National Competition Policy and Australia's Health Care System: A Look at the Policy Landscape with New Eyes

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Australia spends nearly 10% of its gross domestic product on health services. With such a substantial financial commitment, even relatively minor improvements in efficiency, effectiveness and productivity can increase community welfare. Competition is a well-recognised policy lever implemented to achieve these goals in market economies. However, it has for many years struggled to gain traction in the health care sector. This article traces recent attempts to promote competition principles in Australia's health care sector. Highlighting where these attempts have stalled, it compares Australia's recent health reforms with those instituted in the United Kingdom's National Health Service where a sector-specific competition regulator has been in place for several years. It concludes that there is room in Australia's regulatory landscape to improve public reporting and increased choice in health care. A sector-specific regulator is envisaged to support these important competition-based initiatives.

Keywords: *competition principles; regulation; health care reform; productivity; funding; choice*

I. Introduction

The World Health Organization defines a health system as "all the activities whose primary purpose is to promote, restore and/or maintain health".[1] Australia's health system is founded on the principle that its citizens should be provided with "timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country".[2] To achieve this objective Australia spends nearly 10% of its gross domestic product (GDP) on health services, the majority of which is government-funded.[3] With such a substantial financial commitment, even relatively minor improvements in efficiency, effectiveness and productivity can have a positive impact on peoples' quality of life[4] and increase community welfare.[5] The Productivity Commission noted that an efficiency improvement of 10% in service delivery in the health sector would provide cost savings equivalent to around 1% GDP, and as much as 2% by 2050.[6] Such cost saving could be drawn on to improve service quality and access to the health care system, and to help meet the costs of servicing an ageing population.

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[1] World Health Organization, *Health Systems Strengthening Glossary* <http://www.who.int/healthsystems/Glossary_January2011.pdf>.

[2] Council of Australian Governments, *National Healthcare Agreement 2012*, A-2 <http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf>.

[3] Australian Institute of Health and Welfare, *Australia's Health 2016*, Australia's Health Series No 15 (2016) 26.

[4] Australian Government Competition Policy Review Panel, *Competition Review, Final Report* (March 2015) 34 (Harper Review). See also Productivity Commission, *Review of National Competition Policy Reforms*, Report No 33 (2005) xliii.

[5] Independent Committee of Inquiry into Competition Policy in Australia, *National Competition Policy* (1993) (Hilmer Committee Report).

[6] Productivity Commission, n 4, xliii.

Competition is a well-recognised policy lever implemented to stimulate efficiency, effectiveness and productivity (and innovation) in market economies.[7] Competition exists when unrelated and uncoordinated entities make alternate offers to provide goods and services to satisfy the needs and desires of users.[8] The notion that competition could improve efficiency, effectiveness and productivity in health care has been discussed for more than 50 years.[9] However, for several reasons, health care services and competition have not been well matched. First, unlike traditional markets where the user or consumer is assumed to be appraised of all relevant information, health care decisions are frequently made in the context of significant information asymmetry and uncertainty.[10] This setting potentially distorts the supply side of the market.[11] Second, when health care services are financed by a third party such as Medicare, both supply and demand are affected and ideal market-based conditions no longer apply.[12] And third, the provision of health care services emphasises social objectives such as equity, care and welfare, prioritising these over market concerns such as price and choice that are associated with competition.[13] Focusing on the features that separate the provision of health care services from traditional markets, however, ignores the fact that there may be elements of the system that are amenable to greater competition.[14] This suggests that a more careful appraisal is required.

This article traces recent attempts to promote competition principles in Australia's health care sector. It is structured in eight parts. Part II introduces the findings from the 1993 *Independent Committee of Inquiry into Competition Policy in Australia* (Hilmer Committee) that provided the foundation for Australia's comprehensive National Competition Policy (NCP). As a central element of the NCP, this part also describes the purpose of the legislation review program and its application in the health sector. It concludes by highlighting the findings of a Productivity Commission review of the NCP in 2005 which included a recommendation to review and reform Australia's health care system.[15] In 2009 the National Health and Hospitals Reform Commission (NHHRC) was formed to undertake this extensive task.[16] Part III describes this process, the recommendations of the NHHRC and the legislation that followed. Aiming to ensure that Australia's competition policy remained fit for purpose, a further review was requested in 2015. Part IV describes the recommendations and outcomes of this review with a focus on competition in health care. This part highlights the similarities with previous reviews and demonstrates that despite all Australian governments continued support of dedicated competition policy, its impact in the health sector remains marginal. Part V then compares Australia's recent health reforms with those instituted in the United Kingdom's National Health Service (NHS). The trajectory of these two health systems has been remarkably similar. In contrast to Australia's attempts, however, competition is an explicit policy lever implemented to improve efficiency and productivity in the NHS. In Part VI the article offers an analysis of the reasons why competition-based principles in health care have struggled to gain traction in Australia. Mindful that there are alternate policies that encroach into the competition space, the article concludes in Part VII that genuine efforts to promote competition in the Australian

[7] Hilmer Committee Report, n 5.

[8] Expert Panel on Effective Ways of Investing in Health, *Report on Investigating Policy Options regarding Competition among Providers of Health Care Services in EU Member States* (07 May 2015) <https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/008_competition_healthcare_providers_en.pdf>.

[9] Kenneth J Arrow, "Uncertainty and the Welfare Economics of Medical Care" (1963) 53 *American Economic Review* 941.

[10] Uwe E Reinhardt, "Can Efficiency in Health Care Be Left to the Market?" (2001) 26 *Journal of Health Politics, Policy and Law* 967.

[11] Pauline Allen, "An Economic Analysis of the Limits of Market Based Reforms in the English NHS" (2013) 13 *BMC Health Services Research* 3.

[12] Expert Panel on Effective Ways of Investing in Health, n 8.

[13] Productivity Commission, n 4, 310.

[14] Expert Panel on Effective Ways of Investing in Health, n 8, 20.

[15] Productivity Commission, n 4, xxxv.

[16] Kevin Rudd, "Press Conference with Minister Roxon and Dr Christine Bennett. Subject: National Health and Hospitals Reform Commission; Business Council of Australia Budget Submission; Tax Cuts; NATO Summit; Campaign Finance Reform" (Press Conference, 25 February 2008) <http://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/0HRP6/upload_binary/0hrp62.pdf>.

health care system requires a clear and distinct purpose, and oversight by a sector-specific regulator. This is desirable because increased efficiency, effectiveness and productivity mean that the considerable financial resources available to health care can be applied to improve service quality and access.

II. Competition Policy in Australia

Competition is a key element of economic policy in Australia because facilitating competitive markets is believed to incentivise efficiency, productivity and innovation.[17] In 1993 the Hilmer Committee[18] found strong and widespread community support for an NCP that would increase market efficiency, improve international competitiveness and ultimately standards of living. The Hilmer Committee proposed an NCP, comprising a suite of laws, principles and processes, to support the foundational proposition that any anti-competitive conduct needed to be explicitly justified.[19] To give effect to the Hilmer Committee recommendations, the Council of Australian Governments (CoAG) endorsed three intergovernmental agreements. These agreements were the *Competition Principles Agreement* (CPA), the *Conduct Code Agreement* and the *Agreement to Implement the National Competition Policy and Related Reforms*.[20] Together the agreements set out the reforms governments committed to co-ordinate and implement,[21] with the specific goal of improving living standards in Australia.[22]

The Hilmer Committee recognised that the greatest impediment to enhanced competition in many key sectors were the restrictions imposed through governmental regulation.[23] To address this, a central principle of the NCP is that arrangements that detract from competition should be retained only if they can be shown to be in the public interest.[24] This was then codified in the CPA:

> The guiding principle is that legislation (including Acts, enactments, Ordinances or regulations) should not restrict competition unless it can be demonstrated that:
>
> (a) The benefits of the restriction to the community as a whole outweigh the costs; and
> (b) The objectives of the legislation can only be achieved by restricting competition.[25]

To give effect to this clause CoAG agreed to develop a timetable for review and, where appropriate, reform all existing legislation that restricted competition contrary to the public interest by the year 2000.[26] This was later extended to 2002, and then 2005.[27] The health-related legislation that was reviewed included statutes regulating health practitioners such as the *Medical Practice Act 1992* (NSW), *Dentists Act 1984* (SA) and the *Nursing Act 1992* (Qld).[28] The regulation of private health facilities and nursing homes[29] and pathology services under Medicare[30] were also considered.

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[17] Hilmer Committee Report, n 5, 1.

[18] Hilmer Committee Report, n 5.

[19] Hilmer Committee Report, n 5, xviii.

[20] The Council of Australian Governments adopted the Agreements on 11 April 1995; the agreements are set out in the National Competition Council, *Compendium of National Competition Policy Agreements* (Australian Government Publishing Service, 1997).

[21] National Competition Council, n 20. Following review of the NCP, minor amendments to the *Competition Principles Agreement* were endorsed in 2007.

[22] Harper Review, n 4, 24.

[23] Hilmer Committee Report, n 5, 200.

[24] Hilmer Committee Report, n 5, 206. See also Productivity Commission, n 4, xiv.

[25] Council of Australian Governments, *Competition Principles Agreement* (1995) cl 5(1).

[26] Council of Australian Governments, n 25, cl 5(6).

[27] National Competition Council, *Legislation Review Compendium* (6th ed, 2010) 1.

[28] National Competition Council, n 27.

[29] National Competition Council, n 27. The legislation reviewed included the *Health Act 1937* (Qld) and associated regulations; *Private Health Facilities Act 1999* (Qld); *Nursing Homes Act 1988* (NSW); *Private Hospital and Nursing Homes Act 1981* (NT).

[30] National Competition Council, n 27. The legislation reviewed included *Health Insurance Act 1973* (Cth) Pt IIA, which related to licensing pathology collection centres.

In 2005, at the request of CoAG, a review of NCP arrangements was conducted by the Productivity Commission.[31] Although the focus of Australia's competition policy had been removing impediments to efficiency and enhancing competition, the review extended beyond the economic impact of the NCP reforms and considered their impact on the Australian community more broadly.[32] Additionally, the review assessed the need for ongoing legislation review and opportunities to strengthen "gate-keeping arrangements for new or amended regulations containing restrictions on competition".[33] Alert to the challenges from Australia's ageing population and the economic impact this will have on the Australian economy, the review concluded that increasing national productivity and sustainability were imperative to improve living standards and community wellbeing.[34] Specifically, reforms in "health care … should be pursued through separate nationally coordinated initiatives".[35] Arguing that an "integrated health care reform framework and program under the auspices of CoAG, would bring much needed impetus to the pursuit of better health outcomes, in the same way that its sponsorship has been a precondition for the success of the NCP",[36] the Productivity Commission recommended that an independent public review of the health system be established.[37] Further, that the review:

> should include consideration of: the key future determinants of demand for and supply of health services; health financing issues …; coordination of health care services …; the interface between private and publicly provided services; information management; and the appropriate balance of resourcing between prevention and treatment.[38]

These broad recommendations were consistent with the observation that analysis of the factors and policies that contribute to community wellbeing require a holistic approach.[39] The next parts set out developments following the review affecting health legislation. This detail is important because this provides the context for the current debates.

III. Health Care and the NCP

At the June 2005 meeting CoAG acknowledged the significant reforms flowing from implementation of the NCP reform agenda, along with the preliminary steps that were being taken to reform the health system.[40] Recognising that the processes for transitioning between acute and sub-acute care could be improved, and that the challenges of service delivery in rural and remote areas of Australia should be addressed,[41] it was agreed that any broad health care reform needed to ensure that the roles and responsibilities of each level of government, and concurrently, the allocation of health care funding would need explicit clarification.[42]

The initial efforts accelerated with a change in the Australian Government in 2007. At the first meeting of CoAG after the election, a working group on health and ageing was established with the aspirational objective of improving "health outcomes for all Australian's and the sustainability of the Australian health system".[43] As part of this expansive goal the group would address the lengthy waiting times for

[31] Productivity Commission, n 4.

[32] Productivity Commission, n 4, iv.

[33] Productivity Commission, n 4, 249.

[34] Productivity Commission, n 4, 359.

[35] Productivity Commission, n 4, 359.

[36] Productivity Commission, n 4, 332.

[37] Productivity Commission, n 4.

[38] Productivity Commission, n 4, 334.

[39] Productivity Commission, n 4, 165.

[40] Council of Australian Governments, *Communiqué 03 June 2005* (Department of Prime Minister and Cabinet, 2005).

[41] Council of Australian Governments, n 40.

[42] Council of Australian Governments, n 40.

[43] Council of Australian Governments, *Communiqué 20 December 2007* (Department of Prime Minister and Cabinet, 2005) Attachment.

elective surgery in the public hospital system, investment in aged care, public dental programs and preventive health care.[44] In this endeavour, the working group would be supported by the newly formed NHHRC.[45]

One of the first tasks of the NHHRC was to provide "advice on the framework for the next *Australian Health Care Agreements*, including on performance benchmarks and practical reforms to the Australian health system".[46] Prior to 2009, the Australian Government was partly responsible for funding the operation of public hospitals, while the States and Territories agreed to provide equitable access to these hospitals as needed.[47] *Australian Health Care Agreements* formalising these funding arrangements were required because of the "vertical fiscal imbalance"[48] between the relative revenue and spending responsibilities of two levels of government. This meant that the States and Territories were dependent on Australian Government grants to meet their expenditure commitments.[49] The NHHRC noted that this was a crucial driver of the blame shifting and intergovernmental criticism colloquial termed the "blame game" in health.[50]

The first of three NHHRC reports was delivered in April 2008.[51] Titled "Beyond the Blame Game", it began by setting out the principles that would underpin the expectations of the health system and inform the process of health reform.[52] It also identified 12 health and health care challenges that the next *Australian Health Care Agreements* needed to address.[53] Importantly, the NHHRC clearly outlined which level of government should assume accountability for the performance benchmarks associated with the 12 challenges,[54] so as to reduce the potential for blame-shifting.[55] In December 2008 the NHHRC released an interim report that built on the principles and key issues identified in the first report.[56] Taking a long-term perspective, the report examined ways to enhance the health of all Australians through four themes: (1) taking responsibility, (2) connecting care, (3) facing inequities and (4) driving quality performance.[57]

A key message in the interim report was that no single Commonwealth, State or Territory government viewed the health system as a whole.[58] The disjointed views translated into fragmented services and

[44] Council of Australian Governments, n 43.

[45] Council of Australian Governments, n 43. See also Department of Prime Minister and Cabinet, "Joint Media Release from the Prime Minister and Minister for Health and Ageing, National Health and Hospitals Reform Commission" (Media Release, 15776, 25 February 2008).

[46] Council of Australian Governments, n 43, Attachment, 5.

[47] National Rural Health Alliance, "A Brief History of 'Health Reform' in Australia, 2007–2009" (2010) 18 *The Australian Journal of Rural Health* 49.

[48] Richard Webb, "Public Finance and Vertical Fiscal Imbalance" (Research Note No 13, Parliamentary Library, Parliament of Australia, 2002).

[49] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians – Interim Report* (December 2008) 280.

[50] National Health and Hospitals Reform Commission, n 49. This was echoed by Professor Stephen Duckett who reported that the previous *Australian Health Care Agreements* were endorsed after "vituperative debate and intransigence from the Commonwealth that vitiated the negotiation process", explaining why an alternate process was deemed imperative: Stephen J Duckett, "The Australian Health Care Agreements 2003–2008" (2004) 1 *Australia and New Zealand Health Policy* 1.

[51] National Health and Hospitals Reform Commission, "Beyond the Blame Game: Accountability and Performance Benchmarks for the Next Australian Health Care Agreements" (April 2008).

[52] National Health and Hospitals Reform Commission, n 51, 5, App B.

[53] National Health and Hospitals Reform Commission, n 51, 11.

[54] National Health and Hospitals Reform Commission, n 51, 23.

[55] National Health and Hospitals Reform Commission, n 51, 20.

[56] National Health and Hospitals Reform Commission, n 49.

[57] National Health and Hospitals Reform Commission, n 49, 45.

[58] National Health and Hospitals Reform Commission, n 49, 273.

widespread dissatisfaction among consumers and those working in the system.[59] This provided impetus for three potential proposals, under the theme of "driving quality performance", for systemic governance reform.[60] The first was to retain shared responsibility for the provision of health service between the differing levels of government, but with clearer accountability. In this option, both Commonwealth and State/Territory levels of government would remain involved in planning, funding and decision-making about health services.[61] Second, the Commonwealth could take sole responsibility of health services with delivery through regional authorities, or third, a complete takeover by the Commonwealth.[62] The final option would require the Commonwealth to establish a tax-funded community insurance scheme under which people would choose from multiple competing health plans covering services such acute hospital care, pharmaceutical and allied health service provision.[63] The health plans, representing a type of "social insurance" would be funded by taxation revenue as is the case in several European countries.[64] The approach would also provide "competitive pressures for efficiency, with health plans having an incentive to maximise the cover they can offer to attract more members while maintaining or improving their operating margins".[65] After presenting the interim report, a further period of stakeholder consultation was undertaken, and feedback used to inform the final phase of the work.[66]

After more than a year of discussion, debate, consultation, research and deliberation,[67] the NHHRC's final report proposed more than 100 reforms.[68] The observation that governments "do not have a monopoly on health system reform, but are uniquely able to influence the architecture of the health system and so create imperative and support for others",[69] is reflected in the fact that of the 123 recommendations, the NHHRC formed the view that the Australian Government would be best placed to lead 110 of these. There were 27 recommendations sought legislative review or changes.[70] These ranged from requiring governments to identify regulatory barriers to the uptake of wellness and health promotion programs,[71] through to the drafting and implementation of legislation that would establish national health care practitioner registration and education accreditation.[72]

Thirty seven of the NHHRC recommendations focused on "driving quality performance",[73] by reforming governance and funding arrangements.[74] This included reallocating responsibility for a significant portion of health policy to the Australian Government. While States and Territories would retain management of the public hospital system,[75] funding would be linked to the actual services provided rather than on a per capita

[59] National Health and Hospitals Reform Commission, n 49, 273.

[60] National Health and Hospitals Reform Commission, n 49, 274.

[61] National Health and Hospitals Reform Commission, n 49, 289.

[62] National Health and Hospitals Reform Commission, n 49, 274.

[63] National Health and Hospitals Reform Commission, n 49, 294.

[64] National Health and Hospitals Reform Commission, n 49, 296. The report notes that France, Germany and The Netherlands all have universal health care based on social insurance schemes.

[65] National Health and Hospitals Reform Commission, n 49, 297.

[66] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians – Final Report* (June 2009) 40.

[67] National Health and Hospitals Reform Commission, n 66, 12. See also National Health and Hospitals Reform Commission, n 49, 43 where it was noted that more than 530 submissions were received from organisations and individuals outlining their views on health reform.

[68] National Health and Hospitals Reform Commission, n 66.

[69] National Health and Hospitals Reform Commission, n 66, 73.

[70] National Health and Hospitals Reform Commission, n 66, 198.

[71] National Health and Hospitals Reform Commission, n 66, 200.

[72] National Health and Hospitals Reform Commission, n 66, 231.

[73] National Health and Hospitals Reform Commission, n 66, 27–35.

[74] National Health and Hospitals Reform Commission, n 49, 19.

[75] National Health and Hospitals Reform Commission, n 66, 113.

basis.[76] This "activity-based funding" (ABF) would create the incentive for greater cooperation between both levels of government and ensure that the most efficient services were employed to meet health needs.[77]

Restructuring health care funding was identified as an important reform measure. However, a quality, high-performing and sustainable health care system also needed the flexibility to innovate in the face of changing circumstances and support "self-improvement".[78] Consumer choice and provider competition were considered fundamental to an innovative, sustainable and efficient system[79] because they promote autonomy and system responsiveness to user needs.[80] To achieve greater choice and competition the NHHRC proposed that people should be able to select a "health and hospital plan" of their choice to deliver on their Medicare entitlement.[81] Although a tax-funded community insurance scheme had been proposed to achieve this, in response to stakeholder feedback, the NHHRC recommended that rather than importing an "outside" social health insurance scheme it would be preferable to build on and extend the current system.[82] This reformed model was given the working title *Medicare Select*.[83]

Under *Medicare Select*, all Australians would be allocated a government-operated health and hospital plan, but could choose to move to another plan operated by a not-for-profit or private enterprise.[84] The Australian Government would distribute funds to health and hospital plans on a risk-adjusted basis for each person – that is, funding would follow the person and reflect the likely health needs of that person, based on factors such as age, known health risks and previous health service utilisation.[85] It was anticipated that plans would compete for membership based on premium prices, product range, quality and reputation.[86] For the market to be truly competitive, consumers would need to be able to change plans with relative ease, as it would be the threat of consumers switching plans that placed pressure on the health and hospital plans to perform.[87]In this setting *Medicare Select*, it was postulated, would provide the mix of drivers required for a self-improving public health system: (1) pressure from the top, with government determining the strategic direction, standards and regulation, as well as accountability and performance management arrangements; (2) horizontal pressure, with competition and contestability for providers on the supply side; and (3) bottom-up pressure, with increased consumer choice on the demand side.[88] Launching the NHHRC *Final Report* in July 2009 the Prime Minister set out seven principles that would inform future health care reform. These seven principles addressed: (1) building a health system focused on people, (2) maximising the focus on prevention, (3) delivering comprehensive primary care, (4) minimising waiting times for acute care, (5) improving care provided after hospital, (6) improving quality and safety in the health care system and (7) improving efficiency by clearly defining the roles and responsibilities to the Australian, State and Territory governments.[89] However, there was no reference to *Medicare Select*.[90]

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[76] National Health and Hospitals Reform Commission, n 66, 137.

[77] National Health and Hospitals Reform Commission, n 66, 150. See also Australian Government, *2010–11 Australian Government Budget – A National Health and Hospitals Network for Australia's Future. Delivering Better Health and Better Hospitals* (2010) 9 <http://www.budget.gov.au/2010–11/content/glossy/health/download/health_overview.pdf>.

[78] National Health and Hospitals Reform Commission, n 66, 155.

[79] National Health and Hospitals Reform Commission, n 66.

[80] Julian Le Grand, *The Other Invisible Hand: Delivering Public Services through Choice and Competition* (Princeton University Press, 2007) 30.

[81] National Health and Hospitals Reform Commission, n 66.

[82] National Health and Hospitals Reform Commission, n 66, 156.

[83] National Health and Hospitals Reform Commission, n 66.

[84] National Health and Hospitals Reform Commission, n 66.

[85] National Health and Hospitals Reform Commission, n 66.

[86] Anne-marie Boxall, "What is Medicare Select" (Background Note, Parliamentary Library, Parliament of Australia, 2009).

[87] National Health and Hospitals Reform Commission, n 66, 158.

[88] National Health and Hospitals Reform Commission, n 66.

[89] Kevin Rudd, "Reforming Australian Health Care" (Address at the John Curtin School of Medical Research Canberra, 27 July 2009).

[90] Rudd, n 89.

In 2010, the Australian Government published their response to the NHHRC's report, outlining the reform recommendations they would carry forward.[91] The most substantial reform was the establishment of a *National Health and Hospitals Network* (NHHN) to support restructured financing and governance arrangements in Australia's health and hospital system.[92] Where previously all Australian, State and Territory governments were required to negotiate *Australian Health Care Agreements* every five years, under the NHHN the Australian Government would become the majority funder of the public hospital system, and assume full policy and funding responsibility for primary health care and aged care.[93] Governance and management of local health and hospital services, however, would be devolved to the new local institutions that could remain responsive and flexible to local needs.[94] Transparent performance reporting against new national standards was to be introduced to enable easy identification of poor performance, and assist Australians to make more informed choices about the health services they choose.[95] The combination of reforms were codified in the *National Health and Hospitals Network Agreement,* and signed by all Australian, State and Territory governments, except Western Australia, in 2010.[96] This short-lived agreement was superseded in 2011 when all the Australian, State and Territory governments signed the *National Healthcare Agreement*[97] and *National Health Reform Agreement* (NHRA).[98] The former of these agreements encompassed the "collective aspirations of Commonwealth, State and Territory governments on prevention, primary and community care, hospital and related care and aged care",[99] while the latter set out the parties' commitments in relation to public hospital funding, performance reporting and local governance of elements of the health system.[100] To assess the performance of governments towards achieving these objectives detailed progress measures and outputs were described.[101] Competition-based reforms to support these objectives, however, were either subsumed within the performance reporting and restructured funding arrangements,[102] or omitted.

To give legislative force to the health reform agreements the *National Health and Hospitals Network Bill 2010* (Cth) was introduced, but lapsed at dissolution without being debated.[103] The Bill was re-introduced

[91] Australian Government, n 77; see also Christine Bennett, "Are We There Yet? A Journey of Health Reform in Australia" (2013) 199 *Medical Journal of Australia* 251. Of the 123 recommendations, 48 were agreed to, 45 supported, 29 noted and only 1 was not supported.

[92] Council of Australian Governments, *National Health and Hospitals Network Agreement 2010*, cll 1–2 <http://jacksonryan.com.au/wp-content/uploads/2010/05/National-Health-and-Hospitals-Network-Agreement-COAG-19-April-2010.pdf>.

[93] Council of Australian Governments, n 92, Sch C.

[94] Council of Australian Governments, n 92.

[95] Council of Australian Governments, n 92.

[96] Council of Australian Governments, n 92. See also Senate Finance and Public Administration References Committee, *Report on the Implementation of the National Health Reform Agreement* (March 2013) App 3; Geoff Anderson and Andrew Parkin, "Federalism: A Fork in the Road" in Chris Aulich and Mark Evans (eds), *The Rudd Government: Australian Commonwealth Administration 2007–2010* (Australian National University Press, 2010) 97, 98. In establishing the National Health and Hospital Network, the Commonwealth would appropriate one-third of the GST revenue that had previously flowed to the States. This proposal severely strained fraternal ties with the Labor-governed States and say the Liberal government of Western Australia reject Rudd's plan outright.

[97] Council of Australian Governments, *National Healthcare Agreement 2011* <http://www2.curtin.edu.au/research/jcipp/local/docs/National_Healthcare_Agreement_2011.pdf>.

[98] Council of Australian Governments, *National Health Reform Agreement 2011* <http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf>.

[99] Council of Australian Governments, n 97, cl 10.

[100] Council of Australian Governments, n 98, cl 3.

[101] Council of Australian Governments, n 98, cl 16.

[102] Council of Australian Governments, n 98, cl 33. For example – improvements in the technical efficiency of public hospital services were associated with the implementation of activity-based funding, and patient's experience of a healthcare service would be supported by accurate online information.

[103] Commonwealth, *Parliamentary Debates*, House of Representatives, 23 June 2010, 6252.

without changes as the *National Health and Hospitals Network Bill 2011* (Cth) and was passed with only minor amendments[104] commencing on 1 July 2011.[105] The Act provided for the establishment of the Australian Commission for Safety and Quality in Health Care (ACSQHC) as a permanent, independent statutory authority under the *Commonwealth Authorities and Companies Act 1997* (Cth).[106] The Bill's explanatory memorandum noted that the ACSQHC will be required to formulate and monitor quality and safety standards, but would not have any regulatory functions.[107] As anticipated, a series of amendments followed shortly after. Amendments in October 2011 established the National Health Performance Authority (NHPA).[108] This statutory agency would provide independent monitoring and reporting of the performance of important elements of the health system.[109] Publicly reporting health service performance is strongly associated with improving quality of care, and thus formed an important element of Australia's health reform program.[110] Two subsequent amendments established the Independent Hospital Pricing Authority and the National Health Funding Authority and associated Administrator.[111] The former would work with Australian health departments to classify health care services and determine the level of Australian Government funding for public hospital services.[112] While the latter would provide for Australian Government payments to the States for public hospital services, through a National Health Funding Pool operated by the Administrator.[113] Table 1 sets out the series of amendments.

As recommended by the NHHRC, the legislation ultimately created four authorities that would support new funding arrangements, develop and monitor clinical standards, and provide transparent, accessible performance information. However, some of the most substantive recommendations, the "horizontal" and "bottom-up" drivers associated with competition and choice were not included.[114] Rather, improvements in efficiency and productivity would continue to rely on "top-down" pressure generated by policy, standards and regulations determined by governments.[115] While governments can institute performance reporting to encourage continuous quality improvement, the impact is limited by the absence of user choice. Similarly, without effective competition, ABF potentially de-incentivises health care for those with complex needs,[116] diluting the benefits envisioned by the recommendations.

A further consequence was the lost opportunity to consider how the public interest test might apply in the health care context. An important element of Australia's competition policy is that regulation should be pro-competitive and legislative provisions that restrict competition must demonstrate a public benefit.[117] The recognised process for assessing restrictive practices is through the development of a

[104] Commonwealth, *Parliamentary Debates*, House of Representative, 27 October 2010, 1886 (Nicola Roxon) Votes in the House of Representatives, Ayes 74 and Noes 69; Commonwealth, *Parliamentary Debates,* Senate, 03 March 2011, 1094 (Jan McLucas). Votes in the Senate, Ayes 31 and Noes 29.

[105] *National Health and Hospitals Network Act 2011* (Cth) s 2.

[106] *National Health and Hospitals Network Act 2011* (Cth) s 8.

[107] Explanatory Memorandum, *National Health and Hospital Network Bill 2010* (Cth) 4.

[108] *National Health Reform Amendment (National Health Performance Authority) Act 2011* (Cth).

[109] Explanatory Memorandum, *National Health Reform Amendment (National Health Performance Authority) Bill 2011* (Cth) 8.

[110] National Health Performance Authority, *National Health Performance Authority Annual Report 2011–2012* (17 October 2012) 2.

[111] *National Health Reform Amendment (Independent Hospital Pricing Authority) Act 2011* (Cth); *National Health Reform Amendment (Administrator and National Health Funding Body) Act 2012* (Cth).

[112] Explanatory Memorandum, *National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011* (Cth), 5.

[113] Explanatory Memorandum, *National Health Reform Amendment (Administrator and National Health Funding Body) Bill 2011*, 3.

[114] National Health and Hospitals Reform Commission, n 66, 159.

[115] National Health and Hospitals Reform Commission, n 66.

[116] Kathy Eagar, *A Literature Review on Integrating Quality and Safety into Hospital Pricing Systems*, Australian Health Services Research Institute (2013) <https://www.safetyandquality.gov.au/wp-content/uploads/2012/12/Literature-Review-on-Integrating-Quality-and-Safety-into-Hospital-Pricing-Systems1.pdf>.

[117] Council of Australian Governments, *Competition Principles Agreement*, cl 5(1).

Regulation Impact Statement (RIS).[118] However, as the NHHRC competition-based recommendations were not included in the reforms, neither the originating Bill, nor series of amendments that followed were assessed as having a regulatory impact,[119] negating not only the need for a RIS, but also appraisal of any anti-competitive effects. The tension between productivity, economic efficiency and equitable access to increasingly complex services that inheres in the provision of health care is well recognised.[120] Yet the impact of competition in this space has yet to be addressed. NCP appraisal of the *Health Reform Act 2010* (Cth) under the RIS framework would have made explicit how competition in this sector is viewed by the government to be in the public benefit.

TABLE 1. ***National Health Reform Act 2011*** **(Cth) series of amendments**

Date	Bill	Objective	Regulatory impact described in the EM	Assent
September 2010	*National Health and Hospitals Network Bill 2011* (Cth)	Established the ACSQHC	No regulatory function	April 2011
October 2011	*National Health Reform Amendment (National Health Performance Authority) Bill 2011* (Cth)	Established the National Health Performance Authority	These measures will not have regulatory impact on business and individuals or the economy	October 2011
December 2011	*National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011* (Cth)	Established the Independent Hospital Pricing Authority	No reference to regulatory impact	November 2011
March 2012	*National Health Reform Amendment (Administrator and National Health Funding Body) Bill 2012* (Cth)	Introduced with the Federal Financial Relations Amendment (National Health Reform) Bill 2012. The Bill establishes the Administrator of the National Health Funding Pool and National Health Funding Body	No reference to regulatory impact	June 2012
August 2016	*Budget Savings (Omnibus) Bill 2016* (Cth)	Abolishes the National Health Performance Authority	NA	September 2016

[118] Department of Prime Minister and Cabinet, *The Australian Government Guide to Regulation* (2014) 2 <https://www.pmc.gov.au/resource-centre/regulation/australian-government-guide-regulation>.

[119] Email from Office of Best Practice Regulation to Jayne Hewitt, 27 October 2017.

[120] Productivity Commission, *Efficiency in Health* (Commission Research Paper, 2015) 7.

In 2013, just over a year after the last of the amendments were passed, the Australian government changed. One of the first initiatives of the new government was the establishment of a *National Commission of Audit* (NCoA).[121] Under its terms of reference the NCoA had "broad remit to examine the scope for efficiency and productivity improvements across all areas of Commonwealth expenditure".[122] The NCoA report, "Toward Responsible Government", contained 86 recommendations that were viewed as a preamble to austerity measures that were to be proposed in the 2014 and 2015 federal budgets.[123] For example, the Audit Commission recommended the introduction of a Medicare co-payment for consultations with general practitioners, and the 2014 Budget proposed that those patients who were "previously bulk-billed can expect to contribute $7 per visit toward the cost of standard general practitioner consultations and out-of-hospital pathology and imaging services".[124] While this Budget announcement received a good deal of (mostly) negative publicity,[125] a more substantive change was that the hospital funding model agreed to in the NHRA would cease.[126] The new Government pledged that from 2017 to 2018 Budget funding would revert to the former block funding model based on indexation at the Consumer Price Index and population growth, generating substantial savings for the Commonwealth.[127] Consistent with the recommendation of the NCoA,[128] further budget savings were proposed by amalgamating the newly formed NHPA, the Independent Hospital Pricing Authority, the Administrator of the National Health Funding Pool and the ACSQHC with the Australian Institute of Health and Welfare. The functions of these bodies, it was recommended, would be assumed by a new Health Productivity and Performance Commission.[129]

These NCoA proposals did not proceed and the three statutory authorities that underpin the governance of the health system were not amalgamated.[130] However, on 1 July 2016, the activities of the NHPA were transferred to the Australian Institute of Health and Welfare, the ACSQHC and the Commonwealth Department of Health.[131] Later that year CoAG agreed to reinstate the Commonwealth contribution to funding public hospitals on an activity basis.[132] The most recent health care agreement affirms that Australia's health system should be person-centred and provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.[133] However, there was no mention of competition or the earlier proposals to introduce competitive measures into health care. Thus, while seeking to improve health outcomes for all Australian's and ensure that the system is sustainable, a commitment to increased competition or choice that was championed in

[121] Peter Khoury, "Neoliberalism, Auditing, Austerity and the Demise of Social Justice" (2015) 34 *Social Alternatives* 25, 26.

[122] National Commission of Audit, *Towards Responsible Government. The Report of the National Commission of Audit, Phase One* (February 2014) 254.

[123] Khoury, n 121.

[124] Australian Government, *Budget 2014–15 Overview* (13 May 2014).

[125] Price Waterhouse Coopers, *Australian Federal Budget 2014 – Health* (May 2014) <https://www.pwc.com.au/tax/assets/federal-budget/federal-budget-2014-health.pdf>.

[126] Senate Select Committee on Health, Parliament of Australia, *Final Report on the Abbott Cuts to Health 2014* (2014) 25.

[127] Australian Government, *Budget Measures 2014–15, Budget Paper No 2, Part 2: Expense Measures* (13 May 2014) 126.

[128] National Commission of Audit, n 122, xxvii, 210.

[129] Australian Government, n 127, 71. This measure did not progress and in the 2016 Budget, the Government noted the decision not to proceed with the establishment of a Health Productivity and Performance Commission.

[130] Australian Government, *Budget 2016–17, Agency Resourcing, Budget Paper No 4* (3 May 2016) 140.

[131] The National Health Performance Authority, *Final Annual Report for the Period 01 July 2015–31 Oct 2016* (March 2017) vi. *Budget Savings (Omnibus) Act 2016* (Cth) Sch 7, The National Health Performance Authority was formally abolished on 1 November 2016.

[132] Council of Australian Governments, n 98, Sch 1 – Addendum to the National Health Reform Agreement: Revised Public Hospital Arrangements.

[133] Council of Australian Governments, *National Health Care Agreement 2012*. <http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf>.

2009 by the NHHRC has with time been diluted so that by 2016 it was a notable omission in Australia's health services policy.

IV. Still Room for Greater Competition in Australia's Health Care System

Recognising that the Australian economy had changed considerably since the Hilmer Committee in 1993, in 2015 Australia's competition policy, laws and institutions were re-examined by the *Competition Policy Review Panel* (Harper Review).[134] The Harper Review observed that "important unfinished business remains from the original [NCP] agenda, and new areas have arisen where competition policy ought to apply".[135] Echoing the Productivity Commission in 2005, the Harper Review formed the view that the focus of competition policy should "extend beyond infrastructure public monopolies and government business to encompass the provision of government services more generally".[136] While the approach of the Hilmer Committee was to inform competition policy beyond existing laws (primarily the then *Trade Practices Act 1974* (Cth)) to "government businesses (including public monopolies), statutory marketing arrangements for certain agricultural products and some professions",[137] the remit of the 2015 Harper Review was even broader.[138] The terms of reference stipulated that the review was to identify "regulations and other impediments across the economy that restrict competition and reduce productivity, which are not in the broader public interest".[139] Consistent with this directive, the Harper Review noted:

> Australia's ageing population will impose greater demands on health and aged care services. Establishing choice and contestability in government provision of human services can improve services for those who most need them. If managed well, this can both empower service users and improve productivity at the same time.[140]

To support a wider purview for competition policy in Australia, the Harper Review recommended a new set of competition principles that would provide direction for governments committed to further competition reform. The principles were based on the central notion that competition policy, laws and institutions should promote the long-term wellbeing of the public, and re-affirm that competition should not be impeded unless it is in the public interest.[141] The Harper Review noted that the public interest test does not put competition above all other considerations.[142] It does, however, require that the effect on competition always be carefully considered as part of the overall assessment of the net public interest, and that the costs of anti-competitive regulation should be properly assessed in any cost–benefit analysis.[143]

The Harper Review's recommendation to include an overarching set of competition principles in a future reform agenda was supported by the Australian Government,[144] as was the recommendation to adopt choice and competition principles in the domain of human services.[145] Additionally, the

[134] Harper Review, n 4.

[135] Harper Review, n 4.

[136] Harper Review, n 4, 18.

[137] Hilmer Committee Report, n 5, 183.

[138] Harper Review, n 4, 534.

[139] Harper Review, n 4, 526.

[140] Harper Review, n 4, 254.

[141] Harper Review, n 4, 99.

[142] Harper Review, n 4, 97.

[143] Harper Review, n 4, 36.

[144] The Australian Government, *Australian Government Response to the Competition Policy Review* (The Treasury, 2015) 3.

[145] The Australian Government, n 144, 4.

Government committed to commission a review into human services, including research on past or ongoing reforms to incorporate principles of choice, competition and contestability.[146] Identifying the need for review was an important step for future reforms and innovation in service delivery in this dynamic sector.[147]

The Australian Government's response was supported by CoAG which later committed to a new reform agenda that would drive "productivity and economic growth, to deliver high quality and responsive health, education and social services systems".[148] Formalising the agenda, the Commonwealth, New South Wales, Western Australia, Tasmania, the Australian Capital Territory and Northern Territory (but not Victoria and Queensland) signed the *Intergovernmental Agreement on Competition and Productivity-enhancing Reforms* (IGA) to promote efforts to remove unnecessary regulatory barriers to competition.[149] Comprising eight principles that guide the development and formation of government policy and regulation, the agreement requires governments to promote consumer choice when providing goods or services[150] and reiterated a public interest test as a central tenant of competition policy.[151] To implement the reforms, governments that were party to the agreement would transparently review regulation and remove unnecessary restrictions on competition.[152] Consistent with the recommendations of the Harper Review, the agreement explicitly includes the provision of "innovative ways to delivery high quality, efficient human services"[153] as a sector amenable to competition reform.

In April 2016, the Productivity Commission was requested to inquire into Australia's human services with a focus on "innovative ways to improve outcomes through introducing the principles of competition and informed user choice whilst maintaining or improving quality of service".[154] The inquiry was to be conducted in two stages, where the aim of the first was to identify those human sector services amenable to the introduction of greater competition, contestability and user choice.[155] This would be followed by an extensive analysis designed to generate recommendations on how to introduce and implement competition reforms in those sectors.[156]

As part of the first stage of the inquiry, the Productivity Commission assessed the scope for policy settings to increase the wellbeing of the community as a whole by improving the provision of human services.[157] It went on to consider whether the "characteristics of the service user, the service itself and the supply environment" suggests that the introduction of competition and user choice would improve service provision.[158] Finally an assessment of the cost of any potential reform was undertaken.[159] The

[146] The Australian Government, n 144, 4.

[147] The Australian Government, n 144, 4.

[148] Council of Australian Governments, *Communiqué 09 December 2016* (Department of Prime Minister and Cabinet, 2007).

[149] Council of Australian Governments, n 148.

[150] Council of Australian Governments, *Intergovernmental Agreement on Competition and Productivity-enhancing Reforms* 2016, cl 9(c) <https://www.coag.gov.au/sites/default/files/agreements/IGA-productivity-reforms.pdf>.

[151] Council of Australian Governments, n 150, cl 10.

[152] Council of Australian Governments, n 150, App A.

[153] Council of Australian Governments, n 150, cl 12(b).

[154] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, Draft Report, Canberra (2 June 2017).

[155] Productivity Commission, n 154, v.

[156] Productivity Commission, n 154.

[157] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*, Study Report (5 December 2016) 44.

[158] Productivity Commission, n 157, 46.

[159] Productivity Commission, n 157, 47.

process culminated with a decision that the provision of public hospital services was one of the six human services best suited for competition-based reform.[160] The term "public hospital service" used in the draft report referred to "health care that specialists and hospitals provide to public patients".[161] The draft report addressed only one, albeit important, aspect of health care in relation to public hospital service – the choice of hospital and clinician.

A guiding principle of the 2017 Productivity Commission inquiry was that human services, including health care, should be user-focused,[162] with choice at the heart of service provision and delivery.[163] In the draft report the Commission noted that there were many benefits associated with improved patient choice,[164] yet when patients are referred to a public outpatient clinic or private specialist their choices are often limited.[165] Five reform actions to increase choice for referred patients were recommended. These included clarifying the provisions of the *Health Insurance Regulations 1975* (Cth) so that patients can choose which public clinic or private specialist they attend when a referral is required and requiring public outpatient clinics to accept any patient with a referral letter for treatment for a condition the clinic covers.[166] Further recommendations directed at supporting patient choice included developing best-practice guidelines for general practitioners who are responsible for the vast majority of referrals.[167] Noting the essential role that having access to accurate, user-friendly information has, other recommendations to support patient choice involved reporting of publicly collected health care data. This would serve the dual purposes of supporting choice and encouraging performance improvement by hospitals and medical specialists.[168] Both outcomes were canvassed in the NHHRC report eight years earlier. However, where the NHHRC made the direct link between choice and competition, the recent Productivity Commission Draft report notes that "the intrinsic value of user choice means it has meaning to people *for its own sake,* independent of whether it drives changes in price or quantity, or drives innovation and efficiencies".[169] The Productivity Commission also noted that choice can drive competition and this in turn is generally associated with higher quality care.[170] The final report was provided to the Australian Government on 27 October 2017, and scheduled for release early in 2018.[171]

Since 2005, the need for reform to promote competition in Australia's health care system has been frequently recommended. Table 2 sets outs the repetitive themes that have endured for more than a decade. However, they generally failed to progress beyond mere recommendations. In fact, in contrast to the extensive reforms recommended by the NHHRC in 2009, the most recent reforms recommended in the draft report by the Productivity Commission in 2017 focus on promoting choice. Although choice is necessary for competition, it may not be sufficient. To explore whether there are alternate ways of progressing competition it is instructive to look to other jurisdictions, such as the United Kingdom where competition policy is an integral part of the NHS.

[160] Productivity Commission, n 157, 48.

[161] Productivity Commission, n 154, 260.

[162] Productivity Commission, n 154, 261.

[163] Productivity Commission, n 154, 2.

[164] Productivity Commission, n 154, 206.

[165] Productivity Commission, n 154, 259.

[166] Productivity Commission, n 154, 272.

[167] Productivity Commission, n 154.

[168] Productivity Commission, n 154, 312.

[169] Productivity Commission, n 154, 56.

[170] Productivity Commission, n 154, 280.

[171] Productivity Commission, *Complete Inquiries – Human Services* <https://www.pc.gov.au/inquiries/completed/human-services>.

TABLE 2. Recurrent themes around competition and health care services 2005–2017

Theme	Productivity Commission 2005	NHHRC 2009	Harper 2015	Productivity Commission 2016–2017
The need for reform	An "overarching" policy review of the entire health system should be the first step in developing a nationally coordinated reform program to address problems that are inflating costs, reducing service quality and limiting access to services (p xii). In the Commission's judgement, the human service area that currently offers the largest potential benefits from a national coordinated [competition] reform approach is health care (p xxxiv).	The Australian health system faces significant challenges, including large increases in demand for and expenditure on health care, unacceptable inequities in health outcomes, growing concerns about safety and quality and inefficiency (p 3). Overall, we are aiming for a system "with incentives for reform embedded within it". To embed incentives for responsiveness, efficiency and sustainability, we believe, requires greater consumer choice and provider competition (p 155).	Australia's ageing population will impose greater demands on health and aged care services. Establishing choice and contestability in government provision of human services can improve services for those who need them. If managed well, this can both empower service users and improve productivity at the same time (p 8).	While governments have made progress in introducing competition, contestability and user choice to human services provision, the efficiency and effectiveness of the delivery of services within the sector varies significantly between jurisdictions. Service delivery frameworks in the human services sector that are inefficient and/or ineffective can result in significant costs to the economy and individuals, including poorer outcomes and reduced productivity (p iv).
The benefit of competition and choice	Carefully implemented consumer choice policies can encourage the provision of services that better and more cost-effectively meet the needs of clients. But there will often be limits on the amount of choice that is possible or desirable. Thus, policy makers have to strike an appropriate balance (p 318).	There are 3 main arguments in favour of opening up the health system to greater consumer choice and provider competition: It empowers consumers through choice of provider. It creates the right incentives for health and hospital plans to attract and retain customers and deliver added value. It provides the right incentives for health service providers to deliver both higher quality care and greater efficiency (p 162).	By promoting user choice and encouraging a diversity of providers, competition policy plays an important role in improving performance in sectors such as human services. Choice and diversity have the potential to improve outcomes for users, especially but not only by stimulating innovation (p 31). The Panel considers that a "presumption of choice" could have significant benefits in many human services sectors. Putting users in control of the human services they access … drives service providers to become more responsive to individual requirements (p 35).	In a well-designed and managed market, informed choice can improve outcomes for users because it: Has intrinsic value by empowering people to have greater control over their lives Enables people to make decisions that best meet their needs and preferences Can generate powerful incentives for providers to be more responsive to users' needs and can drive innovation and efficiencies in service delivery (p 6).

TABLE 2. *Continued*

Recommendations	An integrated health services reform program…would add much needed impetus to addressing structural problems of long standing that are preventing the health care system from performing to its potential (p 303). Reforms in the health care … area[s] should be pursued through separate nationally coordinated initiatives (p 359).	If the full benefits of choice and competition are to be realised, the Commonwealth Government must design a policy and regulatory framework which includes a number of key elements. The Government would need to develop regulation governing the establishment and operation of health and hospital plans. There would also be accountability and performance monitoring arrangements for plans set by the Commonwealth Government, such as access targets, quality indicators and performance benchmarks (p 158).	Each Australian government should adopt choice and competition principles in the domain of human services (p 254). Users should have access to objective, outcomes-based data on available services, and/or feedback from previous users (p 236). Where complexity is high, there can be a role for "meditated choice", such as using a purchasing advisor (p 237).	Public hospital patients should be given greater control over the pathway leading to planned admissions. This requires removing barriers to patients choosing the outpatient clinic or specialist they initially attend when given a referral by their general practitioner. Improved public reporting on individual hospitals and specialists would support greater user choice and encourage performance improvements in hospitals (p 2)

V. COMPETITION IN THE NHS

The NHS was launched in 1948, and like the Australian health care system, was founded on the principles of universality, equity and access on the basis of need, not ability to pay.[172] Also, like the Australian system, the NHS has been subject to different periods of reform. One of the most significant followed publication of two White Papers – *Working for Patients* and *Caring for People* in 1989.[173] The broad recommendations in these papers were incorporated in the *National Health Service and Community Care Act 1990* (UK)[174] and, with the aim of making the system more responsive and efficient fundamentally changed the structure of the NHS. The hierarchical government-regulated NHS planning and resource allocation system was decentralised and replaced with an "internal market" where the roles of service purchases and service providers were clearly separated.[175] In the restructured system, administrative bodies known as District Health Authorities would focus on procuring services.[176] They were meant to do so selectively, after assessing local needs, and systematically favouring better performing providers.[177] In this setting, it was anticipated that patients would choose the service that best suited their needs, creating competition and improved efficiency.[178] The provision of health services would fall to legal entities

[172] Konstantina Grosios, Peter B Gahan and Jane Burbidge, "Overview of Healthcare in the UK" (2010) 1 *The EPMA Journal* 529.

[173] Department of Health (UK), *Working for Patients*, Cm 555 (1989); Department of Health (UK), *Caring for People*, Cm 849 (1989).

[174] *National Health Service and Community Care Act 1990* (UK).

[175] David Hughes, "The Reorganisation of the National Health Service: The Rhetoric and Reality of the Internal Market" (1991) 54 *Modern Law Review* 88, 89.

[176] Hughes, n 175. See also Lindsay Stirton, "Back to the Future? Lessons on the Pro-Competitive Regulation of Health Services" (2014) 22 *Medical Law Review* 180, 185. Stirton records that most DHAs covered a population up to 750,000 people. They were abolished in 1995 by the *Health Authorities Act 1995* (UK).

[177] Kristian Niemietz, "Internal Markets, Management by Targets, and Quasi-Markets: An Analysis of Health Care Reforms in the English NHS" (2015) 35 *Economic Affairs* 93.

[178] Hughes, n 175, 98.

known as NHS Trusts.[179] These bodies would essentially be self-governed, rather than being within the broad purview of the centrally governed NHS.[180] Accordingly, NHS Trusts had authority to "acquire and dispose of assets, borrow, retain an operating surplus in normal circumstances, determine their own management structures, decide their own staffing structure and policy, and advertise their services".[181] At the time, the creation of NHS Trusts was considered "among the most controversial of the reforms" proposed by the government.[182] Believing that NHS Trusts would receive significant financial advantages over those hospitals that continued to be managed centrally, critics were concerned that it was the first step down the path of privatisation.[183] Research that evaluated the effectiveness of internal markets, however, did not provide convincing evidence that this structural change had in fact resulted in private ownership, or achieved the desired improvements in efficiency.[184]

Moving beyond the year 2000, reform efforts to promote market principles such as choice continued and were supported by structural changes to funding and incentives for even greater decentralisation. Having an ability to choose, was not only considered a "good" in its own right, but also believed to drive quality and efficiency, and create competition between providers.[185] Consequently, the new *Health and Social Care (Community Health and Standards) Act 2003* (UK) retained and enhanced market-based practices such as ensuring that patients could choose their health service provider.[186] To provide additional incentives for health services to attract patients, the Act also introduced a prospective payment system, similar to ABF, where providers receive a standardised tariff per case.[187] Known as "payment by results",[188] this system replaced block contracts that were in place prior to 2003.[189] The third change brought about with passage of the Act was the creation of Foundation Trusts. Over time, NHS Trusts that performed well under the choice and payment reforms could apply for Foundation Trust status.[190] The benefit of achieving Foundation Trust status was even greater financial and managerial freedom than NHS Trusts.[191] Their creation reflected the desire to further decentralise health care and invite innovation in the provision of services tailored to the particular needs of local communities.[192]

Demonstrating the strong commitment to competition, the *Health and Social Care (Community Health and Standards) Act 2003* (UK) also provided for the creation of an Independent Regulator of NHS Foundation Trusts.[193] The role of this body was to assess applications for Foundation Trust status,

[179] *National Health Service and Community Care Act 1990* (UK) s 5.

[180] Hughes, n 175.

[181] Department of Health (UK), *Working for Patients: Self-governing Hospitals: An Initial Guide.* (1989) para 2.3, cited in Hughes, n 175, 93.

[182] Hughes, n 175, 94.

[183] Hughes, n 175.

[184] Julian Le Grand, Nicholas Mays and Jo-Ann Mulligan, *Learning from the NHS Internal Market: A Review of the Evidence* (Kings Fund, 1998).

[185] Stephen Peckham et al, "Devolution and Patient Choice: Policy Rhetoric Versus Experience in Practice" (2012) 46 *Social Policy and Administration* 199.

[186] *Health and Social Care (Community Health and Standards) Act 2003* (UK) c 43, ss 28V, 177.

[187] Niemietz, n 177.

[188] Some authors have observed that "payment by results" is a misnomer. It should really be called "Payment by activity". See, eg, Niemietz, n 177, 100.

[189] Niemietz, n 177.

[190] *Health and Social Care (Community Health and Standards) Act 2003* (UK) c 42, s 1(1).

[191] Stirton, n 176, 189.

[192] Department of Health (UK) A Short Guide to Foundation Trusts (November 2005).

[193] *Health and Social Care (Community Health and Standards) Act 2003* (UK) c 43, s 2. Later repeal and replaced by *National Health Service Act 2006* (UK) c 41, s 31(1) and then *Health and Social Care Act 2012* (UK) c 7, s 61(1)(b) where it was renamed Monitor. From 1 April 2016, Monitor was incorporated with NHS Improvement – an organisation responsible for overseeing foundation trusts, NHS trusts and other providers of NHS care.

granting authorisation and monitoring compliance with the terms of authorisation.[194] The combination of patient choice, pay by results, and relative operational autonomy meant that, as in the market, providers were more directly accountable to their patients. Once again, the impact of these "competition tools" was equivocal,[195] but policy makers were not dissuaded from the competition path.

The *Health and Social Care (Community Health and Standards) Act 2003* (UK) was largely repealed in 2007 and re-enacted on that date in a consolidating statute, the *National Health Service Act 2006* (UK) retaining the Independent Regulator.[196] Shortly after, it was recognised that the increasing autonomy of NHS Trusts and Foundation Trusts, devolution of decision-making and greater patient choice meant that management of this complex system required clear rules, particularly "of issues relating to competition".[197] In 2007 guidance for health system managers, commissioners and providers on the expected behaviours and rules governing co-operation and competition in the provision of NHS services, Principles and Rules for Cooperation and Competition (Principles and Rules) was published by the United Kingdom Department of Health.[198] Recognising that effective competition required sustained and active sectoral involvement,[199] a non-statutory advisory body, the Co-operation and Competition Panel was also established and charged with investigating potential breaches of the Principles and Rules and offering recommendations to the Department of Health on their resolution.[200]

The now longstanding policy that the NHS should operate as a market was further enhanced following passage of the *Health and Social Care Act 2012* (UK). Notably, while maintaining the position that competition encourages improvements in the quality and efficiency of health services, the Act extended the role of the Independent Regulator and renamed it Monitor.[201] The previous Co-operation and Competition Panel would now form part of Monitor's Cooperation and Competition Directorate.[202] Although the *Health and Social Care Bill 2011*(UK) had originally sought to *promote* competition in the NHS, this provision was strongly contested, and subsequently omitted.[203] Consequently, Monitor's statutory role is to protect and promote patient interests by promoting economic, efficient and effective health care services while maintaining or improving quality.[204] It achieves this by licensing providers, publishing national tariffs and addressing anti-competitive behaviour in the provision and procurement of services for the purposes of health service.[205] The Act specifically sets out the matters that Monitor must have regard to in the exercise of its functions.[206] They include maintaining patient safety, the need for continuous improvement in quality and efficiency and ensuring that there is fair access to services based on need, not ability to pay.[207] Mindful that excessive regulation can act as a barrier to efficiency, Monitor must ensure that it does not impose unnecessary regulatory burdens on the providers of health

[194] Explanatory Notes to the *Health and Social Care (Community Health and Standards) Act 2003* (UK) para 43.

[195] Peckham et al, n 185.

[196] Monitor, *NHS Foundation Trusts: Consolidated Accounts 2016/17* (10 July 2017).

[197] Department of Health (UK), *Principles and Rules for Cooperation and Competition* (13 December 2007) 3.

[198] Department of Health (UK), n 197.

[199] Stirton, n 176, 190.

[200] The Health Foundation, *Co-operation and Competition Panel*, Policy Navigator (2018) <http://navigator.health.org.uk/content/co-operation-and-competition-panel>.

[201] *Health and Social Care Act 2012* (UK) c 7, s 61.

[202] House of Commons Health Committee, *2012 Accountability Hearing with Monitor*, Tenth Report of Session 2012–13 (26 February 2013) 22.

[203] House of Commons Health Committee, n 202, 4.

[204] *Health and Social Care Act 2012* (UK) c 7, ss 61–66.

[205] *Health and Social Care Act 2012* (UK) c 7, s 62(1)(a)(b).

[206] *Health and Social Care Act 2012* (UK) c 7, s 66.

[207] Explanatory Notes to the *Health and Social Care Act 2012* (UK) [14].

services[208] and must assess the impact of potential regulatory activities.[209] A key feature of the 2012 Act is its much greater emphasis on the use of legal rules and enforcement mechanisms to regulate the NHS market in areas such as tariff pricing, procurement and competition.[210] The reforms therefore represented a shift from internal, managerial accountability for anti-competitive conduct (with legal action as a distant threat) to a system emphasising external, legal accountability for such conduct.[211] The practical effects of these provisions were subject to considerable argument in the United Kingdom Parliament,[212] suggesting that the unique features of health care services continue to provide a challenge for market-based incentives that promote efficiency and productivity.

An ongoing difficulty for competition-based policy options is that unlike pure economic markets, there is a concurrent and essential need for health care to maintain standards of quality and safety, while striving for efficiency. In the United Kingdom, as in Australia, quasi-autonomous non-government organisations bodies are responsible for setting and monitoring predetermined standards.[213] In the United Kingdom the Care and Quality Commission (CQC) is charged with protecting and promoting the health, safety and welfare of people who use health and social care services.[214] The need to maintain a degree of central regulation and oversight also constrains the organisational autonomy needed to create pure market-driven competition.[215]

The existence of different bodies or organisations with a remit to promote health care safety, quality and efficiency, means that there is potential for regulatory overlap in this sphere. The *Health and Social Care Act 2012* (UK), therefore, places a specific duty on Monitor to co-operate with the CQC.[216] Together the CQC and Monitor share information in relation to assessment of NHS Trusts for foundation trust status, during the processes of quality monitoring, investigation and enforcement action.[217] An example of this collaborative regulatory process can be seen in the assessment and monitoring of clinical care, and financial management at the Cambridge University Hospitals NHS Foundation Trust.[218] In addition to finding that there were inadequate staffing levels and delays in outpatient treatment, serious governance failings had resulted in a substantial financial deficit. Both the CQC and Monitor were involved in formulating plans to address the inadequacies in the hospital's performance.[219] This collaboration reflects a concurrent model of regulation that enables bodies such as Monitor, to discharge their responsibilities with a deeper understanding of the nuances of the sector in which they are situated. Further, they can guide and support other bodies with regulatory authority to develop an awareness of the goals and benefits of competition.[220] It may be that such a body could also support the uptake of competition policy in Australia's health sector.

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[208] *Health and Social Care Act 2012* (UK) c 7, s 68.

[209] *Health and Social Care Act 2012* (UK) c 7, s 69.

[210] Anne CL Davies, "This Time, It's for Real: The Health and Social Care Act 2012" (2013) 76 *The Modern Law Review* 564.

[211] Davies, n 210.

[212] House of Commons Health Committee, n 202, 26.

[213] Peter Littlejohns et al, "Setting Standards and Monitoring Quality in the NHS 1999–2013: A Classic Case of Goal Conflict" (2017) 32 *The International Journal of Health Planning and Management* e185.

[214] *Health and Social Care Act 2008* (UK).

[215] Allen, n 11.

[216] *Health and Social Care Act 2012* (UK) c 7, s 288.

[217] UK Government, *Memorandum of Understanding between Monitor and the Care Quality Commission*, Publications (26 February 2015) <https://www.gov.uk/government/publications/monitor-and-the-care-quality-commission-memorandum-of-understanding>.

[218] National Health Executive, *Failing Cambridge Trust Put in Special Measures after CAC and Monitor Investigations*, Inspection and Regulation (22 September 2015) <http://www.nationalhealthexecutive.com/News/failing-cambridge-trust-put-in-special-measures-after-cqc-and-monitor-investigations/119449>.

[219] National Health Executive, n 218.

[220] Dabbah M Maher, "The Relationship between Competition Authorities and Sector Regulators" (2011) 70 *The Cambridge Law Journal* 113, 123.

VI. Is a Sector-specific Regulator the Answer for Australia?

Australia, as a federation of State and Territories, faces unique challenges in the provision of safe, effective health care services. However, similarities with the United Kingdom's NHS make it a useful comparator in relation to the inclusion of competition principles in health care. First, both jurisdictions are faced with increasing health care costs that are perceived as unsustainable, and both see competition as a tool to support improved efficiency and productivity. Another similarity is the creation of statutory bodies to guide and monitor safety and quality in health care; Australia's *Health Reform Act 2009* (Cth) provided for the ACSQHC, and *Health and Social Care Act 2008* (UK) provided for the CQC. However, in relation to the use of competition as a tool to promote efficiency in health care, United Kingdom's Monitor has no comparator in Australia.

The creation of this statutory body with wide regulatory powers in the NHS evolved over the course of 20 years. Consequently, they have substantial history and experience as a sector-specific regulator, and the ability to apply broad competition principles in a nuanced way. In its recent investigation the Harper Review reported that "reinvigorating competition policy in Australia requires leadership from an institution specifically constituted for the purpose".[221] They recommended the creation of a new national competition body with a mandate to provide leadership and drive implementation of the evolving competition agenda.[222] In addition to taking over the roles of the current National Competition Council, such a body (tentatively named the *Australian Council for Competition Policy*) should have a broad role encompassing:

- advocacy, education and promotion of collaboration in competition policy;
- independently monitoring progress in implementing agreed reforms and publicly reporting on progress annually;
- identifying potential areas of competition reform across all levels of government;
- making recommendations to governments on specific market design issues, regulatory reforms, procurement policies and proposed privatisations;
- undertaking research into competition policy developments in Australia and overseas; and
- Ex post facto evaluation of some merger decisions.[223]

On the face of it, such a body could include the role of a sector-specific competition regulator for Australia's health care sector, similar to that undertaken by Monitor. However, there does not appear to be much political appetite for this. The *Competition and Consumer Amendment (Competition Policy Review) Bill 2017* (Cth) introduced the legislative changes to the *Competition and Consumer Act 2010* (Cth) arising from the Australian Government's acceptance of a series of recommendations emanating from the Harper Review. Although the Australian Government supported the need for a body to oversee competition reform it deferred establishing such a body.[224] Instead the National Competition Council was retained, with its relatively limited functions in relation to advising ministers on infrastructure and gas access matters.[225] This omission may be seen either as a missed opportunity, or dodging a policy that was unlikely to achieve its aims.[226] Once again, it is instructive to consider the outcomes of the most recent United Kingdom attempts at regulating competition in health care for reasons why competition policy struggles to integrate in health care, and the possible benefits of a sector-specific regulator to address some of the challenges.

Perceived obstacles to effective competition in health care include weak incentives for providers to compete and a regulatory environment discouraging competition. The *Health and Social Care Act 2012*

[221] Harper Review, n 4, 75.

[222] Harper Review, n 4, 75.

[223] Harper Review, n 4, 77.

[224] The Australian Government, n 144, 34.

[225] *Competition and Consumer Act 2010* (Cth) s 29B. See also Harper Review, n 4, 444. The Panel noted that the NCC has "not maintained the capacity to readily step into a broader role again".

[226] Joe Kelly, "Harper Review: Market Power Law Worse Than N Korea's: Fels", *The Australian*, 26 November 2015, 4.

(UK) attempted to address these, but, its passage was extraordinarily turbulent.[227] Multiple attempts to block, stall or delay the Bill meant that debate went on for more than a year, and was subject to more than 1,000 amendments.[228] While some argued that the reforms were a "logical, sensible extension of changes put in place by Tony Blair", this support was almost lost among the barrage of critique.[229] The British Medical Association, for example, described the Bill as a "massive gamble" and promised to campaign against its extension of competition and use of the private sector.[230] Unrest around competition in the NHS was not quelled with the passing of the Bill. Consequently, Monitor was called to address the House of Commons Health Committee in 2012 shortly after the legislation was passed,[231] and again in 2013.[232] During these meetings concerns were raised about the application of the rules that govern procurement, choice and competition, and the processes for enforcing competition law.[233] Set out in the NHS provider licence,[234]and the *National Health Service (Procurement Patient Choice and Competition) (No 2) Regulations 2013* (UK)[235] the bespoke rules for the healthcare sector provide a mechanism for Monitor, as sector regulator to investigate complaints and take enforcement action.[236] The regulations were designed as an accessible and effective alternative to challenging decisions in the courts. However, an absence of practical guidance on how to interpret and use the new regulations on competition and patient choice meant that users were forced to resort to legal advice[237] that was often uncertain.[238] This led the NHS Chief Executive Officer to surmise that competition was not working to improve quality and that a change in the law might be needed to ensure that the intent of the policy was implemented.[239]

Recent efforts at enhancing competition policy in health care in the United Kingdom have encountered challenges at various stages. First in passing the legislation providing for a sector-specific competition regulator in the NHS,[240] and second in the application and evaluation of competition measures.[241] It appears that transferring what was learnt about the competition regulation of utilities to the implementation of the *Health and Social Care Act 2012* (UK) has been problematic because of "differences in understanding of competition between Monitor's relatively more 'medicalist' approach and the pure 'marketism' of the United Kingdom's competition authorities".[242] This has effectively discouraged the use of competition powers by Monitor.[243] An examination of Monitor's investigations into potential

[227] Stirton, n 176, 192.

[228] Victoria Chico et al, "Markets and Vulnerable Patients: Health Law after the 2012 Act" (2014) 22 *Medical Law Review* 157.

[229] Nicholas Timmins, Never Again? The Story of the Health and Social Care Act 2012: A Study in Coalition Government Policy Making (The King's Fund, 2012) 87.

[230] Timmins, n 229, 86.

[231] House of Commons Health Committee, n 202, 4.

[232] House of Commons Health Committee, *2013 Accountability Hearing with Monitor*, Ninth Report of Session 2013–14 (19 March 2014).

[233] *Health and Social Care Act 2012* (UK) c 7, s 72.

[234] Monitor, *The New NHS Provider Licence* (NHS, 2013) 28 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285008/ToPublishLicenceDoc14February.pdf>.

[235] *National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013* (UK) SI 2013/500 replaced the *National Health Service (Procurement, Patient Choice and Competition) Regulations 2013* (UK) SI 2013/257. The regulations are made pursuant to *Health and Social Care Act 2012* (UK) ss 75, 76, 77, 304(9) and (10).

[236] *National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013* (UK) s 13.

[237] House of Commons Health Committee, n 232, para 69.

[238] House of Commons Health Committee, n 232, para 65.

[239] House of Commons Health Committee, *Public Expenditure on Health and Social Care*, Seventh Report of Session 2013–14 (4 February 2014) para 87.

[240] Chico et al, n 228.

[241] Stirton, n 176, 185.

[242] Stirton, n 176.

[243] Stirton, n 176, 197.

infringement of competition rules that found the NHS avoids entanglement with competition law, and that in certain circumstances Monitor is adopting a "translating" role between the NHS and competition authorities.[244] In cases related to commissioning and procurement, the longstanding practice has been to resolve potential conflicts informally.[245] Indicating that, despite dedicated efforts which included a sector-specific regulatory body, difficulties establishing workable competition strategies alongside health services persist.[246]

However, eschewing all competition-related reform because of challenges encountered in particular areas is not a prudent approach.[247] The issues encountered by the United Kingdom provide an ideal learning opportunity for Australian policy makers and, as the Productivity Commission observed in 2005, if "well implemented in appropriate circumstances, competition-based change can bring overall benefit".[248] For this to occur, it is important to be clear about what such a policy is designed to accomplish and acknowledge that it needs to be able to do this within the limits imposed by the health care services context. Following the detailed examination of four Government-commissioned reviews that persistently recommended a role for competition policy in the provision of Australia's health services, and drawing on the recent United Kingdom experiences, the final part of the article addresses these areas.

VII. A Potential Pathway for Competition Policy in Australia's Health System

Across all of the Australian reviews, increased competition in health care is recommended. Exposure to competitive market conditions is believed to promote efficiency and stimulate the improvements in productivity that ultimately lead to enhanced wellbeing for all Australians.[249] In the setting of increasing health care expenditure improving productivity is a worthy goal. Embedding competition policy into a sector that is traditionally focused on other societal goals such as equitable access on the basis of need, is, as the United Kingdom experience has demonstrated, potentially challenging. Taking heed of lessons learned from Monitor in the United Kingdom and, building on the foundation created by the *National Health Reform Act 2011* (Cth), an Australian health care specific competition regulator is envisaged to address these challenges. Importantly, such a body could do this by collaborating with statutory bodies that have, or have had regulatory authority in health care where they are less likely to experience resistance.[250]

The benefits of having such a body are threefold. First, it could promote competition in a way that is sensitive to the nuances of the health care setting, such as increasing user choice supported by transparent, accurate and accessible information. Second, it could provide guidance on the application of health care-specific completion rules and investigate complaints related to breaches and seek appropriate resolution. Finally, the competition regulator could assess restrictions on competition in health care that are not in the public interest. This would have the additional benefit of making explicit the benefits of competition, and over time developing a clear picture of what constitutes "public interest" in this sector. These benefits, and how they may be attained will now be detailed.

Following its initial formation by CoAG in 2006, the *National Health Reform Act 2011* (Cth) established ACSQHC as a corporate Commonwealth entity. In 2017, in compliance with their legislative

[244] Stirton, n 176.

[245] Stirton, n 176.

[246] Stirton, n 176, 199.

[247] Productivity Commission, n 4, 312.

[248] Productivity Commission, n 4.

[249] John McDonald, "Legitimating Private Interests. Hegemonic Control Over 'the Public Interest' in National Competition Policy" (2007) 43 *Journal of Sociology* 349, 351.

[250] Fiona Moffatt, Paul Martin and Stephen Timmons, "Constructing Notions of Healthcare Productivity: The Call for a New Professionalism?" (2014) 36 *Sociology of Health and Illness* 686, 690. This study specifically looked at the concept of productivity but noted that the "commodification of health care may therefore be viewed as a threat to professional autonomy, particularly if the impetus comes from above rather than from within the profession".

responsibility,[251] ACSQHC released the second edition of the *National Safety and Quality Health Service (NSQHS) Standards*.[252] All Australian hospitals and day procedure services are assessed against the NSQHS standards,[253] and those demonstrating full compliance are awarded accreditation.[254] This point highlights that health care organisations already engaged with the regulatory requirements of ACSQHC. A competition regulator who worked collaboratively with this statutory authority may encounter less resistance, increasing the likelihood of embedding competition-based reforms.

ACSQHC's strategic plan 2016–2019 identifies four priority areas[255] that align with two competition-promoting strategies – choice and access to information. In order to choose what is right for them, patients and consumers must be able and willing to gather and process the right information. Ideally this information should be freely available, aggregated, easy to interpret and access, and relevant to their needs. The Harper Review suggested that access to objective, outcomes-based data on available services and/or feedback from previous users of the service, would support informed choices.[256] They noted that Australian governments already collect and store significant amounts of data on various services. Careful release of existing data, with particular attention to ensuring that the information is not "gamed", could play an important role in helping users make informed choices and helping providers to deliver responsive and high-quality services.[257] The Harper Review noted that comparative websites such as *MyHospital* could facilitate this.[258]

Previously, the NHPA was required to report "nationally consistent, locally relevant information about Australia's health care organisations".[259] With its dissolution in 2016, the bulk of the work published by the NHPA was expected to be continued under the ACSQHC and the Australian Institute of Health and Welfare.[260] This has stalled while the health system performance information and reporting frameworks were reviewed.[261] Given that the Harper Review envisaged a new national competition body that would independently monitor, and publicly report on reform progress,[262] the health system reporting frameworks could be reinstated with competition-based oversight by an Australian health care specific competition regulator, similar to that offered by Monitor in the NHS. Aligning with the ACSQHC priority areas would provide a sound platform for collaboration.

In reviewing Australia's NCP in 2015, the Harper Review formed the view that those who use a service are best placed to decide which service suits their needs,[263] and recommended that the Australian Government and State and Territory governments should agree on choice principles that could be implemented in

[251] *Health Reform Act 2011* (Cth) s 9(1)(e).

[252] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (ACSQHC, 2nd ed, 2017). The standards were endorsed by CoAG Health Ministers in June that year.

[253] Australian Commission on Safety and Quality in Health Care, *Information for Health Services Organisations Undergoing Assessment to the NSQHS Standards* (03 January 2017) <https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/information-for-health-service-organisations>. General Practices are assessed against standards developed collaboratively by the ACSQHC and the Royal Australian College of General Practitioners.

[254] ACSQHC, n 253.

[255] ACSQHC, n 252, 6. The four areas are patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide safe and high-quality care.

[256] Harper Review, n 4, 236.

[257] Harper Review, n 4, 238.

[258] Harper Review, n 4, 295.

[259] National Health Performance Authority, *National Health Performance Authority Annual Report 2014–15* (24 September 2015) v.

[260] National Health Performance Authority, *Home page* <http://www.health.gov.au/internet/nhpa/publishing.nsf/Content/home-1>.

[261] Nous Group, *Review of Australia's Health System Performance Information and Reporting Frameworks* <https://www.healthperformanceframeworksreview.com.au/>; Australian Institute of Health and Welfare, *MyHospitals overview* (2018) <https://www.myhospitals.gov.au/about-myhospitals/overview#performance-indicator-reporting>. A scan of the Myhospitals website on 11 January 2018 shows that a number of the reported performance indicators are currently under development, requiring "extensive methodological development to create accurate, nationally comparable information at the local level".

[262] Harper Review, n 4, 75.

[263] Harper Review, n 4, 230.

Australian human services markets.[264] The Panel also recommended that the competition agenda needed support from an independent regulator. While not specifically detailed in the recommendations, an Australian health care specific competition regulator could be charged with developing these principles. A noteworthy lesson gleaned from the United Kingdom experience, was that health services needed detailed guidance on the application of competition rules and principles.[265] An Australian equivalent body could proactively publish guidance and provide support for health care organisations implementing competition-based principles.

Options for individual choice were strongly supported in the Draft recommendations made by the Productivity Commission two years later in 2017. In particular, the ability to choose a treating health care practitioner was endorsed. Currently, people are free to select the General Practitioner of their choice. However, treatment by a medical specialist requires referral either to a private practitioner or public clinic. Referral requirements are set out in the *Health Insurance Regulations 1975* (Cth)[266] and include the need for information regarding the patient's condition to be provided in writing, signed and dated by the referring practitioner. Although there is currently no need to name a particular clinic or specialist, the Productivity Commission reported that patients often unnecessarily contact their general practitioner's office to get the name of the specialist on a referral letter changed.[267] Anecdotally, it is not just patients making these requests. A recent article in the trade publication *Australian Doctor*, reported that "GPs have hit out at public hospital managers for telling them to redirect referrals from outpatient clinics to private specialists in an attempt to shift care costs onto Medicare".[268] One general practitioner reported that due to the demand to rewrite referrals he now defaults to private referrals,[269] in spite of this being in breach of provisions of the NHRA.[270] Currently, there are limited options for redress in these circumstances. However, as a competition-related complaint an Australian health care specific competition regulator could investigate and educate organisations of the need to accept any patient referral letter for a condition that the clinic covers, regardless of where the patient lives.

The third benefit would be the potential for competition-focused regulatory impact analysis of health care reforms. In support of the Australian Government's objective of promoting effective and efficient legislation and regulations, an RIS is required to address any potential for restriction on competition.[271] For example, regulation may limit choices available to consumers, which, in relation to health care the OECD noted, may limit quality of care.[272] However, to date, the regulatory impact, including the potential anti-competitive effect of health-related legislation in Australia has been limited.[273] The *National Health Reform Act 2011* (Cth) was assessed as not requiring an RIS. An RIS was prepared in association with the ACSQHC review of the NSQHS Standards,[274] but it did not specifically address the requirements of cl 10 of the *Intergovernmental Agreement on Competition and Productivity-Enhancing Reforms Agreement*, by subjecting them to a public interest test. Although there are many different views about how the "public interest" test should be applied,[275] there is currently no application of it in

[264] Harper Review, n 4, 239.

[265] House of Commons Health Committee, n 232.

[266] *Health Insurance Regulations 1975* (Cth) regs 29, 30, 31.

[267] Productivity Commission, n 154, 271.

[268] Rachel Worsley, "GPs Bristle at Hospital Requests to Rewrite Referrals", *Australian Doctor*, 31 October 2017.

[269] Worsley, n 268.

[270] Council of Australian Governments, n 98, Sch G.

[271] Department of Prime Minister and Cabinet, n 118, 36.

[272] OECD, *Competition Assessment Toolkit. Volume 1: Principles* (OECD Publishing, 2016) 21.

[273] Some health-related legislation was reviewed as part of the NCP legislation review process, but this did not include the *Health Reform Act 2011* (Cth).

[274] Australian Commission on Safety and Quality in Health Care, *Review of the National Safety and Quality Health Service Standards* (Decision Regulation Impact Statement, September 2016).

[275] Charles Lawson, "Patent Privileges and the National Competition Policy-Patent Scope and Allocation? (2005) 33 *Australian Business Law Review* 7.

recent health-related regulation. Competition oversight by a sector-specific regulator is one option for addressing this gap, and further increasing the probability that competition can successfully achieve the efficiency and productivity benefits believed to support Australia's health care service.

VIII. Conclusion

Australians have the benefit of universal access to a world-class health care system on the basis of need, not ability to pay. As the cost of providing this service continues to grow policy makers are keen to ensure that it is funded sustainably. Competition in market-based economies has traditionally been relied upon to promote efficiency and productivity. This is necessary to expend the limited financial resources in a way that delivers the best outcomes for the lowest prices, and allows any surplus to be allocated to more health care. However, health care exhibits fundamental differences from traditional markets and these have created barriers to the successful integration of competition principles.

By chronologically tracing the publication of several different government-commissioned reports this article revealed that recommendations for increased competition in our health care service have largely been disregarded. The fact that health care is not a traditional market-based enterprise, but one that traditionally focused on social values such as equity and care contributes to this. However, there is much that can be learnt from a comparable jurisdiction, such as the United Kingdom.

The NHS has had a sector-specific competition regulator in place for several years. The Harper Review noted that there are benefits associated with a sector-specific regulator, and while they did not recommend the creation of such a body for Australia's health care sector, it may provide the impetus required. There currently exists a gap in health performance reporting that was left when the NHPA was dissolved. As transparent access to accurate information is integral to support choice, the role previously performed by the NHPA could form part of a broader role for an Australian health care specific competition regulator. Additionally, a sector-specific regulator could assist health care organisations integrate competition principles and monitor compliance with them.

Despite ongoing calls for greater competition in health care in Australia, to date there has been limited assessment of the anti-competitive effects of health-related legislation and regulation. As the health care sector does not conform to traditional market-based economies, regulation impact assessments conducted by, or with the support of a statutory body with detailed sector knowledge can aid in the development of how the "public interest" in this important sector should be understood.

Finally, the competition-related levers of choice and access to information that have the potential to positively impact health care in several different ways. Even in the event that their impact is marginal, "the intrinsic value of user choice means it has meaning to people *for its own sake,* independent of whether it drives changes in price or quantity, or drives innovation and efficiencies".[276] Recent history suggests that these benefits are unlikely to be realised without the support of a health care-specific competition regulator. Reinstating the functions of the recently dissolved NHPA within an Australian health care specific competition regulator is one option for addressing this need.

[276] Productivity Commission, n 154, 56.