process of institutionalisation — a process that has produced an imposing edifice of health care, buttressed by powerful elements:

- Information asymmetries between clinician and patient;
- Funding arrangements for activities not outcomes;
- Persistent industrial practices that shape relations between clinicians, between primary care and specialisms, between clinicians and allied health care;
- Capital formation processes that strongly influence the allocation of capital to physical assets, and certain types of assets at that, for instance acute hospitals;
- Demarcation and boundary management issues that riddle the sector;
- Training models that too often reflect and entrench existing boundaries; and

Relationships with bureaucracy that are inflected by government's many and sometimes conflicting roles, including as funder, regulator, and as itself a producer.

In parallel, technology and managerial systems have leapt ahead, leaving the health care sector flailing expensively; trying to deal with chronic disease, explosions in scientific knowledge and ageing populations using increasingly outmoded industrial, technological, and managerial models.

Against this condition, one might suggest a number of prescriptions as to how you might foster business systems innovation. Clearly, microeconomic reform approaches have much potential value to offer

In part, the sector eluded such an approach during the major reform era due to its inherent complexity, the splayed nature of health care across all levels of government and across market sectors, its structural rigidities (including its connection with the rigidities of our federal system and the powerful persistence of its historical clinical configuration), and its relatively unsurveyed nature. Governments at all levels fail to generate effective system-wide regulatory and accountability frameworks because of their incomplete and fragmented coverage together with their essential complicity in the operations of parts of the sector.

In this vein, there is much to pick up from the recent Harper Review of Competition policy; including the material opportunities to challenge business models in the service economy, particularly where governments are themselves participants and complicit in industry shape—including the resistant and self-forgiving configurations of the health care sector.

We need to invest in public, transparent, and improving systems of measurement.

The Productivity Commissioner has been reiterating the ready availability of savings in the health care of some 20 percent, by driving it towards levels of efficiency that it manages to achieve in some of its parts, but which it seems unable to generalise across the sector.

Twenty percent of the some $150 billion that is expended annually on health care (by all payers) is more, at $30 billion, than any likely increase and net reallocation of GST to health care is ever likely to achieve. Further, real and extensive business model innovation (rather than just improved accountability and efficiency in the current system) could lead to even more considerable improvements in the value achieved for our health dollar.

At the very least we need to invest in public, transparent, and improving systems of measurement for health care and its participants. Even this limited call can raise howls of protest about the complex exceptionalism of health care by many a complicit stakeholder. To them, I offer Galileo's insight: "Measure what is measurable, and make measurable what is not so."