would be less easily repeated once the hospital system has been reformed. Because of the impact of new and expensive technologies and new pharmaceutical products it has been widely accepted in the United States that its share of GDP spent on health is likely to rise above 20 per cent in the next decade and the Health Care Financing Administration has warned that on present trends, one third of the GDP could be spent on health by 2030 (HCFA 1992). Even discounting such long run projections it is evident that the present US health system is not considered capable of resisting the 'technological imperative' to adopt new procedures. *Table 4* suggests that the Australian system may not have been significantly more successful in this respect.

Table 4
Comparison of health expenditure growth in Four Countries
1980 to 1990 (percent)

Growth Components	Australia	Canada	United Kingdom	United States of
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				America
1 Share of health expenditure in GDP 1989	7.4	7.5	5.9	9.2
2 Nominal health expenditure growth	12.2	10.7	9.8	10.4
3 <i>Health care price deflator</i>	8.2	6.9	7.6	6.9
4 of which GDP deflator	8.1	5.1	6.1	4.1
5 of which excess health care inflation	0.1	1.8	1.3	2.7
6 <i>Real expenditure growth</i>	3.7	3.5	2.1	3.3
7 of which population growth	1.5	1.0	0.2	1.0
8 of which per person real expenditure growth	2.2	2.5	1.9	2.3
9 Share of health expenditure in GDP 1990	7.8	9.5	6.0	12.2
Source: Australian Institute of Health and Welfare, 1994				

6 Longer Term Solutions

The achievement of allocative efficiency requires both information about the appropriate allocation of resources and an incentive to adopt this allocation. The first of these issues is discussed elsewhere (Carter 1994; Harris 1994; Segal & Richardson 1994).

In the present health care system there are very few incentives for allocative efficiency and, in the context of current budgetary processes, the irrational division of the system between Federal and State jurisdictions creates significant disincentives. This lack of incentive for achieving allocative efficiency has characterised most other health systems and explains the upsurge of interest in the 1990s in improving supply-side efficiency through 'managed competition' and schemes involving a 'purchaser/provider' split.

In both of these models one or more 'budget holders' would contract for services from competing providers (hospitals, doctors etc) with a degree of discretion over the type of services purchased. In both models budget holders would be sufficiently large and well informed to overcome the problem of asymmetric information that invalidates the assumption that unregulated markets produce efficient outcomes. In both models the ability to shift resources between subsectors of the medical system increases the likelihood of allocative efficiency. The essential difference between the two models is that the 'purchaser/provider' split attempts to form a health care market by separating supply and demand and encourages competition in the 'internal market' between providers. Managed competition adds the objective of reforming funder (insurer) behaviour and creates competition between the funders as a means of encouraging the purchase of the most cost-effective services (Street 1994).

The United Kingdom and New Zealand have adopted variants of the purchaser/provider model. In the United Kingdom, general practitioner groups have been allowed to become 'budget holders' with the responsibility for the purchase of a defined range of drugs, procedures and hospital services. In New Zealand regional authorities have been given global budgets and the responsibility for purchasing all health services from either private or public providers. The latter are under the jurisdiction of a public authority that is legally separate from the authority responsible for the provision of the public services. The emphasis in this type of model is upon the negotiation of favourable contracts between budget holders and providers.

By contrast, the Netherlands is implementing, and the United States is considering, the use of managed competition. In this model budget holders (which may be public as well as private) compete to provide a package of services to the public. They are constrained by regulation designed to require the provision of a comprehensive range of services and to exclude cost shifting and risk skimming. By contrast with the purchaser/provider model there is an emphasis upon the competition between budget holders and it is assumed that appropriate contracts will emerge between purchasers and providers as the former compete to offer the most attractive package to the public.

The second model has been adapted to Australian conditions by Scotton (1992, 1993). In his version of the model, Scotton proposes a rationalisation of government functions: the Commonwealth would be responsible for raising the revenue, paying a risk adjusted premium to budget holders, defining the standard service package and regulating the provider/funder market. State governments would continue to provide the existing range of public services, while an independent arm of the State government would establish and supervise public, area-based, 'budget holders'. The private sector would be free to establish competitive plans and to compete for the Commonwealth capitations, which could be supplemented through private contributions. All Australians would automatically become members of an area-based public fund if they did not enrol in a private fund. All 'budget holders' would be free to contract with both public and private providers except that the public budget holders would not cover private inpatient treatment. As all budget holders would offer a basic package of services equivalent to Medicare and other public benefit programs, and as most medical claims would continue to be processed by the Health Insurance Commission, the transition to such a scheme would pass unnoticed by many members of the public.

The logic behind the Scotton proposal is persuasive. With present regulation there is very little chance that the existing health insurers will be motivated to evaluate and purchase cost-effective services from the lowest cost or highest quality providers. As a minimum step towards achieving this end, community rating and the existing reinsurance arrangements would have to be ended. Markets cannot operate efficiently in the absence of meaningful price signals and with the incentive for efficiency anaesthetised by a set of cross subsidies. With the removal of community rating, the social objective of restraining the premium costs to the elderly and high risk population would have to be taken over by the government through the provision of risk-adjusted subsidies/premiums. To eliminate the artificial bifurcation of the system into a public and private

sector, it is desirable to allow the recipients of the government premium - the budget holders - to purchase from either type of provider. Finally to encourage the achievement of allocative efficiency the budget holders should be responsible for each of the major services which may substitute for one another; namely, hospital and nursing home services, medical care and pharmaceutical products. Once these preconditions for allocative efficiency were implemented, the Australian scheme would have evolved into something very similar to the Scotton model of managed competition.

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