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COMPETITION IN HOSPITAL SERVICES

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FOREWORD

This document comprises proceedings in the original languages of a Roundtable on Competition in Hospital Services held by the Competition Committee (Working Party No.2 on Competition and Regulation) in February 2012.

It is published under the responsibility of the Secretary General of the OECD to bring information on this topic to the attention of a wider audience.

This compilation is one of a series of publications entitled "Competition Policy Roundtables".

PRÉFACE

Ce document rassemble la documentation dans la langue d'origine dans laquelle elle a été soumise, relative à une table ronde sur la concurrence dans les services hospitaliers qui s'est tenue en février 2012 dans le cadre du Comité de la concurrence (Groupe de travail No.2 sur la concurrence et la réglementation).

Il est publié sous la responsabilité du Secrétaire général de l'OCDE, afin de porter à la connaissance d'un large public les éléments d'information qui ont été réunis à cette occasion.

Cette compilation fait partie de la série intitulée "Les tables rondes sur la politique de la concurrence".

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EXECUTIVE SUMMARY

By the Secretariat

The following key points emerged from the background and expert papers, country contributions and the discussion during the roundtable on *Competition in Hospital Services* held on 13 February 2012 at the OECD Conference Centre in Paris.

(1) Concerns about increasing healthcare expenditures are a major motivation for introducing competition in hospital services. While competition on quality can lead to better outcomes, competition on prices has uncertain results. Considering the particularities of healthcare markets, mainly characterised by asymmetric information, clearly defining the scope for competition is key to delivering socially beneficial outcomes.

Competition in hospital services has been introduced or fostered in an increasing number of OECD countries. Ten years ago, the United States, the United Kingdom and the Netherlands were among the first to encourage competition amongst hospitals. Since then, however, many other countries (such as Finland and Sweden) have embraced reforms enhancing patients' choice. The introduction of competition has mainly been motivated by increasing healthcare expenditures. Hospital expenditures are not only the single-most important component of total health spending, with the OECD average representing around 30% of the total, but in themselves they amount to around 3% of GDP in most OECD countries. Attempts to control costs by regulatory means, such as reducing fees paid to healthcare providers and rationing user access, have typically only been temporarily successful. Market-oriented approaches have been introduced to foster productivity with the objective of cutting costs without reducing quality or entitlements.

The particularities of healthcare markets highlight the importance of the careful design of competition mechanisms in order to ensure the desired outcomes. Given the potentially extreme consequences of a reduction in healthcare quality for end users, hospital services have been traditionally over-regulated. With the introduction of competition, certain hospital services have been deliberately exempt from it. For example, the dominant criterion for the provision of urgent care is the proximity of the hospital to the patient, rather than criteria based on the potential benefits of competitive service delivery. However, even when these kinds of services are explicitly exempt from competition, they may still benefit from positive spill over effects induced by fostering efficiency in other hospital services.

Hospital markets deviate from the theoretical notion of perfectly competitive markets because services are differentiated rather than homogeneous, market structures tend to be oligopolistic, entry and exit are costly, while transaction costs are very high. Moreover, hospital services are credence goods, which are characterised by the difficulty of assessing quality both before and after consumption. In addition, bounded rationality together with imperfect, or more specifically asymmetric information between providers and patients, is a key characteristic of healthcare markets.

The potential benefits of introducing competition in hospital services are supported both by economic theory and empirical evidence. The background paper of the Secretariat as well as expert papers by Martin Gaynor and Zack Cooper detail the effects of competition on price and quality. Economic theory predicts that under administered prices, quality increases if prices are above marginal costs. In contrast, when prices are market-determined, the effects on overall welfare are uncertain. However, if the elasticity of demand

with respect to quality increases or elasticity of demand with respect to price decreases, both price and quality increase. Empirical evidence on the effects of competition on the provision of hospital services is available only for a small number of countries. In markets with regulated prices, competition improves quality as measured by mortality rates. In this case, the impact of competition can be substantial and long-lasting. In contrast, the evidence is mixed when prices are determined by the market.

(2) An active governmental role is key in ensuring quality provision and containing costs. Enforcers can address the lack of competition while regulators need to carefully define the set of variables on which it operates. If insurance companies play an intermediary role, government-set provisions on minimum coverage as well as non-discrimination in access or pricing are often established. Governments are increasingly relying on different forms of private involvement to respond to increasing demand, although the profit-seeking incentives may pose some challenges.

The introduction of competition should be accompanied by an active governmental role to ensure quality provision and to contain costs. Diverging views on the appropriate nature of competition in healthcare markets emphasise the importance of ensuring that efforts of, for example, competition authorities and health regulators are mutually supportive. Undesirable outcomes may arise when there is insufficient competition or inadequate regulatory frameworks. Regulators have to carefully define the set of variables according to which competition will operate and enforcers ensure market behaviour is competitive.

Centralised governance structures may facilitate the adoption of the concurrent policies required to ensure that competition leads to positive outcomes across all regions. Zack Cooper underlines in his paper that this has indeed been one of the keys for success in the United Kingdom. In decentralised healthcare markets, the introduction of competition may bring additional challenges. In Brazil, where each level of government has responsibilities for financing the healthcare system, the Federal government has limited capacity to address national concerns. In Finland, pricing policies are set by each local government authority, which raises issues of inequality of access for end users and financial compensation amongst local authorities.

In jurisdictions where private insurance companies play an intermediary role in providing access to healthcare, competition between insurers needs to be ensured given their role in determining the choice of hospitals and treatments available to individuals, as well as the associated premium costs. Among others, in Colombia, Chile and Peru, the emergence of private insurers has led to the existence of two large separate networks, where employed individuals typically opt for private coverage while unemployed and other vulnerable groups are covered by a publicly subsidised system. In Colombia, the benefits of both networks were harmonised in 2011 following a constitutional court order.

Governments typically impose conditions on private insurers to ensure minimum coverage and non-discrimination in access or pricing. Difficulty in assessing the quality embedded in insurance plans has led to the creation of government-determined minimum coverage plans. In Peru, the government not only determines the features of a minimum coverage plan, but also sets rules for two other additional plans with different levels of coverage. The prohibition of discrimination in access or pricing is often accompanied by a financial compensation to insurers depending on the risks borne. In the Netherlands, an equalisation fund serves to compensate insurers for risks not sufficiently covered by premiums and subscriptions from vulnerable population groups.

The extent of private involvement in delivery of hospital services differs across countries, from fully publicly financed direct provision by governments to loosely regulated and highly privatised markets. Rising demand for healthcare services, higher consumer expectations, and increasing costs, are increasingly favouring consideration of different combinations of public and private provision. To avoid

bias in favour of public providers, as outlined by the BIAC delegate, private involvement requires separation of the purchaser and provider functions with possibly additional measures. Such measures include impartial management in the public-private mix, equal remuneration and equal treatment in the event of deficit.

When not-for-profit hospitals are permitted to retain surpluses, experience from the United States shows that they behave similarly to profit-making hospitals with respect to pricing, market structure and the provision of uncompensated care. In spite of this, profit-seeking by hospitals can present challenges as noted by a number of jurisdictions. For example, in France, the treatments offered by private providers tend to be the most profitable ones. Also, the experiences of Brazil and Colombia suggest that access to private healthcare may be limited where service provision is costly, such as in remote areas. Finally, profit-seeking may lead to increasing quality rather than decreasing prices, as in South Africa, thereby failing to achieve wider user access.

Public-private partnerships (PPPs) allow provision of healthcare infrastructure with limited burden on public finances. PPPs in the healthcare sector usually come in the form of long-term contracts in which the private party is responsible for some or all of the construction, maintenance and service delivery activities. PPPs have been introduced in a number of countries, such as in Turkey where PPPs have been used extensively. However, no comprehensive evaluation of these partnerships has yet been conducted, thus there is little conclusive evidence on their relative merits.

(3) Meaningful competition in hospital services is underpinned by the following conditions: (i) the existence of a range of accessible options, (ii) patients interested in choosing in which hospital to be treated (iii) relevant information to make well-informed choices, and (iv) incentives for hospitals to attract patients.

Firstly, the existence of a range of accessible options is a prerequisite for enabling patients to have real choice in healthcare. One possibility consists of increasing the geographical area in which patients can access hospitals, for example by providing access to other public hospitals and subsidising transport costs. Such measures have been implemented in Norway. Another option is to facilitate access to private hospitals. Publicly funded private provision may be limited to situations when there is no or little capacity left in the public system. For example, in Finland, vouchers for private hospitals were provided to reduce waiting times. Also, private practice may be permitted within public hospitals, such as in Ireland where 20% of public hospital beds are available for use by private patients.

Adequate capacity, whether public or private, is essential not only to ensure healthcare provision but also choice. To this end, governments can contribute to financing capital investments. In Germany, for example, financial support can be provided to hospitals on the basis of an annual capacity plan. Productivity increases can also generate additional resources: experience in the United Kingdom illustrates how efficiency can be achieved via the reduction of pre-surgery hospital stays, although there may be concerns about incentives to limit hospital stays abusively. Conversely, excessive capacity can generate incentives for overprovision as noted by the delegate from South Africa. New hospitals can also increase capacity. However, government regulation may increase the costs of entry. In the United States, for example, the construction of new hospitals requires a governmental authorisation known as “certificates of need”. Although the original purpose of these certificates has become obsolete, some states have not yet withdrawn them. Furthermore, any increase in capacity may entail an initial period of limited economies of scale for hospitals due to low patient numbers. Attempts by new hospitals to reduce fixed costs by employing part-time staff may be problematic. Experience in the United Kingdom illustrates that health practitioners may be reluctant to work on multiple sites.

Second, in order for competition to be meaningful, patients need to be interested and capable of choosing among services. Increasing demand and expectations seem to indicate that patients are responsive to quality, and therefore susceptible to choosing where they want to be treated. In the United Kingdom, for example, surveys show that 75% of patients want to choose where they receive their care and, granted the choice, 30% of patients deviate from the default option. Also, in this country, research indicates that choice is particularly relevant to those who would not be able to afford it, suggesting that competition can also increase equity.

Third, information is essential to well-informed decision-making. Where patients do not bear the costs of hospital services directly, or where alternatives are apparently equal in price, their decisions are predominantly influenced by the perceived quality of care. Asymmetric information about the quality of care, however, can lead providers to focus on improving those aspects of care that are most visible to users, such as the hospital environment or waiting times, to the detriment of health outcomes. In light of this, sufficient information for patients and those making decisions on their behalf to observe quality is essential for effective price competition. In a competitive environment, publication of information on hospital performance induces changes in hospitals' behaviour if their boards believe that competition influences demand, regardless of patients' actual responsiveness.

In addition to end users themselves, it is important that other actors involved in the provision of healthcare are able to facilitate more informed choices. Many health systems are structured in such a way that professionals inform patients about hospital choice. Purchasers of healthcare services, usually insurance companies or HMOs, represent one example of source of information for patients, although their incentives to seek quality and efficiency may not be fully aligned with patients' needs.

"Gatekeepers" or informed agents who act as advisers to the patient or can play a crucial role in decision-making. For example, a general practitioner, primary care professional or an independent patient advocate can advise patients on their choices. Since general practitioners usually make the same referral for several patients, they can perceive quality *ex post* and use the information obtained from previous patients to inform future patients.

The information made available should be widely publicised, timely, accessible and easy to understand. Furthermore, information should be contextualised by risk-adjusted measures as well as ratings to facilitate comparisons. Chinese Taipei has created a system of voluntary hospital accreditation, which results in a ranking based on a large number of indicators. In Israel, a quality assurance system is also being designed, as described in their submission. The paper by Zack Cooper notes that the increasing liberalisation of hospital markets will open up markets for information. He argues that data should go beyond mortality rates to include patients' reported outcomes and satisfaction, and should be available both at a procedure level and at an illness level to inform choices more effectively. Advertisements by hospitals can also inform choices and promote competition. In Japan, the scope of contents that can be advertised has recently been enlarged.

Fourth, hospital staff, including senior management, must be responsive to financial incentives. This means linking hospitals' revenues to the number of patients and permitting them to retain profits in order to create incentives to compete for patients. In the United Kingdom, hospitals can carry forward their surpluses and the extent of their autonomy depends on their financial position.

Hospital autonomy can spur innovation and increase productivity. There is considerable diversity in the structure, institutions and operations of different health systems across jurisdictions. Despite the moves towards greater autonomy, the extent to which hospitals have autonomy to influence their operations and resource allocation to function on a more competitive basis is debated. For instance, boards are not always

sufficiently politically independent to be able to make controversial decisions and the costs of personnel, which represent around 60% of total operating cost, are often determined centrally.

The payment method is key to making competition work. Fixed budgets or reimbursement schemes create inefficiencies. In recent decades, many countries have adopted Diagnostic Related Groups (DRG) funding systems, which have proven to be more efficient and provide incentives for competition, as typically payments follow the patient. While the concept of DRG is common to all countries and there are only a handful of models, each country has tailored them to its specific system.

The expected impact of competition in hospital markets depends to a large extent on the actual prices. DRGs benchmark different types of hospital services on the basis of their clinical complexity and assign an "efficient" price per case delivered. Optimal prices can spur clinical improvements, innovation and productivity gains. In contrast, suboptimal prices can lead to undesired outcomes, such as discrimination against patients on the basis of the treatment required relative to reimbursement prices.

New mechanisms are being considered to foster efficiencies. One example is selective contracting, which allows insurers to engage in price negotiations with hospitals, leading to substantially tougher price competition. In the Netherlands, not only do insurers engage in selective contracting with hospitals, but they have also recently been made partly responsible for hospitals deficits. In Germany, a report by the Competition Authority (Monopolkommission) published in 2008 revealed that the legal framework in place was insufficient to lower the costs of hospital services and suggested selective contracting to encourage price competition. Another option is tiering, which consists of contracting with a subset of hospitals and charging higher prices to patients opting for other hospitals. In the United States, this is an approach, which is increasingly considered.

The design of funding systems should also take into account other issues, the first of which is hospitals that run into deficit. Hospital closures are rare in many countries, such as Germany, Norway or France. However, in these countries some sanctions can be applied, such as intensive supervision or removal of the hospital board. Second, there may be cross-subsidies between covered and uncovered services. Third, services may be of different quality. To enable hospitals to be rewarded for quality, a reimbursement cap has been established in Turkey to contain costs. However, additional fees can be charged depending on the quality provided.

(4) Enforcers are responsible for ensuring competitive market structures. Hospital market concentration should be avoided when prices are not administered, as hospitals may abuse market power to the detriment of end users. Vertical or horizontal integration needs to be carefully assessed, as this can lead to behaviour that restrains competition. There may be risks of collusion in premiums, insurance plans or procurement.

Competition authorities are responsible for the preservation of the competitive market structures created by the regulatory framework, advising regulators, monitoring the hospital market and enforcing competition. For example, in the Netherlands, the Competition Authority has been involved throughout the negotiation process of co-ordination agreements in order to contain costs.

Hospital market concentration is to be avoided when prices are not administered as it may permit abuse of market power. Some countries have experienced a trend towards concentration during the last decade. Noteworthy is the case of the United States, where enforcers unsuccessfully opposed eight straight hospital mergers during the 1990s that led to the currently highly concentrated market in major cities. Similarly, in South Africa, significant price increases have been observed following greater market concentration in the late 1990s. Evidence from the United States shows that hospitals with market power are able to charge higher prices on a permanent basis and consumers bear the full costs. Estimates of price

increases range from 3.5 to 53%, depending on the availability of close substitutes. From the cost perspective, mergers are most likely to result in meaningful cost decreases when the merging facilities operate as a more fully integrated entity, which illustrates the potential tension between reducing costs of provision whilst ensuring acceptable prices.

Vertical integration may provide efficiencies by aligning incentives, allowing for better co-ordination of care and joint investments, which can also raise the quality of care. In spite of this, integration may harm competition by foreclosing rivals from access to relevant inputs. There is relatively little evidence on the effects of vertical restraints in health care or the existence of positive gains from integration. During the roundtable discussion, the UK delegate explained that the impartiality of general practitioners, who play a prominent role in informing patients' choices, is a concern when faced with conflicts of interest arising from mergers. In this respect, recommendations have recently been made to ensure that patients have a sufficient choice of general practitioners and that there is full disclosure of potential conflicts of interest.

Integrated care and competition are not mutually exclusive, but enforcers play an important role in preventing conflicts of interest and discriminatory behaviour. Ageing population leads to increased demand for seamless care, which can consist of bundled tariffs to setting up multi-disciplinary teams between health and social care. The submission from the United Kingdom details potential implications and benefits of integrated care, which include improving the quality and care of services, avoiding duplications and minimising discomfort to patients. Integrated care may demand cooperation between hospitals (for example, transferring patient records effectively between them and referring patients to the best specialist hospitals). Although the existence of these networks can promote competition, it can also be constrained in the presence of exclusionary behaviours.

Collusion is another source of concern. Insurers may collude on premiums or on insurance plans. In this regard, the delegate from the Netherlands noted that insurance premiums are very similar, while the Chilean delegate indicated that the coverage of insurance plans can differ considerably. Collusion can also occur in procurement of hospital services. The submission from Norway discusses several cases of bid-rigging that have been discovered recently and encourages enforcers to launch an awareness campaign.

SYNTHÈSE

Par le Secrétariat

Le document de référence, les rapports d'expert, les contributions des pays et les discussions de la table ronde sur la *Concurrence dans les services hospitaliers*, qui s'est tenue le 13 février 2012 au Centre de conférence de l'OCDE à Paris, ont permis de mettre en évidence les points clés suivants.

(1) Les inquiétudes relatives à la hausse des dépenses de santé sont un motif majeur d'instauration de la concurrence dans les services hospitaliers. Tandis que la concurrence sur le plan de la qualité peut conduire à une amélioration des résultats, la concurrence sur le plan des prix a des résultats incertains. Au vu des particularités des marchés de la santé, qui se caractérisent principalement par des asymétries d'information, il est essentiel de définir clairement les possibilités de concurrence afin d'obtenir des résultats positifs d'un point de vue social.

Un nombre croissant de pays de l'OCDE instaurent ou encouragent la concurrence dans les services hospitaliers. Il y a dix ans, les États-Unis, le Royaume-Uni et les Pays-Bas ont été parmi les premiers à favoriser la concurrence hospitalière. Depuis, de nombreux autres pays (comme la Finlande et la Suède) ont mis en œuvre des réformes afin d'accroître le choix offert aux patients. L'instauration de la concurrence a été principalement motivée par la hausse des dépenses de santé. Les dépenses hospitalières sont non seulement la principale composante des dépenses de santé, soit environ 30 % des dépenses totales selon la moyenne des pays de l'OCDE, mais elles représentent à elles seules près de 3 % du PIB dans la plupart des pays de l'OCDE. Les tentatives de maîtriser les coûts par des moyens réglementaires, comme la réduction des tarifs versés aux prestataires de santé et le rationnement de l'accès aux soins, n'ont été efficaces qu'un certain temps. Des approches axées sur le marché ont été adoptées afin d'encourager la productivité, l'objectif étant de réduire les coûts sans nuire à la qualité ou aux droits.

Les particularités des marchés de la santé soulignent l'importance de concevoir soigneusement les mécanismes de concurrence afin de parvenir aux résultats souhaités. En raison des conséquences potentiellement graves d'une diminution de la qualité des soins pour les utilisateurs finaux, les services hospitaliers ont généralement fait l'objet d'une sur-réglementation. Malgré l'instauration de la concurrence, certains services hospitaliers y échappent délibérément. Par exemple, le critère dominant dans la prestation de soins urgents est la proximité de l'hôpital avec le domicile du patient, plutôt que des critères fondés sur les avantages potentiels d'une prestation de services concurrentielle. Toutefois, même lorsque ces types de services échappent explicitement à la concurrence, ils peuvent encore bénéficier de retombées positives induites par l'amélioration de l'efficience dans d'autres services hospitaliers.

Les marchés hospitaliers échappent à la notion théorique de concurrence parfaite du fait que les services hospitaliers sont plus disparates qu'homogènes, que ces marchés tendent à avoir une structure oligopolistique, que l'entrée et la sortie sont coûteux, alors que les coûts de transaction sont très élevés. En outre, les services hospitaliers sont des biens de confiance, qui se caractérisent par une difficulté à en évaluer la qualité avant et après la consommation. En outre, la rationalité limitée, alliée à des informations imparfaites, ou plus précisément asymétriques, entre les prestataires et les patients, est une caractéristique essentielle des marchés de la santé.

La théorie économique comme les données empiriques confirment les avantages potentiels d'une instauration de la concurrence dans les services hospitaliers. Le document de référence du Secrétariat, ainsi que les rapports d'expert de Martin Gaynor et Zack Cooper, détaillent les effets de la concurrence sur les prix et la qualité. La théorie économique prédit que dans un contexte de prix administrés, la qualité augmente si les prix sont supérieurs aux coûts marginaux. À l'inverse, lorsque les prix sont déterminés par le marché, les effets sur le bien-être global sont incertains. Toutefois, si l'élasticité de la demande par rapport à la qualité augmente ou que l'élasticité de la demande par rapport au prix diminue, le prix et la qualité augmentent. Les données empiriques relatives aux effets de la concurrence sur la prestation de services hospitaliers ne sont disponibles que pour un petit nombre de pays. Sur les marchés où les prix sont réglementés, la concurrence améliore la qualité mesurée par le taux de mortalité. Dans ce cas, elle peut avoir un impact substantiel et durable. À l'inverse, lorsque les prix sont déterminés par le marché, les données sont mitigées.

(2) Il est essentiel que les pouvoirs publics jouent un rôle actif afin de garantir des prestations de qualité et contenir les coûts. Les autorités d'exécution peuvent remédier au manque de concurrence, tandis que les autorités de réglementation doivent définir soigneusement l'ensemble de variables régissant son fonctionnement. Si les sociétés d'assurance jouent un rôle d'intermédiaire, des dispositions des pouvoirs publics instaurant une couverture minimale ainsi que des mesures de non-discrimination en matière d'accès ou de tarification sont souvent adoptées. Les pouvoirs publics s'appuient de plus en plus sur différentes formes d'interventions privées pour répondre à l'accroissement de la demande, bien que les incitations à rechercher le profit puissent poser certaines difficultés.

L'instauration de la concurrence doit s'accompagner d'un rôle actif des pouvoirs publics afin de garantir des prestations de qualité et de contenir les coûts. Les divergences d'opinion quant à la nature que doit revêtir la concurrence sur les marchés de la santé montrent l'importance de garantir que les efforts des autorités de la concurrence et des autorités de réglementation de la santé, par exemple, se renforcent mutuellement. Des résultats indésirables peuvent survenir si la concurrence est insuffisante ou l'environnement réglementaire inadapté. Les autorités de réglementation doivent définir soigneusement l'ensemble de variables régissant le fonctionnement de la concurrence, tandis que les autorités d'exécution s'assurent que le comportement du marché est concurrentiel.

Les structures de gouvernance centralisées peuvent faciliter l'adoption des politiques concertées nécessaires pour que la concurrence ait des résultats positifs dans toutes les régions. Dans son rapport, Zack Cooper souligne que cela a été l'une des clés du succès au Royaume-Uni. Sur les marchés de la santé décentralisés, l'instauration de la concurrence peut poser des difficultés supplémentaires. Au Brésil, où chaque niveau de l'administration intervient dans le financement du système de santé, le gouvernement fédéral dispose d'une marge de manœuvre limitée pour régler les problèmes nationaux. En Finlande, les politiques de tarification sont élaborées par chaque autorité administrative locale, ce qui pose des problèmes d'inégalité d'accès aux utilisateurs finaux et de compensation financière entre les autorités locales.

Dans les pays où les sociétés d'assurance privées jouent un rôle d'intermédiaire dans l'accès aux soins, la concurrence entre assureurs doit être garantie, étant donné leur rôle dans le choix des hôpitaux et des traitements, ainsi que dans la détermination du montant des primes associées. En Colombie, au Chili et au Pérou notamment, l'apparition d'assureurs privés a conduit à l'émergence de deux grands réseaux séparés, dans le cadre desquels les salariés optent habituellement pour une couverture privée, alors que les chômeurs et les autres groupes vulnérables bénéficient d'une couverture financée par les pouvoirs publics. En Colombie, les prestations des deux réseaux ont été harmonisées en 2011 à la suite d'une décision de la Cour constitutionnelle.

Les pouvoirs publics imposent généralement certaines conditions aux assureurs privés afin de garantir une couverture minimale et d'empêcher toute discrimination en matière d'accès et de tarification. La difficulté à évaluer la qualité intrinsèque des plans d'assurance a conduit à la création de prestations de base définies par les pouvoirs publics. Au Pérou, ces derniers déterminent non seulement les caractéristiques de ces prestations de base, mais fixe également des règles pour les deux autres plans offrant des niveaux de garanties différents. L'interdiction de la discrimination en matière d'accès ou de tarification est souvent assortie d'une compensation financière accordée aux assureurs en fonction des risques encourus. Aux Pays-Bas, un fonds de péréquation permet de dédommager les assureurs des risques insuffisamment couverts par les primes et cotisations versées par les groupes de population vulnérables.

L'implication du secteur privé dans la prestation de services hospitaliers varie selon les pays, depuis les services de santé directement assurés par les pouvoirs publics et entièrement financés sur fonds publics, jusqu'aux marchés faiblement réglementés et fortement privatisés. La hausse de la demande de services hospitaliers, les attentes toujours croissantes des consommateurs et l'augmentation des coûts encouragent de plus en plus les pays à envisager différentes combinaisons de prestations publiques et privées. Pour éviter un biais en faveur des prestataires publics, comme l'a souligné le délégué du BIAC, l'implication du secteur privé nécessite une séparation des fonctions d'acheteur et de prestataire, éventuellement assortie de mesures complémentaires, à savoir une gestion impartiale de la répartition public-privé, une rémunération égale et un traitement équitable en cas de déficit.

L'expérience des États-Unis montre que lorsque les hôpitaux à but non lucratif sont autorisés à conserver leurs excédents, ils adoptent le même comportement que les hôpitaux à but lucratif en termes de tarification, de structure du marché et de prestation de soins non pris en charge. Malgré tout, la recherche du profit par les hôpitaux peut poser des difficultés, comme on l'a constaté dans un certain nombre de pays. En France par exemple, les traitements proposés par les prestataires privés sont généralement les plus rentables. De même, les expériences du Brésil et de la Colombie donnent à penser que l'accès aux soins privés peut être restreint lorsque les prestations de services sont coûteuses, dans les régions isolées par exemple. Enfin, la recherche du profit peut conduire à améliorer la qualité plutôt qu'à diminuer les prix, comme c'est le cas en Afrique du Sud, ce qui ne permet pas d'améliorer l'accès aux soins pour les utilisateurs.

Les partenariats public-privé (PPP) permettent de construire des infrastructures tout en faisant peser des contraintes limitées sur les finances publiques. Dans le secteur de la santé, les PPP revêtent généralement la forme de contrats à long terme en vertu desquels la partie privée est responsable de tout ou partie de la construction, de la maintenance et des activités de prestation de services. Des PPP ont été instaurés dans un certain nombre de pays, comme la Turquie, qui y recourt très largement. Toutefois, aucune évaluation approfondie de ces partenariats n'a encore été menée, il existe donc peu de données probantes quant à leurs mérites relatifs.

(3) L'instauration d'une concurrence utile dans les services hospitaliers est liée aux conditions suivantes : (i) existence d'un éventail d'options accessibles, (ii) patients éprouvant de l'intérêt à choisir l'hôpital dans lequel ils seront traités (iii) informations pertinentes permettant de faire des choix éclairés, et (iv) incitations des hôpitaux à attirer les patients.

Premièrement, l'existence d'un éventail d'options accessibles est une condition nécessaire pour permettre aux patients d'avoir véritablement le choix en matière de soins de santé. Une possibilité consiste à élargir la zone géographique dans laquelle les patients peuvent être hospitalisés, par exemple en leur donnant accès à d'autres hôpitaux et en prenant en charge les frais de transport. De telles mesures ont été mises en œuvre en Norvège. Une autre solution consiste à faciliter l'accès aux hôpitaux privés. La prise en charge des prestations privées par les pouvoirs publics peut être limitée aux situations dans lesquelles il y a peu ou pas de capacités disponibles dans le système public. Par exemple, en Finlande, on remet aux

patients des coupons donnant accès aux hôpitaux privés afin de réduire les délais d'attente. De même, des consultations privées peuvent être autorisées au sein des hôpitaux publics, comme en Irlande, où 20 % des lits publics sont à disposition des patients privés.

Des capacités adéquates, qu'elles soient publiques ou privées, sont essentielles non seulement pour garantir la prestation de soins de santé, mais également offrir un choix suffisant aux patients. À cette fin, les pouvoirs publics peuvent contribuer au financement des dépenses d'équipement. En Allemagne par exemple, un soutien financier peut être fourni aux hôpitaux sur la base d'un plan de capacité annuel. Les hausses de la productivité peuvent également générer des ressources supplémentaires : l'expérience du Royaume-Uni illustre comment obtenir des gains d'efficience en réduisant la durée des séjours préopératoires, en dépit d'inquiétudes quant aux incitations abusives à limiter la durée des séjours hospitaliers. À l'inverse, un excédent de capacités peut inciter à fournir des prestations superflues, comme l'a fait remarquer le délégué de l'Afrique du Sud. Les nouveaux hôpitaux peuvent également contribuer à accroître les capacités. Toutefois, la réglementation officielle peut augmenter les coûts d'entrée. Aux États-Unis, par exemple, la construction de nouveaux hôpitaux nécessite une autorisation gouvernementale nommée « certificat de besoins ». Bien que l'objet initial de ces certificats soit désormais obsolète, certains États y ont encore recours. En outre, toute augmentation des capacités peut être suivie d'une période initiale où les hôpitaux réalisent peu d'économies d'échelle, en raison du faible nombre de patients. Les tentatives des nouveaux hôpitaux de réduire les prix fixes en employant du personnel à temps partiel peuvent s'avérer problématiques. L'expérience du Royaume-Uni montre que les professionnels de santé peuvent être réticents à travailler dans plusieurs établissements.

Deuxièmement, pour que la concurrence soit utile, les patients doivent éprouver de l'intérêt à choisir entre les services, et en être capables. L'accroissement de la demande et des attentes semble indiquer que les patients sont sensibles à la qualité, et donc susceptibles de choisir l'établissement dans lequel ils souhaitent être traités. Au Royaume-Uni, par exemple, les études montrent que 75 % des patients veulent choisir l'établissement où ils seront soignés et, lorsqu'ils ont cette possibilité, 30 % s'écartent de l'option par défaut. De même, les recherches menées dans ce pays indiquent que le choix est particulièrement important pour ceux qui n'auraient pas les moyens de se le permettre, ce qui donne à penser que la concurrence peut également améliorer l'équité.

Troisièmement, les informations sont essentielles à une prise de décision éclairée. Lorsque le coût des services hospitaliers n'est pas directement à la charge des patients, ou que les différentes options qui s'offrent à eux sont apparemment équivalentes en termes de coût, leurs décisions sont principalement influencées par la qualité perçue des soins. Des informations asymétriques quant à la qualité des soins peuvent toutefois conduire les prestataires à se concentrer sur l'amélioration des aspects des soins les plus visibles pour les utilisateurs, comme l'environnement hospitalier ou les délais d'attente, au détriment des résultats médicaux. Sachant cela, il convient de communiquer suffisamment d'informations relatives à la qualité aux patients et à ceux qui prennent des décisions en leur nom pour instaurer une concurrence efficace sur le plan des prix. Dans un environnement concurrentiel, la publication d'informations relatives aux performances des hôpitaux induit un changement de comportement de ces derniers si leurs conseils d'administration considèrent que la concurrence influence la demande, quelle que soit la véritable réaction des patients.

Outre les utilisateurs finaux eux-mêmes, il est important que les autres acteurs impliqués dans la prestation de soins de santé soient en mesure de permettre aux patients de faire des choix plus éclairés. De nombreux systèmes de santé sont structurés de telle manière que les professionnels informent les patients sur le choix des hôpitaux. Les acheteurs de services de santé, soit généralement les sociétés d'assurance ou les réseaux de soins coordonnés, sont une source d'information parmi d'autres, bien que leurs incitations à rechercher la qualité et l'efficience ne soient pas forcément totalement ajustées aux besoins des patients.

On dit des agents informés qui donnent des conseils aux patients ou jouent un rôle crucial dans la prise de décision qu'ils jouent un rôle de « filtre ». Par exemple, un médecin généraliste, un professionnel des soins primaires ou un représentant indépendant des patients peuvent aider ceux-ci à faire un choix. Dans la mesure où les médecins généralistes font ordinairement la même recommandation à plusieurs patients, ils sont en mesure de percevoir la qualité *ex post* et d'utiliser les informations recueillies auprès d'anciens patients pour informer les futurs patients.

Les informations mises à disposition doivent être largement et opportunément diffusées, accessibles, et facilement compréhensibles. En outre, elles doivent être replacées en contexte à l'aide d'indicateurs ajustés en fonction des risques, ainsi que d'évaluations destinées à faciliter les comparaisons. Le Taipei chinois a créé un système d'accréditation facultative des hôpitaux, qui classe les établissements en fonction d'un large nombre d'indicateurs. En Israël, un système d'assurance qualité est également en cours d'élaboration, comme décrit dans la note de ce pays. Dans son rapport, Zack Cooper remarque que la libéralisation accrue des marchés hospitaliers permettra l'ouverture de marchés de l'information. Il avance que les données ne devraient pas être limitées aux taux de mortalité, afin d'intégrer les résultats et la satisfaction rapportés par les patients, et devraient être disponibles tant au niveau des procédures que des pathologies afin d'éclairer plus efficacement les choix. Les publicités des hôpitaux peuvent également éclairer les choix et favoriser la concurrence. Au Japon, l'étendue des contenus publicitaires a récemment été élargie.

Quatrièmement, le personnel hospitalier, y compris les cadres supérieurs, doit être sensible aux incitations financières. Cela nécessite d'établir un lien entre les revenus hospitaliers et le nombre de patients et d'autoriser les hôpitaux à conserver leurs bénéfices, afin de les inciter à se livrer concurrence pour attirer les patients. Au Royaume-Uni, les hôpitaux peuvent conserver leurs excédents, et leur degré d'autonomie dépend de leur situation financière.

L'autonomie des hôpitaux peut stimuler l'innovation et améliorer la productivité. La structure, les institutions et les activités des différents systèmes de santé sont extraordinairement variées. Malgré la tendance à une autonomie accrue, la question de savoir si les hôpitaux disposent de l'autonomie nécessaire pour influencer leurs activités et l'affectation des ressources, et fonctionner ainsi sur une base plus concurrentielle, fait débat. Par exemple, les conseils d'administration ne sont pas toujours suffisamment indépendants politiquement pour être en mesure de prendre des décisions sujettes à controverse, et les charges de personnel, qui représentent quelque 60 % du coût d'exploitation total, sont souvent déterminées au niveau central.

La méthode de rémunération est essentielle au bon fonctionnement de la concurrence. Les budgets fixes ou les régimes de remboursement génèrent des inefficiences. Au cours des dernières décennies, la plupart des pays ont adopté des systèmes de financement fondés sur des Groupes homogènes de malades (GHM), qui se sont avérés plus efficients et intègrent des incitations à la concurrence, dans la mesure où les paiements suivent les patients. Bien que le concept de GHM soit commun à tous les pays et que les modèles se comptent sur les doigts d'une main, chaque pays les a adaptés à son propre système.

L'impact attendu de la concurrence sur les marchés hospitaliers dépend dans une large mesure des prix réels. Les GHM évaluent différents types de services hospitaliers en fonction de leur complexité clinique et leur attribuent un prix « efficient » par cas traité. Des prix optimaux peuvent favoriser les améliorations cliniques, l'innovation et les gains de productivité. À l'inverse, des prix sous-optimaux peuvent conduire à des résultats indésirables, comme une discrimination des patients sur la base du traitement requis par rapport aux remboursements reçus.

Les nouveaux mécanismes sont censés favoriser les gains d'efficience. Prenons l'exemple de la contractualisation sélective, qui permet aux assureurs de négocier les prix avec les hôpitaux, d'où une

concurrence beaucoup plus rude sur le plan des prix. Aux Pays-Bas, non seulement les assureurs s'engagent dans une contractualisation sélective avec les hôpitaux, mais ils assument depuis peu une partie de la responsabilité des déficits hospitaliers. En Allemagne, un rapport de la Commission des monopoles *(Monopolkommission)* publié en 2008 révèle que l'environnement législatif en vigueur est insuffisant pour faire baisser le coût des services hospitaliers, et propose de recourir à la contractualisation sélective afin d'encourager la concurrence sur le plan des prix. Autre option, la différenciation *(tiering)*, qui consiste à passer un contrat avec un sous-ensemble d'hôpitaux et à faire payer plus cher les patients qui choisissent d'autres établissements. Cette approche est de plus en plus envisagée aux États-Unis.

La conception des systèmes de financement doit également prendre en compte d'autres problèmes, à commencer par les hôpitaux qui se retrouvent en déficit. Dans la plupart des pays, comme l'Allemagne, la Norvège ou la France, les fermetures d'hôpitaux sont rares. Toutefois, certaines sanctions peuvent être mises en œuvre, comme une surveillance intensive ou une éviction du Conseil d'administration. Ensuite, il peut exister des subventions croisées entre les services couverts et non couverts. Enfin, les services peuvent être de qualité différente. Pour permettre aux hôpitaux d'être récompensés pour la qualité de leurs services, un plafond de remboursement a été établi en Turquie afin de contenir les coûts. Toutefois, des dépassements d'honoraires peuvent être facturés en fonction de la qualité des services fournis.

(4) *Les autorités d'exécution sont chargées de garantir des structures de marché concurrentielles. Il convient d'empêcher la concentration du marché hospitalier lorsque les prix ne sont pas administrés, les hôpitaux étant susceptibles d'abuser de leur pouvoir de marché au détriment des utilisateurs finaux. L'intégration verticale ou horizontale doit faire l'objet d'une évaluation soigneuse, dans la mesure où cela peut conduire à un comportement restreignant la concurrence. Il peut exister des risques de collusion en ce qui concerne les primes, les garanties ou les marchés publics.*

Les autorités de la concurrence sont chargées de préserver les structures de marché concurrentielles instaurées par le cadre réglementaire, de conseiller les autorités de réglementation, de surveiller le marché hospitalier et de faire respecter le droit de la concurrence. Par exemple, aux Pays-Bas, l'autorité de la concurrence s'est impliquée tout au long du processus de négociation des accords de co-ordination afin de contenir les coûts.

Il convient d'empêcher la concentration des marchés hospitaliers lorsque les prix ne sont pas administrés, dans la mesure où elle peut conduire à des abus de pouvoir de marché. Certains pays ont constaté une tendance à la concentration au cours de la dernière décennie. Le cas des États-Unis, où les autorités d'exécution se sont opposées sans succès à huit fusions hospitalières au cours des années 1990, d'où la forte concentration du marché actuel dans les grandes villes, est remarquable. De même, en Afrique du Sud, des hausses de prix considérables ont été observées à la suite d'un accroissement de la concentration du marché à la fin des années 1990. Les données des États-Unis montrent que les hôpitaux disposant d'un pouvoir de marché peuvent faire payer des prix plus élevés sur une base permanente, et que les coûts sont entièrement supportés par les consommateurs. Les hausses de prix sont estimées entre 3.5 et 53 %, en fonction de la disponibilité de substituts proches. Du point de vue du coût, les fusions sont davantage susceptibles d'aboutir à une diminution importante des coûts lorsque les parties à la fusion fonctionnent comme une entité plus intégrée, ce qui illustre les tensions potentiellement causées par la nécessité de diminuer le coût des prestations tout en garantissant un niveau de prix acceptable.

L'intégration verticale peut favoriser les gains d'efficience en ajustant les incitations, en permettant une meilleure co-ordination des soins et des investissements conjoints, ce qui peut également améliorer la qualité des soins. Malgré tout, l'intégration peut nuire à la concurrence en empêchant les concurrents d'accéder aux intrants utiles. Il existe relativement peu de données quant aux effets des contraintes verticales sur les soins de santé ou à l'existence de gains positifs dus à l'intégration. Au cours des

discussions de la table ronde, le délégué du Royaume-Uni a expliqué que l'impartialité des médecins généralistes, qui contribuent grandement à éclairer le choix des patients, devient préoccupante en présence de conflits d'intérêts engendrés par des fusions. À cet égard, des recommandations ont été récemment formulées afin de garantir que les patients aient le choix entre un nombre suffisant de médecins généralistes, et que les éventuels conflits d'intérêts fassent l'objet d'une transparence totale.

Les soins intégrés et la concurrence ne s'excluent pas mutuellement, mais les autorités d'exécution jouent un rôle majeur dans la prévention des conflits d'intérêt et des comportements discriminatoires. Le vieillissement de la population se traduit par une augmentation de la demande de soins intégrés, qui peuvent correspondre à diverses situations, depuis la mise en œuvre de tarifs groupés jusqu'à l'établissement d'équipes pluridisciplinaires par les services de santé et les services sociaux. La note du Royaume-Uni détaille les implications et les avantages potentiels des soins intégrés, tels que l'amélioration de la qualité des services et des soins, la prévention des redondances et la minimisation de l'inconfort pour les patients. Les soins intégrés peuvent nécessiter une coopération entre les hôpitaux (par exemple, un transfert efficace des dossiers des patients d'un établissement à un autre, et l'envoi des patients dans les meilleurs hôpitaux spécialisés). Bien que l'existence de ces réseaux puisse favoriser la concurrence, cette dernière peut également être freinée par des comportements d'exclusion.

La collusion est une autre source d'inquiétude. Les assureurs peuvent s'entendre sur les primes ou sur les garanties accordées. À cet égard, le délégué des Pays-Bas fait remarquer que les primes d'assurance sont très similaires dans son pays, tandis que le délégué du Chili indique que les garanties peuvent varier considérablement. La collusion peut également toucher les marchés publics de services hospitaliers. La note de la Norvège évoque plusieurs cas de soumissions concertées découverts récemment et encourage les autorités d'exécution à lancer une campagne de sensibilisation.

COMPETITION IN HOSPITAL SERVICES – THE POLICY DIMENSION

By the Secretariat[*]

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Annex 1: Hospital beds 69
Annex 2: Average length of stays 71

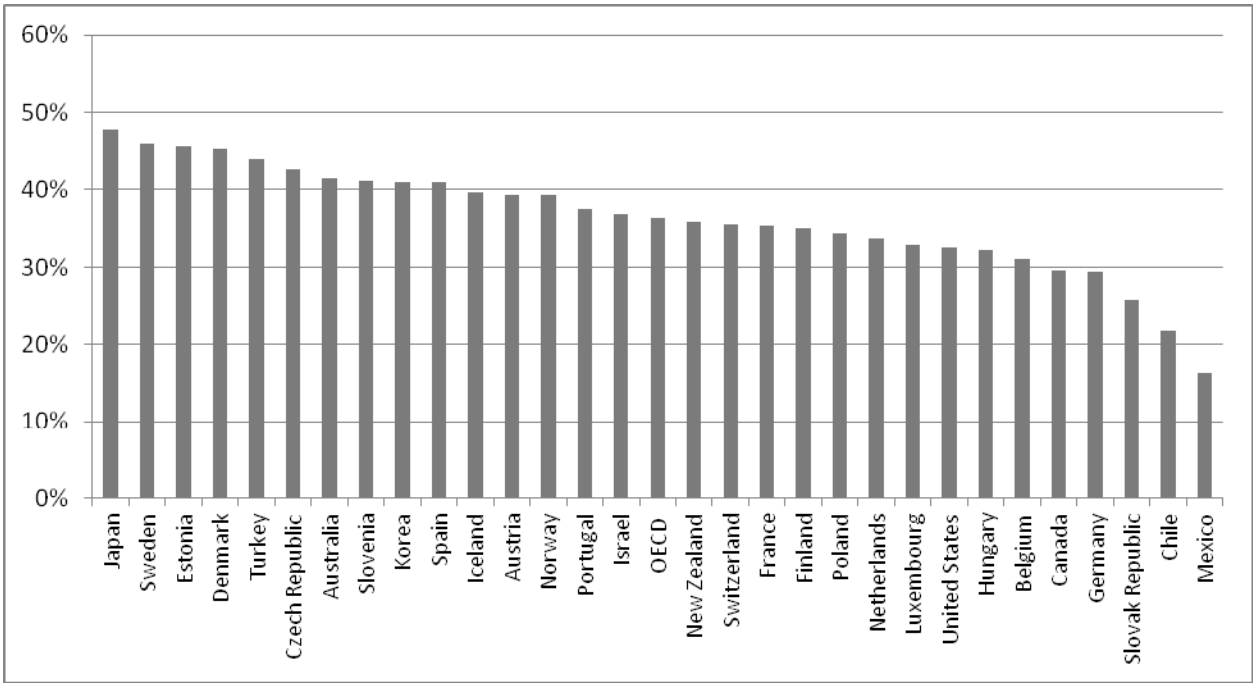
[*] The paper was prepared by Frank Maier-Rigaud from the Competition Division. The two Annexes, Section 3.2.2 and the first part of Section 3.2.3 were prepared by Ankit Kumar from the Health Division. The boxes on Italy, the Netherlands and Poland and the second part of Section 3.2.3 were prepared by Anna Pisarkiewicz from the Competition Division.

1. Introduction

This paper describes the potential for introducing or strengthening competition in the hospital services sector. It discusses the literature on competition in hospital markets of direct relevance to health system design. While health systems must generally be seen in terms of their broader goals, this paper focuses on the possibilities of introducing competitive processes into the provision of hospital services, more specifically inpatient acute care treatment, with the aim of improving health outcomes and ameliorating the provision of services. In order to do so, it draws on the relevant body of literature on hospital service and intermediaries competition including empirical analyses describing the experiences gained in various countries in the past from both, regulatory changes and mergers and acquisitions.

This paper should be seen as complementary to the 2006 OECD Roundtable Compilation on Competition in the Provision of Hospital Services. In contrast to this paper, the 2006 roundtable was not focused on policy questions and regulatory design but on competition law issues in this sector that are not always directly pertinent to regulatory design. The reverse applies to this paper: whilst it may shed some light on market definition and the impact of mergers and acquisitions in hospital services (including intermediaries), it does not attempt to analyse the sector through a specific competition law lens.[1] In addition the paper is complemented by two expert reports.[2]

Figure 1: Spending on hospitals as a proportion of current health expenditure (2009 or earliest year available[3])



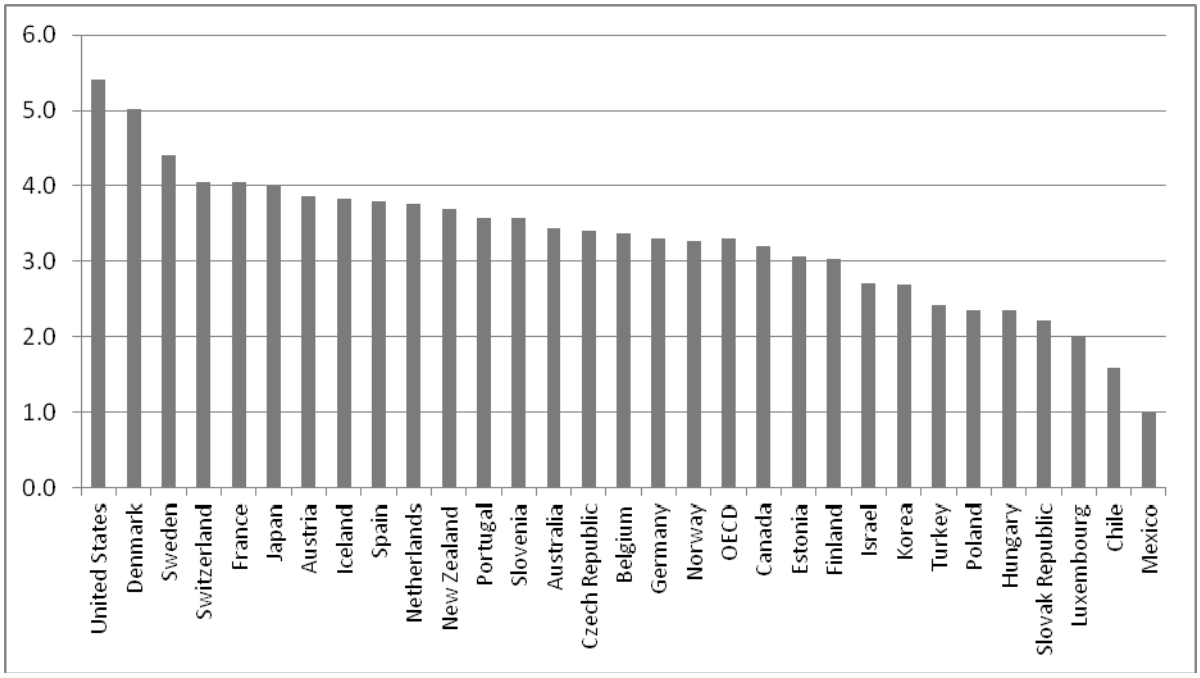
1 For a competition law focussed treatment of the sector see OECD (2006) or for example Varkevisser and Schut (2009) discussing hospital merger control in the US, the Netherlands and Germany. See also Canoy and Sauter (2010) and the overview in Gaynor and Town (2011).

2 The expert reports are written by Zack Cooper and Martin Gaynor respectively.

3 OECD (2011).

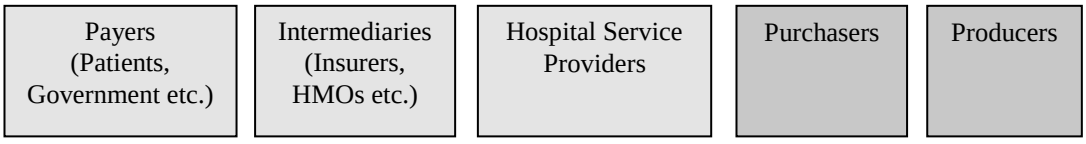
As can be seen in Figure 1, Hospitals are the single largest component of health expenditure across all OECD countries. On average, 33 percent of annual current health expenditure is spent on hospitals across OECD countries.

Figure 2: Spending on hospitals as a proportion of GDP (2009 or earliest year available)[4]



Hospital expenditures are not only the single most important component of health expenditure but in themselves constitute a substantial part of GDP in a lot of OECD countries as can be seen in Figure 2. On average, OECD countries spent 3.3 percent of their GDP on hospitals in 2009. This ranges from more than 5.0 percent of GDP in the United States to 1.0 percent of GDP in Mexico.

Figure 3: Hospital Services Value Chain[5]



Health care policies, either intentionally by design or as an unintended consequence often affect the incentives of health care providers to enter, exit, invest, merge and innovate. Health policy therefore has a direct bearing on service provider market structure and on the outcomes influenced by that market structure. This encompasses price, quantity and quality even if they are outside the immediate reach of the policy. The incentives provided by the regulatory frameworks within which hospital service providers operate are a central force determining the costs and quality of hospital services. These incentives may

4 OECD (2011).

5 Adaptation based on Burns et al. (2002).

differ by the ownership status of hospitals and thus policies may also have a bearing on the ownership structure as well as the mix of not-for-profit and for-profit hospitals.

Figure 3 sets out the hospital services value chain. In the following section the first three blocks of the value chain, i.e. the ultimate beneficiaries or buyers of hospital services, eventual intermediaries (such as insurance companies HMOs etc.) and of course the hospital service providers themselves are discussed. The input side to hospital services, i.e. the purchasers of medical equipment or producers of pharmaceutical products are left out. The main input to the production of hospital services in terms of cost, i.e. personnel such as doctors and nurses will, however, briefly be treated.

2. Competition as an instrument

> In *every* society conflicts of interest among members of that society must be solved. The process by which that resolution (not elimination!) occurs is known as *competition*. Since, by definition, there is no way to eliminate competition, the relevant question is what kind of competition shall be used in the resolution of conflicts of interest.[6]

As expressed in the introductory quote by Alchian, competition, understood in a wide sense, is a process in which conflicts are resolved in society. Even without any explicit introduction of competitive processes into the provision of hospital services, the provision of such services is constrained by the available funding. Conflicts over the type, quality and volume of access to hospital services are pre-programmed and "resolved" by competitive processes. This is true for both, resolution via an economic allocation mechanism, for instance using prices (competition in a narrow sense) but also for other "resolutions" not relying on economic mechanisms and determined, for example, by wielding political power (competition in the widest sense).

Competition is a difficult concept. Difficulties are exacerbated by different associations with the concept. In the health care literature competition is often associated with privatisation and "laissez faire". It is likewise equated with compromised public health objectives and deteriorating health outcomes. In competition law in contrast, competition is associated with dynamic innovation and better outcomes for consumers in terms of prices and quality. These views appear incommensurate but in some sense, both these positions may be accurate descriptions of specific competitive outcomes.

An explanation for these different perspectives may be the following. That competition authorities typically have a more positive outlook on competition is due to the fact that they enforce competition law, i.e. they operate within an existing legal framework where the private hindrance, elimination or circumvention of competition generally entails negative outcomes. Health regulators on the other hand are often concerned with the problems of existing frameworks and are considering changes to those frameworks. In that context, the introduction of competition may not necessarily entail positive outcomes; eliminating competition on certain aspects may in fact be the appropriate regulatory response.[7]

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6 Alchian (1977:127).

7 In fact economic incentives, for instance to reduce service quality in fixed price systems, is rightfully identified as problematic by regulators, reinforcing this perspective.

The problem of hospital service provision is a problem of conflict over scarce resources for health - and quite often in OECD countries, scarce public resources.[8] This paper reviews the literature on the role of competition between providers of hospital services and other relevant players (such as insurers) and how competition can alleviate the budget constraints and improve overall outcomes. It is fundamentally about harnessing competitive processes, streamlining and constraining them via appropriate regulatory means to achieve better outcomes.

Viewed as a process, competition allows an efficient allocation of resources, irrespective of the underlying set of preferences. In the absence of market failures this works well and a competition authority's role is to protect the proper workings of the market process. Competitive processes, as emphasized in some of the health and also more general literature, may, however, also result in undesirable outcomes. Such undesirable outcomes may not only be due to a destruction of the proper working of the competitive process[9] but possibly due to the particularly smooth functioning of competition and high competitive pressure. An example of the latter category, where the process of competition remains intact or is even enhanced, is the externalisation of cost. The externalisation of cost or the lack of internalisation has been debated and tackled through environmental policies. It is clear that a well-functioning competitive process will drive firms to lower their costs in order to improve their competitive situation. In hospital markets with fixed prices and asymmetric information for example, competition may result in suboptimal levels of quality being provided. While this does not affect the competitive process and is indeed only a manifestation of a functioning competitive process, it is typically not associated with positive outcomes.[10] With respect to environmental externalities it is generally accepted that competitive forces have to be harnessed for addressing the externality problems in an efficient way, allowing competitive advantages to those firms that produce at lower pollution levels as opposed to those employing no or less efficient abatement methods. The approach used is to force a full internalization of externalities, and thereby allow the competitive pressures to stimulate innovation also in this area. A similar argument applies to other market failures, for example in case of minimum quality standards in the supply of hospital services under case-based remuneration schemes ensuring that competitive advantages cannot be realized by risking the lives of patients.[11]

In summary, there are two distinct ways in which competition is constrained and channelled. The first constraint ensures that the competitive *process* is maintained and not undermined. The second ensures that competition takes place on the appropriate set of variables, i.e. excludes the externalisation of cost or leads towards what has also been termed "race to the bottom". While both contain normative elements, public interest considerations are of course much more visible in the latter category.[12]

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8 See for example Hauck et al. (2004) discussing the literature on priority setting in health care as a result of finite national health budgets.

9 Such elimination or reduction in competition may, for example, be due to abuse of dominance, cartel or anti-competitive merger.

10 As a result the term "market failure" is somewhat unfortunate as such a "failure" often occurs exactly in those instances where market processes work extremely well but outcomes are viewed as undesirable.

11 These examples demonstrate that with respect to outcomes, competition may "naturally" be over- or under inclusive so that policies are aimed at either exposing new aspects to a competitive process or to take certain aspects out of the competitive process. The type of finding discussed in Propper et al. (2004) and (2008) that increased competition in markets without fixed regulated prices may increase mortality rates, for example, has been used as an argument to exclude the price variable from competition in certain systems.

12 This is certainly true if one considers how controversial certain aspects in the latter category can be. Health care is among the best examples of this.

From this perspective it is not any, but rather a very specific type of competition that competition advocates have in mind when they talk about the benefits of introducing it in hospital services –namely a form of competition that neither undermines itself nor allows competition on a different set of variables than the ones considered desirable. The question to be addressed here therefore is one of finding the appropriate regulatory design that allows an optimal provision of health services.[13] This implies the use of competition as an instrument in the provision of hospital services.[14]

The competitive processes can be put to use to the benefit of society in many areas if it is channelled and constrained by an appropriate frameworks. Health care in general and hospital services in particular are no exception. Distinguishing between competition as an *a priori* neutral process and the question in what domain and on what aspects competitive processes can be fruitfully deployed to fulfil public interest considerations is important in framing the debate on hospital services. Specifying certain characteristics of a racing car engine, for example, eliminates the competition between racing car teams on that element of engine development.[15] As this is the very purpose of such specifications, it is a fruitless argument to point out that competition on these elements will be eliminated by the measure. The question whether such specifications should be introduced or not, can, however, be fruitfully discussed with reference to the desirability of the general consequences of such a change in the rules. It may for instance be well justified to eliminate competition on that level to render the actual race more interesting to the viewers as there may otherwise be a risk that the race is determined less by the skills of the drivers than by the quality of the engine. Re-introducing competition on that element will then rightfully be viewed as problematic.[16]

Similarly, the institutional and regulatory conditions within which competition for hospital services take place matters. Just as a race may become more attractive when competition on engine development is eliminated, it may be part of a desirable framework to eliminate price competition between hospitals to the extent that this then allows for more intense quality competition and potentially fosters more desirable outcomes.

Once a framework can be considered appropriate in terms of fostering worthwhile patient outcomes and encouraging the prudent use of health service expenditures is devised, successful providers of hospital services will be rewarded. Conversely, unsuccessful providers of services will find it increasingly difficult to operate and will either leave the market or merge with more successful operators. If the framework within which hospital competition takes place is well-designed, there should be no concern with hospitals exiting the market. In fact, one cannot have it both ways, benefit from the efficiencies inherent to a

13 Obviously competition does not take place in an institutional vacuum but within a set of rules. Health outcomes depend on the quality of these rules.

14 Generally, a mixture of appropriate regulatory constraints on competition explicitly excluding competition on certain aspects with the possibility to compete on all other factors allow for an optimal provision of health services. This effectively then only leaves out philosophical objections of the sort that those caring for the sick ought to be intrinsically motivated not extrinsically by pecuniary means. The role of intrinsically motivated "knights" and pecuniary motivated "knaves" in the transformation of the general public from uninformed "pawns" to informed "queens" is discussed in Le Grand (2006).

15 Of course the reasons for this are somewhat different than in market competition as the variables on which the competition is focussed on are typically driven by considerations on how to make the game more attractive to audiences. Rule changes in many sports disciplines are motivated by such considerations and it can be observed quite generally that competition on the level of the individual athlete (or team of athletes) is favoured over competition on employed equipment.

16 These are in fact the two stylized positions introduced above. While it may be difficult for competition authorities to accept the select elimination of competition as beneficial, it may be equally difficult for health regulators to allow the select introduction of competition. This is not a fundamental conflict but a technical misunderstanding.

competitive organisation of the sector on the one hand and argue against the closure of hospitals that are an inevitable ingredient of this process. Nonetheless, hospital closures remain a contentious issue across OECD countries.

It is the aim of this paper to not only give some initial ideas and stylized facts under what conditions competition can be beneficially introduced in the hospital sector but to also provide enough comfort to policy makers that once competition is properly introduced, they have enough confidence to resist the pressure to curb competition once particular hospital closures appear problematic.[17]

3. General considerations

3.1. The role of economics

Competition in health care markets, and the hospital services sector in particular, can support better incentives for providers to work efficiently and deliver better outcomes for patients. This holds the potential to reduce costs and fiscal pressures in countries with high levels of public health expenditure. The success of competition, however, often hinges on a country's regulatory and institutional environment as well as the responses of consumers and health care service providers. Therefore, in health care, increasing competition rarely implies abolishing all regulation. On the contrary, the successful introduction of competition more often than not is dependent on the design of appropriate (and sometimes complex) regulation. In a sector where quality is difficult to measure even *ex post* and where bounded rational consumers regularly face information asymmetries in making potentially life changing decisions, there is an active role for regulation to ensure that health care services work well. For these reasons, health policy makers, supported by influential provider and other professional organisations, have often been slower to embrace reforms that introduce competitive markets for services. To the extent that countries have successfully established competition, minimum standards of quality of care are often an essential ingredient, and are regularly complemented by the provision of information and comparisons of supply side performance. It is often argued that regulating the prices of hospital services can foster socially useful competition on quality and performance.

Markets for hospital services differ substantially from standard textbook competitive markets. Due to the different types of treatment and different geographic locations of hospitals, the supply of hospital services is differentiated. From the demand side, information is imperfect. Hospital services and healthcare services more generally are credence goods.[18] Credence goods share with experience goods the property that it is difficult for customers to decide *ex ante* whether the service is of high or low quality. In contrast to experience goods, however, assessing the properties of credence goods or services remains difficult or impossible even after it has been delivered. This is a well-established cause of market failure that has led to (often extensive) government regulation. In addition, also the presence of a substantial amount of not-for-profit hospitals even in otherwise fully market-based systems renders the analysis of hospital services with standard theoretical economic tools difficult. As many basic assumptions in economic models are not fulfilled, theory provides limited guidance under what conditions and when competition will lead to desirable results.

Despite these limitations, the following two subsections will provide a short review of the insights economic theory holds for the efficient provision of hospital services, both from a supply and from a demand perspective. The approach followed is rather standard. It rests on the (controversial) welfare economic notion of Pareto optimality.

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17 See in particular the literature discussing the impact of hospital closure on efficiency and patient outcomes in Box 7.

18 The term has been coined by Darby and Karni (1973).

3.2. Supply side factors

Hospital services are differentiated products. This encompasses both horizontal and vertical differentiation.[19] From a theory point of view, quality and variety can be oversupplied, undersupplied or supplied optimally. In the spectrum from monopoly to perfect competition the provision of quality and variety may vary considerably and theoretical models currently do not allow discriminating between possible outcomes.

A monopolist may oversupply variety as it is the only seller in the market and therefore capable to capture the consumer surplus whereas competitive firms may undersupply variety for the same reason. Also the reverse is possible as competition may provide too much variety to the extent that additional profits may derive from variety generated to "steal" competing hospitals market share.[20] As shown by Gaynor and Vogt (2000), the known result will be an oversupply of variety as individual hospitals will not take the externality of stealing demand into account when choosing variety.

Also the research that takes the multi-product nature of hospital services into account demonstrates that the impact of competition between hospital services on quality, variety and price is ambiguous.[21] Theory suggests that the impact of competition will depend on the responsiveness of the demand for hospital services to price, variety and quality. If the quality of hospital services cannot be measured or properly reported, patients (or insurers) will not know which hospital is best and therefore will not be able to make optimal choices. This is typically captured by a relatively inelastic demand for individual hospital services.

Healthcare markets are often characterised by high levels of state funding and financing systems that ensure that patients do not care about prices and often do not even observe them. If this is the case, and if quality is readily observable, then there may be an incentive to increase costly services, and possibly supply them in quantities that are not optimal. To the extent that quality of actual hospital services is not readily observable, other aspects, such as the "hotel" properties of the hospital may become salient. This may encourage hospitals to offer higher quality on service dimensions that are less important to health outcomes. Similarly, if patients know the price and care about it (as for instance in case of high out of pocket costs) but quality is not easy for them to observe (because properly assessing it requires diagnostic capabilities and knowledge of clinical outcomes and may remain ambiguous even after the service was offered), then this could foster a race to the bottom with less than optimal quality provision.

3.2.1. Prices and payment systems

How prices are set and how the overall remuneration of hospital services is determined matters. In hospital markets with limited price regulation and payment systems that provide scope for generous reimbursement of hospital activities, hospitals may not face incentives to be efficient and patients will be sensitive mostly to quality or additional services. In markets with less generous payment systems, hospitals may compete on prices but leave quality to fall below optimal levels.

If there is a single fixed price for all providers, competition will be on quality and possibly produce too low or too high of a quality depending on the fixed price. Diagnosis Related Group (DRG, see Box 1 below) remuneration can lead to providers undersupplying quality in order to reduce their costs relative to

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19 Horizontal differentiation is sometimes referred to as product variety while vertical differentiation is usually associated with product quality.

20 See Gaynor (2004).

21 Dranove and Satterthwaite (2000).

the fixed prices on which they are reimbursed. The level at which prices are set can also lead to patient selection on the basis of the severity of their condition, creating incentives for hospitals to prefer patients that are less costly to assist relative to reimbursement prices.[22]

A single price is therefore likely to affect patients differently depending on the severity of their illness. These risks exist in fixed price systems based on DRG classifications or any type of system where maximum payments are fixed prior to the treatment.[23]

Establishing case-based fixed prices has been a recent trend as OECD countries increasingly shift towards DRG based payments for hospitals. Theoretical research suggests that competition for quality amongst hospitals is more likely to occur when prices are fixed.[24] Payments on the basis of DRGs imply that different hospitals are paid similar prices for similar services. DRGs seek to benchmark different kinds of hospital services according to their clinical complexity and (theoretically) assign an 'efficient' price per case delivered. Those hospitals that are able to deliver services more efficiently realise a windfall, while hospitals that are less efficient face losses on particular services. These *de facto* price signals provide an incentive to improve efficiency and can encourage competition on quality, but they need to be carefully managed.

Box 1. Diagnosis Related Group (DRG)

Diagnosis-related group (DRG) is a description of systems that aim to classify hospital services into groups. The original intent was to identify the "products" that a hospital provides. By definition, patients within a DRG category, such as for example the "product" appendectomy, are clinically similar and are therefore expected to require the same level of hospital resources. A DRG is therefore a weight that indicates the amount of resources necessary to treat a patient with a given diagnosis (McCellan, 1997).

The system was originally developed as a replacement for wide-spread "cost based" reimbursement of hospital services. DRGs have been used in the US since 1982 to determine Medicare payments to the hospital for each "product". DRG based payment systems have since been introduced to varying degrees, i.e. with more or less extensive exceptions and additional qualifications, in other reimbursement systems world-wide. Since its initial introduction the hospital services sector has evolved and developed an increased demand for patient classification systems that can serve its original objective at a higher level of sophistication and precision. As a result, there exist many different DRG based systems, sometimes even within a country. For example the UK introduced Health Care Resource Groups (HRGs), France has Groupes Homogènes de Malades (GHMs), Canada has Case Mix Groups (CMG) and Australia has National DRGs (AN DRGs).

The basic principle of DRG based prices is that the actual payment is independent of the duration and the treatments received during a hospital stay. Indeed, the theoretical objective of DRG based prices is to specify and pay the "efficient" price for a particular service. As higher quality treatment and longer hospital stays entail additional cost, DRG based systems provide incentives for early (including so-called 'bloody') release and a reduction in treatment quality. Fixed price systems transfer the treatment risk from the insurer to the hospital. If a patient requires a certain treatment that is only partially covered by the DRG

22 This may lead to patients who are more expensive to treat to remain untreated or to get worse quality, known in the literature as "skimping" or "dumping" while hospitals competing for lower cost patients by offering better quality is known as "creaming". See Ellis (1998).

23 Countries that have shifted to some form of DRG or case-based payment for hospital care include for example Chile, Israel, Singapore, Switzerland, Chinese Taipei, the Netherlands, Germany, the UK, the US (for Medicare and Medicaid). For a description of the health care reforms in the former six countries see Okma et al. (2010).

24 The empirical literature is reviewed in the next section.

flat rate or if the hospital stay has to be extended, the hospital is forced to absorb the extra cost. Generally speaking flat rates based on DRG are designed in a way that should allow reasonably sized hospitals (some estimates consider more than 8000 cases a year to be sufficient) to be able to deal with such particularly expensive cases.[25] Some systems, such as the one currently in force in Germany (see Box 2), introduced a ceiling based on the length of the hospital stay. If the duration exceeds this threshold, hospitals are reimbursed on a daily rate basis for the period exceeding the threshold. This helps render the distribution of the risk between hospitals and insurers more balanced.[26]

Box 2. Institutional context of hospital services in Germany[27]

Introduction

Universal health care in Germany is achieved by mandating individual enrolment in a statutory health insurance fund. The German government requires low and middle income earners to enrol in the sickness funds, but higher-income individuals can opt out and choose to purchase their own private health insurance.

The structure of the German hospital sector

The German hospital sector exhibits a variety of not-for profit and for-profit hospitals with different ownership structures. Beside the public hospitals, which are owned by municipalities, regional districts or the federal states, there has been a long tradition of not-for-profit hospitals run by churches and various welfare organisations. For quite a long time there have also been some private hospitals mainly in the form of small and specialised clinics. There was not much change in the composition of hospital ownership until the early 1990s, where following German unification in 1990, a first wave of privatisations of hospitals– mainly in eastern Germany – took place. Since the beginning of the new millennium a second wave of hospital privatisations has started which now covers all regions of Germany.[28]

The funding system in Germany is considered to be dual as the federal states are responsible for the investment cost of building, expanding or modifying hospitals while the health insurance funds are responsible for the operating costs.[29] As laid down in the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*, KHG), only hospitals that are officially registered within the national hospital plans receive funding from the federal states. The federal states have to respect the various ownership structures and have to assure that all different types of hospitals – be they for-profit or not-for-profit, public or private – receive sufficient funding. And according to the German Social Security Code (Sizialgesetzbuch, SGB) only these or the hospitals that have a contract for hospital services with the federal associations of sickness funds can receive funding from the health insurance funds (*Sozialgesetzbuch*, SGB Code No. 5, Article 108).

In principle all patients, i.e. those with private health insurance and those with statutory health insurance, can choose freely among the registered hospitals. The costs are borne by the private or statutory health insurance funds

25 See Monopolkommission (2008).

26 At the same time, OECD countries often supplement DRG prices with surveillance and monitoring of average lengths of stay and key clinical indicator checklists – these act as safeguards to try and identify if there is systematic under-servicing of patients, or that key quality processes are not being undertaken in providing patient care. The extent to which these systems are effective is dependent on their design and implementation and an area of considerable ongoing research.

27 The box draws on the German contribution reprinted in OECD (2006), Schulte (2006) and Monopolkommission (2008).

28 See the contribution from Germany in OECD (2006:135ff.) specifying that between 1991 and 2004 the proportion of private hospitals increased from 14.8 percent to 25.4 percent. At the same time the share of public hospitals decreased from 46 percent to 36 percent while the proportion of non-profit hospitals remained relatively stable.

29 See the Federal German Law of Hospital Financing (KHG). Maintenance is considered part of the operating costs. Furthermore, with tight public budgets, more and more hospital investments are only partially paid by the states, the remaining part being financed through operating "profits".

that are responsible for the running costs of the hospital. Another important factor is that all hospitals, including the public hospitals, are independent in their structure and organisation. The recruitment of doctors or administrative staff is not subject to specific regulation. The outsourcing of certain areas, such as kitchen and laundry services, is allowed, as well as the external operation of dormitories, provided overall responsibility remains with the hospital.

Remuneration of hospital services

With the health reforms undertaken in 2000 the system was transformed from a financing system focused on the costs of individual services delivered to one of financing cases over a patient's hospital stay. The conversion to the system of Diagnosis Related Groups, DRG, became binding as of 1 January 2004 and implies regulated prices. One of the objectives of such a service-oriented grouping system is to avoid wrong incentives emanating from a remuneration system based on patient days, which leads to patients staying longer, and to replace it with a more performance-oriented remuneration system. The introduction of DRGs in Germany has in addition improved transparency regarding the type and volume of services provided by hospitals. This increased transparency provides information on the hospitals' areas of focus and specialisation and makes it possible to compare individual hospitals. These improved possibilities of comparison have also strengthened the health insurance funds' strategic position in budget negotiations with the hospitals.

Due to the DRG system it was expected that losses incurred by hospitals that are not used to full capacity or that are uneconomic for other reasons, will increase further. More and more public and non-profit operators of hospitals will be forced to either close down their hospitals or sell them to commercial operators.

Ensuring the quality of hospitals

The following quality assurance measures are applicable to hospitals:

- Hospitals are obliged to introduce and further develop an internal quality management system.
- Hospitals are obliged to adhere to comparative quality assurance measures. Any irregularities may be subject to selective intervention.
- The quality of diagnostic and therapeutic services as well as the necessity of their provision are assessed on the basis of uniform criteria; in this respect, expensive medical-technology services are of particular significance.
- Hospitals must fulfil minimum requirements regarding structural quality and quality of results.
- In cases where the quality of the treatment results depends in particular on the quantity of services provided, such medical services may only be provided if a minimum number of operations can be proved.

Since 2005 all registered hospitals are obliged to draft a quality report that is published. Of particular interest is the comparison of quality conducted by the Bundesgeschäftsstelle Qualitätsicherung (BQS) on the basis of individual hospital submissions. Since 2007 hospitals are obliged to release quality indicators on a certain amount of procedures twice a year.[30]

In addition, DRG based fixed price systems have repercussions on the financial incentives for patient selection. For any given DRG flat rate, patients who can receive treatment at low cost to the hospital will be particularly attractive to the hospital. This implies that hospitals will have strong incentives to influence the decision making of GPs or any other gatekeeper towards directing particularly unattractive cases to other hospitals. Moreover, the hospital itself has a variety of means to avoid such patients by pleading for example limited specialization in this area, no available capacity or inflated waiting times. Daily rate reimbursements above a threshold may generally mitigate these incentives although they are obviously

30 See Monopolkommission (2008:320) arguing for a systematic quality register to increase transparency for patients.

incapable of addressing the additional costs not associated with the length of stay. The risks of too early release can be reduced by minimum stay thresholds and by discharge criteria linked to payments. While the hospital may financially benefit from such early releases, the patient or insurer is likely to face additional cost down the road due to necessary additional treatments. The risk of this can be mitigated by reducing possibilities of reimbursement for repeated admissions based on the same diagnosis and a minimum length of stay. If a patient is released earlier than the minimum duration specified, the flat rate is reduced.

Generally speaking the DRG based flat rate system is prone to reductions in quality, manipulation of the coding and abusive behaviour that is unlikely to be fully eliminated by the safeguards discussed.[31]

DRG based flat rate systems can also influence the scope and the incentives for innovation. Any fixed price system will encourage those medical innovations that keep overall treatment costs constant or reduce them. These incentives can support innovation and improve efficiency. At times, they may also require a renegotiation of the DRG flat rate, thereby substantially contributing to the already substantial administrative costs of operating such a system.

As in other areas, such incentives remain independent of the degree of competition but high levels of competition are likely to render such incentives particularly salient. Nonetheless, if regulated prices genuinely reflect a considered judgement on what an 'efficient' price ought to be – they can drive hospitals to become more efficient. When hospitals cannot lower their cost sufficiently quickly, or maintain operations at the prescribed fixed prices, they may withdraw services. Where the withdrawal of services is contrary to universal service obligations, fixed prices are likely to be supplemented by additional government support or through service providers cross-subsidising essential services – limiting scope for competition on quality. There are also certain hospital services, such as mental health services, trauma and emergency, where it is too difficult or not optimal to establish fixed prices.

A recent theoretical paper by Janssen and Parakhonyak (2011) analyses the effect of regulated price structures (such as DRG or case-based systems) on the decision of service providers to deny services or to provide non-required services in markets for credence goods. Their results are based on three assumptions: (i) consumers differ in the type of services required and arrive sequentially in time; (ii) price structures are fixed by a regulator and depend on the service required and (iii) service providers can freely decide on the service themselves and service truthfully, deny the service or cheat and give a different treatment.

Based on these assumptions, the paper analyses dynamic selection effects in markets for credence goods such as hospital services showing that for a large class of price structures some types of patients are not treated and will be refused. As intuition would indicate, equilibria where this happens are welfare inferior to equilibria without selection. As the market becomes larger or service providers become more patient (remember the sequential treatment assumptions implying discounting) the class of selection-free price structures shrinks and in the limit becomes unique. This unique price structure is characterized by a set of prices where service providers are indifferent to providing any possible treatment thereby eliminating incentives to cheat.[32]

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31 This is for example described in Monopolkommission (2008:326). With the introduction of the DRG system in Germany the quantity of births classified as "normal" radically diminished in favour of much more lucrative births "with complications".

32 In addition, this optimal price structure also removes the moral hazard problem of overtreatment. This is probably the most unconvincing argument made by the authors because overtreatment, as defined in the paper, is equivalent to giving a different treatment.

The existing body of theoretical literature on quality competition under a fixed price regime indicates a positive relationship between competition and quality.[33] However, Brekke et al. (2011) provide a theoretical model mimicking the empirical finding that competition in hospital markets with regulated prices may lead to ambiguous quality effects. Their model is based on three variations of the standard approach. The authors populate their model with semi-altruistic health care providers, i.e. providers that care to some extent about patient utility and are not pure profit maximisers. In addition, heterogeneous patients (with respect to gross benefits of treatment) and quality elastic total demand for health care are introduced, implying that some patients will forego treatment in equilibrium. Finally, general cost functions that are weakly convex in activity and non-separable in activity and quality are used. This implies increasing marginal cost of treatment and also that quality and cost are modelled as complements, the latter being justified by learning-by-doing effects.[34] Based on these assumptions the authors analyse the effect of competition on quality in hospital services with regulated prices. To do so, they distinguish between monopoly provision and competitive provision with variations through either reductions in transportation costs (increased substitutability) or a higher number of hospitals. Their paper may shed some light on the set of necessary conditions for competition to increase quality under a fixed price regime as a positive relationship between competition and quality is no longer guaranteed, in particular when hospitals are sufficiently altruistic and compete for a large number of patients. Brekke et al. (2011:465) caution though that even if "policy measures to increase competition among health-care providers do not lead to the expected results- higher quality of health care – it does not automatically follow that such policy measures should not be undertaken" as this may still be welfare improving.

Another aspect of quality that patients may care about and that has been modelled theoretically is waiting times. Brekke et al. (2008) for example argue that limiting patient choice may allow certain hospitals to attract high benefit patients reducing waiting times.

In conclusion, economic theory would predict that quality may either increase or decrease with increased competition when firms are setting both quality and price. Whether competition leads to increased or decreased quality will depend on the relative impact on hospitals price and quality elasticities of demand. When prices are regulated, the majority of the theoretical literature predicts increases in quality although some recent literature also allows for more ambiguous results. With competition under regulated prices, quality will depend on the administered price and its relation to marginal cost.

3.2.2. Hospital autonomy and health system characteristics

The extent to which hospital managers have autonomy to hire and fire staff is a key supply side factor in influencing the capacity for hospitals to compete on efficiency and quality. The OECD's Health System Characteristics Survey reports that in a majority of OECD countries (20 out of 29), hospital managers have complete autonomy in recruiting medical staff. By contrast, in Canada, France, Greece, Italy, Ireland, Mexico, Norway, Spain and Turkey, central or local governments make decisions about medical staff recruitment.

Yet while a majority of OECD countries provide managers with the capacity to hire and fire, a much smaller number allow them to influence the pay of doctors. Physicians' remuneration in hospitals is most often constrained by a pay scale negotiated at the national level (in 17 out of 29 countries). In 11 countries, hospital managers have complete autonomy for both the recruitment and pay of medical staff. In the Netherlands, however, managers have in practice little influence on the recruitment and remuneration of specialists since decisions are often made by specialists already present in the group-practices.

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33 See for example Karlsson (2007) and Brekke et al. (2006).

34 As one may suppose that increasing quality increases cost it is unusual not to model quality and costs as complements. The authors acknowledge that.

More frequently, hospitals retain a complete autonomy for recruiting health professionals (in 21 out of 29 countries) other than doctors. Central or local level governments make decisions in seven countries (Canada, Greece, Italy, Ireland, Mexico, Spain and Turkey) and hospitals must negotiate with local authorities in Luxembourg. Hospitals can most often determine autonomously the remuneration level (11 countries) but national pay scales are defined in 18 countries. In 11 countries, hospital managers have a complete autonomy in both the recruitment and remuneration setting for non-medical health staff.

There is considerable diversity in the structure, institutions and operations of different health systems across OECD countries. To help policy makers make worthwhile comparisons in terms of performance, the OECD's work on health systems performance has sought to 'cluster' health systems into groups of countries with similar institutions.

While some judgement is always needed to define the optimal number of clusters because of the trade-off between the number of groups and the degree of heterogeneity within groups, the cluster analysis suggests that OECD countries can reasonably be grouped into six clusters.

These country clusters display the following key institutional features:

- Germany (see Box 2), the Netherlands (see Box 5), the Slovak Republic and Switzerland rely extensively on market mechanisms in regulating the basic insurance coverage. Private providers play an important role and are mostly paid through fee-for-service schemes. Users are offered ample choice among providers but gate-keeping arrangements are in place. There is no strict spending rule and little reliance on regulation of prices paid by third-party payers to control public spending growth. These countries still differ significantly in the degree of decentralisation: sub-national governments have extensive autonomy in managing health care services in Switzerland, while the Netherlands is at the opposite side of the spectrum.

- A second group of countries – Australia, Belgium, Canada and France – features public basic insurance coverage combined with heavy reliance on market mechanisms at the provider level: users are given a wide choice among providers; private provision of both in-patient and outpatient care is relatively abundant; incentives for providers to produce high volumes of services tend to be important, and user information on quality and prices may act as a disciplining factor. Over-the-basic insurance coverage plays a significant role in these countries. In France and to a lesser extent in Belgium, the basic coverage package imposes significant cost-sharing on users, which is largely covered by complementary insurance. Canada has a large supplementary market (67 percent of the population) whereby private insurance pays for prescription drugs and dental care that are not publicly reimbursed. In Australia, over-the-basic coverage both takes the form of supplementary and duplicative private insurance. In this group of countries, cost control generally takes the form of moderate gate-keeping arrangements and strict priority setting arrangements (benefit basket defined at the central government level by a positive list and/or effective use of health technology assessment in determining which goods and services should be included in the basic coverage package).

- The third group – which includes Austria, the Czech Republic, Greece, Japan, Korea and Luxembourg – is also characterised by extensive private provision of care and wide patient choice. But there is no gate-keeping system in place, and the available information on quality and prices is scarce, creating little competitive pressures on providers. Over-the-basic coverage is limited. The budget constraint tends to be less stringent than in other country groups.

- The health care systems of Iceland, Sweden and Turkey offer free choice of provider to patients in all three areas of care – primary, specialist and hospital care – with no gate-keeping. However,

private provision is very limited, suppliers have few incentives to increase volumes and their prices tend to be tightly regulated. The budget constraint is weak, except in Sweden, where it is very strict.

- In the group consisting of Denmark, Finland, Mexico, Portugal and Spain, health care is mainly provided by a heavily regulated public system. Patients' choice among providers is extremely limited and the role of gate-keeping is important. There is a public spending target for health care but no strict budget constraint, except in Portugal. Among these countries, Spain and Finland are clearly more decentralised than the OECD average.

- The last group also consists of heavily regulated public systems – Hungary, Ireland, Italy (see Box 4), New Zealand, Norway, Poland (see Box 3) and the United Kingdom (see Box 6). The budget constraint is more stringent than in most other OECD countries. Compared with the previous group, the possibility for patients of choosing between providers tends to be large and sub-national government autonomy tends to be lower. Over-the-basic coverage is very limited, except in Ireland and New Zealand, where duplicative coverage is significant and provides faster private-sector access to medical services.

Box 3. Institutional context of hospital services in Poland

Introduction

Prior to the 1999 reform, the Polish health care system - then based on 'free access' to health care services - was financed directly by the state budget. With the introduction of a mandatory and universal health insurance, income-related social contributions have become the main source of funding for the sickness funds, which in 2003 have been replaced by the National Health Fund (*Narodowy Fundusz Zdrowia, NFZ*).

As of August 2004, health insurance is regulated by the Act on Health Care Services Financed from Public Means. Mandatory social health insurance, which covers nearly all of the population, is at the moment set at the level of 9 percent of an employee's salary (of which 7.5 percent is tax deductible). Contributions are collected by the Social Insurance Institution (*Zaklad Ubezpieczen Spolecznych, ZUS*), and then transferred to the NFZ. The NFZ centrally divides its budget and transfers it to its 16 regional offices, which then contract health services in their respective regions. In addition to the mandatory insurance, it is possible to buy since 1998 voluntary health insurance. In contrast to mandatory insurance, which is provided exclusively by the National Health Fund, voluntary health insurance is provided by private companies.

The structure of the Polish hospital sector

The Polish healthcare system is characterised by a strict separation of outpatient and inpatient healthcare structures. The outpatient healthcare services are provided mostly by private medical practices, whereas inpatient care (i.e. hospitals) remains predominantly public. The process of hospital ownership transformation began in 1995. While the share of non-public hospitals in comparison to the total number of hospitals (currently around 25percent) has been steadily increasing, this share remains low in terms of beds (around 7percent).[35] Such a difference is caused by the fact that private hospitals tend to be much smaller than public hospitals and focus mostly on the most profitable and highly specialised areas of medicine. The majority of non-public hospitals (around 65percent) is run by a private entity, while the remaining 35percent is run by local government.

Inpatient healthcare services can be provided by both public and private hospitals. However, regional health funds can only contract services that are included in the list of procedures contracted by the NFZ.

Remuneration of hospital services

Prior to the introduction of the DRG system in Poland, the hospital payment system was based on a very similar so-called Catalogue of Health Care Products system. Under that system hospitals were paid a flat per-admission fee corresponding to the value of a given product. The scope of the catalogue, however, was continuously increasing, and the system overall was not deemed transparent. The use of the DRG payment system on a national basis was introduced in July 2008, and is now mandatory in all public and non-public hospitals that have signed contracts with the NFZ.

3.2.3. Public and private provision of hospital services

Delivery patterns in public healthcare services can be seen as a continuum of provision models ranging from fully publicly financed direct provision by governments to loosely regulated and highly privatized markets. However, as governments are more and more often confronted with rising demand for healthcare services (due to the growing percentage of elderly population, patient's choice, awareness of differences in services' quality), rising consumer expectations, and rising costs, utilising different forms of the public/private provision is becoming increasingly important.

35 In the aftermath of the ownership transformation, new structures have emerged such as the Polish National Association of Non-Public Hospitals and the Polish National Association of Non-Public Local Government Hospitals. These undertake various joint initiatives promoting changes in the organisation of health services in Poland that would provide equal treatment for/of public and private health care service providers.

The public/private mix in the provision of hospital services can be assessed from two different perspectives: from a system wide perspective, which can be characterised by the share of beds in public/private hospitals and the possibility of exercising private practice by self-employed as well as salaried doctors in public hospitals, or it can also be seen through the perspective of purchasing strategies by governments in the context of public-private partnerships and public-private collaboration (PPPs and PPC).

The public-private mix in health systems at large

In several OECD countries, the public/private mix in the provision of hospital services varies according to the type of care (acute, rehabilitation, long-term). As it was not possible to collect information for all types of services, the OECD's Survey on Health Systems Characteristics focused on acute in-patient care to gain an overall understanding of the extent of the public/private mix across OECD countries. For most OECD countries, acute in-patient care is the dominant activity in the hospital sector. Hospital acute care beds account for on average ¾ of all hospital beds in OECD countries, ranging from 51 percent in Ireland to 93 percent in Turkey.[36]

There are two broad indicators that were used to characterise the extent of the public / private mix in hospital services across OECD countries:

- The respective shares of acute care beds located in "publicly owned hospitals", "not-for-profit privately owned hospitals" and "for-profit privately owned hospitals".

- Whether private practice was allowed in public hospitals, for self-employed doctors and/or for salaried doctors.

It is also worth noting that in a few OECD countries, organisations providing covered health services cannot earn profits. This is the case for instance in Japan. In Canada, though health services covered through the Canada Health Act must be provided on a not-for-profit basis, a small number of for-profit hospitals exist and provide covered health services. However, most hospitals are public or not-for-profit entities.

Acute hospital care is mainly provided by the public sector in all OECD countries, except Belgium, Japan, Korea and the Netherlands, where the private not-for-profit sector is the predominant provider. The private for-profit sector plays an important role in the Slovak Republic (40 percent of acute beds), in Mexico (35 percent), in Greece (28 percent), as well as in France and Korea (25 percent each).

Private practice in public hospitals is authorised in 18 out of 29 countries. Indeed, physicians working in public hospitals are not always salaried staff. For instance, in Belgium and some Canadian provinces, the vast majority of doctors working in public hospitals are self-employed and paid on a fee-for service basis.

In some countries (e.g. France, the United Kingdom), salaried doctors of public hospitals are permitted in some circumstances to treat patients on a private basis. In France, this privilege was granted as a concession to attract and keep experienced doctors in public hospitals where salaries are in general lower than in the private sector. In both countries, private practice in public hospitals is however limited.

[36] See OECD (2011).

Table 1: Public-private mix in the provision of hospital acute care[37]

Country	Percentage of total acute care beds in:			Is private practice in the public hospital setting allowed?		
	Publically owned hospitals	Not-for-profit privately owned hospitals	For-profit privately owned hospitals	For self-employed doctors	For salaried doctors	No
Australia	69.59	14.38	16.03		X	
Austria	72.5	18.8	8.7		X	
Belgium	34	66	0	X	X	
Canada	100	0	0	X		
Czech Republic	91	0	9			X
Denmark	96.7	2.5	0.8			X
Finland	89	0	11			X
France	66	9	25		X	
Germany	49	36	15	X		
Greece	69	3	28		X	
Hungary	n.a.	n.a.	n.a.			X
Iceland	100	0	0			X
Ireland	88	0	12		X	
Italy	81.5	16.7	1.8		X	
Japan	26.3	73.7	0	X	X	
Korea	10	65	25			X
Luxembourg	68	29	3	X	X	
Mexico	65	0	35			X
Netherlands	0	100	0	X(2)	X(2)	
New Zealand	81	9.5(1)	9.5(1)			X
Norway	99	1	0			X
Poland	95	0	5	X		X
Portugal	85.7	6.6	7.7		X	
Slovak Republic	59.6	0	40.4	n.a.	n.a.	n.a.
Spain	74.23	17	8.77			X
Sweden	98	0	2	X		
Switzerland	82.7	4.8	12.5	X	X	
Turkey	89.5	0	10.5		X	
United Kingdom	96	4	0		X	

Note: (1) OECD imputation; (2) Both salaried and self-employed doctors in not-for-profit hospitals.
Note: n.a. means Not Available.

37 Paris et al. (2010). Note that the entry for Italy deviates from the original entry.

Box 4. Institutional context of hospital services in Italy[38]

Introduction

The current model of the Italian health care system, explicitly modeled on the British NHS, is the outcome of three fundamental reforms that took place in 1978, 1992 and 1999. The first reform replaced over 100 health insurance funds with the National Health Service (*Servizion Sanitario Nazionale, SSN*), which now provides universal health assistance to all citizens as well as legal foreign residents free of charge at the point of service. Insurance is mandatory and there is no possibility to opt-out. In addition, patients may buy private health insurance and receive services from non-accredited private hospitals at their own expense. The second reform, driven by difficulties in controlling health-related public expenditures introduced the principles of "private" management and brought more autonomy to hospitals with a view to encouraging competition and boosting efficiency in the provision of health care services. The Local Health Units were transformed in Local Health Care Enterprises (*Aziende Sanitarie Locali*, *ASLs*), under the direction of managers appointed by the Region on a contractual basis with performance related remuneration. The third reform, completed in 2001, introduced the concept of the basic benefit package (*Livelli Essenziali di Assistenza, LEA*) and finalized the transformation of the SSN into a regional system.

Decentralised organisation of the system is built upon a three-tier structure, which involves the national government, the regions and local health authorities. At the national level, the Ministry of Health determines general objectives as well as the basic benefit package (*LEA*)[39] and allocates the SSN resources to regions. The Regions, on the other hand, are responsible for the organisation and administration of publicly financed healthcare, while the local level ASLs are entrusted with the delivery of healthcare services.

The SSN is funded through general taxation, and in particular direct taxes (income tax IRPEF and regional IRAP - around 40 percent) as well as indirect taxes (VAT and petrol tax – around 42 percent).[40] These constitute regions' income. Moreover, ASLs obtain direct revenues from prescription charges as well as provision of services subject to payment.

The structure of the Italian hospital sector

Hospital services in Italy are provided by public, private-for-profit and private non-profit organisations.[41]

Overall, around 54 percent of hospitals are public, and 46 percent are private.[42] Responsibility for providing hospital services rests with the ASLs, which can contract services from public as well as private hospitals, as long as the latter are accredited. However, some Regions impose ceilings on the total amount of private services reimbursed by ASLs.

Remuneration of hospital services

The DRG payment system was implemented in Italy in 1994. It applies to public as well as private hospitals, and covers most devices used in hospitals. The Ministry of Health adopts a set of DRG tariffs at the national level, but regions are free to depart from them and adopt lower individual tariffs.[43]

Hospitals and ASLs are increasingly forming procurement commissions (*Commissioni Terapeutiche di Area Vasta – CTAV*) to obtain better prices. The use of innovative and costly devices, which are not covered by the DRG funding, can be reimbursed separately from the regions budget.

38 The box draws on the Italian contribution reprinted in OECD (2006).

39 Regions are free to provide services not included in LEA, but these they must finance themselves.

40 The remaining part comes from other transfers from public and private sectors (around 14%), and from ASLs'own sources of income (around 3%). See Tediosi et al. (2009).

41 Private non-profit hospitals include mostly teaching and research hospitals incorporated as private entities as well as church-run hospitals.

42 Ministero della Salute, *Relazione sullo Stato Sanitario del Paese 2009-2010*, p. 433

43 For instance, Lombardy, which has above average level of health care, decided to set its own reimbursement rates, and encourage equal treatment of public and private hospitals by treating them equally in terms of eligibility for public funds.

The use of public-private partnerships in delivering hospital services

Increasing financial constraints have prompted governments to search for and use alternative provision models with a view of optimising economic performance in the provision of public services. The increasing support for the use of PPPs in the healthcare sector, seen as a means of investing in healthcare capital while limiting the impact of this expenditure on the public finances, can be seen as a response to that challenge.

Currently there is no clear definition of what constitutes a public-private partnership in health services, despite the fact that PPPs have been in use since 1990s. A public-private partnership is defined "as an agreement between the government and one or more private partners (which may include the operators and the financers) according to which the private partners deliver the service in such a manner that the service delivery objectives of the government are aligned with the profit objectives of the private partners and where the effectiveness of the alignment depends on a sufficient transfer of risk to the private partners."[44]

PPPs in the healthcare sector usually take the form of long-term contracts (most commonly of a duration between 15 and 30 years) between a public authority and a private entity, referred to as special-purpose vehicle (SPV). The private party builds, maintains and/or manages delivery of contracted services upon payment received from the public authority.

PPPs can take a variety of forms, each with a different degree of responsibility and risk born by private and public parties. The most commonly used models are described in Table 2 below:

Table 2: Models of public–private partnership in hospital provision[45]

Model	Description
Franchising	Public authority contracts a private company to manage existing hospital
DBFO (design, build, finance, operate)	Private consortium designs facilities based on public authority's specified requirements, builds the facility, finances the capital cost and operates their facilities
BOO (build, own, operate)	Public authority purchases services for fixed period (say 30 years) after which ownership remains with private provider
BOOT (build, own, operate, transfer)	Public authority purchases services for fixed period after which ownership reverts to public authority
BOLB (buy, own, lease back)	Private contractor builds hospital; facility is leased back and managed by public authority
Alzira model	Private contractor builds and operates hospital, with contract to provide care for a defined population

The choice of a specific PPP model depends on the regulatory framework which is in place and may require amendments in order to accommodate the possibility to use new forms of partnership.

The policy framework for PPPs adopted by many countries around the world has been strongly influenced by the UK model, called the Private Finance Initiative (PFI), which uses the DBFO model.[46]

44 See OECD (2008).

45 See McKee et al. (2006).

There, the private sector finances and constructs a hospital building, and also delivers the service and maintenance functions. Other models, in particular *Alzira*, go as far as entrusting private sector not only with financing, constructing and operating the hospital building, but also with the actual provision of clinical services. La Ribera hospital in the Valencia region in Spain is a case in point.

Despite diversity of the PPPs models and the fact that PPPs hospitals have been operational since 1990s, there is still no conclusive and comprehensive evaluation of the merits of such a mixed provision.[47] Various authors, such as Hodge and Greve (2007), point out that PPPs should be subjected to rigorous analysis. While PPPs can certainly alleviate the burden on public finances, they may not always offer the most efficient solution, which is why it is important that governments carry out a careful up-front evaluation. McKee et al. (2006) draw attention to such contentious issues as cost, quality, flexibility and complexity.

3.3. Demand side factors

The Economics of hospital services typically focuses on supply side factors and the literature normally refers to supplier induced demand. To understand why demand may be largely supplier induced, hospital services as credence goods are discussed. The asymmetric information and the boundedly rational behaviour of patients also play an important role in rendering demand largely supplier induced. Finally, there are several policy initiatives that aim at increasing transparency and moving at least partially away from a purely supplier induced demand mainly by strengthening the informational basis of patients for hospital choice.

3.3.1. Hospital services as credence goods

An essential feature of hospital services derives from the nature of the service, usually referred to as credence good or service. The term refers to goods and services for which consumers are incapable of discovering the optimal quantity and quality *ex ante* and *ex post*. Typically, providers of credence goods not only provide the good or service but also act as experts determining the customer requirements. Credence goods are found not only in medical services but exist also in the provision of taxi services, legal and financial advice, as well as in a wide variety of repair professions. As customers never determine the quality of the product or service and often cannot even judge whether the service has been performed at all, these goods and services have been called credence goods.[48]

According to Emond (2001) this asymmetry of information gives sellers several opportunities to exploit consumers. The seller may choose to take advantage of a buyer by recommending unnecessary expensive treatments - a problem which has been dubbed ‘demand inducement’ in the health economics literature. If, in contrast, other activities are more profitable, sellers may not perform urgently needed treatments.

Emond (2001:376) gives some anecdotal evidence to demonstrate this point. He writes that patients in Switzerland with the minimum level of schooling are twice as likely to have their womb or gall-stones

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46 This model has been adopted by Spain, Italy, Mexico, South Africa, France and Australia. For an overview of the use of PPS in the European context, see Nikolic and Maikisch (2006).

47 Even for the UK, which has one of the longest experiences with the use of PPPs in the provision of hospital services, no such evaluation is available. The UK National Audit Office (NAO), which controls public spending on behalf of the parliament, pointed out that they “have yet to come across truly robust and systemic evaluation of the use of private finance built into PPPs at either a project or programme level”. See National Audit Office (2009)..

48 See Dulleck and Kerschbamer (2006) for an overview of the literature on credence goods.

removed than patients with a university degree and that for hip-joint operations the probability is even 150 percent higher. According to him, ordinary children are 80 percent more likely to have their tonsils taken out than children of medical doctors. Emond refers to an article in the Economist[49] conjecturing that a third of current health-care spending in the US goes on irrelevant tests, unproven procedures, and unnecessarily pricey drugs and devices.[50]

3.3.2. Bounded rationality

In addition to the credence good characteristics of hospital services and the implied information asymmetry, it is now largely recognized also by economists that economic actors in general and hospital patients in particular are boundedly rational[51], exacerbating the credence good aspects of hospital services.

Bounded rationality is generally characterized as having two components: the limitations of the human mind, and the structure of the environment within which the human mind operates. The first component addresses the fact that in many real-world situations, optimal strategies are unknown or unknowable.[52] Even in a game such as chess, where an optimal response exists at every stage of the game, no (computer) algorithm exists that would allow to calculate this move in a reasonable amount of time. This is surprising as chess in stark contrast to most other environments is a well-defined game. If identifying an optimal strategy is not even possible in such an environment it surely is impossible in more complex scenarios. As a result, humans "must use approximate methods to handle most tasks".[53]

The second component of bounded rationality, namely environmental structure, is of crucial importance because it provides an explanation for why humans remain capable of reasonably good decision making despite these inherent limitations. To the extent that the decision processes are adapted to the environment through an evolutionary process, they will do reasonably well.[54]

One form of bounded rationality is Simon's concept of satisficing - a method for making a choice from a set of alternatives encountered sequentially when probabilities are unknown. In such situations, there may be no optimal method for stopping the search - for instance, there would be no optimal way of deciding when to stop looking for a suitable hospital for any particular treatment. Satisficing takes the shortcut of setting an aspiration level and ending the search for alternatives as soon as a hospital is found that exceeds the aspiration level. Obviously, there is a big difference if satisficing is focussed on the

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49 Economist of 13 February 1999.

50 Emons (2001) provides a signalling model based on capacity and prices for diagnosis and treatment in the context of monopoly provision of credence goods.

51 It is important to note the distinction between boundedly rational behaviour and what has sometimes been referred to as decision biases. While for example the experimental literature in economics and psychology originally focussed on so-called biases or deviations from the rational actor model, essentially describing behaviour as rational and measuring deviations from it, it is now generally recognized that the research program into boundedly rational behaviour is systematically different from a characterization of behavioural biases as deviations from perfectly rational decision making. This is unfortunately not (yet) well understood in antitrust as exemplified in Bennett et al. (2010) or Garcés-Tolon (2010).

52 See Simon (1987).

53 See Simon (1990:6).

54 The classic example of this given by Simon (1956) concerns imaginary organisms foraging according to simple rules. The behaviour of these organisms can only be understood by looking at the structure of the information in the environment.

"hotel" qualities of the hospital rather than mortality rates for example. The apparent preference for local hospitals may be the result of a satisficing approach to choosing a hospital.[55]

The study of Hoffrage and Gigerenzer (1998) demonstrates the relevance of bounded rationality aspects not only for understanding patient choices but also for understanding decisions of health professionals. In their study, the capabilities of gynaecologists for understanding positive mammograms was tested with the result that many physicians do not know the probabilities that a patient has a disease given a positive screening test—that is, the positive predictive value. The authors also find that they are unable to estimate it from the relevant health statistics when the statistics are framed in terms of conditional probabilities, even when this test is in their own area of specialty.[56]

3.3.3. Increasing transparency

The market failure attributed to the credence good characteristics of hospital services, paired with the boundedly rational decision making of patients can be mitigated by increasing the informational basis for hospital choice – either by providing more information or making it more accessible to patients.[57] Various OECD countries have sought to report on hospital performance according to indicators of quality of care (such as mortality rates) or performance/access (such as waiting times) to alleviate information asymmetries. These measures had varying degrees of success in supporting patients to make informed decisions when choosing between hospitals.

While good information can support better decision making in selecting hospital services, information often may not need to be provided to a patient directly. Indeed, many OECD countries actively structure their health system so that professionals help patients overcome information asymmetries in choosing their hospital.[58] Establishing 'purchasers' of health care such as insurance companies or HMOs (health maintenance organisations) are one way of driving competition between hospitals, as they should seek improvements in quality and efficiency in negotiating contracts for health services.

This way of increasing competition between hospitals focuses on the role that insurers or HMOs can take in the selection of hospitals that they want to conclude agreements with. While it is not always clear whether insurer preferences are fully aligned with patients, it is clear that insurance companies have the capabilities of performing market screens. Such screening may take place concerning both, the costs but also the quality of hospital services as measured for instance by re-admissions or mortality rates. While insurers can probably be relied upon weeding out the least cost efficient hospitals in those systems that

55 See Dixon et al. (2010) who provide an empirical overview of choice in the UK. That distance or travel time has a large and negative effect in hospital demand is also set out in Beckert et al. (2012), Capps et al. (2001), Capps et al. (2003), Capps et al. (2009), Ho (2006), Sivey (2011), Tay (2003). That quality may also matter is shown in Beckert et al. (2012). The lower the mortality rate and the shorter the waiting time, the more likely a patient is to choose a hospital. In addition, UK patients are more likely to choose a hospital the higher the CQC rate and the lower the number of MRSA infections is.

56 Gigerenzer et al. (2007:58) provide several additional examples pointing to "the collective statistical illiteracy of patients, physicians and politicians, as well as the considerable costs health systems pay as a consequence." Their article focuses on different ways of framing the information in order to make it more comprehensible to boundedly rational humans. They also analyze the question whether patients are likely to find transparent information in medical pamphlets and on the internet suggesting more appropriate ways of presenting statistical evidence.

57 Accessibility covers both, the framing or presentation of the information and also the facility for patients to gain physical access to it.

58 See Annex II: Information on Provider Services for more information on the different types of information available to patients in different health systems.

allow for free price formation, even without exerting buyer power, their effect on quality is more ambiguous and will largely depend on how costly positive and negative deviations from some fixed quality is. So while potentially capable of accessing a much wider set of information on costs and quality, it is not always clear whether insurer preferences fully align with patients needs in terms of hospital selection.[59] While purchasers may also seek to limit the extent of consumer choice, in an effort to channel consumers towards higher quality hospital services, the market structure and the nature of individual purchasers can sometimes compromise the incentive for purchasers to improve quality or reduce price on behalf of their patients. In encouraging patient choice amongst hospitals, regulation can also affect the capacity for insurers to channel patients towards providers that deliver higher quality or more efficient outcomes.

A second way of driving competition between hospitals is the use of informed agents, who could act as an impartial adviser to the patient, or indeed as a 'gatekeeper' that helps determine if (and what kind of) hospital service is worthwhile for the patient. This may, for example, be a general practitioner (GP), primary care professional or an (assigned) independent patient advocate who helps and advises patients on their choices. To the extent that such approaches work well, it may mean that patient choice in the market can be the driver of competition, rather than competition via contract negotiations.

In conclusion, while price inelastic demand for hospital services can in part be explained by information asymmetries and the credence good properties discussed above, a certain degree of inelasticity is of course a deliberate social policy choice. An additional point of relevance is also the fact that for non-elective treatments, for example in acute cases, satisficing is likely to occur earlier than with elective treatments. In case of emergency, for example in case of a coma, there is no room for demand side choices. This puts some natural constraints on the possibilities for moving away from supplier induced choice of hospital services.

4. Empirical evidence

The following subsections seek to compile a catalogue of stylized facts based on the relevant empirical investigations conducted into competition in hospital services. Its (geographical) scope is limited to those systems that have more often been empirically investigated, implying a certain bias towards countries such as the US, the UK and the Netherlands. Furthermore, the majority of studies discussed here address primarily positive questions and only few allow for straight forward normative policy conclusions. In addition, the causalities that are posited typically do not address the underlying mechanism that generated or enhanced causality[60] so that even if a strong and robust relationship is found, the scientific explanation for its occurrence remains open, rendering policy advice particularly difficult.

The following studies are mostly based on the structure conduct performance (SCP) paradigm as an underlying structure of the econometric approach.[61] This means that a causal link between market structure, market conduct and market performance is made although most models disregard performance. A generally accepted conduct measure in the industrial organization literature is price or the price-cost margin but in analyzing hospital services this is often replaced by some measure of quality. Market structure is generally measured using the Herfindahl-Hirschmann Index (HHI)[62] although this is not

59 There are obviously various other ways in which insurance companies and HMOs can negatively affect patients, for instance by excluding certain treatments or declining proper payment.

60 Some doubts may also apply as to whether the posited causalities are indeed causalities as opposed to correlations. See Black (1982) for a very readable discussion of this problem in general terms.

61 The classic contributions are from Edward Mason and Joe Bain. See Bain (1956) and (1959). Schmalensee (1989) provides an overview.

62 The Index is given by $HHI = \sum_{i=1}^{N} s_i^2$ where s_i is the market share of firm i in the market, and N is the number of firms. Thus, in a market with two firms that each have 50 percent market share, the Herfindahl-

without difficulty in hospital service markets.[63] Using the SCP conjecture in econometric models is known to be problematic. For example, structure, irrespective of how it is measured, is usually considered to be endogenous.[64] Any unmeasured variation in demand and cost factors for example both affect quality and market structure, i.e. a firm with low costs is likely to have both a high market share resulting in a high HHI and choose high quality.[65] Besides the SCP approach, some studies look at the impact of mergers or regulatory changes while others look at the relationship between the volume of particular procedures and patient health outcomes. These studies are normally based either on simulations or event studies that compare events before and after the merger or change in regulation.[66]

4.1. Studies on competition on quality under a fixed price regime

The following studies all address the question of what happens to quality of hospital services when comparing hospitals subject to various degrees of competition under a fixed price regime.[67]

Fixed price regimes can be observed in many countries including the UK (see Box 6), the US (for Medicare and Medicaid beneficiaries), the Netherlands (see Box 5) and Germany (see Box 2).[68] As prices are regulated, they are not a strategic variable for hospitals.

Hirschmann Index equals $0.50^2 + 0.50^2 = 0.5$. The Herfindahl-Hirschmann Index (*HHI*) ranges from $\frac{1}{N}$ to 1, where N is the number of firms in the market. Equivalently, if percentage integers are used as in 75 instead of 0.75, the HHI can range up to 100^2, or 10000.

63 The main theoretical problem is that the HHI derives from a homogenous good Cournot model and therefore there is no theoretical foundation for using this model in hospital services. Furthermore, hospitals provide differentiated products an important feature typically left unaccounted for in HHI calculations.

64 Endogeneity is arguably the single most problematic aspect of modelling hospital services. Technically speaking, a parameter or variable is said to be endogenous when there is a correlation between the parameter or variable and the error term. In other words, the model suffers from endogeneity if the dependent and the independent variable are both in a causal relationship with each other. Consider for example the (negative) relationship between the volume of a particular treatment in any particular hospital and mortality rates. Even if this relationship is significant and also substantial, it remains unclear whether it is due to patients being attracted to hospitals with better mortality rates, thereby leading to higher volumes or whether higher volumes in any particular hospital leads to improved mortality rates due to some learning-by-doing effect or other quality improvements linked to volume. The way causality (mainly) goes, or in other words, which one is the strongest effect, is of direct relevance to antitrust. If volume causes higher quality then higher market concentration that by definition causes higher volume and thereby quality could be considered having a positive effect on patient outcomes. For example, both, Gaynor et al. (2005) and Gowrisankaran et al. (2004) using an instrumental variable approach find a significant and substantial causal effect of volume on outcome. See, however, Huesch (2009) who fails to identify a learning-by-doing effect possibly excluding this explanation for the volume-quality causality. Gaynor and Town (2011:79ff.) review these and other studies attempting to investigate volume-quality causality.

65 See Gaynor and Town (2011:60f.) who also draw attention to other specification issues of relevance to hospital markets.

66 With increasing interest in an *ex post* assessment of competition policy effects, the literature on merger event studies in the hospital sector is likely to grow significantly in the coming years.

67 One of the justifications for leaving out a discussion of studies looking at the effects of competition on quality when also prices are being set by hospitals is their mainly US relevance and the ambiguous results, rendering it impossible to draw conclusions without going into much more institutional detail.

68 In addition it may of course make a difference if hospitals are for-profit or not-for-profit including various mixed forms.

Kessler and McClellan (2000), one of the first studies attempting to draw inferences about causal effects of competition on hospital service quality, consider the impact of market concentration as measured by HHI predictions (drawn from a patient choice model mainly relying on hospital distance) on the quality of hospital services as measured by the risk-adjusted one year mortality rate from acute myocardial infarction (heart attack). The results of this US study are striking as their quality measure is substantially and significantly higher in less concentrated markets. Patients in the most concentrated markets had mortality probabilities 1.46 points higher than those in the least concentrated markets. This constituted a substantial 4.4 percent difference in mortality rates or, in other words, over 2000 fewer (statistical) deaths in the least versus the most concentrated markets for their data. With regard to expenditures the relationship inverts over time with expenditures first being higher in less concentrated markets and then lower. While looking at the more recent data, both expenditures and mortality rates are lower in less concentrated markets implying higher health benefits for patients combined with lower cost. The claim of welfare gains from competition is, however, uncertain, as the expenditure measure used is not equivalent to economic cost as required in a welfare analysis.[69]

Box 5. Institutional context of hospital services in the Netherlands

Introduction

Prior to 2006, the Netherlands had a rather complex health insurance and finance system that relied on the coexistence of mandatory social and voluntary private health insurance. The 2006 reform, undertaken with a view to introducing competition between health insurers, abolished the division between these two types of insurances, and replaced it with a universal mandatory scheme. In accordance with the Health Insurance Act (*Zorgverzekeringwt, ZvW*), all residents are now required to subscribe for insurance with one of the competing health insurers, who can be chosen on annual basis (open enrolment). All insurers operate under private law.

The Dutch health insurance system is based on the distinction between long-term (chronic diseases, long-term hospital care), basic (routine) and supplementary care (i.e. dental services, physiotherapy). Mandatory universal insurance for the long-term care, introduced in 1968, is regulated by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, ABWZ*). It is financed through income-based salary deductions as well as government revenue grant. The financing of the statutory basic health insurance comes from income-related employer contributions (50 percent), community-rated notional premiums (45 percent), and from generated tax revenues (5 percent). Insurance for children up to the age of 18 is covered by government through general taxation. The scope of the minimum care package is defined by public authorities.

The structure of the Dutch hospital sector

The dominant pattern in the Dutch hospital sector is that of private, not-for-profit hospitals, which are predominantly owned and operated by locally controlled not-for-profit foundations. Hospital budgets are defined on the basis of a formula consisting of a fixed and a variable component. The fixed component is defined by such parameters as patient volume, the number of beds as well as the number of licensed specialists. The variable component, which relates to production, is in contrast calculated on the basis of parameters such as regional agreements, inpatient and daycare patients' days and the number of first-time visits.

Prior to 2008, entry to the hospital market was virtually impossible as the construction of a new hospital required a building permit from the government as well as access to legally guaranteed full reimbursement of capital investment.[70] Moreover, hospitals are not allowed to compensate financiers by paying dividends, which renders entry for private firms highly unattractive. Entry regulation, however, has been slowly relaxed. As of 2008, the building permits are no longer required. As for the opportunity of profit making, law on other admission of health care institutions (*WTZi*) enables the relevant rules to be changed in order to allow for profit health care providers in the future (target date 2012).

69 See Gaynor and Town (2011:63f.).

70 See Schut and Van de Ven (2011).

In addition to hospitals, healthcare is also provided by Independent Treatment Centers (*zelfstandige behandelcentra*), which have been present in the market since 1998. However, such centres can only provide treatments, which do not require an overnight stay.

Remuneration of hospital services

In 2005, a new hospital and medical specialist payment system – the DBC (Diagnosis Treatment Combination) - was introduced to ensure that prices are cost-related. All hospital care services fall into one of the two segments: A – with fixed rates - and Bwhich can be priced freely by the health insurance companies, except for those of specialists and anaesthesiologists for the treatments in that segment, which are set by the NZa, the Dutch Health Authority. [71]

Ensuring the quality of hospitals

In accordance with the 1996 Care Institutions Quality Act hospitals are required to set up their own Quality Management System with a view to improving the quality of the care they provide. While the Act does not require any specific standards to be used, it imposes on hospitals as well as on other care institutions an obligation to publish an annual quality report. Moreover, an increasing number of hospitals implement the quality assurance standards developed by NIAZ (The Netherlands Institute for Accreditation of Hospitals). The Netherlands Health Insurance Association annually publishes a special guide that includes performance indicators for specific DTCs.

Gowrisankaran and Town (2003) follow a similar approach as Kessler and McClellan (2000) but find an opposite effect. Kessler and Geppert (2005) extend this approach to the impact of concentration on differences in quality between groups of patients. They examine outcomes (re-admissions and mortality) and expenditures for heart attack patients but contrast outcomes and expenditures for high- and low-risk patients[72] in highly concentrated and unconcentrated markets. They conclude that competition leads to increased variation in patient expenditures and that this is welfare enhancing since the more intensive treatment that low-risk patients receive in highly concentrated markets results in no statistically different outcomes whereas high-risk patients receive less intense treatment paired with significantly worse outcomes in such markets.

Cooper et al. (2010a) in a study based on UK data, considered whether hospitals facing more competition lowered heart attack death rates more quickly than hospitals in monopoly markets after competition in the form of limited patient choice was introduced into the health system in 2006 (see Box 6). In light of the debate concerning the appropriate empirical measure of hospital competition, the study relies on four different methods for defining hospital service markets and two measures of competition. The study consistently finds that hospitals facing greater competition decrease mortality rates in heart attack cases about a third of a percentage point more quickly than monopoly providers. With a 12percent mortality rate, this difference is substantial. The authors also conjecture that these results are in part driven by demand aspects due to the role GPs play in the UK system. It appears plausible that the expert knowledge and experience gained by GPs renders the importance of quality more salient for hospitals competing for patients.

Cooper et al. (2010b), in another study based on UK data, attempted to explore whether competition would prompt hospitals to become more efficient by measuring patient's length of stay in hospital for an elective hip replacement in terms of two key components: the time a patient waited after admission for the surgery and the time from the surgery to discharge. While the latter relies heavily on the patients characteristics, the former is a direct function of hospital efficiency. The study found that competition

71 Most services fall into segment A and are regulated by government. However, a number of routine services falling into segment B has been steadily increasing. In 2009, around 34 percent of hospital expenditure could have been freely negotiated.

72 Where high-risk patients are defined as patients that were hospitalized with a heart attack in the previous year.

reduces the pre-surgery stay compared to monopoly providers, whereas the post surgery stay was not significantly different, indicating that competition would increase efficiency without reduction in quality.[73] This evidence suggests that hospital competition within fixed price markets can increase efficiency.

In a study entitled "Death by Market Power", Gaynor et al. (2011b) find strong evidence that under a regulated price regime hospitals engage in quality competition. Within two years of the implementation of the 2006 NHS reforms (see Box 6) significant improvements in mortality and reductions in length of stay without changes in total expenditure or increases in expenditure per patient were found. They conclude that if the UK were to pursue policies that lead to de-concentration of hospital markets, the gains could be substantially larger than their estimate of 276 million GBP.

Bijlsma et al. (2010) focus on the relationship between competition and quality in the Dutch hospital sector after healthcare reform (see Box 5). They find that the increased attention to hospital quality and its growing importance in the context of the reform have led to an increased voluntary disclosure of quality indicators by Dutch hospitals. Using panel data on hospitals from 2004 to 2008 including both process (a variable that according to the authors is more easily and directly controlled by hospitals) and outcome indicators of hospital quality, and employing a model that takes the correlation between the disclosure decision and the level of the disclosed information into account, the performance on process indicators but not on outcome indicators could be explained by competition. Their results suggest that competition between hospitals puts pressure on profits margins, forcing hospitals to improve production efficiency. According to Bijlsma et al. (2010:35), "one way to improve production efficiency entails a more intensive use of hospital operation capacity, which probably explains a greater proportion of cancellations (on short notice) and delays of operations in more competitive areas. Furthermore, competition may provide hospitals incentives to improve on quality indicators that can easily be observed by patients and perceived as a signal of quality (such as the time the patient has to wait for a diagnosis and check-up frequency for chronic patients)."

In contrast, although not focussing on process indicators, Mukamel et al. (2001) find no statistically significant impact of concentration as measured by HHI on mortality in their study.

[73] In addition, the reduction in length of stay did also not lead to selection effects, i.e. operations on healthier, wealthier or younger patients.

Box 6. Institutional context of hospital services in the UK[74]

National Health Service (NHS) hospital services in England are funded by the government and are mainly provided by publicly owned, not-for-profit hospitals. NHS hospitals operate subject to a budget constraint and have a statutory obligation to break even. Certain hospitals (so-called Foundation Trusts) can retain a surplus if it is to be reinvested in services for patients. Local government organisations called Primary Care Trusts (PCTs) are responsible for purchasing hospital services based on a fixed budget for their local population. Local and national government organisations play a role in determining the appropriate configuration of hospital services. Successive governments have used various forms in an attempt to increase competition and create incentives for hospitals to improve quality.

Reforms since 2002 focused on the role of patient choice in driving hospital competition. From 2006, patients in England have been offered a constrained choice of hospital and since 2008 they have had the right to choose any hospital with a contract to provide NHS-funded services and prepared to accept the fixed government price for that treatment. The choice of which hospital to attend for treatment is supposed to be made by the patient with the support and advice of their general practitioner (GP). Using the webpage Choose and Book, the GP can show the patient the set of hospitals available to them.[75]

Hospitals are reimbursed at a fixed price per period of care, per patient for groups of clinically similar treatments that use common levels of healthcare resources. Minimum standards of quality of care are regulated by the Care Quality Commission (CQC), a government body that also rates the clinical and financial quality of hospitals.[76] The government, via the CQC and local purchasing organisations, sets targets for minimum quality of care including minimum waiting times and MRSA[77] infection rates.

Tay (2003) examines the effect of a range of aspects on the probability of a patient being admitted to a particular hospital. The aspects considered include distance, quality measures (mortality and complication rate), a measure for input intensity (nurses per bed) and a measure of sophistication in cardiac services (whether the hospital can perform catherization or revascularization). She finds that hospital demand is negatively affected by patient distance and positively by quality. Furthermore she does some comparative statics by simulating the effect of introducing either a catherization or a revascularization treatment or increasing the nurse per bed ratio. All these introductions result in substantial increases in demand for the hospital. The comparative static nature of the exercise is, however, an important constraint on these findings as becomes clear when considering the predicted effects in case all hospitals in the region adopt all treatments. Obviously aggregate demand for hospital services, even if largely supplier induced, is likely to remain unaffected by all these individual "business-stealing" measures rendering the predictions off-equilibrium.[78]

74 The box draws heavily on Beckert et al. (2012). See also Sussex (2009) and Dixon and Propper (2011), who provide good overviews. See also Commonwealth Fund (2010) a publication containing short descriptions of the health systems in the US, Germany, Canada, Australia, Switzerland, the Netherlands, the UK, France, Denmark, Italy, Norway, Sweden and Switzerland.

75 http://www.chooseandbook.nhs.uk/

76 Ratings are publicly available and can be accessed at www.cqc.org.uk.

77 Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is especially troublesome in hospitals and nursing homes, where patients with open wounds, invasive devices, and weakened immune systems are at greater risk of infection than the general public

78 This is also noted by Gaynor and Town (2011:68) who state that effects could potentially even be zero. See also Schmidt-Dengler (2006) who for magnetic resonance imaging (MRI) devices in the US finds substantial demand effects that are traced back to business stealing effects in the adoption of the technology.

Quality improvements may, however, be due to other factors than increased competition as demonstrated by Propper et al. (2010). In their study, the authors analyse the effects of performance target instruments concerning waiting time. The paper exploits a natural policy experiment between England and Scotland in the UK. To establish the effectiveness of such targets, the authors considered waiting times and found that introducing a target led to a reduction in waiting time without diverting activity from other less well monitored aspects of health services and without negative impact on patient health on discharge.

4.2. Studies on hospital market concentration

As the results of studies analysing the impact of competition on quality when both quality and prices are a choice variable for the hospital are ambiguous, this section will rather focus on a more general discussion of the impact of concentration on price, quality and operating costs. The discussion starts with a description of the international consolidation trend in the hospital sector. The analysis focuses on the US as most of the studies are conducted based on US data.

For the US and in the time period spanning from 1990 to 2003, Town et al (2006) find that "the aggregate magnitude of the impact of hospital mergers is modest but not trivial. In 2001, average HMO premiums are estimated to be 3.2percent higher than they would have been absent any hospital merger activity during the 1990s."

Capps (2009:7) writes that although US Courts appear to have been in favour of rather wide market definitions for hospital mergers in the 1990s, evidence indicates that hospitals generally "compete locally and that hospital mergers – even those that have very small effects on metropolitan statistical area (MSA)-level or multicounty HHI's- can lead to large price increases".[79] As has been pointed out in the literature it would be desirable to define markets based on patient flow between facilities instead of larger and more arbitrary classifications such as MSA's, nevertheless, even such studies result in average price increases of roughly 5percent for an increase in HHI of 800 points.[80] Capps (2009:8) suggests that over "the 15 years spanning 1993-2008, antitrust policy likely had little restraining effect on hospital mergers" as the FTC and DOJ lost six consecutive hospital merger challenges and the State of California the 7th in 2001 resulting in a decade where "neither the FTC nor the DOJ challenged a prospective hospital merger in court"[81].

Figure 4 below is an indication of the concentration trend as most markets were highly concentrated in 2006 in contrast to 1990. It also demonstrates that the average results are not due to outliers but that the concentration trend is a general and broad phenomenon.

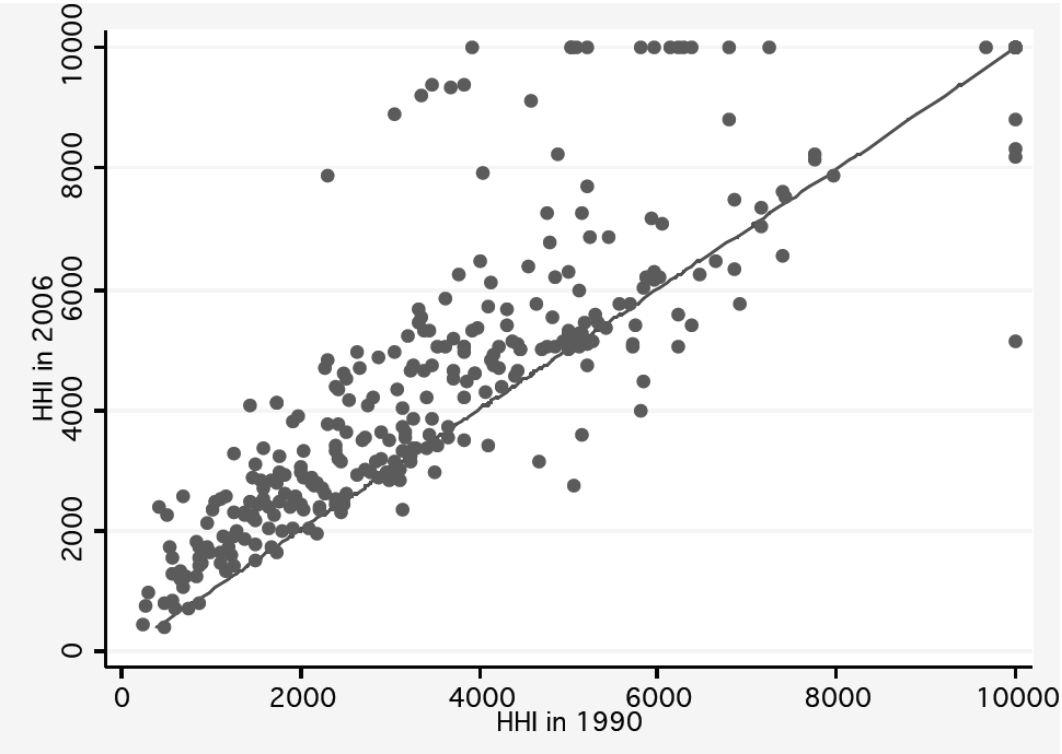
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79 His view is also shared by Vogt and Town (2006) who explicitly state that hospital markets appear to be narrower than suggested by US courts. See also Varkevisser and Schut (2009) who argue that it is better for authorities to be too restrictive due to the serious anticompetitive effects and the particular difficulties of post merger enforcement in this sector.

80 See Vogt and Town (2006).

81 See Capps (2009:8). This trend seems to have halted in 2008 with the INOVA/ Prince William Hospital Merger. According to Gaynor and Town (2011:46) "the FTC has been more aggressive in challenging hospital mergers".

Figure 4: Scatterplot of HHI values in 1990 and 2006 for US hospital markets[82]



This trend in hospital consolidation is not confined to the US or to systems with market-based pricing but can be found, among other countries, also in Germany, the Netherlands and the UK.[83] In all these countries this trend has been explained by pricing pressure and the need to exploit cost advantages although the empirical evidence for example for the US is mixed. The argument advanced in the US is that the rise of HMO's introduced aggressive price negotiations with hospitals that were subsequently forced to consolidate in order to increase their bargaining power but possibly also to become more efficient, with smaller hospitals failing. This is for example suggested by the empirical study conducted by Fuchs (2007) although Town et al. (2007) find no significant correlation between hospital market structure and HMO penetration.[84]

There is, however, an important difference between the situation in the US and in the other countries mentioned. To the extent that prices for hospital services are administrated, to name only one important institutional difference between systems, the impact of higher concentration is likely to be different.

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82 The Figure is taken from Town and Gaynor (2011:130). Note that markets are based on Metropolitan Statistical Areas (MSA) and may therefore not correspond to actual markets in an antitrust sense.

83 In Germany this has for instance triggered a debate as to whether the notification threshold for the Federal Cartel Office should be calculated differently in order to allow antitrust scrutiny of those hospital mergers that otherwise would fall through the filter. In particular the German monopolies commission (Monopolkommission) suggested to multiply the turnover in the hospital sector by 3 and use the resulting figure in determining whether a merger should be notified to and scrutinized by the competition authority. See Monopolkommission (2008).

84 According to Gaynor and Town (2011), Town and Park (2011), however, provide some support for the hypothesis that it was less the actual entry of HMOs as the anticipated future importance of HMOs. They identify a significant negative relationship between HMO exit and hospital consolidation.

4.2.1. Effects of concentrated markets on price

US hospital markets are highly concentrated and have become so relatively recently and mostly through mergers and acquisitions.[85] According to Gaynor and Town (2011) the average HHI in US hospital markets was 2340 in 1987 but increased by over 900 points to an HHI of 3161 in 2006.[86] Gaynor and Town (2011:34) distinguishing between studies using aggregated measures of price and those using insurer claims data, find price increases (or faster increasing prices relative to trend) relative to the control group in all merger studies they review except in one that they dismiss as using relatively poor measures of price and costs.

According to the review of studies conducted by Vogt and Town (2006), the hospital consolidation wave in the "1990s raised prices by at least 5percent and likely by significantly more". Their review of the empirical literature distinguishes between estimates derived from three different methods: event studies,[87] SCP based studies and simulations. The consolidation specific simulation results are the most striking with estimates of as much as 53percent. Event studies estimate price increase effects of between 10-40percent[88] and SCP approaches yield the lowest price increase predictions ranging between 4 to 5percent.

Analysis for hospital mergers in the US between 1993 and 1999 indicates that hospital consolidation has increased total national healthcare expenditures by roughly $10-$12 billion annually or roughly 0.5percent.[89]

These effects are largely confirmed by studies focusing on the effects of individual hospital mergers. Tenn (2011) in an analysis of a single US hospital merger finds price increases between 28 and 44percent. Similar effects are also found by Kemp and Severijnen (2011) for hip replacement costs after two mergers in the Netherlands. Akosa Antwi et al. (2009) consider hospital prices in California in the period from 1999 to 2006 and find a 100percent price increase in this period although concentration was not found to be a significant factor.[90]

With respect to the hope that market power effects are mitigated in case of not-for-profit hospitals, Capps et al. (2010b) find no evidence that not-for-profit hospitals offer more charitable services in response to an increase in market power than for-profit hospitals based on a 7 year sample of hospital data in California.[91]

4.2.2. Effects of concentrated markets on quality

In their review of 10 studies that directly analyse the effect of consolidation on the quality of hospital services, Vogt and Town (2006:8) find that on balance, "the evidence suggests that increasing hospital concentration lowers quality. The authors do, however, caution by pointing out the sensitivity of the results to the type of methodology applied and geographic zone analysed. As noted previously it is extremely

85 See Town et al. (2006).

86 The FTC and the DoJ consider a market "highly concentrated" if its HHI is equal to or above 2500.

87 Event studies are based on a comparison of relevant data taken from before and after a particular event such as a merger or change in regulatory framework conditions.

88 The 40percent estimate goes back to Dafny (2005)

89 See Capps (2009) and Town et al. (2006).

90 See also Martin et al. (2011).

91 Several other studies on possible differences between for-profit and not-for-profit hospitals under a largely non-fixed price regime are discussed in Gaynor and Town (2011:42).

difficult to draw conclusions on the effects of market concentration on quality when prices are also a choice variable. Similarly Maeda and LoSasso (2011) only find marginal incremental benefits of lower HHI values to inpatient heart-failure care, concluding that "market competition might be a blunt instrument and it may not be the most suitable policy tool to drive hospital quality-improvement effects".[92]

Generally speaking there seems to be little evidence that mergers in price regulated hospital systems improve quality. An analysis of hospital mergers in the UK between 1997 and 2006, for example, puts in question whether mergers in publicly funded and regulated markets deliver better patient outcomes.[93]

4.2.3. Effects of concentrated markets on costs

There are many reasons why mergers may result in cost reductions for the newly created entity not least among which cost reduction due to increases in buyer power and economies of scale as well as cost reductions due to knowledge transfer and the consolidation of services. Even when such reductions arise, reductions in the costs of hospital services are not identical with reductions in the prices paid by insurers or patients.

Reductions in cost through merger may come in two general forms, ownership consolidation and facilities consolidation. While a pure consolidation of ownership produces no effects on hospital costs according to the review conducted by Vogt and Town (2006:10), the actual consolidation of facilities tends to lower costs. Dranove and Lindrooth (2003), for example, match merging hospitals with hospitals that share the main characteristics and distinguish between single license mergers, where the two hospitals give up one license and where the merging hospitals continue to operate under two licenses. Of the 122 mergers they study between 1989 and 1996, 81 combined licenses and resulted in a significant and substantial (14percent) reduction in hospital operating costs whereas the others did not lead to significant cost reductions.

Research on for-profit hospital mergers suggests that most mergers yield modest cost savings,[94] have no or a negative effect on quality[95] and to the extent that they lessen price competition do have substantial price effects.[96]

Bloom et al. (2010), for example, provide some evidence emphasizing the importance of management autonomy. They find that better managed hospitals are not only more cost-effective but also provide better

92 See Maeda and LoSasso (2011:821). The analysis is based on HHI values of hospital referral regions and self-reported hospital performance data in the US from 2003 to 2006.

93 See Beckert et al. (2012) and Gaynor et al. (2011a). There is a host of literature on mergers in for-profit hospital markets in the US. See for example the retroactive studies by Haas-Wilson and Garmon (2011) and Haas-Wilson and Vita (2011) and the simulation work by Capps et al. (2001). Beckert et al. (2012) also provide a method for conducting merger simulation by looking at demand before and after the merger following Capps et al. (2001). Less elastic demand post merger suggests a limited competitive pressure from other hospitals making room for unilateral quality reductions.

94 See Vogt and Town (2006) suggesting that the balance of evidence indicates that hospital consolidation produces cost savings and that these cost savings can be significant when hospitals consolidate their services fully.

95 See Vogt and Town (2006) finding 5 studies indicating reductions in quality for some procedures, four with quality improvements in some procedures and three with no effect out of a total of 10 studies reviewed.

96 See for example Capps et al. (2003) and the studies listed in Vogt and Town (2006).

outcomes for patients. As competition would tend to benefit well managed hospitals, the study shows that it may not be problematic to let less well managed hospitals be driven out of the market (see Box 7).

Box 7. Hospital failures

The displacement of inefficient firms is a normal process in competitive markets. Allowing inefficient firms to fail is the flip-side of allowing efficient firms to succeed and allowing this process to work is considered essential in harvesting the benefits of competition. In fact, in most markets the decline and failure of inefficient firms is the main source of productivity gains. Facilitating the exit of inefficient firms from the market has even been considered a beneficial by-product of economic crises.[97]

That hospital closure may be a good thing for patients is argued by Capps et al. (2010a) who find that the loss in consumer welfare is more than compensated by the savings of hospital closure in the five hospital closures in Arizona and Florida they considered. Similarly, Lindrooth et al. (2003) examine the impact of hospital closure on the average cost of hospital care in the market. They find that the hospitals that close are less efficient and that closure reduces service cost by 2-4percent overall and up to 8percent on average for the former patients of the closed hospital.

These findings are, however, not confirmed by Buchmueller et al. (2006) who argue that hospital closures in California did have negative effects on the surrounding population in terms of health outcomes, a result mainly driven by the fact that hospital distance is crucial for emergency care.

As argued in the section "Competition as an Instrument", whether competitive outcomes are considered appropriate or not crucially hinges on the framework within which competition takes place. It therefore seems crucial to design an appropriate framework – one that establishes safety and quality standards and helps policy makers and hospital managers to make informed decisions on whether the services they are providing are being delivered prudently. With such a framework in place, it is important for health systems and decision makers to allow for hospital failures. This can help ensure that patients receive services in safe and appropriate facilities and also that (public) funding is being directed to its most efficient use to improve population-wide health outcomes.

4.3. Studies on effects of intermediaries

The health insurance choice of a patient is typically made prior to the hospital choice and actual treatment. This is the reason that hospital services markets are considered to be option demand markets. As some insurance companies constrain the hospital or treatment choices of patients and as even those that do not, determine the price to be paid for insurance, an analysis of hospital markets requires the study of intermediaries. In particular the question of whether insurance markets are competitive or not has a direct bearing on insurance cost and therefore ultimately also hospital services. The same applies to HMOs and other intermediaries.

4.3.1. Empirical studies on demand elasticity of intermediaries

The effect of insurance companies, HMOs or PPOs (see Box 8) predicted by theory is that they increase the price elasticity of demand facing hospitals. This increased price elasticity is likely to lead to quality reductions in particular in less concentrated markets. Shen (2003), for example, finds a significant negative relationship between changes in administered prices and mortality and a significant positive effect between HMO penetration and mortality. Mukamel et al. (2001), however, find that HMO penetration is associated with lower than predicted risk-adjusted mortality rates.

97 Needless to say that this "cleansing" theory of economic crises is highly controversial.

Box 8. HMOs and PPOs

A health maintenance organization (HMO) is an organization that provides managed care for health insurance contracts in the United States as a liaison with health care providers (hospitals, doctors, etc.). It is common for HMOs to require members to select a primary care physician (PCP), a doctor who acts as a "gatekeeper" to direct access to medical services. With the exception of medical emergency, patients need a referral from the PCP, usually a general practitioner (GP) in order to see a specialist, and the gatekeepers often authorize referrals on the basis of HMO guidelines. "Open access" HMOs do not use gatekeepers - there is no requirement to obtain a referral before seeing a specialist - but may employ beneficiary cost sharing in the form of higher co-payment or coinsurance for specialist care.

A preferred provider organization (PPO) also enters into contractual agreements with health care providers and creates a "provider network." But unlike HMOs, PPO health insurance will cover some – but not all – of the cost of care administered by out-of-network providers. A third type of health plan - known as a point-of-service (POS) plan – offers a combination of PPO health insurance and HMO insurance services. In fact, the "point of service" in the name reflects the fact that you make your choice of whether to use HMO or PPO services each time you see a provider.

Dafny (2010) find an increase in the concentration of insurance markets in the US. This trend is confirmed by Dafny et al. (2011b) who report an increase in the mean HHI in their sample consisting of the large employer segment of the insurance market, from an HHI of 2286 in 1998 to an HHI of 2984 in 2006. CR4 increased to 90percent and the average number of insurance companies declined to 9.6 from a previous 18.9.[98]

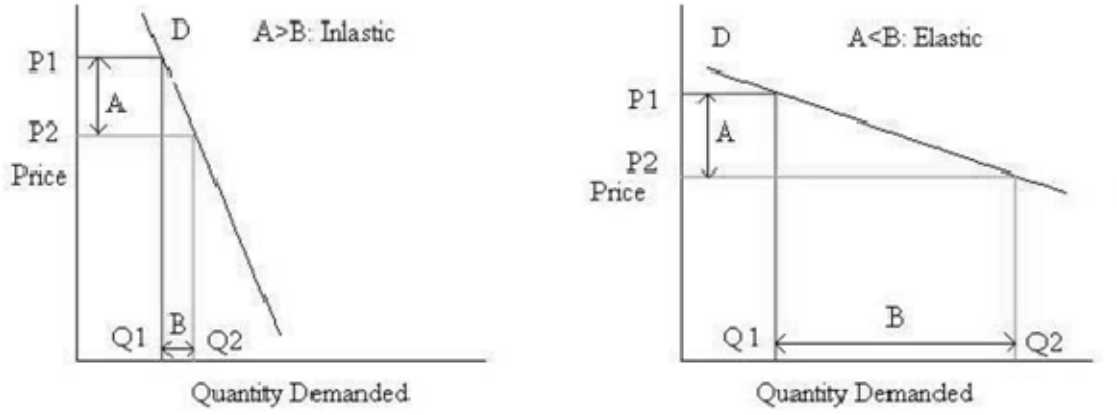
If insurance firms face a high absolute price elasticity of their residual demand, the industry is competitive as there is not much mark-up potential given the substantial quantity effect such an elastic residual demand would trigger.[99] In fact the residual demand that a firm faces in a perfectly competitive industry is perfectly elastic with an absolute elasticity of infinity implying that any price increase results in all sales being lost. The reverse is true, as is commonly known through the Lerner index that exploits that property, for less elastic or inelastic residual demand that is indicative of market power.[100] Figure 5 provides an intuitive presentation of demand functions exhibiting different elasticities.

98 See the summary contained in Gaynor and Town (2011) for further references.

99 This is actually the reason that collusion is considered to be less stable in markets where firms face elastic demand: there are huge benefits of deviating from the collusive outcome as the higher the price elasticity, the more sensitive consumers are to price changes.

100 There is the potential additional complication that it is theoretically not clear why a firm would ever want to operate on the inelastic portion of its residual demand curve.

Figure 5: Example of relatively inelastic and relatively elastic demand curves[101]



In a study on the Netherlands, van Dijk et al. (2008) use administrative data to estimate the absolute price elasticity[102] of the residual demand of an insurance firm to range between 0.1 and 0.38, implying very limited competition between insurance companies in the Netherlands as a 1percent increase in price only leads to a 0.1 to 0.38 decrease in demand.

Schut et al. (2003) estimate individual demand elasticities for Germany (3.45) and the Netherlands (0.41). Tamm et al. (2007) estimate a short run price elasticity of 0.5 and a long run elasticity of 12 for Germany. Based on the Lerner index, this implies that there is still an 8.4 percent mark-up over marginal cost in the long run and much more substantial mark-ups in the short run in Germany and in the Netherlands.[103]

4.3.2. Buyer power of intermediaries

Another aspect of relevance is the potential buyer power of insurance companies, HMOs or other intermediaries.

When hospitals negotiate prices with intermediaries with buyer power (up to monopsonist) hospitals face what in the bargaining literature is considered a large discrepancy between agreement and disagreement outcomes.

It is therefore not surprising that Shen et al. (2010) find that hospital revenue is significantly lower in markets with high HMO penetration and low hospital concentration. Similarly, Moriya et al. (2010) find

101 Note that elasticity being a percentage based concept varies along the line of every individual demand function. As a unit price change based on a high price results in a lower percentage change, demand curves are more elastic at the top and become less elastic approaching the x-axis where percentage price changes are relatively large.

102 Elasticity is almost always negative, as demand curves slope downwards, but usually expressed in terms of absolute value (i.e. as positive numbers) since the negative can be assumed. If the elasticity is greater than 1 demand is said to be elastic; between zero and one demand is inelastic and if it equals one, demand is unit-elastic. A perfectly elastic demand curve is horizontal (an elasticity of infinity) whereas a perfectly inelastic demand curve is vertical (an elasticity of 0).

103 The Lerner Index is given by $\frac{1}{\varepsilon}$ where ε denotes elasticity. For an elasticity of 12 is $\frac{1}{12}$ = 0.084 implying a cost mark-up of 8.4percent.

that increases in insurance market concentration are significantly associated with decreases in hospital prices, whereas increases in hospital concentration do not imply significant effects on insurance prices. A hypothetical merger between equal sized insurers from 5 to 4 is estimated to have a disciplining decreasing effect of 6.7 percent on hospital prices. These results are, however, not replicated by the study from Schneider et al. (2008a) who found no significant impact of insurance market concentration on physician prices in contrast to significant price effects of physician market concentration on physician prices.

4.4. Summary of stylized facts

The empirical literature investigating the relationship between competition and various outcome variables such as price and quality has grown rapidly in the last ten years and begun to help establish the foundations for a broader basis for efficient market structures in health care.

Based on the results of merger and concentration studies reviewed here it seems reasonable to conclude that hospital market concentration is to be avoided when prices are not administered. The often substantial price effects due to increases in market power leave one wondering as to the effects of market power on quality when prices are not a choice variable for hospitals. In any case, the literature considering the effects of competition on quality under regulated prices seems to confirm the important role competitive processes can play. In particular, increased demand driven competition seems to entail positive outcomes on both, quality but also efficiency. Of interest is certainly also the literature on public/private and in particular for-profit and not-for-profit hospitals that broadly suggests that the structure within which these hospitals operate is more important than their management structure or ownership.

These stylised facts present an academic perspective on market design and the nature and operation of incentives and market structures on the delivery of hospital services. With health policy and health services researchers undertaking considerable work on measuring quality and efficiency in hospitals, in time, a further convergence in these two bodies of work could help inform more explicit policy recommendations on how best to design hospital markets that can harness competition to deliver socially beneficial outcomes.

5. Conclusion

This paper analysed the policy question of when and how competitive mechanisms could fruitfully be introduced into the hospital services sector. The starting point was to establish an unambiguous notion of competition itself, in order to overcome the often differing interpretations in the spheres of health policy and among competition law practitioners. On the surface these views appear incommensurate but can be reconciled by distinguishing between competitive *processes* and *outcomes* of competitive processes. Whereas functioning competitive processes are a guarantee for efficiency, they are not a guarantee for desirable outcomes. With such a distinction the question of introducing competitive processes is a quest for appropriate regulatory conditions that may reduce or eliminate competition in certain instances and introduce or expand competition in others.

The theoretical literature on competition in hospital services in particular with respect to the research considering quality competition under administered prices suggests that introducing competition on quality is beneficial but will of course accentuate the role of the administered price. Quality will depend on the administered price and in particular the effective price relative to marginal cost will be a key to appropriate outcomes. When both prices and quality are variables of choice for hospitals, the guidance of the theoretical literature is limited as it is not possible to discriminate between results. The prediction then largely depends on the respective price and quality elasticity of demand.

The empirical literature reviewed here mainly focused on findings in circumstances where prices were administered, reflecting what is increasingly becoming the norm across OECD Health Systems. Outcomes were mixed, but tend to reinforce theoretical work that competitive processes, if introduced carefully, can improve outcomes and in particular quality of hospital services. While this paper has not put an emphasis on the review of empirical studies of effects of competition in instances where prices and quality are market based, the results again mirror the theoretical work in providing ambiguous findings. As should be no surprise for competition practitioners, competition is found to generally reduce prices whereas effects on quality are mixed.

The empirical and theoretical research together therefore points to the specific circumstances under which competition takes place as a key element in determining whether it is considered (socially) beneficial or not. The rather crude finding that excluding competition on price fosters beneficial competition on quality is proof of the need to consider carefully in what circumstances and on what variables competition should be introduced and when it should be excluded. This requires a detailed, country specific analysis that can, however, draw on international best practice and the discussion summarized here.

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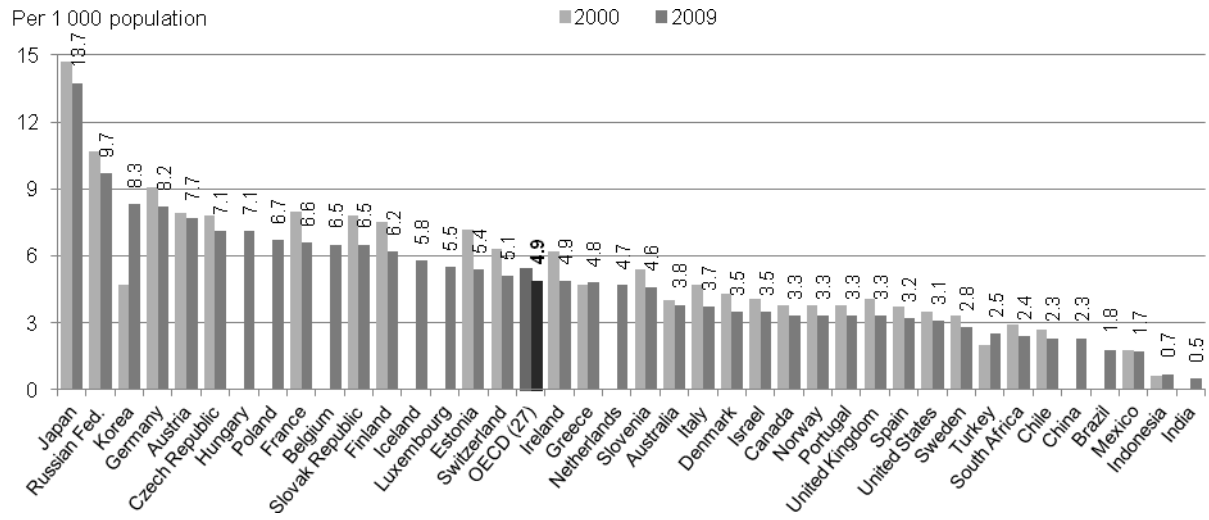
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ANNEX I: CHARACTERISTICS OF THE HOSPITAL SECTOR

1. Hospital beds

The number of hospital beds provides a measure of the resources available for delivering services to inpatients in hospitals. The following figures present data on the total number of hospital beds, how they are allocated across curative (acute), psychiatric, long-term and other types of care. An indicator of bed occupancy rates focuses on curative care beds.

Figure - Hospital beds per 1 000 population, 2000 and 2009 (or nearest year)

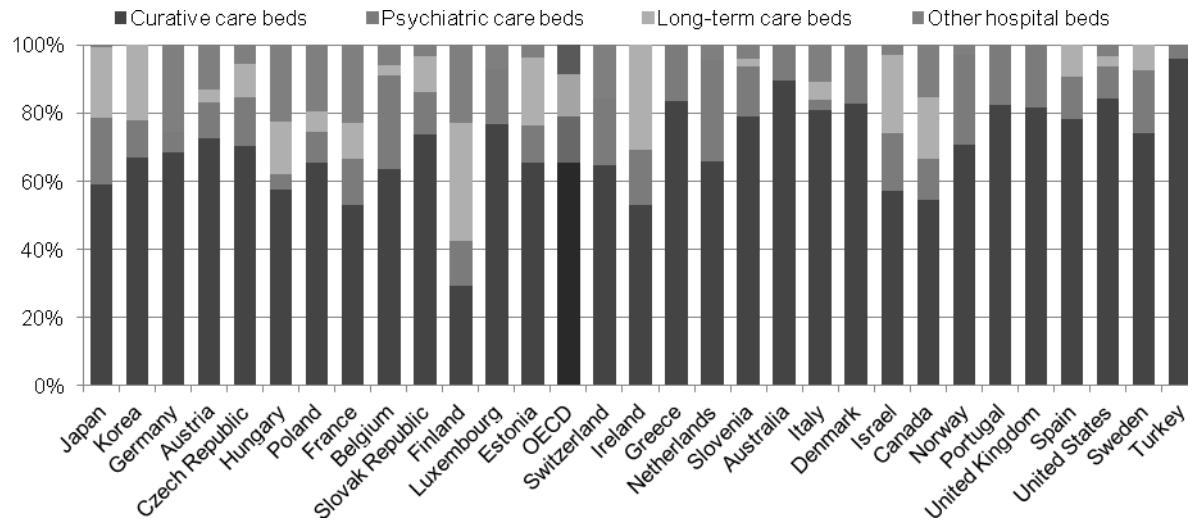


Source: OECD Health Data 2011; national sources for non-OECD countries.

Among OECD countries, the number of hospital beds per capita is the highest in Japan and Korea, with over eight beds per 1 000 population in 2009. Both Japan and Korea have "social admissions", that is, a significant part of hospital beds are devoted to long-term care. The number of hospital beds is also well above the OECD average in the Russian Federation, Germany and Austria. On the other hand, large emerging countries in Asia (India, Indonesia and China) have relatively few hospital beds compared with the OECD average. This is also the case for OECD and emerging countries in Central and South America (Mexico, Brazil and Chile). The number of hospital beds per capita has decreased at least slightly over the past decade in most OECD countries, falling from 5.4 per 1 000 population in 2000 to 4.9 in 2009.

This reduction has been driven partly by progress in medical technology which has enabled a move to day surgery and a reduced need for hospitalization. The reduction in hospital beds has been accompanied in many countries by a reduction in hospital discharges and the average length of stay. Only in Korea, Greece and Turkey has the number of hospital beds per capita grown between 2000 and 2009.

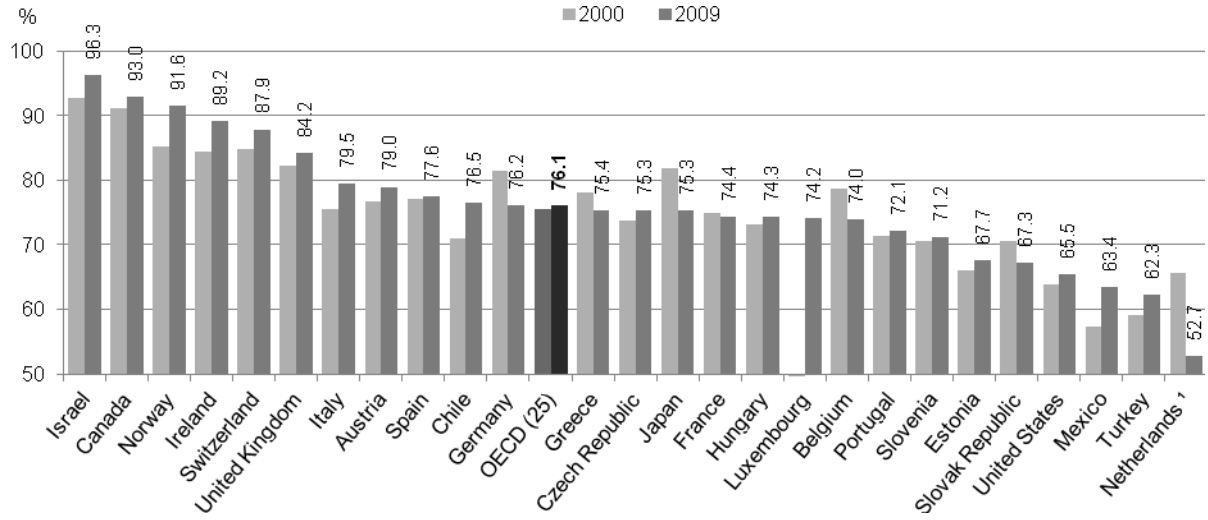
Figure - Hospital beds by function of health care, 2009 (or nearest year)



Source: OECD Health Data 2011.

On average, two-thirds of hospital beds are allocated for curative care across OECD countries. The rest of the beds are allocated for psychiatric (14percent), long-term (12percent) and other types of care (8percent). In some countries, the share of beds allocated for psychiatric care and long-term care is much greater than the average. In Finland, a greater number of hospital beds is in fact allocated for long-term care than for curative care, because local governments (municipalities) use some beds in health care centres (which are defined as hospitals) for at least some of the institution-based long-term care. In Ireland, just over half of hospital beds are allocated for acute care, while 30percent are devoted to long-term care.

Figure - Occupancy rate of curative (acute) care beds, 2000 and 2009 (or nearest year)



Source: OECD Health Data 2011.

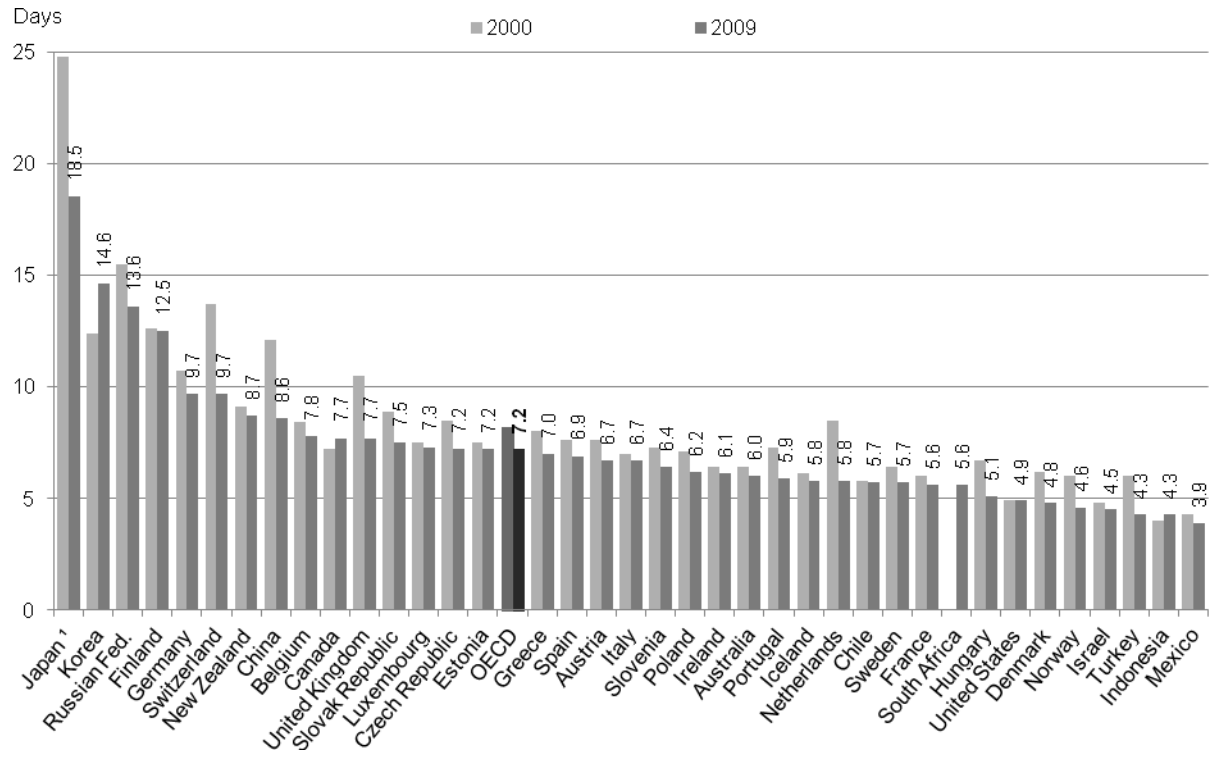
In several countries, the reduction in the number of hospital beds has been accompanied by an increase in their occupancy rates. The occupancy rate of curative (acute) care beds stood at 76 percent on

average across OECD countries in 2009, slightly above the 2000 level. Israel, Canada, Norway, Ireland, Switzerland, and the United Kingdom had the highest occupancy rates in 2009. All of these countries have fewer curative care beds than most other OECD countries. On the other hand, the Netherlands, Turkey and Mexico have the lowest occupancy rates, although the occupancy rate has increased over the past decade in Turkey and Mexico. In the Netherlands, the low occupancy rates can be explained at least partly by the fact that hospital beds include all administratively approved beds and not only those available for immediate use.

2. Average length of stays

The average length of stay in hospitals (ALOS) is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. However, shorter stays tend to be more service intensive and more costly per day. Too short a length of stay could also cause adverse effects on health outcomes, or reduce the comfort and recovery of the patient. If this leads to a greater readmission rate, costs per episode of illness may fall only slightly, or even rise.

Figure - Average length of stay in hospital for all causes, 2000 and 2009 (or nearest year)



Source: OECD Health Data 2011; WHO-Europe for the Russian Federation and national sources for other non-OECD countries.

In 2009, the average length of stay in hospitals for all causes among OECD countries was the lowest in Mexico, Turkey and Israel. It was also low in Norway and Denmark, as well as in the United States, all at less than five days. The average length of stay was highest in Japan, followed by Korea. The OECD average was about 7 days.

Several factors can explain these cross-country differences. The abundant supply of beds and the structure of hospital payments in Japan provide hospitals with incentives to keep patients longer. Financial incentives inherent in hospital payment methods can also influence length of stay in other countries. The average length of stay in hospitals has fallen over the past decade in nearly all OECD countries – from 8.2 days in 2000 to 7.2 days in 2009 on average across OECD countries. It fell particularly quickly in some of the countries that had relatively high levels in 2000 (e.g. Japan, Switzerland and the United Kingdom). Several factors explain this decline, including the use of less invasive surgical procedures, changes in hospital payment methods, and the expansion of early discharge programmes which enable patients to return to their home to receive follow-up care.

ANNEX II: INFORMATION ON PROVIDER SERVICES

The availability of information on quality and prices for users or purchasers has the potential to enhance the basis for consumer choices in their choice of hospital, and drive competition amongst hospitals. Studies suggest that information on quality is seldom used by consumers but nevertheless impacts the quality of care and has the power to influence providers' performances (see Canadian Health Services Research Foundation, 2006 for a review). The extent of consumer information on prices and quality of hospital services varies dramatically across OECD countries, this section provides a high level overview of which countries publish information and the kinds of information they make available.

1. Information on prices

In the vast majority of OECD countries, health services are free of charge for patients or have uniform prices (and copayments) set at the national level (as detailed in the table below). In both of these circumstances, information on prices is not really needed by or useful to users.

Information on prices of providers' services

Country	Q45a. May prices differ prices across providers?	Q45b. Information on prices of physicians' consultations	Q45c. Information on prices of medical exams
Australia	Prices may differ	No information	No information
Austria	No price or unique price	-	-
Belgium	Prices may differ	Readily available	No information
Canada	No price or unique price	-	-
Czech Republic	No price or unique price	-	-
Denmark	No price or unique price	-	-
Finland	No price or unique price	-	-
France	Prices may differ	Readily available	Readily available
Germany	No price or unique price		
Greece	Prices may differ	Readily available	Readily available
Hungary	n.a.	n.a.	n.a.
Iceland	No price or unique price	-	-
Ireland	Prices may differ	No information	No information
Italy	No price or unique price	-	-
Japan	No price or unique price	-	-
Korea	No price or unique price	-	-
Luxembourg	No price or unique price	-	-
Mexico	No price or unique price(1)	-	-
Netherlands	Prices may differ(2)	No information	No information
New Zealand	Prices may differ	Readily available	No information
Norway	No price or unique price	-	-
Poland	No price or unique price	-	-
Portugal	No price or unique price	-	-
Slovak Republic	Prices may differ	Readily available	Readily available
Spain	No price or unique price	-	-
Sweden	No price or unique price	-	-
Switzerland	No price or unique price	-	-
Turkey	Prices may differ	Readily available	No information
United Kingdom	No price or unique price	-	-

Note : (1) In Mexico, prices may differ for services which are not covered by voluntary or compulsory health insurance ;
(2) In the Netherlands, prices may differ but only for the so-called B-segment which accounts for 34% of all DRGs.
n.a. means Not Available; "-"Not Applicable.

Source: OECD Survey on health system characteristics 2008-2009

In other countries, prices may differ across providers. This is the case for instance in Belgium, where information on prices is readily available for doctors consultations but not for medical procedures.

France, Greece and the Slovak Republic reported that information on prices is readily available for both types of services (consultations and procedures). In France, the national insurance fund for salaried workers (CNAMTS) publishes on its website the average price of current medical procedures for individual doctors. The situation of Greece is more complicated since informal payments are frequent.

In Australia, whilst the Medical Benefits Schedule (MBS) fee and the patient rebates are publicly available, the actual fee that the practitioner charges for the services may be more difficult to obtain. Under the Australian Constitution, the Australian Government cannot control the price that practitioners can

charge for their services. Patients are required to do their own research regarding the fees that are charged by individual practitioners.

2. Information on quality

Seventeen OECD countries provided details regarding available information on the quality of hospital services (see Table below). In Denmark, Germany, New Zealand, Norway, the Slovak Republic and the United Kingdom, four types of information are available: clinical outcomes, appropriate processes, patient satisfaction and patient experience. This information is published by the government in Denmark, New Zealand, and Norway; by the government and health insurers in the Slovak Republic; and by the government and "other NGOs" in the United Kingdom. In Germany, insurers, media and other NGOs publish such information.

In Belgium, France, Ireland, Korea, Mexico and Switzerland, published information is limited to clinical matters (outcomes measures and/or processes of care). The information is published by the government in Ireland and Mexico, by the government and insurers in Belgium, by insurers and NGOs in Korea, by the government and NGOs in Switzerland. In France, the government publishes information on the use of appropriate processes in terms of safety, as well as information about the equipment and volume of activity performed in each hospital. The media publishes hospital rankings based on different indicators of performance (including attractiveness, use of advanced technologies and degree of specialisation, etc.[17]).

In Hungary and the Netherlands, the focus is on patient satisfaction and experience. Information is ublished by insurers and media in Hungary, while in the Netherlands, the government, insurers and NGOs release this information.

In Australia, different levels of government publish information on clinical outcomes and processes, as well as information on patient experience. Some state governments publish information in a form that facilitates comparisons across providers. In the Czech Republic, insurers, the media and NGOs publish information on clinical outcomes and patient satisfaction.

		About hospitals							
Country	**Q46. Is there any comparable information published on the quality of services supplied by individuals providers?**	**Data on clinical outcomes**	**Data on the use of appropriate processes**	**Data on patient satisfaction**	**Data on patient experiences**	**Is the information in a form that facilitates cross-provider comparisons?**	**Who develops and/or publishes such information:**	**Is there evidence that such information is used by prospective patients in selecting providers?**	**Is there evidence that such information is used by providers in informing referrals?**
Australia	yes	X	X	X	X	yes	Government[(1)]	n.a.	n.a.
Austria	no								
Belgium	yes	X				yes	Government, Insurers	n.a.	n.a.
Canada	no								
Czech Republic	yes	X		X		yes	Insurers, Media, other NGOs	n.a.	n.a.
Denmark	yes	X	X	X	X	yes	Government	no	yes
Finland	no								
France	yes		X			yes	Government, Media		
Germany	yes	X	X	X	X	yes	Insurers, Media, other NGOs	no	no
Greece	no								
Hungary	yes			X	X	n.a.	Insurers, Media	n.a.	n.a.
Iceland	no								
Ireland	yes		X			no	Government	no	yes
Italy	no								
Japan	no								
Korea	yes	X	X			no	Insurers, other NGOs	n.a.	n.a.
Luxembourg	no								
Mexico	no	X				no	Government	no	no
Netherlands	yes	X	X	X	X	yes	Government, Insurers, other NGOs (*)	n.a.	n.a.

	About hospitals

Country	Q46. Is there any comparable information published on the quality of services supplied by individuals providers?	Data on clinical outcomes	Data on the use of appropriate processes	Data on patient satisfaction	Data on patient experiences	Is the information in a form that facilitates cross-provider comparisons?	Who develops and/or publishes such information:	Is there evidence that such information is used by prospective patients in selecting providers?	Is there evidence that such information is used by providers in informing referrals?
Norway	yes	X	X	X	X	yes	Government	n.a.	n.a.
Poland	no								
Portugal	no								
Slovak Republic	yes	X	X	X	X	yes	Government, Insurers	n.a.	n.a.
Spain	no								
Sweden	no								
Switzerland	yes	X	X			yes	Government, other NGOs	n.a.	n.a.
Turkey	no								
United Kingdom	yes	X	X	X	X	yes	Government, other NGOs	n.a.	n.a.

Note: n.a. means Not Available.

LA CONCURRENCE DANS LES SERVICES HOSPITALIERS – DIMENSION POLITIQUE

par le Secrétariat[*]

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[*] Le présent document a été préparé par Frank Maier-Rigaud de la Division de la concurrence. Les deux annexes, la section 3.2.2 et la première partie de la section 3.2.3 ont été préparées par Ankit Kumar, de la Division de la santé. Les encadrés sur l'Italie, les Pays-Bas et la Pologne ainsi que la deuxième partie de la section 3.2.3 ont été préparés par Anna Pisarkiewicz, de la Division de la concurrence.

1. Introduction

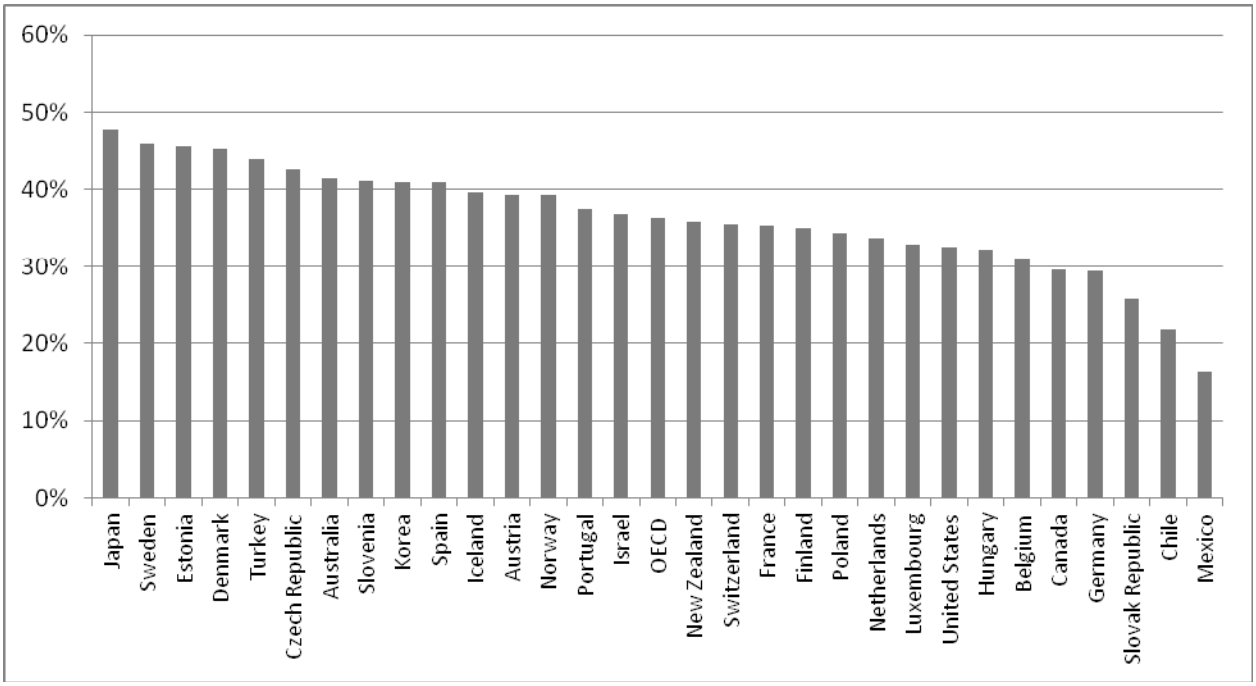
Le présent document décrit les possibilités d'instauration et de renforcement de la concurrence dans le secteur des services hospitaliers, et analyse les études relatives à la concurrence sur les marchés hospitaliers intéressant directement la conception des systèmes de santé. Bien que ces derniers doivent généralement être considérés en termes d'objectifs généraux, le présent document se concentre sur les possibilités de mise en œuvre des processus concurrentiels dans la prestation de services hospitaliers, et notamment les traitements aigus en milieu hospitalier, l'objectif étant d'améliorer les résultats médicaux et la prestation de services. À cette fin, il s'appuie sur la documentation pertinente relative à la concurrence dans les services hospitaliers et entre intermédiaires, et notamment les analyses empiriques décrivant l'expérience acquise par le passé dans différents pays, tant en matière de modification de la réglementation que de fusions et acquisitions.

Le présent document vient compléter la compilation de la table ronde de l'OCDE relative à la concurrence dans la prestation de services hospitaliers, en date de 2006. Contrairement au présent document, la table ronde de 2006 n'était pas axée sur les questions de fond et la conception de la réglementation, mais sur des questions relatives au droit de la concurrence dans ce secteur, qui ne concernent pas toujours directement la conception de la réglementation. À l'inverse, le présent document, tout en apportant un certain éclairage sur la définition du marché et l'impact des fusions et acquisitions sur le secteur des services hospitaliers (intermédiaires compris), ne tente pas d'analyser le secteur à travers le prisme spécifique du droit de la concurrence.[1] Il est par ailleurs complété par deux rapports d'expert.[2]

[1] Pour une analyse du secteur sous l'angle du droit de la concurrence, voir OCDE (2006) ou Varkevisser et Schut (2009) par exemple, qui abordent le contrôle des fusions hospitalières aux États-Unis, aux Pays-Bas et en Allemagne. Voir également Canoy et Sauter (2010) et la vue d'ensemble de Gaynor et Town (2011).

[2] Ces rapports d'expert ont été rédigés par Zack Cooper et Martin Gaynor, respectivement.

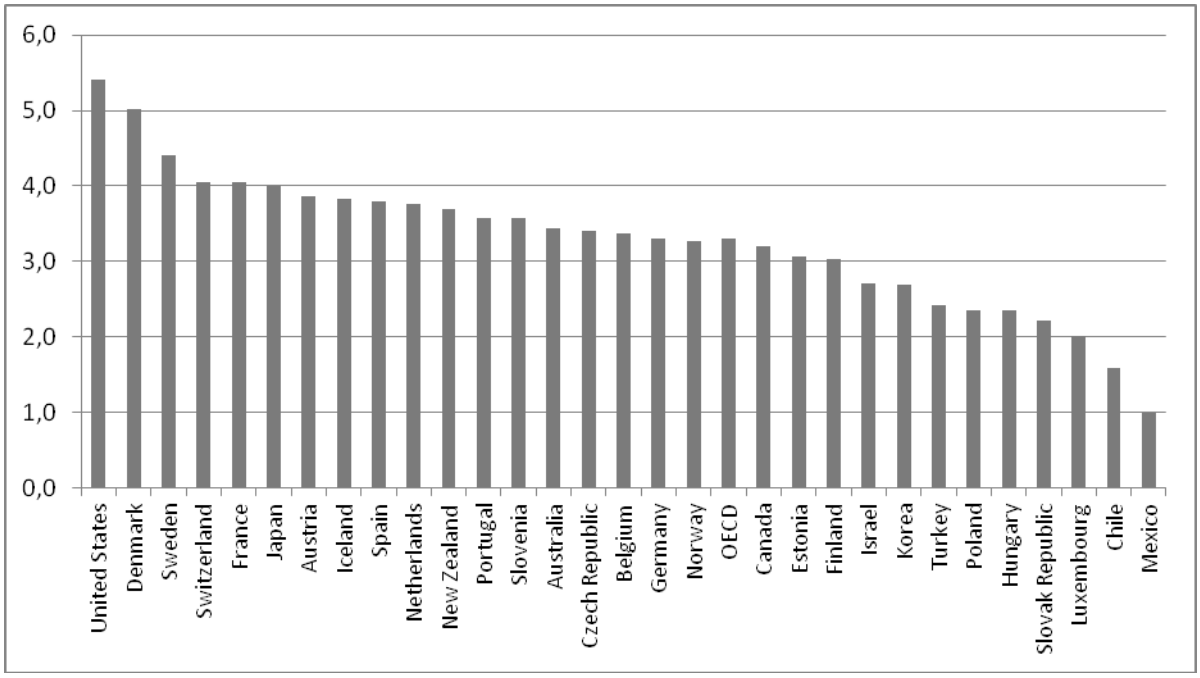
Graphique 1 : dépenses consacrées aux hôpitaux en pourcentage des dépenses courantes de santé (2009 ou plus ancienne année disponible[3])



Comme le montre le graphique 1, les hôpitaux représentent la première composante des dépenses de santé dans l'ensemble des pays de l'OCDE. Ces derniers consacrent en moyenne 33 % de leurs dépenses courantes annuelles de santé aux hôpitaux.

3 OCDE (2011).

Graphique 2 : dépenses consacrées aux hôpitaux en pourcentage du PIB (2009 ou plus ancienne année disponible)[4]



Les dépenses hospitalières sont non seulement la principale composante des dépenses de santé, mais elles représentent à elles seules une part non négligeable du PIB d'un grand nombre de pays de l'OCDE, comme le montre le graphique 2. En moyenne, les pays de l'OCDE ont consacré 3.3 % de leur PIB aux hôpitaux en 2009. La part du PIB consacrée aux hôpitaux s'échelonne de 1 % au Mexique à plus de 5 % aux États-Unis.

Figure 3 : Chaîne de valeur des services hospitaliers[5]

Payeurs (patients, pouvoirs publics, etc.)	Intermédiaires (assureurs, HMO, etc.)	Prestataires de services hospitaliers	Acheteurs	Fabricants

Les politiques de soins de santé, que ce soit à dessein ou par inadvertance, ont souvent un impact sur les incitations qui poussent les prestataires de santé à entrer, sortir, investir, fusionner et innover. La politique de santé a donc une incidence directe sur la structure du marché des prestataires de services et sur les résultats influencés par cette structure de marché, à savoir le prix, la quantité et la qualité, même s'ils ne dépendent pas directement de cette politique. Les incitations émanant des cadres réglementaires au sein desquels évoluent les prestataires de services hospitaliers jouent un rôle central dans la détermination du coût et de la qualité des services hospitaliers. Ces incitations sont susceptibles de varier en fonction du régime de propriété des hôpitaux, et il se pourrait donc que les politiques aient également une influence sur

4 OCDE (2011).

5 Établi à partir de Burns *et al.* (2002).

la structure de propriété ainsi que sur la manière dont se répartissent les établissements à but non lucratif et à but lucratif, ainsi que sur la structure de propriété.

La figure 3 présente la chaîne de valeur des services hospitaliers. Nous traiterons ci-après les trois premiers maillons de cette chaîne de valeur, à savoir les bénéficiaires ou acheteurs finaux de services hospitaliers, les éventuels intermédiaires (tels que les sociétés d'assurances, les HMO, etc.) et bien entendu les prestataires de services hospitaliers eux-mêmes. Les services hospitaliers ne seront pas abordés du point de vue des intrants, à savoir les acheteurs d'équipements médicaux et les fabricants de produits pharmaceutiques. Toutefois, nous nous pencherons brièvement sur le principal facteur de production de services hospitaliers en termes de coût, à savoir le personnel, comme les médecins et les infirmiers.

2. La concurrence en tant qu'instrument

> Les conflits d'intérêts entre les membres de *toute* société doivent être résolus. Le processus permettant cette résolution (et non élimination !) se nomme *concurrence*. Dans la mesure où il n'existe par définition aucun moyen d'éliminer la concurrence, il s'agit de se demander à quel type de concurrence il convient de recourir pour résoudre les conflits d'intérêts.[6]

Comme l'indique la citation introductive d'Alchian ci-dessus, la concurrence au sens large désigne le mécanisme avec lequel les conflits sont résolus dans une société. Même en l'absence d'introduction explicite de processus concurrentiels dans la prestation de services hospitaliers, la prestation de ces services est restreinte par les financements disponibles. Les conflits relatifs au type, à la qualité et à l'ampleur de l'accès aux services hospitaliers sont programmés à l'avance et sont « résolus » par les processus concurrentiels. Cette résolution peut passer par un mécanisme d'allocation économique, utilisant par exemple les prix (concurrence au sens étroit), mais peut également prendre d'autres formes non fondées sur des mécanismes économiques et déterminées, par exemple, par le pouvoir politique en place (concurrence au sens large).

La concurrence est un concept complexe qui fait l'objet de nombreuses associations, ce qui exacerbe encore les difficultés. Dans les publications relatives aux soins de santé, la concurrence est souvent associée à la privatisation et au « laisser-faire ». Elle est considérée comme un obstacle à la réalisation des objectifs de santé publique et un facteur de dégradation des résultats médicaux. En revanche, dans le droit de la concurrence, elle est synonyme de dynamisme en matière d'innovation et d'amélioration des résultats pour les consommateurs en termes de prix et de qualité. Ces points de vue paraissent diamétralement opposés, mais dans une certaine mesure, chacun d'eux est susceptible de décrire précisément des effets spécifiques de la concurrence.

Ces différents points de vue peuvent s'expliquer comme suit. Si les autorités de la concurrence portent systématiquement un regard plus bienveillant sur la concurrence, c'est parce qu'elles appliquent le droit de la concurrence, c'est-à-dire qu'elles évoluent dans un environnement législatif où les obstacles à la concurrence, son élimination ou son contournement ont généralement des conséquences négatives. D'autre part, les autorités de santé sont souvent préoccupées par les problèmes posés par les cadres existants, et cherchent à modifier ceux-ci. Dans ce contexte, l'instauration de la concurrence n'a pas nécessairement des

6 Alchian (1977:127).

conséquences positives: l'élimination de certains aspects de la concurrence pourrait bien constituer une réponse réglementaire adaptée.[7]

Le problème de la prestation de services hospitaliers se pose en termes d'insuffisance des ressources dans le secteur de la santé — et assez souvent dans les pays de l'OCDE, d'insuffisance des ressources publiques — ce qui engendre des conflits.[8] Le présent document passe en revue les publications traitant du rôle de la concurrence entre prestataires de services hospitaliers et autres acteurs concernés (tels que les assureurs) et de la manière dont la concurrence permet d'alléger les contraintes budgétaires et d'améliorer les résultats globaux. Il s'agit fondamentalement de canaliser les processus concurrentiels, de les rationnaliser et de les restreindre par le biais de moyens réglementaires adaptés, afin d'améliorer les résultats.

Envisagée comme un processus, la concurrence permet une allocation efficace des ressources, quel que soit l'ensemble sous-jacent de préférences. Cela ne pose aucun problème en l'absence de défaillances du marché, et le rôle d'une autorité de la concurrence est de préserver le bon fonctionnement des mécanismes du marché. Toutefois, les processus concurrentiels, comme le soulignent certaines études relatives à la santé et d'autres études plus générales, peuvent également aboutir à des résultats indésirables. Ces résultats peuvent être non seulement imputables à une dégradation du fonctionnement du processus concurrentiel[9] mais également au fonctionnement particulièrement harmonieux de la concurrence et à une pression concurrentielle élevée. L'externalisation des coûts, qui préserve, voire renforce le processus de concurrence, illustre parfaitement ce dernier cas. L'externalisation des coûts, ou l'absence d'internalisation, a été débattue et abordée dans le cadre des politiques environnementales. Il apparaît clairement qu'un processus concurrentiel fonctionnant correctement poussera les entreprises à abaisser leurs coûts afin d'améliorer leur situation concurrentielle. Sur des marchés hospitaliers caractérisés par des prix fixes et une asymétrie d'information par exemple, la concurrence peut aboutir à une dégradation excessive de la qualité. Bien que cela n'affecte pas le processus concurrentiel et qu'il ne s'agisse que d'une manifestation de son bon fonctionnement, cela n'aboutit généralement pas à des résultats positifs.[10] En ce qui concerne les externalités environnementales, il est généralement admis que les forces concurrentielles doivent être canalisées afin de régler efficacement les problèmes d'externalités, en accordant des avantages concurrentiels aux entreprises qui polluent moins, par opposition à celles qui ne mettent en œuvre aucune méthode de dépollution, ou des méthodes moins efficaces. L'approche utilisée vise à imposer une internalisation totale des externalités, et à faire en sorte que les pressions concurrentielles stimulent l'innovation dans ce domaine également. Une argumentation similaire s'applique aux autres défaillances du marché, par exemple dans le cas de l'application de normes minimales de qualité à la prestation de services hospitaliers dans le cadre de systèmes de paiement forfaitaire à la pathologie, visant à garantir qu'aucun avantage concurrentiel ne puisse être obtenu si la vie des patients est mise en danger.[11]

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7 Les incitations économiques, qui ont par exemple pour effet de diminuer la qualité des services dans les systèmes de prix fixes, sont légitimement considérées comme problématiques par les autorités réglementaires, ce qui renforce ce point de vue.

8 Voir par exemple Hauck *et al*. (2004), qui analysent les publications relatives à la définition des priorités dans le secteur de la santé dans un contexte de limitation des budgets nationaux alloués la santé.

9 Une telle élimination ou dégradation de la concurrence peut être due à un abus de position dominante, un cartel ou une fusion anticoncurrentielle, par exemple.

10 Par conséquent, il est quelque peu inapproprié de parler de « défaillance du marché », dans la mesure où une telle « défaillance » se produit souvent précisément dans des circonstances où les mécanismes de marché fonctionnent extrêmement bien, mais les résultats sont jugés indésirables.

11 Ces exemples montrent qu'en ce qui concerne les résultats, la concurrence peut être « naturellement » trop large ou trop étroite, les politiques visant alors à intégrer de nouveaux aspects à un processus concurrentiel,

Pour résumer, il existe deux façons distinctes de restreindre et de canaliser la concurrence. La première garantit que le *processus* concurrentiel est préservé et n'est pas compromis. La seconde garantit que la concurrence s'exerce en respectant un ensemble approprié de variables, c'est-à-dire qu'elle exclut l'externalisation des coûts ou qu'elle aboutit à ce que l'on appelle aussi « une course à la déréglementation. ». Bien que toutes deux contiennent des éléments normatifs, les considérations liées à l'intérêt public sont bien entendu beaucoup plus visibles dans la dernière catégorie.[12]

De ce point de vue, les tenants de la concurrence n'ont pas à l'esprit n'importe quel type de concurrence, mais un type de concurrence bien particulier, lorsqu'ils évoquent les avantages liés à son instauration dans les services hospitaliers. Ce type de concurrence ne se porte pas préjudice à lui-même et ne peut pas s'exercer s'il est associé à un ensemble de variables différent de celles considérées comme souhaitables. Par conséquent, il s'agit de concevoir convenablement la réglementation afin de fournir les services de santé dans des conditions optimales.[13] Cela nécessite d'utiliser la concurrence comme un instrument dans la prestation de services hospitaliers.[14]

Le processus concurrentiel peut être utilisé au bénéfice de la société dans de nombreux domaines s'il est canalisé et encadré convenablement, les soins de santé en général et les services hospitaliers en particulier ne faisant pas exception. Pour structurer le débat sur les services hospitaliers, il est important de faire la distinction entre la concurrence en tant que processus *a priori* neutre et la question de savoir dans quel domaine et vis-à-vis de quels aspects les processus concurrentiels peuvent être déployés fructueusement pour satisfaire les considérations liées à l'intérêt public. Le fait de spécifier certaines caractéristiques d'un moteur de voiture de course, par exemple, élimine la concurrence entre les écuries sur cet aspect du développement du moteur.[15] Dans la mesure où c'est précisément l'objectif de telles spécifications, il est tout à fait inutile de souligner que la concurrence sur le plan de ces éléments sera éliminée par cette intervention. La question de savoir s'il faut avoir recours à de telles spécifications peut toutefois être utilement débattue. Il s'agira notamment de se demander si les conséquences générales d'un tel changement de règles sont souhaitables. Il peut par exemple être tout à fait justifié d'éliminer la concurrence sur ce plan afin de rendre la course plus intéressante aux yeux des spectateurs, dans la mesure

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ou au contraire à en éliminer certains. Le type de résultat évoqué par Propper *et al.* (2004) et (2008), selon lequel une concurrence accrue sur les marchés où les prix ne sont pas réglementés peut entraîner une hausse du taux de mortalité, par exemple, a été utilisé comme argument pour exclure la variable prix de la concurrence dans certains systèmes.

12 Cela est certainement vrai si l'on considère à quel point certains aspects de la dernière catégorie peuvent prêter à controverse. Les soins de santé comptent parmi les meilleurs exemples.

13 Manifestement, la concurrence est incompatible avec le vide institutionnel et nécessite un ensemble de règles. Les résultats médicaux dépendent de la qualité de ces règles.

14 En général, un ensemble de contraintes réglementaires appropriées en matière de concurrence, excluant explicitement toute concurrence en ce qui concerne certains aspects tout en l'autorisant pour tous les autres facteurs, permet d'assurer une prestation optimale de services de santé. Ce n'est qu'à ce moment-là que l'on peut écarter les objections philosophiques selon lesquelles ceux qui soignent les malades devraient être motivés intrinsèquement et non extrinsèquement par des moyens pécuniaires. La manière dont les « chevaliers » intrinsèquement motivés et les « valets » motivés par l'argent contribuent à transformer le grand public de « pions » mal informés en « reines » éclairées est abordé par Le Grand (2006).

15 Bien entendu, les mécanismes à l'œuvre sont quelque peu différents de ceux intervenant dans la concurrence sur les marchés puisque les variables sur lesquelles la concurrence est axée sont typiquement guidées par des considérations liées à la manière de rendre la course plus attractive pour le public. Les changements de règles observés dans de nombreuses disciplines sportives sont également motivés par de telles considérations, et l'on peut observer de manière assez générale que la concurrence au niveau d'un athlète individuel (ou d'une équipe d'athlètes) a la préséance sur la concurrence au niveau des équipements utilisés.

où dans le cas contraire, on s'exposerait au risque que l'issue de la course soit moins déterminée par les compétences des pilotes que par la qualité du moteur. Le fait de réinstaurer la concurrence à ce niveau sera donc légitimement considéré comme problématique.[16]

De même, le contexte institutionnel et réglementaire dans lequel les services hospitaliers sont mis en concurrence a également de l'importance. Tout comme la course est susceptible de devenir plus intéressante lorsque la concurrence est éliminée sur le plan de la conception du moteur, il peut être souhaitable d'éliminer la concurrence tarifaire entre les hôpitaux dans la mesure où cela permet d'intensifier la concurrence sur le plan de la qualité et de potentiellement obtenir des résultats plus désirables.

Dès qu'un cadre ayant un impact positif sur la santé des patients et favorisant une utilisation prudente des dépenses de services de santé aura été conçu, les meilleurs prestataires de services hospitaliers seront récompensés. Les autres auront de plus en plus de difficultés à exercer leur activité et n'auront d'autre choix que de quitter le marché ou de fusionner avec de meilleurs prestataires. Si le cadre dans lequel la concurrence hospitalière s'exerce est bien conçu, le fait que des hôpitaux quittent le marché ne devrait pas poser problème. Il faut en effet faire un choix, on ne peut pas à la fois profiter des avantages inhérents à une organisation concurrentielle du secteur et se prononcer contre les fermetures d'hôpitaux, qui font partie intégrante de ce processus. Malgré tout, les fermetures d'hôpitaux demeurent controversées au sein des pays de l'OCDE.

Le présent document vise non seulement à présenter des ébauches d'idées et des faits stylisés quant aux conditions dans lesquelles la concurrence peut être instaurée de manière bénéfique dans le secteur hospitalier, mais également de donner aux responsables politiques les armes nécessaires de manière qu'une fois que la concurrence sera correctement établie, ils se sentent suffisamment en confiance pour résister aux pressions anticoncurrentielles pour le cas où certaines fermetures d'hôpitaux sembleraient poser problème.[17]

3. Considérations générales

3.1. Le rôle de l'économie

La concurrence sur les marchés de la santé, et notamment dans le secteur des services hospitaliers, peut encourager les prestataires à travailler efficacement et à améliorer les résultats des patients. Elle est susceptible de réduire les coûts et les tensions budgétaires dans les pays où les dépenses de santé publique sont élevées. Toutefois, le succès de la concurrence dépend souvent de l'environnement réglementaire et institutionnel d'un pays et de la réaction des consommateurs et des prestataires de services de santé. Pourtant, en matière de santé, l'accroissement de la concurrence nécessite rarement d'abolir toute réglementation. Au contraire, la réussite de son instauration est généralement tributaire de la conception d'une réglementation adaptée (et parfois complexe). Dans un secteur où la qualité est difficile à mesurer, même *ex post*, et où des consommateurs à la rationalité limitée sont régulièrement confrontés à des asymétries d'information lorsqu'ils prennent des décisions susceptibles de changer leur vie, la réglementation contribue activement à la garantie du bon fonctionnement des services de santé. Pour ces raisons, les responsables des politiques de santé, soutenus par des prestataires influents et d'autres

16 Il s'agit en fait des deux positions types exposées précédemment. Bien qu'il puisse être difficile pour les autorités de la concurrence d'admettre le caractère bénéfique de l'élimination choisie de la concurrence, il peut être tout aussi difficile pour les autorités de santé de faire le choix d'instaurer la concurrence. Il ne s'agit pas d'un conflit fondamental mais d'un malentendu technique.

17 Voir notamment les publications évoquant l'impact de la fermeture d'hôpitaux sur l'efficience et la santé des patients à l'encadré 7.

organisations professionnelles, ont souvent mis plus de temps à mettre en œuvre des réformes instaurant des marchés concurrentiels de services. Lorsque les pays ont réussi à instaurer une concurrence, les normes minimales de qualité des soins sont souvent un ingrédient essentiel, et sont régulièrement complétées par des informations et des comparaisons des performances des prestataires. Il est souvent avancé que la réglementation des prix des services hospitaliers peut favoriser une concurrence au niveau de la qualité et des performances utile sur le plan social.

Les marchés de services hospitaliers sont très différents des marchés concurrentiels classiques. En raison des différents types de traitement et emplacements géographiques des hôpitaux, l'offre de services hospitaliers varie. Du côté de la demande, les informations sont imparfaites. Les services hospitaliers et les services de santé plus généralement sont des biens de confiance.[18] Les biens de confiance partagent un point commun avec les biens d'expérience : il est difficile pour les clients de décider *ex ante* si le service est de bonne ou de mauvaise qualité. Toutefois, contrairement aux biens d'expérience, il demeure difficile, voire impossible d'évaluer les propriétés des biens ou des services de confiance, même après leur délivrance. Il s'agit d'une cause bien établie de défaillance du marché qui a conduit les autorités à réglementer (souvent de manière assez poussée). En outre, la présence d'un nombre substantiel d'hôpitaux à but non lucratif, même dans des systèmes obéissant totalement aux règles du marché, rend difficile l'analyse des services hospitaliers avec les outils économiques théoriques standard. Dans la mesure où de nombreuses hypothèses fondamentales des modèles économiques ne se vérifient pas, la théorie ne donne que peu d'indications quant aux conditions dans lesquelles la concurrence permettra d'obtenir des résultats satisfaisants, ni au moment auquel ce sera le cas.

Malgré ces limites, les deux sous-sections suivantes passent brièvement en revue les idées formulées par la théorie économique en vue de fournir efficacement des services hospitaliers, tant du point de vue de l'offre que de la demande. L'approche suivie est plutôt standard. Elle repose sur la notion (controversée) de l'optimalité de Pareto, tirée de l'économie du bien-être.

3.2. Facteurs liés à l'offre

Les services hospitaliers sont des produits différenciés, tant horizontalement que verticalement.[19] D'un point de vue théorique, la qualité et la variété de l'offre peuvent être excessives, insuffisantes, ou optimales. Entre le monopole et la concurrence parfaite, la qualité et la variété de l'offre peuvent varier considérablement, et les modèles théoriques actuels ne permettent pas de discriminer les différents résultats possibles.

Un acteur en position de monopole est susceptible de proposer une offre excessivement variée dans la mesure où il est le seul vendeur sur le marché, ce qui lui permet donc de capter le surplus du consommateur, tandis que des entreprises se livrant concurrence peuvent, pour la même raison, restreindre la variété de leur offre. L'inverse est également possible puisque la concurrence est susceptible de favoriser une variété excessive dans la mesure où les bénéfices supplémentaires peuvent provenir d'une variété générée pour « voler » la part de marché des hôpitaux concurrents.[20] Comme l'ont montré Gaynor et Vogt (2000), on peut s'attendre à une variété excessive de l'offre dans la mesure où les hôpitaux, pris individuellement, ne prendront pas en compte l'externalité que représente le vol de la demande lorsqu'ils opteront en faveur d'une variété de leur offre.

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18 Ce terme a été inventé par Darby et Karni (1973).

19 La différenciation horizontale est parfois assimilée à la variété des produits tandis que la différenciation verticale est généralement associée à la qualité des produits.

20 Voir Gaynor (2004).

De même, les études qui prennent en compte le caractère multiproduits des services hospitaliers montrent que l'impact de la concurrence entre services hospitaliers sur la qualité, la variété et le prix est ambigu.[21] La théorie suggère que l'impact de la concurrence dépendra de la réactivité de la demande de services hospitaliers aux prix, à la variété et à la qualité. Si la qualité des services hospitaliers ne peut être mesurée ou communiquée comme il se doit, les patients (ou les assureurs) n'ont aucun moyen de savoir quel hôpital est le meilleur et ne sont donc pas en mesure de faire des choix optimaux. Ce phénomène se traduit généralement par une demande relativement inélastique des différents services hospitaliers.

Les marchés de la santé se caractérisent souvent par des niveaux élevés de financement public et des systèmes de financement conçus de telle manière que les patients ne se soucient pas des prix, et n'y prêtent même pas attention la plupart du temps. Si c'est effectivement le cas, et si la qualité est facilement observable, cela peut créer une incitation à accroître les services coûteux, voire à les proposer en quantités non optimales. Dans la mesure où la qualité des services hospitaliers n'est pas facilement observable en réalité, d'autres aspects, comme les qualités « hôtelières » de l'hôpital, peuvent devenir prépondérants. Cela peut encourager les hôpitaux à améliorer la qualité sur des aspects des services moins importants que les résultats médicaux. De même, si les patients connaissent le prix et y attachent de l'importance (en cas de reste à charge élevé par exemple) mais que la qualité n'est pas facilement observable (car une évaluation correcte de la qualité nécessite d'être capable de poser un diagnostic et de connaître les résultats cliniques, et peut demeurer ambiguë même après la délivrance du service), cela pourrait favoriser une course à la déréglementation et des prestations de qualité sous-optimale.

3.2.1. Prix et systèmes de paiement

La manière dont les prix sont fixés et dont la rémunération globale des services hospitaliers est établie a son importance. Sur les marchés hospitaliers où la réglementation des prix est limitée et où les systèmes de paiement prévoient un remboursement généreux des activités hospitalières, les hôpitaux ne seront probablement pas incités à se montrer efficients, et les patients seront principalement sensibles à la qualité et aux services complémentaires. Sur les marchés où les systèmes de paiement sont moins généreux, les hôpitaux peuvent se concurrencer sur les prix mais laisser la qualité tomber en dessous des niveaux optimaux.

En présence d'un prix fixe unique pour tous les fournisseurs, la concurrence se fera sur le plan de la qualité, et cette qualité sera plus ou moins élevée, selon le niveau de ce prix fixe. La rémunération des groupes homogènes de malades (GHM, voir encadré 1 ci-dessous) peut conduire les prestataires à fournir une qualité insuffisante afin de réduire leurs coûts par rapport aux prix fixes sur la base desquels ils sont remboursés. Le niveau auquel ces prix sont fixés peut également conduire à une sélection des patients en fonction de la gravité de leur maladie, les hôpitaux étant incités à donner la priorité aux patients moins coûteux à soigner par rapport aux remboursements reçus.[22]

Un prix unique est donc susceptible d'affecter différemment les patients, en fonction de la gravité de leur maladie. Ces risques existent dans les systèmes de prix fixes fondés sur les classifications GHM ou tout type de système dans lequel la rémunération maximale est fixée avant le traitement.[23]

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21 Dranove et Satterthwaite (2000).

22 Cela peut conduire les patients dont le traitement est plus coûteux à rester sans soins ou à recevoir des soins de qualité moindre, une pratique désignée sous le nom de « *skimping* » ou de « *dumping* » dans les publications. Les hôpitaux qui se livrent à une concurrence pour attirer les patients dont le traitement est moins coûteux en améliorant la qualité pratiquent ce que l'on appelle « l'écrémage ». Voir Ellis (1998).

23 Parmi les pays qui sont passés à une forme de GHM ou à un paiement forfaitaire à la pathologie pour les soins hospitaliers, on compte notamment le Chili, Israël, Singapour, la Suisse, le Taipei chinois, les Pays-

Le système de paiement forfaitaire à la pathologie est une tendance récente dans la mesure où les pays de l'OCDE sont de plus en plus nombreux à opter pour une rémunération des hôpitaux fondée sur les GHM. Les recherches théoriques montrent que les hôpitaux sont davantage susceptibles de se concurrencer sur le plan de la qualité lorsque les prix sont fixes.[24] Les paiements fondés sur les GHM impliquent que les différents hôpitaux soient payés le même prix pour des services similaires. Le mécanisme des GHM a pour objet d'évaluer différents types de services hospitaliers en fonction de leur complexité clinique et de leur attribuer (de manière théorique) un prix « efficient » par cas traité. Les hôpitaux en mesure de fournir ces services plus efficacement réalisent un bénéfice, tandis que les hôpitaux moins efficaces encourent des pertes sur ces services particuliers. Ces signaux de prix *de facto* incitent à améliorer l'efficience et encouragent la concurrence sur le plan de la qualité, mais doivent être gérés avec prudence.

Encadré 1. Groupe homogène de malades (GHM)

Le groupe homogène de malades (GHM) décrit des systèmes visant à classifier les services hospitaliers en groupes. À l'origine, l'intention était d'identifier les « produits » fournis par un hôpital. Par définition, les patients d'une catégorie de GHM, par exemple le « produit » appendicectomie, sont similaires d'un point de vue clinique et sont donc censés mobiliser le même niveau de ressources hospitalières. Un GHM est donc une pondération indiquant la quantité de ressources nécessaires pour traiter un patient souffrant d'une maladie donnée (McCellan, 1997).

À l'origine, ce système a été conçu pour remplacer le système largement répandu du remboursement « sur la base du coût » des services hospitaliers. Les GHM sont utilisés aux États-Unis depuis 1982 pour déterminer les versements effectués par Medicare aux hôpitaux en contrepartie de chaque « produit ». Les systèmes de paiement fondés sur les GHM ont depuis été introduits à divers degrés, c'est-à-dire avec plus ou moins d'exceptions et de restrictions, dans d'autres systèmes de remboursement à travers le monde. Le secteur des services hospitaliers a évolué depuis que les GHM ont été introduits pour la première fois, et il est de plus en plus demandeur de systèmes de classification des patients capables de remplir leurs objectifs initiaux à un niveau de technicité et de précision plus élevé. Par conséquent, il existe de nombreux systèmes différents fondés sur les GHM, parfois au sein d'un même pays. Par exemple, le Royaume-Uni a instauré des *Health Care Resource Groups* (HRG), la France des *Groupes Homogènes de Malades* (GHM), le Canada des *Case Mix Groups* (CMG) et l'Australie des *National DRG* (AN DRG).

Le principe fondamental des prix fondés sur les GHM est que le montant effectivement versé est indépendant de la durée du séjour hospitalier et des traitements reçus lors de ce séjour. En effet, l'objectif théorique des paiements fondés sur les GHM est de définir et de payer un prix « efficient » en contrepartie d'un service spécifique. Dans la mesure où un traitement de meilleure qualité et un séjour hospitalier plus long entraînent des coûts supplémentaires, les systèmes fondés sur les GHM favorisent les sorties anticipées (qualifiées de *blutige Entlassungen*, « sorties sanglantes », par certains auteurs germanophones) et incitent à réduire la qualité du traitement. Les systèmes de prix fixes transfèrent les risques liés au traitement de l'assureur à l'hôpital. Si un patient nécessite un traitement particulier qui est seulement couvert en partie par le prix fixe sur la base des GHM, ou si le séjour hospitalier doit être prolongé, l'hôpital est forcé de prendre à sa charge l'excédent de coût. En règle générale, les prix fixes fondés sur les GHM sont établis de manière à permettre aux hôpitaux de conserver une taille raisonnable (certaines estimations considèrent que plus de 8 000 cas par an suffisent) afin de pouvoir gérer ces cas particulièrement coûteux.[25] Certains systèmes, comme celui actuellement en vigueur en Allemagne (voir encadré 2), plafonnent la durée des séjours hospitaliers. Si la durée du séjour excède ce plafond, les

Bas, l'Allemagne, le Royaume-Uni, les États-Unis (pour Medicare et Medicaid). Pour une description des réformes de santé menées dans les six premiers pays, voir Okma *et al.* (2010).

24 Les études empiriques sont examinées à la section suivante.

25 Voir Monopolkommission (2008).

hôpitaux sont remboursés sur la base d'un tarif journalier pour la période excédant le plafond. Cela contribue à répartir les risques de manière plus équilibrée entre les hôpitaux et les assureurs.[26]

Encadré 2. Le contexte institutionnel des services hospitaliers en Allemagne[27]

Introduction

En Allemagne, la couverture maladie universelle repose sur l'inscription individuelle obligatoire à une caisse publique d'assurance maladie. L'inscription à l'assurance maladie est obligatoire pour les travailleurs à faibles revenus et à revenus intermédiaires, mais les plus hauts revenus peuvent y renoncer et choisir une assurance privée.

La structure du secteur hospitalier allemand

Le secteur hospitalier allemand se compose d'une multitude d'hôpitaux à but non lucratif et à but lucratif, aux structures de propriété différentes. Outre les hôpitaux publics, qui sont la propriété des municipalités, des districts régionaux ou des Länder, il existe une longue tradition d'établissements à but non lucratif dirigés par l'Église et diverses organisations caritatives. Quelques hôpitaux privés ont également existé assez longtemps, principalement sous la forme de petites cliniques spécialisées. La composition de la propriété des hôpitaux n'a quasiment pas changé jusqu'au début des années 1990, lorsque qu'une première vague de privatisations — en Allemagne de l'Est principalement — a eu lieu dans le sillage de la réunification de 1990. Une deuxième vague de privatisations concernant cette fois toutes les régions d'Allemagne a commencé au début des années 2000.[28]

Le système de financement allemand sa caractérise par sa dualité : en effet, la construction, l'agrandissement ou la modification des hôpitaux (coûts d'investissement) sont à la charge des Länder, alors que les coûts d'exploitation sont à la charge de la caisse d'assurance maladie.[29] Comme le dispose la Loi sur le financement des hôpitaux (*Krankenhausfinanzierungsgesetz*, KHG), seuls les établissements officiellement inscrits dans les plans hospitaliers nationaux reçoivent de l'argent des Länder : ces derniers doivent respecter les différentes structures de propriété et s'assurer que les différents types d'hôpitaux — à but lucratif ou non, publics ou privés — reçoivent des financements suffisants. Et selon le Code allemand de la sécurité sociale (*Sozialgesetzbuch*, SGB), seuls ces hôpitaux ou ceux ayant conclu un contrat de services hospitaliers avec les associations fédérales de caisses d'assurance maladie peuvent recevoir des financements des caisses d'assurance maladie (SGB, code n° 5, article 108).

En principe, tous les patients, c'est-à-dire ceux ayant souscrit une assurance maladie privée ou les bénéficiaires de l'assurance maladie publique, peuvent faire librement leur choix entre les hôpitaux inscrits. Les coûts sont supportés par les caisses d'assurance maladie privées ou publiques, qui sont responsables des coûts de fonctionnement de l'hôpital. Autre facteur important : tous les hôpitaux, y compris les établissements publics, sont indépendants en termes de structure et d'organisation. Le recrutement des médecins ou du personnel administratif n'est pas soumis à une réglementation spécifique. L'externalisation de certaines prestations, comme les services de restauration ou de blanchisserie, est autorisée, ainsi que la gestion externe des chambres, sous réserve qu'elles

26 Parallèlement, les pays de l'OCDE complètent souvent le mécanisme des prix fondés sur les GHM par la surveillance et le suivi de la durée moyenne des séjours et par des listes de contrôle des principaux indicateurs cliniques — autant de garde-fous visant à empêcher que la prise en charge des patients soit systématiquement insuffisante ou que les principaux processus de qualité des soins ne soient pas appliqués. L'efficacité de ces systèmes dépend de leur conception et de leur mise en œuvre, et fait actuellement l'objet de nombreuses études.

27 Cet encadré s'appuie sur la contribution de l'Allemagne figurant dans OCDE (2006), sur Schulte (2006) et Monopolkommission (2008).

28 Voir la contribution de l'Allemagne dans OCDE (2006:135 sqq.), qui spécifie qu'entre 1991 et 2004, la part des hôpitaux privés est passée de 14.8 à 25.4 %. Dans le même temps, la part des hôpitaux publics est passée de 46 à 36 %, tandis que la part des hôpitaux à but non lucratif est restée relativement stable.

29 Voir la loi fédérale sur le financement des hôpitaux (KHG). La maintenance fait partie des coûts d'exploitation. En outre, en raison de budgets publics serrés, un nombre croissant d'investissements hospitaliers sont financés seulement en partie par les Länder, le reste étant financé par les « bénéfices » d'exploitation.

restent supervisées par l'hôpital.

Rémunération des services hospitaliers

Avec les réformes du secteur de la santé entreprises en 2000, on est passé d'un système de financement axé sur les coûts de services individuels reçus à un système de financement du séjour hospitalier total d'un patient. Le passage au système de groupes homogènes de malades (GHM) est devenu obligatoire à compter du 1er janvier 2004 et implique un encadrement des tarifs. Un tel système de groupement axé sur les services a notamment pour objectif d'éviter les incitations négatives émanant d'un système de rémunération fondé sur les jours-patients, qui conduit à prolonger la durée d'hospitalisation, et à le remplacer par un système de rémunération davantage axé sur les performances. Par ailleurs, l'introduction du système de GHM en Allemagne a amélioré la transparence en ce qui concerne le type et le volume des services fournis par les hôpitaux. Cette transparence accrue donne des informations sur les domaines d'intérêt et de spécialisation des hôpitaux, et permet de comparer les différents établissements. Cette amélioration des possibilités de comparaison a également renforcé la position stratégique des caisses d'assurance maladie dans les négociations budgétaires avec les hôpitaux.

On s'attendait à ce que le système de GHM augmente encore les pertes encourues par les hôpitaux qui ne sont pas utilisés à pleine capacité ou ne sont pas rentables pour d'autres raisons. Un nombre croissant d'exploitants d'hôpitaux publics à but non lucratif seront obligés soit de fermer leurs établissements, soit de les vendre à des exploitants commerciaux.

Garantir la qualité des hôpitaux

Les mesures d'assurance qualité suivantes sont applicables aux hôpitaux :

- Les hôpitaux sont obligés d'introduire et de développer un système interne de gestion de la qualité.
- Les hôpitaux sont obligés de se soumettre à des mesures comparatives d'assurance qualité. Toute irrégularité fera l'objet d'une intervention sélective.
- La qualité et la nécessité des services diagnostiques et thérapeutiques sont évalués sur la base de critères uniformes ; les coûteux services faisant appel aux technologies médicales sont particulièrement visés.
- Les hôpitaux doivent satisfaire des critères minimaux en concerne la qualité structurelle et la qualité des résultats.
- Dans les cas où la qualité des résultats du traitement dépend plus particulièrement de la quantité de services fournis, les services médicaux correspondants ne peuvent être proposés que si l'établissement peut justifier d'un nombre minimal d'interventions.

Depuis 2005, tous les hôpitaux inscrits sont obligés d'établir et de publier un rapport sur la qualité. Les comparaisons de la qualité menées par l'Agence fédérale pour l'assurance qualité (*Bundesgeschäftsstelle Qualitätssicherung* - BQS) sur la base des rapports soumis par chaque hôpital sont particulièrement intéressantes. Depuis 2007, les hôpitaux ont l'obligation de publier deux fois par an des indicateurs de qualité portant sur un certain nombre de procédures.[30]

En outre, les systèmes de prix fixes fondés sur les GHM ont des répercussions sur les incitations financières à la sélection des patients. Pour un prix fixe donné, les patients en mesure de recevoir un traitement relativement rentable à l'hôpital seront particulièrement attractifs pour l'hôpital. Ainsi, les hôpitaux seront fortement incités à influencer la décision des médecins généralistes ou de tout autre acteur jouant un rôle de filtrage afin qu'ils envoient les cas particulièrement peu attractifs vers d'autres hôpitaux. En outre, les hôpitaux eux-mêmes disposent de toute une palette de moyens pour refouler ces patients en

30 Voir les arguments de la Monopolkommission (2008:320) en faveur d'un registre de qualité systématique visant à améliorer la transparence pour les patients.

arguant par exemple d'une spécialisation limitée dans le domaine concerné, d'une indisponibilité ou de délais d'attente trop longs. Les remboursements sur la base d'un tarif journalier au-delà d'un certain seuil permettent généralement d'atténuer ces incitations, bien qu'ils ne soient manifestement pas en mesure de compenser les coûts supplémentaires sans lien avec la durée du séjour. Des seuils de séjour minimal ainsi que des critères de décharge liés aux paiements peuvent atténués les risques de sortie trop précoce. Bien que l'hôpital puisse retirer un avantage financier de ces sorties précoces, le patient ou l'assureur risque de faire face à des coûts ultérieurs supplémentaires en raison des traitements complémentaires nécessaires. Ce risque peut être atténué en réduisant les possibilités de remboursement pour des réadmissions pour le même diagnostic et en définissant une durée minimale de séjour. Si la durée de séjour d'un patient est inférieure à la durée minimale spécifiée, le prix fixe est réduit.

En général, le système de prix fixes fondés sur les GHM est associé à des baisses de la qualité et à des manipulations des codes, un comportement abusif qui ne risque pas d'être éliminé par les garde-fous évoqués.[31]

Les systèmes de prix fixes fondés sur les GHM peuvent également influencer les possibilités d'innovation et les incitations à innover. Tout système de prix fixes encouragera les innovations médicales qui maintiennent le coût global du traitement à un niveau constant, ou le réduisent. Ces incitations peuvent soutenir l'innovation et améliorer l'efficience. Parfois, elles peuvent également nécessiter une renégociation du prix fixe fondé sur les GHM, alourdissant ainsi considérablement les coûts administratifs déjà assez importants liés à l'exploitation d'un tel système.

Comme dans d'autres secteurs, ces incitations demeurent indépendantes du degré de concurrence, mais un haut niveau de concurrence est susceptible de leur donner un poids considérable. Néanmoins, si les prix réglementés sont le reflet sincère d'une réflexion approfondie sur ce que devrait être un prix « efficient » — ils peuvent conduire les hôpitaux à améliorer leur efficience. Lorsque les hôpitaux ne peuvent pas baisser leurs coûts assez rapidement, ou continuer de proposer les opérations aux prix fixes prescrits, ils peuvent cesser de proposer ces services. Lorsque cette interruption des services va à l'encontre des obligations de service universel, les prix fixes sont susceptibles d'être complétés par des aides publiques supplémentaires ou par un recours des prestataires de services à des subventions croisées pour financer les services essentiels — ce qui limite la concurrence sur le plan de la qualité. Il existe également des services hospitaliers, tels que les services pyschiatriques, de traumatologie et d'urgence, pour lesquels il est trop difficile ou non optimal d'établir des prix fixes.

Une étude théorique récente par Janssen et Parakhonyak (2011) analyse l'effet des structures de prix réglementés (comme les GHM ou les systèmes de paiement forfaitaire à la pathologie) sur la décision des prestataires de services de refuser des services ou de fournir des services non requis sur les marchés de biens de confiance. Les résultats sont fondés sur trois types d'hypothèses : (i) les consommateurs diffèrent en fonction du type de services demandés et arrivent de manière séquentielle dans le temps ; (ii) les structures de prix sont fixées par une autorité de réglementation et dépendent du service requis et (iii) les prestataires de services peuvent décider librement du service et le fournir honnêtement, refuser de le fournir, ou tricher et administrer un traitement différent.

Sur la base de ces hypothèses, l'étude analyse les effets de sélection dynamique sur les marchés de biens de confiance comme les services hospitaliers, ce qui montre que pour une large catégorie de structures de prix, certains types de patients ne sont pas traités et seront refusés. Comme on pourrait le penser intuitivement, les équilibres où cela se produit sont moins porteurs de bien-être que les équilibres

[31] Ce phénomène est décrit par exemple dans Monopolkommission (2008:326). À la suite de l'instauration du système de GHM en Allemagne, le nombre de naissances classées « normales » a radicalement diminué au profit des naissances « avec complications », beaucoup plus lucratives.

sans sélection. À mesure que le marché s'élargit ou que les prestataires deviennent plus patients (rappelez-vous les hypothèses de traitement séquentiel impliquant un avantage de prix), la catégorie des structures de prix sans sélection se réduit et, à la limite, la structure de prix devient unique. Cette structure de prix unique est caractérisée par un ensemble de prix en présence duquel les prestataires de services acceptent indifféremment de mettre en œuvre n'importe quel type de traitement, éliminant ainsi les incitations à la fraude.[32]

Les études théoriques relatives à la concurrence sur le plan de la qualité dans le cadre d'un régime de prix fixes mettent en évidence une corrélation positive entre concurrence et qualité.[33] Toutefois, Brekke *et al.* (2011) présentent un modèle théorique simulant le résultat empirique selon lequel la concurrence sur les marchés hospitaliers dont les prix sont réglementés peut donner lieu à des effets ambigus sur la qualité. Leur modèle est fondé sur trois variantes de l'approche standard. Les auteurs peuplent leur modèle de prestataires de soins de santé semi-altruistes, à savoir de fournisseurs qui se soucient dans une certaine mesure de l'utilité pour les patients et ne sont pas de purs maximiseurs de profit. En outre, l'hétérogénéité des patients (par rapport aux bénéfices bruts du traitement) et l'élasticité de la demande totale de soins de santé par rapport à la qualité sont introduits, ce qui implique que certains patients renonceront au traitement dans une situation d'équilibre. Enfin, des fonctions du coût général qui convergent faiblement en termes d'activité et sont indissociables en termes d'activité et de qualité sont utilisées. Cela nécessite d'augmenter le coût marginal du traitement, mais également de modéliser la qualité et le coût en tant que compléments, ce dernier cas étant justifié par des effets d'apprentissage par la pratique.[34] Sur la base de ces hypothèses, les auteurs analysent l'effet de la concurrence sur la qualité des services hospitaliers dont les prix sont réglementés. Pour ce faire, ils font la distinction entre configuration monopolistique et configuration concurrentielle, avec des variations dues soit à la réduction des coûts de transport (substituabilité accrue), soit à un nombre plus important d'hôpitaux. Leur étude pourrait apporter un certain éclairage sur l'ensemble des conditions nécessaires à l'amélioration de la qualité dans le cadre d'un régime de prix fixes, dans la mesure où une corrélation positive entre concurrence et qualité n'est plus garantie, notamment lorsque les hôpitaux sont suffisamment altruistes et se disputent un plus grand nombre de patients. Brekke *et al.* (2011:465) avertissent toutefois que même si « des mesures politiques pour améliorer la concurrence entre les prestataires de soins de santé ne conduisent pas aux résultats attendus — à savoir une amélioration de la qualité des soins de santé — cela ne signifie pas forcément que ces mesures politiques ne doivent pas être mises en œuvre », dans la mesure où cela pourrait tout de même entraîner une amélioration du bien-être.

Les délais d'attente sont un autre aspect de la qualité dont les patients se soucient et qui a été modélisé de manière théorique. Brekke *et al.* (2008) par exemple avancent que le fait de restreindre le choix offert aux patients peut permettre à certains hôpitaux d'attirer des patients très rentables en réduisant les délais d'attente.

En conclusion, la théorie économique voudrait que l'accroissement de la concurrence entraîne une amélioration ou une dégradation de la qualité lorsque les entreprises décident à la fois de la qualité et des prix. L'impact de la concurrence sur la qualité dépendra de l'impact relatif de l'élasticité de la demande par rapport aux tarifs hospitaliers et à la qualité. Lorsque les prix sont réglementés, la majeure partie des études

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32 En outre, cette structure de prix optimale élimine également le problème d'aléa moral lié aux traitements excessifs. Il s'agit probablement de l'argument le moins convaincant avancé par les auteurs dans la mesure où un traitement excessif, tel qu'il est défini dans cette publication, équivaut à administrer un traitement différent.

33 Voir par exemple Karlsson (2007) et Brekke *et al.* (2006).

34 Comme on peut supposer que l'amélioration de la qualité entraîne une hausse du coût, il est inhabituel de ne pas modéliser la qualité et les coûts en tant que compléments. Les auteurs le reconnaissent.

théoriques prédisent des améliorations de la qualité, bien que certaines publications récentes tablent également sur des résultats plus ambigus. Il apparaît qu'en situation de concurrence dans un contexte de prix réglementés, la qualité dépendra du prix administré et de son rapport au coût marginal.

3.2.2. Autonomie des hôpitaux et caractéristiques des systèmes de santé

L'autonomie dont disposent les dirigeants hospitaliers pour embaucher et licencier leur personnel est un facteur clé lié à l'offre qui influe sur la capacité des hôpitaux à se livrer concurrence sur le plan de l'efficience et de la qualité. Il ressort de l'enquête de l'OCDE sur les caractéristiques des systèmes de santé que dans la majorité des pays de l'OCDE (20 sur 29), les dirigeants d'hôpitaux disposent d'une autonomie totale dans le recrutement du personnel médical. À l'inverse, au Canada, en France, en Grèce, en Italie, en Irlande, au Mexique, en Norvège, en Espagne et en Turquie, ce sont les administrations centrales ou locales qui sont décisionnaires en matière de recrutement du personnel médical.

Bien que la majorité de pays membres de l'OCDE permettent aux dirigeants de recruter et de licencier, une minorité de pays leur permettent d'influer sur la rémunération des docteurs. La rémunération des médecins des hôpitaux s'inscrit le plus souvent dans le cadre d'une échelle de rémunération négociée au niveau national (dans 17 pays sur 29). Dans 11 pays, les dirigeants hospitaliers disposent d'une autonomie totale pour recruter et rémunérer le personnel médical. Aux Pays-Bas, toutefois, les dirigeants ont en pratique peu d'influence sur le recrutement et la rémunération des spécialistes dans la mesure où les décisions sont souvent prises par les spécialistes déjà présents dans les cabinets de groupe.

Plus souvent, les hôpitaux disposent d'une autonomie totale pour le recrutement des professionnels de santé (dans 21 pays sur 29) qui ne sont pas des médecins. Les administrations centrales ou locales sont décisionnaires dans sept pays (Canada, Grèce, Italie, Irlande, Mexique, Espagne et Turquie) et au Luxembourg, les hôpitaux doivent négocier avec les autorités locales. Les hôpitaux peuvent le plus souvent déterminer de manière autonome le niveau de rémunération (11 pays), mais des échelles de rémunération nationales sont en vigueur dans 18 pays. Dans 11 pays, les dirigeants hospitaliers disposent d'une autonomie totale pour le recrutement et la rémunération du personnel soignant non médical.

La structure, les institutions et le fonctionnement des différents systèmes de santé des pays de l'OCDE sont extrêmement variés. Afin d'aider les décideurs à comparer efficacement les performances, les travaux de l'OCDE sur les performances des systèmes de santé ont tenté de « regrouper » les systèmes de santé en groupes de pays ayant des institutions analogues.

Bien qu'une part de subjectivité soit toujours présente dans la définition du nombre optimal de groupes, compte tenu de l'arbitrage à effectuer entre leur nombre et le degré d'hétérogénéité en leur sein, l'analyse typologique semble indiquer que les pays de l'OCDE peuvent raisonnablement être répartis en six groupes.

Ces groupes de pays possèdent les grandes caractéristiques institutionnelles suivantes :

- L'Allemagne (voir encadré 2), les Pays-Bas (voir encadré 5), la République slovaque et la Suisse s'appuient très largement sur les mécanismes du marché pour réguler l'assurance de base. Les prestataires privés jouent un rôle important et leur rémunération prend essentiellement la forme d'honoraires. Les utilisateurs bénéficient d'un large choix s'agissant de ces derniers, mais des mécanismes de filtrage sont en place. Il n'existe aucune règle de dépenses stricte et ces pays réglementent faiblement les prix acquittés par les tiers payeurs pour maîtriser l'augmentation des dépenses publiques. En revanche, ils se distinguent nettement par leur degré de décentralisation : en Suisse, les administrations infra-nationales disposent d'une grande autonomie en matière de gestion des services de santé, alors que c'est exactement l'inverse aux Pays-Bas.

- Un deuxième groupe de pays — Australie, Belgique, Canada et France — se caractérise par une combinaison entre couverture de base publique et recours marqué aux mécanismes du marché au niveau des prestataires : les usagers bénéficient d'un large choix s'agissant de ces derniers ; la prestation privée de soins avec hospitalisation et de soins ambulatoires occupe une place relativement importante ; les mesures visant à inciter les prestataires à fournir des volumes de services élevés sont généralement nombreuses, et l'information des usagers sur la qualité et les prix des services peut faire office de facteur disciplinant. La couverture en plus de l'assurance de base joue un rôle important dans ces pays. En France et, dans une moindre mesure, en Belgique, la couverture de base impose aux usagers un niveau élevé de partage des coûts, largement couvert par l'assurance complémentaire. Au Canada, le marché de l'assurance supplémentaire est important (67 % de la population), les assurances privées prenant en charge les médicaments et les soins dentaires non remboursés par le régime public. En Australie, la couverture en plus de la couverture de base relève des assurances supplémentaire et parallèle. Dans ce groupe de pays, la maîtrise des coûts passe généralement par des dispositifs de filtrage, et des mécanismes stricts de définition des priorités (panier de prestations défini au niveau de l'administration centrale par une liste positive et/ou utilisation efficace de l'évaluation des technologies de la santé pour déterminer quels biens et services devraient être inclus dans la couverture de base).

- Le troisième groupe, qui comprend l'Autriche, la République tchèque, la Grèce, le Japon, la Corée et le Luxembourg, se caractérise également par l'importance de la prestation privée des services de santé et l'ampleur du choix accordé aux patients. Mais aucun dispositif de filtrage n'est en vigueur. Et les informations disponibles sur la qualité et les prix des services sont rares, ce qui modère les pressions concurrentielles pesant sur les prestataires. La couverture en plus de l'assurance de base est limitée. La rigueur budgétaire est généralement moins marquée que dans d'autres groupes de pays.

- Les systèmes de santé de l'Islande, de la Suède et de la Turquie autorisent les patients à choisir le prestataire de leur choix dans les trois domaines de soins (soins généraux, soins spécialisés et soins hospitaliers), en l'absence de tout dispositif de filtrage. Néanmoins, la prestation privée de services de santé est très limitée et les prestataires sont faiblement incités à accroître les volumes, tandis que leurs prix ont tendance à être étroitement encadrés. La rigueur budgétaire est faible, hormis en Suède, où elle est très importante.

- Dans le groupe constitué du Danemark, de la Finlande, du Mexique, du Portugal et de l'Espagne, les services de santé sont essentiellement assurés dans le cadre d'un système public lourdement réglementé. Le choix du prestataire par les patients est extrêmement limité, et le filtrage joue un rôle non négligeable. Un objectif de dépenses publiques de santé a été fixé, mais il n'est associé à aucune rigueur budgétaire marquée, sauf au Portugal. Parmi ces pays, l'Espagne et la Finlande sont nettement plus décentralisés que la moyenne des membres de l'OCDE.

- Le dernier groupe rassemble également des systèmes publics lourdement réglementés — Hongrie, Irlande, Italie (voir encadré 4), Nouvelle-Zélande, Norvège, Pologne (voir encadré 3) et Royaume-Uni (voir encadré 6). La rigueur budgétaire est plus marquée que dans la plupart des autres pays de l'OCDE. Par rapport au groupe précédent, la liberté accordée aux patients dans le choix du prestataire est importante et l'autonomie des administrations infranationales est généralement moindre. La couverture en plus de l'assurance de base est extrêmement limitée, sauf en Irlande et en Nouvelle-Zélande, où l'assurance parallèle occupe une place importante et permet de se faire soigner plus rapidement dans le secteur privé.

Encadré 3. Contexte institutionnel des services hospitaliers en Pologne

Introduction

Avant la réforme de 1999, le système de santé polonais — alors fondé sur le 'libre accès' aux services de santé — était directement financé par le budget public. Avec l'instauration d'une assurance maladie obligatoire et universelle, les cotisations sociales sur les revenus d'activité sont devenues la principale source de financement des caisses maladie, qui ont été remplacées en 2003 par le Fonds national de la santé (*Narodowy Fundusz Zdrowia,* NFZ).

Depuis août 2004, l'assurance maladie est réglementée par la Loi sur les prestations de santé financées par l'argent public. Les cotisations d'assurance maladie obligatoire, qui couvre pratiquement toute la population, représentent actuellement 9 % du salaire d'un employé (dont 7.5 % sont déductibles des impôts). Les cotisations sont collectées par l'Institut des assurances sociales (*Zakład Ubezpiecze Społecznych,* ZUS), puis transférées au NFZ. Le NFZ répartit son budget entre ses 16 antennes locales, qui passent ensuite des contrats avec des prestataires de services de santé dans leurs régions respectives. Outre l'assurance maladie obligatoire, il est possible depuis 1998 de souscrire une assurance maladie volontaire. Contrairement à l'assurance obligatoire, qui est fournie exclusivement par le Fonds national de la santé, l'assurance maladie volontaire est fournie par des sociétés privées.

La structure du secteur hospitalier polonais

Le système de santé polonais est caractérisé par une séparation stricte entre les structures hospitalières et les structures de soins ambulatoires. Les services ambulatoires sont assurés principalement par des cabinets privés, tandis que les soins hospitaliers demeurent principalement publics. Le processus de transformation de la structure de propriété des hôpitaux a débuté en 1995. Bien que la part des hôpitaux non publics par rapport au nombre total d'établissements (actuellement environ 25 %) ait augmenté régulièrement, elle demeure faible en termes de nombre de lits (environ 7 %).[35] Cette différence est due au fait que les hôpitaux privés sont généralement plus petits que les hôpitaux publics et se concentrent principalement sur les disciplines médicales les plus rentables et les plus spécialisées. La majorité des hôpitaux non publics (environ 65 %) sont dirigés par une entité privée, alors que les 35 % restants sont dirigés par l'administration locale.

Les services hospitaliers peuvent être fournis tant par des hôpitaux publics que privés. Toutefois, les caisses régionales ne peuvent passer des contrats que pour les services inclus dans la liste de procédures établie par le NFZ.

Rémunération des services hospitaliers

Avant l'instauration du système fondé sur les GHM, le système de paiement polonais reposait sur un système très similaire, le « Catalogue des produits de santé ». Les hôpitaux recevaient un forfait par admission correspondant à la valeur d'un produit donné. Toutefois, ce catalogue ne cessait de grossir, et le système était jugé opaque. Le système de financement fondé sur les GHM, instauré au niveau national en juillet 2008, est désormais obligatoire dans tous les hôpitaux publics et non publics ayant signé un contrat avec le NFZ.

3.2.3. Prestations publique et privée de services hospitaliers

L'offre de services de santé publics comprend toute une gamme de modèles possibles, depuis les services de santé directement assurés par les pouvoirs publics et entièrement financés sur fonds publics, jusqu'aux marchés faiblement réglementés et fortement privatisés. Toutefois, comme les pouvoirs publics sont de plus en plus souvent confrontés à une hausse de la demande de services de santé (en raison de la part croissante des personnes âgées dans la population, du choix accru accordé aux patients, des meilleures possibilités de comparaison de la qualité des services), aux attentes grandissantes des consommateurs, et à

35 Dans le sillage de cette transformation, de nouvelles structures sont apparues, comme l'Association nationale des hôpitaux non publics et l'Association nationale des hôpitaux non publics des administrations locales. Ces structures mènent différentes initiatives conjointes afin de promouvoir un changement d'organisation des services de santé polonais et assurer ainsi un traitement équitable aux prestataires publics et privés de services de santé.

une augmentation des coûts, l'utilisation de différentes formes de prestations publiques/privées commencent à s'imposer de plus en plus.

La part respective des secteurs public et privé dans la prestation de services hospitaliers peut être évaluée sous deux angles différents : du point de vue du système, qui peut être caractérisé par le nombre respectif de lits dans les hôpitaux publics/privés et la possibilité offerte aux médecins libéraux ainsi qu'aux médecins salariés des hôpitaux publics d'accorder des consultations privées, ou du point de vue des stratégies d'achat des pouvoirs publics dans le contexte de partenariats et de collaborations public-privé (PPP et CPP).

La répartition des secteurs public et privé dans les systèmes de santé au sens large

Dans plusieurs pays de l'OCDE, la part respective des secteurs public et privé dans la prestation de services hospitaliers varie en fonction du type de soins (aigus, réadaptation, longue durée). Comme il n'était pas possible de recueillir des informations sur tous les types de services, l'enquête de l'OCDE sur les caractéristiques des systèmes de santé s'est concentrée sur les soins hospitaliers aigus afin d'avoir une compréhension globale de la répartition public/privé dans les pays de l'OCDE. Dans la plupart de ces pays, les soins hospitaliers aigus constituent la principale activité du secteur hospitalier. Les lits de soins aigus représentent en moyenne ¾ de tous les lits d'hôpitaux dans les pays de l'OCDE ; de 51 % en Irlande, cette part atteint 93 % en Turquie.[36]

Deux indicateurs généraux ont été utilisés pour caractériser la répartition public/privé dans les services hospitaliers des pays de l'OCDE :

- Les parts respectives des lits de soins aigus dans les « hôpitaux publics », les « hôpitaux privés à but non lucratif » et les « hôpitaux privés à but lucratif ».

- La question de savoir si les consultations privées sont autorisées dans les hôpitaux publics, pour les médecins libéraux et/ou les médecins salariés.

Il convient également de noter que dans un petit nombre de pays de l'OCDE, les organisations fournissant des services de santé couverts ne peuvent pas faire de bénéfices. C'est le cas par exemple au Japon. Au Canada, bien que les services de santé couverts par la Loi canadienne sur la santé doivent être fournis sur une base non lucrative, un petit nombre d'hôpitaux à but lucratif dispensent tout de même des services de santé couverts. Toutefois, la plupart des hôpitaux sont publics et à but non lucratif.

Dans la totalité des pays de l'OCDE, les soins hospitaliers aigus sont principalement dispensés par le secteur public, sauf en Belgique, au Japon, en Corée et aux Pays-Bas, où le secteur privé à but non lucratif est le principal prestataire. Le secteur privé à but lucratif joue un rôle important en République slovaque (40 % des lits de soins aigus), au Mexique (35 %), en Grèce (28 %), ainsi qu'en France et en Corée (25 % chacune).

Les consultations privées dans les hôpitaux publics sont autorisées dans 18 pays sur 29. En effet, les médecins qui travaillent dans les hôpitaux publics ne sont pas toujours salariés. Par exemple, en Belgique et dans certaines provinces canadiennes, la grande majorité des médecins travaillant dans les hôpitaux publics ont le statut de travailleur libéral et sont rémunérés à l'acte.

Dans certains pays (par exemple la France, le Royaume-Uni), les médecins salariés des hôpitaux publics sont autorisés dans certaines circonstances à traiter les patients dans le cadre d'une consultation

[36] Voir OCDE (2011).

privée. En France, ce privilège est une concession accordée pour attirer et fidéliser les médecins expérimentés dans les hôpitaux publics, où les salaires sont généralement plus bas que dans le secteur privé. Dans les deux pays, les consultations privées dans les hôpitaux publics sont toutefois limitées.

Tableau 1: Part des secteurs public et privé dans la prestation de soins hospitaliers aigus[37]

Pays	Pourcentage de lits de soins aigus dans les :			Les consultations privées sont-elles autorisées dans les hôpitaux publics ?		
	Hôpitaux publics	Hôpitaux privés à but non lucratif	Hôpitaux privés à but lucratif	Médecins libéraux	Médecins salariés	Non
Australie	69.59	14.38	16.03		X	
Autriche	72.5	18.8	8.7		X	
Belgique	34	66	0	X	X	
Canada	100	0	0	X		
République tchèque	91	0	9			X
Danemark	96.7	2.5	0.8			X
Finlande	89	0	11			X
France	66	9	25		X	
Allemagne	49	36	15	X		
Grèce	69	3	28		X	
Hongrie	n.d.	n.d.	n.d.			X
Islande	100	0	0			X
Irlande	88	0	12		X	
Italie	81.5	16.7	1.8		X	
Japon	26.3	73.7	0	X	X	
Corée	10	65	25			X
Luxembourg	68	29	3	X	X	
Mexique	65	0	35			X
Pays-Bas	0	100	0	X(2)	X(2)	
Nouvelle-Zélande	81	9.5(1)	9.5(1)			X
Norvège	99	1	0			X
Pologne	95	0	5	X		X
Portugal	85.7	6.6	7.7		X	
République slovaque	59.6	0	40.4	n.d.	n.d.	n.d.
Espagne	74.23	17	8.77			X
Suède	98	0	2	X		
Suisse	82.7	4.8	12.5	X	X	
Turquie	89.5	0	10.5		X	
Royaume-Uni	96	4	0		X	

Remarque : (1) imputation de l'OCDE ; (2) Médecins à la fois salariés et libéraux dans les hôpitaux privés à but non lucratif.
Remarque : n.d. signifie non disponible.

37 Paris *et al.* (2010). À noter que les chiffres de l'Italie ont été modifiés.

Encadré 4. Contexte institutionnel des services hospitaliers en Italie[38]

Introduction

Le modèle actuel du système de santé italien, explicitement inspiré du NHS britannique, résulte de trois réformes fondamentales menées en 1978, 1992 et 1999. La première réforme a remplacé plus d'une centaine de caisses d'assurance maladie par le Service national de la santé (*Servizio Sanitario Nazionale,* SSN), qui fournit désormais à tous les citoyens ainsi qu'aux résidents étrangers en situation régulière une assistance sanitaire universelle gratuite au point de délivrance des soins. L'assurance est obligatoire et il n'est pas possible de s'y soustraire. Par ailleurs, les patients peuvent souscrire une assurance privée et recourir aux services d'hôpitaux privés non conventionnés à leurs propres frais. La deuxième réforme, motivée par les difficultés à maîtriser les dépenses de santé publiques, a introduit le principe de gestion « privée » et a accordé davantage d'autonomie aux hôpitaux dans la perspective d'encourager la concurrence et d'améliorer l'efficience des prestations de services de santé. Les Unités sanitaires locales ont été transformées en Établissements sanitaires locaux (*Aziende Sanitarie Locali*, ASL) placés sous l'autorité de directeurs nommés par la Région sur une base contractuelle, et rémunérés selon leurs performances. La troisième réforme, achevée en 2001, a introduit le principe des prestations de base (*Livelli Essenziali di Assistenza,* LEA) et a finalisé la décentralisation du SSN.

L'organisation décentralisée du système repose sur une structure à trois niveaux : l'administration nationale, les régions, et les autorités sanitaires locales. Au niveau national, le ministère de la Santé détermine les objectifs généraux ainsi que les prestations de base (*LEA*)[39] et répartit les ressources du SSN entre les régions. D'autre part, les régions sont en charge de l'organisation et de l'administration des soins de santé publics, tandis que les ASL sont chargés de dispenser les services de santé.

Le SSN est financé par l'impôt, et notamment l'impôt direct (impôt sur le revenu des personnes physiques, IRPEF et taxe professionnelle, IRAP – environ 40 %) ainsi que l'impôt indirect (TVA et taxe sur les produits pétroliers – environ 42 %).[40] Ces impôts constituent les revenus des régions. En outre, les ASL tirent des revenus directs des tickets modérateurs ainsi que de la prestation de services payants.

La structure du secteur hospitalier italien

En Italie, les services hospitaliers sont fournis par des établissements publics, privés à but lucratif et privés à but non lucratif.[41]

Globalement, environ 54 % des hôpitaux sont publics, et 46 % sont privés.[42] La responsabilité de la prestation de services hospitaliers revient aux ASL qui peuvent passer des contrats tant avec les hôpitaux publics que les hôpitaux privés, du moment que ces derniers sont conventionnés. Toutefois, certaines régions plafonnent le nombre total de services privés remboursés par les ASL.

Rémunération des services hospitaliers

Le système de financement fondé sur les GHM a été instauré en Italie en 1994. Il s'applique tant aux hôpitaux publics que privés, et couvre la plupart des dispositifs utilisés dans les hôpitaux. Le ministère de la Santé adopte un

38 Cet encadré s'appuie sur la contribution de l'Italie figurant dans OCDE (2006).

39 Les régions sont libres de fournir des services non inclus dans les LEA, mais elles doivent alors les financer elles-mêmes.

40 Le reste provient d'autres transferts des secteurs publics et privés (environ 14 %), et des propres ressources des ASL (environ 3 %). Voir Tediosi *et al.* (2009).

41 Les hôpitaux privés à but non lucratif sont principalement des établissements universitaires et de recherche constitués en entités de droit privé, ainsi que des hôpitaux gérés par l'Église.

42 Ministero della Salute, *Relazione sullo Stato Sanitario del Paese 2009-2010*, p. 433

ensemble de tarifs des GHM au niveau national, mais les régions sont libres de ne pas les respecter et d'opter pour des tarifs individuels inférieurs.[43]

Les hôpitaux et les ASL forment de plus en plus de commissions d'achats (*Commissioni Terapeutiche di Area Vasta – CTAV*) afin d'obtenir de meilleurs prix. L'utilisation de dispositifs innovants et coûteux non couverts par le système fondé sur les GHM peut être remboursée séparément sur le budget de la région.

Le recours aux partenariats public-privé dans la prestation de services hospitaliers

Les contraintes financières croissantes ont incité les pouvoirs publics à rechercher et à mettre en œuvre d'autres modèles de prestation de services afin d'optimiser les performances économiques dans la prestation de services publics. Le soutien accru à l'utilisation de PPP dans le secteur de la santé, considéré comme un moyen d'investir dans ce secteur tout en limitant l'impact de ces dépenses sur les finances publiques, peut être une solution pour relever ce défi.

Actuellement, il n'existe pas de définition claire de ce qu'est un partenariat public-privé dans les services de santé, bien que les PPP soient utilisés depuis les années 1990. Un partenariat public-privé est défini comme « un accord entre l'État et un ou plusieurs partenaires privés (parmi lesquels figurent éventuellement les opérateurs et les financiers) en vertu duquel les partenaires privés fournissent un service selon des modalités qui permettent de concilier les buts de prestation poursuivis par l'État et les objectifs de bénéfice des partenaires privés, l'efficacité de la conciliation dépendant d'un transfert suffisant du risque aux partenaires privés. »[44]

Les PPP dans le secteur de la santé prennent généralement la forme de contrats à long terme (le plus souvent d'une durée comprise entre 15 et 30 ans) entre une autorité publique et une entité de droit privé, désignés sous le nom d'entités à finalité spécifique (*special-purpose vehicles* – SPV). La partie privée organise, assure et/ou gère la prestation des services pour lesquels un contrat a été passé et reçoit en contrepartie un paiement de l'autorité publique.

Les PPP peuvent prendre différentes formes, chacune étant associée à un degré variable de responsabilité et de risque pour les parties publique et privée. Les modèles les plus courants sont décrits dans le tableau 2 ci-dessous :

43 Par exemple, la Lombardie, dont le niveau d'activité dans les services de santé est supérieur à la moyenne, a décidé de définir ses propres tarifs de remboursement, et d'encourager le traitement équitable des hôpitaux publics et privés en imposant les mêmes critères d'octroi des fonds publics.

44 Voir OCDE (2008).

Tableau 2 : Modèles de partenariats publics privés dans la prestation de services hospitaliers[45]

Modèle	Description
Franchise	L'autorité publique passe un contrat avec une entreprise privée pour la gestion d'un hôpital existant
DBFO (Conception-construction-financement-exploitation)	Un consortium privé conçoit un équipement sur la base d'un cahier des charges défini par l'autorité publique, le construit, prend à sa charge le coût d'investissement et exploite l'équipement
BOO (Construction-possession-exploitation)	L'autorité publique achète des services pour une période fixe (disons 30 ans), après quoi la propriété revient au prestataire privé
BOOT (Construction-possession-exploitation-transfert)	L'autorité publique achète des services pour une période fixe, après quoi la propriété revient à l'autorité publique
BOLB (Construction-possession-location)	Le contractant privé construit l'hôpital ; l'équipement est loué et géré par l'autorité publique
Modèle Alzira	Le contractant privé construit et exploite l'hôpital dans le cadre d'un contrat de prestation de soins visant une population donnée

Le choix d'un modèle de PPP spécifique dépend du cadre réglementaire en place, qu'il peut être nécessaire de modifier afin de permettre le recours à de nouvelles formes de partenariat.

Le cadre d'action pour les PPP adoptés par de nombreux pays à travers le monde a été fortement influencé par le modèle britannique, baptisé Initiative à financement privé (IFP), qui est fondé sur le modèle DBFO.[46] Au Royaume-Uni, le secteur privé finance et construit l'hôpital, et assure également les fonctions d'exploitation et de maintenance. D'autres modèles, comme *Alzira*, vont jusqu'à confier non seulement le financement, la construction et l'exploitation des hôpitaux au secteur privé, mais également les prestations de services cliniques. L'hôpital La Ribera, dans la province espagnole de Valence, en Espagne, en est un exemple.

Malgré la diversité des modèles de PPP et le fait que des hôpitaux fonctionnent dans ce cadre depuis les années 1990, il n'existe toujours pas d'évaluation probante et complète de ces partenariats.[47] Différents auteurs, comme Hodge et Greve (2007), soulignent que les PPP devraient faire l'objet d'une analyse rigoureuse. Bien que les PPP puissent certainement alléger la charge pesant sur les finances publiques, ils ne constituent pas toujours la solution la plus efficace, c'est pourquoi il est important que les pouvoirs publics procèdent à une évaluation soigneuse en amont. McKee *et al.* (2006) attirent l'attention sur des questions prêtant à controverse, telles que le coût, la qualité, la flexibilité et la complexité.

45 Voir McKee *et al.* (2006).

46 Ce modèle a été adopté par l'Espagne, l'Italie, le Mexique, l'Afrique du Sud, la France et l'Italie. Pour une vue d'ensemble de l'utilisation des PPP dans le contexte européen, voir Nikolic et Maikisch (2006).

47 Même le Royaume-Uni, qui possède pourtant l'une des plus vastes expériences en matière de mise en œuvre de PPP dans la prestation de services hospitaliers, ne dispose d'aucune évaluation de cette sorte. Le National Audit Office (NAO) britannique, qui contrôle les dépenses publiques pour le compte du Parlement, a souligné qu'il « convient désormais de mener une évaluation véritablement robuste et systématique de l'utilisation des financements privés dans le cadre de PPP, soit au niveau d'un projet, soit d'un programme ». Voir National Office Audit (2009).

3.3. Facteurs liés à la demande

L'économie des services hospitaliers est typiquement axée sur les facteurs liés à l'offre, et les études font généralement référence à la demande induite par l'offre. Pour comprendre pourquoi la demande peut être dans une large mesure induite par l'offre, nous nous pencherons sur les services hospitaliers en tant que biens de confiance. Les asymétries d'information et la rationalité limitée des patients contribuent également grandement au fait que la demande soit largement induite par l'offre. Enfin, plusieurs initiatives politiques visent à améliorer la transparence et à s'éloigner au moins partiellement d'une demande purement induite par l'offre, principalement en renforçant les informations que les patients ont à leur disposition lors du choix d'un hôpital.

3.3.1. Les services hospitaliers en tant que biens de confiance

Une caractéristique essentielle des services hospitaliers a trait à leur nature. Ils sont en effet généralement qualifiés de biens ou services de confiance. Ce terme désigne des biens ou services dont les consommateurs sont incapables de déterminer la quantité et la qualité optimales *ex ante* et *ex post*. Généralement, les fournisseurs de biens de confiance ne se contentent pas de fournir ces biens ou services, mais tiennent aussi lieu d'experts pour déterminer les besoins des clients. Les services médicaux ne sont pas les seuls biens de confiance. Les services de taxi, les conseils juridiques et financiers, ainsi que d'un grand nombre de prestations de réparation en font également partie. Comme les clients ne n'évaluent jamais la qualité du produit ou du service, et ne sont souvent même pas en mesure de juger si le service a vraiment été fourni, ces biens et services sont nommés biens de confiance.[48]

Selon Emond (2001), cette asymétrie d'information donne aux vendeurs de multiples occasions de profiter des consommateurs. Le vendeur peut choisir d'abuser un acheteur en lui recommandant des traitements onéreux et inutiles — un problème désigné sous le nom de « demande induite » dans les publications relatives à l'économie de la santé. Si, à l'inverse, d'autres activités sont plus rentables, les vendeurs sont susceptibles de renoncer à administrer les traitements urgents.

Emond (2001:376) fournit des éléments supplémentaires à ce sujet. Il écrit qu'en Suisse, les patients ayant un faible niveau d'éducation ont deux fois plus de risques de subir une hystérectomie ou une cholécystectomie que des patients ayant une formation universitaire, et que cette probabilité atteint même 150 % en ce qui concerne les opérations de la hanche. Selon lui, les enfants « ordinaires » ont 80 % de risques en plus de subir une amygdalectomie que les enfants de médecins. Il fait également référence à un article de *The Economist*[49] selon lequel un tiers des dépenses de santé actuelles aux États-Unis seraient dues à des examens non justifiés, des procédures non éprouvées et des médicaments et dispositifs inutilement coûteux.[50]

3.3.2. Rationalité limitée

Outre le caractère de bien de confiance des services hospitaliers et l'asymétrie d'information qui en résulte, les économistes reconnaissent désormais également largement que les acteurs économiques en

48 Voir Dulleck et Kerschbamer (2006) pour un tour d'horizon des publications relatives aux biens de confiance.

49 *The Economist* du 13 février 1999.

50 Emons (2001) présente un modèle d'envoi de signaux stratégiques fondé sur les capacités et les prix du diagnostic et du traitement dans le contexte d'une fourniture monopolistique de biens de confiance.

général et les patients des hôpitaux en particulier font preuve d'une rationalité limitée[51], ce qui exacerbe le caractère de bien de confiance des services hospitaliers.

La rationalité limitée comporte généralement deux aspects : les limites de l'esprit humain, et la structure de l'environnement au sein duquel l'esprit humain évolue. Le premier aspect concerne le fait que dans de nombreuses situations réelles, on ne connaît pas et on ne peut pas connaître les stratégies optimales.[52] Même dans un jeu comme les échecs, où une réponse optimale existe à tous les stades de la partie, il n'existe aucun algorithme (informatique) permettant de calculer ce coup dans un délai raisonnable. Cela est surprenant dans la mesure où les échecs, contrairement à la plupart des autres environnements, sont un jeu bien défini. Si l'identification d'une stratégie optimale n'est même pas possible dans un tel environnement, elle est sûrement impossible dans des scénarios plus complexes. Par conséquent, les êtres humains « doivent utiliser des méthodes approximatives pour gérer la plupart des tâches ».[53]

Le second aspect de la rationalité limitée, à savoir la structure environnementale, revêt une importance cruciale car il explique pourquoi les êtres humains demeurent capables de prendre des décisions raisonnablement bonnes malgré ces limites inhérentes. Dans la mesure où les processus décisionnels se sont adaptés à l'environnement par le biais d'un processus d'évolution, ils fonctionneront raisonnablement bien.[54]

Le principe du « seuil de satisfaction » défini par Simon — qui permet de faire un choix entre un ensemble de possibilités rencontrées les unes à la suite des autres lorsque les probabilités associées sont inconnues — est une forme de rationalité limitée. En l'occurrence, il se peut qu'il n'existe aucune méthode optimale permettant de mettre fin aux recherches — il n'y aurait ainsi aucune solution optimale permettant de décider quand arrêter de chercher un hôpital convenable pour un traitement donné. Le principe du « seuil de satisfaction » permet d'aller droit au but en définissant un niveau d'aspiration et de mettre fin aux recherches dès que l'on juge qu'un hôpital est supérieur à ce niveau. À l'évidence, il existe une grande différence si le seuil de satisfaction est axé sur les qualités « hôtelières » de l'hôpital plutôt que sur les taux de mortalité, par exemple. L'apparente préférence dont bénéficient les hôpitaux locaux pourrait ainsi résulter du fait que le choix entre plusieurs hôpitaux se fonde sur le principe du seuil de satisfaction.[55]

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51 Il est important de faire la distinction entre la rationalité limitée et ce qui est parfois appelé « biais décisionnels ». Alors que, par exemple, les publications empiriques dans le domaine de l'économie et de la psychologie étaient axées à l'origine sur ce qu'il est convenu d'appeler des « biais » ou des « écarts » par rapport au modèle de l'acteur rationnel, se contentant de décrire ce qu'est un comportement rationnel et de mesurer les écarts par rapport à ce comportement, il est désormais largement admis que le programme d'étude consacré à la rationalité limitée s'éloigne systématiquement de la caractérisation des biais comportementaux en tant qu'écarts par rapport à une prise de décision parfaitement rationnelle. Malheureusement, cet aspect n'est pas (encore) bien appréhendé par le droit de la concurrence, comme l'ont montré Bennett et al. (2010) ou Garcés-Tolon (2010).

52 Voir Simon (1987).

53 Voir Simon (1990:6).

54 L'exemple classique donné par Simon (1956) concerne des organismes imaginaires recherchant de la nourriture sur la base de règles simples. Le comportement de ces organismes ne peut être compris qu'en observant la structure des informations dans l'environnement.

55 Voir Dixon *et al.* (2010), qui donnent un aperçu empirique des choix au Royaume-Uni. Le fait que la distance ou le temps de trajet ait un impact négatif majeur sur la demande qui est faite d'un hôpital est également abordé dans Beckert *et al.* (2012), Capps *et al.* (2001), Capps *et al.* (2003), Capps *et al.* (2009), Ho (2006), Sivey (2011), Tay (2003). Beckert *et al.* (2012) montrent que la qualité peut également entrer en jeu. Plus le taux de mortalité est bas et le délai d'attente court, plus il y a de chances qu'un patient

L'étude de Hoffrage et Gigerenzer (1998) démontre la pertinence des aspects relatifs à la rationalité limitée pour comprendre les choix des patients mais aussi les décisions des professionnels de santé. Ces deux auteurs ont évalué, dans leur étude, la capacité des gynécologues à interpréter les mammographies positives. Il en est ressorti que la plupart de ces médecins n'ont pas connaissance des probabilités qu'une patiente ayant subi un test de dépistage positif souffre effectivement de la maladie — c'est-à-dire la valeur prédictive positive du dépistage. Les auteurs constatent également que ces spécialistes sont incapables de l'estimer à partir des statistiques pertinentes lorsque ces statistiques sont formulées sous forme de probabilités conditionnelles, même lorsque le test relève de leur spécialité.[56]

3.3.3. Améliorer la transparence

La défaillance du marché imputable au caractère de bien de confiance des services hospitaliers, associée au fait que les décisions sont prises par des patients dont la rationalité est limitée, peut être atténuée en améliorant la base d'informations sur laquelle repose le choix de l'hôpital — soit en fournissant davantage d'informations, soit en les rendant plus accessibles pour les patients.[57] Différents pays de l'OCDE ont cherché à rendre compte des performances des hôpitaux au moyen d'indicateurs de la qualité des soins (comme les taux de mortalité) ou de performance/accès (comme les délais d'attente), afin de pallier les asymétries d'information. Ces mesures ont permis d'aider plus ou moins efficacement les patients à faire un choix éclairé entre plusieurs hôpitaux.

Alors que de bonnes informations peuvent aider à prendre de meilleures décisions au moment de choisir des services hospitaliers, il se peut que ces informations n'aient pas systématiquement besoin d'être communiquées directement à un patient. En effet, de nombreux pays de l'OCDE structurent activement leur système de santé de manière que les professionnels aident les patients à surmonter les asymétries d'information en choisissant l'hôpital à leur place.[58] Le recours à des « acheteurs » de soins de santé comme les compagnies d'assurance ou les HMO est une façon de mettre les hôpitaux en concurrence, dans la mesure où ils doivent chercher à améliorer la qualité et l'efficience lors de la négociation des contrats de services de santé.

Cette méthode d'accroissement de la concurrence entre les hôpitaux met l'accent sur le rôle que les assureurs ou les HMO peuvent jouer dans la sélection des hôpitaux avec lesquels ils souhaitent passer des contrats. Bien que l'on ne sache pas toujours clairement si les préférences d'un assureur sont tout à fait conformes à celles des patients, il est clair que les sociétés d'assurance ont les moyens de réaliser des études de marché. Ces études peuvent porter à la fois sur les coûts et la qualité des services hospitaliers, mesurée par exemple par les taux de réadmission ou de mortalité. Bien que l'on puisse certainement compter sur les assureurs pour éliminer les hôpitaux les moins rentables dans les systèmes où les prix sont

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choisisse l'hôpital. En outre, les patients britanniques sont d'autant plus susceptibles de choisir un hôpital que la note de la Commission de la qualité des soins (CQC) est élevée et que le nombre d'infections à SARM est bas.

56 Gigerenzer *et al.* (2007:58) donnent plusieurs exemples supplémentaires soulignant « l'analphabétisme statistique collectif des patients, des médecins et des responsables politiques, ainsi que les coûts considérables que les systèmes de santé paient en conséquence. » Leur article fait état de différentes façons de présenter les informations afin de les rendre plus compréhensibles pour des êtres humains à la rationalité limitée. Ils analysent également dans quelle mesure les patients sont susceptibles de trouver des informations transparentes dans des brochures médicales et sur Internet, et suggèrent des façons plus appropriées de présenter les données statistiques.

57 L'accessibilité concerne à la fois la présentation des informations et la facilité pour les patients à y accéder physiquement.

58 Voir Annexe II : Informations sur les prestataires de services pour plus de détails sur les différents types d'informations à disposition des patients dans les différents systèmes de santé.

libres, même sans exercer le pouvoir de l'acheteur qu'ils détiennent, leur impact sur la qualité est plus ambigu et dépendra largement du coût induit par les écarts positifs ou négatifs par rapport à un niveau de qualité donné. Ainsi, bien qu'ils soient potentiellement en mesure d'accéder à un ensemble bien plus vaste d'informations sur le coût et la qualité, on ne sait pas toujours clairement si les préférences des assureurs sont tout à fait conformes aux besoins des patients en termes de choix des hôpitaux.[59] Et bien que les acheteurs puissent chercher à restreindre le choix des consommateurs dans un effort visant à les orienter vers des services hospitaliers de meilleure qualité, la structure du marché et la nature des acheteurs individuels peuvent parfois les désinciter à améliorer la qualité ou à réduire les prix au profit de leurs patients. En offrant aux patients le choix entre plusieurs hôpitaux, la réglementation peut également restreindre la capacité des assureurs à orienter les patients vers des prestataires offrant des services de meilleure qualité ou obtenant de meilleurs résultats.

Une deuxième façon de stimuler la concurrence entre les hôpitaux consiste à recourir à des agents informés, qui peuvent agir en tant que conseillers impartiaux auprès du patient, ou jouer un rôle de filtrage en aidant à déterminer si un service hospitalier (quel type de service) convient à un patient. Il peut par exemple s'agir d'un médecin généraliste, d'un professionnel de soins primaires ou d'un représentant indépendant des patients (désigné), qui aide ceux-ci à faire des choix et les conseille. Dans la mesure où ces approches sont efficaces, on pourrait en conclure que l'exercice par les patients de leur choix sur le marché stimule davantage la concurrence que la négociation de contrats.

En conclusion, tandis qu'une demande de services hospitaliers inélastique par rapport aux prix peut s'expliquer en partie par les asymétries d'information et leurs propriétés de biens de confiance évoquées précédemment, un certain degré d'inélasticité est bien entendu un choix délibéré de politique sociale. Autre élément intéressant, le fait que pour des traitements urgents, dans les cas les plus graves par exemple, le seuil de satisfaction soit susceptible d'être atteint plus tôt que pour les traitements n'ayant aucun caractère d'urgence. En cas d'urgence, de coma par exemple, les choix émanant du côté de la demande n'ont pas leur place. Cela limite naturellement les possibilités de s'éloigner d'un choix de services hospitaliers induit par l'offre.

4. Preuves empiriques

Les paragraphes suivants tentent d'établir un catalogue de faits stylisés sur la base des études empiriques pertinentes relatives à la concurrence dans les services hospitaliers. Son étendue (géographique) est limitée aux systèmes qui ont fait le plus souvent l'objet d'études empiriques, d'où un certain biais en faveur de pays comme les États-Unis, le Royaume-Uni et les Pays-Bas. En outre, la majorité des études abordées ici traitent principalement des questions positives et seul un petit nombre d'entre elles permettent de tirer des conclusions simples sur le plan normatif. En outre, les causalités postulées ne concernent généralement pas le mécanisme sous-jacent qui a généré ou accentué la causalité[60] de manière que même si une corrélation solide et robuste est constatée, l'explication scientifique de son apparition demeure ouverte, d'où les difficultés à formuler des conseils.

Les études suivantes sont principalement fondées sur le paradigme structure-comportement-performance (SCP) en tant que structure sous-jacente de l'approche économétrique.[61] Cela signifie qu'un

59 Bien évidemment, les compagnies d'assurance et les HMO peuvent avoir un impact négatif sur les patients de bien d'autres façons, par exemple en excluant certains traitements ou en refusant une prise en charge décente.

60 On peut également avoir certains doutes quant à savoir si les causalités postulées sont effectivement des causalités et non des corrélations. Voir Black (1982) pour une analyse générale très claire de ce problème.

61 Les contributions classiques proviennent d'Edward Mason et de Joe Bain. Voir Bain (1956) et (1959). Schmalensee (1989) donne une vue d'ensemble.

lien de causalité est établi entre la structure, le comportement et la performance du marché, bien que la plupart des modèles ne tiennent pas compte de la performance. Le prix ou la marge prix-coût sont un indicateur du comportement généralement accepté dans les études relatives à l'économie industrielle, mais dans les analyses consacrées aux services hospitaliers, ils sont généralement remplacés par un indicateur de la qualité. La structure du marché est généralement mesurée à l'aide de l'indice de Herfindahl-Hirschman (IHH)[62] bien que cela n'aille pas sans poser de difficultés sur les marchés des services hospitaliers.[63] L'utilisation de la conjecture SCP dans les modèles économétriques est connue pour être problématique. Par exemple, la structure, quelle que soit la façon dont elle est mesurée, est généralement considérée comme endogène.[64] Toute variation non mesurée de la demande et des facteurs de coûts par exemple affecte à la fois la qualité et la structure du marché, ce qui signifie qu'une entreprise dont les coûts sont bas est susceptible d'avoir une part de marché importante, d'où un IHH élevé, et de faire le choix d'une qualité élevée.[65] Outre l'approche SCP, certaines études s'intéressent à l'impact des fusions ou des changements de réglementation alors que d'autres se penchent sur la relation entre le volume de procédures spécifiques et les résultats médicaux des patients. Ces études se fondent généralement soit sur des simulations, soit sur

62 Cet indice est exprimé par la formule suivante : $HHI = \sum_{i=1}^{N} s_i^2$, où s_i représente la part de marché de l'entreprise *i*, et *N* le nombre d'entreprises. Ainsi, sur un marché dont deux entreprises détiennent une part de 50 % chacune, l'indice de Herfindahl-Hirschman est égal à $0.50^2 + 0.50^2 = 0.5$. L'indice de Herfindahl-Hirschman (IHH) est compris entre $\frac{1}{N}$ et 1, où *N* représente le nombre d'entreprises sur le marché. De même, si les pourcentages sont indiqués sous forme de nombres entiers, comme 75 au lieu de 0.75 par exemple, l'IHH peut atteindre 100^2, soit 10 000.

63 Le principal problème théorique est que l'IHH dérive d'un modèle de Cournot dans lequel les entreprises offrent des biens homogènes, et qu'aucun fondement théorique ne justifie donc d'appliquer ce modèle aux services hospitaliers. En outre, les hôpitaux fournissent des produits différenciés, une caractéristique importante dont les calculs de l'IHH ne tiennent généralement pas compte.

64 L'endogénéité est sans doute l'aspect le plus problématique de la modélisation des services hospitaliers. Techniquement parlant, un paramètre ou une variable est dit endogène lorsqu'il existe une corrélation entre ce paramètre ou cette variable et le terme d'erreur. En d'autres termes, le modèle souffre d'endogénéité si les variables dépendante et indépendante entretiennent une relation causale l'une avec l'autre. Prenons par exemple la corrélation (négative) entre le volume d'un traitement particulier dans n'importe quel hôpital et le taux de mortalité. Même si cette corrélation est significative et donc importante, on ne sait pas si cela est dû au fait que les patients sont attirés par les hôpitaux affichant des taux de mortalité inférieurs, d'où des volumes plus importants, ou au fait que les volumes plus importants dans un hôpital donné conduisent à une amélioration des taux de mortalité du fait d'un effet d'apprentissage par la pratique, ou d'autres améliorations de la qualité liées au volume. Le sens (principal) de la causalité, ou en d'autres termes, la question de savoir quel est l'effet prépondérant, présente un intérêt direct du point de vue du droit de la concurrence. Si le volume est à l'origine d'une amélioration de la qualité, on pourra donc considérer qu'une plus grande concentration du marché, qui par définition entraîne une hausse du volume et donc de la qualité, a un effet positif sur les résultats des patients. Par exemple, tant Gaynor *et al.* (2005) que Gowrisankaran *et al.* (2004), qui utilisent une méthode faisant intervenir une variable instrumentale, constatent un lien de causalité significatif et important entre le volume et le résultat. Voir, toutefois, Huesch (2009), qui, ne parvenant pas à identifier un effet d'apprentissage par la pratique, exclut éventuellement cette explication pour le lien de causalité volume-qualité. Gaynor et Town (2011:79 sqq.) passent en revue ces études, ainsi que d'autres études tentant d'examiner le lien de causalité volume-qualité.

65 Voir Gaynor et Town (2011:60 sq.) qui attirent également l'attention sur d'autres problèmes de spécification en rapport avec les marchés hospitaliers.

des études d'événements qui comparent les événements avant et après la fusion ou le changement de réglementation.[66]

4.1. Études relatives à la concurrence sur le plan de la qualité dans un régime de prix fixes

Les études suivantes portent toutes sur la question de savoir ce qui arrive à la qualité des services hospitaliers lorsque l'on compare des hôpitaux soumis à divers degrés de concurrence dans un régime de prix fixes.[67]

Des régimes de prix fixes sont en place dans de nombreux pays, comme le Royaume-Uni (voir encadré 6), les États-Unis (pour les bénéficiaires de Medicare et Medicaid), les Pays-Bas (voir encadré 5) et l'Allemagne (voir encadré 2).[68] Avec l'introduction de réglementation sur les prix, ceux-ci perdent leur statut de variable stratégique pour les hôpitaux.

L'étude de Kessler et McClellan (2000), qui est l'une des premières à tenter de tirer des conclusions quant aux liens de causalité entre la concurrence et la qualité des services hospitaliers, examine l'impact de la concentration du marché mesurée par l'IHH (à partir d'un modèle de choix du patient reposant principalement sur la distance à laquelle se trouve l'hôpital) sur la qualité des services hospitaliers mesurée à l'aide du taux de mortalité par infarctus aigu du myocarde (crise cardiaque), ajusté en fonction du risque, sur un an. Les résultats de cette étude menée aux États-Unis sont saisissants. En effet, la qualité mesurée est sensiblement supérieure sur les marchés moins concentrés. Sur les marchés les plus concentrés, la probabilité de mourir était supérieure de 1.46 point à ce qu'elle était sur les marchés les moins concentrés. Ces données font apparaître un écart non négligeable de 4.4 % entre les taux de mortalité, soit plus de 2 000 décès (statistiques) en moins sur les marchés les moins concentrés par rapport à ceux qui le sont le plus. En ce qui concerne les dépenses, la corrélation s'inverse avec le temps, les dépenses étant d'abord plus élevées sur les marchés moins concentrés, puis moins élevées. Lorsque l'on examine les données les plus récentes, les dépenses et les taux de mortalités sont inférieurs sur les marchés moins concentrés, ce qui implique de meilleurs bénéfices pour la santé des patients, associés à des coûts inférieurs. L'affirmation selon laquelle la concurrence améliore le bien-être est toutefois incertaine, étant donné que l'indicateur des dépenses utilisé n'est pas équivalent au coût économique, comme une analyse du bien-être l'exigerait.[69]

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66 En raison de l'intérêt croissant porté à l'évaluation *ex post* des effets de la politique de la concurrence, les études relatives aux fusions dans le secteur hospitalier risquent de se multiplier au cours des prochaines années.

67 L'un des arguments avancés pour renoncer à l'analyse des études s'intéressant aux effets de la concurrence sur la qualité lorsque les prix sont fixés par les hôpitaux est qu'elles concernent principalement les États-Unis et que leurs résultats sont ambigus, d'où l'impossibilité de tirer des conclusions sans entrer dans des détails beaucoup plus institutionnels.

68 En outre, le fait que les hôpitaux soient à but lucratif ou non lucratif, ou relèvent de l'une des très nombreuses formes mixtes, peut également jouer.

69 Voir Gaynor et Town (2011:63 sq.).

Encadré 5. Contexte institutionnel des services hospitaliers aux Pays-Bas

Introduction

Avant 2006, les Pays-Bas étaient dotés d'un système d'assurance maladie et de financement assez complexe fondé sur la coexistence d'une assurance sociale obligatoire et d'une assurance privée volontaire. La réforme de 2006, entreprise dans le but d'instaurer une concurrence entre les assureurs, a mis fin à la dichotomie entre ces deux types d'assurance, pour les remplacer par un régime universelle obligatoire. Conformément à la loi sur l'assurance des soins de santé (*Zorgverzekeringswet,* ZvW), tous les résidents doivent désormais souscrire une assurance auprès d'un des assureurs en concurrence, qui peut être choisi sur une base annuelle (adhésion ouverte). Tous les assureurs relèvent du droit privé.

Le régime néerlandais d'assurance maladie se fonde sur la distinction entre les soins de longue durée (maladies chroniques, hospitalisations de longue durée), les soins de santé (routiniers) et les soins complémentaires (services dentaires, physiothérapie). L'assurance universelle obligatoire pour les soins de longue durée, instaurée en 1968, relève de la Loi générale sur les dépenses médicales exceptionnelles (*Algemene Wet Bijzondere Ziektekosten,* AWBZ). Elle est financée par des retenues sur salaire proportionnelles aux revenus ainsi que des contributions versées par l'État. Le financement de l'assurance maladie obligatoire provient à 50 % de cotisations liées au revenu et perçues à la source, à 45 % de primes nominales versées par les assurés, et à 5 % d'une contribution versée par l'État. L'assurance des enfants de moins de 18 ans est prise en charge par les pouvoirs publics par le biais de l'impôt. L'étendue des prestations de base est définie par les autorités publiques.

Structure du secteur hospitalier néerlandais

Le secteur hospitalier néerlandais est dominé par des hôpitaux privés à but non lucratif, qui sont majoritairement la propriété de fondations à but non lucratif contrôlées localement, qui assurent également leur exploitation. Les budgets hospitaliers sont définis sur la base d'une formule comportant une composante fixe et une composante variable. La composante fixe est définie par des paramètres tels que le volume de patients, le nombre de lits ainsi que le nombre de spécialistes conventionnés. La composante variable, qui a trait à la production, est à l'inverse calculée sur la base de paramètres tels que les accords régionaux, les jours-patients d'hospitalisation et de soins ambulatoires, et le nombre de premières visites.

Avant 2008, l'entrée sur le marché hospitalier était quasiment impossible dans la mesure où la construction d'un nouvel hôpital nécessitait un permis de construire délivré par les pouvoirs publics ainsi qu'un accès à la garantie légale de remboursement intégral de l'investissement en capital.[70] En outre, les hôpitaux n'étaient pas autorisés à dédommager les financiers en leur versant des dividendes, ce qui rendait l'entrée fort peu attractive pour les entreprises privées. La réglementation à l'entrée a toutefois été progressivement assouplie. Depuis 2008, les permis de construire ne sont plus nécessaires. Quant aux opportunités de profits, la Loi sur l'admission des établissements de santé (WTZi) prévoit une modification des règles en vigueur afin d'autoriser à l'avenir les prestataires de santé à but lucratif (à l'horizon 2012).

Outre les hôpitaux, les soins hospitaliers sont également fournis par des centres de traitements indépendants (*zelfstandige behandelcentra*), présents sur le marché depuis 1998. Toutefois, ces centres peuvent prescrire uniquement des traitements ne nécessitant pas d'hospitalisation.

Rémunération des services hospitaliers

En 2005, un nouveau système de rémunération des spécialistes hospitaliers et médicaux, le DBC (*Diagnose Behandeling Combinatie*), a été instauré pour garantir que les prix soient liés aux coûts. Tous les services de soins hospitaliers sont répartis dans deux segments : A – avec des prix fixes - et B, dont les prix peuvent être librement fixés par les organismes d'assurance maladie à l'exception des tarifs des spécialistes et des anesthésistes pour les traitements relevant de ce segment, qui sont fixés par l'autorité néerlandaise des soins de santé (NZa).[71]

70 Voir Schut et Van de Ven (2011).

71 La plupart des services relèvent du segment A et sont réglementés par les pouvoirs publics. Toutefois, le nombre de services de routine relevant du segment B est en constante augmentation. En 2009, près de 34 % des dépenses hospitalières auraient pu être négociées librement.

Garantir la qualité des hôpitaux

Conformément à la loi de 1996 sur la qualité des établissements de soins, les hôpitaux doivent définir leur propre système de gestion de la qualité dans une perspective d'amélioration de la qualité des soins prodigués. Bien que la loi n'impose pas l'application de normes spécifiques, elle impose aux hôpitaux ainsi qu'aux autres établissements de soins l'obligation de publier un rapport de qualité annuel. En outre, un nombre croissant d'hôpitaux mettent en œuvre les normes d'assurance qualité élaborées par le NIAZ (Institut néerlandais d'accréditation des hôpitaux). L'Association néerlandaise de l'assurance maladie publie chaque année un guide spécial comprenant des indicateurs de performance pour des DBC spécifiques.

Gowrisankaran et Town (2003) adoptent la même approche que Kessler et McClellan (2000) mais relèvent un effet opposé. Kessler et Geppert (2005) étendent cette approche à l'impact de la concentration sur les différences de qualité entre les groupes de patients. Ils examinent les résultats (réadmissions et mortalité) des patients victimes de crise cardiaque et les dépenses qu'ils engendrent, mais comparent les résultats et les dépenses relatifs aux patients à haut risque et à faible risque[72] sur les marchés très concentrés et non concentrés. Ils concluent que la concurrence conduit à une variation accrue des dépenses consacrées aux patients et que cela entraîne une amélioration du bien-être dans la mesure où le traitement plus intensif que les patients à faible risque reçoivent sur les marchés très concentrés n'entraîne pas de résultats statistiquement différents, tandis que les patients à haut risque reçoivent un traitement moins intensif associé à des résultats bien plus mauvais sur ces marchés.

Cooper *et al.* (2010a), dans une étude fondée sur des données recueillies au Royaume-Uni, ont cherché à savoir si les hôpitaux faisant face à une concurrence accrue ont fait baisser leur taux de mortalité par crise cardiaque plus rapidement que les hôpitaux en situation de monopole après l'instauration d'une concurrence dans le système de santé en 2006 sous la forme d'une restriction du choix offert aux patients (voir encadré 6). À la lumière du débat relatif à la mesure empirique appropriée de la concurrence hospitalière, cette étude se fonde sur quatre méthodes différentes de définition des marchés de services hospitaliers et deux indicateurs de mesure de la concurrence. Les auteurs de l'étude font systématiquement le même constat : dans les hôpitaux confrontés à une concurrence accrue, la baisse du taux de mortalité par crise cardiaque est supérieure d'environ un tiers de point de pourcentage à celle observée chez les prestataires monopolistiques. Avec un taux de mortalité de 12 %, cette différence n'est pas négligeable. Les auteurs supposent également que ces résultats sont partiellement imputables aux aspects de la demande dus au rôle joué par les médecins généralistes dans le système britannique. Il semble plausible que les connaissances spécialisées et l'expérience acquises par les médecins généralistes permettent aux hôpitaux en concurrence de mieux appréhender l'importance de la qualité.

Une autre étude de Cooper *et al.* (2010b) fondée sur les données du Royaume-Uni tente de déterminer si la concurrence est susceptible d'inciter les hôpitaux à améliorer leur efficience en mesurant la durée du séjour des patients hospitalisés pour une arthroplastie de la hanche sans caractère urgent eu égard à deux composantes clés : le délai d'attente de l'opération après l'admission à l'hôpital, et la durée de l'hospitalisation après l'opération. Tandis que cette dernière dépend largement des caractéristiques des patients, la première est directement fonction de l'efficience de l'hôpital. Il ressort de l'étude que la concurrence réduit la durée du séjour préopératoire par rapport à une situation de monopole, alors qu'aucune différence significative n'est constatée en ce qui concerne la durée du séjour postopératoire, ce qui indique que la concurrence augmenterait l'efficience sans nuire à la qualité.[73] Les données suggèrent que la concurrence hospitalière sur des marchés à prix fixes peut améliorer l'efficience.

72 Les patients à haut risque sont définis comme des patients hospitalisés pour une crise cardiaque au cours de l'année précédente.

73 En outre, la diminution de la durée du séjour n'a pas non plus entraîné d'effets de sélection, c'est-à-dire d'opérations pratiquées sur des patients en meilleure santé, plus riches ou plus jeunes.

Dans une étude intitulée « Death by Market Power », Gaynor *et al.* (2011b) apportent la preuve que dans un régime de prix réglementés, les hôpitaux se livrent concurrence sur le plan de la qualité. Dans les deux années qui ont suivi la mise en œuvre de la réforme du NHS de 2006 (voir encadré 6), des améliorations significatives de la mortalité et des réductions considérables de la durée des séjours ont été constatées, sans que les dépenses totales s'en trouvent modifiées, ni que les dépenses par patient augmentent. Ils en concluent que si le Royaume-Uni mettait en œuvre des politiques conduisant à la déconcentration des marchés hospitaliers, les gains pourraient être bien supérieurs à leur estimation de 276 millions GBP.

Bijlsma et al. (2010) se concentrent sur la corrélation entre la concurrence et la qualité dans le secteur hospitalier néerlandais à la suite de la réforme du secteur de la santé (voir encadré 5). Ils constatent que l'attention accrue portée à la qualité hospitalière et l'importance croissante de cette dernière dans le contexte de la réforme ont incité les hôpitaux néerlandais à publier leurs indicateurs de qualité. À l'aide de données de panel hospitalières couvrant la période comprise entre 2004 et 2008, incluant à la fois des indicateurs de processus (variable qui, selon les auteurs, est plus facilement et plus directement contrôlée par les hôpitaux) et des indicateurs de résultats de la qualité des hôpitaux, et utilisant un modèle tenant compte de la corrélation entre la décision de publication et le niveau d'informations publiées, on pourrait expliquer par la concurrence les performances mises en évidence par les indicateurs de processus, mais non celles ressortant des indicateurs de résultats. Leurs résultats suggèrent que la concurrence entre les hôpitaux pèse sur les marges bénéficiaires, ce qui les contraint à améliorer l'efficacité de la production. Selon Bijlsma *et al.* (2010:35), « l'une des façons d'améliorer l'efficacité de la production consiste à faire un usage plus intensif de la capacité opérationnelle des hôpitaux, ce qui explique probablement une plus grande proportion d'annulations (à court terme) et de retards d'opérations dans les secteurs plus concurrentiels. En outre, la concurrence peut inciter les hôpitaux à améliorer les indicateurs de qualité facilement compréhensibles par les patients et perçus comme un signal de qualité (comme le temps que le patient doit attendre pour recevoir un diagnostic et la fréquence des consultations de suivi pour les patients atteints de maladie chronique). »

À l'inverse, bien qu'ils ne se concentrent pas sur les indicateurs de processus, Mukamel *et al.* (2001) ne constatent pas d'impact statistiquement significatif de la concentration mesurée par l'IHH sur la mortalité dans leur étude.

Encadré 6. Contexte institutionnel des services hospitaliers au Royaume-Uni[74]

Les services hospitaliers du Service national de santé (NHS) britannique sont financés par les pouvoirs publics et sont principalement assurés par des hôpitaux publics à but non lucratif. Les hôpitaux du NHS sont soumis à des contraintes budgétaires et ont l'obligation légale de maintenir l'équilibre de leurs comptes. Certains hôpitaux (les Fondations hospitalières — *Foundation Trusts*) peuvent conserver leurs excédents et éventuellement les réinvestir dans les services aux patients. Des organisations locales nommées *Primary Care Trusts* (PCT, groupements de soins primaires) sont en charge des achats de services hospitaliers pour leur population locale sur la base d'un budget fixe. Les organisations des autorités locales et nationales jouent un rôle dans la détermination de la configuration idéale des services hospitaliers. Les gouvernements successifs ont eu recours à différentes configurations dans une tentative visant à accroître la concurrence et à inciter les hôpitaux à améliorer la qualité.

Depuis 2002, les réformes se concentrent sur le rôle du choix offert aux patients comme facteur de concurrence entre les hôpitaux. À partir de 2006, les patients britanniques se sont vu offrir un choix d'hôpitaux très limité, et depuis 2008, ils ont le droit de choisir n'importe quel hôpital ayant signé un contrat pour fournir des services financés par le NHS et prêt à accepter le prix fixé par les pouvoirs publics pour le traitement concerné. Le choix de l'hôpital auquel s'adresser pour recevoir le traitement est supposé être fait par le patient avec le soutien et le conseil de son médecin généraliste. À l'aide de la page web *Choose and Book*, le médecin peut présenter aux patients les hôpitaux disponibles.[75]

Les hôpitaux reçoivent un remboursement fixe par période de soin et par patient pour des groupes de traitements cliniquement similaires utilisant des niveaux normaux de ressources de santé. Les normes minimales de qualité des soins sont réglementées par la Commission de la qualité des soins (CQC), un organisme public qui évalue également la qualité clinique et financière des hôpitaux.[76] Les pouvoirs publics, via la CQC et les organismes d'achat locaux, définissent des objectifs minimaux de qualité des soins, notamment en termes de délais d'attente et de taux d'infection à SARM.[77].

Tay (2003) examine l'effet d'un ensemble d'aspects sur la probabilité qu'un patient soit admis dans un hôpital en particulier. Les aspects pris en compte comprennent la distance, des indicateurs de la qualité (taux de mortalité et de complications), de l'intensité des intrants (ratio infirmiers par lit) et du niveau de technicité des services cardiaques (l'hôpital est-il en mesure de réaliser une cathétérisation ou une revascularisation). Elle constate que la demande de l'hôpital est affectée négativement par la distance et positivement par la qualité. En outre, elle procède à quelques exercices de statique comparative en simulant l'effet de l'introduction d'un traitement par cathétérisation ou par revascularisation ou de l'augmentation du ratio infirmiers par lit. Toutes ces introductions se traduisent par une hausse substantielle de la demande de l'hôpital. La nature statique comparative de l'exercice pèse toutefois sur les résultats, comme on peut le constater lorsque l'on examine les effets anticipés dans le cas où tous les hôpitaux de la région adoptent l'ensemble des traitements. Manifestement, la demande globale de services hospitaliers, même si elle est

74 Cet encadré s'appuie principalement sur Beckert *et al.* (2012). Voir également Sussex (2009) et Dixon et Propper (2011), qui donnent également de bonnes vues d'ensemble, ainsi que Commonwealth Fund (2010), une publication décrivant brièvement le système de santé des États-Unis, de l'Allemagne, du Canada, de l'Australie, de la Suisse, des Pays-Bas, du Royaume-Uni, de la France, du Danemark, de l'Italie, de la Norvège, de la Suède et de la Suisse.

75 http://www.chooseandbook.nhs.uk/

76 Ces évaluations sont à disposition du public et peuvent être consultées sur le site www.cqc.org.uk.

77 Le *Staphylococcus aureus* résistant à la méticilline (SARM) est une bactérie responsable de plusieurs infections difficiles à traiter chez l'homme. Le SARM pose particulièrement problème dans les hôpitaux et les centres de soins infirmiers, en raison de la présence de patients présentant des plaies ouvertes, des dispositifs invasifs et des systèmes immunitaires affaiblis, qui ont davantage de risques de contracter une infection que le public général.

largement induite par les prestataires, est susceptible de demeurer inaffectée par toutes ces mesures individuelles de « diversion de la demande », déséquilibrant les prévisions.[78]

Les améliorations de la qualité peuvent toutefois être dues à d'autres facteurs que l'accroissement de la concurrence, comme l'ont montré Propper *et al.* (2010). Dans leur étude, les auteurs analysent les effets des objectifs de performance sur les délais d'attente. Ils se fondent sur une expérience en conditions réelles pour analyser les différences entre l'Angleterre et l'Écosse. Pour déterminer l'efficacité de ces objectifs, les auteurs ont examiné les délais d'attente et ont constaté que la définition d'un objectif entraînait une réduction du délai d'attente sans détourner l'activité d'autres aspects moins bien contrôlés des services de santé, et sans impact négatif sur la santé du patient à sa sortie de l'hôpital.

4.2. Études de la concentration du marché hospitalier

Étant donné l'ambiguïté des résultats des études analysant l'impact de la concurrence sur la qualité lorsque la qualité et les prix constituent une variable de choix de l'hôpital, la présente section sera plutôt axée sur un débat plus général concernant l'impact de la concentration sur les prix, la qualité et les coûts d'exploitation. Ce débat débute par une description de la tendance internationale à la consolidation dans le secteur hospitalier. Cette analyse se concentre sur les États-Unis dans la mesure où la plupart des études exploitent des données de ce pays.

Pour les États-Unis et la période comprise entre 1990 et 2003, Town et al (2006) constatent que « l'ampleur totale de l'impact des fusions hospitalières est modeste mais pas insignifiante. En 2001, on estimait que les primes moyennes des HMO étaient supérieures de 3.2 % à ce qu'elles auraient été en l'absence de toute activité de fusion hospitalière dans les années 1990. »

Capps (2009:7) écrit que bien que les tribunaux américains semblent avoir été favorables à une définition plutôt large du marché pour les fusions hospitalières dans les années 1990, certaines preuves indiquent que les hôpitaux « se livrent généralement concurrence localement et que les fusions hospitalières — même celles qui ont des effets très restreints sur l'IHH à l'échelle de la zone statistique métropolitaine (MSA) ou de plusieurs comtés — peuvent conduire à des augmentations de prix très importantes ».[79] Comme souligné dans les études, il serait souhaitable de définir les marchés sur la base du flux de patients entre les établissements plutôt que d'utiliser des classifications plus larges et plus arbitraires comme les MSA ; néanmoins, même ces études concluent à une augmentation moyenne du prix d'environ 5 % pour une augmentation de l'IHH de 800 points.[80] Selon Capps (2009:8), au cours des « 15 années comprises entre 1993 et 2008, la politique antitrust n'a probablement eu qu'un effet restrictif limité sur les fusions hospitalières », dans la mesure où la FTC et le DoJ ont perdu six procès consécutifs

78 Cette remarque est également faite par Gaynor et Town (2011:68), qui déclarent que ces effets pourraient même être potentiellement nuls. Voir également Schmidt-Dengler (2006) qui, pour les dispositifs d'imagerie à résonnance magnétique (IRM) aux États-Unis, constate des effets non négligeables sur la demande, imputables aux effets de diversion de la demande liés à l'adoption de la technologie.

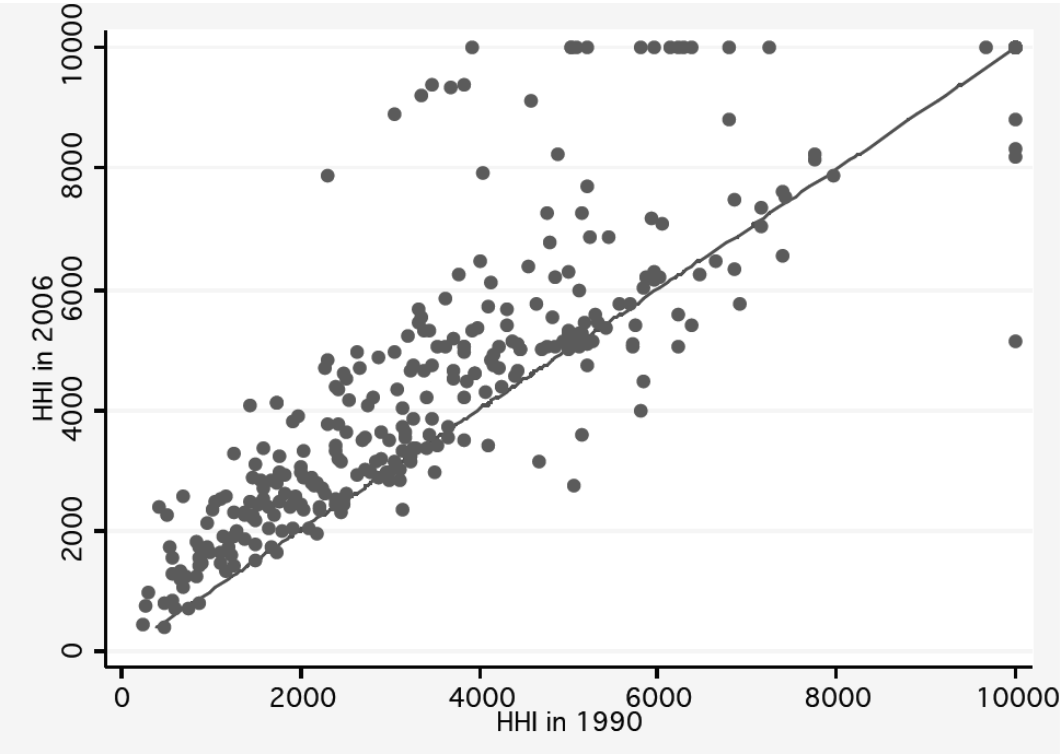
79 Cet avis est également partagé par Vogt et Town (2006), qui déclarent explicitement que les marchés hospitaliers semblent plus étroits que ne le suggèrent les tribunaux américains. Voir également Varkevisser et Schut (2009), qui affirment qu'il est préférable que les autorités soient trop restrictives en raison des effets anticoncurrentiels sérieux et des difficultés particulières liées à l'application de la loi dans ce secteur à l'issue de la fusion.

80 Voir Vogt et Town (2006).

dans des affaires de fusion d'hôpitaux, et l'État de Californie un 7e en 2001, d'où une décennie où « ni la FTC ni le DoJ n'ont pu empêcher un projet de fusion hospitalière devant la justice. »[81.]

La figure 4 ci-dessous donne une indication de la tendance à la concentration, la plupart des marchés étant fortement concentrés en 2006 par rapport à 1990. Elle montre également que les résultats moyens ne sont pas dus à des valeurs aberrantes, mais que la tendance à la concentration est un phénomène général et large.

Graphique 4 : nuage de points des valeurs de l'IHH en 1990 et 2006 pour les marchés hospitaliers des États-Unis[82]



Cette tendance à la consolidation hospitalière ne se limite pas aux États-Unis ou aux systèmes dans lesquels le prix est déterminé par les marchés, mais concerne également l'Allemagne, les Pays-Bas et le Royaume-Uni, entre autres.[83] Dans tous ces pays, elle s'explique par la pression sur les prix et la nécessité

81 Voir Capps (2009:8). Cette tendance semble avoir pris fin en 2008 avec la fusion INOVA/Prince William Hospital. D'après Gaynor et Town (2011:46), « la FTC s'est montrée plus agressive lors de ses actions en justice contre les fusions hospitalières ».

82 Ce graphique est tiré de Town et Gaynor (2011:130). À noter que les marchés sont fondés sur les zones statistiques métropolitaines (MSA) et peuvent donc ne pas correspondre aux marchés réels au sens du droit de la concurrence.

83 En Allemagne, cela a par exemple donné lieu à un débat sur la question de savoir si le seuil de notification à l'Office fédéral des ententes devrait être calculé différemment afin de permettre une surveillance au regard du droit de la concurrence de fusions hospitalières qui passeraient sinon au travers des mailles du filet. La Commission allemande des monopoles (Monopolkommission) a plus particulièrement suggéré de multiplier le chiffre d'affaires dans le secteur hospitalier par trois et d'utiliser le résultat obtenu pour déterminer si une fusion doit être notifiée et surveillée par l'autorité de la concurrence. Voir Monopolkommission (2008).

de tirer parti des avantages en termes de coûts, bien que les données empiriques relatives aux États-Unis, par exemple, soient mitigées. L'argument avancé aux États-Unis est que le développement des HMO a donné lieu à des négociations agressives avec les hôpitaux, qui ont par la suite été obligés de fusionner afin d'augmenter leur pouvoir de négociation, voire améliorer leur efficience, les hôpitaux plus petits étant voués à l'échec. C'est ce que suggère par exemple l'étude empirique menée par Fuchs (2007), bien que Town *et al.* (2007) ne constatent aucune corrélation significative entre la structure du marché hospitalier et la pénétration des HMO.[84]

Il existe, toutefois, une différence importante entre la situation aux États-Unis et dans les autres pays mentionnés. Dans la mesure où les prix des services hospitaliers sont administrés, pour ne citer qu'une seule différence institutionnelle importante entre les systèmes, un accroissement de la concentration risque d'avoir un impact différent.

4.2.1. Effets des marchés concentrés sur les prix

Aux États-Unis, les marchés hospitaliers sont très concentrés et le sont devenus relativement récemment à la suite de fusions et d'acquisitions.[85] D'après Gaynor et Town (2011), l'IHH moyen sur les marchés hospitaliers des États-Unis se montait à 2 340 en 1987, mais a augmenté de plus de 900 points pour atteindre 3 161 en 2006.[86] Gaynor et Town (2011:34), faisant la distinction entre les études utilisant des mesures globales du prix et celles utilisant les données relatives aux demandes de remboursement, constatent une augmentation des prix (ou une augmentation plus rapide des prix par rapport à la tendance) par rapport au groupe témoin dans toutes les études sur les fusions qu'ils ont examinées, à l'exception d'une qu'ils ont ignorée car elle se fonde sur des mesures relativement médiocres des prix et des coûts.

D'après l'analyse menée par Vogt et Town (2006), la vague de consolidation hospitalière des « années 1990 a entraîné une hausse des prix d'au moins 5 %, voire bien plus ». Leur analyse des études empiriques fait la distinction entre les estimations dérivées de trois méthodes différentes : des études d'événements[87], des études fondées sur le paradigme SCP et des simulations. Les résultats des simulations de concentration sont les plus frappants, avec des estimations atteignant pas moins de 53 %. Les études d'événements estiment que la hausse des prix est comprise en 10 et 40 %[88] et les approches SCP génèrent les prévisions d'augmentation les plus basses, comprises entre 4 et 5 %.

L'analyse des fusions hospitalières menées aux États-Unis entre 1993 et 1999 indique que la concentration hospitalière a entraîné une augmentation annuelle des dépenses nationales de santé d'environ 10 à 12 milliards USD, soit environ 0.5 %.[89]

Ces effets sont largement confirmés par les études axées sur les effets des fusions hospitalières individuelles. Dans l'analyse d'une fusion hospitalière menée aux États-Unis, Tenn (2011) constate une

84 D'après Gaynor et Town (2011), Town et Park (2011), toutefois, accordent quelque crédit à l'hypothèse selon laquelle cela est moins dû à l'arrivée des HMO sur le marché qu'à l'anticipation de leur importance future. Ils identifient une corrélation négative significative entre leur sortie du marché et la concentration hospitalière**.**

85 Voir Town *et al.* (2006).

86 La FTC et le DoJ considèrent qu'un marché est « hautement concentré » si l'IHH est supérieur ou égal à 2 500.

87 Les études d'événements sont fondées sur une comparaison des données pertinentes précédant et suivant un événement particulier, comme une fusion ou une modification du cadre réglementaire.

88 Ce chiffre de 40 % est tiré de Dafny (2005)

89 Voir Capps (2009) et Town *et al.* (2006).

augmentation des prix comprise entre 28 et 44 %. Des effets similaires ont également été constatés par Kemp et Severijnen (2011) sur les coûts de l'arthroplastie de la hanche après deux fusions menées aux Pays-Bas. Akosa Antwi *et al.* (2009) examinent les prix pratiqués par les hôpitaux californiens entre 1999 et 2006, et constatent une augmentation du prix de 100 % au cours de cette période, bien que la concentration ne semble pas avoir joué un rôle important.[90]

Pour ce qui est de l'espoir que les effets du pouvoir de marché soient atténués dans le cas des hôpitaux à but non lucratif, Capps *et al.* (2010b) ne trouvent, sur la base d'un échantillon de données hospitalières recueillies en Californie pendant sept ans, aucun élément indiquant que les hôpitaux à but non lucratif offrent davantage de services à vocation principale de bienfaisance pour faire face à l'accroissement du pouvoir de marché que les établissements à but lucratif.[91]

4.2.2. Effets des marchés concentrés sur la qualité

Dans leur analyse de 10 études portant sur l'impact de la concentration sur la qualité des services hospitaliers, Vogt et Town (2006:8) constatent que « tout bien pesé, les éléments probants suggèrent que l'accroissement de la concentration hospitalière entraîne une dégradation de la qualité. » Les auteurs émettent toutefois des réserves en soulignant la sensibilité des résultats au type de méthodologie employé et à la zone géographique analysée. Comme nous l'avons remarqué précédemment, il est extrêmement difficile de tirer des conclusions quant aux effets de la concentration du marché sur la qualité lorsque les prix sont également une variable de choix. De même, Maeda et LoSasso (2011) constatent qu'un IHH inférieur n'a que des bénéfices additionnels marginaux sur la prise en charge de l'insuffisance cardiaque en ambulatoire, et concluent que « la concurrence de marché pourrait être un instrument assez peu incisif, et n'est pas probablement pas l'outil le plus adapté pour induire des effets d'amélioration de la qualité hospitalière. »[92]

En règle générale, il semble peu d'éléments viennent prouver que les fusions dans les systèmes de prix réglementés améliorent la qualité. Une analyse des fusions hospitalières menées au Royaume-Uni entre 1997 et 2006, par exemple, laisse planer le doute quant à savoir si les fusions sur les marchés financés et réglementés par l'État se traduisent par de meilleurs résultats pour les patients.[93]

4.2.3. Effets des marchés concentrés sur les coûts

Il existe de nombreuses raisons pour lesquelles les fusions peuvent se traduire par des baisses de coûts au profit de l'entité nouvellement créée, comme une baisse du coût due à des hausses du pouvoir de l'acheteur et aux économies d'échelle, ainsi que des baisses de coût dues au transfert de connaissances et à la concentration des services. Même lorsque de telles baisses se produisent, les réductions des coûts des services hospitaliers ne sont pas identiques aux réductions des prix payés par les assureurs ou les patients.

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90 Voir également Martin *et al.* (2011).

91 Gaynor et Town (2011:42) rendent compte de plusieurs autres études relatives aux éventuelles différences entre les hôpitaux à but lucratif et non lucratif dans un régime de prix majoritairement non fixes.

92 Voir Maeda et LoSasso (2011:821). L'analyse est fondée sur les IHH des régions des hôpitaux de référence et les données relatives aux performances publiées par les hôpitaux aux États-Unis entre 2003 et 2006.

93 Voir Beckert *et al.* (2012) et Gaynor *et al.* (2011a). Il existe de nombreuses études relatives aux fusions sur les marchés hospitaliers à but lucratif aux États-Unis. Voir par exemple les études rétroactives de Haas-Wilson et Garmon (2011) et Haas-Wilson et Vita (2011) et les travaux de simulation de Capps *et al.* (2001). Beckert *et al.* (2012) donnent également une méthode pour conduire une simulation de fusion en examinant la demande avant et après la fusion, dans le sillage de Capps *et al.* (2001). Une demande post fusion moins élastique suggère une pression concurrentielle limitée de la part des autres hôpitaux, ce qui ouvre la voie à des réductions unilatérales de la qualité.

Les réductions de coûts imputables aux fusions peuvent prendre deux formes générales : la concentration de l'actionnariat et la concentration des établissements. Alors qu'une simple concentration de l'actionnariat n'a aucun impact sur les coûts hospitaliers d'après l'analyse menée par Vogt et Town (2006:10), la concentration des établissements tend à abaisser les coûts. Dranove et Lindrooth (2003), par exemple, mènent une comparaison entre des hôpitaux ayant fusionné et des établissements partageant les mêmes caractéristiques principales, et font la distinction entre les fusions dans le cadre desquelles l'un des deux hôpitaux renoncent à son agrément, et les fusions dans le cadre desquelles les hôpitaux fusionnant restent l'un et l'autre agréés. S'agissant des 122 fusions étudiées entre 1989 et 1996, 81 des établissements ainsi créés n'ont conservé qu'un seul agrément et ces opérations se sont dans ce cas traduites par une réduction sensible (14 %) des coûts d'exploitation ; alors que pour les autres établissements, la fusion n'a pas conduit à des réductions de coûts significatives.

Les études relatives à la fusion des hôpitaux à but lucratif suggèrent que la plupart des fusions ont engendré des économies modestes[94], ont eu un effet négatif, voire nul, sur la qualité[95] et ont eu un impact substantiel sur les prix dans la mesure où elles ont réduit la concurrence sur le plan du prix.[96]

Bloom *et al.* (2010), par exemple, démontrent l'importance de l'autonomie de gestion. Ils constatent que des hôpitaux mieux gérés sont non seulement plus rentables, mais qu'ils offrent également de meilleurs résultats aux patients. Dans la mesure où la concurrence aurait tendance à profiter aux hôpitaux bien gérés, l'étude montre qu'il n'est pas forcément problématique de laisser des hôpitaux moins bien gérés quitter le marché (voir encadré 7).

94 Voir Vogt et Town (2006), selon lesquels un faisceau d'éléments indique que la concentration hospitalière engendre des économies, et que ces économies peuvent être importantes lorsque les hôpitaux concentrent totalement leurs services.

95 Voir Vogt et Town (2006), qui constatent que 5 études mettent en évidence des réductions de la qualité pour certaines procédures, 4 des améliorations de la qualité pour certaines procédures, et 3 aucun effet, sur un total de 10 études examinées.

96 Voir par exemple Capps *et al.* (2003) et les études citées par Vogt et Town (2006).

Encadré 7. Les fermetures d'hôpitaux

L'éviction des entreprises inefficientes est un processus normal sur les marchés concurrentiels. Le dépôt de bilan des entreprises inefficientes est le revers de la prospérité des entreprises efficientes, et il essentiel de laisser ce processus s'exercer pour pouvoir récolter les fruits de la concurrence. De fait, sur la plupart des marchés, le déclin et la faillite des entreprises inefficientes constituent la principale source de gains de productivité. Le fait que les crises économiques facilitent la sortie du marché des entreprises inefficientes est même cité parmi leurs effets bénéfiques.[97]

Capps *et al.* (2010a) avancent l'idée selon laquelle les fermetures d'hôpitaux pourraient avoir un impact positif sur les patients. Ils constatent en effet que la perte de bien-être des consommateurs a été plus que compensée par les économies engendrées par les fermetures des cinq hôpitaux d'Arizona et de Floride qu'ils ont étudiées. De même, Lindrooth *et al.* (2003) examinent l'impact des fermetures d'hôpitaux sur le coût moyen des soins hospitaliers sur le marché. Ils constatent que les hôpitaux qui ferment sont moins efficients, et que leur fermeture diminue le coût des services d'environ 2 à 4 %, voire jusqu'à 8 % en moyenne pour les patients de l'hôpital fermé.

Toutefois, ces résultats ne sont pas confirmés par Buchmueller *et al.* (2006), qui avancent que les fermetures d'hôpitaux en Californie ont eu des répercussions négatives sur la population environnante en termes de résultats médicaux, un résultat principalement lié au fait que la distance à laquelle se trouve l'hôpital joue un rôle crucial en ce qui concerne les soins urgents.

Comme avancé dans la section intitulée « La concurrence en tant qu'instrument », les résultats concurrentiels sont considérés comme appropriés ou non en fonction du cadre dans lequel la concurrence s'exerce. Il semble donc crucial de concevoir un cadre approprié – définissant des normes de sécurité et de qualité et aidant les responsables politiques et les dirigeants hospitaliers à prendre des décisions éclairées sur la question de savoir si les services qu'ils fournissent sont délivrés avec circonspection. Avec un tel cadre en place, il est important que les systèmes de santé et les décideurs autorisent les fermetures d'hôpitaux. Cela permet de s'assurer que les patients sont soignés dans des locaux sécurisés et adaptés, mais également que les financements (publics) sont utilisés le plus efficacement possible pour améliorer les résultats médicaux de l'ensemble de la population.

4.3. Études relatives aux effets sur les intermédiaires

Le choix de l'assurance maladie d'un patient est généralement effectué avant le choix de l'hôpital et du traitement. C'est la raison pour laquelle Capps *et al.* considèrent les marchés de services hospitaliers comme des « marchés à la demande indéterminée » *(option demand markets)*. Dans la mesure où certaines sociétés d'assurance restreignent le choix de l'hôpital ou du traitement pour les patients, et que même celles qui ne le font pas déterminent le montant des cotisations, une analyse des marchés hospitaliers nécessite une étude des intermédiaires, et notamment de la question de savoir si les marchés d'assurance sont concurrentiels ou s'ils ont une influence directe sur les coûts d'assurance, et donc les services hospitaliers. Il en va de même pour les HMO et les autres intermédiaires.

4.3.1. Études empiriques relatives à l'élasticité de la demande des intermédiaires

En théorie, les sociétés d'assurance, les HMO ou les PPO (voir encadré 8) auraient pour effet d'augmenter l'élasticité-prix de la demande à laquelle les hôpitaux font face. Cette élasticité-prix accrue risque d'entraîner une baisse de la qualité, notamment sur les marchés moins concentrés. Shen (2003), par exemple, constate une corrélation négative significative entre l'évolution des prix administrés et la mortalité et une corrélation positive significative entre la pénétration des HMO et la mortalité. Toutefois, Mukamel *et al.* (2001) constatent que la pénétration des HMO est associée à des taux de mortalité ajustés en fonction des risques moins importants que prévus.

97 Inutile de dire que cette théorie du « caractère purificateur » des crises économiques est extrêmement controversée.

Encadré 8. HMO et PPO

Un réseau de soins coordonnés (*health maintenance organization*, HMO) est une organisation qui assure des soins coordonnés dans le cadre des contrats d'assurance maladie aux États-Unis, en lien avec les prestataires de soins (hôpitaux, médecins, etc.). Il est fréquent que les HMO demandent à leurs membres de choisir un médecin traitant, qui filtre l'accès aux services médicaux. Sauf urgence médicale, les patients ont besoin de passer par un médecin référent, généralement un médecin généraliste, avant de pouvoir consulter un spécialiste, et ces médecins orientent souvent les patients sur la base des directives des HMO. Les HMO en « accès libre » n'ont pas recours à ce système de filtrage — il n'est pas nécessaire de s'adresser à un médecin référent pour voir un spécialiste — mais peuvent recourir au partage des coûts avec les bénéficiaires en augmentant le ticket modérateur pour les soins spécialisés.

Les PPO (*preferred provider organization*), plans médicaux où la couverture des participants est assurée par un réseau de prestataires, passent également des contrats avec des prestataires de santé et créent un « réseau de prestataires », mais contrairement aux HMO, ces plans ne couvrent qu'une partie du coût des soins prodigués par les prestataires hors réseau. Un troisième type de plan, dit « point-of-service » (POS) – combine les systèmes HMO et PPO et offre la possibilité au patient de choisir entre l'un ou l'autre à chaque fois qu'il consulte un prestataire.

Dafny (2010) constate une hausse de la concentration des marchés de l'assurance aux États-Unis. Cette tendance est confirmée par Dafny *et al.* (2011b), qui font état d'une augmentation de l'IHH moyen dans leur échantillon composé du vaste segment employeurs du marché de l'assurance, qui est passé de 2 286 en 1998 à 2 984 en 2006. Le ratio de concentration d'ordre quatre est passé à 90 % et le nombre moyen de sociétés d'assurance est tombé à 9.6, contre 18.9 précédemment.[98]

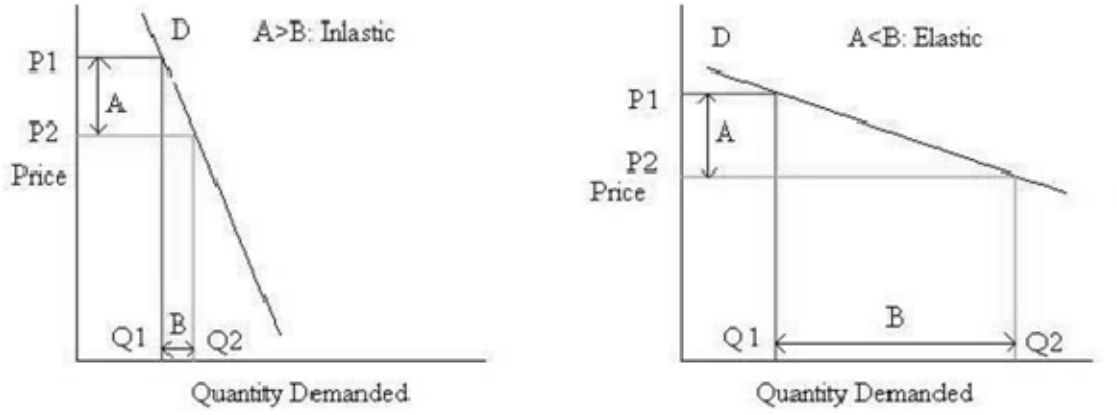
Si les sociétés d'assurance sont confrontées à une élasticité-prix élevée en valeur absolue de leur demande résiduelle, le secteur est concurrentiel dans la mesure où le taux de majoration potentiel du prix est limité en raison de l'important effet quantité que cette demande résiduelle élastique déclencherait.[99] De fait, la demande résiduelle à laquelle une entreprise fait face dans un secteur parfaitement concurrentiel est parfaitement élastique, avec une élasticité infinie en valeur absolue impliquant que toute augmentation de prix se traduit par une perte de la totalité des recettes**.** L'inverse est vrai, comme le montre l'indice de Lerner, qui exploite cette propriété, pour une demande résiduelle moins élastique ou inélastique qui est un indicateur du pouvoir de marché**.**[100] Le graphique 5 fournit une présentation intuitive des fonctions de la demande mettant en évidence différentes élasticités.

98 Voir le résumé de Gaynor et Town (2011) pour plus d'informations.

99 C'est en fait la raison pour laquelle la collusion est considérée comme moins stable sur les marchés où les entreprises font face à une demande élastique : il est très avantageux de s'éloigner d'une collusion dans la mesure où plus l'élasticité-prix est importante, plus les consommateurs sont sensibles à l'évolution des prix.

100 À cela s'ajoute une éventuelle complication, à savoir que la raison pour laquelle une entreprise pourrait vouloir agir sur la portion inélastique de sa courbe de demande résiduelle n'est pas claire en théorie.

Graphique 5 : Exemple de courbes de la demande relativement inélastique et relativement élastique[101]



Dans une étude relative aux Pays-Bas, van Dijk *et al.* (2008) utilisent des données administratives pour estimer que l'élasticité-prix absolue[102] de la demande résiduelle d'une société d'assurance est comprise entre 0.1 et 0.38, ce qui implique une concurrence très limitée entre les sociétés d'assurance aux Pays-Bas, dans la mesure où une hausse du prix de 1 % se traduit par une baisse de la demande comprise entre 0.1 et 0.38 seulement.

Schut *et al.* (2003) estiment l'élasticité de la demande en Allemagne (3.45) et aux Pays-Bas (0.41). Tamm *et al.* (2007) estiment une élasticité-prix à court terme de 0.5 et une élasticité à long terme de 12 pour l'Allemagne. Sur la base de l'indice de Lerner, cela implique qu'il subsiste un taux de majoration du prix de 8.4 % par rapport au coût marginal à long terme et des taux de majoration bien plus importants à court terme en Allemagne et aux Pays-Bas.[103]

4.3.2. Pouvoir de l'acheteur des intermédiaires

Autre aspect important, le pouvoir de l'acheteur potentiellement détenu par les sociétés d'assurance, les HMO et autres intermédiaires.

Lorsque les hôpitaux négocient les prix avec des intermédiaires dotés d'un pouvoir de l'acheteur (voire en position de monopsone), ils se trouvent confrontés à ce qui est considéré comme un écart important entre les conséquences des accords et des désaccords dans les études relatives à la négociation.

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101 À noter que l'élasticité, en tant que concept exprimé en pourcentage, varie le long de la courbe de chaque fonction de la demande. Lorsqu'un changement de prix unitaire fondé sur un prix élevé entraîne une variation moindre en pourcentage, les courbes de la demande sont plus élastiques au sommet et deviennent moins élastiques à mesure que l'on approche de l'axe des abscisses, où les variations des prix en pourcentage sont relativement importantes.

102 L'élasticité est presque toujours négative lorsque les courbes de la demande sont descendantes, mais généralement exprimée en valeur absolue (c'est-à-dire sous la forme de nombres positifs), puisque l'on peut tenir pour acquis qu'elle négative. Si l'élasticité est supérieure à 1, la demande est élastique ; entre zéro et un, la demande est inélastique et si elle est égale à un, la demande est dite unitaire. La courbe d'une demande parfaitement élastique est horizontale (élasticité égale à l'infini) tandis que la courbe d'une demande parfaitement inélastique est verticale (élasticité égale à 0).

103 L'indice de Lerner est obtenu à l'aide de la formule $\frac{1}{\varepsilon}$, où ε représente l'élasticité. Pour une élasticité de 12, il est égal à $\frac{1}{12}$ = 0.084, ce qui implique un taux de majoration du prix de 8.4 %.

Il n'est donc pas surprenant que Shen *et al.* (2010) constatent que les revenus des hôpitaux sont significativement inférieurs sur les marchés où la pénétration des HMO est élevée et la concentration des hôpitaux faible. De même, Moriya *et al.* (2010) constatent qu'une hausse de la concentration du marché des assurances est associée de manière significative à des baisses des prix hospitaliers, alors qu'une augmentation de la concentration hospitalière n'a pas d'effets significatifs sur les prix des assurances. On estime qu'une fusion hypothétique entre des assureurs de taille égale, qui passeraient de 5 à 4, aurait un effet disciplinant entraînant une baisse des prix hospitaliers de 6.7 %**.** Toutefois, Schneider *et al.* (2008a) ne parviennent pas à ces mêmes résultats. Dans leur étude, ils n'ont constaté aucun impact significatif de la concentration du marché des assurances sur les tarifs des médecins, contrairement à la concentration du marché des médecins qui a un effet significatif sur leurs prix.

4.4. Résumé des faits stylisés

Les publications empiriques étudiant la corrélation entre la concurrence et différentes variables de résultat comme le prix et la qualité se sont multipliées au cours des dix dernières années, et ont commencé à jeter les bases d'un socle plus large pour des structures de marché efficientes dans les soins de santé.

Sur la base des résultats des études relatives aux fusions et à la concentration examinées ici, il semble raisonnable de conclure que la concentration du marché hospitalier doit être évitée lorsque les prix ne sont pas administrés. Les effets prix souvent substantiels dus à des augmentations du pouvoir de marché soulèvent des interrogations quant aux effets du pouvoir de marché sur la qualité lorsque les prix ne constituent pas une variable de choix des hôpitaux. Dans tous les cas, les études examinant les effets de la concurrence sur la qualité dans un contexte de prix réglementés semblent confirmer le rôle important que les processus concurrentiels sont susceptibles de jouer. En particulier, la hausse de la concurrence induite par la demande semble avoir des conséquences positives sur la qualité ainsi que l'efficience. Les études relatives aux hôpitaux publics/privés et notamment à but lucratif et non lucratif, qui laissent largement entendre que la structure au sein de laquelle ces hôpitaux fonctionnent est plus importante que leur structure de gestion ou de propriété, sont également certainement intéressantes.

Ces faits stylisés présentent la conception du marché et la nature et le fonctionnement des incitations et des structures de marché en lien avec la prestation de services hospitaliers d'un point de vue universitaire. Les chercheurs dans le domaine de la politique de la santé et des services de santé entreprenant des travaux considérables pour mesurer la qualité et l'efficience des hôpitaux, à terme, une convergence supplémentaire de ces deux domaines pourrait aider à formuler des recommandations politiques plus explicites sur la meilleure manière de concevoir des marchés hospitaliers capables de tirer parti de la concurrence pour obtenir des résultats positifs d'un point de vue social.

5. Conclusion

Le présent document a analysé la question stratégique de savoir quand et selon quelles modalités des mécanismes concurrentiels pouvaient être instaurés efficacement dans le secteur des services hospitaliers. Il s'agissait au départ d'établir une définition non équivoque de la concurrence elle-même, afin de surmonter les interprétations souvent différentes qui en sont faites dans le domaine de la politique de la santé et entre les praticiens du droit de la concurrence. À première vue, ces points de vue paraissent diamétralement opposés, mais il est possible de les rapprocher en distinguant les *processus* concurrentiels des *résultats* des processus concurrentiels. Bien que des processus concurrentiels fonctionnant correctement soient une garantie d'efficience, ils ne garantissent pas l'obtention des résultats escomptés. Avec une telle distinction, la question de l'instauration des processus concurrentiels s'inscrit dans le cadre de la recherche de conditions réglementaires appropriées susceptibles de réduire ou d'éliminer la concurrence dans certains contextes, et de l'instaurer et de la développer dans d'autres.

Les études théoriques portant sur la concurrence dans les services hospitaliers, et notamment celles examinant la concurrence sur le plan de la qualité dans un contexte de prix réglementés, suggèrent que l'instauration d'une concurrence sur le plan de la qualité est bénéfique, mais qu'elle aura bien entendu pour effet d'accentuer le rôle des prix administrés. La qualité dépendra de ces prix, et le prix effectif par rapport au coût marginal en particulier sera essentiel à l'obtention de résultats appropriés. Lorsque les prix et la qualité sont des variables de choix des hôpitaux, les études théoriques ne donnent qu'une orientation limitée dans la mesure où elles ne permettent pas de discriminer les différents résultats possibles. La prévision dépend alors largement de l'élasticité de la demande par rapport au prix et à la qualité.

Les études empiriques examinées ici se concentrent principalement sur les résultats obtenus dans un contexte de prix administrés, reflétant ce qui est en train de devenir la norme au sein des systèmes de santé de l'OCDE. Les résultats étaient mitigés, mais tendent à confirmer les travaux théoriques selon lesquels les processus concurrentiels, s'ils sont instaurés avec soin, peuvent améliorer les résultats et notamment la qualité des services hospitaliers. Bien que la présente publication n'ait pas examiné en détail les études empiriques des effets de la concurrence dans des contextes où les prix et la qualité sont déterminés par le marché, les résultats reflètent là encore les travaux théoriques de par leur ambiguïté. Comme les praticiens de la concurrence devraient s'y attendre, on constate que la concurrence se traduit généralement par une diminution des prix, alors que les effets sur la qualité sont mitigés.

Ainsi, les études empiriques et théoriques soulignent le caractère essentiel des contextes spécifiques dans lesquels la concurrence s'exerce pour déterminer si elle peut être considérée comme positive (d'un point de vue social) ou non. La constatation assez rudimentaire selon laquelle l'élimination de la concurrence sur le plan des prix encourage une concurrence bénéfique sur le plan de la qualité prouve la nécessité d'examiner soigneusement dans quelles circonstances et sur la base de quelles variables la concurrence devrait être instaurée, et quand elle devrait être exclue. Cela nécessite une analyse détaillée et spécifique par pays, pouvant toutefois s'appuyer sur les meilleures pratiques internationales et le débat résumé ici.

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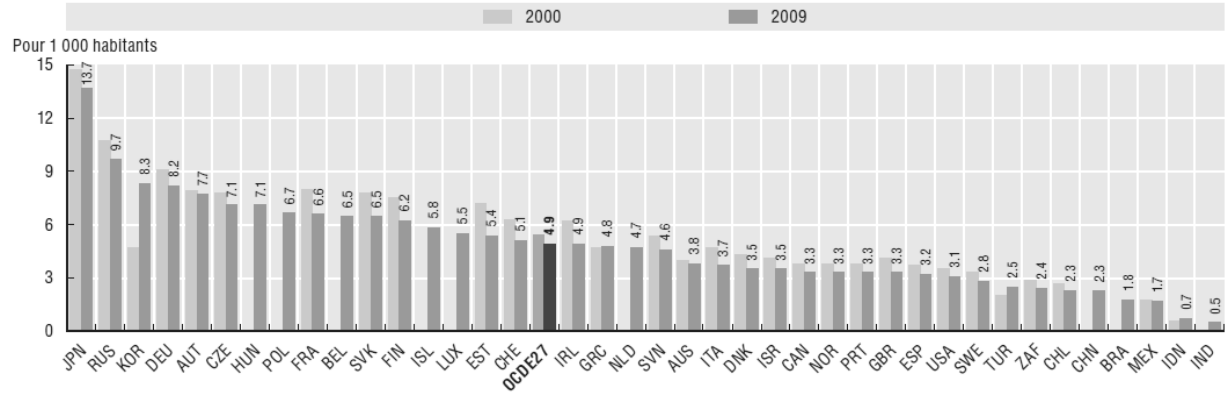
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ANNEXE I : CARACTÉRISTIQUES DU SECTEUR HOSPITALIER

1. Lits d'hôpitaux

Le nombre de lits d'hôpitaux mesure les ressources disponibles pour l'offre de services aux patients hospitalisés. Cette section présente des données sur le nombre total de lits d'hôpitaux, notamment les lits affectés aux soins curatifs, aux soins psychiatriques, aux soins de longue durée et autres types de soins. Elle fournit également un indicateur du taux d'occupation des lits centré sur les lits de soins curatifs (aigus).

Graphique – Lits d'hôpitaux pour 1 000 habitants, 2000 et 2009 (ou année la plus proche)

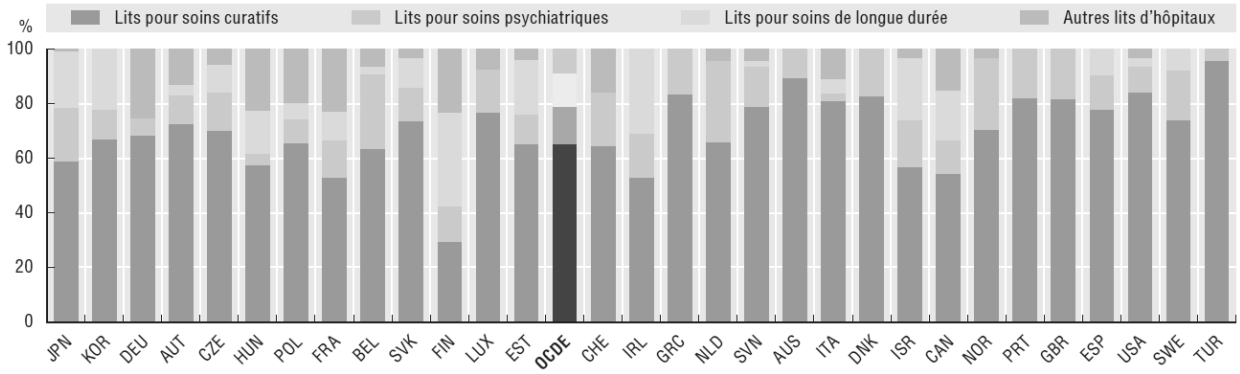


Source : Base de données de l'OCDE sur la santé 2011; sources nationales pour les pays non membres de l'OCDE.

Parmi les pays de l'OCDE, c'est au Japon et en Corée que le nombre de lits d'hôpitaux par habitant est le plus élevé avec plus de huit lits pour 1 000 habitants en 2009 (graphique 4.3.1). Ces deux pays réalisent des « admissions sociales », ce qui signifie qu'une proportion importante de lits d'hôpitaux est affectée aux soins de longue durée. Le nombre de lits d'hôpitaux est également bien supérieur à la moyenne de l'OCDE dans la Fédération de Russie, en Allemagne et en Autriche. En revanche, les grands pays émergents d'Asie (Inde, Indonésie et Chine) n'ont qu'un nombre relativement faible de lits d'hôpitaux (comparé à la moyenne de l'OCDE). Il en est de même pour les pays de l'OCDE et les pays émergents d'Amérique centrale et du Sud (Mexique, Brésil et Chili). Le nombre de lits d'hôpitaux par habitant a légèrement diminué sur les dix dernières années dans la plupart des pays de l'OCDE. En moyenne dans la zone de l'OCDE, ce nombre est passé de 5.4 pour 1 000 habitants en 2000 à 4.9 en 2009.

Cette diminution résulte, du moins pour partie, des progrès des technologies médicales qui ont permis d'évoluer vers la chirurgie ambulatoire et ont réduit la nécessité de l'hospitalisation. La fermeture des lits d'hôpitaux s'est accompagnée dans un grand nombre de pays d'une diminution des sorties d'hôpitaux et de la durée moyenne de séjour. La Corée, la Grèce et la Turquie sont les seuls pays dans lesquels le nombre de lits d'hôpitaux par habitant a augmenté entre 2000 et 2009.

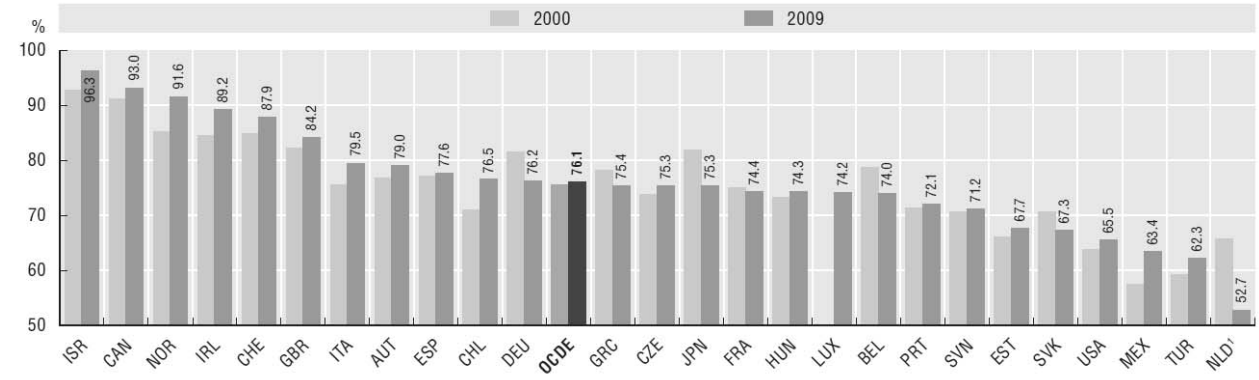
Graphique – Lits d'hôpitaux par type de soins de santé, 2009 (ou année la plus proche)



Source : Base de données de l'OCDE sur la santé 2011.

En moyenne dans les pays de l'OCDE, les deux-tiers des lits d'hôpitaux sont affectés aux soins curatifs. Le tiers restant est affecté aux soins psychiatriques (14 %), aux soins de longue durée (12 %) et autres types de soins (8 %). Mais dans certains pays, la proportion de lits affectés aux soins psychiatriques et aux soins de longue durée est bien supérieure à la moyenne. En Finlande, le nombre de lits d'hôpitaux affecté aux soins de longue durée est en fait supérieur à celui affecté aux soins curatifs. Cela tient au fait que les collectivités locales utilisent des lits d'hôpitaux pour certains soins de longue durée normalement dispensés en institution. En Irlande, à peine plus de la moitié des lits d'hôpitaux sont affectés aux soins aigus, tandis que 30 % sont consacrés aux soins de longue durée.

Graphique – Taux d'occupation des lits de soins curatifs (aigus), 2000 et 2009 (ou année la plus proche)



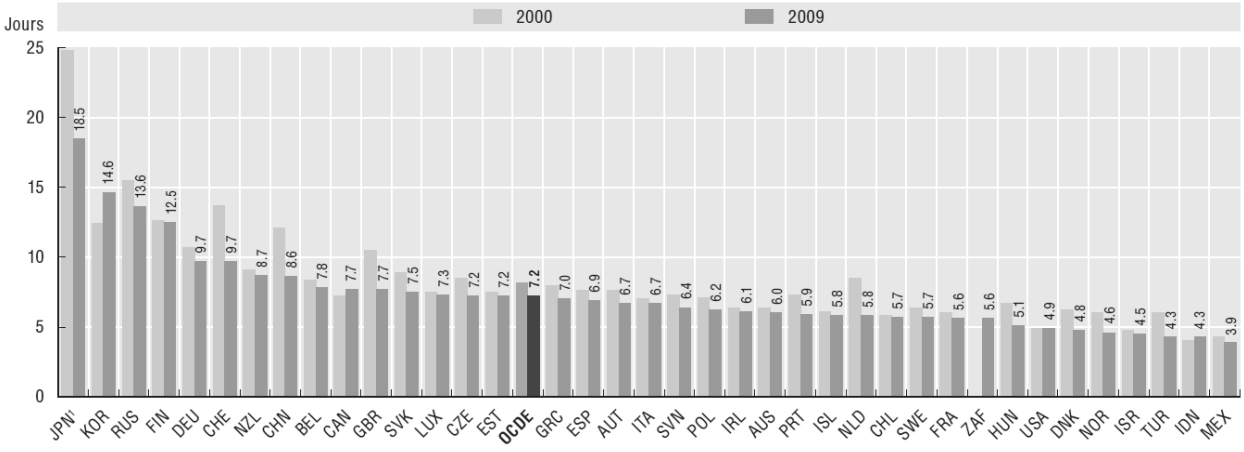
1. Aux Pays-Bas, les lits d'hôpitaux incluent tous les lits approuvés administrativement au lieu des lits effectivement disponibles.
Source : Base de données de l'OCDE sur la santé 2011.

Dans un certain nombre de pays, la réduction du nombre de lits d'hôpitaux s'est accompagnée d'une augmentation de leur taux d'occupation. En 2009, le taux d'occupation des lits de soins curatifs (aigus) s'établissait à 76 % en moyenne dans les pays de l'OCDE, soit un niveau légèrement supérieur à celui de 2000. En 2009, Israël, le Canada, la Norvège, l'Irlande, la Suisse et le Royaume-Uni avaient les taux d'occupation les plus élevés. Tous ces pays ont un nombre de lits affectés aux soins curatifs inférieur à celui de la plupart des autres pays de l'OCDE. Les Pays-Bas, la Turquie et le Mexique ont, au contraire, les taux d'occupation les plus faibles, même si ces taux ont augmenté dans les dix dernières années en Turquie et au Mexique. Aux Pays-Bas, les faibles taux d'occupation s'expliquent en partie par le fait que les lits d'hôpitaux incluent tous les lits approuvés administrativement, et pas seulement ceux qui sont disponibles pour une utilisation immédiate.

2. Durée moyenne de séjour à l'hôpital

La durée moyenne de séjour à l'hôpital est fréquemment utilisée comme indicateur de l'efficience. Toutes choses égales par ailleurs, un séjour plus court diminue le coût par sortie et déplace les soins aux patients hospitalisés vers le cadre moins onéreux des soins post-aigus. Toutefois, un séjour plus court exige généralement une intensité de services plus élevée et coûte plus cher par journée d'hospitalisation. Un séjour trop court peut aussi compromettre l'efficacité du traitement et s'avérer préjudiciable au confort du patient ou à son rétablissement. Si cela se traduit par une augmentation des taux de réadmission, les coûts par épisode de maladie ne diminueront que modérément ou risquent même d'augmenter.

Graphique – Durée moyenne de séjour à l'hôpital, toutes causes confondues, 2000 et 2009 (ou année la plus proche)



1. Les données pour le Japon correspondent à la durée moyenne de séjour en soins aigus (excluant les lits d'hôpitaux pour soins de longue durée).
Source : Base de données de l'OCDE sur la santé 2011 ; OMS-Europe pour la Fédération de Russie et sources nationales pour les pays non membres de l'OCDE.

En 2009, parmi les pays de l'OCDE c'est au Mexique, en Turquie et en Israël que la durée moyenne de séjour à l'hôpital pour toutes causes confondues était la plus courte. La durée moyenne de séjour était courte également en Norvège et au Danemark, mais aussi aux États-Unis (moins de 5 jours). C'est au Japon, suivi de la Corée qu'elle était la plus élevée. La moyenne de l'OCDE était de l'ordre de 7 jours.

Plusieurs facteurs peuvent expliquer ces disparités. L'offre abondante de lits et la structure de paiement des hôpitaux au Japon peuvent inciter les hôpitaux à garder les patients plus longtemps. Des incitations financières inhérentes aux modes de paiement des hôpitaux peuvent également influer sur la durée de séjour dans d'autres pays. La durée moyenne de séjour dans les hôpitaux a chuté au cours des dix dernières années dans pratiquement tous les pays de l'OCDE, passant de 8.2 jours en 2000 à 7.2 jours en 2009 en moyenne dans les pays de l'OCDE. Elle a chuté particulièrement vite dans certains des pays qui avaient en 2000 des taux relativement élevés (par exemple, le Japon, la Suisse et le Royaume-Uni). Plusieurs facteurs expliquent cette baisse, en particulier des interventions chirurgicales moins invasives, une évolution des modes de paiement des hôpitaux et le développement des programmes de sorties précoces qui permettent le suivi des patients à domicile.

ANNEXE II : INFORMATIONS SUR LES SERVICES DES PRESTATAIRES

La disponibilité d'informations relatives à la qualité et aux prix destinées aux utilisateurs ou aux acheteurs peut potentiellement conforter les consommateurs dans leur choix d'un hôpital, et favoriser la concurrence entre les hôpitaux. Les études suggèrent que les consommateurs ont rarement recours aux informations sur la qualité, mais qu'elles ont néanmoins un impact sur la qualité des soins et peuvent potentiellement influencer les performances des prestataires (voir Fondation canadienne de la recherche sur les services de santé, 2006 pour une vue d'ensemble). L'étendue des informations relatives aux prix et à la qualité destinées aux consommateurs variant considérablement entre les pays de l'OCDE, cette section donne un aperçu détaillé des pays publiant ces informations, et du type d'informations mises à disposition.

1. Informations sur les prix

Dans la grande majorité des pays de l'OCDE, les services de santé sont gratuits pour les patients ou soumis à des prix (et tickets modérateurs) uniformes définis à l'échelle nationale (comme détaillé dans le tableau ci-dessous). Dans les deux cas de figure, les utilisateurs n'ont pas vraiment besoin d'informations sur les prix.

Informations sur les prix des services des prestataires

Pays	Q45a. Les prix peuvent-ils varier en fonction des prestataires?	Q45b. Informations sur les prix des consultations médicales	Q45c. Informations sur les prix des examens médicaux
Australie	Les prix peuvent varier	Aucune information	Aucune information
Autriche	Pas de prix ou prix unique	-	-
Belgique	Les prix peuvent varier	Directement disponibles	Aucune information
Canada	Pas de prix ou prix unique	-	-
République tchèque	Pas de prix ou prix unique	-	-
Danemark	Pas de prix ou prix unique	-	-
Finlande	Pas de prix ou prix unique	-	-
France	Les prix peuvent varier	Directement disponibles	Directement disponibles
Allemagne	Pas de prix ou prix unique		
Grèce	Les prix peuvent varier	Directement disponibles	Directement disponibles
Hongrie	n.d.	n.d.	n.d.
Islande	Pas de prix ou prix unique	-	-
Irlande	Les prix peuvent varier	Aucune information	Aucune information
Italie	Pas de prix ou prix unique	-	-
Japon	Pas de prix ou prix unique	-	-
Corée	Pas de prix ou prix unique	-	-
Luxembourg	Pas de prix ou prix unique	-	-
Mexique	Pas de prix ou prix unique(1)	-	-
Pays-Bas	Les prix peuvent varier(2)	Aucune information	Aucune information
Nouvelle-Zélande	Les prix peuvent varier	Directement disponibles	Aucune information
Norvège	Pas de prix ou prix unique	-	-
Pologne	Pas de prix ou prix unique	-	-
Portugal	Pas de prix ou prix unique	-	-
République slovaque	Les prix peuvent varier	Directement disponibles	Directement disponibles
Espagne	Pas de prix ou prix unique	-	-
Suède	Pas de prix ou prix unique	-	-
Suisse	Pas de prix ou prix unique	-	-
Turquie	Les prix peuvent varier	Directement disponibles	Aucune information
Royaume-Uni	Pas de prix ou prix unique	-	-

Remarque : (1) Au Mexique, les prix des services non couverts par l'assurance maladie volontaire ou obligatoire peuvent varier ;
(2) Au Pays-Bas, les prix peuvent varier mais seulement dans le segment B, qui représente 34 % de tous les GHM.
n.d. signifie non disponible, « - » signifie sans objet.

Source : Étude de l'OCDE sur les caractéristiques des systèmes de santé 2008-2009

Dans d'autres pays, les prix peuvent varier en fonction des prestataires. C'est le cas par exemple en Belgique, où les informations tarifaires sont facilement accessibles pour les consultations médicales, mais pas pour les procédures médicales.

La France, la Grèce et la République slovaque ont déclaré que les informations sur les prix sont facilement accessibles pour les deux types de services (consultations et procédures). En France, la Caisse nationale de l'assurance maladie des travailleurs salariés (CNAMTS) publie sur son site Internet les tarifs

moyens des médecins pour les procédures médicales courantes. La situation de la Grèce est plus complexe dans la mesure où les paiements dissimulés sont fréquents.

En Australie, bien que les tarifs du régime de prestations maladie (Medical Benefits Schedule — MBS) et les ristournes consenties aux patients soient publiés, le tarif que le praticien facture réellement pour ses services risque d'être plus difficile à obtenir. En vertu de la Constitution australienne, le gouvernement australien ne peut contrôler les prix que les praticiens facturent pour leurs services. Les patients doivent faire leurs propres recherches pour connaître les tarifs pratiqués par les médecins.

2. Informations sur la qualité

Dix-sept pays de l'OCDE ont donné des détails sur les informations disponibles relatives à la qualité des services hospitaliers (voir tableau ci-dessous). Au Danemark, en Allemagne, en Nouvelle-Zélande, en Norvège, en République slovaque et au Royaume-Uni, quatre types d'informations sont disponibles : les résultats cliniques, les processus appropriés, la satisfaction des patients et l'expérience des patients. Ces informations sont publiées par les pouvoirs publics au Danemark, en Nouvelle-Zélande et en Norvège ; par les pouvoirs publics et les assureurs en République slovaque ; et par les pouvoirs publics et les « autres ONG » au Royaume-Uni. En Allemagne, ces informations sont publiées par les assureurs, les médias et les autres ONG.

En Belgique, en France, en Irlande, en Corée, au Mexique et en Suisse, les informations publiées se limitent aux questions cliniques (indicateurs de résultats et/ou processus de soins). Les informations sont publiées par les pouvoirs publics en Irlande et au Mexique, par les pouvoirs publics et les assureurs en Belgique, par les assureurs et les ONG en Corée, par les pouvoirs publics et les ONG en Suisse. En France, les pouvoirs publics publient des informations sur l'utilisation de processus appropriés en termes de sécurité, ainsi que des informations sur les équipements et le volume d'activité de chaque hôpital. Les médias publient des classements des hôpitaux fondés sur différents indicateurs de performances (notamment l'attractivité, le recours aux technologies avancées et le degré de spécialisation, etc.[17]).

En Hongrie et aux Pays-Bas, l'accent est mis sur la satisfaction et l'expérience des patients. Les informations sont publiées par les assureurs et les médias en Hongrie, alors qu'aux Pays-Bas, ce rôle est dévolu aux pouvoirs publics, aux assureurs et aux ONG.

En Australie, les informations sur les résultats et les processus cliniques, ainsi que les informations relatives à l'expérience des patients, sont publiées à différents niveaux de l'administration. Certains gouvernements d'État publient les informations sous une forme facilitant les comparaisons entre les prestataires. En République tchèque, les assureurs, les médias et les ONG publient des informations sur les résultats cliniques et la satisfaction des patients.

		À propos des hôpitaux							
Pays	**Q46. Des informations comparables sur la qualité des services fournis par les prestataires individuels sont-elles disponibles ?**	**Données sur les résultats cliniques**	**Données sur l'utilisation de processus appropriés**	**Données sur la satisfaction des patients**	**Données sur les expériences des patients**	**Les informations sont-elles présentées sous une forme facilitant les comparaisons entre les prestataires ?**	**Qui élabore et/ou publie ces informations ?**	**Existe-t-il des éléments indiquant que ces informations sont utilisées par les patients candidats à une intervention pour choisir un prestataire ?**	**Existe-t-il des éléments indiquant que ces informations sont utilisées par les prestataires pour informer les médecins référents ?**
Australie	oui	X	X	X	X	oui	Pouvoirs publics(1)	n.d.	n.d.
Autriche	non								
Belgique	oui	X				oui	Pouvoirs publics, assureurs	n.d.	n.d.
Canada	non								
République tchèque	oui	X		X		oui	Assureurs, médias, autres ONG	n.d.	n.d.
Danemark	oui	X	X	X	X	oui	Pouvoirs publics	non	oui
Finlande	non								
France	oui		X			oui	Pouvoirs publics, médias		
Allemagne	oui	X	X	X	X	oui	Assureurs, médias, autres ONG	non	non
Grèce	non								
Hongrie	oui			X	X	n.d.	Assureurs, médias	n.d.	n.d.
Islande	non								
Irlande	oui		X			non	Pouvoirs publics	non	Oui
Italie	non								
Japon	non								
Corée	oui	X	X			non	Assureurs, autres ONG	n.d.	n.d.
Luxembourg	non								
Mexique	non	X				non	Pouvoirs publics	non	Non
Pays-Bas	oui	X	X	X	X	oui	Pouvoirs publics, assureurs, autres ONG(*)	n.d.	n.d.

		À propos des hôpitaux							
Pays	**Q46. Des informations comparables sur la qualité des services fournis par les prestataires individuels sont-elles disponibles ?**	**Données sur les résultats cliniques**	**Données sur l'utilisation de processus appropriés**	**Données sur la satisfaction des patients**	**Données sur les expériences des patients**	**Les informations sont-elles présentées sous une forme facilitant les comparaisons entre les prestataires ?**	**Qui élabore et/ou publie ces informations ?**	**Existe-t-il des éléments indiquant que ces informations sont utilisées par les patients candidats à une intervention pour choisir un prestataire ?**	**Existe-t-il des éléments indiquant que ces informations sont utilisées par les prestataires pour informer les médecins référents ?**
Norvège	oui	X	X	X	X	oui	Pouvoirs publics	n.d.	n.d.
Pologne	non								
Portugal	non								
République slovaque	oui	X	X	X	X	oui	Pouvoirs publics, assureurs	n.d.	n.d.
Espagne	non								
Suède	non								
Suisse	oui	X	X			oui	Pouvoirs publics, autres ONG	n.d.	n.d.
Turquie	non								
Royaume-Uni	oui	X	X	X	X	oui	Pouvoirs publics, autres ONG	n.d.	n.d.

Note : n.d. signifie « non disponible ».

CHILE

1. Health sector: institutions and framework

A trend towards private sector involvement in health services began in Chile at the end of the seventies, as part of a broader move towards privatization, deregulation and market reform. As a consequence, the public sector lost its exclusivity in supplying health services and in managing resources for health services. From then onwards people could switch to the private system provided they could afford it[1] [2].

In 1981, with the establishment of private health insurers, called "ISAPRES"[3], working population was allowed to contribute to an Isapre instead of staying affiliated to the public managed sector. By 2011, the Isapres industry is composed by 6 competing companies which offer health insurance plans priced according to risk of diseases, age and other factors[4].

The resources for the public system are managed by "FONASA"[5]. During the first years of the mixed system, FONASA also played the role of regulator of Isapres. FONASA stopped playing these dual functions when a Regulator for Isapres was created in 1990. The latter was replaced in 2005 by a Health Regulator (*Superintendencia de Salud*) whose powers extend not only to supervise Isapres and Fonasa but also to legal duties with respect to direct suppliers of health services such as public hospitals and private health centers[6] [7].

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1 Independent workers or people out of work are not obliged by law to have a health insurance neither in the public nor in the private systems, i.e. they have the option to pay directly to the providers, for the health assistance they need. Conversely, dependent workers should pay monthly at least a 7% of their gross income for health coverage purposes, whether to Fonasa or to an Isapre.

2 For lower income workers the public system grants better benefits and coverage than the private system at the same price.

3 Acronym for "*Instituciones de Salud Previsional*"

4 An accusation of collusion against 5 of the 6 existing Isapres motivated a proceeding before Competition Authorities in 2007, but the case was dismissed in a divided ruling by the Competition Tribunal first and then by the Supreme Court. See a summary of the case in the Appendix.

5 Acronym for *"Fondo Nacional de Salud"*

6 Those described as public and private systems are the main but not the only systems for health services available in Chile. In addition, several 'closed' Isapres offer insurance plans to employees of specific companies, either public or privately owned. Further, armed forces and the police have their own health systems. According to a government survey, in 2009, 78,8% of people were affiliated to Fonasa, 13,1% to Isapres and 6,3% to other systems and uninsured. Less than 2% did not know or did not answer. Available on-line at: http://www.ministeriodesarrollosocial.gob.cl/casen/definiciones/salud.html
According to an OECD report, the total expenditure in Health for 2009 was a 8,4% of the GDP, where 3,9% was public expenditure and 4,5% was private. Available on-line at: http://www.isapre.cl/?cat=3

7 The Health Regulator is divided in two branches: A branch in charge of the insurers sector (Isapres and Fonasa) and another branch in charge of the health suppliers. The powers of the Health Regulator include (i) supervising, monitoring and controlling Isapres and ensuring compliance with their legal, regulatory and

In the segment of suppliers of health services the described trend towards privatization and market reform has resulted into significant private investment in private health centers during the last 30 years.

Individuals affiliated to the public system, in order to receive health services, may attend the network of public providers (hospitals and health centers). In case of higher earnings, affiliates can opt for private health centers under a system called "free choice", within Fonasa[8] [9].

Individuals affiliated to the private system, according to their insurance plan receive a partial or full coverage for health services and may choose to be treated either by public or private health providers. However, there are asymmetries in the coverage of the Isapres' plans in the private and in the public sector which favors the use of private health suppliers. It is worth noting that Isapres form alliances with private hospitals and in several cases they are even vertically integrated with them.

Few cases in the health sector have called for the intervention of the Competition Authorities in the past; the most important ones are described in the Appendix. Fiscalía Nacional Económica (or "FNE) is the competition agency, administrative in nature, in charge of investigating cases and litigating them before the Competition Tribunal. The FNE has also powers in the field of competition advocacy. The Competition Tribunal (or "TDLC") is a judicial body with adjucative powers in the field of competition law. The TDLC may also issue non-binding recommendations of pro-competitive regulatory reforms.

Notwithstanding the relatively low number of competition law cases in the health sector, the FNE lead a team of consultants that carried out a market study on private providers of health services between 2008 and 2009. The health regulator provided comments and feedback on the study. Even though the research was limited to private providers, (i.e. competition between public and private health suppliers was not explored), this research provides useful insights for the purposes of this roundtable. Another market study in the health sector will be carried out for the FNE by external consultants, during 2012.

In the remaining part of this contribution we elaborate on the structure of relevant markets identified by the above mentioned market study and on the key factors of competition in these markets, according to the current institutions and framework for the health sector in Chile. Regulatory amendments in the health sector are briefly described in section VI.

2. Health Care Services suppliers: Relevant Markets

A market study in the sector of private providers of health services was carried out during 2008 and 2009, by the FNE with feedback and comments from the Health Regulator. Several reasons at that time

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contractual duties; (ii) supervising, monitoring and controlling Fonasa in some specific issues; and, (iii) regulating all health providers, both public and private, with respect to their accreditation and certification, as well as ensuring compliance with standards specified by the accreditation.

8 In the last few years new mechanisms allowing public system affiliates to receive health services provided by private suppliers, have been implemented. For instance, this is the case of the "Bono AUGE", a kind of voucher that consumers of public hospitals may use before private suppliers when public suppliers' services are unsatisfactory or untimely.

9 Affiliates to the public system are divided in four groups: A, B, C and D. A and B, i.e. the poorer, receive health services for free (i.e., without paying a deductible) from public suppliers. B, C and D may receive services from private suppliers under the "free choice" system. However, for B affiliates, attending private health suppliers is costly, and in the case of C and D the deductibles they must pay to the private providers are significantly higher than the one they must pay to the public supplier. Thus, the budgetary restrictions and price incentives of the public system lead affiliates to request health services from the available public suppliers.

led to concentrate the efforts of the research in the private sector. First, in a proceeding against five private health insurers in 2007, the TDLC held that for consumers earning above USD 800, there was a low degree of substitution between private and public providers[10]. Second, previous researches conducted by the Health Regulator found that providers of the public system do not compete among themselves, because patients should attend the public provider corresponding to his geographic area. In addition, Isapres' affiliates attending public providers are very few and the same is true for Fonasa affiliates attending private providers. Besides, a very small proportion of the population is uninsured. Hence, most people have access to health services whether through Isapres or Fonasa. Thus, the system of insurance was crucial for determining the health suppliers available. All these reasons led to focus on private providers of health services which offer the most extended segments where competition takes place.

Research activities for elaborating the market study used a mix of qualitative and quantitative techniques aimed at collecting different and complementary information[11] [12].

The final purpose of the determination of relevant markets was then to identify the private suppliers of health services considered as substitutes by consumers.

2.1. Product relevant market

From the point of view of the product, relevant markets consider health services providers. This broad definition includes by and large ambulatory health care consultations (treatments, diagnosis or interventions) as well as non-ambulatory interventions (i.e. hospitalizations), and hence on the supply-side consider medical practices, joint practices, general health centers, laboratories, specialized health centers, private hospitals, public hospitals, etc.

As a matter of definition, an outcome of the study revealed that Isapres' consumers commonly associate the concept of health services with services in the health sector in which they trust as a mean for solving their health problems.

Due to similarities in proceedings and techniques used, health services can be grouped in three 'fields:

- **Health care consultations**: including general consultations, consultations of medical specialties and medical urgent care;
- **Hospitalizations**: in-patient treatment;
- **Medical tests**: tests performed by laboratories, including blood tests, images, X-rays, etc. aimed at diagnosis;

Within each of these fields specific health care services may be grouped:

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10 TDLC, July 17th, 2007, Ruling No 57/2007, Rc. 53°.

11 Considering the low levels of information available when this market study was initiated, the use of the SSNIP test was not feasible. So, research purposes were oriented towards identifying consumers' evaluating criteria when choosing a provider. This research strategy allowed identifying relevant competitive variables.

12 On the one hand, research activities aimed at developing an understanding of consumers' underlying motives driving the selection of a health services supplier (taking into account consumer's age, family life cycle, and socioeconomic group) and, on the other hand, on the basis of expressed preferences of a statistically significant sample, research activities aimed at identifying effective substitution among different private suppliers of health services, for different categories of relevant medical services.

Fields	Specific health care services
Health care consultations	General consultations Specialties consultations Urgency consultation Clinical psychologist consultation Psychiatric treatments
Hospitalizations	Surgeries Services associated with giving birth Beds rental Inputs and other chirurgical materials
Medical tests	Echotomography X-rays

The decision process for choosing a certain health supplier is driven by different values associated with the service and the supplier. Evaluations and expectations of users include rational and emotional aspects.

On the rational side, the alternatives opened to users depend on the agreed contract with the Isapre. Thus, if the affiliate is facing a brief treatment and/or a diagnosis that does not derivate complications or the service is considered mere routine, the determinant variables driving affiliates in choosing a supplier are linked to costs (measured as the amount of the complementary fee paid by the consumer –the deductible, or as the time used by the consumer in the service supplying, or as the availability of other facilities such as parking space).

Emotional aspects appear in more complex health services including interventions having higher risk of death, and those services needing higher levels of doctor-patient trust, such as those provided in the medical branches of gynecology and pediatrics. The selection of a supplier in these cases is oriented to the best provider available according to consumer's budget.

Thus, the decision about a health services provider depends on expectations and budgetary restrictions, which are reflected in the coverage of each individual health insurance plan.

As a consequence, on a provider level, determining the substitutes depends on alternative insurance plans provided by each Isapre and the Isapres' alliances with health services providers. Besides, since Isapres' insurance plans have been designed on the basis of different income levels of consumers, substitution among health services suppliers will be strongly segmented according to socioeconomic features of the corresponding group of consumers.

2.2. Geographic relevant market

A relevant market extends geographically until the point where a specific supplier has no more substitutes from the point of view of consumers, able to discipline non-transitory increases in prices by the first supplier. In case of health services markets, geographic elements of relevant markets are linked to the influence area of the supplier.

The influence area may be considered as a function of the maximum duration a consumer is willing to accept for displacement to an alternative supplier.

The research revealed that willingness for displacement depends on the expected seriousness of the illness or expected complexity of the intervention. Thus, in case of expected simple health services or light

illness or general treatment, the duration of displacement variable is determinant and the patients are likely to prefer to receive the services by the provider most nearly located. Conversely, in case of expected complex health services or serious illness, as well as in case of diseases that last for long periods, the duration of displacement becomes a less relevant variable, since patients tend to be more interested in receiving care by the best or most specialized health provider and hence are willing to travel even to another city.

The elements appearing relevant for the purposes of product and geographic market definition led to the conclusion that using the methodology known as 'brand/price trade off analysis' (BPTO) could bring more accurate outcomes than the SSNIP test. According to BPTO, cross-elasticity is calculated by identifying hypothetically the consumers' maximum willingness to pay when a limited number of suppliers are compared, instead of identifying cross-elasticity by the actual data of consumers' reactions when facing small but significant non-transitory increases in price[13].

3. Key factors for competition in health care services: conditions for and repercussions of price or quality competition

As mentioned in the above section, it seems that objective aspects such as price or quality could not be clearly and directly identified as the only driving factors of competition in health services sector. These variables may be prevalent in some simpler health services, but in more complex services, subjective or emotional factors appear to influence decision making.

In addition, the system of insurance (public or private) and the features of the plan are key factors in the identification of the 'available providers'[14]. In the case of medical tests and simpler health care consultations, variables associated with costs (cost of deductible, expediency in service, location, facilities, etc.) seem to be determinant. In the case of hospitalizations and health care consultations that may trigger subsequent interventions, other, more subjective factors are usually more relevant.

The consumer's decision depends on his expectations triggered by his illness. Indeed, very often, services belonging to different 'fields' need to be combined. For instance, a medical consultation might trigger a hospitalization (e.g. a pregnant woman consults a gynecologists but gives birth in hospitalization); and medical consultations are also linked to medical tests since the latter contribute to diagnosis, a chain that may also involve hospitalization. The need of these combinations is part of the consumers' expectations defined ex-ante on the basis of the likelihood of complexity of the health care needed[15]. These linkages should be considered when defining markets.

As an industry reaction to these circumstances, major developments of integral suppliers (i.e. suppliers providing health services belonging to the different 'universes' mentioned above) have taken

13 The BPTO methodology was used in an actual case where a private health care center was accused of tying the rental of facilities for giving birth with the professional team in charge of providing health care services in giving birth. The accusation was dismissed by the FNE because the facts neither satisfied the legal standards of tying nor of refusal to deal. Besides, bundling facilities with professional health care services associated efficiencies, particularly those related with risks mitigation. Using BPTO methodology allowed concluding that 75% of ISAPRES's affiliates were not sensitive to price increases, so this segment of consumers was locked-in and similar providers were not able to discipline it. The decision ordering to file this case is available here: http://www.fne.gob.cl/wp-content/uploads/2011/05/arch_0052_2010.pdf

14 Alternative providers do often exist but they do not appear convenient for the consumer due to the higher costs of the deductible.

15 E.g. "If I have the flu I'd attend to this supplier whereas if I have a pain on my breast I'd attend to this other one".

place. Regarding incentives in the case of integral suppliers, loyalty strategies are frequently used. For instance, these private health centers develop a 'complementary insurance' or 'scholarly insurances' for children. These strategies may reduce costs for service users once they face the need of health care services but at the same time increase the likelihood of getting locked-in to the corresponding health care center.

Thus, according to the report the most important variables for defining relevant markets and for evaluating competition are the following:

- Isapre's insurance plan held by the consumer, particularly, in case of lower income consumers[16];
- Consumer's expectations about the complexity of his illness;

So, price and quality variables of competition are reflected indirectly through the above mentioned variables. In what follows some specific factors on the demand side and the supply side are identified.

4. Relevant demand side factors in health care services

The market study revealed that according to consumers' perceptions, features of best medical suppliers include:

1. Reputation on the basis of objective data (e.g. acquisition of advanced equipment and technology);
2. Affiliations with universities or recognized national or international centers;
3. Experience and good references (e.g. successful interventions) and absence of negative ones;
4. General facilities (e.g. parking);
5. Profile of average user (i.e. attendance by higher income users turns into a perception of quality about the services provided);
6. Prices are considered as a proxy of quality and facilities: the higher the prices, the better the quality and facilities perceived.

5. Relevant supply side factors in health care services

The health service providers' industry in Chile has experienced several changes since privatization started thirty years ago. On the basis of interviews with main players in the private health sector, today's industry structure in health services is the outcome of changes in the health insurance sector. According to interviewees, when analyzing the supply side it seems useful to consider distinctions between ambulatory and hospitalization services, between simple and complex interventions, and different capital intensity of services provided.

As to medical consultations, for instance, in the eighties these services used to be provided by isolated doctor practices spread along the cities, but since the mid nineties, a model of consolidated ambulatory health care centers concentrated the supply providing consultations for different specializations in the same

[16] Indeed, the research revealed that in the case of lower income consumers, they choose the insurance plan first and only thereafter they define the health supplier. In case of higher income consumers, they choose the supplier first (the clinic, hospital or health facility) and only thereafter they define the insurance plan more convenient for the already chosen suppliers.

building. At the same time, these centers included medical test services achieving economies of scale and scope and costs reductions and time savings for patients. Today this structure is quite similar to a one-stop-shop: in most cases it is not even necessary to go to the Isapre since these centers include offices or online insurer facilities were patients can ask questions about coverage and pay deductibles.

Another common feature of these private health centers is that they provide a wide range of specialties. Conversely, specialized health centers have not proliferated and seem successful only in some areas such as ophthalmology and cosmetic medicine.

Even though some integral suppliers have been able to include hospitalizations and complex interventions into the packet composed by ambulatory services and medical tests, these are most commonly provided by more sophisticated suppliers in a segment of the industry having different features. Indeed it is traditionally considered as a segment with less output (available places for hospitalization) and with higher levels of concentration.

Vertical integration between Isapres and health care centers is another principal characteristic of the industry. Most Isapres own shares of private health centers though the opposite is forbidden by law (health centers owning an Isapre).

Entry barriers were not clearly identified by the research. Some sources identified overcapacity as a possible entry deterrent in some health care services but additional inquires would have to be done in order to test this hypothesis. Reputation was another factor identified by sources as a significant condition that may delay expedient entry, but this factor is also present in other industries.

6. Institutional and regulatory pro-competitive reform in health care services

Incorporating a private insurance model as a mechanism for financing health services was a significant change for the health sector in Chile. Even though not exempted from criticism, the private health system has triggered significant private investments in facilities for supplying health care services in the last 30 years[17].

The Isapres have been criticized for the absence of transparency and extreme heterogeneity of the plans they offer, which turns into a significant obstacle when comparing services. Remedies such as imposing a homogenization of insurance plans and limiting the number of alternatives available in the market as well as creating an on-line automatic comparative calculator of health services prices (deductibles) have been proposed in the past in order to solve these problems.

Another important criticism has been the lack of transparency in the methodologies Isapres use when increasing insurance prices. Subsequent law amendments have tried to reduce the Isapres' discretion in this process and to introduce an equity pillar in order to protect the more 'expensive' or riskier affiliates[18].

17 An illustration of this as a remaining trend in 2005 may be found here: http://businesschile.cl/es/noticia/reportaje-principal/el-vigoroso-crecimiento-de-las-clinicas-privadas-en-chile

18 At the beginning of the system, the tariffs of the plans were the result of a base price multiplied by a risk factor grounded on sex and age. But plans informed just the final tariff and not the factors grounding its calculation. Act N. 19.381/1995 introduced the obligation to maintain the same relation of prices by age and sex established by the original contract. The purpose was to protect older affiliates and to introduce an equity element into the system. However, different charts of factors designed by each Isapre made difficult for consumers to compare alternative plans. Thus, Act N. 20.015/2005 regulated the mechanism for determining tariffs of health insurance plans: tariffs are now determined by multiplying a base price by the risk factor of the corresponding affiliate according to a chart of factors designed by the Isapre. Each plan

However, these regulatory solutions have not ended dissatisfaction and interventions from the judiciary power have been increasingly requested since 2010[19].

This situation led the government in December 2011 to submit a bill before the Congress aimed at introducing significant reforms in the private health care system. The major amendments included in this bill consider the duty of each Isapre of supplying a Basic and Standard Health Insurance Plan (*Plan Garantizado de Salud* or *PGS*) with a flat tariff (i.e. without weighting age, sex, or individual health condition) defined by each Isapre and available to every affiliated member. Isapres will be able to offer complementary benefits over this standard. In addition, mechanisms ensuring objectivity in PGSs' price increases would be introduced such as the calculation of statistical indicators of variations in health services prices, of variations in the frequency of use of health services and of variations in the expenditure for disability benefits. These reforms will be complemented by the work of an expert group in charge of calculating annually indexes of variation on the basis of the above indicators.

These suggested amendments aim at introducing more competition and transparency into the system. If passed, they will change relevant elements of the framework under which the private health sector has developed, so some changes in the industry may be expected in the future.

may be associated with only one chart of factors and each Isapre may have a maximum of two charts of factors in total. These amendments aimed at designing a mechanism of limited variability of the tariffs of the plans along the life cycle of affiliates, a mechanism predictable for consumers at the time of subscribing the plan.

19 One of the major decisions was issued by the Constitutional Tribunal. In August 2010 (file number 1.710), this Tribunal held that several recitals of a section of an Act regulating the structure of the chart of factors, were contrary to the Constitution, violating the constitutional rights to health protection and social security. In addition, a huge number of increases in Isapres' plans tariffs have been declined by Court of Appeals and the Supreme Court on the grounds of absence of justification for these increases. This has created a significant judicial workload for the industry, since it is relatively easy for affiliates to obtain judicial representation for challenging these increases.

APPENDIX: MAIN COMPETITION LAW ENFORCEMENT CASES IN THE HEALTH SECTOR

ISAPRES CASE

In 2005, the FNE submitted charges against the major private health insurance companies (ISAPREs), accusing them of colluding for reducing the percentage of coverage of the benefits of their marketed health plans, harming their affiliates. Until May 2002 plans offering 100-80 coverage (i.e. 100% coverage in hospitalizations and 80% in ambulatory services) represented 96,7% of Isapres' sold plans. From May 2002 onwards until 2004 after a serial of constant reductions by each defendant Isapre, 100-80 coverage plans became only a 7,5% of the sold plans whereas 90-70 plans reached a 90,6% of the total selling. In addition to these changes in the available plans offered in the market, increases in Isapres' benefits were identified.

However, the FNE's case did not succeed due to insufficient evidence for satisfying the standard of proof of the existence of an agreement[1]. Notwithstanding the dismissal, the TDLC endorsed the FNE's position that information flows regarding the companies' sales teams and periodical reports about the insurers and their insurance plans disclosed by the sector regulator, were an expeditious information channel leading to parallel conduct.

[1] TDLC, Ruling No 57/2007. Spanish text available at: http://www.tdlc.cl/Portal.Base/Web/VerContenido.aspx?ID=794&GUID=

FINLAND

1. Introduction: the Finnish health care system

The Finnish health care system is characterized by a large, preponderantly tax-financed public sector. Everyone residing in Finland is entitled to receive publicly-provided health care within set time frames. Residents pay only a heavily-subsidized fee for the services they receive. The fees are administrative and are not intended to steer the allocation of resources to health care services. Up to now, thus, the Finnish public health care system is based on a non-market approach. Municipalities are obliged to provide their residents with access to medical care services. This concerns both primary and specialized health care. Although the law does not outright force the municipalities to produce the public health care services themselves, up to now they have owned the productive units, in particular the health care centers and the hospitals that supply the services falling under the public health care. The Finnish public health care system has, thus, been to a great extent vertically integrated. Municipal health centers take care of primary care while hospital districts are entrusted with providing specialized care and, thereby, maintain hospitals for specialized health care. All municipalities are obliged to be a member in one law-designated hospital district (there are currently 20 hospital districts). A member municipality is obliged to participate in the financing of the hospital district's outlays. Although it is not, strictly speaking, obliged to buy all performances of specialized health care required for its residents from the hospital district it is a member of, the municipality is strongly incentivized to do so, and so they do. Some treatments and operations deemed to constitute highly specialized medical care may be centralized on a national level in specific catchment areas. More detailed stipulations as to the specific catchment areas have been made by Government decree. There are currently five catchment areas in each of which the area of several hospital districts is included. The catchment areas centralize the most demanding treatments or operations to the university hospitals; indeed, now even the catchment areas are specializing on only some of such highly specialized treatments or operations.

The demand for public health care services has steadily exceeded the available public resources, which has resulted in persistent queues of patients. This encouraged the lawmakers to provide maximum waiting times by law. At the same time, measures have been taken to unify criteria for patient entrance and treatment. It was an administrative command that did not change the planned nature of the public health care system.

Alongside the public sector there is a private health care service market in Finland, the share of which of all health care is close to 20%. The prices charged for the private health services are unregulated but customers have a right to receive a partial reimbursement of the cost they have incurred from the state funds. The reimbursement is paid by the Social Insurance Institution of Finland on the basis of the National Health Insurance Act. The reimbursement is based on a tariff that has not been revised for a very long time. Therefore, the significance of the reimbursement has markedly decreased as the unit prices of the private health services have increased.[1] Some of the private market health services are supplied in private hospitals. There are only a few operators, and the total private hospital capacity is relatively modest, to be

[1] That is why the FCA has recently regarded the private hospital services and public hospital services as not belonging to the same relevant product markets. Terveystalo Healthcare Oy/ ODL Terveys Oy, Dnro 1116/14.00:10/20/10.

sure, and there is currently no private-sector hospital capacity for very specialized treatments or operations or urgent care. For example, there is no private hospital capacity available in Finland for demanding cardiac surgery. Substantial institutional reforms are required to encourage private hospital capacity of this kind. The number of private hospitals has increased but these private hospitals are often specialized and have a limited assortment of services to offer to citizens. Finland still belongs to the OECD members with the lowest private share of hospital beds.

2. Free choice of public hospital – a new and path breaking element

Obvious on the basis of the above, the idea of public hospitals competing with each other has been alien to the Finnish public health care system. As a rule, as recipients of public health care the residents of a municipality have not had any choice as to the health care center, public hospital or medical professional that treats them.

After the entry into force of the new Health Care Act in 1 May 2011, however, this issue commands quite topical interest. The new Act (Section 47) provides that individuals have the right to choose which one of the health center units operating in their municipality they go to for primary health services. In addition, in situations where a physician or a dentist considers that a patient is in need of specialized medical care, the individual may choose to use any of the local authority specialized care units found within the catchment area in which his or her municipality of residence is located. Patients shall discuss their choice or treatment unit with the referring physician or dentist. As of 2014, free choice of a health center or a public hospital is extended to comprise the whole nation.

This is a great challenge to the Finnish public health care system, the governance of which has been and continues to be largely inconsistent with the idea of citizens' choice being given the decisive role as to how resources are allocated to health care and its various treatments and operations. It appears to be the case that the drafters of the bill and the lawmakers have not fully appreciated that the current institutional set-up of the public health care system is inconsistent with free choice really being effective rather than symbolic in the day-to-day activities of the public health care system. If nothing is done to fulfill the promise of free choice, free choice would, in practice, amount to a private redetermination of queues. The next few years, by force, will witness a major overhaul of the governance of the Finnish public health care system and of public hospitals in particular, if these free choice provisions are to be made truly effective.[2]

No surprise, while we are not aware of any official data available, it seems that this choice has been, up to now, quite modestly exercised. This is surely partly due to the citizens being inexperienced to engage themselves in active choice; capacity to put choice in action takes time to develop. As indicated above, a major reason surely is that the institutional set-up to encourage citizens to put choice to bear does not exist yet.

In chapter 4, the main issues of the institutional re-setup are identified from the angle of contemporary scholarship. In chapter 3, the current status of the gradually increasing upstream competition among hospitals is discussed.

3. Competition in hospital service on the upstream level

Traditionally, the Finnish public special health care system has relied on vertical integration, the municipalities or their associations owning the public hospitals and producing and making themselves available to citizens the tax-financed health care services who have paid administrative, heavily-subsidized

[2] The analysis of the challenges free choice poses to the Finnish Public Health Care regime presented in this paper is based on Virtanen-Joutsimo 2010, and Virtanen 2011.

fees for the services. There has, thus, been little room for public procurement of health care services on the upstream level.

More recently, though, some hospital districts have started to use public procurement of elective care treatments, in several cases inviting both publicly-owned and privately-owned hospitals to bid. The reason for using public procurement is lack of resources within the own hospital district and the need to comply with the maximum waiting times explicated in law.[3]

As public procurement has only recently increased, it is not surprising that errors have been made in the procurement.[4] In the course of time, fewer errors may be expected. To use public procurement properly, it is important to prevent distortions of competition between the various types of producers by creating a competitively neutral environment for producers and unbiased criteria for public procurement.

Upstream competition is growing, if at all, quite gradually.[5] Free choice being introduced to the downstream level it may well be that the development of competition in hospital services will henceforth take place mostly on the downstream level.

4. The challenge of creating truly effective free choice for consumers in hospital services

As explained above, currently municipalities purchase the special health care services that they are entrusted with organizing from the Hospital Districts. Every municipality is obliged to be a member of a designated Hospital District and has to participate in covering the operating costs of the particular Hospital District it belongs to. Although the municipality is, strictly speaking, not obliged to buy services from the Hospital District it is a member of, municipalities are strongly incentivized to buy the services from that Hospital District. It is the latter that organize and own the public hospitals and decide about the services each hospital produces. Citizens have a legal right to receive health care by the public health care organizations to whose area their residence belongs to. Resources are allocated to hospitals through the planning apparatus of the Hospital District, and the citizens who enter the hospitals according to administrative rules and proceedings, only pay heavily subsidized administrative charges for the services which are not designed to influence the resource allocation and production structure of the public hospitals. The presence of alternative productive capacity and free choice for citizens was an altogether alien idea to this public health care system and was almost totally missing. Each hospital had its exclusive place in the productive system and was not, save exceptional circumstances, to be replaced by other hospitals in the same district. Nor could citizens choose the professional staff within the hospital to treat them. The same lack of choice concerned the care supplied within the catchment area for highly specialized care.

The free choice of the public hospital within a catchment area for highly specialized care implies a regionally confined market on which the public hospitals are, in principle, alternative suppliers. There is no guarantee that the choices of the citizens would correspond to the allocation of resources the planning apparatus has determined, in view of the hospitals and of what kind of activities and operations they are engaged with. If public hospitals are not allowed and enabled to change (increase, cut, exit, modify) their

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3 A case in point was the large (worth around 17 million euros) public procurement of elective operations that the city of Helsinki arranged in the aftermath of the 2001 strike of physicians to shorten the very long queues of patients that this long strike had led into. Another, national effort to shorten the queues was made. The operations were procured from two hospital districts (not the ones Helsinki belongs to) and eleven private hospitals or foundations.

4 E.g. Helsingin ja Uudenmaan sairaanhoitopiirin kuntayhtymä/HYKS, Jorvin sairaala vs. Sairaala Pulssi Oy MAO: 165/1/02, 166/1/02.

5 According to the information received in the context of the merger case mentioned in footnote 1, procurement of services accounted for only 3 % of the total outlays of public health care in 2008.

capacity on the basis of the manifested preferences of citizens, free choice will, in practice, amount to little else than entrusting the citizens with reallocating queues among the public hospital units within the catchment area. Either the market or planning must be used to determine the allocation resources, not both at the same time. That planning and market (through free choice) would lead into the same allocation would be a most unlikely co-incidence and public hospitals are no exception. As a matter of fact, what would be required is not only the planned resource allocation of one hospital district being consistent with citizen choice but that should be required of all hospital districts belonging to the same special responsibility area. If free choice is to be made real, the public hospitals must be able to make the capacity decisions so as to adapt themselves to the manifested preferences of citizens. Capacity decisions could not be any longer imposed on hospitals by the hospital district planning apparatus.

The resources of the public health care system are preponderantly financed by municipal income tax, each municipality collecting the tax and financing the hospital district on the basis of a mutual agreement. Free choice, if truly implemented, would result either in the relative capacity needs of hospitals in the member municipalities departing from the planned distribution of labor or the relative capacity needs of hospital districts members of a catchment area departing from the planned. If the financing practice were not changed, inhabitants of a municipality or a hospital district might have to finance service use of non-inhabitant citizens while inhabitants of another municipality or another hospital district would escape financing the service use of some of their citizens. In 2014, free choice will involve the whole territory of Finland; subsequently, one hospital district might be forced to finance the health care service supplied to citizens resident in any part of the country which is obviously unbearable. Free choice is feasible only, if public money follows the citizen. The financing system is sure to require reform in view of the free choice reform.[6]

Free choice, in practice, concerns elective care. It is important to identify very clearly what kind of care or medical conditions are included in the free choice regime. It has not been discussed how free choice of elective care within the special responsibility area might affect the public hospitals that supply both urgent and elective treatments.[7] It is also in this respect that free choice in one part of the public health care system may give rise to governance reform in other parts of the system as well.

It is heavily contested how citizens are capable of taking advantage of free choice in health care services. The better-educated and the better-off are argued to have a stronger potential to and indeed make better use of the choice than the less-educated and the poor.[8] There seems to be wide agreement, though, on the need to provide the citizens and their counseling physicians with ample and relevant information as to the availability and quality of health care services in competing hospitals. Free choice reforms in other countries have witnessed the development of new information sources to support reasonable choices.

6 A capitation-type financing model is likely to be the solution.

7 These hospitals have used their resources in elective care if they have not been required in urgent care. Free choice in elective care might decrease their revenue in elective care which would increase the cost of maintaining urgent care (e.g. intensive care departments) as the rate of capacity utilization of the resources of urgent care would decrease.

8 See e.g. Le Grand 2006, Clarke 2006, Fotaki 2010. Critics argue this increases inequality among citizens as recipients of public health care. On the other hand, even if the less-educated and the poor turned out to be less capable of making use of free choice, they might still benefit in comparison to their position before the reform. Assisting less capable citizens to become active consumers may be one of the main issues to develop in the revision of the institutional set-up. New man-made institutions may be required, and emergence of new market institutions to deal with the issue may also be anticipated.

Decisive progress on this score seems strictly necessary. Indeed, such information sources are being developed in Finland.[9]

Finally, it must be considered and settled how the public hospitals that citizens could choose can compete for citizens' choice, and on what criteria citizens may make their choices. Public hospitals will have to truly compete for citizens' favor. If hospitals are under no or weak pressure to compete, the allocative impact of free choice will be feeble. It must become critically important to public hospitals to dispose of customers for care and fatal to be largely rejected by customers. It would totally run counter to the very idea of free choice to protect the public hospitals from the impact of customer choices.

The prevalent position of the contemporary literature to competition between hospitals is that hospitals can effectively compete on quality, truly spurring quality while price competition might possibly lead to a race to the bottom, i.e. to price reductions that are based on quality debasement citizens or public financiers of health care may only imperfectly observe either *ex ante* or *ex post*[10].

Through the free choice provision, the reform of the Health Care Act paves the way to competition between public hospitals. The institutional set-up that is necessary to fully implement the free choice scheme could be further developed by allowing private hospitals to compete for the citizens' choices which has been realized in many countries that have introduced the free choice scheme. That would be likely to increase the competitive pressure on the market of public sector elective health care treatments and operations to the citizens' and to the public benefit. Correspondingly, public hospitals could be allowed to compete for private health care treatments and operations on the private markets.

Even if only public hospitals were permitted to compete for the free choices of citizens, substantial attention must be attached to attaining a level playing field among the hospitals, i.e. to reasonable competitive neutrality. A reasonable level of competitive neutrality between the hospitals will be a precondition for consumer choice –enhancing competition which is a challenge for the institutional set-up. This would be all the more important if both private and public hospitals were allowed to compete for the citizens' free choices as to public sector health care treatments and operations.

5. Hospital services and the FCA

Because of the very nature of the public hospital regime in Finland, the FCA has, up to now, not been much involved in public hospital –related issues. The most essential issues related to the public health care system that the FCA has assessed are related to the marketized support functions of the public health care regime. Municipal enterprises have been established to take care of laboratory services of a certain hospital district, and these enterprises have also sold their services to the private markets which has raised doubts as to unduly low prices on the latter markets enabled by cross subsidization which is argued to be possible because of the protected monopoly of laboratory services within the hospital district concerned.[11]

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9 The National Institute for Health and Welfare is engaged with developing a net-based information source for citizens known as "Service Scales" (Palveluvaaka). It contains comparative information as to the public productive units, allows citizens to give feedback on the care they have received, and offers statistics as to the social and health care of each municipality.

10 See e.g. Cooper et al. 2011, F230-F231 in particular. Competition on quality could be encouraged by setting the prices for the public health care treatments or operations that fall under the free choice scheme.

11 E.g Pirkanmaan sairaanhoitopiirin kuntayhtymä, Tampereen laboratoriokeskus, Dnro 1057/61/1998. The FCA did not consider the criteria for abuse of market dominance having been fulfilled, but emphasized the need for accurate cost accounting and commercial pricing principles on the private markets.

The challenge of introducing free choice is likely to increase the need for FCA involvement in the reset-up of the public hospital regime. Indeed, there is now evidence of increased involvement.

The requisite institutional reforms are no doubt going to be quite profound, and the national competition policy experience accumulated as to inviting competition in public welfare services are a useful ingredient of the future deliberations of the reform. The public hospitals that participate in a free choice competition process may be deemed to be active on a market as undertakings falling under the Competition Act. The FCA must strive for contributing to institutional conditions that minimize the risk of prohibited restrictive practices and are conducive to workable competition of public health care services.

6. Conclusions

The reform of the Health Care Act last year was truly pioneering as it implied a turnaround from a non-market planning approach to a competitive market approach in a significant part if not all of the public health care services. Instead of exclusive planning the legislative reform envisions a mixed planning/market governance approach to organizing the Finnish Public Health Care system. The very basic issues of how a market of public health care is going to be established, how the public hospitals can engage themselves in competition with each other and on what information and criteria citizens can choose the hospital they desire to go to will have to be settled. Thereby, Finland is about to follow the precedents of most other OECD members that have recently introduced free choice in their health care system.

Competition between the public hospitals is feasible but substantial reforms of the institutional set-up are required to make free choice effective and competition the true driving force of public hospital activity. From the competition policy angle this overhaul is of tremendous significance. No clear strategy as to how free choice is to be veritably activated in the public health care system has been presented. This is the topical challenge that government and lawmakers face in Finland. [12]

[12] The challenge to make progress on this score is invigorated by the new EU Directive on Cross-Border Health Care that will also enter into force at the beginning of 2014. The directive provides – with certain conditions and limitations- for the right of EU citizens to receive health care treatment in another Member State and to claim reimbursement on the basis of what they would have been entitled to had they received the treatment domestically.

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FRANCE

1. Les conditions et les répercussions d'une concurrence prix et qualité sur le secteur des services hospitaliers

Un tarif (un forfait par séjour) est établi sur la base d'une classification médico-économique en Groupe Homogène de Malades (GHM), pour l'hospitalisation complète et pour l'hospitalisation de jour, 600 racines sont déclinées en niveaux de sévérité : 2 300 Groupes sont constitués. Il y a un préalable, le programme de médicalisation des systèmes d'information (PMSI). Ce financement par un forfait inclut (presque) l'ensemble des prestations nécessaires. Face à chacun de ces groupes médicaux est affecté un TARIF : le Groupe Homogène de Séjour (GHS).

Les objectifs de la tarification à l'activité (T2A) sont les suivants : restructurer des établissements, inciter et donner un intérêt à agir, inciter les établissements à se donner des outils de gestion et à développer leur efficience. L'objectif n'est pas tant de réduire les dépenses, que de laisser plus de latitude aux établissements pour gérer la production de soins et permettre une plus grande équité de traitement entre établissements

Cet outil « économique » doit contribuer au développement d'une politique d'amélioration de la qualité du système de soins, qui a vocation à agir sur le comportement des acteurs. Il a un impact sur la qualité (management de la qualité, contractualisation interne, benchmarking) et sur l'évolution de l'offre de soins (développement des soins d'aval, des soins palliatifs, promotion de la prise en charge ambulatoire). En effet, la T2A fournit des incitations économiques à optimiser les pratiques, tant sur le plan médico-économique que sur le plan de la qualité (par la satisfaction des patients, la diminution du risque nosocomial, le développement des alternatives à l'hospitalisation, une planification adaptée, l'accès des patients aux innovations médicales et techniques, le développement d'indicateurs de performance, la certification des établissements, l'évaluation des pratiques professionnelles…).Cependant la T2A a des effets théoriques négatifs non désirés, comme le risque de «sélection» de patients, de «spécialisation » des établissements, de diminution de la durée moyenne de séjour.

De plus, la T2A peut être considérée comme un moyen permettant d'atteindre la convergence tarifaire entre établissements de santé (publics et privés), de manière intrasectorielle, puis à terme, intersectorielle. La volonté de rapprocher les tarifs des deux secteurs participe à la mise sous tension du dispositif de production de soins et constitue l'un des facteurs clefs susceptible d'enclencher une dynamique de concurrence entre les établissements.

2. les facteurs clés de la demande de soins hospitaliers et comment ils peuvent contribuer à une concurrence réelle en matière de prix et de qualité des soins et prestations hospitalières

Le ministère chargé de la santé et la haute autorité de santé (HAS) mettent en œuvre un recueil d'indicateurs de qualité des soins dans les établissements de santé (hôpitaux et cliniques). L'utilisation de ces indicateurs de qualité vise 4 objectifs d'utilisation :

- Fournir aux établissements de santé de nouveaux outils et méthodes de pilotage et de gestion de la qualité : il s'agit pour les établissements de santé de mettre en place leur programme d'actions,

des actions de sensibilisation et de formation des professionnels de santé et permettre des comparaisons entre les établissements de santé.

- Répondre à l'exigence de transparence portée par les usagers : les données sont diffusées sur internet avec des comparaisons en vue de faciliter leur compréhension et mises à disposition du public par les établissements. Les résultats des indicateurs font l'objet de procédures de contrôles en vue de mesurer leur fiabilité.

- Aider à la décision et au pilotage des politiques d'intervention à l'échelon régional et national : les indicateurs de qualité des soins sont intégrés dans les contrats pluriannuels d'objectifs et de moyens (CPOM), etc.

- Simplifier et améliorer la procédure de certification : la certification utilise les indicateurs dans sa procédure.

Les établissements de santé recueillent les données sur la base d'une méthodologie nationale et saisissent les données sur une plateforme de l'Agence technique de l'information sur l'hospitalisation (ATIH).

Les indicateurs qualité accessibles dans la base de données PLATINES : PLATeforme d'INformations sur les Etablissements de Santé MCO (Médecine, Chirurgie, Obstétrique) et SSR (Soins de Suite et de Réadaptation) sur le site de la HAS concernent la sécurité des soins : lutte contre les infections nosocomiales, hygiène des mains, surveillance des patients opérés, bon usage des antibiotiques…

En France s'applique le principe du libre choix par le patient de son médecin et de son prestataire de santé. Il n'y a pas d'incitation du patient vers un parcours hospitalier particulier.

3. Les facteurs clés de l'offre de soins hospitaliers pour déterminer les domaines auxquels doit s'étendre la concurrence hospitalière et les mesures qui peuvent être prises pour l'améliorer

En France, l'offre de soins est régulée par des instruments budgétaires et de planification.

Le cadre budgétaire de cette offre de soins est fixée au plan national par l'objectif national de dépenses d'assurance maladie et son volet hospitalier. Cet objectif conduit à encadrer les volumes d'activité des établissements afin de permettre des hausses de tarif et de garantir la qualité des pratiques. En effet, une hausse importante de l'activité dans un domaine conduit à réexaminer les tarifs afin de respecter l'ONDAM. Le Schéma régional d'offre de soins (SROS) est un outil de rationalisation de l'offre de soins globale au regard des enjeux nationaux de respect de l'ONDAM et de gestion du risque. Afin de conférer au SROS toute sa portée de régulation de l'activité, deux moyens vont être mis en place : le chiffrage a priori des SROS et la mise en place d'un dialogue de gestion Etat/ ARS/ établissements de santé sur la construction et le suivi d'indicateurs de pilotage de l'activité (IPA). Ces objectifs sont contractualisés entre l'Agence régional de santé et chacun des établissements de santé dans des contrats pluri annuels d'objectifs et de moyens. Les activités de chacun des établissements de santé sont autorisées pour bénéficier de prise en charge d'assurance maladie. Il y a une autonome juridique des établissements de santé qui sont des établissements publics mais ces établissements mais les tarifs sont fixés nationalement pour chacune des activités.

La loi Hôpital, Patients, Santé, Territoires (2009) prévoit des restructurations de l'offre de soins en favorisant la constitution de communautés hospitalières publiques et les coopérations publiques/privées permettant l'élaboration d'une stratégie commune et/ou la mutualisation des moyens. L'émergence sur des

territoires de santé de nouveaux acteurs à taille critique peut contribuer à stimuler la concurrence même s'il ne subsiste que quelques opérateurs.

Par ailleurs, les rémunérations des personnels de santé sont fixées au plan national pour la plupart:

- La fonction publique hospitalière : leur rémunération est fixée dans le cadre d'une grille

- les médecins : ils sont régis par des statuts de contractuels nationaux avec une grille nationale, soit par des contrats régis au plan local avec des rémunérations encadrées au plan national mais avec une marge de manœuvre des directions d'établissement. La rémunération des gardes est fixée par un arrêté national.

Les salaires sont donc fixés de manière similaire dans l'ensemble des régions et ne sont pas un facteur de concurrence à l'hôpital public entre régions.

A l'hôpital privé, il est fait application de conventions collectives pour les personnels infirmiers et les médecins sont rémunérés à l'acte puisqu'il s'agit d'honoraires.

4. Le cadre institutionnel approprié et les réformes politiques appropriées pour introduire davantage de concurrence dans les services hospitaliers

En France, le système de financement vise à assurer un service public de qualité à l'ensemble des patients qu'ils soient dans le public ou le privé. *L*e principe du libre choix par le patient de son médecin et de son prestataire de santé s'applique et il n'y a pas d'incitation du patient vers un parcours hospitalier particulier.

La tarification dans le secteur privé est prévue selon les mêmes modalités que le secteur public. La différence est que ce tarif ne comprend pas la rémunération du médecin qui perçoit des honoraires au titre d'un paiement à l'acte. Le secteur privé n'est pas assujetti aux mêmes règles de continuité des soins que l'hôpital public, 24 h sur 24 et 365 jours par an. Les tarifs publics et privés sont donc d'un montant différent.

Le système de financement de la T2A prévoit sa régulation prix/volume qui permet de réduire un tarif au plan national quand l'activité hospitalière augmente notablement dans cette activité. C'est le ministère de la santé et l'Etat qui arrêtent les tarifs. En outre, il est envisagé de renforcer l'utilisation d'indicateurs de pilotage. Ce système ne régule pas directement la concurrence entre public et privé amis mais bien davantage le volume et le coût global de l'activité.

Une convergence se met progressivement en place entre les tarifs publics et privés afin d'éviter les distorsions de concurrence sous l'égide de l'État. Ainsi, l'échéance finale de l'objectif de convergence intersectorielle entre secteur public et secteur privé dont a été reporté à 2018. Une des difficultés tient à l'évaluation et à la prise en compte des contraintes de service public.

GERMANY

1. Introduction

Ensuring equal access to health services, including hospital services, for all citizens while at the same time guaranteeing a high quality standard of health care provision is considered to be of paramount political importance in many countries. Over the last years, health care expenditure has been steadily increasing worldwide, due to demographic and technological changes. In 2009, Germany spent EUR 278 billion, equaling over 11% of GDP, on health care, of which EUR 71 billion were expenditures for hospital services.[1] Against this background, it is therefore important to strengthen competition within the health system to ensure choice and at the same time cost effectiveness.

This also applies to hospital services. A number of hospital mergers examined by the *Bundeskartellamt* in Germany in recent years have prompted a discussion about the potential role of competition in the market(s) for the provision of hospital services in light of these developments.[2] Competition on hospital markets improves the quality of services, reduces expenditures on health care services and thus increases the efficiency of the provision of health care services.

This paper describes the legal framework relevant to competition in the market for hospital services in Germany. It presents recent regulatory reforms and developments intended to promote competition in these markets. However, as the provisions establishing the legal framework for hospitals in Germany are manifold and found in a number of different statutes, a detailed description of the regulatory system would be beyond this paper's scope. Therefore only a broad picture of the most relevant features will be presented here.[3]

2. Specific features of the markets for hospital services

In most services markets, competition between service providers takes place with regard to all parameters of competition, such as price or quality[4]. However, when it comes to hospital services, a number of special features and difficulties relating to the functioning of the market are discussed in health care economics as well as in the political discourse.

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1 German Federal Statistical Office (Destatis): http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2011/04/PD11_135_23611,templateId=renderPrint.psml

2 The term 'hospital services' will hereafter be used as referring mainly to stationary treatment provided by hospitals, in particular diagnosis and treatment.

3 For more details on the legal and economic framework of the German hospital markets see Bundeskartellamt, B10-123/04 *Rhön-Klinikum/Landkreis Rhön-Grabfeld*, Prohibition Decision of 10 March 2005; Press Release in English on www.bundeskartellamt.de. The decision was confirmed by the Higher Regional Court in Düsseldorf on 11 April 2007 and by the Federal Supreme Court on 16 January 2008 (Press Release of 17 January 2008 in English on www.bundeskartellamt.de.

4 Quality of hospital services can, in addition to successful treatment, also include the quality of the technical equipment, waiting periods, room quality, customer-orientedness of the hospital staff, or the quality of the food.

One of the difficulties and a reason for potential market failure are information asymmetries between the service provider (hospital) and the consumer (patient). Hospital services are considered "credence goods", i.e. goods, whose quality or the extent to which they are needed cannot (or only under very high costs) be adequately assessed by the consumer, both before and even after the purchase.[5] With regard to hospital services, this can refer to the necessity, the extent as well as the quality of the medical treatment provided. In many cases the consumer's (patient's) decision which hospital to choose for stationary treatment will also be based on the advice of his general practitioner or relatives/close friends who have had experience with the hospital in question.

In this context a further cause for potential market failure may arise from the moral hazard problem posed by (full) insurance coverage. Since 2009, health insurance has been mandatory for all citizens in Germany. A large majority of the population is insured with a statutory health insurance fund (also called sickness fund) and a minority, roughly 10 % of the population, has a private health insurance. In both cases the recipient of the service demanded (the patient) is not identical with the entity which ultimately has to bear the costs for the services (health insurance funds or the private health insurances). This division can have adverse effects on the demand side of the market for hospital services, as the patient may not take the costs of different options of treatment offered to him adequately into account.

Impediments to an optimal market outcome may also arise on the suppliers' side. There may be incentives for over- or under-provision of treatment by hospitals, arising from the fact that patients find it difficult to assess the need for and quality of the treatment offered to them. Such potential over- or under-provision of services may concern both, the quantity and the quality of treatment. However, the extent to which this becomes an issue will depend *inter alia* on the specific remuneration scheme for providers of hospital services.

Due to these and other causes of potential market failure, public intervention in the market for hospital services may be required.[6] Such intervention would also respond to concerns of society that unregulated competition could lead to an insufficient level of quality of hospital services. Such intervention may also ensure that the goal of ubiquitous provision of and equal access to hospital services is met, which in Germany as in many other countries are considered primary concerns of the society, may not be achieved solely by means of a competitive market outcome.

3. General framework for the hospital services market in Germany

The German hospital market is highly regulated by various codes and acts, such as the Social Code (*Sozialgesetzbuch*), the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*), the Hospital Remuneration Act (*Krankenhausentgeltgesetz*) and the Hospital Codes of the federal states (*Krankenhausgesetze der Länder*) as well as the Trade Code (*Gewerbeordnung*).

Providers of hospital services can be distinguished according to ownership structure. In 2010, roughly 30 % of the hospitals in Germany were public hospitals, owned by municipalities, regional districts or federal states. Around 37 % were charitable hospitals, run by non-profit organizations (in particular the churches). The remaining 33 % were privately owned hospitals, whose number has increased in recent years.[7] However, in terms of accommodation capacity, the picture is quite different. Public hospitals

5 Compare i.a. Winand Emons, Credence goods and fraudulent experts, RAND Journal of Economics Vol. 28, No. 1, Spring 1997, pp. 107–119. Available at: http://staff.vwi.unibe.ch/emons/

6 Naturally, that could only be the case for planned, elective hospital care and not for emergency care, where the decisive factor is getting initial treatment as quickly as possible.

7 Private hospitals may further be distinguished according to whether or not they are listed in the Hospital Plan and therefore allowed to provide services to patients with a statutory health insurance.

account for around 49 % of accommodation capacity, charitable hospitals for around 34 % and private hospitals for the remaining 17%.[8]

3.1. Regulation on remuneration of hospitals forming part of the German Hospital Plan

The remuneration of all public and most private hospitals depends on two streams of revenue: a) the financing of investments (building, expanding and modifying of hospitals, also including investment in equipment) is provided or supported by investment subsidies paid by the federal states (*Länder*), b) the remuneration of operating costs is provided through payments by the health insurance funds and private health insurance companies for services rendered and, to a lower extend, by the patients themselves.

3.1.1. Funding for capital investment

In order to be entitled to receive investment subsidies, hospitals need to be listed in their federal state's "Hospital Plan" (*Krankenhausplan*). This plan is a capacity plan established on a yearly basis by each federal state in cooperation with the hospitals and health insurers active in the relevant federal state. The plan is to provide capacity in hospitals needed in order to meet the expected demand for stationary treatment. The regional needs are estimated on the basis of a number of indicators, such as population, average length of stay and capacity utilisation. Based on the Hospital Plan, each federal state determines the investments needed and sets up an investment programme on the basis of which hospitals can apply for subsidies.[9]

3.1.2. Funding for operating costs

In view of the ever rising costs of hospital and health services the German government considered different approaches to set optimal incentives for hospitals to balance quality and efficiency.

In 2003, Germany introduced the Diagnosis Related Groups (G-DRG) system to calculate hospital remuneration and prices for treatments. Similar systems have been installed in other OECD countries. A „DRG" describes an in-patient case and sums up all hospital resources devoted to that case from the beginning of hospitalization until discharge. The system classifies all hospital cases into different groups, depending on the main diagnosis, different treatment procedures, complications, length of stay, discharge reason, etc. The introduction of this system in Germany represented a change from a merely cost-based remuneration scheme for hospitals, which was seen as providing unwanted incentives for hospitals to over-admit patients, to a more generalized, case related one.

Roughly, the system is designed as follows. At federal level each of the 1200 G-DRGs[10] is given a specific cost weight with regard to a general per-diagnosis-value, which is determined on the basis of the average costs of all cases in the relevant federal state. More costly G-DRGs (for example those encompassing more expensive treatment procedures) receive a weight above the average costs, i.e. the basis, and less costly G-DRGs (for example those with minimum cost treatment) receive a lower weight.

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8 German Federal Statistical Office (Destatis), see above.

9 With the last amendment to the Hospital Financing Act at the end of 2011, a possibility for federal states was introduced to deviate from this form of investment subsidies. Beginning 2012 they may switch to an investment-surcharge instead, which is related to Diagnosis Related Groups (see below).

10 If the cost range within a certain G-DRG is too wide, the G-DRG is split up into several G-DRGs, which has led to an increase in the number of G-DRGs. The large number of G-DRGs, incorporating actual cost differences between hospitals, has been criticised as resembling a cost-based reimbursement scheme and thereby reducing the advantages the G-DRG system could bring about. See Monopolkommission (2008), 17. Hauptgutachten, http://dip21.bundestag.de/dip21/btd/16/101/1610140.pdf

The weights for individual G-DRGs are defined annually for the whole of Germany on the basis of cost-samples taken from a number of hospitals.

At federal state level, the health insurance funds negotiate with the regional hospital association in the state a certain base rate. This base rate is calculated on the basis of the average costs of all in-patient cases in that state. The amount of money a hospital situated in the respective federal state receives for a specific treatment is calculated by multiplying the relevant DRG's with the base rate.

Moreover, each hospital negotiates with the health insurance funds the amount of services to be rendered according to the assignment in the Hospital Plan. This figure enables the partners to calculate the hospital's annual budget (*Erlösbudget*). Hospitals therefore are not remunerated solely on the basis of the actual services they have provided. If, at the end of the year, the hospital provided more services than agreed upon, it does not receive full remuneration for the extra services provided.[11] If, on the other hand, it did not render as many services as agreed upon, it still receives a part of remuneration for services it did not perform.[12]

3.2. Other Regulations

A number of regulations are concerned with ensuring a minimum quality in hospital services provided. These can be distinguished according to whether they relate to structural, process or outcome quality. Structural quality is to be maintained by legally requiring minimum training standards for hospital staff, as well as a minimum amount of standard treatments performed in hospitals.[13] Quality of process is to be guaranteed by guidelines regarding examination and treatment procedures in hospital, which are devised and published collectively by the joint self-government of doctors, dentists, psycho-therapists, hospitals and health insurers.[14] Outcome quality is to be secured by requiring hospitals to publish reports every two years in which they report the number and form of services rendered, whether they fulfilled legal quality requirements, as well as measures undertaken with regard to internal quality management.

Special rules also apply to public advertising for hospital services which is restricted by the Act on Advertising in the Health Care Sector (*Heilmittelwerbegesetz*) and the Medical Association's professional code of conduct (*Berufsordnung der Ärzte*).

4. Competition in the German hospital market

4.1. Impact of the G-DRG system

The introduction of the G-DRG system, which in effect acts as a price cap, led to increased pressure on hospitals, especially on less efficient ones, to reduce costs and to become more efficient. The G-DRG system also prevents hospitals with market power from using their position to raise prices beyond the cap.

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11 In fact, hospitals at first receive payment by the health insurance funds on behalf of the patients, however, if they rendered extra services, they have to pay back parts of these payments in the final annual settlement.

12 The reason for that is that in the agreed budget also fixed costs (not investment costs) are incorporated, while the remuneration of additional services rendered only covers variable costs. Also, only the fixed costs of services not rendered are paid.

13 If a hospital does not perform the minimum amount of treatments established, it will no longer be allowed to offer these services (SGB V § 137). It may be possible, however, to provide convincing arguments why it would be able to do so for the next planning and contracting period.

14 See The Federal Joint Committee (G-BA): http://www.g-ba.de/institution/themenschwerpunkte/qualitaetssicherung/ergebnisqualitaet/

Incentives for keeping patients too long or discharging them too early are reduced.[15] The reason is that G-DRGs are connected to an average length-of-stay range, providing hospitals with reduced payments when this range is undercut or exceeded. The regulations on minimum requirements regarding hospital staff, quality management and hospital reports have drawn the attention of government, service providers and patients to the quality assessment of hospital services. After the reform, hospitals increasingly recognized the necessity to become more efficient as well as the need to compete with other hospitals. Some commentators have therefore reported an improvement in efficiency and competition on the German market for hospital services.[16]

4.2. Remaining impediments to competition

Although a case-oriented remuneration scheme establishing specific payments for specific treatments is generally regarded to be more efficient than a reimbursement system based purely on the actual costs incurred, and the possibilities for hospitals to abuse market power in setting prices have been largely excluded, there may still be room for improvement. The actual design of the German remuneration system may create some impediments to competition, including competition on quality. These may however partly be justified as unavoidable trade-offs between different goals.

The strong emphasis on planning quantities and investments has some drawbacks as it requires an adequate prediction of demand by the central planning agencies, including estimations for the types and amount of services needed, accommodation capacity and technical equipment. Moreover, as long as the number of beds forms a basis for central planning issues, hospitals will only reduce overcapacity if the costs of maintaining the overcapacity are larger than the expected benefits resulting from a larger capacity in the central planning negotiations.

Restrictions on investment decisions arise from the central planning process that could make the specialization of hospitals on certain types of services more difficult.[17] In particular, new technologies or procedures for diagnosis or treatment need to be approved ex ante upon application by the hospital, which, after approval, may negotiate remuneration with the health insurers. The possibilities to establish new medical departments in hospitals are also reduced due to the necessity to be incorporated into the Hospital Plan. These difficulties are exacerbated by the fact that investment payments to hospitals have been continuously reduced in the last decade, leading to an often discussed investment lag (*Investitionsstau*).[18]

Incentives and realisation possibilities for specialisation efforts, which could be considered beneficial for competition on quality, can be diminished further by ex-ante planned budgets for the hospitals and the related services to be rendered. Hospitals can deviate from these plans and provide more or less than the agreed amounts of services and still receive some remuneration, but when hospitals over-perform, the remuneration for the additional services will be less than for the planned amount. While this may counteract potential incentives for hospitals to admit more patients and to perform more treatments than actually needed, it also reduces incentives to engage in specialisation efforts that have not been incorporated ex ante into the Hospital Plan and the contract between hospitals and health insurance funds.

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15 "Too long/too early" as compared to the established average length of stay, not compared to the actual length of stay necessary from a medical point of view.

16 See for example J. Debatin, Krankenhäuser – Mehr Qualität und Effizienz durch Wettbewerb, in: Medizin zwischen Humanität und Wettbewerb: Probleme, Trends und Perspektiven, Konrad-Adenauer-Stiftung e.V (Ed.), Herder, 2008, p.392.

17 The effects of the recent changes in the law as described above remain to be seen.

18 Monopolkommission 2008, see above.

The G-DRG system exerts pressure on hospitals to reduce costs. However, once organisational inefficiencies are taken care of, hospitals have limited possibilities to reduce costs any further and therefore there may be incentives for hospitals to save costs by reducing quality wherever it is less observable.[19] Hospitals may be tempted to discourage patients with complex needs or classify patients strategically into more profitable G-DRGs whenever this is possible. They could also discharge patients too early, making follow-up treatment necessary. Such "revolving door effects" have sometimes even led to bilateral "kick-back agreements" with referring physicians, who would provide follow-up care against payment from the hospital.[20] Such agreements can distort the decision of the physician as to which hospitals patients should be referred to and consequently hinder competition.

And finally, competition on quality is still inhibited by the lack of transparency and information in laymen's terms regarding the quality of hospital services, which could form the basis for an informed consumer's choice.[21] This difficulty is even more important as hospital services and medical services in general have a much greater impact on the quality of life of individuals than any other need or purchase.

Because of these and other additional considerations, different proposals have been discussed as to how competition on the German markets for hospital services could be fostered further. The German Monopolies Commission proposed a system of "monistic" financing of hospitals instead of a dualistic system.[22] The proposal, which can only be summarized here, includes the possibility for health insurance funds to contract selectively with hospitals where elective hospital treatment is concerned, options for health insurance funds to restrict the freedom of choice of hospital for the insured, and an investment premium on remuneration for hospital services. To insure the socially desired all-encompassing provision of hospital services, additional hospital services should be publicly provided through auctions similar to public procurement procedures. However, this solution could be criticised as focusing on cost-efficiency elements, potentially to the detriment of quality competition, and ignoring equity concerns, as paying more for an additional health insurance in order to maintain some freedom of hospital choice may not be a realistic option for all members of society.[23]

5. Competition law enforcement on hospital market in Germany

Given the regulatory framework described there is little room for price competition on the German market for hospital services. The aim of competition law enforcement therefore is to protect the remaining competition in the market, in particular concerning competition on quality. This is primarily achieved by merger control; however, the abuse of a dominant position can also be pursued, since the Act against Restraints of Competition is generally applicable to hospitals.

As internal growth, potentially necessary for the realization of economies of scale, is only possible within the boundaries set by regulation, and also because budgets of public local authorities have been declining in recent years, mergers have played an increasingly important role in the markets for hospital

19 Empirical studies seem to corroborate this assessment, finding increasing observable quality and diminished unobservable quality, see Coenen/Haucap/Herr: Regionalität- Wettbewerbliche Überlegungen zum Krankenhausmarkt,Ordnungspolitische Perspektiven, Juni 2011.

20 Monopolkommission 2008, see above. Such agreements can be illegal, Decision of the Higher Regional Court (OLG) Düsseldorf of 01.09.2009 (I-20U 121/08).

21 Monopolkommission 2008, see above. J. Debatin 2008, see above.

22 Monopolkommission 2008, see above.

23 See for example response of the German Hospital Federation (DKG) to Monopolkommission (2008): www.dkgev.de/media/file/8238.RS286-10_Anlage1.pdf

services. In the last eight years, the Bundeskartellamt reviewed around 150 hospital merger cases. A large majority of these cases were cleared within the first phase proceedings and only four were prohibited.[24]

Substantive issues in merger control primarily concern the definition of the relevant product market.[25] The Federal Court of Justice (*BGH*) confirmed in 2008 that the relevant market is one for regular hospital services, including all in-patient medical services provided by hospitals.[26] The market is not to be divided according to specialization in specific medical disciplines.

The relevant geographic market is generally established by analysing patient flow data, taking into account only patients that are travelling to the hospitals of the merging parties and not, as may be done elsewhere, aggregate patient inflows to all hospitals in the hypothetical geographic market. All case-specific characteristics as well as the specificities of the health care sector are analysed and taken into account.[27]

A merger will be prohibited if it is expected to lead to the creation or strengthening of a dominant position. Competition in the market for hospital services, within the regulatory framework, is thus protected. So far no hospital merger has been blocked which led to market shares of the merging parties of less than 50%.

6. Conclusions

In order to reduce unnecessary costs borne by society as well as provide incentives for quality competition and innovation in the hospital services market, it is a very important task for competition authorities to protect competition on the hospital market at least as far as it exists within the current legal framework.

At the same time, the regulatory framework concerning the market for hospital services in Germany leaves little scope for price competition. The regulations aim to ensure access to health providers for all citizens, insuring high quality concerning the services provided as well as decreasing inefficiencies in the market due to rising expenditure on health care. These goals may not always be mutually compatible and consequently lead to unavoidable trade-offs. However, it will be an ongoing effort to consider ways of improving the existing regulatory framework in order to further reduce impediments to competition.

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24 One of these subsequently succeeded in obtaining a ministerial authorization on grounds of overriding public interests.

25 Except for gynaecology, obstetrics and ophthalmology services, which could each be considered as independent markets, see BGH, Decision of 16.1.2008, KVR 26/07 - Kreiskrankenhaus Bad Neustadt. .

26 BGH, Decision of 16.1.2008, KVR 26/07 - Kreiskrankenhaus Bad Neustadt.

27 Bundeskartellamt, B10-109/04 Rhön-Klinikum/Krankenhaus Eisenhüttenstadt, Prohibition Decision of 23 March 2005; Press Release in English on www.bundeskartellamt.de. Bundeskartellamt, B3-125/08 Gesundheit Nordhessen/Werra-Meißner, Prohibition Decision of 18 Juni 2009; Press Release in English on www.bundeskartellamt.de

IRELAND

1. Introduction

In Ireland, hospital services are supplied through public and private hospitals. This submission provides some background on the Irish hospital system and the associated public policy issues. It then focuses on the privately provided hospital sector in Ireland, the role of private health insurers and how a concentrated buyer market may restrict private hospitals' ability to compete in or to enter the market for privately-funded hospital services.

2. The Hospital System in Ireland

There is a complex mix of publicly and privately provided hospital services in Ireland.

The Minister for Health is politically accountable for the health service. The Department of Health provides support to the Minister and is responsible for strategic policy and planning, evaluation of resource allocations and the development of an effective legislative and regulatory framework for the health system. The public body responsible for the management and operation of health services in Ireland is the Health Services Executive (HSE).[1]

There are over 50 public hospitals in the State. All public hospitals receive funding from the HSE. *Publicly funded hospitals* fall into two categories, HSE Public Hospitals and Voluntary Public Hospitals, which differ from each other on the basis of their ownership, management and governance.[2] HSE Public Hospitals are State-owned, are overseen by HSE-appointed managers and are directly accountable to the HSE. (Thus the HSE has a dual operational role as both funder and manager of services delivered by HSE Public Hospitals.)[3] Voluntary Public Hospitals, while also publicly-funded, are privately owned and are managed by autonomous institutions (e.g. religious institutions) rather than the HSE. Thus, in relation to the Voluntary Public Hospitals, the HSE has a single role as the provider of funding (although that role clearly gives it significant influence over the operation of such hospitals).

Private Hospitals are privately-owned and operated independent hospitals which receive no direct State funding. There are approximately 20 purely private hospitals.[4] There are also many private clinics; in total, there are about 50 private medical facilities in Ireland.[5]

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1 Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume I, Section 1.4.2

2 *Ibid*, Volume I, Section 1.4.5.2

3 *Ibid*, Volume I, Section 7.2.2

4 McDaid, D., Wiley, M. M., Maresso, A. & Mossialos, E. (2009) Ireland: Health System Review. *Health Systems in Transition,* 11(4), p36

5 The Competition Authority, *Competition in the Private Health Insurance Market,* January 2007. Para 7.16.

Within public hospitals, medical consultants are permitted, within limits, to treat patients on a private basis (i.e., on the basis that the patient or the patient's insurer pays for the medical services and accommodation involved). Thus, publicly-funded and privately-funded hospital services are very often administered in a single public hospital by the same staff, using the same facilities.[6]

In order to control the level of private activity in publicly-funded hospitals and to help ensure equitable access for public patients to services in these facilities, a system of bed designation is operated in public hospitals. Approximately 20% of public hospital beds are designated as private (i.e., as available for use by private patients). Public hospitals can only charge private patients for their services when those patients are treated in designated private beds.[7]

Together with private beds in public hospitals, the stock of private beds in the acute hospital system amounts to approximately 35 per cent of total (public and private) hospital beds.[8]

3. Entitlements and Purchasers of Hospital Services

Hospital services in Ireland are funded out of a combination of (i) general tax revenue for the provision of public hospital services, (ii) payments made by private health insurance companies for services provided to their policy-holders, and (iii) out of pocket expenditure by individuals. The biggest funder or buyer of hospital services is the State.

Everyone in the State is entitled to public hospital services. All people in the State fall into either one of two categories.[9]

1. Persons below a certain income threshold are entitled to free public hospital care and other medical services.

2. All other persons are entitled to public hospital care with liability for statutory inpatient and outpatient charges for public care in public hospitals.[10] The majority of the population in Ireland falls into this category.

If a patient attends a public hospital under these entitlements they are known as a "public patient". When a patient uses a private hospital or opts for private in-patient care in a public hospital they are known as a "private patient". Private patients can either pay for this themselves or via private health insurance.

Many people in the second category, and a small number in the first category, purchase supplementary private health insurance ("PHI"). Approximately, 50% of the population hold PHI.[11] The

6 Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume I, Section 1.4.5.3

7 http://debates.oireachtas.ie/dail/2011/11/24/00186.asp

8 Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume I, section 7.3.2

9 *Ibid*, Volume I, Section 1.4.4.2 and 1.4.4.3

10 The standard daily charge for public inpatient care is 75, up to an annual maximum of 750. The outpatient charge is 100, including attendance at an emergency department (ED), except where a referral letter is provided.

advantage of PHI is that it offers consumers a greater choice of treatments and facilities, higher standards of accommodation during treatment, and potentially shorter waiting times for treatment than would be the case if they had no PHI. The better access to health care which this system provides for these patients has been the subject of considerable debate and criticism, particularly where the private patient is treated in a public hospital (albeit in exchange for payment for the medical services and accommodation involved). This has led to the current Government's proposal to introduce a system of universal health insurance (discussed below).

4. Public Policy

The national health strategy supports the principle of a mix of public and private providers of health services.[12] By permitting a mix of public and private beds in public hospitals the intention is to ensure that the public and private sectors can share resources, clinical knowledge, skills and technology.[13]

Government support of the private market is also apparent through subsidising the cost of PHI through, among other things, tax relief on PHI premiums and on medical expenses that are not otherwise reimbursed (whether by public funding or by private health insurance). In addition, where privately insured care is delivered in public hospitals the charges do not cover the full economic cost of that care, thereby providing additional subsidies for privately-funded healthcare.[14] The national health strategy states *"Private health insurance is a long-established feature of the system of acute care provision in Ireland and acts as a strong complement to the publicly funded system."* [15]

The current Government, elected in February 2011, has revised Ireland's health service policy. It intends to introduce Universal Health Insurance ("UHI") designed according to the European principle of social solidarity by 2016. The Programme for Government 2011 states that the current two-tier public/private system will be replaced with a single-tier health service which guarantees access to care for all in public and private hospitals. Insurance, provided by competing public and private health insurers, will be compulsory with insurance payments related to ability to pay. It also states that *"as a statutory system of health insurance, guaranteed by the State, the Universal Health Insurance system will not be subject to European or national competition law."*[16]

This new UHI system will, however, have implications for competition between providers as well as insurers. It will also likely affect arrangements between providers and insurers. It is not yet clear, beyond what is stated in the Programme for Government, how the system will work and exactly what elements of the system will not be subject to competition law.

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11 Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume I, Section 1.4.3.4

12 Department of Health and Children 2001, Quality and Fairness: A Health System for You. P.15

13 Ibid P.43

14 Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume II, Section 10.3.2.

15 Department of Health and Children 2001, Quality and Fairness: A Health System for You. P.111

16 http://www.taoiseach.gov.ie/eng/Publications/Publications_2011/Programme_for_Government_2011.pdf

5. Private Provision of Hospital Services

Notwithstanding the fact that many public hospitals provide services to private patients, the provision of hospital care to public and private patients involves two distinct markets. Public patients are not covered in private hospitals, unless they are willing to pay for the private hospital services out of their own resources. In public hospitals, current rules require that patients must make a clear declaration of their status - private or public - in respect of both medical services and accommodation).[17]

Private hospitals do not automatically get access to PHI policyholders. A policyholder cannot get treatment in any private hospital he/she wants; he/she can only get access to those hospitals registered with their private health insurer. Thus, in order to get access to the widest possible pool of customers, private hospitals need approval from the PHI firms to treat its policyholders. If a private medical facility is approved by the health insurer, the facility can treat that insurer's policyholders. When the policyholder uses the hospital, the hospital is reimbursed from the insurer at the price agreed between the hospital and insurer (prices are reviewed annually). If a medical facility is not approved by an insurer, then it cannot treat that PHI firms' policyholders (unless the policy holder pays for it themselves).

There are three providers of PHI:[18]

- Vhi Healthcare, the largest PHI firm, had a market share of 65.5% as of December 2009;
- Quinn Healthcare had a market share of 24%; and
- Aviva had a market share of 11%.

Thus, the purchasing side of the private hospital services market is concentrated, with only three main purchasers. Of the PHI firms, Vhi Healthcare is the biggest buyer of services. Vhi Healthcare's market share on the PHI market underestimates Vhi Healthcare's purchasing share on the market for privately provided secondary medical care. Vhi Healthcare has the largest proportion of the older age cohorts that have PHI. Older people use hospitals more. Vhi Healthcare's 2010 annual report states that "*while Vhi Healthcare has a 60% market share, we actually fund 82% of private health insurance care.*"[19]

New private hospitals thus find it difficult to prosper without securing Vhi Healthcare's approval and support. Vhi Healthcare's buyer power gives it the status of being a "gatekeeper" of significant importance.[20] This means that one private health insurer has, in practice, the ability to significantly influence the supply of private hospital services in Ireland.

6. Competition in Private Hospital Services

Private hospitals in Ireland face a market with few health insurers buying their services. As already explained, one insurer can be categorised as a gatekeeper into the market for the provision of hospital

17 These rules are not always adhered to, particularly where patients are admitted as an emergency. In some circumstances, private patients may be accommodated in public beds. Public patients may also occupy private beds on occasions. Department of Health and Children 2001, Quality and Fairness: A Health System for You. P.107.

18 Government publication May 2010, Health Insurance Market Reforms Frequently Asked Questions, Section 3

19 Vhi Healthcare, Annual Report 2010, p.10. https://www.vhi.ie/pdf/about/annual_report_10.pdf

20 Competition Authority 2007, Competition in the Private Health Insurance Market.

services. The strong buying position of Vhi Healthcare gives it a powerful bargaining tool. Buyer power benefits certain purchasers of hospital services since large buyers can negotiate better deals with medical facilities than smaller competitors or individual consumers could do on their own. . This is good for consumers if the savings are passed on to consumers. However buyer power may also have negative welfare implications. These can arise if:

- The buyer gets lower prices but does not face strong competition in its own market. In this scenario, price reductions arising from the exercise of market power may not be passed on to the final consumer.

- It creates barriers to entry. If suppliers become dependent on, and must contract with, one buyer to enter the market, this results in one health insurer determining supply of services.

- It affects the long term viability of existing suppliers.

By virtue of its size, Vhi Healthcare has a significant influence over the level of private hospital capacity in Ireland. Media reports suggest that new private hospitals are not opening because of the refusal by Vhi Healthcare to cover the facility; it is also reported that it is not covering increases in bed capacity at providers already covered Vhi Healthcare.[21] According to media reports, Vhi Healthcare is currently not covering any new private hospitals as it sees no need for additional beds[22] which, if they were covered, would allegedly cost Vhi Healthcare millions of Euro annually.[23]

It is expected that financially prudent health insurers will exercise caution in deciding which facilities to cover. It is prudent for health insurers to refuse coverage for medical facilities where there are justifiable concerns that such facilities would constitute unused surplus capacity. This is because, where capacity is not being fully utilised, the average fixed cost per patient to the health insurer is high. Average cost as a whole falls as more capacity is used.

Whether Vhi Healthcare's gatekeeper status is ultimately to consumers' benefit or detriment would require a complex and difficult assessment.

Vhi Healthcare's refusal to cover new private hospitals has also affected the public health system. The last Government tried to improve access to hospitals for public patents by increasing capacity in the private hospital sector through the construction of eleven new private hospitals on the campuses of public hospitals.[24] The intention was to transfer private activity to new private hospitals thereby freeing up capacity for public patients.[25] The "co-location" initiative appears, however, to have stalled. One of the reported reasons for this was the refusal by the largest health insurer to cover the proposed new hospitals.[26]

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21 http://examiner.ie/ireland/no-Vhi Healthcare-cover-puts-private-hospital-in-jeopardy-174051.html ; http://examiner.ie/ireland/Vhi Healthcare-refuses-to-cover-bons-extension-174190.html ; http://www.imt.ie/news/latest-news/2011/05/Vhi Healthcare-not-covering-new-hospitals-beds.html

22 Irish Examiner, *Vhi Healthcare refuses cover for healthcare facility,* 17 November 2011.

23 http://www.irishhealthinsurance.ie/cork-medical-centre-set-to-reopen.html

24 Department of Health and Children 2001, *Quality and Fairness: A Health System for You.* P.93 and Competition Authority 2007, *Competition in the Private Health Insurance Market.*

25 National Development plan 2007-2013, p.213 - http://www2.ul.ie/pdf/932500843.pdf

26 Irish Examiner, Vhi Healthcare *could be forced to deal with co-location*, 15 February 2011 http://examiner.ie/ireland/Vhi Healthcare-could-be-forced-to-deal-with-co-location-145276.html

PHI firms do not have an incentive to move private beds from public hospitals to private hospitals. Public hospitals can only apply charges to private patients when they are treated in designated private beds.[27] The Comptroller and Auditor General has previously found that charges are not raised in respect of about half of all private patients in public hospitals because they are occupying public beds rather than designated private beds.[28] In addition, the charge for private patients falls short of the full economic cost of treatment incurred in by the public hospital.[29]

This puts pressure on the public hospital system and restricts entry by private hospitals. Recently the Government has announced plans to require public hospitals to charge health insurers the full cost of treating private patients, irrespective of whether they were allocated a public or private bed.[30] However this will likely have a price effect for PHI policyholders which in turn may have a significant impact on the PHI and private hospital market.

7. Conclusion

The current Irish health system is a hybrid of publicly and privately provided services. This system is due to change with the introduction of universal health insurance; however it is not yet clear how the system will work and how competition will be affected.

Under the current system, the State, through the HSE, is by far the largest purchaser of hospital services. However, privately-funded hospital services generally (and purely private hospitals, in particular) are reliant on private health insurers. PHI firms have buyer power in Ireland, although the extent of buyer power held by each firm varies widely, with the majority of it vested in one firm. In practice, this means that one firm is a gatekeeper into the privately-funded hospital sector. While large buyers can bring benefits, having one buyer which most, if not all, providers are dependent on has risks. Its role as gatekeeper directly affects capacity levels in both the private and public sector and has affected entry and innovation in the private hospital sector.

From a competition law perspective, this raises complex questions with regard to dominant buyers. Balancing good versus bad buyer power in a complex market, where public policy has a huge impact, is not a straightforward task.

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27 In receiving treatment in a private designated bed in an acute public hospital, private patients are liable for a maintenance charge (determined by the Minister for Health) in addition to the public hospital inpatient charge.

28 http://debates.oireachtas.ie/dail/2011/11/24/00186.asp

29 The maintenance charge is calculated on the basis of the average cost for treating all (public and private) patients. Resource Allocation , financing and Sustainability in Health Care, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Prepared by the ESRI, July 2010. Volume I, section 7.4.3 Also see http://debates.oireachtas.ie/dail/2011/11/24/00186.asp

30 Sunday Business Post, *Concern over hospital insurance plans*, 11 December 2011.

ISRAEL

COMPETITION AND/OR REGULATION IN HOSPITAL SERVICES[1]

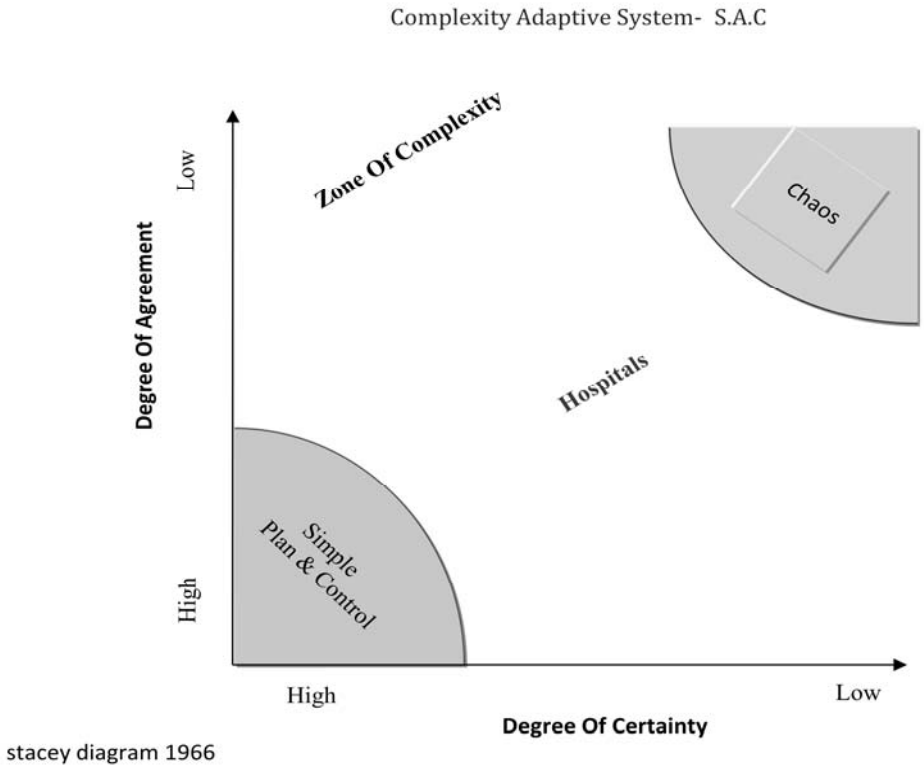
1. Complexity of health organizations

Health organizations are essentially different from industrial/business organizations, primarily by the predictability of their end-products. While the product of the latest is largely predictable, based on known inputs and processes, clinical outcomes cannot be systematically predicted. This is due both to the vast variability in case-mix, as even for patients with the exact same diagnosis, it is likely to see case-mix variability as determined by patients' socio-demographic characteristics, co-morbidities, severity of illness and functional status and due to legitimate differences in the clinical process, reflecting differences in physicians' knowledge, experience and professional perceptions. These components bring collectively about a high degree of legitimate variability in clinical and economic outcomes in health organizations.

When exploring the degrees of agreement and certainty in organizations, according to the Complexity Adaptive System model (by Stacey RD, Fig 1), health organizations are positioned in the "Zone of complexity", somewhere between simple organizations, characterized by a high degree of both certainty and agreement, and chaotic organizations, where low degrees of future certainty and aims/managements agreement are typical (e.g., start-ups). Health organizations are situated in this seam, as these are characterized by moderate levels of certainty regarding clinical outcomes, and agreement regarding the clinical treatment process.

[1] This paper was prepared by Ahuva Weiss-Meilik and Ronni Gamzu, from the Health Ministry of Israel.

Figure 1. Complexity Adaptive System model



Therefore, market forces (as competition and regulation) that apply in the industrial and business world often lack relevance to the realm of health organizations. Yet, health organizations primarily aspire to high quality, excellence and accountability. Therefore regulation and competition mechanisms are required in health organizations, but necessitate adaptation to these semi-chaotic frameworks, while taking into account the specific strengths and limitations archetypal of the medical environment.

2. Regulation and competition

Regulation of health services in hospitals requires the application of standards of care. Most guidelines specify requirements for certain parts of the clinical process or treatment, define measurable goals and measure their achievement. Thus, regulation ensures a minimal standard of care to protect the customers. However, since most regulating mechanisms lack the ability to account for patients' case mix variability, no goals can be defined for outcome measures, so that regulation does not encourage excellence in clinical care (unless the regulator defines higher standards over time).

In contrast, **competition** is a major driving force for improvement of performance. Yet, building upon competition to achieve excellence in care has some limitations: when competition takes place for pre-defined objectives, organizations might redirect efforts in an unproportional manner to the specific aspects of care as defined by these goals, thereby creating a "tunnel effect" while neglecting other aspects of the clinical process. Also, the existence of effective competition depends upon the provision of reliable, valid and understandable information to customers, which will allow them to choose between care providers based on their actual performances. However, comparative information on hospital performances is usually incomplete, a-symmetrical and prone to biases, and its understanding often requires professional knowledge that most customers do not possess.

3. Suggested concept: establishment of Clinical Performances Assessment Center or mechanism

In order to cope in an integrative manner with the limitations of both regulatory and competition mechanisms related to the quality of hospital clinical care and costs, it is necessary to create and systematize appropriate measurement and assessment mechanisms, standardized at the national or international level. These mechanisms will enable comprehensive data collection of parameters taking into consideration patients' case-mix parameters, chosen aspects of clinical processes, and clinical outcomes. The chosen parameters should be validated, evidence-based, and/or consensus parameters. In order to prevent abuse of these mechanisms by health organizations, it is recommended to form an independent professional body that will conduct data collection and analysis and will provide customers with transparent and certified comparable information regarding hospitals performances (e.g., in form of rating, such as League Tables), and will provide hospitals with continuous feedback on their performances.

This setting will also serve to improve costing mechanisms, by introducing information regarding patients' case-mix into costing algorithms. In contrast, in the current situation costing is based on average costs, without taking into account the actual case-mix and its effect on expenses. Also, in most cases costing is independent of quality. Creating a situation where costs will be related to the quality of care is especially important where payment is defined on a daily basis, and poor quality of care may not only harm customers but also increase payment to the hospital by prolonging hospitalization.

Thus, the suggested mechanism will provide answers to 3 main issues: coping with limitations of competition in health organizations, coping with limitations of regulation in health organizations, and appropriate costing. One of the important matters to address when approaching planning of a quality assessment mechanism is the need to separate it from bodies providing health care *de-facto*, and from those paying for it (insurers). A possible model is the model of The LeapFrog Group (http://www.leapfroggroup.org), positioned between customers, providers and insurers. This organization provides the customer with information regarding hospitals performances and therefore protects customer's interests *vs.* the insurance companies. Such a body may provide information on "total value" of a health care provider by balancing quality and cost of care (e.g., the Balanced Score Card method), in a formula that weights quality and cost scores of the specific "clinical product". Thus, it will become possible to produce procedure/diagnosis-specific rating of hospitals, based on weighted "total value".

The establishment of appropriate quality and cost performance assessment mechanisms is likely to face a number of organizational and practical challenges:

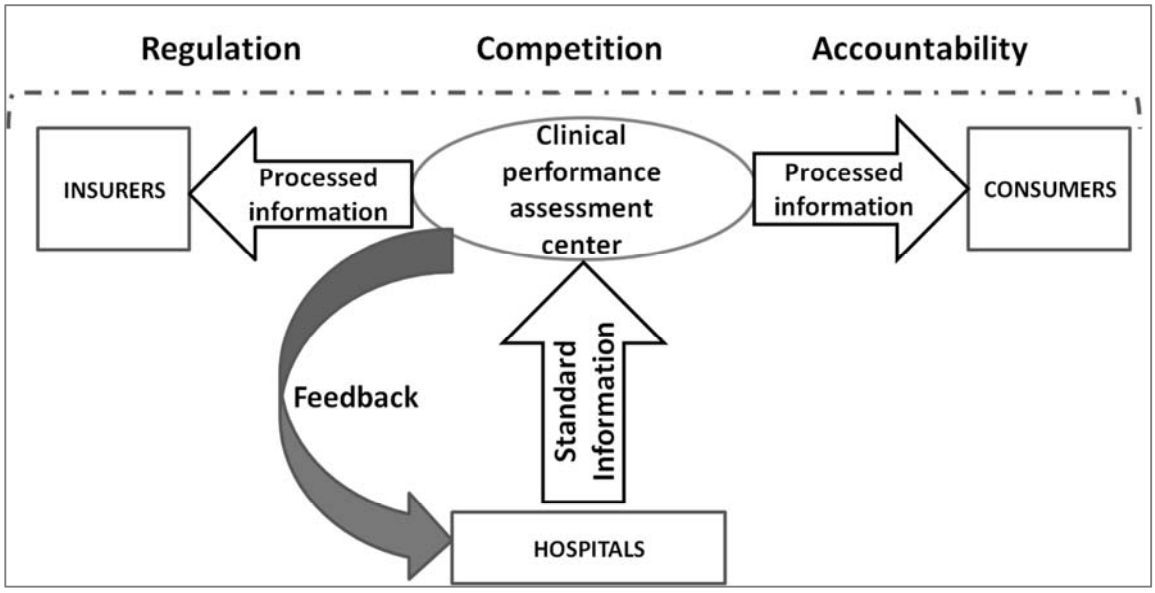
1. Achieving **agreement and co-operation** between all relevant factors. Some bodies in the health system may see the establishment of a clinical quality assessment center as contradictory to their interest, and may resist changing that requires systematic introduction of measurement and transparency.

2. **Costs** of establishment and maintenance of the quality assessment mechanism.

3. Implementation of **information technologies** to support the establishment of quality assessment mechanisms. It is likely that investment in technologic infrastructure and its implementation will be necessary in order to achieve minimal standards in all hospitals. It should be noted, though, that positive and/or negative incentives in contracting (between insurers and hospitals) may accelerate this process.

4. **Compliance**. In order to ensure full and reliable delivery of all relevant clinical data, it will be necessary to obtain full cooperation of hospital physicians. Involving and rallying the clinical staff may be challenging and may require professional intervention.

Figure 2. Clinical Performance Assessment Center（CPAC*)*



Note: Data is collected from hospitals in a standardized manner by the **CPAC**, analyzed and transmitted to customers and insurers in a comparable format, in a process that enhances regulation, competition and accountability in hospital clinical care.

JAPAN

1. Introduction

Taking advantage of an opportunity to have a roundtable discussion on competition in hospital services, Japan's contribution paper explains recent issues concerning regulations of hospital services in Japan related to competition, as well as the relations between hospital services and the Antimonopoly Act.

2. Recent issues regarding regulations of hospital services

Concerning regulations of hospital services, in November 2002, the Japan Fair Trade Commission (hereinafter referred to as "the JFTC") made public: "The State of Regulation in the Medical Services Business and Approach from the Viewpoint of Competition Policy." Recently, discussions on government regulations and systems have been held in "the Government Revitalization Unit," established in the Cabinet Office (Subcommittee on Regulatory and System Reforms) with an aim of revamping national budgets, systems and other governmental administrations, while at the same time reviewing the allocation of roles among the national and local governments and the private sector, all from a citizen's standpoint. There are several related Cabinet decisions existing, which include discussions on the regulations of hospital services. "The New Growth Strategies" adopted by the Cabinet on June 18, 2010, state that, "the hospital, nursing and health-related industries, in which high growth and generation of employment opportunities are expected, will be positioned clearly as industries leading growth in Japan, while at the same time systems that can provide diverse user-centered services will be established by promoting entries of new private service providers while at the same time ensuring safety and improving service quality."

A summary of "The State of Regulation in the Medical Services Business and Approach from the Viewpoint of Competition Policy" and issues concerning the regulation of hospital services that could relate to competition will be introduced below.

2.1. Summary of "The State of Regulation in the Medical Services Business and Approach from the Viewpoint of Competition Policy" (November 2002).

The JFTC convened the "Study Group on Government Regulations and Competition Policy" and published a report in November 2002 titled, "The State of Regulation in the Medical Services Business and Approach from the Viewpoint of Competition Policy."

This report is based on the viewpoint that (i) in order to realize hospital services for patients as consumers, a system is necessary whereby patients can choose hospital institutions according to their needs and similarly, hospital institutions, as suppliers, can compete with each other. (ii) At the same time, it is essential to enhance the negotiation power of patients and insurers, and (iii) it is important to review regulations at both the supply and demand side in order to promote competition in this area and bring benefits. Based on this viewpoint, the report shows the following:

2.1.1. Promotion of competition among hospital institutions

a) Review of restrictions on opening hospital institutions and management body

Regulations on the entry of stock companies, etc., based on Medical Law, should be reviewed to enable current medical corporations (legally incorporated hospital institutions) to change their status to stock companies in order to diversify methods of financing, or, for stock companies to open and run hospital institutions.

b) Review of the issue of mixed treatment

Approving mixed treatment (i.e. mixed billing of insurance-covered treatment and non-insurance-covered treatment, to be mentioned later) should be considered by establishing a list of criteria patients need to qualify for insured treatments and defining the scope of coverage by health insurance as well as enabling patients the possibility to assume the costs themselves for uninsured services. In this case, it would be necessary to oblige hospital institutions to properly disclose information to patients because patients need to judge the rationality of mixed treatment.

2.1.2. Choice of hospital institutions by patients and the insurers (Review of regulations on advertisements)

In order to ensure health benefits are applicable to patients upon choosing the hospital institution, and to promote fair competition, advertising by hospital institutions should be liberalized as a general rule, by taking all the measures through which the information released or distributed is true and any inappropriate advertisements are eliminated.

2.1.3. The role of the JFTC

As the review of regulations in the medical services progresses, it is becoming more important to exclude anticompetitive practices of enterprises by enforcing the Antimonopoly Act, as well as by promoting more active competition among enterprises in medical services. The JFTC not only considers and co-ordinates regulatory reform but also needs to follow the developments of reform, as well as monitor enterprises and trade associations to identify if there is conduct (either self-initiated or through administrative guidance) that restrains competition, excludes new entries or conducts cartels in the liberalized industry. If such acts above do occur, the JFTC must take strict measures against violations to the Antimonopoly Act.

2.2. Points on issues in hospital services that could relate to competition

2.2.1. Mixed treatment

When both “insurance-covered” medical treatment (to which public health insurance is applicable) and “private” medical treatment (to which public health insurance is not applicable) exist in a series of medical practices, such medical treatment is referred to as a “mixed treatment.” Pursuant to the current Health Insurance Act, except in certain cases, patients do not qualify for health insurance benefits for mixed treatments (Article 86, Health Insurance Act). As a result, patients are required to assume all treatment costs. (There is no competition in medical fees paid for “insurance-covered” medical treatments to which public health insurance is applicable because the fee is calculated based on officially allocated points for each medical practice.)

With regard to this “mixed treatment,” it has been pointed out that options for patients are limited financially when they wish to choose advanced medical care or treatments suited to their individual situation. It has also been pointed out that patients cannot be eligible for insurance benefits as a compensation for the insurance premium which is forcibly collected when the patients used both “insurance-covered” medical treatment and “private” medical treatment at the same time. This problem has been mentioned as a matter to be discussed with regard to regulatory reform.

Recently, "The Policy on Measures Related to Regulatory and System Reforms" adopted by the Cabinet on June 18, 2010, mentions an "expansion of the scope of the Special or Specified Medical Care Coverage System in which 'private' medical treatments can be received with 'insurance-covered' medical treatments," as a matter to be discussed in regulatory reforms.

In the dispute on the legality of prohibiting mixed treatments as a general rule, the Supreme Court decided on October 25, 2011 that the prohibition was legal, stating that, "the Special or Specified Medical Care Coverage System" exists to ensure the safety and effectiveness of insurance-covered medical treatments and prevention of unreasonable burden on the patients, and the prohibition of mixed treatments is a prerequisite for this system. The interpretation that the patient should assume all medical costs in the case of mixed treatment is justifiable in view of consistency for the entire Health Insurance Act."

2.2.2. Participation in the hospital market by stock companies

The Medical Care Act prohibits establishment of hospital institutions that pursue commercial gain (Article 7 paragraph 5 and Article 54 of the Medical Care Act). Therefore, stock companies may not establish hospital institutions since they pursue commercial gain.

In "the Policy on Regulatory and System Reforms" adopted by the Cabinet in 2011 (April 8), the "Review of the Regulations Regarding Support for Rehabilitation and Merger of Medical Corporations" was included in the matters to be discussed in the regulatory and system reforms.

In addition, the "Act on Special Districts for Structural Reform" that was amended in May 2004 exceptionally allows stock companies that satisfy certain standards to establish hospital institutions that offer advanced hospital care in the area of private medical treatment to which public health insurance is not applied. "The Three-Year Plan for Promoting Regulatory Reforms" (re-revised third edition), (adopted by the Cabinet on March 31, 2009) also mentions "lifting the ban on hospital institutions operated by stock companies" as a matter related to regulatory reforms, and the decision was made to "monitor the situation of hospital institutions operated by stock companies in special districts for structural reform, and study their nationwide dissemination further."

2.2.3. Restrictions on advertising

The Medical Care Act has adopted a system that allows only matters that are objective and verifiable to be advertised (positive list method). The amendment to the Medical Care Act of 2007 adopted a "Comprehensive Provision Method" that made the restriction method an inclusive one, significantly enlarging the scope of contents that can be advertised.

"The Subcommittee on Regulatory and System Reforms" established in "the Government Revitalization Unit" has mentioned mitigation of advertising restrictions as a matter to be discussed for regulatory reform. In December 2010, the "Life Innovation Working Group" (in its second term) established under the subcommittee, a draft reform measure to "liberalize, as a general rule, advertising launched by hospital institutions, by revising the positive list method."

3. The Health Services and the Antimonopoly Act

3.1. Introduction

To secure fair and free competition, the Antimonopoly Act stipulates a number of provisions concerning the activities of enterprises and trade associations.

For example, if a doctor simply works as a researcher or an employee, the doctor is not classified as an "enterprise" under the Antimonopoly Act. However, if the doctor engages in the hospital services as a business, the doctor is classified as an "enterprise." Whether a doctor conducts medical activities as a business or not is based on whether the doctor engages in medical activities repeatedly and continuously as an operating body. Under the Antimonopoly Act, "Trade Associations" means associations that unite or combine two or more enterprises, mainly aiming to increase their common profits by engaging in businesses. If an association of hospital institutions satisfies this requirement, the said association of hospital institutions comes under the definition of "Trade Association" which is subject to the Antimonopoly Act.

We introduce "Guidelines Concerning the Activities of Medical Associations Based on the Antimonopoly Act" and the cases where the Antimonopoly Act was applied in the hospital service market below.

3.2. "Guidelines Concerning the Activities of Medical Associations Based on the Antimonopoly Act" (August 7, 1981)

A "doctor" is one type of business associated with health professions. As already noted, if a doctor satisfies certain requirements, the Antimonopoly Act is applied to the doctor as an enterprise. Medical associations, which exist as a professional body of doctors, do not necessarily fall under the definition of trade associations based on the Antimonopoly Act. However, if a medical association satisfies certain requirements, the Antimonopoly Act is applied to the association as a trade association. If a medical association as a trade association commits an act to restrain competition, for example by limiting the number of present or future hospital institutions in a certain business area on the pretext of "proper placement," or if a medical association commits an act to unjustly restrict the function and activities of doctors who are members of the association, then such acts shall be regarded as violations to the Antimonopoly Act. Therefore, the JFTC published the "Guidelines Concerning the Activities of Medical Associations Based on the Antimonopoly Act" in 1981, based on the results of a survey concerning the activities of medical associations and cases in which the activities of medical associations were deemed to be in violation of the Antimonopoly Act.

With respect to whether the Antimonopoly Act is applied to a medical association, the Guidelines stipulate that if a medical association is purely an academic association, the medical association is not regarded as a trade association based on the Antimonopoly Act. However, if a medical association is an association for the purpose of increasing common profits by engaging in businesses, the medical association is regarded as a trade association based on the Antimonopoly Act and the Act is in turn applied. The following acts, conducted by medical associations, which are deemed to be trade associations, such as (i) acts that restrict the opening of a new hospital institution, (ii) acts that unjustly disrupt business activities, (iii) acts in which hospitals fix fee tables for private medical treatment, etc., or (iv) acts concerning hospital care hours and advertisements, can be classified in three categories: "acts in violation of the Antimonopoly Act in principle," "acts that may be in violation of the Antimonopoly Act" or "acts not in violation of the Antimonopoly Act in principle."

Concretely, if a medical association, through its code, limits the number of hospital institutions in a specified area or the distance between two hospital institutions, or decides on private medical treatment fees or document fees of its members, then the association will be acting against the Antimonopoly Act in principle because these acts will unjustly restrain the business activities of the association's members, or may substantially restrain competition of hospital profession in the area. In contrast, if a medical association provides reasonable advice in response to an approach by a party wishing to establish a hospital institution, encourages members to show its fee table, or unifies the form of fee tables, it will not be acting against the Antimonopoly Act in principle.

3.3. Cases where the Antimonopoly Act was applied in the hospital service market

3.3.1. (Hearing Decision) No.1 of 1997: Case of Mitoyo District Medical Association of Kan-onji City

Mitoyo district Medical Association has:

1. Restrained the number of current and future medical practitioners in the Kan-onji Mitoyo district by restricting the establishment of hospital institutions.

2. Unreasonably restrained the functions and activities of existing medical practitioners by restricting the addition of areas of medical care practiced by members, increase in the number of beds, expansion or renovation of hospital institutions and the establishment of health care facilities for the elderly.

3.3.2. (Recommendation) No. 18 of 2004: The case against Yokkaichi City Medical Association

Yokkaichi City Medical Association has:

1. At a meeting of its board of directors held on or around 15 October, 2002, the medical association decided to set the fee for a flu vaccination administered by its members to persons under the age of 65 at a minimum of 3,800 Japanese yen per vaccination effective as of October 2002; this act substantially restrained competition in the field of trade of flu vaccinations within the area of Yokkaichi City.

2. Based on an internal code of the consultation committee, unreasonably restrained the functions and activities of its members by restricting the addition of areas of medical care, increase in the number of beds and establishment of health care facilities practiced by members.

NETHERLANDS

1. Introduction

This contribution sets out the view of the Netherlands Competition Authority (hereafter; NMa) on the space that the competition rules allow for collaboration between hospitals and insurers, with regard to specialization and concentration, as well as the reduction of capacity. The context for this discussion is a health care system, based on managed competition, in which the market participants themselves are expected to realize the reshaping of the health care landscape. Both developments should contribute to ensuring a controlled increase in health care spending in the Netherlands. Previous experience with capacity reduction stems mainly from countries where antitrust aspects in health care have played a lesser role (for example, the UK and Canada), or from countries where the government clearly took the helm in the reorganization process (for example, Denmark).

2. The Dutch health care system in a nutshell

The Dutch health care system underwent a major overhaul in 2006.[1] The transition had to be made from a centrally-controlled (supply-driven) system to one that is, where possible, demand-oriented. In a demand-oriented system, insurers, health care providers, and the insured, have more opportunity to reconcile supply and demand. The current system in the Netherlands is founded on three pillars:

i) the health insurance market, where consumers take out a 'basic' insurance package, which is mandatory for all individuals and covers the most essential health care services. Health insurers compete for the consumers' business and are required to accept everyone who wishes to take out the basic insurance package. Consumers have the opportunity to switch insurers once a year, at a fixed time, which means that insurers are constantly kept sharp.[2]

1 The Dutch health care system is based on the distinction between a.) basic curative (routine and acute) and supplementary curative care (i.e. dental services, physiotherapy), b.) long-term care (chronic diseases, long-term hospital care, care for the elderly) and c.) home care services. This paper focuses on basic routine and acute health care services, including hospital services. Regarding long-term care, mandatory universal insurance was introduced in 1968, regulated by the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, ABWZ). There is no competition between insurers for patients for long-term care, unlike hospital services. The long-term care sector is divided into regions where one care office (Zorgkantoor) is responsible for the contracting of long-term care services. The care office is closely related to the biggest insurer in the region. The health care providers in the region do compete with each other for a contract with the care office. Regarding home care services, local municipalities purchase a selected range of health services. With the introduction of the Home care services act (Wet Maatschappelijke Ondersteuning, WMO), local municipalities are responsible for the contracting of among other services, domestic care services for elderly people, disabled people or people with mental health care problems. Providers for these services compete with each other for a contract with the local municipality.

2 In addition, consumers can choose to purchase supplementary insurance packages (e.g. to cover the costs of physiotherapy, dental work, etc.). It is however neither mandatory for consumers to do so, nor are insurers required to accept everyone who wishes to purchase such supplementary packages.

ii) the health care purchasing market, where insurers buy health care to meet their customers' expected health care requirements, and health care providers vie with each other for the insurers' business. In this process, insurers and providers are, to a considerable extent, able to bargain over the price of health care that is to be provided. In the case of hospitals, for example, about 70 per cent of the hospital care turnover is negotiable as of 2012. Insurers are allowed to negotiate contracts on a selective basis, so that providers are increasingly faced with additional incentives to offer good quality and affordable health care.

iii) the health care provision market, where patients select those health care providers that offer the health care they require, taking into consideration the terms and conditions of their health insurance policies. So both health care providers and insurers vie for the consumers' business, and if consumers are dissatisfied, they are able to switch.

3. The NMa's role in the Dutch health care sector

3.1. Merger control

The NMa has actively enforced competition in health care since 2004. Prior to that, competition between health care providers was simply not possible, due to the regulations that were then in force. Since 2004, the NMa has investigated more than 150 health care concentration cases (domestic care, intramural elderly care, disabled care, mental health care, hospital care and health insurance). In late 2011, the NMa blocked a proposed merger for the first time. In previous cases, once it seemed likely that the NMa would block a proposed merger, the plans were modified with the addition of remedies to remove competition concerns, or the merger plans in question were retracted. Recently, a considerable number of merger plans involving hospitals have been filed with the NMa, in part because of the need to specialize and concentrate.

As of 1 January 2008, the turnover thresholds for notification of health care mergers, in the Netherlands were lowered by more than 50%. The reason behind this sector-specific reduction was the fact that in the health care sector, geographic markets are generally small (local or regional), and it is therefore more likely that competition concerns may arise at relatively low turnover levels. As a result, the NMa has intervened in various cases that would not have constituted notifiable mergers had the turnover thresholds remained at normal levels.

3.2. Cartel prohibition

The NMa has dealt with various cartel cases in the hospital sector, among general practitioners and in domestic-care services. For example, in the domestic-care services cases, fines have been imposed on nine undertakings for market-sharing and/or product-sharing agreements, or for bid-rigging. In co-operation with trade associations in this sector, the NMa drew up an alternative regulatory scheme for domestic care providers. This alternative scheme was intended to help the sector to start with a clean slate. Although the members of the trade associations accepted to implement a sector wide compliance program, they voted to reject the proposed alternative settlement scheme. Following this rejection, the NMa resumed its investigations into alleged cartels and imposed the above-mentioned fines. The NMa has observed an increase in competition awareness in the sector since then. Recently, in 2011, several commitment decisions were adopted by the NMa, in which regional domestic-care services agreed to reorganize their working practices to avoid any future breaches of competition law.

4. Recent developments: Specialization, concentration and capacity-reduction

4.1. Framework Agreement

In 2011, the Dutch Minister of Health, Welfare and Sport (hereafter; the Minister) reached a so-called "Administrative Framework Agreement" with the trade associations of hospitals, and health insurers, on cost control in health care (hereafter; Framework Agreement). Both parties agreed to aim for an annual structural cost increase of approximately 5.25%, rather than the 6-7% increase that had been common in previous years. One of the methods to achieve this objective chosen in the Framework Agreement is to remould the Dutch health care landscape. This reorganization is centred on further specialization of health care provision, the substitution of GP care for hospital care, where possible, and reduction of excess hospital capacity, where necessary.

According to the Minister, as well as those in the sector, specialization and concentration of health care provision is needed in order to improve the quality of health care delivered. The philosophy behind specialization and concentration of particular hospital treatments, is that it improves the quality of those treatments, while reducing the likelihood of complications. The reasoning is that, as specialists or multidisciplinary teams perform more treatments of a particular type (higher volume), they gain more experience in that particular treatment (the so-called experience or learning curve). Furthermore, an increase in quality levels should lead to cost-reductions, for example, because of a decrease in the number of complications, and as a result, in the number of follow-up surgeries.

The need to concentrate health care provision in such a way is predominantly stimulated by the increasing number of quality norms and standards developed by scientific associations, which require hospitals or specialists, for example, to perform a minimum number of certain types of treatments annually. Individual hospitals may not be able to meet these volume requirements alone, resulting in a need to concentrate those types of treatments. This is particularly the case for high complexity – low volume treatments, such as bladder cancer treatments and surgical treatments for pancreatic cancer and liver metastases. Although most attention in the Framework Agreement is devoted to this category of treatments, the reasoning could also be said to apply to low complexity – high volume health care.

Reduction of excess hospital capacity will lead directly to cost reductions, as it will eliminate the need for double investments, and allow existing capacity to be utilized more efficiently. This is particularly the case with regard to acute and obstetric care. In certain regions, for example, it is not necessary for all hospitals to have emergency rooms operational 24/7. However, it may be necessary to compensate hospitals temporarily for certain measures they may have to undertake to reduce capacity or close down departments. In accordance with the Framework Agreement, health insurers will therefore take the lead in creating a restructuring fund, that will offer compensation for those reductions of excess capacity that have a "proven benefit to society".

The Minister has explicitly stated that, when reshaping the health care landscape, providers and insurers must stay within the boundaries set by the Dutch Competition Act with regard to collaboration.

4.2. Impact of the reorganization on the competitive environment

When hospitals specialize or their capacity is reduced, it basically means that providers that currently offer certain types of health care will not necessarily be offering them in the future. If a number of providers no longer offer certain treatments, competitive pressure may be reduced on those providers that continue to offer those types of treatments. Hospitals that still offer such treatments will therefore face fewer incentives to keep investing in quality or to keep operating efficiently. The idea behind managed competition in health care is that if patients have the ability to choose between hospitals, the hospitals will

then be stimulated to perform well by raising quality. Similarly, having enough capacity also has a controlling effect, as patients will have viable alternatives in other hospitals, and insurers can credibly threaten to move their purchases of hospital care to other hospitals. Reducing capacity will reduce these possibilities for patients and insurers to choose. A certain tension therefore arises between the desire to raise quality and efficiency, by concentrating health care or by reducing capacity, on the one hand, and the reduction of competitive pressure, that in itself would be a safeguard for quality and efficiency, on the other hand.

4.3 International Perspective

Other countries have already dealt with tasks similar to that facing hospitals and insurers, in the Netherlands. As mentioned earlier, similar reforms have taken place in Denmark, the UK and Canada. However, contrary to the situation in the Netherlands, the reforms in those countries were characterized by more direct government involvement. In Denmark, for example, the number of hospitals offering emergency rooms had to be reduced from 40 in 2006, to 20-25 in 2015, as part of a sector-wide overhaul, to modernize health care.[3] The range of health care treatments provided in each region had to be re-evaluated and redefined. To that end, the government created an expert group to evaluate the plans submitted by the different regions and their hospitals. Regions were ordered to adhere strictly to the guidelines drawn up by the National Board of Health. Based on these recommendations, the government subsequently sat down with the individual regions to discuss the final plans.

In Ontario, Canada, the government in 1996 gave an independent commission, the Health Services Restructuring Commission (HSRC), instructions to rationalize the health care system.[4] This Commission was given the explicit task to determine specifically what number of hospitals was needed, what kind of health care they were allowed to offer, and who was allowed to provide this health care. The Commission's proposed course of action involved, among other measures, the closing down of 38 hospital locations.

In London, UK, an independent commission, consisting of health care experts, was created in 2007, with the aim to improve the quality of major trauma and stroke services.[5] London hospitals were asked to submit proposals to this Commission in order to remain eligible to offer these services in the future. In this process, the Commission had to choose explicitly between different hospitals and their networks.

5. Competition law assessment

When reviewing concentration and specialization initiatives with regard to hospital care, from a competition law perspective, it is important to know which parties decide what types of treatments are concentrated at what hospital. Horizontal agreements between competing hospitals will almost automatically have welfare-reducing consequences. It is therefore important to ascertain whether concentration and specialization are the result of the individual, or joint, choices of hospitals, the choices of insurers, or the choices jointly agreed upon by hospitals and insurers.

With regard to organizing specialization and concentration, hospitals notably tend to claim that such plans are best discussed in their own consultations with other hospitals. In their view, it is the hospitals themselves that are best able to determine which hospital is best suited to provide certain types of

3 Møller Pedersen, Kjeld. "Restructuring & modernizing the hospital sector". Health Policy Monitor, April 2009. Available at http://www.hpm.org/survey/dk/a13/5.

4 Dunan G. Sinclair, Mark Rochon and Paul Kilbertus. "A Status Report on Hospital Restructuring in Ontario". Hospital Quarterly, Fall 1998.

5 http://www.nhshistory.net/stroketraumaconsult.pdf.

treatments.[6] Hospitals are currently jointly developing a variety of plans to give shape to what they see as necessary and desirable in terms of specialization and concentration. These plans are focused on certain treatments and are based on the quality standards developed by scientific associations, such as the minimum volume standards mentioned above.

5.1. Independent decisions by hospitals

Where hospitals decide individually to specialize, there is no competition law issue at stake. In the current debate on specialization and concentration, it is often forgotten that hospitals can decide for themselves to become a leader in a certain specialism, and frequently do so. Hospitals may do this, for example, 1) by taking measures to attract additional patients, independent of any steering role of the insurer, perhaps by positioning themselves as the best providers in a specific specialism in terms of quality, or 2) by securing a selective contract from the insurer(s).

Obviously, hospitals could also choose to no longer offer, and thus discontinue the provision of certain treatments themselves, for example, if they expect not to be able to meet the applicable minimum volume requirements, or because they wish to specialize in a different treatment. This trend is taking place at present. For example, one in four Dutch hospitals that currently offer highly specialist treatments for pancreatic cancer, has indicated plans to discontinue these treatments in 2012. Their reason is that, individually, they do not meet the minimum volume requirements as drawn up by the Dutch Association for Surgery (NVvH). Hospitals are of course allowed to make arrangements with other hospitals about treatments they no longer offer, for example, where it concerns handing over patients in a proper manner. Such arrangements do not cause any competition law concerns.

5.2. Mutual agreements between hospitals

Considerable competition concerns arise where hospitals make arrangements amongst themselves on specialization and concentration matters. It is therefore unlikely that mutual agreements between hospitals will be permitted under competition law. There are roughly three broad reasons why there are significant concerns with regard to such agreements:

1. Health care providers may make choices that are not necessarily in the interest of patients and/or the insured, thereby creating unnecessarily powerful market positions. A hospital could become a leader in certain treatments, not because it is best-suited to perform the treatments in question, but as the result of a trade-off with another hospital.

2. The arrangements may go beyond what is strictly necessary. For example, the arrangements may cover not only the concentration of high complexity-low volume treatments, but also the concentration of high volume-low complexity treatments (to compensate the hospital that loses production). Health care providers are perfectly able to compete with one another on the provision of high volume-low complexity treatments.

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[6] If hospitals were to decide among themselves which hospital would specialize in certain treatments, and which hospitals would discontinue these treatments, they would be considered to be making specialization arrangements. These specialization arrangements should not be confused with the various types of specialization and joint production agreements that may qualify for block exemption. Generally speaking with specialization and joint production agreements, the undertakings involved continue to offer the service in question, because they make mutual supply arrangements, and the providers stay in the market. In the case of specialization arrangements under discussion here, some hospitals will leave the market for the treatments subject to specialization.

3. There is a considerable risk of competition-sensitive information being exchanged, such as information on prices and volumes, that is unrelated to the types of health care for which specialization and concentration is necessary.

Patients and the insured would therefore most likely get the short end of the stick, because hospitals would have fewer incentives to invest in quality, and to charge reasonable prices for the treatments concerned. This in turn would translate into higher premiums for the insured. Generally speaking, if providers make mutual arrangements regarding specialization, they often do so with their most direct competitors. In addition, in segments for complex treatments, there are fewer competitors, and it is not clear which providers will end up offering certain treatments because specialization and concentration will also have taken place in other regions. For these reasons, specialization arrangements agreed between hospitals are likely to breach competition law.

Hospitals can, however, apply for an exemption from the prohibition of cartels under Article 101, paragraph 3, TFEU, if they believe that the quality benefits of their mutually agreed arrangements outweigh the drawbacks of the reduction of competitive pressure, caused by the concentration of certain treatments, in one particular hospital. Choosing this option does pose certain risks in that the arrangements may not meet the exemption criteria under the Dutch Competition Act and the NMa must act *ex post*. Where a specialization arrangement comes into existence under the influence of the health insurer, a breach of the Dutch Competition Act is considerably less likely.

5.3. Role of the health care insurer in concentration and specialization arrangements

In the Dutch Health Insurance Act and the Framework Agreement, private health care insurers are called upon to contract on a selective basis, in order to realize health care that is efficient and of high quality. As a result of the role that they have been allocated, insurers are seen by the NMa as well as by the Minister of Health as the most appropriate players to realize specialization and concentration in the health care sector, through the use of selective contracting. The NMa believes that a full adoption of this role by health care insurers is the method by which specialization and concentration of health care can be achieved, with the fewest competition law concerns. Given a well functioning insurance market, insurers will make objective choices that are in the interest of their customers. Insurers will therefore take into account any powerful positions on the providers' side of the market when selecting the hospitals at which to concentrate hospital care for particular treatments. Such powerful positions may affect the range of products offered by insurers on the health insurance market, and particularly, may affect the premiums they need to charge their customers. If they make the wrong choice, and if they have to pay too high a price for the treatments that have been concentrated, compared with other insurers, they will be punished for these mistakes on the insurance market. The punishment will be that individual customers will switch to insurers that *did* make the right choice in other regions.[7] In addition, when selectively contracting treatments, insurers will not be likely to compensate hospitals that have lost a certain share of production by giving them high volume-low complexity treatments, the type of treatments for which no concentration is needed.

[7] In the Netherlands, there are four major insurers, and seven smaller ones. Most often it is the biggest regional insurer that will take the lead, in that region, in deciding at what hospital certain health care treatments need to be concentrated, if individual hospitals are unable to meet the relevant minimum volume requirements. The other insurers will likely have to follow that choice if the other hospitals are unable to meet the minimum volume requirements themselves. Those insurers may therefore be harmed if the biggest regional insurer has not made the right choice. However, those insurers may be able to make their own choices in the areas where they themselves are the biggest insurer. By making the right decisions in those areas, they are able to differentiate themselves on the health insurance market from insurers that have not made the right choices.

Insurers are well-placed and competent to take on this role. Insurers are statutorily required to provide for the health care their customers may need. Given this statutory requirement, they must contract treatments for which specialization and concentration is required, given the minimum volume standards. At the same time, there is a trend that, apart from scientific associations, insurers themselves increasingly create quality standards that they, and other insurers, use when selecting health care providers.[8] Where such information is not publically available, insurers can easily ask hospitals individually for such information, in order to be able to make a choice about in which hospital to concentrate certain health care treatments.

If insurers decide individually from which hospitals they wish to buy certain treatments, no competition law concerns will arise. If multiple hospitals wish to offer the same types of treatments, insurers could ask each hospital to submit their offers, explaining why insurers should select them. Each insurer could then pick a hospital from these 'bids.' Alternatively, insurers could compare hospitals based on pre-determined quality aspects.

5.4. Insurers working together

Individual insurers may not always be able to effect the necessary specialization and concentration of health care, or the required reduction of capacity. For example, consider an area, where there are four insurers active, each having five customers with a specific, complex health care need. When a minimum volume standard of twenty treatments is introduced, and multiple hospitals offer this type of treatment, it is then highly uncertain that specialization and concentration will come into existence through selective contracting by individual insurers. This means there is an increased likelihood of co-ordination problems, whereby one insurer chooses provider A, while another insurer chooses provider B, and none of the hospitals will be able to meet the minimum volume standard. In such a situation, health insurers are allowed jointly to select a hospital for those treatments. This is allowed only if co-operation is needed to be able to ensure that a health care provider will process a sufficient amount of treatments in order to meet the minimum volume standard for this kind of treatment. In situations where insurers, through their buying strategies, are able to ensure that hospitals realize the minimum volume standards, collaboration is not needed. For example, if insurers wish to collaborate with regard to high volume health care, they will need to invoke Article 101, paragraph 3, TFEU.

Insurers are additionally allowed to collaborate if they are unable, individually, to reduce the number of emergency rooms or obstetric care locations, where such reduction would otherwise be feasible.

Although, in some situations, insurers are therefore allowed to collaborate when selecting health care providers, the general rule remains that health insurers are to compete with one another as much as possible. Health care insurers should thus continue to negotiate individually with providers, and are not allowed to exchange among themselves any competition-sensitive information that is not strictly necessary for the type of collaboration that is allowed.

6. Conclusion

In conclusion, the NMa is of the opinion that the Framework Agreement can be fully implemented, and all its objectives achieved, without any breach of competition law. Firstly, hospitals are able to decide for themselves whether or not they want to specialize or to discontinue certain types of treatments for

[8] Insurers may set such standards, provided that; 1) these standards are medically and scientifically validated, 2) these standards are agreed on by the scientific associations, 3) these standards are not set at a higher level than existing norms of the Netherlands Inspectorate of Health Care, and 4) individual insurers have the possibility to set higher standards.

which they know in advance that they will not be able to meet the minimum volume standards. Secondly, insurers are able to bring about the necessary and desired specialization and concentration through selective contracting. If insurers are unable to make choices by themselves with regard to specialization and concentration, or to capacity reduction, they may, under certain conditions, collaborate with other insurers. If insurers assume this role, and handle it well, it may help control health care costs.

However, as specialization and concentration in the sector develops, it will remain necessary to ensure that no horizontal agreements are developed between providers or insurers, that may damage the system of managed competition and patient welfare in the health care sector. In addition, the Framework Agreement relies on the health insurer taking on a specific role in the sector in the selective contracting of health care providers. The health insurers' performance of that role should therefore also be monitored carefully in the coming period.

NORWAY

1. Introduction

In the letter asking for contributions to the WP2 Roundtable on competition in hospital services, the Chairman states that the OECD Competition Committee seeks to consider whether competition can deliver improvements in health and hospital services.

In Norway, the state has the overall responsibility for the financing and provision of key social welfare tasks such as health, care and education. The health enterprise model, with four regional health enterprises, is the cornerstone of the Norwegian system for providing hospital and other specialist health services. The activities within the regional health enterprises are financed through a combination of basic grants and activity based funding. The overall state governance of the four regional health enterprises imply that most of the health services are provided within what the Norwegian Competition Authority (the NCA) in a decision in 2005 concluded was one enterprise. Moreover, even though there has been a substantial growth in the last 20 years, the private providers' share of the activity in the national health care system is still very limited.

These features combined with the policy of the current government which explicitly leaves a limited role for commercial actors within the health care system, obviously give limited space for competition as well as enforcement of the competition law in relation to the health care system in general and hospital services in particular.

There are nevertheless important tasks for the Competition Authority in relation to this sector, both with respect to enforcement as well as pointing out restrictive effects on competition of public measures. Thus, competition law and its enforcement can be an important contribution to efficient use of resources, i.e. more health for a given budget, in this area.

Before substantiating how, a description of the Norwegian health care system will be presented, as well as the current government's policy towards competition in the health care system. As part of the discussion on the scope and role of competition law and enforcement in relation to hospital services in Norway, we will also present some of the competition issues related to the health care system encountered by the NCA.

2. The political framework

2.1. Policy on competition in general

The Competition Policy of the present government is described ia. in the 2012 Budget proposition. Here it is stated that an active competition policy is instrumental in stimulating an effective use of resources in the society, and that markets with well-functioning competition contribute to the State using no more resources than necessary.

Furthermore, the government states that competition contributes to an innovative and adaptive industry structure that produces goods and services in an efficient manner. This will strengthen Norway's competitiveness internationally. To the consumers, competition ensures a wide range of goods and services

with good quality at the right price. Consequently, the Government states that it will have a policy stimulating competition.

2.2. Current policy on competition in the health care system

The political platform for the current majority government (*The Soria Moria Declariation*) is very clear on the public sector's responsibility and role in the provision and financing of key social welfare tasks such as health, care and education. The government is also explicit in that it will oppose the commercialization of these areas. More explicitly, it is a stated goal to ensure that the scope of agreements between regional health enterprises and private commercial hospitals shall be limited. Available capacity in the public hospitals shall be utilised, and agreements between health enterprises and private commercial hospitals shall not have a scope that undermines the catchment populations for the small local hospitals.

In the political platform, it is also stated that it is important to safeguard that "hospitals owned and operated by non-governmental organisations shall be ensured good terms through agreements with the public authorities".

Moreover, the Government Policy Declaration on "Competition policy, public support and public procurement" at the Ministry website also includes a commitment to community solutions and public control instead of compulsory competitive tendering in important welfare fields like education, health and care services[1], reflecting the political platform presented in the "Soria Moria Declaration".

3. Structural framework for health services[2]

A health system can be defined as all organizations, institutions and resources that are devoted to producing health actions – the latter being defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health. The health care system comprises a wide range of different services. Here we will mainly focus on specialist health care services.

3.1. The Norwegian health care system - specialist health services.

Norway has a national health care system. Hospital services are mainly financed by the government, and the right to receive hospital services is regulated by law.

From 1975 until the state took over the hospitals, the county authorities had the responsibility for running hospitals. As of 2002, the hospitals have been organized as state-owned health enterprises. The purpose of the reform was to entail a comprehensive reform of organization and responsibilities, with a clear division of remits and roles to permit continued political control. Equally, the aim was to create conditions conducive to the autonomy of the operating enterprises.

The enterprises are separate legal entities, which do not form a part of the central public administration. The State has no authority or responsibility for the day-today operation of the enterprises.

However, as owner the State lays down the articles of association and other framework conditions and objectives, and selects the board members. Through special regulatory documents issued annually by the

1 See http://www.regjeringen.no/en/dep/fad/Selected-topics/competition-policy.html?id=1363

2 This description is based on http://www.helsedirektoratet.no/english/publications/health-creates-welfare--the-role-of-the-health-system-in-norwegian-society/Sider/default.aspx as well as a previous submission to the OECD WP2 roundtable on competition in health services, in 2005.

Ministry of Health and Care Services to the regional health authorities, and meetings with the authorities, health-policy steering notices, grants and conditions applicable to allocations are communicated.

The Ministry of Health and Care Services may also, in the general meeting, lay down instructions for the boards of the regional enterprises. All decisions of considerable importance must be presented at the general meeting. It is clear from the preparatory works to the Health Enterprises Act that the State as owner is entitled to make decisions of strategic, financial or other vital nature. It was also an explicit premise that the reform should lead to a centralized management of the health enterprises.

The ownership division of the Ministry of Health and Care Services exercises corporate governance, while the Minister of Health and Care Services constitutes the annual general meeting. Both the four regional health enterprises and the local health enterprises have the status of their own legal entity, with their own boards. These boards have comprehensive and supreme responsibility as supervisory, strategy-laying and decision-making bodies.

The public-sector specialist health service is currently organized into 23 health enterprises (HF) in 4 health regions under the respective regional health enterprises (RHF), i.e. north, middle, west, and south-eastern part of Norway.

3.2. Responsibilities

The State is responsible for providing specialist health services to the public, according to the Patients' Rights Act. This act states that the patient is entitled to receive necessary health care from the specialist health service. The specialist health service shall also set a time limit within which the patient shall receive necessary health care. If the patient does not receive such care within the time limit, the patient has a right to receive necessary health care immediately – if necessary from a private service provider or from a service provider outside Norway.

The RHFs are directed to fulfil this responsibility of providing hospital services for the population in their own region. The RHFs have two possible ways of doing this. Their own subsidiaries (the health enterprises) can produce the services, or the RHFs can buy the services from other suppliers – private or public.

Each RHF and each HF is responsible for its own economic result. The enterprises are obliged to be in economic balance over time, within the framework conditions set by the State. The Norwegian Accounting Act applies for the public health enterprises as well as for private enterprises. There is, however, an exception made for the estimation of the capital value in the opening balance at the time of foundation. Health enterprises also differ from other enterprises because they can not be taken under bankruptcy proceedings. The state has instructed the RHFs to co-ordinate the activities of the subsidiaries when required. Based on the ownership the RHFs can request the health enterprises to co-operate.

3.3. Private provision of health services

Hospital services are supplied mainly by government-owned institutions, but also to some extent by non-profit private institutions in addition to some commercial private providers of hospital services.

The non-profit institutions have a similar role to public health enterprises (HFs). They are financed in a similar way, and their agreements with the RHFs resemble the agreements between a RHF and its HFs. Non-profit institutions may provide a broad range of specialist health services, including emergency help. After the Health reform in 2002 some of these non-profit institutions became public health enterprises.

The extent of commercial private providers of hospital services has grown significantly the last 20 years. The private providers' share of the activity in the national health care system is, however, still very limited. They also play a different role than non-profit institutions in the health system

The figures in the table below encompass 21 private institutions with a contract with one of the regional health enterprises. These private providers have specialized in scheduled treatment, especially outpatient surgeries.

Table 1. Number of patients with at least one day-and-night stay, one day treatment or one polyclinic consultation (out-patient treatment) in public hospital or publicly financed at private hospital with a contract with the regional health enterprise, 2nd tertiary 2001[3]

	Public hospital	Private hospital
Day-and-night stay	406 379	5596
Day treatment	138 478	12 542
Polyclinic consultation (out-patient treatment)	1 221 823	21 200

The NCA stated in its contribution to the OECD roundtable on Competition in the provision of hospital services that the private commercial providers constituted a competitive benchmark and contributed to innovation. In addition, they had also played an important role in reducing waiting time and shortening the queue of patients waiting for outpatient surgeries or diagnostics by radiology or laboratory testing.

Private specialists outside hospitals also provide specialist health services. Their activities range from basic surgery to complex nursing and care services. They are all subject to the authorities' supervision. For some specialties they provide a substantial part of the total services. In 2009, the so called Contract specialists (*Avtalespesialister*) took care of one third of total out-patient treatment in the somatic areas, as well as psychic health care for adults.[4]

3.4. Financing of the health enterprises

In general, the Norwegian health system is funded primarily through taxes and transfers from the state. There is no earmarked health tax. The national insurance scheme guarantees the population the right to health, care and nursing services. Treatment at public sector hospitals is free, including medicines. There is partial fee-for-service payable for consultations with GPs and specialists, for outpatient care and for certain medications, along with transportation. In principle, patients have to pay the full cost of treatment from private-sector service providers, unless the private provider has a contract with one of the RHF's, and the patient has a referral to treatment.

The financing model for the regional health enterprises in Norway is a mixed model, combining a fixed budget appropriation and an output-based reimbursement. The main features of this model were

[3] http://www.helsedirektoratet.no/tall-analyse/aktivitetstall/somatikk/Documents/Aktivitetsdata-somatikk-tertial2-2011.pdf

[4] http://www.helsedirektoratet.no/tall-analyse/aktivitetstall/avtalespesialister/Sider/default.aspx

implemented in 1997, when a system of activity based financing for general hospitals was introduced on a comprehensive basis.[5]

Prospective payment is often adjusted based on performance of median or best practice hospitals. Many countries are introducing prospective payment systems in order to encourage hospitals to improve their outputs for the funds they receive. Thus, the primary purpose of the reform was to increase activity so that more patients could receive treatment more quickly without reducing the quality of care. Thus, the regional health authorities are basically financed by a combination of basic grants and activity-based funding.

The activity based financing system (*Innsatsstyrt finansiering*, ISF) is a DRG-based[6] reimbursement system, which applies to most of the hospitalised treatment. This percentage has varied from year to year. In 1997, when the system was implemented, the percentage was 30 per cent. In 2003 it was 60 per cent, then reduced to 40 per cent in 2004 and again increased to 60 per cent in 2005. The RHFs currently receive 40 per cent of the calculated DRG-price (equivalent to the average operating cost for each DRG). The basic grant constitutes approximately the remaining 60 per cent. The size of the basic grant depends on the number of inhabitants in the region, as well as the demographic properties with respect toe.g. age distribution, and is independent with respect to the actual production of health services. In addition to the activity based financing and the basic grant comes grants to the specialists with contract with the RHF's as well as private laboratory and radiology services

For outpatient treatment, radiology and laboratory services there is another output-based reimbursement system which is based on fixed payments for each type of consultation. The patients themselves also pay a small amount for each consultation (there are some exceptions to this).

Private providers of hospital services must have an agreement with one of the regional health enterprises to obtain state reimbursement. If the provider has no agreement with a RHF the patient will be responsible for paying for the treatment.

4. Contracting and competition mechanisms

4.1. Entry for new providers

Private hospitals or private health care service providers must be authorized by the Ministry of Health and Care Services. The Ministry focuses on whether the services in question are beneficial from both a social and economic point of view. It is also emphasized whether there is an actual need for the services, and if the intended use of health care personnel is considered to be reasonable. Lastly, it is also taken into consideration whether the services are sound from a professional viewpoint.

A patient with a right to necessary scheduled treatment has a statutory right to choose the hospital or other institution in which the treatment shall be carried out. It is a condition that the institution is owned by a regional health enterprise, or has an agreement with a regional health enterprise that entitles the patient to make such a choice.

Private laboratory and radiology service providers need a professional authorization to be allowed to supply their services, according to the specific regulations for this kind of services.[7] Moreover, an

5 http://www.helsedirektoratet.no/publikasjoner/regelverk-innsatsstyrt-finansiering-2012/Publikasjoner/regelverk-innsatsstyrt-finansiering-2012.pdf

6 Diagnosis-related group /DRG) is a system of classification for hospital cases.

7 See http://www.lovdata.no/for/sf/ho/xo-20001201-1276.html (in Norwegian)

agreement with a regional health enterprise is a condition to be entitled to public reimbursement. Thus, the RHFs have a key role regarding the entry of new providers.

4.2. Benchmark competition

ISF-payment is a prospective payment system which implies a form of benchmark competition for hospital services. The hospitals have incentives to be more efficient, and they have incentives to shut down inefficient units. In its contribution to the OECD roundtable on this issue in 2005,[8] the NCA noted that since ISF was introduced, two kinds of restructuring had been observed. First, an increasing part of the treatment were performed as day treatment (the patient is leaving the hospital the same day as he arrives). The NCA proposed various explanations for this; arguing that economic reasons were the most likely among them.

Second, the length of stay (LOS) were significantly reduced since the prospective payment systems were introduced. For most DRGs the decrease in LOS had been between 10 % and 20 % from 2000 to 2004. This was partly due to the increase in day treatment for conditions that earlier demanded several days of hospitalization. However, the length of stay was also significantly reduced for treatment where the patients stayed for more than 24 hours.

The NCA proposed that more efficient procedures could be one of the explanations for this, and found reasons to believe that the potential of benchmark competition were far from exhausted.

It can be added that a recent study shows that hospitals that have implemented ISF on a department level has managed to increase productivity without increasing costs.[9]

In its submission in 2005, the NCA also argued that the change in political signals with regard to the role of private providers in the health care system conditions had made it difficult for the enterprises to make rational decisions about investments or closing down of units.

The NCA also found it possible that the requirement for private enterprises to have an agreement with the RHFs represented an entry barrier, and thus reduced the number of competitors.

4.3. Outsourcing of services

The RHFs are responsible for providing hospital services to the population in their region. They can produce the services in their own HFs, or they can buy the services from other providers; private as well as HFs in the other regions.

Services like surgery, other kinds of scheduled treatment, radiology, laboratory services and ambulance services are to some extent tendered, thus introducing competition among private providers of these services. The RHFs are free to bargain prices and other conditions with the private providers. The per unit payment can be considered as a two part tariff with a fixed refund determined centrally and a part determined through the tender.

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8 Norwegian submission to Roundtable on Competition to Promote Efficiency in the Provision of Hospital Services, held by the Working Party n°2 of the Competition Committee in October 2005

9 One of the essays in a recently submitted Phd thesss by Afsaneh Bjorvatn with the title ”Four Essays on Health Care Reforms in Norway”at the Univerity of Bergen (January 2012).

One potential issue of concern from a competition point of view is the dual role of the RHFs. The RHF is responsible for the provision of the relevant health services, and also a dominant producer of the same services.

In the OECD Competition assessment toolkit (version 2.0), it is pointed out that a number of rules and regulations can have the effect of limiting the actual number or the type of suppliers of goods and services in the marketplace, thus a concern from a competition point of view. The rationale for the concern is e.g. that entry by new businesses plays a crucial role in preserving the vitality of markets by offering competition to the incumbent firms and fostering innovation and growth in the longer-run.

The NCA recognize that it is the responsibility of the RHF to determine if services shall be produced in-house or bought in the market. The make-or-buy decision depends on several factors like transactions costs, what is considered as core-activities and so on. It is, however important that the regulatory framework and the assessment and allocation of relevant costs within the RHF is designed so that make-or-buy decision can be based on actual costs of providing the services.

In its submission in 2005, the NCA argued that it should be possible to increase both scope and scale of outsourcing, maybe also by paving the ground for competition on equal terms among private and public hospitals.

4.4. Free choice of hospitals.[10]

Patients' rights are described in The Patients' Rights Act. The objective of this Act is to give the population equal access to high quality health care by granting patients' rights in their relations with the health service.

Since 2001, patients are according to the law free to choose a hospital for scheduled treatment (and specialist consultations/diagnostic services). Free hospital choice means that a patient who is referred to further investigations and/or treatment has the right to choose the hospital. The patient's travelling costs, and costs for food/accommodation, are reimbursed by the RHF. The patient only pays a limited amount.

The system is based on a gatekeeper model. All citizens are entitled to a personal general practitioner (GP). The GP sees the patient for initial diagnosis, and then decides whether the patient should be referred to the specialist health service. The specialist health service will then decide whether the diagnosis give the patient a right to treatment.

To facilitate patients' rights to choose where to receive treatment, the Norwegian Ministry of Health in 2003 launched an information service on the Internet; "Free Hospital Choice".

The service offers patients, next of kin and clinical personnel up to date quality information concerning patient's rights, waiting times and quality information about the different hospitals, as well as other relevant information.

This enables patients to make better informed decisions as to which hospital/institution to choose for different types of treatment. The patients may ask their GP to help them to choose, book treatment themselves by using a web site constructed specially for this purpose, or call a toll-free telephone number. In addition to the internet service, an existing telephone service was improved to support the peoples' right of free choice of hospital.

10 Based on http://www.frittsykehusvalg.no/english.

The information covers all public and private hospitals that have an agreement with the RHFs to perform selected treatments. One purpose of this service is to contribute to a better utilization of the capacity of treatment within the Norwegian healthcare services, and to increase competition among state-run hospitals.

In general, promoting consumer ability to choose is important for making markets work well. Thus, when patients according to the law are free to choose a hospital for scheduled treatment, this is from a competition point of view applaudable.

In its OECD submission in 2005, the NCA referred to studies that confirm that the freedom of choice reduces the waiting time for each patient that uses this right. A recent report from the Office of the Auditor General's, submitted to the Norwegian Parliament on 20 October 2011, confirms that patients who make use of the free choice of hospital scheme experience shorter waiting times.[11] Moreover, a recently submitted PhD dissertation at the University of Bergen, Norway also presents evidence that free choice of hospital has increased patient mobility.[12]

In the NCA's view, it is important that patients have good, reliable, comparable and easily accessible information on relevant aspects of the different options. However, last year "The Norwegian Board of Technology"[13] presented a report to the Norwegian Parliament on free patient choice. One conclusion was that the information available to patients was highly inadequate. This is confirmed by the Office of the Auditor General's investigation, which states that in order to give patients a better basis for making decisions concerning choice of hospital, the scheme's website – www.frittsykehusvalg.no – needs to be improved with more reliable, up-to-date, relevant and realistic information.

The investigation of the Office of the Auditor General's also shows that the primary reason why patients exercise their right to free choice of hospital is that their GP has informed them about the system. Nearly half the patients were not given this information by their GPs. The investigation also shows that the patients receive inadequate information from hospitals about the possibility of shortening waiting times by changing hospitals – despite the fact that many hospitals have long waiting times for many types of treatment. The system is used most by patients with high incomes and higher education who are in employment

The Office of the Auditor General's recommend that the Ministry of Health and Care Services ensure that GPs and hospitals make more active use of the free choice of hospital system in order to achieve health policy goals. Better guidance can contribute to the provisions of the Patients' Rights Act concerning free hospital choice combining the goals of increased patient participation in decision-making and equal access to health services. At the same time, increased utilization of the free choice of hospital system can help to improve utilization of the specialist health service's capacity.

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11 Document 3:3 (2011-2012) "The Office of the Auditor General's investigation into the free choice of hospital system".An English resume can be found at http://www.riksrevisjonen.no/en/Formedia/PressReleases/Pages/freechoice.aspx.

12 One of the essays in a recently submitted Phd thesss by Afsaneh Bjorvatn with the title "Four Essays on Health Care Reforms in Norway"at the Univerity of Bergen (January 2012).

13 The Norwegian Board of Technology is an independent body for technology assessment established by the Norwegian Government in 1999, following an initiative by the Norwegian Parliament (Stortinget)

4.5. Exit/restructuring

Exit of non-efficient units is in an essential feature of a market based economy to realize efficiency improvements. The board of a HF can in principle decide to shut down hospitals. In practice there are severe obstacles to this.

Firstly, the political platform of the current government, i.e. the Soria Moria declariation, states that "No local hospital shall be closed down". Secondly, according to the Health enterprises act (section 30), matters with substantial effects on the society shall be submitted to the Ministry of Health and Care Services as owner, by the board of the regional health enterprise. Thus, both the board of the RHF and the Ministry as owner can reverse such decisions in the general meeting. In such situations, it is up to the HF to find other ways to improve efficiency to be able to meet the budget constraints.

If the HFs or RHFs choose to close down hospitals to increase efficiency, the protection of vulnerable consumers is ensured partly through the standards defined in the Patients' Rights Act, partly through the right to choose hospital. In this respect there are important differences between scheduled treatment and emergency care. When closing down hospitals, the health enterprise can choose to supply scheduled treatment from other institutions in the enterprise, or reduce its total supply. In any case, the patients are guaranteed to get the services they have legal right to. The combination of free choice of hospital, and waiting list guarantee, ensures this. Concerning emergency care it is the RHFs' responsibility to ensure this in all parts of its region, according to the standards defined in the Patients' Rights Act.

5. Competition law and enforcement

The NCA has only limited experience with applying competition law in this area. We will in the following describe the legal framework as well as some relevant cases.

5.1. The Norwegian competition law

The current Competition Act entered into force on 1 May 2004[14] when it replaced the Act relating to competition in commercial activity (Competition Act 1993).[15] The purpose of the Act is stated as to "further competition and thereby contribute to the efficient utilisation of society's resources". When applying the Act, special consideration shall be given to the interests of consumers.

The NCA's main task is to enforce the competition law. The NCA shall according to the law supervise competition in the various markets (section 9), among other things by ensuring adherence to the prohibitions and orders of the competition law and intervene where necessary against concentrations in addition to calling attention to any restrictive effects on competition of public measures

The prohibition in Section 10 and 11 in the Competition Act is harmonized with Article 101 and 102 TFEU and Articles 53 and 54 of the EEA Agreement.

Finally, note that according to Section 3, certain markets or industries may by regulation be exempt from all or part of this. Of particular relevance in this context is the exemption from the competition law

[14] Act on competition between undertakings and control of concentrations of 5th March 2004 No. 12 (Competition Act 2004).

[15] Act relating to competition in commercial activity of 11th June 1993 No. 65 (Competition Act 1993).

for co-operation etc. for certain groups of doctors with private practice, psychologists and physiotherapists (regulations 2009.06.19 no 0674).[16]

5.2. The scope of the competition law in relation to the health care system

All undertakings operating in Norway are obliged to comply with the Norwegian Competition Act.[17]

An undertaking is defined as any *private or public entity* that carries out commercial activities (Section 2). Thus, the Norwegian Competition Act applies fully to public corporations and state-owned enterprises in the health care sector in the same way as to private corporations to the extent they are involved in commercial activities. Thus, a public body in the health care system can be considered as an undertaking in the context of competition law for certain parts of its activity, even though other parts fall outside of the scope of the law.

According to Norwegian Competition Act, the Competition Authority shall also call attention to any restrictive effects on competition of public measures and, where appropriate, submit proposals aimed at furthering competition and facilitating market access by new competitors (Section 9e). If the Competition Authority so requires, a response from the public body responsible for the measure must be made within the deadline specified by the Competition Authority. The response must include inter alia a discussion of how the competition concerns will be dealt with.

Consequently, even though the public sector's responsibility and role in the provision and financing of key social welfare tasks such as health, care and education is an important feature of the current government's policy, and the policy explicitly leaves limited scope for commercial actors, there are nevertheless still important tasks for the competition authority relating to this sector, both relating to enforcement as well as pointing out restrictive effects of public measures.

5.3. Case 1: Are the regional health entreprises undertakings with respect to competition law?

As described above, a core part of the Norwegian health care system is the regional health enterprises. To what extent the regional health enterprises could be considered as undertakings in the context of competition law was considered by the NCA in a decision in 2005 (Decision A2005-21) as well as a guidance note in August 2005. Here the authority concluded that the five regional health enterprises (now four) should be considered as one economic entity. Thus, cooperation between the different regional health co-operation's would not be considered as a restriction of competition violating section 10 of the competition law.

The case was a complaint from the Private Hospital Association. The Association argued that the government’s regional health organizations were in breach of section 10 of the Act due to collusive pricing.

As alluded to above, the RHFs are responsible for providing hospital services to the population in their region. The RHFs are organized as separate legal entities, but the Ministry of Health and Care Services is ultimately responsible for both financing and management of the service. Private companies offer to some extent specialist health services. The private service providers generally have agreements with the RHFs regarding payment for rendered services.

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16 There is also a temporary exemption from the competition law for an agreement on clinical veterinary call duty (2010.12.17 no. 1660).

17 The prohibitions in the Norwegian Competition Act are aligned with Article 101 and 102 TFEU, and Articles 53 and 54 of the EEA Agreement.

As the RHFs use of private institutions to help reduce medical waiting lists has increased, the private healthcare providers had agreements with more than one RHF.

The RHFs therefore demanded that the lowest price offered by the private institution for rendering a specific service to one RHF should be applicable to all RHFs. The Private Hospital Association asked for an evaluation of this practice.

In this case the NCA had two basic questions to answer. First, whether the RHFs are enterprises under the Competition Act i.e. carries on an “economic activity”. Secondly, whether the RHFs were to be considered as different economic entities, since section 10 of the Act only applies to agreements between two or more independent enterprises.

The NCA did not give a specific answer to the first question. They gave a general description of the concept "economic activity" in accordance with EU case law, and concluded that it was not possible to give a general answer as to when the a RHF is engaged in economic activity. RHFs would in some circumstances be considered as enterprises and not in others. This will, according to case law, depend especially on whether the activities concerned have an economic nature and what role the principle of solidarity plays. The NCA therefore stated that it is essential that a case by case assessment is made.

Regarding the second question the NCA concluded that the five RHFs are considered to be one economic entity. It was important for the conclusion that the RHFs where 100 % state owned, hereunder that the state was in charge of financing and strategic decisions. Furthermore it was emphasised that the Ministry of Health and Care Services is formally and actually in control of the RHFs and their activities, (by law).

The question of the application of competition law will be accentuated where there is a provision of health services in parallel from public and private entities. In these cases, an assessment of the characteristics of the actual health services supplied must be undertaken. To what extent there exists a commercial market for that service independent of the public procurement of the service. It cannot in general be determined whether the regional health enterprises shall be considered as undertakings. This must be assessed on a case by case basis.

5.4. Case 2: Competition between private and public hospitals

The second case handled by the NCA relating to hospitals were in some ways similar to the first one. A private hospital asked the NCA to examine the competition situation between public and private hospitals in general. As mentioned above, the first question to be answered in these cases is whether public specialist healthcare providers are considered to be enterprises. It is not possible to give a general answer to this question because one must do a case by case assessment. The Competition Authorities therefore gave a description of the principles laid down by the ECJ in their practice, but a more explicit conclusion was not reached.

5.5. Case 3: Laboratory services

In a case concerning laboratory services, the NCA made a concrete assessment of whether a public health provider is engaging in “economic activity”, and whether section 11 of the Competition Act is applicable (abuse of dominance). The case concerned a private laboratory which has made a complaint against one of the HF's laboratories. The latter gave rebates to customers (doctors) that requisitioned more than 5.000 laboratory samples a year.

First, the NCA had to address the question whether the HF offering laboratory services is engaging in "economic activity". Second, the NCA had to consider whether the rebate system in question amounted to an abuse of a dominant position.

However, when the HF decided cessation of the arrangement, the authority in 2006 decided not to give priority to dealing with the case.

5.6. Case 4: Collusion between two health centers in RHF tender

An example of collusion is found in the Competition Authority's decision V2008-1, where two health centers in Bergen were instructed by the NCA to end their co-operation with regards to pricing of medical services during tender competitions.

The illegal co-operation occurred during submission of tenders in the market for ear, nose and throat surgery. The independent undertakings quoted the same prices in their separate and individual bids. The undertakings admitted co-operation with regards to pricing, citing the use of the same building, same equipment and same personnel as the reason for the collusion.

5.7. Case 5 and 6: Collusion in tender for patient transport.

About NOK[18] 2 billion is spent annually on patient transport in Norway. Most of this is related to taxi journeys. The Regional Health Authorities (RHF) are responsible for the procurement of patient transport. The health authorities use competitive tendering procedures to procure public transport in order to stimulate competition and thus reduce their expenditure on patient transport. Lower expenditure on public transport will make more money available for the treatment of patients.

Both the licensing authorities (the county administrations) and the purchasers (RHF) are able to influence the degree of competition in tenders for patient transport. The county administrations may, for example, increase competition by allowing more taxi central dispatchers in an area and by increasing the number of taxi licences. The health authorities can influence the competitive situation through how they formulate the call for tender and by acting as vigilant purchasers who keep an eye out for signs of illegal collusive tendering. In March 2009 the Competition Authority sent a letter to the county administrations and the Regional Health Authorities informing them about various methods for increasing competition.

Where there is competition, illegal co-operation among competing taxi businesses can weaken or eliminate competition, and increase the costs of providing health services. Case 5 and 6 presented below illustrate this clearly.

Case 5. In September 2006 Taxi Midt-Norge AS – a countywide dispatch service that organises taxi licence holders in the county of Nord-Trøndelag – submitted a tender on behalf of all the taxi dispatchers and taxi licence holders in a competitive tendering procedure advertised by the Central Norway Regional Health Authority for the purchase of patient transport for Nord-Trøndelag. The bid thus involved collusive tendering (bid-rigging) among all the taxi licence holders in Nord-Trøndelag.

The Central Norway Regional Health Authority submitted a complaint about this collusive tendering to the Competition Authority. After considering all the information relating to the case, the Competition Authority decided that the bid submitted by Taxi Midt-Norge AS in the competitive tendering procedure constituted illegal collusive tendering in breach of Section 10 of the Competition Act. Notification of a fine for breach of the law was issued in December 2008, and the final decision was made in March 2009. Taxi

[18] 1 Euro = 7,66 NOK (January 2012).

Midt-Norge was fined NOK 300,000 for violation of the Competition Act. The Central Norway Regional Health Authority conducted a round of tenders in 2008 with a view to entering into new contracts and having new suppliers from 1 January 2009. However, the round was cancelled because the bids submitted would have resulted in considerably higher costs than budgeted for patient transport in Nord-Trøndelag. The Central Norway Regional Health Authority therefore engaged in direct negotiations with several potential providers in the market.

This resulted in three providers receiving contracts for patient transport in various parts of Nord-Trøndelag during the period 1 January 2009 to 31 December 2011, with the option for a 1-year extension. According to the Nord-Trøndelag Health Trust the savings achieved by having competing bids for patient transport amount to approximately NOK 2 million per year. The health authority has stated that the Competition Authority's notification of its intervention against Taxi Midt-Norge played an important part in gaining acceptance for the outcome of their negotiations with the various providers.

One important point in the Competition Authority's assessment of the co-operation via Taxi-Midt Norge was the question of whether the various taxi businesses were actual or potential competitors in the tender. The call for tender stipulated no requirements that bidders be able themselves to offer services to one or more municipalities, and each of the central dispatchers and licence holders could in principle submit bids for just parts of the tender. The Competition Authority therefore based its decision on the licence holders associated with the main county service being largely actual or potential competitors.

In a similar case in the county of Nordland, the health authority made greater demands with respect to capacity. In much of the county, there were no grounds for submitting more than one bid in the competition. In these areas the health authority would not have received more than one offer, even without co-operation through the countywide taxi business. The Competition Authority therefore decided that there was no reason to intervene in the case in Nordland.

Case 6. The second case relating to illegal collusion in a tender for patient transport is from 2010. The tender was advertised by the Oslo University Hospital. Two competing taxi dispatchers, Follo Taxisentral and Ski Taxi, collaborated through a jointly-owned company, Ski Follo Taxidrift AS, on submitting bids during two competitive tendering rounds during the autumn of 2010. These competitive tendering rounds applied to the transport of patients for the Oslo University Hospital, valued respectively at up to NOK 20 million and NOK 30 million.

The Competition Authority learnt about this illegal collusive tendering from the Oslo University Hospital HF when the Hospital expressed its concern about the lack of competition in respect of patient transport in the Follo region. During the first round of competitive tendering, the collaboration between the taxi ranks resulted in the Oslo University Hospital only receiving one tender. The Oslo University Hospital decided to cancel the competition due to a lack of competition. When the second round of tenders was advertised the taxi ranks also submitted common bids. There were two other tenderers in this tendering round.

Follo Taxisentral and Ski Taxi were competitors in the taxi market in Follo, and these two companies could have submitted independent bids in both tendering rounds. The basic tendering material provided by the Oslo University Hospital contained nothing to prevent these companies from submitting individual bids. When instead they decided to collaborate, they violated Section 10 of the Competition Act which bans collaboration between competitors designed to limit competition.

In 2011 the NCA decided a fine of NOK 2.2 million for Ski Follo Taxidrift. Follo Taxisentral had to pay a fine of NOK 400,000 and Ski Taxi a fine of NOK 250,000. All three fines imposed for breaches of

Section 10 of the Competition Act which bans collaboration between competitors designed to limit competition.[19]

These examples relating to tenders for patient transport illustrate well how important it is to create a good basis for competition through formulating the call for tenders, vigilantly carrying out competitive tendering procedures, and actively enforcing the Competition Act.

If little attention is paid to the effects on competition, then county administrations and the Regional Health Authorities must be prepared for transport services to be more expensive. If no arrangements are made for competition then the competition rules will not normally have a decisive impact either. If only one taxi company or one combination of such companies is able to submit a bid because of the terms of the call for tender, there will be no illegal collusive tendering to intervene against.

5.8. Calling attention to any restrictive effects on competition of public measures

As mentioned above, one of the important questions in the cases the NCA has dealt with is whether the public hospital service in question is engaging in "economic activity", is to be considered as an undertaking in the legal sense.

Moreover, a public body is not considered as an undertaking in its exercise public authority, or if the public service is part of a solidary arrangement with a social purpose.

However, if the public measure has restrictive effects on competition the NCA can, according to Section 9 e referred to above, call attention to this, and where appropriate, submit proposals aimed at furthering competition and facilitating market access.

In 2009, the NCA used this tool; sending a letter to the Ministry of Health and Care Services calling attention to concerns regarding the public operating grants to private practice physiotherapists, arguing that the arrangement implied a substantial risk for lowering the quality of services. Although the concerns were directed toward the agreements with the private practice physiotherapists, the concerns would in principle also apply to the agreements with psychologists and specialist doctors (*avtalespesialister*). The NCA proposed changes in the agreements that would alleviate the problems. In its reply the Ministry said that the financing system for the physiotherapists was in the process of being reconsidered, that the concerns of the NCA would be part of this assessment. The Ministry said that after this assessment it would come back to the issue with the NCA. This is still pending.

6. Public procurement

The Norwegian Complaints Board for Public Procurement's (KOFA), primary task is to safeguard that public bodies adhere to public procurement rules. The public sector in Norway procures goods and services for vast sums every year. The objective of the public procurement regulation is to ensure equal treatment for all suppliers. In a similar vein, the public procurement rules ensure that the procurement processes are transparent, predictable and can be effectively reviewed. Last, but not the least, the regulations are to ensure that effective competition is maintained in public procurement processes.

KOFA handles complaints of violation of the procurement rules. The board's secretariat is placed, administratively, under the Norwegian Competition Authority (NCA). A substantial number of the cases involve non-compliance with the procurement rules. Cases where public authorities have failed to announce publicly public procurements also feature prominently on the secretariat's activities.

[19] The firms involved have decided to try this case before the court.

Several of the cases KOFA has handled over the last years has involved the RHF's. Focusing on the period 2005-2007, KOFA assessed 28 complaints related to the procurement of specialist health care services by the RHF's or HF's. The services encompass somatic elective care, laboratory services, ambulance services, x-ray/radiotherapy and substance abuse treatment. In 19 of these cases, a violation of the procurement rules was concluded.

7. The role of competition policy and enforcement in health care

In Norway, the health care services are to a large extent publicly financed and publicly provided. The policy of the current government is that it will oppose the commercialization of key social welfare tasks such as health, care and education. Moreover, the Government Policy Declaration includes a commitment to community solutions and public control instead of compulsory competitive tendering in these important welfare fields. In the last budget proposition, it is stated that the government will take action to further the interaction between the public sector and non-profit organizations as providers of health and social services.

Nevertheless, different parts of the health care system is to varying degrees also operated by private for-profit as well as private not-for-profit (e.g. non-governmental organization). The health care system is in other words a structure that in the various parts of its interconnections has undertakings operating in a market, thus subject to competition law, or where various public measures in the health care system may have restrictive effects on competition. In addition, the various providers of health care services within the health care system also often rely upon a competitive bidding process to achieve better value for money. Competitive prices and/or better services and products are obviously desirable because it results in resources being saved or freed up for use on more health care, or better health care. The competitive process can contribute to this only when the companies genuinely compete.

Consequently, the health care system is a concern of the competition authorities. This follows from the tasks the NCA are obliged to take care of by law. The competition issues the NCA have dealt with related to the health care system illustrate the importance if these tasks.

This suggests that there are at least two important areas where competition policy and enforcement can contribute in relation to the health care system:

- Efficient borderlines for competition between public and private providers in the health care system

- Healthy competition in tenders for goods and services to the health care system by deterring collusion and abuse of dominance

SWEDEN

1. The system of choice in the Swedish health care sector – The supervisory role of the Swedish Competition Authority

1.1. Background

The Act on System of Choice in the Public Sector (2008:962) (the act on system of choice) can be employed by municipalities and county councils who wish to expose e.g. support activities and care of the elderly and the disabled or health care services, to competition.

The Swedish healthcare system is a third part funded system, i.e. funded by taxes, and largely decentralized. The responsibility for health care is shared by the State, the 20 county councils and regions and the 290 municipalities.[1] The county councils are responsible for the hospitals and out-patient medical clinics, while the responsibilities of municipalities include care for the elderly and the disabled in special forms of housing or in the form of home care (hemtjänst). Their responsibility also include care for people with mental disorders and for providing support and services for people released from hospital care as well as for school health care. The Health and Medical Service Act (1982:763) regulates the responsibilities of the county councils and municipalities. The act is designed to give the county councils and municipalities a greater flexibility in the provision of health and medical services. The role of the Government is to establish principles and guidelines and to set the political agenda for healthcare. This is done by laws and ordinances or by reaching agreements with the Swedish Association of Local Authorities and Regions, which represents the county councils and municipalities.

In Sweden, consumer choice models have been used by some local authorities since the beginning of the 1990s, a few even before that. The consumer choice models were mainly used for simpler services, such as foot care services for the elderly and people with diabetics, and in a relatively small scale. The experiences were quite positive, but the lack of legislation led to questions whether the models used were in line with the EU legislation and especially the public procurement directives. In spite of this, an important step was taken in 2007 when the county council in Halland introduced a consumer choice model for healthcare clinics (vårdcentraler). Only one year after that, in 2008, consumer choice models for healthcare clinics were introduced in additional two county councils, Stockholm and Västmanland. That same year, the Swedish parliament decided on the introduction of The Act on System of Choice in the Public Sector (2008:962) which entered into force on 1 January 2009. This Act applies when a contracting authority decides to apply a system of choice regarding services within health and social services and is an alternative to the Public Procurement Act (2007:1091). The Act can be applied to health care services and social services, i.e. B services, category 25 in annex 3 to the Public Procurement Act on system of choice. The act is a voluntary tool for municipalities but mandatory for county councils and regions.

[1] One municipality, Gotland, an island in the Baltic Sea, has the same responsibilities for health care as the county councils.

1.2. System of choice for increased competition and consumer benefits

The main purpose of introducing the customer choice system has been to increase freedom of choice for users, quality, accessibility and efficiency by encouraging competition and diversity among players and supply in the Swedish health care sector. The act is supposed to provide municipalities and county councils with a new tool that they can use in situations where they wish to expose in-house provided health care services to competition and to transfer the choice of provider to the user. Thus, the opportunity for individuals to exercise choice will make publicly funded services more responsive to the needs and wishes of the individual user. This can lead to better opportunities for companies and NGOs to operate and develop by being able to compete in a simpler way with municipalities' and county councils' in-house services. Furthermore, systems of choice are considered to favor diversity and provide greater opportunities for small businesses, value-based activities and co-operatives of various kinds to enter the market.

1.3. Design of the system of choice

The Act on System of Choice applies when a contracting authority opens up parts of its activities for competition by establishing a system of choice for the services covered by the system. In establishing a system of choice the contracting authority transfers the possibility to choose a service provider within the system to the users of the services. The users may, in many cases, choose between private suppliers with whom the contracting authority has concluded a contract within the system of choice, or service providers within the contracting authority´s own organization. The level of payment given to the suppliers is set by the contracting authority and stated in the contract documents, and is depending on the number of users choosing the particular supplier as their service provider. According to the Act, contracting authorities are county councils, with regards to primary care, and municipalities who have decided to establish systems of choice in health care and social services. According to the Health and Medical Service Act, since 1 January 2010 it is mandatory for county councils to introduce a healthcare choice system within their primary healthcare service, which mainly concerns medical clinics.

The principles of system of choice are basically the same as for Public Procurement, i.e. non-discrimination, equal treatment, proportionality, transparency and mutual recognition, and must be considered during the whole procedure. Accordingly, service providers within the contracting authority´s own organization and the private suppliers in the system of choice must be treated equally. Also the requirements set by the contracting authority, which the suppliers must satisfy, must be relevant. The contracting authority shall provide information about all suppliers within the system of choice to the users of the services. The contracting authority is also responsible for assisting the individual user and explaining what the freedom to choose entails and what providers are available. For people who are not capable of choosing by themselves, or who want help from someone else in making their choice, there are rules on deputies, representatives and legal assistance as in ordinary cases when a system of choice have not been introduced. An individual, who does not want to choose, will not have to do so. In these cases, the user will be referred to the no-choice alternative decided in advance by the public authority and described in the authority's information material. The same quality requirements apply to the no-choice alternative as to the other providers.

The individual also has to be given the chance to change provider in a simple way. It is the individual's opportunity to choose and choose again that is the very core of the system which is intended to help to maintain and further develop the quality of the services included.

A contracting authority that has decided to establish or change a system of choice shall publish the relevant contract documents on the national website specifically set up for this purpose (www.valfrihetswebben.se) and continuously request applications for contracts. The database is

administered by The Legal, Financial and Administrative Services Agency (Kammarkollegiet). If the contracting authority has breached a provision of the Act and this has meant that a supplier has suffered or may suffer damage, the general administrative court shall decide, after application by the supplier, that the contracting authority shall implement rectification. In contrast to the position for public procurement, relevant contract information about contracts will be advertised continuously. The main purpose of the database is to make it easier for providers to find municipalities and county councils that have introduced a system of choice. Another purpose to set up this database is to simplify the exchange of experience between authorities that are considering the system or wish to develop it. Advertising in the national database is mandatory but can also be made in other appropriate media. Suppliers interested in providing services in the authority's system of choice submit their application to the authority, which assesses whether they meet the requirements specified in the contract documents. If so, the supplier is entitled to sign an agreement with the authority. Unlike under the Public Procurement Act, the tenders do not have to be assessed according to the principles of "most advantageous in financial terms" or "lowest price". All providers that fulfill the requirements in the contract documents are admitted to the system. An agreement under civil law is signed between the authority and the provider.

1.4. Requirements concerning providers

One important part of the political process in applying the act on system of choice is deciding what requirements to specify for prospective providers of health care services. In addition to the fundamental requirement that the service has to be conducted in accordance with current law, there are a number of other requirements that municipalities and county councils can set up on the condition that they comply with the principles of Community law that are applicable in this context, i.e. non-discrimination, transparency, predictability, mutual recognition and proportionality. One question that the political leadership must decide upon is quality requirements. Other requirements that are relevant to set up for suppliers may include the level of education of staff and managers, liability insurance, financial capacity, co-operation between the provider and the authority, R&D co-operation, crisis and disaster preparedness, and accessibility. The list of requirements may differ substantially depending on the service being bought and the aims of the county council or municipality. The effects of the requirements set up must be assessed in advance so as to be able to attain the objectives specified for the system of choice. Small businesses and hence also female entrepreneurs may seldom be able to live up to high levels of requirements concerning financial capacity, for example. All requirements have to be stated in the contract documents.

1.5. Contract documents

When applying the act on system of choice, the county council or the municipality must specify in the contract documents what requirements the provider must meet for an agreement to be concluded. In addition, the authority also has to state the payment that the supplier will receive for providing a particular service. The basis of the system of choice is that there is no price competition between suppliers. The county council or municipality lays down the price in advance. All providers, including, in principle, the in-house provider, will be paid according to the same principles. The design of the payment can vary depending on the service being bought; the main issue is for it to be transparent and non-discriminatory.

In addition, there should be a description of the service, contact information, monitoring, follow-up and control rules as well as other contractual terms and conditions. In addition to the type of requirement set out above, this refers to rules on the term of agreements, rules for the amendment of contractual conditions, the duty to provide information, the monitoring and the follow-up of the service, cancellation of the agreement due to a breach of contract and the possibility for the supplier to cancel the agreement if, for instance, it does not succeed in attracting enough users.

The design of the reimbursement system differs across county councils and municipalities. In the council counties' primary care the reimbursement is often based on consumer choice (capitation) and performance (number of actual patient visits at the health care clinic). The balance between capitation and performance based reimbursement vary between different county councils. In the municipalities, the design of the reimbursement system differs between municipalities and type of services provided. In care for the elderly or home care, for example, the reimbursement is often based on actual performance, i.e. per hour of care, or on an estimated level of performance needed in order to provide the service with a certain level of quality. The basic idea is that the contracting authority is to design the reimbursement system for different types of services.

1.6. Review

The act on system of choice contains the possibility of requesting a review by a general court. The court has to order correction in cases where the county council or municipality has breached the fundamental principles of equal and non-discriminatory treatment or some other provision of the act. A correction can also be sought if an authority does not approve a provider because the authority assesses that the provider does not meet the requirements in the contract documents. In that case, the provider can request a review of the authority's decision by the County Administrative Court. For the Court to order correction, the applicant, i.e. a provider who has not yet been approved in the system, must show that it has suffered damage or may suffer damage as a result of the incorrect action of the authority.

2. The Swedish Competition Authority's evaluation and supervision strategy

2.1. Implementation of the system of choice in Sweden - evaluation

As stated above, since 1 January 2010 it is mandatory for county councils/regions to introduce a healthcare choice system within their primary healthcare service. The Swedish Competition Authority (SCA) has been assigned by the Swedish Government to supervise the reform from the perspective of competition. In order to prevent infringements, the SCA also gives general guidance and information concerning the Act. The SCA has evaluated the healthcare choice reform concerning primary care in the county councils in reports to the Government.

In 2010, the SCA conducted a first evaluation of the establishment of the system of choice in the county councils and regions' primary health care service.[2] In the evaluation report that was issued to the Government, the SCA concluded that the reform had been successful and that there had been a significant increase in the opportunities to choose healthcare clinic and also an increase in the number of alternatives to county councils' healthcare clinics. The number of healthcare clinics had increased by 223 (or 23 per cent) since healthcare choice was introduced and the number of clinics run privately increased from 28 per cent in 2009 to 37 per cent in 2010. Two out of three privately run clinics were operated by small enterprises.

The SCA also observed that the opportunity to establish new healthcare centres has been important in terms of generating and maintaining competition in the market. The initial process of listing patients appears to be important in terms of how many new healthcare centres could be set up. Furthermore, the report shows that the confidence that new healthcare providers have in the county council has clearly influenced their willingness to start-up healthcare centres.

[2] Swedish Competition Authority, 2010 "Uppföljning av vårdval i primärvården. Valfrihet, mångfald och etableringsförutsättningar – Rapport 2010:3" "Healthcare choice in primary healthcare services – freedom of choice, diversity and conditions for market entry"

The SCA has proposed that county councils should continue to develop healthcare choice systems for other types of health care services and areas, which has also been the case in several county councils. According to a survey assigned by the Government and conducted by the SCA in 2011, around half the county councils, 22 in total, had introduced or were exploring the possibility of introducing healthcare choice within more areas than just primary care. The number and the areas covered vary between these county councils and in several cases relate to operations that, within other county councils, already comprise part of the mandatory healthcare choice mandate within primary healthcare services. For example, the Stockholm County Council introduced a patient choice system in 2008 for somatic specialists. Since then the system has been supplemented with more than 20 additional health care areas such as maternity and pregnancy care, child dental care, vaccinations, and hip and knee replacement surgery.

Regarding the implementation of system of choice in the municipalities, the Swedish government has allocated about SEK 300 million for incentive grants to the stimulate and accelerate implementation of system of choice in the municipalities. since the reform was introduced. All municipalities have been able to apply and receive government grants to investigate the conditions for introducing a system of choice in their municipality. In total 247 of the 290 county councils and regions have applied and received the grants to investigate the issue. In December 2011, 102 of the 247 municipalities that had received the incentive grants had introduced a system of choice for care and health care services and another 61 municipalities have decided to implement a system of choice. 55 municipalities had not yet made a decision on the issue and 29 of the municipalities had after investigation decided not to introduce a system of choice. This means that more than half of the municipalities had already introduced the system of choice or had decided to so. However, these municipalities cover an even larger part of the Swedish population as several of these municipalities have a large population.

2.2. Future work – main areas to study and evaluate

In a recent interim report to the Government on the implementation of system of choice in municipalities and its effect on competition, the SCA concluded that a main challenge is to design a system of choice that is neutral with regard to competition and does not discriminate against any provider.[3] One of the main reasons for this is that the contracting authority often has the role of both the party placing the order and providing services. According to the SCA, it is thus important that the contracting authority manages to differentiate between these two roles and that the design of the system do not favor the in-house provision or any specific external provider. Areas that the SCA considers to be relevant to examine is the impact of the reform in various municipalities, the diversity regarding size, ownership and offering among suppliers. Other areas of importance is how the design of contracts and no-choice alternative may have impact on market entry and competition neutrality, as the SCA has identified a risk that the contracting authority may favor its in-house provision or established players by designate them as no-choice alternatives. Furthermore, the SCA has concluded that the design of the reimbursement system, especially the balance between capitation and performance based reimbursement, may also affect market entry and competition. A reimbursement system based mainly on capitation will of course give established players and no-choice alternatives certain competitive advantages which in the long run will lead to barriers to market entry and less effective competition.

2.3. Important starting-points for the supervision

An important prerequisite for a well-functioning freedom of choice system is that there is a diversity of suppliers for individuals to choose amongst. The SCA's objective with the supervisory activities is to

[3] Swedish Competition Authority, 2012, Rapport 2012:1, "Kommunernas valfrihetssystem- så fungerar konkurrensen" ("System of Choice in Swedish Municipalities – A Competition Perspective")

contribute to the rules being observed in accordance with the intention of the legislation. In this respect it is of particular importance that the suppliers act under competition-neutral conditions, that the conditions are transparent and that the procuring authority does not impose any additional demands on procurers than what is requested to fulfil the desired goals. Through the supervisory activities, the SCA wishes to increase the awareness of, and the knowledge about, the system of choice; notably within municipalities and county councils. The supervision strategy is based on a few supervision keywords. These state that the SCA's supervision should be:

- **Initiative-driven** – this means that the SCA shall use tip-offs and complaints as a point of departure for the direction of actions and to a high extent take own initiatives regarding what matters to investigate.

- **Thematic** – this means for example that the SCA should study a certain aspect of the system of choice simultaneously in different county councils. When the SCA works in a thematic way, the authority shall prioritise typical problem areas and base the analysis on a representative sample of county councils or and /municipalities.

- **Focussed** – this means that the SCA shall focus on issues which are important for the development of practice.

- **Solution-oriented** – this means that the SCA shall communicate its own interpretation of the regulatory framework and provide examples of solutions that favour competition.

The supervision is carried out in dialogue with the concerned stakeholders since the Act on System of Choice does not contain any legal sanctions.

2.4. Prioritization of matters and other relevant areas

The following factors are taken into account when selecting which matters to investigate:

- The severity of the problem or the occurrence.

- The importance to provide guidance.

- Whether any other authority or actor is better-suited to act on the matter, or whether the issue is better dealt with within a different regulatory framework.

According to the supervision strategy the SCA should also suggest improvements to the regulation to the Government and make the Government aware of legislation and practices which obstruct the freedom of choice. Furthermore, it is important for the SCA to convey relevant and up-to-date information about its activities, including information and guidance, e.g. through publications, booklets, oral and written replies to requests, through participating in conferences and seminars, and also through its website.

In order to cover several areas of the system of choice, the SCA co-operates with several public agencies to discuss matters regarding freedom of choice, such as the Swedish Agency for Economic and Regional Growth, The National Board of Health and Welfare, The Swedish Public Employment Service, The Legal, Financial and Administrative Services Agency and The Swedish Association of Local Authorities and Regions The SCA also keeps a current dialogue with suppliers and supplier organisations to discuss issues regarding the legislation.

TURKEY

1. Introduction

1.1. Historical Overview of Turkish Health Care Industry

Healthcare sector has maintained its privileged position in the public agenda of Turkey since healthcare services were institutionalized with the establishment of Ministry of Health in 1920. Healthcare related priorities of Turkey have altered in accordance with the society's needs. In the first years of the Turkish Republic, preventive care and medical education were the top priorities. After World War II, curative services started to gain importance as well and first social security organization of Turkey (SSK) was established to provide health, disability and retirement benefits to workers in 1945. After the 1960s, policies of the government mainly focused on extending healthcare, making healthcare services easily and equally accessible to everyone and encouraging private sector to invest in private hospitals. The 1990s are mostly remembered by political instabilities and economic crises in the near history of Turkey. Throughout the 90s several reform packages were tried to be put into action; between 1988 and 1993, national health policy and a healthcare reform program (first health project) had been maintained, until it was interrupted due to the change of cabinet in 1993. In subsequent years Turkey conducted other health projects in association with World Bank based on a loan agreement signed in 1994. Main objectives of the reform packages from 1989 to 2003 were increasing efficiency of hospitals to get better quality services, initiating competition among state owned healthcare providers, promoting preventive services as well as curative health services, uniting social security bodies under the same roof and enabling Ministry of Health to be the authority to determine health policies and monitor standards[1].

Despite substantial efforts to solve longstanding problems of the health care system, there has not been significant progress throughout the mentioned period. Turkey stepped in to the new millennium with serious healthcare system problems such as: loss of confidence in public health services, considerable amount of people without any kind of social security coverage, the concentration of one third of the hospital beds and almost half the doctors in the three largest cities or other inequalities in the geographical distribution of healthcare personnel.

With the declaration of Rapid Action Plan (RAP) in 2002, the vision of which for healthcare sector was providing healthcare for everyone in equal conditions. To implement the vision brought with RAP, Turkey launched a project in 2003, known as "Health Transformation Program" (HTP), and with this program Turkey made considerable progress and made radical changes to the healthcare system.

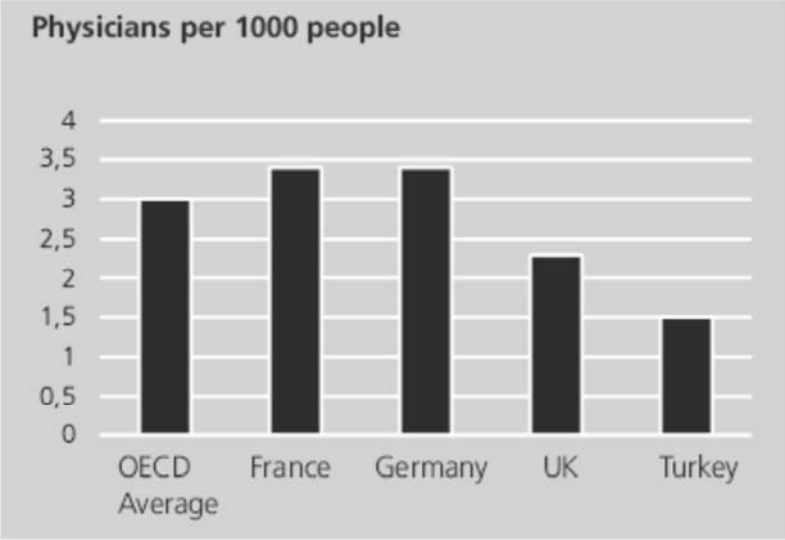
Throughout this discussion paper, Turkey's endeavors to improve its healthcare system and experiences gained during the implementation process of HTP are assessed from a competition law point of view. It also touches upon key concepts addressed in the call for contribution, such as the impact of market structure on the price and quality of hospital services, in light of Turkey's experiences as of 2003.

[1] Health Care Systems in Transition, TURKEY ; Savas, Karahan ve Saka- 2002 Page: 20,21)

1.2. Current Market Characteristics in Turkey:

According to the data obtained from the former OECD report, Turkey falls below its OECD counterparts in terms of the number of physicians.

Table 1: Number of physicians per 1000 people



Source: OECD Health economics in Turkey and in the world 2008, DELO TTE; 17

Basic healthcare indicators in Table 2 demonstrate current health status of Turkey in comparison to other countries with similar income per person.

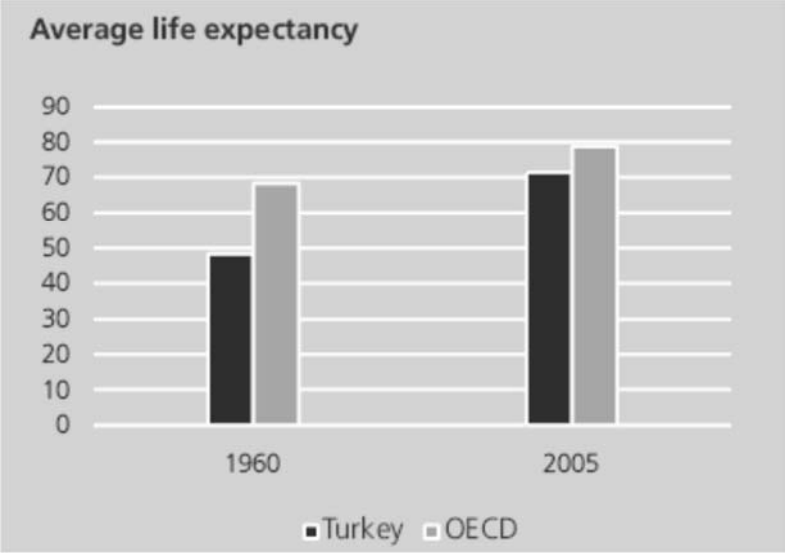
Table 2: Infant and maternal mortality rates in TURKEY

Some Basic Healthcare Indicators					
	Baby Mortality Rate (per 1000 babies)	Mortality rate below the age of 5 (per 1000 children)	Mother Mortality Rate (per 100,000 births)	Vaccination Rate (%, for 12 to 23-month babies)	
				DPT	Measles
Spain	4	4	4	98	97
Greece	4	5	9	88	88
Portugal	4	5	5	99	96
Brazil	33	35	260	96	99
Czech Republic	4	5	9	97	99
Mexico	23	28	83	91	96
Hungary	8	7	16	99	99
Poland	6	7	13	99	97
Malaysia	7	7	41	96	92
Slovakia	7	8	3	99	99
Turkey	33	39	70	68	75
Thailand	23	26	44	90	96
Russia	16	21	67	98	96
Romania	18	20	49	97	97
Bulgaria	12	17	32	96	96
Source: The World Bank, Turkey Public Expenditure Review 2006					

Source: Health economics in Turkey and in the world 2008, DELO TTE;18

On the other hand Turkey made formidable progress in life expectancy and mortality rates with the reforms made in the last decade.

Table 3: Average life expectancy in Turkey compared to OECD average



Source: Health economics in Turkey and in the world 2008, DELO TTE; 17

Expectations indicate that health expenditure will increase in the near future in Turkey as it is rising in the rest of the world. According to the data provided by the World Bank, the projected growth rate is 15% annually. Main reason of increase in health care expenditures is extending healthcare coverage and accessibility of medical services achieved with the introduction of the Universal Health Service.

Another important reason of placing great deal of emphasis on healthcare expenditures is the fact that despite of its relatively young population and lower demand for healthcare services, Turkey has huge amount of healthcare expenditures. Because today's young population ages in time, the demand for healthcare services will increase significantly. Therefore; control of excessive health care expenditures is going to be vital in the near future. According to the estimations, when Turkey's population aged above 65, healthcare expenditures will double from its current level of %7 to %14.

1.3. Impacts of Health Transformation Program on Hospital Services

The basic objectives of HTP were increasing quality, efficiency, productivity of the healthcare services and providing these services in equal basis either geographically or individually, enhancing the number of citizens under the coverage of social security system. As part of HTP, public insurance funds namely for public and private workers (SSK), self-employed (Bag-Kur) and civil servants (Emekli Sandigi) were brought together under the Social Security Institution (SSI[2]). Restructuring of the public-supported insurance funds was aimed at improving governance, user and provider satisfaction, long-term fiscal sustainability and eliminating fragmentation and duplication in the financing and delivery of healthcare systems.

Before HTP was implemented, the health system in Turkey was composed of both private and public practices and facilities. There were also differences between public hospitals, with three key public hospital service providers in the healthcare system: i) the Ministry of Health ii) SSK, and iii) university hospitals. To synchronize coverage of health insurance provided by different insurers and to increase the accessibility of healthcare services, important steps were taken in line with the HTP, which are listed below chronologically.

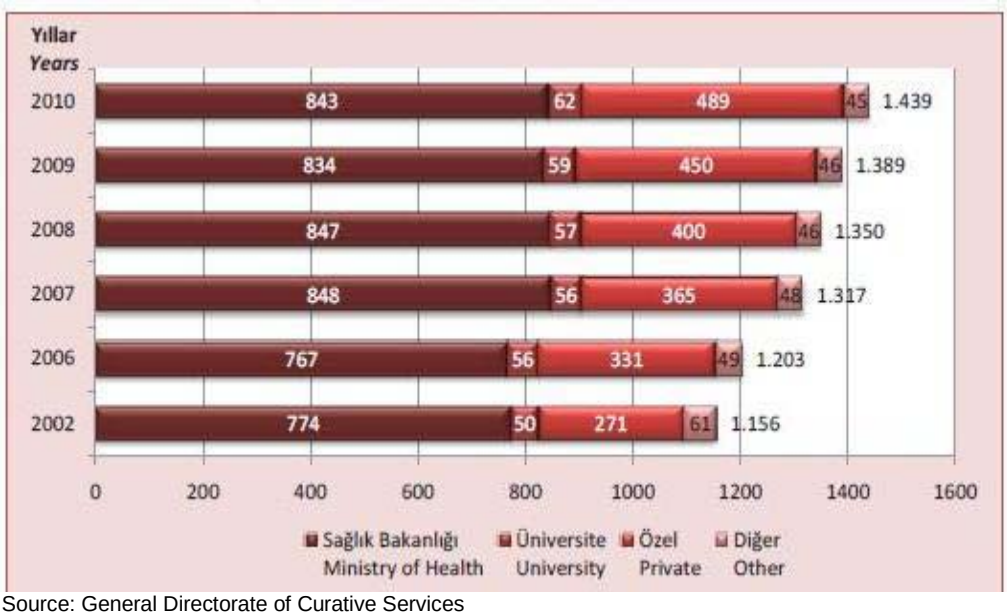
- In 2005, Green Card Holders had same level of benefits with SSI, Bag-Kur and Emekli Sandigi beneficiaries,
- In 2005 all public hospitals and pharmacies were opened to the use of SSK beneficiaries,
- In 2005, state hospitals, SSI hospitals and Institution hospitals were united under MoH.
- In 2006 SSK, Bag-Kur and Emekli Sandigi were gathered under SGK.
- As one of the most important results of this reform, patients as consumers were able to get health services from any hospital which contracted with the Social Security Institution (SSI).
- In 2007, citizens of Turkey were given the right to access free primary care, even if they are not covered under the social security system,
- In 2007 SSI issued a communiqué called SUT (Saglik Uygulama Tebligi). SUT determines bases and procedures related to healthcare services financed by SSI and indicates contribution amounts, patient co-pays set out by Healthcare Services Pricing Commission,

[2] Sosyal Güvenlik Kurumu (SGK) in Turkish

- SUT increased the harmonization between different insurance schemes, and referral requirement for accessing university hospitals were removed

We can summarize aims of all these reforms carried out within the HTP as facilitating access to health services, improving the service quality, strengthening the planning and supervising role of the Ministry of Health, improve and structure the institutional position of the primary health care in a way to have authority and control over other service levels, developing health information systems, ensuring the rational use of medicines and supplies, and establishing a universal health insurance system.

Table 4: Number of Hospitals by Years and Sectors, Turkey



Source: General Directorate of Curative Services

2. 2008 General Health Insurance Law (No: 5510) and Transition of the Industry to a Competitive Market

Social Insurances and General Health Insurance Law no. 5510, in other words, the Social Security reform has entered into force October 1, 2008 in Turkey. As one of the most important results of this reform, patients as consumers were able to get health services from any hospital which contracted with the SSI. This also gives consumers the freedom to choose among hospitals. After the enactment of the Law No. 5510, beneficiaries had the right to get services from any private healthcare entity having contract with SSI. Opening private utilities to beneficiaries caused significant growth in number of private hospitals and increased competition between them. For example; in 2002 there were 271 private hospitals in Turkey, this number became 365 in 2007, 450 in 2009 and 489 in 2010.

Opening the doors of private hospitals to those covered by public insurance enabled public hospitals compete with the private sector for service provision, which increases the quality and accessibility of healthcare services. The fact that private healthcare facilities opened their doors to SSI beneficiaries has alleviated the burden of state hospitals. So, the excessive workload which was mostly undertaken by public sector in the past is shared with private healthcare institutions and the provision of healthcare services is facilitated[3]. On the other hand, increasing number of private hospitals in the healthcare sector stimulated

[3] Turkey Health Transformation Program Evoluation Report, June 2011

the demand and healthcare expenditures dramatically increased. To lessen fiscal burden of healthcare expenditures, Government took steps directed towards restricting the new entrance of private hospitals to the healthcare sector. Incentives given to private hospital investments have been reduced and standards that need to be fulfilled to build private medical facilities have been increased. Government stopped receiving new hospital applications as of 15 Sep, 2008 (Unless investors received pre-approval before 15 Feb, 2008). (Daruma Report)

Table 5: 2008Major Changings in the Turkey's Health System Between 2003 and 2008

2003	2004	2005	2006	2007	2008
Ambulance services were made free-of-charge	Individual performance-based supplementary payment system implemented in MoH institutions	Green Card holders covered for outpatient prescription drugs	Global budget implemented for MoH hospitals	No payment required from citizens for primary care, even if not covered under social security.	New MoH Regulation on Private Outpatient Diagnosis and Treatment centres adopted that includes "Certificate of Need" requirement and new licensing procedures to be adopted by MoH
Mechanisms introduced so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated	Green Card holders covered for outpatient services	Institutional and quality criteria added to performance-based supplementary payment system in MoH institutions	Implementation of Law 5502 (integration of social security institutions) begins.		Amendments to Social Security and UHI Law adopted by the Grand National Assembly and signed by the President of the Republic
Total quality management (TQM) put in place in MoH	Reimbursement Commission responsible for reimbursement decisions established according to Ministry of Finance decree	SSK pharmacies closed and members allowed to access private facilities	Family medicine implemented in Eskişehir province	New Health Budget Law adopted (SUT) according to which: *i)* referral requirement from MoH hospital to university hospitals removed for SSK and *Bağ-Kur*; *ii)* patients with chronic condition can refill prescription at pharmacy without authorisation from physician first; *iii)* bundled (fixed-price) payment for outpatient and inpatient procedures based on CPT and ICD-10 introduced in all MoH and university hospitals and private hospitals under contract with the SSI; *iv)* hospitals under contract with the SSI required to provide in-patient pharmaceuticals and medical devices (covered by insurance) for free, and would be fined if they charged patients; *v)* all MoH, university and private hospitals under contract with the SSI required to report claims through MEDULA	Implementation of UHI begins. Green Card programme brought under SSI. Green Card holders to receive same benefits as enrolees in other health insurance schemes under UHI
Performance-based payments piloted in ten MoH hospitals	Right to choose a physician system implemented in MoH hospitals	SSK hospitals transferred to the MoH	Family medicine implemented in Edirne, Denizli, Adiyama and Gumushane provinces	Ambulance services made more accessible in hard-to-reach areas in winter	Pentavalen vaccine introduced in routine immunisation programme
Vaccination days organised in the context of the national campaign of vaccination against measles	Iron supplements distributed free of charge to pregnant women nationally	Co-payment required for Green Card for pharmaceuticals	Pharmaceutical expenditure tracking system established in SSI and work on an integrated claims and utilisation management system for SSI (MEDULA) initiated	Family medicine implemented in Elazig, Isparta, Samsun and Izmir provinces.	Tobacco Control Law passed banning smoking in closed and open public places.
		Family medicine first implemented in Duzce	Public-private Partnerships (PPP) for Health Law adopted by the Grand National Assembly		
		Licensing regulation for pharmaceuticals passed	Measles, mumps and rubella (MMR) vaccinations included in the routine vaccination programme		

3. Globalization of HealthCare Systems and Introducing International Competition in Turkey

Global competition in the Healthcare Industry might be a newly-introduced concept but we believe it is a very important concept and will shape the industry in the near future. In the past, wealthy patients from developing countries have long traveled to developed countries for their high quality medical care. However today, a growing number of less-affluent patients from developed countries are traveling to developing regions once characterized as "third world." The main motivation of this radical change lies behind lower costs of medical care that leads affordable prices for consumers in those countries.

By seeing the opportunity, many western hospital chains started to expand globally and transfer their technology and know-how to developing countries. We believe that this trend will have a positive effect on internal competition since it will force the domestic producers to improve quality and to offer more choices

Recently; Turkish Competition Authority (TCA) received notification on acquisition of Acıbadem Group of Hospitals, (Acıbadem), the leading private hospital chain of Turkey, by Integrated Healthcare Holdings Sdn. Bhd[1] (IHH). IHH is an international healthcare services provider with a Malaysian origin, operating in Bangladesh, Brunei, Cambodia, China, India, Indonesia, Mongolia, Russia, Ukraine and some other countries. TCA approved the acquisition of Acıbadem by IHH on the grounds that said acquisition does not lead to or strengthen dominant position in the private hospital services market and therefore; does not lessen the competition in the whole or part of the country.

Acıbadem's acquisition gains importance in terms of demonstrating the interest of foreign investors in private hospital investments in Turkey. When we consider the amount of investment, increasing domestic demand may not be sufficient to set off the initial investment by itself. Turkey's healthcare tourism potential encourages investing in private hospital industry. Turkey's strategic location and recent developments in transportation facilities enable private medical enterprises located in Turkey providing cross border healthcare services. It is expected that the share of the foreign investment in private hospital industry will rise and concentration will increase in subsequent years.

4. Structure of Turkish Healthcare Industry

Healthcare industry is a heavily regulated one in Turkey like its peers around the world. In health economics the key players are patients, providers of healthcare services, financers of healthcare services, and suppliers/manufacturers of products used in healthcare services. However, healthcare-related issues involve an informational asymmetry: patients do not have as much information about their diseases and the solution methods as physicians, pharmacists and healthcare products manufacturers do. This increases the need for regulation which is a highly controversial issue in Turkey. As discussed in the previous sections three different organizations were brought together and a new organization was founded under the name of SSI.

Although the SSI in its new structure is administratively and financially autonomous, it is still controlled as a related organization by the Ministry of Labor and Social Security. It has a Board of Directors of 10 members, presided by a person appointed via a triple decree upon proposal of the Minister of Labor and Social Security. The Ministry of Labor and Social Security, the Ministry of Finance, and the Treasury Undersecretariat, each has a member representing them in the Board of Directors.

[1] TCA Decision date and number: 29.12.2011,11-64/1659-589. The decision of TCA has not been judicially reviewed yet.

Moreover, the Ministry of Health fulfills important functions in health economics. It is the Ministry which is obliged to supervise and improve public health. Regulations regarding hospitals, which are the basic building stones of health economics, as well as pharmaceuticals, medical supplies and equipment are made by the Ministry of Health (MoH). Actually, this structure makes the situation more complicated since the Ministry of Health assumes the duties of regulation and inspection in addition to being a service provider, which is contrary to the principle that regulation and execution need to be independent of each other. In the near future, with the settlement of the rules and dynamics, we are expecting a separation in the duties of governmental organizations.

5. Public Private Partnership Models (PPP) in Turkey's Healthcare Industry

One of the objectives targeted with HTP was increasing the variety of treatments given in public hospitals, decreasing regional disparities and upgrading the technology of hospitals. When we consider the required amount of cost to attain these objectives, initiation of the projects could last quite long in case of relying on solely government resources. MoH had worked on several project financing alternatives before the PPP model was adopted for healthcare investments; however, the PPP model based on giving concessions to a private company to build and operate a facility that would normally be built and operated by the government was chosen because it presents an opportunity to make capital intensive investments more effectively in comparison to the government, without increasing the public's burden of debt.

Before customizing the PPP model according to Turkey's conditions, PPP models implemented in different countries were investigated to create a model meeting the needs of the healthcare system. The PPP model implementation in Turkey is mainly based on leasing of facilities from the private party and also leaving management and provision of all services other than medical services to the private parties. Building health campuses including health facilities, R&D and high technology center, implementing the latest technologies in the management of hospitals and spreading the variety of the treatment throughout the country will be carried on with the PPP model. To integrate the PPP model to healthcare investment projects, firstly the legal basis has been created; for this purpose, in 2005 an addition was made to the Law no. 5396 and the "Regulation on the construction of new healthcare premises against lease and the renovation of existing healthcare premises against operation of non medical services and functional areas of activity" is being published with Cabinet decision in 03/07/2006.

MoH is planning to make 33,315 beds capacity investment with the PPP model. The work of land in 27 provinces has completed except one province. The preliminary designs and feasibility studies for 17 projects have been completed and the Higher Planning Council (HPC) approved the studies. High-Security Forensic Psychiatric Hospitals and Psychiatric Hospitals projects which are planned in 8 provinces were submitted for approval of the Higher Planning Council. Seven feasibility reports studies are still under progress. Tender process of 10 projects which received HPC approval, are still under progress and 7 projects' tender documents have been prepared.

5.1. Benefits of the PPP Model

The most important reason is that utilizing PPP enables construction and renewal of Healthcare facilities at higher quality and better conditions with the help of resources, experiences and approaches of private sector. PPP model also provides the benefits listed below, making it a feasible solution for the capital intensive nature of healthcare investments:

- Benefiting from private sector's flexibility, creativity and efficient decision making processes in project management,

- Sharing the risk of the investment with private sector,

- Until healthcare facilities become fully utilized, the government does not bear any cost,
- Preventing interruption in the projects because of shortage in government funds,
- By leaning on public funds, healthcare projects could last an average of 8-10 years, private sector participation and its financing capabilities shorten the time span of the projects,
- Instead of taking the burden of initial investment, PPP enables spreading the cost of investments over years,

5.2. Providing all services other than medical services from the private sector

The thought that the most effective method of increasing efficiency in healthcare services is by opening these services to competition is gaining importance. However, there are several anti- thesis are being asserted to this thought:

First of all, it has been claimed that there is no room for efficiency thought in healthcare services. According to this idea, healthcare services should be provided by public without seeking efficiency. This idea which was commonly accepted at 1960's and 70's is losing its significance today. Because, a system completely ignoring pursuit of efficiency could not be sustained[2].

Second important thought is that healthcare services are different than all others; therefore, instead of opening these services to competition, attempts should be made to increase efficiency by regulating healthcare services. This thought is increasingly gaining importance over former thought[3].

One of the basic principles of Turkey's current PPP model of procurement of all services other than medical services from private sector lies somewhere between these two thoughts mentioned above, but closer to second thought. Hospital services consist of a bunch of sub categories such as: building management, hotel services, catering, etc. Those all take important part at overall service provided by insurers. And there is no doubt that private sector could provide these services in a more efficient, qualified and cost-effective manner thanks to its flexibility and promptness. The government can create a competitive environment by pulling itself out from these support services. As a consequence of competition, enhanced efficiency and lowered prices decrease costs of the overall service package financed by insurers.

5.3. PPP Model From a Project Financing Perspective

Project financing is emerging as the preferred alternative to conventional methods of financing infrastructure and other large-scale projects worldwide. Project finance is a fundamental element of the PPP model; the PPP model does not bring a new, unattempted mechanism for the finance of investments. It uses the well-established approach and legal instruments of a technique known as Project Finance. Project Finance includes stages of preparing financial plan, assessing the risks, designing the financing mix and raising the funds. Risks are allocated between the government and the private sector on the basis of who can better manage the risk.

Under a public-private partnership (PPP), a contractual arrangement is formed between public and private sector partners that involve the private sector in the development, financing, ownership, and operation of a public facility or service. Such a partnership creates win-win situations for both parties,

2 Rekabet Gunlugu Yazıları, TÜRKKAN Erdal.

3 Rekabet Gunlugu Yazıları, TÜRKKAN Erdal.

because public and private resources are aggregated and risks shared so that the partners' efforts complement one another. Benefits of PPP for Public have been listed above; PPP presents generous incentives to private sector to get in to partnership with Government as well. Private sector protects itself from identified political risks such as; confiscation, expropriation and nationalization, improve credit ratings, reduce pricing of debt instruments, by forming partnership with public.

6. Competition and Choice

> "Competition usually works well in private markets in the absence of market failures. It places downwards pressure on costs, forces firms to focus on meeting customers' needs and leads to more efficient allocation of resources between firms. It also acts as a spur to innovation. In well functioning markets, strong competition is driven by consumer choice, with active consumers putting pressure on firms to improve their product offering, in part by looking for opportunities to switch." (OFT)

Information asymmetry in healthcare industry is the most prominent reason of malfunctioning of competition in the healthcare sector. Patients rely on provider's opinion more than consumers would in any other market. Patients do not have the potential to make their own purchasing decisions related to core of the service; therefore, patients depend on some other factors while choosing between hospitals. According to conducted researches about patients' hospital preferences, patients build their evaluations upon factors like their distance from the hospital, the image of the hospital, the attitude of the hospital staff, physical conditions of the hospital etc. (Berkowitz and Flexner, 1981).

Patients should be supplied with enough information for being capable of deciding which service, how much and from whom should be taken. In countries where family medicine system is successfully implemented, family practitioners provide that consultancy to the patients.

Some critics claim that even when beneficiaries are provided with the means to make their choices consciously, this does not guarantee effective competition between providers as it is in private markets. Competition could be maintained only if the demand-side of the market works well, well-functioning and competitive market exists when consumers are able to make their choices based on price, quality and other individual characteristics of goods and services.

Price is usually out of assessment in public service markets, in healthcare services insurers finance cost of service, beneficiaries does not pay or pay relatively insignificant amounts. So price is not primarily considered at purchasing decision. Measuring service quality is quite hard, because patients do not know about medical treatment, they cannot make sure that they received the most proper package of treatment. It is needed to emphasize treatment on this issue, patients may be satisfied with side services such as the attitude of the hospital personnel and physical conditions; however, the important and costly part of hospital services consists of treatment, and it is more essential to increase competition in this part. The difficulty of creating competition in medical services supports the Turkish PPP model's "Providing all services other than medical services from the private sector" principle.

7. SSI's Price Regulations

As a consequence of reforms made to expand the breadth and depth of health insurance coverage and improve equality in access to health care services, demand for healthcare services dramatically increased. Correspondingly, total healthcare expenditure soared up. To control the budget deficit in the social security system resulting from the integration of private hospitals to the system, and to lessen the demand for private hospital services, a cap has been put on surcharges (30% on top of the existing government tariffs

on healthcare services) to beneficiaries receiving healthcare from private hospitals with the decision of the council of minister.

This new pricing pattern caused unfair competition between private hospitals, in spite of differences between their service qualities and cost structures, same prices were attributed to different service qualities. Consequently, demand on public hospitals dramatically increased and private sector got into scrape. After that, when it seemed that the sustainability of the implementation was controversial, the government and public sector renegotiated the conditions, SSI introduced a ranking system based on certain quality measures in 2010, ranking system allows hospitals to charge higher percentage of their costs up to 70%, from 30% current level. According to ranking system private hospitals classified under 5 categories from A to E (A is the most qualified class).

8. Concluding Remarks

There are still problems in the sector and much work to be done in terms of rules, laws and regulation compared to OECD and European counterparts. The fact that too many governmental organizations (Ministry of Health Finance, etc) are involved in the industry as both players and regulators sometimes makes the picture even more blurred. However the progress that has been made in the recent years is also very remarkable. With the introduction of private sector investments (both internal and external) and the opening of the market to competition, standards in the industry started to rise. With its formidable potential for growth, the industry started to turn into an attraction center for even medical tourism. The Turkish Competition Authority is trying to establish a level playing field for both private and state-owned hospitals, but since the sector is at the beginning state and there are many regulations to be made, TCA is currently focused on mainly mergers & acquisitions, bidding markets, and public procurement process of state owned medical enterprises.

UNITED KINGDOM

Executive summary

Hospital services in the UK are provided both by publicly and privately funded organisations. Features of hospital markets such as information asymmetries, while not unique, require careful consideration in order to ensure that competition is effective in delivering better outcomes for patients. Competition between hospitals, with the appropriate regulatory framework, creates incentives for hospitals to improve quality and efficiency.

This submission provides a brief overview of the supply of hospital services in the UK, the role of competition and some examples of regulatory measures undertaken to address these characteristics and to ensure that competition is effective. On the demand side, the submission describes steps taken to overcome information asymmetries in the supply of both publicly and privately funded hospital services. On the supply side, the submission describes the role of competition in delivering integrated care for patients, which is an important policy consideration for all healthcare systems.

The remainder of this submission is structured as follows:

- Background – description of the public and private supply of hospital services and the role of competition
- Demand side issues – overcoming information asymmetries
- Supply side issues – competition and integrated care

1. Background

The majority of hospital services in the UK are publicly funded and provided by publicly owned hospitals. Public hospitals in the National Health Service (NHS) provide emergency hospital services are and while there is scope for competition between hospitals to provide these services, the focus of competition in both the NHS and the private sector is on the provision of routine, planned (elective) care. In total, it is estimated that expenditure in England[1] on publicly provided elective hospital services was around £12 billion and the total value of the market for acute private hospital services in the UK was estimated at just over £4.94 bn.

This section provides a brief overview of the supply of publicly and privately funded hospital services in England and the role of competition.

[1] This description applies only to the NHS in England. The devolved administrations in Scotland, Wales and Northern Ireland are responsible for developing their own health policies.

1.1. NHS hospital services

Patient choice and competition has been a central part of the policy framework for routine elective care since 2000. Complementary, supporting policies include the establishment of Foundation Trusts, the national tariff (Payment by Results), the use of independent sector providers, the NHS Choices website, and the Choose and Book appointments system. The introduction of each of these policies has been an important building block for patient choice and competition in routine elective care.

Patients needing routine planned care in England are able to choose between any NHS or independent sector provider of acute elective care in England that is registered with the quality regulator, the Care Quality Commission (CQC), has a government contract, and is willing to provide services at the NHS tariff, the regulated prices set centrally by the government. By February 2011 patients could choose between approximately 165 NHS hospital trusts operating from approximately 300 sites as well as around 15 nationally-contracted independent sector providers of routine elective care operating from a further 175 sites.

Hospital competition and patients' ability to choose between providers for routine elective care is underpinned by a range of supporting infrastructure. Key elements include:

- the *Choose and Book* system, which allows patients (and GPs acting on patients' behalf) to select their provider of choice and book their first outpatient appointment with that provider;
- *Payment by Results*, which remunerates providers for routine elective care according to patient treatment volumes through a framework of fixed tariffs covering a range of procedures;[2] and
- *NHS Choices*, which provides performance information on each provider to assist patients in selecting their preferred provider.

The underlying rationale of providing patients with the ability to choose between providers of routine elective care is that the need to attract patients (in order to earn revenue given the Payment by Results system of tariffs[3]) ensures providers have an ongoing incentive to offer the highest quality care. Providers that are successful in attracting patients will be able to earn revenues that can be reinvested in other services.

Expectations of the patient choice policy at the time of its introduction were that it would assist in driving down waiting times for routine treatments and, more generally, that it would:

- improve quality and safety in service provision;
- improve health and wellbeing;
- improve standards and reduce inequalities in access and outcomes;

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2 We discuss the reality of how Payment by Results is being implemented for routine elective care by PCTs in paragraphs 95 to 106.

3 See, for example, section 26 National Health Service Act 2006 which provides that an NHS Trust must exercise its functions effectively, efficiently and economically. Schedule 5 makes provision about the financing of NHS Trusts – para 2(1) of Schedule 5, states that each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account. We understand that, in general, the delegated duty of the Chief Executive of an NHS Trust reflects these requirements.

- lead to better informed patients;
- generate greater confidence in the NHS; and
- provide better value for money.[4]

Given the relatively recent introduction of patient choice and competition in routine elective care, patients and providers are still learning how to make the most of this new environment. Patient awareness of their ability to choose their provider is relatively high at 54%, but there is scope for this to increase.[5] There is evidence that patients are exercising choice. There has been rapid growth in the number of NHS patients being treated at private facilities, and analysis shows that a significant proportion of patients are selecting a provider other than their local NHS provider and that the quality of care offered by a provider is a significant factor in explaining patients' choice. There is also evidence of patients responding to adverse patient safety events when they occur at their local hospital by choosing to be treated elsewhere in the following months.

Similarly, there is evidence that providers are still adapting to the operation of patient choice in routine elective care. The King's Fund recently found, in a qualitative study, that the threat of patients choosing a different hospital led some providers to focus more on reputation, and noted that providers spoke about actively seeking to attract patients away from other providers in particular geographical areas and marketing their services to GPs.[6]

Despite patients and providers still being in the process of adapting to choice and competition in routine elective care, there is already evidence that choice and competition is leading to improvements in patient care. A number of recent studies have found that higher levels of competition in the provision of routine elective care have led to improvements in clinical performance and efficiency. For example, academic researchers have found that higher levels of competition in the provision of routine elective care under the current fixed prices regime have led to improvements in clinical performance.[7] As patients become increasingly aware of their ability to choose and exercise this choice, and providers respond to the incentives that this creates, then the quality and efficiency of routine elective care can be expected to improve further as a result of this policy.[8]

The policy framework within which hospital competition operates can also be seen as a set of constraints – or restrictions – on the operation of patient choice and competition in routine elective care. For example, the requirement that providers be CQC registered, decisions on which services should be

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4 Department of Health, *Framework for Managing Choice, Cooperation and Competition*, 16 May 2008. In extending patient choice of provider in community and mental health services, the Department of Health states that this is "intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice" (Department of Health, *Operational guidance for the NHS: Extending patient choice of provider*, July 2011, paragraph 1.3).

5 Department of Health, *Report on the National Patient Choice Survey, England*, February 2010 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116958.

6 King's Fund, *Patient choice – how patients choose and how providers respond*, June 2010.

7 "After the introduction of patient choice over secondary care provider, AMI mortality decreased more quickly for patients living in areas with more competitive spatial hospital markets" in Cooper, Gibbons, Jones and McGuire, 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *LSE Health Working Paper No.16/2010*, January 2010 (also in Economic Journal forthcoming).

8 The effects of patient choice and competition in routine elective care is discussed in more detail in Annex A.

open to patient choice, and the use of fixed prices all set boundaries within which patient choice and competition can take place. The set of constraints that the policy framework represents is critical to the success of patient choice and competition in routine planned publicly funded hospital services.

1.2. Private hospital services

The OFT is consulting on a provisional decision to refer the market for private healthcare (PH) to the Competition Commission for a market investigation. The proposal follows an in-depth market study of PH by the OFT including GP surveys and patient interviews.[9] The section below provides an overview of the privately funded healthcare (PH) market, exploring how the various market participants interact and the role of private medical insurance (PMI) in the context of the market study's provisional findings.

In UK, PMI funded patients typically have either a corporate policy, obtained through their employer, or an individual policy, obtained directly from a PMI provider. Approximately 15 per cent of people are covered by such a policy in the UK, the majority holding a corporate or employer funded policy.

GPs act as the key interface in directing PMI funded patients to consultants and PH facilities, and in the provision of information to PMI funded patients about their options of PH provider and consultant. The OFT's patient interviews and the OFT GP survey both indicate that patients place a great amount of trust in their GPs' opinions and recommendations. Consultants also occupy a central position within the patient journey as GPs refer patients to specific named consultants (rather open referrals or referrals to PH facilities) in the majority of cases. The OFT consultant survey suggests that consultants also play a key role in the selection of the PH facility where a PMI funded patient is admitted.

There are five main PH provider groups active in the UK, each of which owns a network of PH facilities located throughout the UK. These top five PH providers accounted for approximately 77 per cent of the PH market by revenue in 2010. The market also includes smaller, independent PH facilities. There are also five main PMI providers active in the UK. Together, these five PMI providers account for approximately 91 per cent of the revenue from PMI policy subscriptions.

PMI policies include a list, or network, of PH facilities which are available to a PMI policy holder. Most PMI providers operate a series of networks comprising (i) facility networks – these include a limited list of PH facilities at which a patient is entitled to be treated; and (ii) treatment networks – a PH provider will be added to a speciality network provided it agrees to meet a price prescribed by the PMI provider for a specific procedure. In general, a lower cost policy will have a more restricted PH facility network but a higher premium policy is likely to offer access to a more extensive network of PH facilities.

The recognition of PH facilities on PMI networks is the subject of negotiation between individual PMI providers and PH providers. The standard practice is to agree a national single network agreement including: the list of PH facilities operated by the PH provider that the PMI provider has agreed to allow its policy holders to be treated at; the medical procedures that each PH facility is entitled to undertake; and the price that the PH provider's PH facilities are entitled to charge for each procedure. Prices are negotiated on a national basis and apply to each PH facility, although ad hoc discounts may be negotiated.

The PMI provider may pay the consultant costs incurred directly in full or pay the costs up to a certain limit, with the PMI funded patient sometimes paying shortfalls (when treatment costs unexpectedly exceed the PMI limit) or top-up fees (when an additional fee in excess of the limit is agreed between the patient and consultant before the treatment starts) directly to the consultant. In some cases, the PMI provider may

9 http://www.oft.gov.uk/OFTwork/markets-work/private-healthcare/

also help the patient choose a PH facility and/or consultant in the event that the GP provides the patient with an 'open referral' letter.

1.3. Interaction with the NHS

The NHS is a provider of healthcare services free at the point of use and so may offer an overall constraint on the PH market, even though in terms of competitive interaction, in providing free healthcare, the NHS is unlikely to be in the same economic market as PH. Nevertheless, NHS performance is an important determinant of the demand for acute PH, particularly for self-pay patients. The NHS is also a participant in the PH market, with just over 70 dedicated PPUs and a number of private beds in NHS facilities. Furthermore, the NHS is a procurer of PH services, as publicly funded patients seek treatments from PH facilities, such as Independent Sector (see paragraph 7 above). These are facilities that only carry out day-case procedures, which are procedures that will require the patient to rest in a bed but do not require an overnight stay.

2. Demand side – information asymmetries

Accessible, standardised and comparable information is vital for ensuring that consumers can exercise informed choice so that markets work well. Information asymmetries, where suppliers have better information about the quality and price of a product than consumers, can dampen competition between suppliers and result in poor outcomes for consumers in terms of price, quality, innovation and productivity.

Certain information asymmetries, though not unique in healthcare markets, are inevitable given that patients are unlikely to know more about their condition than a medical professional, nor able to navigate their choices effectively without expert advice. Clinical procedures are typically experience or credence services and as a result quality is not directly observable by the patient. This means that experienced specialist judgments are often part of evaluating options and making choices between publicly funded hospitals in the NHS and between consultants and PH facilities.

This section examines the extent of information asymmetries in hospital services and the steps taken in the UK to address them:

- the first part considers the importance of accessible, clear information for choice and competition in markets
- the second part considers the role of the GP acting as an informed and impartial agent on behalf of the patient
- the third part describes the ways in which hospital quality information has been made available to help patients who use publicly funded hospital services to make informed choices
- the fourth part discusses the recent OFT market study of privately funded healthcare services.

2.1. Healthcare information asymmetries

Well functioning, competitive markets are characterised by active and informed consumers. Active consumers exert pressure on firms to improve their product and service offerings. Informed consumer choice ensures that consumers are more likely to receive services that they need, and less likely to be inefficiently supplied services from which they do not benefit. This activates competition by rewarding those providers that deliver the best services that most suit their needs. Ultimately, empowered consumers and open competition drive innovation and productivity.

Well functioning markets do not require all consumers to be active and well informed. It is sufficient that some consumers exercise informed choice, or that others exercise informed choice independently on the consumers' behalf. It is key that those consumers that are willing and able to exercise well informed choices have the information to do so.

In relation to healthcare, patients clearly represent a widely diverse population and may differ in the degree to which they value choice and require different types of information on which to base choices.

Information asymmetries represent a significant feature of healthcare markets given that quality is often not directly observable to the patient. This is due to clinical procedures either being experience goods, where a patient may find it difficult to make judgments about the utility or quality of a treatment prior to the procedure being carried out, or credence goods, where a patient cannot make any such judgment even after having the procedure (for example, on whether a diagnostic scan was necessary). In both these cases, the consultant will possess far greater experience and technical information in order to make these judgments.

The following part of this submission describes some of the actions taken in the UK to address information asymmetries in the markets for publicly and privately funded hospital services.

2.2. The role of the GP as an informed agent

GPs play a central role in how patient choices of hospital are made in the UK, acting as an informed agent who determines when secondary care is needed and offers those patients advice on the appropriate treatment that is required. The importance of the GP's role in hospital choice is confirmed in patient interviews conducted by the OFT which showed the large degree of trust and reliance that patients tended to place on their GP's opinion, with many patients seeking to delegate their choice of consultant to their GP. Patient survey data shows that approximately 49% of patients recall being offered a choice of provider, and of these, around 43% said their GP's advice was the most important source of information on which provider to see.

In the UK, GPs referring NHS patients for hospital services may use NHS Choose and Book, a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Effective competition in hospital services requires that the interests of the GP are aligned with those of their patient. Where a GP is independent of all prospective providers of secondary care, the GP has an incentive to act in the best interest of their patients (i.e. consistently with their professional obligations) in advising patients on their choice of provider for acute elective care. In doing so, the GP can benefit through gaining a good reputation and potentially increased business through a larger patient list. The NHS Cooperation and Competition Panel, the body that ensures that patient choice and competition in the NHS is effective and delivers high quality care for patients and value for money for taxpayers, has on a number of occasions investigated arrangements that may compromise the independence of GPs and has put in place measures to ensure that GPs incentives are aligned with the interests of their patients.

2.3. Information on NHS hospitals

The UK Department of Health makes available information on many aspects of NHS hospital services. This information helps patients and their GPs in England to make informed choices and helps to ensure that hospital competition is effective. This information is available in a number of ways, including through the NHS Choices website and the Dr Foster Hospital Report.

NHS Choices is a website that allows patients requiring planned hospital care to search for hospitals in their local area and to find information on many aspects of their services. The website provides feedback from previous patients as well as information from the quality regulator, the CQC. It provides comparable and accessible information on a range of clinical quality indicators (such as the number of weeks free of MRSA and the hospital standardised mortality rate) as well as information on the hospital facilities (such as the cost of car parking).

Dr Foster produces report cards for every NHS hospital based on a traffic light system display and risk adjusted indicators measuring performance across a number of clinical activities. Recently, Dr Foster has been able to produce comparable measures for some procedures (notably knee and hip replacements) undertaken at PH facilities in respect to NHS patient episodes only, and not for PH patient episodes.

In addition to these existing ways of making information available, the government is seeking to bring about an "information revolution" that would ensure that people have the information they need to make informed choices, presented in a way that they can understand. The aim is to provide a range of online services and to make wider use of effective tools like Patient-Reported Outcome measures, patient experience data, and real-time feedback. It intends to enable patients to rate services and clinical departments according to the quality of care they received and staff feedback around the quality of care provided. This is intended to help inform other people with similar conditions to make the right choice of hospital or clinical department and will encourage providers to be more responsive.

2.4. The OFT market study on private healthcare

The OFT market study on private healthcare found, provisionally, a number of features that, individually or in combination, prevent, restrict or distort competition. The OFT provisionally considers that these features impair the ability of patients, GPs and PMI providers to choose between competing service providers, including new entrants, on the basis of superior quality of services to patients and better value for money.

These features include information asymmetries and in particular the OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients, GPs and PMI providers in relation to quality of PH facilities and of consultants. The OFT found that this weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall.

The following section addresses a particular supply side issues that arises in the context of competition in publicly funded hospital services, namely the need to provide integrated care for patients.

3. Supply side - Competition in hospital services and integrated care

One particular issue that arises in relation to competition in NHS hospital services is the need to provide integrated care. One objection that is sometimes raised is that competition implies fragmentation of services that could be dangerous or costly, or both, if an integrated care pathway is desirable to ensure that the patient receives the different elements of care required. This concern relates particularly to the provision of hospital services to people with multiple health conditions or with long term conditions. Integration and competition in hospital services are not necessarily incompatible and as in other markets competition may help to ensure that hospital services are responsive to the patient's needs, even where multiple, integrated hospital services are required.

3.1. Integrated care

Integrated care describes a wide range of situations, from a commissioner's implementation of bundled tariffs to setting up multi-disciplinary teams between health and social care. When commissioners or providers decide to pursue a project of "integrated care" this can involve making changes to one or more of the following:

- the type of care provided;
- the level/amount of care provided;
- the way information flows;
- the way care is delivered;
- the way resources and infrastructure are used;
- the number of locations at which different elements of care are delivered
- the number of providers involved throughout a pathway
- the way care is paid for.

This in turn has effects on the experience of patients who receive that care. The adoption of "integrated care" projects is usually justified by one or multiple of the following aims:

- avoiding duplication;
- minimising waste;
- reducing delays;
- minimising unnecessary discomfort to the patient (or patient group);
- improving the quality of care and service;
- improving health outcomes;
- improving efficiency;
- reducing costs.

3.2. Competition in NHS hospital services and integrated care

Competition in NHS hospital services is one possible mechanism for achieving these outcomes and for delivering integrated care for patients. What patients and commissioners want, and providers will thus have to improve, include many of the aims common to integrated care and listed above (for example, improving quality, minimising unnecessary discomfort to the patient, etc.)

Integrated care may require hospitals to co-operate in the provision of care for the patient. For example, in England many hospitals have formed networks for the treatment of cancer which allow them to

share best practice, to transfer patient records effectively between organisations and to ensure that patients requiring specialist treatment receive care in the specialist hospitals best placed to provide that care. Whilst care must be taken to ensure that such networks do not unnecessarily restrict competition, competition between hospitals in the network, or between networks of hospitals, can be an effective mechanism for ensuring that hospitals have the right incentives to deliver seamless care.

In many instances, integrated care will be a tool which providers can use to improve their competitiveness. Integrated care can both promote competition (for example, a provider will have greater incentive to co-ordinate care provision and improve outcomes as a consequence if can gain patient referrals as a result) and increase competition (for example, the improvement in outcomes of one or a set of providers through the implementation of integrated care will lead to a greater incentive for other providers also to improve outcomes in order not to lose referrals).

4. Conclusion

The demand and supply side issues continue to be the focus of the current debates in the UK related to competition in hospital services for both publicly and privately funded healthcare services. At present publicly funded healthcare services must comply with the Principles and Rules of Co-operation and Competition, which are overseen by an advisory body, the Co-operation and Competition Panel. The Health and Social Care Bill 2011, which is currently passing through Parliament, would establish a new sector specific regulator, Monitor, which would have concurrent powers with the Office of Fair Trading.

UNITED STATES

The competition enforcement agencies of the United States – the Federal Trade Commission ("FTC") and the Antitrust Division of the Department of Justice ("DOJ") (collectively "the Agencies") – have been active in applying competition laws to the health care marketplace, including the hospital industry, for several decades.[1] We are pleased to contribute to this roundtable discussion of whether competition can deliver improvements in the provision of hospital services, and if so, under what regulatory conditions and market structures.

This submission describes the market environment in which hospitals in the United States operate, including competitive and other pressures that hospitals face; the restructuring of the hospital industry that has occurred in recent years, through consolidations and the growth of hospital networks; and recent changes in health care law designed to promote efficiencies, improve quality, and restrain further price increases in the provision of services. The submission also highlights the intensive empirical retrospectives of hospital mergers conducted by FTC staff in recent years, which measure the impacts of consummated mergers on price and quality. Finally, the submission considers the application of competition laws to hospital competition, focusing primarily on how the lessons learned in the hospital merger retrospectives have influenced the Agencies' recent enforcement.

1. Introduction to Structural Conditions in the Hospital Industry[2]

In cities and towns throughout the United States, hospitals are a key part of the health care delivery system. Currently, payments to hospitals for inpatient care account for approximately 33 percent of total health care expenditures in the United States.[3] Expenditures on hospital services have grown over the past three decades, but the rate of spending growth has varied. The federal government's introduction of a prospective payment system in the early 1980's (see discussion in Section II) slowed the rate of hospital expenditure growth. The rise of private sector managed care plans slowed the rate of expenditure growth further; from 1993 through 1998, hospital expenditures increased at an average annual rate of 3.7 percent, and, in some areas of the country, the per diem price of a hospital stay actually decreased. In the past decade, however, rising hospital prices have driven spending on hospitals higher, even though hospital

1 Much of the material in this paper is drawn from Improving Health Care: A Dose of Competition-A Report by the Federal Trade Commission and the Department of Justice (2004) [hereinafter Improving Health Care Report], http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

2 The introductory sections of this paper are taken largely from the Agencies' 2005 submission to the OECD Roundtable on Competition to Promote Efficiency in the Provision of Hospital Services (Oct. 17, 2005), http://www.ftc.gov/bc/international/docs/compcomm/2005--Hospitals.pdf. These sections have been updated to reflect current conditions.

3 Centers for Medicare & Medicaid Services ("CMS"), Office of the Actuary, National Health Statistics Group, "National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2009" (2011), https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.

utilization has leveled off.[4] As discussed below, analysts attribute rising hospital prices to a variety of factors, including hospitals' increasing ability to negotiate higher prices from private payers.[5]

By way of background, hospitals in the United States vary by the types of services they offer, ranging from specialty hospitals that treat only a single type of patient (pediatric and women's hospitals) or condition (cardiac, orthopedic, psychiatric and rehabilitation hospitals) to "general acute care hospitals," which treat a variety of acute medical conditions. Hospitals that provide general acute care services may or may not also offer treatments such as long term rehabilitation, psychiatric care, or substance abuse care. Hospitals also vary in the sophistication of the services they offer, ranging from the most basic hospital services, to the most sophisticated, cutting edge procedures.

Hospitals in the United States are also differentiated by their ownership structure into one of three categories: (1) non-profit (58 percent of hospitals); (2) for-profit (20 percent of hospitals); and (3) governmentally owned (or "public") (22 percent of hospitals).[6] Although these classifications might appear mutually exclusive and immutable, they are not. Many non-profit hospitals own for-profit institutions or have for-profit subsidiaries. Similarly, for-profit systems often manage non-profit and publicly owned hospitals. Hospitals also may change their institutional status. Even without changing their status, hospitals that previously have not competed in the marketplace can choose to do so. For example, some states have granted local governments broad authority to determine how public hospitals under their control will be operated. Relying on that authority, public hospitals are increasingly entering into competition with private hospitals.[7]

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4 See Margaret Jean Hall et. al., "National Hospital Discharge Survey: 2007 Summary" (Oct. 2010), http://www.cdc.gov/nchs/data/nhsr/nhsr029.pdf.

5 See William B. Vogt & Robert Town, "How has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Robert Wood Johnson Foundation Research Synthesis Report No. 9 (Feb. 2006), http://www.rwjf.org/files/research/15231.hospitalconsolidation.report.pdf; Laura Summer, "Integration, Concentration, and Competition in the Provider Marketplace," Academy Health Research Insights Brief (Dec. 2010), http://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf.

6 http://www.aha.org/research/rc/stat-studies/fast-facts.shtml.

7 Authorizing health care statutes in several states, including Michigan, Kentucky, and Ohio, have granted local governments the broad power to operate hospitals. Mich. Comp. Laws Ann. §§ 331.1301(g) et seq.; Ky. Rev. Stat. § 216.335(6); and Ohio Rev. Code § 339.06 (boards of municipal hospital corporations in Ohio "shall have the entire management and control of the hospital, and shall establish such rules for its government and the admissions of persons as are expedient"). The purpose behind many of these broad grants of authority has been to remove the legal constraints upon the operation of public hospitals that inhibit their ability to compete with private hospitals. *See*, e.g., *Surgical Care Ctr. of Hammond v. Hospital Serv. Dist. No. 1 of Tangipahoa Parish*, 171 F.3d 231, 235 (5th Cir. 1999) (en banc) (Louisiana statutes granted additional powers to hospital service districts so they could compete with other entities on a level playing field); *Jackson, Tenn. Hosp. Co. v. West Tenn. Healthcare, Inc.*, 414 F.3d 608, 610 (6th Cir. 2005) (Tennessee statutes intended to remedy a competitive disadvantage of some public hospitals by removing certain legal constraints upon their operations and giving them the same operating and organizational powers enjoyed by private hospital authorities).

2. Contracting and Competition Mechanisms

2.1. Public Payors

Federal and state governments are responsible for almost 55 percent of national expenditures on hospital care.[8] A substantial share of hospital spending is provided by the Federal Centers for Medicare & Medicaid Services (CMS), chiefly for care of the elderly. Each state also has a Medicaid program, which pays for care provided to the poor and disabled. Within broad guidelines established by Federal law, each state sets its own payment rates for Medicaid services and administers its own program.

Prior to 1983, CMS and most other insurers paid hospitals on a cost-based reimbursement system. Under the cost-based reimbursement system, hospitals informed payors of the cost of the care that was provided, and payors reimbursed hospitals for those amounts. The cost-based payment system led to substantial increases in health care spending over time. An important initial effort to curb these increases in spending was launched in 1983, when CMS implemented a prospective payment system for inpatient care.

2.1.1. Prospective Payment Systems

Under the prospective payment system CMS uses for inpatient care (IPPS), the payment that a hospital receives for treating a patient is based on the diagnosis-related group (DRG) that justified the episode of hospitalization. Each DRG has a payment weight assigned to it, based on the average cost of treating patients in that DRG.[9] The hope is that, by receiving a predetermined amount, hospitals will have reduced incentives to use more resources than are necessary to treat patients. The IPPS was intended to moderate rising federal expenditures, create a more "competitive, market-like environment, and curb inefficiencies in hospital operations engendered by reimbursement of incurred cost."[10] Further changes to this system were provided for in the Affordable Care Act of 2010. For example, the act provides for bundled payments by CMS for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement. CMS views this as a way to encourage doctors, hospitals and other health care providers to work together to better co-ordinate care for patients both when they are in the hospital and after they are discharged.[11] Such initiatives can help improve patient health, improve the quality of care, and lower costs.

2.1.2. The Impact of Government Purchasing

As the largest purchaser of health care in the United States, CMS has tremendous influence in the market for medical services, and providers are extremely responsive to the incentives created by CMS. Prior to the adoption of the IPPS, average hospital length-of-stay had been stable for seven years. Once IPPS went into effect, the length-of-stay began an immediate decline.

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8 *See* http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf at Table 7. Because private insurance tends to cover a younger and typically healthier population, it accounts for a smaller share of overall health care spending.

9 The average reimbursement for each DRG is derived from an analysis of the costs of treating both the very ill patients who require more intensive care for a particular DRG, and the "healthier" ill, who do not cost as much to treat.

10 Gregory C. Pope, "Hospital Nonprice Competition and Medicare Reimbursement Policy," 8 J. Health Econ. 147 (1989).

11 *See* CMS, "Bundled Payment for Care Improvement Initiative" (Aug. 23 2011), http://innovations.cms.gov/documents/pdf/Fact-Sheet-Bundled-Payment-FINAL82311.pdf.

There are limitations, however, to CMS's ability to create incentives that encourage price and non-price competition among providers. CMS does not have the freedom to respond to changes in the marketplace as do many private purchasers. For example, CMS has only limited authority to contract selectively with providers or to use competitive bidding to meet its needs. With a few exceptions, CMS cannot require providers to compete for CMS's business or encourage suppliers to reduce their costs and enhance their quality by rewarding them with substantially increased volume or substantially higher payments if they do.

One Medicare program that has generated competitive incentives for providers is a managed care option, the Medicare Advantage (MA) program. MA programs provide Medicare beneficiaries with a range of managed care options, including health maintenance organizations and preferred provider organizations. Medicare beneficiaries who have joined MA plans have often received greater benefits (e.g., prescription drug coverage) in exchange for accepting limits on their choice of providers. Nevertheless, these plans are new and have limited acceptance among Medicare participants, but acceptance is growing and enrollment is greater in urban as opposed to rural areas. In 2009, MA plans provided health care to 10.2 million Medicare beneficiaries, nearly double the number of enrollees as in 2003.[12]

Generally, however, CMS's payment systems do not reward higher quality care, or punish lower quality care. All providers that meet basic requirements are paid the same regardless of the quality of service provided. To be sure, such issues are not unique to Medicare but confront private payors as well. Indeed, health care policy experts note that current fee-for-service compensation models provide little financial reward for improvements in the quality of health care delivery.[13]

Recent changes in U.S. health care law, namely the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the ''Affordable Care Act''), seek to improve the quality and reduce the costs of health care services in the U.S. by, among other things, encouraging physicians, hospitals, and other health care providers to become accountable for a patient population through integrated health care delivery systems.[14] One delivery system reform is the Affordable Care Act's Medicare Shared Savings Program (the ''Shared Savings Program''), which promotes the formation and operation of Accountable Care Organizations (''ACOs'') to serve Medicare fee-for-service beneficiaries. [15] Under this provision, ''groups of providers of services and suppliers meeting criteria specified by the [Department of Health and Human Services] Secretary may work together to manage and co-ordinate care for Medicare fee-for-service beneficiaries through an [ACO].''[16] An ACO may share in some portion of any savings it creates if the ACO meets certain quality performance standards established by the Secretary of Health and Human Services through CMS. The Affordable Care Act requires an ACO that wishes to participate in the Shared Savings Program to enter into an agreement with CMS for not less than three years.[17]

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12 *See* Medicare Advantage Fact Sheet (Apr. 2009), http://www.kff.org/medicare/upload/2052-12.pdf.

13 Institute of Medicine Workshop Series Summary, "The Healthcare Imperative: Lowering Costs and Improving Outcomes," (2010) at 359, http://www.iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx.

14 Health Care and Education Reconciliation Act of 2010, Public Law 111–52, 124 Stat. 1029 (2010); Patient Protection and Affordable Care Act, Public Law 111–48, 124 Stat. 119 (2010).

15 Patient Protection and Affordable Care Act 3022, 124 Stat. at 395–99.

16 *Id.* at 395.

17 *Id.* at 396.

Recent commentary suggests that some health care providers are likely to create and participate in ACOs that serve both Medicare beneficiaries and commercially insured patients.[18] The Agencies recognize that ACOs may generate opportunities for health care providers to innovate in both the Medicare and commercial markets and achieve for many other consumers the benefits Congress intended for Medicare beneficiaries through the Shared Savings Program – improved quality of care and lower health care costs. Such integration, however, also can increase market power and could injure competition. Therefore, to maximize and foster opportunities for ACO innovation and better health for patients and to ensure that the antitrust laws are not perceived as a barrier to procompetitive integration, the Agencies recently issued a statement clarifying their enforcement policy regarding collaborations among independent providers that seek to become ACOs in the Shared Savings Program.[19] The Agencies' policy statement describes (1) the ACOs to which the Policy Statement will apply;[20] (2) when the Agencies will apply rule of reason treatment to those ACOs; (3) an antitrust safety zone; and (4) additional antitrust guidance for ACOs that are outside the safety zone, including a voluntary expedited antitrust review process for newly formed ACOs.[21]

2.2. Private Third-Party Payors

The second largest source of payment for hospital services is payments from private health insurance plans. Private health insurance is obtained primarily through benefits offered by employers, but is also available through other types of groups and through individual purchases from insurance companies. These payors are collectively referred to as third-party payors. Included in this category are employers who self-insure their employees' medical costs, but hire an insurance company to administer the health insurance benefits, including negotiating prices with hospitals for services covered by the employer's plan.

Third-party payors typically contract directly with hospitals to provide services to the patients covered under the payors' plan(s), and the prices are negotiated directly between the payor and the hospital.[22] The

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18 Fed. Trade Comm'n & Dep't of Health and Human Serv., Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty (CMP) Laws (Oct. 5, 2010).

19 Fed. Trade Comm'n & Dep't of Justice, "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," 76 Fed. Reg. 67,026 (2011).

20 The analytical principles underlying the Policy Statement also would apply to various ACO initiatives undertaken by the Innovation Center within CMS as long as those ACOs are substantially clinically or financially integrated.

21 The Policy Statement provides guidance to assist ACOs in determining whether they are likely to present competitive concerns. It does not reflect the full analysis that the Agencies may use in evaluating ACOs or any other transaction or course of conduct.

22 Contracting between hospitals and private payors has sometimes been contentious. Some hospital industry observers claim that hospital systems routinely "terminate then negotiate" for large increases in reimbursement, and use the media to scare the public. *Improving Health Care Report*, *supra* note 1, Chapter 3, at 31-35. They also state that hospital systems insist that all hospitals in the system be included in a payor network ("all or nothing contracts"), irrespective of whether the payor actually wants to include the entire hospital system. *Id.* Hospital representatives claim that they are protecting their institutions' interests and that their services had been artificially and unsustainably underpriced in the past. *Id.* These dynamics have played out in several markets during the past few years. Although commentators have noted that particular hospitals and hospital systems seem to have the upper hand in some markets, whether hospitals or health plans have bargaining advantages varies substantially within and among different markets.

most common payment schemes are per diem rates, per case rates, or discounts-off-charges rates. Under a per diem rate, the third-party payor pays the hospital a fixed price for each day of hospital care without regard to the actual diagnosis of the patient or the resources the hospital uses in the treatment. Under a per case rate, the third-party payor pays the hospital a fixed price for the hospital stay for a particular type of case, regardless of the number of days the patient stays or the resources the hospital uses in the treatment. Under a discount-off-charges rate, also called a percentage-of-charges rate, the third party payor pays a percentage of the hospital's "charges" for the hospital stay, where the "charges" are the prices the hospital charges for each resource used in treating the patient.

In some instances, private payors have copied Medicare's reimbursement strategies or used Medicare DRGs as a reference price for reimbursement negotiations with hospitals. Thus, some payors negotiate either a specified discount or a specified payment relative to the amount CMS would pay for a specified treatment episode. Outpatient payment provisions, where the hospital does not provide an overnight stay for the patient, are typically structured on a percentage-of-billed charges or a fee-schedule basis.

Generally speaking, payors seek to contract with hospitals that contribute to the marketability of their insurance products.[23] Factors that affect marketability include: the price of coverage; the number of hospitals at which care can be provided; the perceived quality, desirability, location, and accessibility of those institutions; and the alternative insurance products that are available in the market. Payors seek to balance the price of the hospital services they must purchase to offer insurance coverage against the desirability of the resulting network to the purchasers of their insurance products. If patients view several hospitals as adequate substitutes for one another, it will be easier for the payor to threaten credibly to exclude one or more of these hospitals. Conversely, if enrollees will drop an insurance plan if their preferred hospital is no longer in its network, the hospital will find it easier to insist on higher reimbursement. These competitive dynamics are illustrated below in Section IV.C.2, which discusses the FTC Administrative Law Judge's recent decision finding that the merger of ProMedica Health System and St. Luke's Hospital in Lucas County (Toledo), Ohio was unlawful, in part, because it increased the hospital system's bargaining leverage in negotiations with payors.

2.2.1. Consumer Price Sensitivity and Information

The lack of consumer information about the costs of hospital services and lack of incentives for the consumer to choose the most cost-effective hospital makes it more difficult for payors to exclude high-priced, but otherwise desirable hospitals from the payors' health plans. Insured consumers often have only a vague idea of the price of the medical services they receive, and insurance largely insulates them from the financial implications of their medical treatment.[24] Consumers who pay the same co-payment, regardless of the price of the treatment they receive, have no reason to inquire into the price of the treatment, or to factor that price into their decisions. Consumers who have co-payments that vary depending on where they receive care will focus on the differing amounts of the co-payment, but not on the total price of the services they receive. Even if consumers become motivated to know the total price of the care they receive, they will find it extremely difficult to obtain that information.[25] Proposals to increase

23 *See generally* Gregory Vistnes, "Hospital, Mergers and Two Stage Competition," 67 Antitrust L. J. 671, 674 (2000). A marketable network is one that is not too expensive and includes hospitals that enrollees and plan physicians want. Complex rules can make a plan less marketable.

24 Herbert Simon, "A Behavioral Model of Rational Choice," in MODELS OF MAN (1957).

25 *See* Uwe E. Reinhardt, "Can Efficiency in Health Care Be Left to the Market?" 26 J. Health Pol., Pol'y & L. 967, 986 (2001) ("[O]ne need only imagine a patient beset by chest or stomach pain in Anytown, USA, as he or she attempts to 'shop around' for a cost-effective resolution to those problems. Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information

consumer price sensitivity must confront this reality, and policy makers must develop strategies to increase the transparency of hospital pricing.[26] As discussed below, insurers appear to be using tiering increasingly as one way to deal with this problem.

2.2.2. Hospital Tiering – A Competitive Response to Market Conditions

Consumer pressure for broader or open networks has made it more difficult for payors to exclude entire hospital systems from their plans, affecting the bargaining dynamics. In some markets, payors have responded by seeking to "tier" hospitals. Tiering is a payor reimbursement method whereby consumers incur different co-payments (i.e., high or low cost sharing) depending on the hospital at which the consumer chooses to have care provided. Tiering generally does not apply to emergency admissions and may depend upon where routine and specialty services are offered.

For payors, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payor network. Tiering allows the payor to maintain a broad network, and include a "must-have" hospital in its plans, but simultaneously creates an incentive for consumers to use lower-cost providers. Some hospitals resist tiering, and with sufficient bargaining power, they can credibly threaten to withdraw from a payor network if they are placed in an unfavorable tier. In some markets, hospital systems have taken pre-emptive steps to negotiate contract language with payors that prohibit tiering. Because tiering is a relatively new development, there are, as yet, no systematic studies available on the prevalence or consequences of this strategy.

3. Restructuring of the Hospital Industry

3.1. Background on the Consolidation Trend

Over the past 30 years, many hospitals have consolidated into multi-hospital systems.[27] While in 1979, only about 31 percent of hospitals were part of a multi-hospital system, by 2001 almost 54 percent of hospitals operated as part of a system, with an additional 12.7 percent in looser health care networks. Initially, consolidations involved national systems acquiring hospitals throughout the United States, but recent acquisitions have been more localized.[28] Experts predict that in the U.S., the 2010 changes in the health care law, which created incentives for health care providers to establish integrated care organizations (ACOs), and several other factors, including the need for capital to finance facility

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infrastructure on which the theory of competitive market and the theory of managed care rest. The prices of health services are jealously guarded proprietary information.").

26 Health savings accounts represent a recent attempt to require consumers to bear some of the increased expenses associated with receiving care at a more expensive hospital. A health savings account provides the consumer with a fixed sum of money to pay for the consumer's portion of their health care costs. If, in a given year, the consumer does not use all of the money, the consumer retains the money for future use. Health savings accounts attempt to raise consumer sensitivity to the costs associated with their health care decisions. For this strategy to work effectively, however, consumers need access to good information about the price and quality of the services among which they must choose. Without good information about the actual prices charged by different hospitals, a consumer facing a 25 percent co-payment at one hospital and a 15 percent co-payment at another cannot accurately assess the financial consequences of choosing one hospital over the other.

27 *See* Vogt, *supra* note 5; Summer, *supra* note 5; Deborah Haas-Wilson, MANAGED CARE AND MONOPOLY POWER: THE ANTITRUST CHALLENGE 28 (2003).

28 David Dranove & Richard Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," 22 J. Health Econ. 983, 984 (2003); Alison Evans Cuellar & Paul J. Gertler, "Trends in Hospital Consolidation: The Formation of Local Systems," 22 Health Affairs 77, 80 (Nov./Dec. 2003).

modernization and the benefits of increased bargaining power, will continue to drive consolidation in the sector.[29] Consolidation can take a number of forms. At one end of the spectrum, consolidated hospitals may share a license and have common ownership, report unified financial records, and eliminate duplicative facilities. At the other end, a common governing body may own the consolidated hospitals, but the hospitals maintain separate hospital facilities, retain individual business licenses, and keep separate financial records. A related recent trend is the growth of hospital employment of physicians. Some studies suggest that hospital employment of physicians, including hospitals acquiring independent physician groups, has accelerated in recent years as hospitals aim to increase market share and revenue.[30]

Some observers of the hospital industry assert that hospital consolidations have provided opportunities for hospitals to compete more efficiently, improved the quality of care, and limited duplication of services and administrative expenses.[31] Others, including many payors, believe that the creation of multi-hospital systems have been motivated by hospitals' desire to gain market power, secure higher reimbursement from payors, and impose other onerous requirements on payors, e.g., "all-or-nothing" contracting.[32] The development of hospital networks, through common ownership, or other affiliations among hospitals, may play a significant role in the evolution of hospital markets. If hospital networks do not include significant integration among the member hospitals, for example, if they are simply "virtual networks" with no integration or real common ownership and are formed merely to set prices collectively, they run the risk of being challenged as illegal combinations under the antitrust laws. Most studies of the relationship between competition and hospital prices generally find that increased hospital concentration is associated with increased prices.[33]

3.2. Certificate of Need (CON) Programs – Entry Limitations

A factor influencing the restructuring of the hospital industry has been the presence or absence of certificate of need (CON) laws or regulations in particular states. CON programs, initially adopted when cost-plus reimbursement was the norm, were intended to control costs by restricting provider capital expenditures. State CON programs generally prevent firms from entering certain areas of the health care

29 *See e.g.,* James C. Robinson, "Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology," The American Journal of Managed Care, 17(6):e241-8 (2011); Summer, *supra* note 5; *see also* Moody's Investor Service. Special Comment, "For-Profit Investment in Not-for-Profit Hospitals Signals More Consolidation Ahead" (Apr. 2010), http://content.hcpro.com/pdf/content/250770.pdf.

30 *See* Ann S. O'Malley, et. al., "Rising Hospital Employment of Physicians: Better Quality, Higher Costs?" Center for Studying Health System Change Issue Brief (Aug. 2011), http://www.hschange.com/CONTENT/1230/1230.pdf; Summer, *supra* note 5.

31 *See* Vogt, *supra* note 5; Summer, *supra* note 5.

32 *See e.g.,* Robinson, *supra* note *29;* Moody's Investor Service. Special Comment, *supra* note 29

33 *See infra* Section IV.B. on the FTC's Hospital Merger Retrospective; David Dranove et al., "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," 36 J.L. & Econ. 179, 201 (1993) (finding that market concentration in California led to rate increases); Glenn A. Melnick et al., "The Effect of Market Structure and Bargaining Position on Hospital Prices," 11 J. Health Econ. 217 (1992) (finding market concentration appears to increase hospitals' bargaining power with insurers and self-insurers); Ranjan Krishnan, "Market Restructuring and Pricing in the Hospital Industry," 20 J. Health Econ. 213, 215 (2001) (mergers that increase hospital market share in specific hospital services, as measured in 33 DRGs, show a corresponding increase in prices of those services).

market unless they can demonstrate to state authorities that there is an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.[34]

3.2.1. Competitive Concerns Raised by CON Programs

CON regimes prevent new health care entrants from competing without a state-issued certificate of need, which is often difficult to obtain. Their effect is to shield incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is depressed below competitive levels. Moreover, CON programs can retard entry of firms that could provide higher quality services than the incumbents. By protecting incumbents, CON programs likewise can delay the introduction and acceptance of less costly, more innovative treatment methods. Similarly, CON programs that curtail services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payors. Empirical studies confirm that CON programs generally fail to control costs and can actually lead to increased prices.[35]

3.2.2. CON and Cost Control

Commentators note that the reason that CON restrictions have been ineffective in controlling costs is that they do not put a stop to supposedly unnecessary expenditures but merely redirect any such expenditures into other areas.[36] Thus, a CON rule that restricts capital investment in new beds does nothing to prevent hospitals from adding other kinds of high-tech equipment and using it to compete for consumers.

Furthermore, CON programs can provide hospitals with a forum in which to engage in anticompetitive conduct. For example, in 2005, the Justice Department charged two competing West Virginia hospitals with using the state CON program as a mechanism for developing an illegal service allocation agreement, in which one hospital agreed not to offer cardiac surgery in return for the other hospital not offering cancer services.[37]

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34 *See* John Miles, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES AND PRACTICE § 16:1, at 16-2, 16-5 to 16-6 (2003); James F. Blumstein & Frank A. Sloan, "Health Planning and Regulation Through Certificate of Need: An Overview," 1978 Utah L. Rev. 3; Randall Boybjerg, "The Importance of Incentives, Standards, and Procedures in Certificate of Need," 1978 Utah L. Rev. 83; Clark C. Havighurst, "Regulation of Health Facilities and Services by 'Certificate of Need'", 59 Va. L. Rev. 1143 (1973).

35 *See* Daniel Sherman, Federal Trade Comm'n, "The Effect of State Certificate-of-Need Laws On Hospital Costs: An Economic Policy Analysis" (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, "Competition Among Hospitals" 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); Keith B. Anderson & David I. Kass, Federal Trade Comm'n, "Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis" (1986) (economic study finding that CON regulation led to higher costs and did little to further economies of scale).

36 *Improving Health Care Report* , *supra* note 1, Chapter 8, at 1-6.

37 Press Release, U.S. Department of Justice, "Justice Department Requires Two West Virginia Hospitals To End Illegal Market-Allocation Agreements" (Mar. 21, 2005) http://www.usdoj.gov/atr/publis/press_releases/2005/208209.htm.

For all these reasons, the Agencies believe that CON programs are generally not successful in containing health care costs and can pose anticompetitive risks.[38] Therefore, the Agencies have urged states with CON programs to reconsider whether the continuation of such programs best serves their citizens' health care needs.[39]

3.3. Development of Specialty Hospitals and Ambulatory Surgery Centers

Competition in the U.S. hospital industry is impacted by specialty hospitals and ambulatory surgery centers. Specialty hospitals are facilities that provide inpatient services in a particular medical specialty such as pediatric, rehabilitation, psychiatric, cardiac and orthopedic surgery hospitals.[40] Single specialty hospitals ("SSHs") may compete with both inpatient and outpatient general hospital surgery departments as well as with ambulatory surgery centers. Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of ASCs are single specialty facilities,[41] including gastroenterology, orthopedics, or ophthalmology. Many SSHs and ASCs are owned, at least in part, by physicians.

Observers have identified a number of market developments that have encouraged the emergence of SSHs and ASCs, including: improved technology; less tightly managed care; the willingness of providers to invest in an SSH or ASC; physicians' desire to provide better, more timely patient care; physicians looking for ways to supplement declining professional fees; and the growth of health care provider entrepreneurs.[42]

Supporters of SSHs and ASCs argue that these facilities can benefit the quality of care patients receive and help to restrain health care costs. Among the asserted benefits of SSHs are better outcomes and important disease management and clinical standards, achieved as a result of focusing on a single area of medical specialty and performing increased volumes of procedures. ASCs require less capital than SSHs, and are generally less difficult to develop because they do not require the facilities or support services needed to offer care twenty-four hours a day, seven days a week. ASCs generally do not have emergency departments, and CON regulations, if they apply at all, often are not as rigorous for ASCs.[43]

Some, however, express concerns about SSHs and ASCs. Critics of SSHs note that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care.[44] Such critics believe this gives SSHs an unfair competitive advantage over 24-hour hospitals with

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38 See e.g. Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform, "Competition in Health Care and Certificates of Need," (Sept. 15, 2008) http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf.

39 *Id.*

40 There are still relatively few SSHs. In 2003, the General Accounting Office (GAO) identified 100 existing SSHs with an additional 26 under development.

41 The number of ASCs has doubled in the past decade, and they currently total more than 5,000. U.S. Department of Health and Human Services, "Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan," http://www.cms.gov/ASCPayment/downloads/C_ASC_RTC%202011.pdf.

42 *Improving Health Care Report, supra* note 1, Chapter 3, at 17-27.

43 *Id.*

44 *Id.*

emergency departments.[45] Other critics of SSHs and ASCs are concerned that SSHs and ASCs siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross-subsidize other socially valuable, but less profitable, care.[46]

Others concerned about SSHs and ASCs suggest that physicians with an ownership interest in an SSH or an ASC have an incentive to over-refer patients to those facilities to maximize their income.[47] The Affordable Care Act of 2010 continues to ban Medicare payments to SSHs, specifically prohibiting the referral of Medicare beneficiaries by physician owners or investors to new physician-owned hospitals or to existing physician-owned hospitals that have expanded their facility capacity beyond their baseline.

4. Hospital Merger Analysis

4.1. Overview

While the Agencies have wide jurisdiction over anticompetitive conduct in the hospital industry,[48] most of the cases brought by the Agencies have involved mergers. Because preservation of hospital competition is vital to health care cost containment, both Agencies maintain vigorous enforcement programs to scrutinize hospital mergers for their potential effects on competition. The Agencies have a long history of such scrutiny, which has on occasion led to their challenging particular hospital mergers. Most hospital mergers and acquisitions, however, do not present competitive concerns.

The Agencies analyze hospital mergers using the same analytical framework they use for other mergers, following the 2010 Horizontal Merger Guidelines ("Merger Guidelines"). The Merger Guidelines specify that "mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise."[49] In applying the Merger Guidelines to hospital mergers, particular issues have arisen with respect to the definition of product and geographical markets. In addition, some questions have been raised about whether the non-profit ownership structure of many hospitals should alter the Merger Guidelines analysis.

The Agencies prevailed in some early challenges to hospital mergers,[50] and also obtained a number of consent decrees, allowing multiple hospital mergers to proceed, subject to requirements that certain

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45 A 2003 GAO study analyzed whether SSHs provided care to Medicare and Medicaid patients. The study found that there were modest differences between the percentage of Medicare and Medicaid patients who received treatment at general hospitals and SSHs. U.S. General Accounting Office, GAO-04-167, "Specialty Hospitals: Geographic Locations, Services Provided and Financial Performance" (2003), http://www.gao.gov/new.items/d04167.pdg. There were larger differences in the frequency of emergency departments (ED) at SSHs and general hospitals. In particular, 92 percent of general hospitals had an ED, while 72 percent of cardiac hospitals, 50 percent of women's hospitals, 39 percent of surgical hospitals, and 33 percent of orthopedic hospitals had an ED. *Id.*

46 *Improving Health Care Report*, *supra* note 1, Chapter 3, at 17-27.

47 *Id.*

48 With some minor exceptions, the Federal Trade Commission does not have jurisdiction over the conduct of nonprofit hospitals outside of merger review. The Antitrust Division is not so limited in its jurisdiction.

49 U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines § 1 (Aug. 2010) [hereinafter Merger Guidelines], http://www.ftc.gov/os/2010/08/100819hmg.pdf.

50 *See, e.g.*, *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986); *American Med. Int'l, Inc.*, 104 F.T.C. 1 (1984), as modified by, 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986).

hospitals be divested.[51] However, in the 1990s, courts rejected the Agencies' (and state attorneys' general) attempts to prevent mergers between hospitals that the Agencies claimed would reduce competition.[52] This string of losses led the FTC to launch its Hospital Merger Retrospective Project.

4.2. FTC Hospital Merger Retrospective Project

In April 2002, the Federal Trade Commission announced the Hospital Merger Retrospective Project (HMRP), a joint Bureau of Competition/Bureau of Economics initiative to study consummated hospital mergers "to determine whether particular hospital mergers have led to higher prices."[53] As described by then-FTC Chairman Timothy Muris in a speech given in the Fall of 2002, the HMRP had two objectives: to allow the Commission to "consider bringing enforcement actions against consummated, anticompetitive hospital mergers"[54] and "to update [the Commission's] prior assumptions about the consequences of particular transactions and the nature of competitive forces in health care."[55] Four consummated hospital mergers were selected for intensive study: the 1998 acquisition of Cape Fear Memorial Hospital by New Hanover Regional Medical Center in Wilmington, North Carolina (New Hanover/Cape Fear); Sutter Health's 1999 acquisition of Summit Medical Center, which combined Summit in Oakland, California with Sutter's Alta Bates Medical Center in Berkeley, California (Summit/Alta Bates); Evanston Northwestern Healthcare's 2000 purchase of Highland Park Hospital in the North Shore suburbs of Chicago (Evanston/Highland Park); and the 2000 merger of Victory Memorial Hospital and Provena St. Therese Medical Center in Waukegan, Illinois (Victory/St. Therese). As discussed below, the Evanston/Highland Park retrospective led to an administrative challenge and the ultimate determination that the acquisition was anti-competitive**.** The results of all four retrospective studies were published in early 2011.[56]

The HMRP led to three important insights about the nature of hospital competition and the competitive effects of hospital mergers that have influenced the Commission's recent hospital antitrust enforcement.[57] First, the HMRP illustrated that the methods used by the courts to define geographic

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51 *Columbia/HCA Healthcare Corp./Healthtrust, Inc. - The Hosp. Co.*, 120 F.T.C. 743 (1995) (consent order); *Healthtrust, Inc. - The Hosp. Co./Holy Cross Health Servs. of Utah*, 118 F.T.C. 959 (1994) (consent order); *Columbia Healthcare Corp./HCA-Hosp. Corp. of Am.*, 118 F.T.C. 8 (1994) (consent order).

52 *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo. June 9, 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000), *amended by* 130 F. Supp. 2d 1109 (N.D. Cal. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 2006), *aff'd per curiam*, 121 F.3d 708 (6th Cir. 1997); *United States v. Mercy Health Servs. & Finley Tri-States Health Group, Inc.*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

53 "Building a Strong Foundation: The FTC Year in Review," Federal Trade Commission, April 2002, page 9, http://www.ftc.gov/os/2002/04/ftcyearreview.pdf.

54 *Id.* at 9.

55 "Everything Old is New Again: Health Care and Competition in the 21st Century," prepared remarks of Chairman Timothy Muris before the 7th Annual Competition in Health Care Forum, Chicago, IL, (Nov. 7, 2002), pages 19-20, [hereinafter Muris remarks] http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf.

56 Deborah Haas-Wilson and Christopher Garmon, "Hospital Mergers and Competitive Effects: Two Retrospective Analyses," 18 Int'l J. of the Econ. of Bus. 17 (2011); Steven Tenn, "The Price Effects of Hospital Mergers: A Case-Study of the Sutter-Summit Transaction," 18 Int'l J. of the Econ. of Bus. 65 (2011); Aileen Thompson, "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," 18 Int'l J. of the Econ. of Bus. 91-101 (2011).

57 Orley Ashenfelter, et. al., "Retrospective Analysis of Hospital Mergers," 18 Int'l J. of the Econ. of Bus. 5 (2011).

markets in past hospital merger challenges can lead to markets that are overly broad, mistakenly implying that some anticompetitive hospital mergers are innocuous. In the hospital merger challenges of the 1980s and 1990s, courts relied on the Elzinga-Hogarty (EH) test to establish the boundaries of hospital geographic markets. The EH test posits that a relevant antitrust geographic market can be defined as an area for which the product flows into and out of the area are sufficiently small. In the context of hospital mergers, the first step of implementing the EH test is to designate a circle or group of zip codes that contain both of the merging hospitals. If most of the patients treated at the hospitals in this area also reside in this area (i.e., the inflows are small) and most of the patients residing in this area seek treatment at hospitals in the area (i.e., the outflows are low), then the area is an EH market. The thresholds used by the courts to define flows that are sufficiently small range from 10 to 25 percent. If either the inflows or outflows exceed the threshold, the market is expanded (usually by adding adjacent zip codes) and the inflows and outflows are recalculated until an area is obtained with inflows and outflows both below the threshold.

Some economists have long argued that the use of the EH test in hospital merger cases is inappropriate and leads to geographic markets that are too broad, especially in and around urban areas where the inflows are typically large, as rural and suburban patients seek care at the larger hospitals in the city.[58] Courts using the EH test in hospital merger cases have, in some cases, defined geographic markets that are over 100 miles in diameter.[59] However, before the HMRP, there was little empirical evidence to support the claim that the EH test results in markets that are too broad. The Summit/Alta Bates retrospective found that the post-merger price increase at Summit Medical Center "was among the largest of any comparable hospital in California, indicating this transaction may have been anticompetitive."[60] Employing the EH test in this case, the court ruled that the relevant geographic market was the entire San Francisco-Oakland metropolitan statistical area (MSA), implying that there would be sufficient post-merger competition and little risk of a post-merger price increase.[61] The Evanston/Highland Park retrospective found that "relative to other [control] hospitals, the merger between Evanston Northwestern and Highland Park Hospital led to large and statistically significant post-merger price increases."[62] Had the EH test been applied in this case, it likely would have resulted in a geographic market of the entire Chicago MSA, implying little risk of a post-merger price increase.[63] Thus, the HMRP provided examples of hospital mergers in urban and suburban areas that led to significant post-merger price increases, contradicting the predictions of analyses based on EH-based market definitions. In the Evanston/Highland Park case, the Commission rejected the use of the EH test to define the relevant geographic market.[64]

Second, the HMRP illustrated that non-profit hospitals do not necessarily abstain from exercising market power gained from a merger. The significance of a hospital's institutional form (non-profit versus for-profit) to competition analysis has been a long-disputed issue in hospital merger cases. In antitrust

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58 Cory S. Capps, et. al., "Antitrust Policy and Hospital Mergers: Recommendations for a New Approach," The Antitrust Bulletin, 677 (Winter 2002); Gregory J. Werden, "The Limited Relevance of Patient Migration Data in Market Delineation for Hospital Merger Cases," 8 J. Health Econ. 363 (1989).

59 *United States v. Carilion Health Systems*, 707 F. Supp. 840 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir.).

60 Tenn, *supra* note 56.

61 *California v. Sutter Health Sys.*, 130 F. Supp. at 1109 (N.D. Cal. 2001).

62 Haas-Wilson and Garmon, *supra* note 56.

63 In Evanston, the Commission rejected the Elzinga-Hogarty test for use in geographic market definition. *In the Matter of Evanston Northwestern Healthcare Corp*., Dkt. No. 9315 (Opinion of the Commission Aug. 2007) [hereinafter Evanston Opinion] at 77.

64 *Id.*

merger analysis the relevant question is not whether non-profit hospitals behave in a manner indistinguishable from for-profit institutions, but whether they would use merger-created market power in ways harmful to consumers. Some courts and analysts have taken the position that even if nonprofit hospitals achieve market power through merger, their long-term public interest missions will prevent them from raising prices above competitive levels. In the Butterworth and Carilion hospital merger challenges,[65] the courts took this position and ruled for the defendants in both cases due at least in part to the hospitals' nonprofit designations. These courts found that because of their non-profit designations, and their boards made up of community leaders, the merged hospitals would not pass on supracompetitive price increases to consumers even if the merger resulted in market power for the combined hospitals. In the HMRP, the Summit/Alta Bates and Evanston/Highland Park transactions both involved non-profit hospitals. The evidence gathered there of large price increases after both transactions dispelled the notion that merged non-profit hospitals necessarily refrain from exercising their market power. In this way, the HMRP supplemented a growing literature that has established that for-profit and non-profit hospitals respond to competitive forces in a similar fashion.[66]

Third, the HMRP highlighted that hospital markets and hospital merger effects are complex, requiring a flexible approach to merger enforcement and analytic tools specifically designed for hospital markets. In all of the retrospectives, the estimated post-merger price changes varied across payers, with some receiving large price increases, while others received moderate price increases or even price decreases. In some cases, mergers of closely competing hospitals in relatively isolated geographic areas (e.g., Victory/St. Therese and New Hanover/Cape Fear) resulted in a mixture of price increases and decreases, while mergers between closely competing hospitals in urban and suburban areas (Summit/Alta Bates and Evanston/Highland Park) resulted in significant price increases across most payers. This has led to the development of new tools to analyze hospital mergers that are theoretically based and capture the complexity of hospital markets and the differentiation across hospitals and payers.[67] For example, one tool that has been used in recent hospital merger investigations is discrete choice modeling. Using hospital discharge data, one can model patient choices as a function of hospital characteristics (e.g., bed size, teaching intensity), patient characteristics (e.g., age, gender, diagnosis), and characteristics specific to the patient-hospital pairing (e.g., the travel time between the patient's residence and the hospital). From these estimates, one can derive a number of statistics that are useful for the analysis of merger effects. For example, one can use the estimated choice probabilities from the model to calculate hypothetical diversion ratios between hospitals to assess whether the hospitals are close competitors. As discussed below, the FTC's Administrative Law Judge in *FTC v. ProMedica Health System* recently relied, at least in part, on diversion analysis to determine which hospitals were close substitutes. One can also use the choice model's estimates to calculate each payer's "Willingness-to-Pay" for each hospital system and other statistics (e.g., patient-weighted Herfindahl-Hirschman Index) that can be used to estimate the effects of hospital mergers.

4.3. A Summary of the Agencies' Recent Hospital Merger Challenges

A goal of the FTC's HMRP, as discussed above, was to develop new strategies for litigating hospital merger cases.[68] After a string of losses in the 1990s, the FTC has had recent success in hospital merger

65 *See Butterworth Health Corp.*, 946 F. Supp. at 1302; *Carilion Health Sys.*, 707 F. Supp. at 849.

66 David Dranove and Richard Ludwick, "Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis," 18 J. Health Econ., 87 (1999); Michael Vita and Seth Sacher, "The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study," 49 J. of Indus. Econ. 63 (2001).

67 Joseph Farrell, et. al., "Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets," 39 Rev. of Indus. Org. 271 (2011).

68 Muris remarks, *supra* note 55.

litigation with a successful challenge to the consummated Evanston/Highland Park merger, an abandoned transaction, and a successful challenge to a consummated acquisition of outpatient medical clinics.[69] Three cases filed in 2011 are ongoing.[70] In this section, we highlight the Evanston/Highland Park case and two of the ongoing cases to illustrate the FTC's use of lessons learned in the HMRP.

4.3.1. Evanston Northwestern Healthcare Corporation: Product and Geographic Market Definition, Anticompetitive Effects, Lack of Efficiencies, and Non-profit Status

The first case filed as a result of the HMRP was against a consummated hospital merger in the Chicago suburbs. In 2004, the FTC issued an administrative complaint challenging Evanston Northwestern Healthcare Corporation's ("Evanston") 2000 acquisition of Highland Park Hospital ("Highland Park").[71] Evanston and Highland Park are located in suburbs north of Chicago, Illinois. The FTC alleged that the consummated acquisition eliminated significant competition between the hospitals and allowed Evanston to exercise market power against health care insurance companies and raise prices at least 9 to 10 percent, to the detriment of consumers.[72] Given that the merger was consummated four years before the Commission brought its complaint, agency staff and its experts were able to gather significant evidence about what happened after the merger.[73] After a trial before an agency administrative law judge and an appeal to the full Commission, the Commission found that the merger violated the Clayton Act and "enabled the merged firm to exercise market power"[74] and raise prices.

In Evanston, the complaint alleged and the Commission held that the relevant product market was "acute inpatient hospital services."[75] The Merger Guidelines provide the framework for defining the relevant product market for hospital services. In hospital merger cases, the product market typically has been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or

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69 In 2008, the Commission challenged a proposed acquisition of Prince William Health System by Inova Health System Foundation, both located in Northern Virginia. The agency alleged that, if consummated, the acquisition would reduce competition for general acute care inpatient hospital services in Northern Virginia, resulting in higher prices, and patients would also lose the benefits of non-price competition. Facing the prospect of an administrative trial, the parties abandoned the transaction. *See* FTC Press Release, "FTC Approves Order Dismissing Administrative Complaint Against Inova Health System Foundation and Prince William Health System, Inc.," (Jun. 17, 2008) http://www.ftc.gov/opa/2008/06/inovafyi.shtm. In July 2009, the FTC issued an administrative complaint challenging Carilion Clinic's 2008 acquisition of an outpatient imaging center and an outpatient surgical center in Roanoke, Virginia. Before trial, Carilion agreed to divest both facilities to resolve the FTC's concerns. *See* FTC Press Release, "Commission Order Restores Competition Eliminated by Carilion Clinic's Acquisition of Two Outpatient Clinics," (Oct. 7, 2009) http://www.ftc.gov/opa/2009/10/carilion.shtm.

70 *In the Matter of ProMedica Health Sys., Inc.*, Dkt. No. 9346 (Administrative Complaint Jan. 6, 2011) [hereinafter ProMedica Complaint]; *In the Matter of Phoebe Putney Health System, Inc.*, Dkt. No. 9348 (Administrative Complaint Apr. 20, 2011) [hereinafter Phoebe Putney Complaint]; the third ongoing case is the FTC's challenge to a hospital merger in Rockford, IL: *In the Matter of OSF Healthcare Sys.*, Dkt. No. 9349 (Administrative Complaint Nov. 18, 2011) (the related federal case is *FTC v. OSF Healthcare Sys.*, No.11-cv-50344 (Nov. 18, 2001), http://www.ftc.gov/os/caselist/1110102/111118rockfordcmpt.pdf).

71 *In the Matter of Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315 (Complaint Feb. 10, 2004).

72 Evanston Opinion, *supra* note 63, at 78.

73 *See* Haas-Wilson and Garmon, *supra* note 56.

74 Evanston Opinion, *supra* note 63, at 5.

75 *Id.* at 57.

observation.[76] (In some cases, however, a smaller product market may be alleged, such as the provision of inpatient services for a particular specialty.[77]) The broad grouping generally makes sense because, from the perspectives of payors and patients, inpatient services are complementary and bundled. Even if inpatient hospital prices are increased, patients and payors cannot separate and outsource nursing care, diagnostic tests, and room and board from the other treatments provided as part of a hospital stay.

Based on lessons learned in the HMRP, as discussed above, the Commission in the Evanston case determined the relevant geographic market without using the EH test. The Commission noted that according to the Merger Guidelines "the relevant geographic market is a region in which a hypothetical monopolist could 'profitably impose at lease a small but significant and nontransitory increase in price [("SSNIP")], holding constant the terms of sale for all products produced elsewhere."[78] After finding that the merger enabled Evanston to raise prices by an amount at least equal to a SSNIP, the Commission concluded that the relevant geographic market was "the geographic triangle in which the three [Evanston Northwestern Healthcare] hospitals are located"[79] and not a larger portion of the Chicago metropolitan area. The Commission also explicitly rejected the EH test for use in geographic market definition.[80]

Merging hospitals often claim that their merger will produce significant efficiencies. Claimed efficiencies often include improved quality of care, avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs.[81] Such efficiencies, if substantiated, are considered and can affect the court's or the agencies' decision about the likelihood of the merger being anticompetitive.[82] In Evanston,

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76 In *American Med. Int'l, Inc.* and *Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. *American Med. Int'l*, 104 F.T.C. 1, 107 (1984); *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986).

77 ProMedica Complaint, *supra* note 70, at ¶ 12 (alleging a market for "inpatient obstetrical services").

78 Evanston Opinion, *supra* note 63, at 57, citing FTC & DOJ Horizontal Merger Guidelines (1992 rev.) at § 1.21.

79 Evanston Opinion, *supra* note 63, at 78.

80 *Id.* at 77.

81 In several merger cases, hospitals have signed "community commitments" or agreements with state attorneys general, promising not to raise prices for a specified period of time or promising to pass on to consumers a specified amount of money from claimed efficiencies. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149; *Butterworth Health Corp.*, 946 F. Supp. at 1302. Other states also have entered into decrees with merging hospitals that provided for some type of community commitment. *See, e.g.*, *Wisconsin v. Kenosha Hosp. & Med. Ctr.*, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree); *Pennsylvania v. Capital Health Sys.*, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree) (court ordered merged hospitals to pass at least 80 percent of the net cost savings to consumers); *Pennsylvania v. Providence Health Sys.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree). Some state attorneys general have signed these agreements in an attempt to translate claimed merger-induced cost savings into actual price reductions to consumers. Community commitments are temporary and do not solve the underlying competitive problem when a hospital merger has increased the likelihood that market power will be exercised. *See Healthcare and Competition Law and Policy Hearings*, March 28, 2003 at 78:16-80:10, http://www.ftc.gov/ogc/healthcarehearings/030328trans.pdf (discussing what happened after one community commitment expired). Community commitments represent a regulatory approach to what is, at bottom, a structural market problem – and that problem will remain after the commitment has expired. Therefore, the Agencies do not endorse community commitments as an effective resolution to likely anticompetitive effects from a hospital (or any other) merger.

82 *See* Merger Guidelines, *supra* note 49, at Section 10.

the defendants argued that the merger produced efficiencies and other competitive benefits that outweighed the harm to competition. Specifically, the merged hospital claimed that the merger resulted in quality of care improvements.[83] The Commission, however, held that the post-merger improvements and expansions of service could and likely would have been made without a merger.[84] The Commission also found that Evanston provided "little verifiable evidence that the changes it made at Highland Park improved quality of care."[85] At trial, the FTC's expert presented results of a retrospective analysis of quality of care resulting from the Evanston/Highland Park merger. This analysis found little evidence that the merger improved quality.[86] Thus, the Commission held that any quality of care improvements or other efficiencies resulting from the merger did not offset the showing of competitive harm (price increases).[87]

The FTC's case against Evanston also demonstrates that, based on the lessons learned in the HMRP, the agency will not hesitate to challenge an acquisition by a non-profit hospital if the Commission has reason to believe the acquisition will be anticompetitive. In Evanston, the merged hospital system argued that its status as a not-for-profit greatly reduced the potential for anticompetitive harm. Both the ALJ and the Commission rejected this argument, with the Commission holding that "the totality of the record shows that [Evanston's] non-profit status did not affect its efforts to raise prices after the merger, and we readily agree with the ALJ that [Evanston's] status as a nonprofit entity does not suffice to rebut complaint counsel's evidence of anticompetitive effects."[88]

4.3.2. ProMedica: Flexible Approach to Merger Effects Analysis

The FTC's case against ProMedica Health System ("ProMedica") demonstrates how the agency is utilizing the insight gained through the HMRP that hospital merger effects are complex, requiring a flexible approach to merger enforcement and analytic tools specifically designed for hospital markets. In January 2011, the FTC challenged the consummated acquisition by ProMedica of St. Luke's Hospital, both of which are located in Lucas County (Toledo), Ohio.[89] The FTC charged that the merger of ProMedica and St. Luke's would substantially lessen competition, and the motivation for the acquisition was "to gain enhanced bargaining leverage with health plans and the ability to raise prices for services."[90] A federal district court granted a preliminary injunction in March 2011 stopping further integration of the hospitals,[91] and in December 2011, the FTC's Administrative Law Judge ruled that ProMedica's acquisition of St.

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83 *In the Matter of Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315, Pretrial Brief of Respondent Evanston Northwestern Healthcare (Jan. 27, 2005) at 31-32.

84 Evanston Opinion, *supra* note 63, at 83.

85 *Id.* at 84.

86 *See* Patrick S. Romano and David J. Balan, "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare," 18 Int'l J. of the Econ. of Bus. 45 (2011).

87 Evanston Opinion, *supra* note 63, at 85.

88 *Id.* at 85.

89 Prior to the acquisition and during the pendency of the FTC's investigation, ProMedica entered into a voluntary hold separate agreement with the FTC that restricted ProMedica from making certain changes to St. Luke's. After investigation, the FTC filed a lawsuit in federal court to preserve the hold separate agreement and enjoin further consolidation while conducting a full trial through its administrative law process.

90 ProMedica Complaint, *supra* note 70, at ¶ 1.

91 *See Federal Trade Comm'n v. ProMedica Health Sys.*, Case No. 3:11CV47 (N.D. Ohio Mar. 29, 2011) (Findings of Fact & Conclusions of Law), http://www.ftc.gov/os/caselist/1010167/110329promedicafindings.pdf.

Luke's Hospital was anticompetitive and ordered that ProMedica divest St. Luke's.[92] The ALJ's Initial Decision has been appealed to the full Commission, which is entitled to de novo review.

In ProMedica, the ALJ recognized the interaction and effect of competitive dynamics in several levels of the market for hospital services, which work to promote efficiencies and restraints on prices, as discussed above in Section II.B.[93] Specifically, the ALJ found that managed care plans "compete with one another to be offered by employers in the menu of insurance products that employers offer to their employees."[94] "Once included in the employer's menu of health insurance products, [managed care organizations] compete with one another to attract enrollees."[95] Hospitals compete among themselves to be included in plans; once included, hospitals compete for patients from the plan based on quality, location, and other mostly non-price aspects.[96]

Using this framework, the ALJ found that "for many patients, St. Luke's and one of ProMedica's hospitals are patients' top two choices for [general acute care] inpatient hospital services" based on the location and other amenities.[97] The merger eliminated a managed care organization's option of contracting with St. Luke's alone. Thus, post-merger, if a managed care organization failed to reach an agreement with ProMedica, the managed care organization would not be able to offer a hospital provider network including one of the local patients' two top hospital choices. Without top choice hospitals, a managed care plan would lose customers. Thus, the ALJ found that "the [merger] will significantly increase [ProMedica's] bargaining leverage in negotiations with [managed care organizations] and provide [ProMedica] with sufficient market power to enable it to increase the reimbursement rates it charges . . . for . . . inpatient hospital services."[98] Complaint counsel presented diversion analysis,[99] which the ALJ found supported the conclusion that "St. Luke's and one or more of the three ProMedica hospitals are close substitutes."[100] Testimony of managed care officials also supported this conclusion.

Finally, the ALJ in ProMedica found that the asserted procompetitive benefits and efficiencies from the transaction, including that the merger would make St. Luke's financially stronger, were insufficient to outweigh the anticompetitive effects of the merger, and that St. Luke's was not a "failing firm" under U.S. case law, such that the merger should be allowed to proceed.[101]

4.3.3. Phoebe Putney: The State Action Defense

In December 2010, PPHS, a nonprofit corporation and operator of Phoebe Putney Memorial Hospital ("PPMH"), entered into an agreement to acquire control of Palmyra Park Hospital ("Palmyra"), the only

92 *In the Matter of ProMedica Health Sys., Inc.*, Dkt. No. 9346 (Initial Decision Dec. 5, 2011) [hereinafter ProMedica Initial Decision].

93 While the federal judge in the U.S. District Court for the Northern District of Ohio reached many of the same conclusions in ordering a preliminary injunction in this matter, this paper focuses on the analysis of the FTC ALJ's Initial Decision, which was reached after a full administrative trial.

94 ProMedica Initial Decision, *supra* note 92, at ¶ 237.

95 *Id.* at ¶ 238.

96 *Id.* at ¶¶ 244 and 245.

97 *Id.* at page 162.

98 *Id.* at 6.

99 See discussion above in section on the HMRP.

100 *Id.* at 159.

101 *Id.* at 7.

competing hospital in Albany, Georgia.[102] The FTC challenged the acquisition, charging that the merger of PPMH and Palmyra under the same operator would constitute a merger to monopoly for inpatient general acute-care hospital services in Albany and its surrounding area, and that even though PPHS is a nonprofit entity, the acquisition "greatly enhances Phoebe Putney's bargaining position in negotiations with health plans, giving it the unfettered ability to raise reimbursement rates without fear of losing customers."[103]

The critical issue in the PPHS case is not its nonprofit status but rather its claimed state action defense. Thus, this case illustrates a supply-side factor in the U.S. that threatens to restrain competition between hospitals – the state action defense or state action immunity. PPHS operates PPMH under a lease from the local hospital authority and owner of the facility ("the authority"). PPHS asked the authority to acquire Palmyra, and PPHS agreed to provide the funds the authority needed for the acquisition. The authority agreed to lease Palmyra to PPHS. The FTC sought a preliminary injunction in federal court to enjoin the merger but the defendants argued that the state action doctrine immunized the authority and the planned combination of the two hospitals from antitrust liability. In the U.S., "[t]he doctrine of state-action immunity protects states from liability under federal antitrust laws."[104] The same protection extends to municipalities or political subdivisions of a state if, "through statutes, the state generally authorizes the political subdivision to perform the challenged action, and [if] through statutes, the state has clearly articulated a state policy authorizing anticompetitive conduct."[105] The FTC countered that PPHS was the effective acquirer and that the authority was only a "straw man" used to give PPHS control of its competitor. In denying the FTC's request for a preliminary injunction, the U.S. Court of Appeals for the 11th Circuit ruled in December 2011 that because the state of Georgia granted to local hospital authorities the power to acquire hospitals and to lease hospitals to others to operate, "the legislature must have anticipated that such acquisitions [if they consolidated ownership or operation of competing hospitals and eliminated competition between them] would produce anticompetitive effects."[106] The FTC is considering its options for appealing this decision.

5. Non-merger Conduct Cases to Protect Competition in Contracting for Hospital Services

The DOJ has focused its resources on investigating and challenging conduct by dominant hospitals that prevents entry or expansion by rival hospitals and other health care facilities. In 2011, the DOJ challenged, under Section 2 of the Sherman Act, United Regional Health Care System's practice of requiring most commercial health insurers to pay significantly higher prices if they contracted with United Regional's competitors. United Regional provides approximately 90 percent of the inpatient hospital care in Wichita Falls, Texas, which made it necessary for all insurers to have United Regional in their networks in order to sell health insurance in Wichita Falls. Because the penalty for contracting with United Regional's rivals was so significant, almost all insurers that offered health insurance in Wichita Falls entered into exclusive contracts with United Regional. As a result, competing hospitals and facilities could not obtain contracts with most insurers and were less able to compete, which helped United Regional maintain its monopoly. The DOJ resolved the lawsuit through a settlement that prohibits United Regional from conditioning the prices or discounts that it offers to commercial health insurers on whether those insurers contract with competing health care facilities. To ensure that United Regional can engage in

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102 Before the acquisition, Palmyra was owned by a for-profit corporation, HCA, Inc.

103 Phoebe Putney Complaint, *supra* note 70, at ¶ 11.

104 *Federal Trade Comm'n v. Phoebe Putney Health Sys.*, D.C. Docket No. 1:11-cv-00058-WLS (11th Cir. Dec. 9, 2011) at 9, [hereinafter Phoebe Putney 11th Circuit Opinion] http://www.ca11.uscourts.gov/opinions/ops/201112906.pdf.

105 Federal Trade Comm'n v. Hosp. Bd. of Dirs. of Lee County, 38 F.3d 1184, 1187-88 (11th Cir. 1994) (citing Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985).

106 Phoebe Putney 11th Circuit Opinion, supra note 104, at 13.

procompetitive discounting, the settlement allows United Regional to offer (a) different prices to different commercial health insurers and (b) incremental volume discounts.

The DOJ has also brought cases involving competition in the health insurance market with direct effects on hospitals.

In November 2011, the DOJ sued Blue Cross and Blue Shield of Montana ("BCBSMT") and five hospitals in Montana. The hospitals owned New West Health Services ("New West"), one of only two significant health insurer competitors to BCBSMT. BCBSMT had agreed to pay $26.3 million to the hospital defendants in exchange for their agreeing to collectively stop purchasing health insurance for their own employees from New West and instead buy insurance for their employees from BCBSMT exclusively for six years. BCBSMT also agreed to provide the hospital defendants with two seats on BCBSMT's board of directors if the hospitals elected not to compete with BCBSMT in the sale of commercial health insurance. The agreement would likely have caused New West to exit the market for commercial health insurance in Montana.

The DOJ settled the case by requiring New West to sell the majority of its commercial health insurance business to a third-party buyer and requiring the five defendant hospital owners to enter into three-year contracts with the acquirer to provide services on terms that are substantially similar to their existing contractual terms with New West. These requirements are important because to compete effectively, health insurers need a network of health care providers at competitive rates.[107]

In October 2010, the DOJ sued Blue Cross Blue Shield of Michigan (BCBSM) alleging that BCBSM had sought to insulate itself from competition in health insurance markets throughout Michigan by entering into "most favoured nation" agreements ("MFNs") with more than 70 hospitals. These agreements either (1) require hospitals to charge BCBSM's competitors more than what the hospitals charge BCBSM, or (2) mandate that the hospitals charge BCBSM's competitors at least as much as they charge BCBSM, which has caused a number of hospitals to raise their prices to BCBSM's competitors and reduced competition. The DOJ alleged that these agreements likely resulted in Michigan consumers paying higher prices for their health care services and health insurance.

BCBSM moved to dismiss the DOJ's complaint on the ground that its conduct was protected by the "state action" doctrine. The DOJ argued that the BCBSM's contracts did not qualify for state action protection because the State of Michigan had not articulated a clear and affirmative policy to allow the anticompetitive MFNs and that the State did not actively supervise the anticompetitive conduct. The court agreed with the DOJ and denied BCBSM's motion to dismiss. The litigation is ongoing.[108]

6. Conclusion

The hospital industry in the United States continues to evolve, as an aging population and higher-cost technologies put pressure on policy makers to adopt programs to constrain costs while improving quality of hospital services. Recent changes in U.S. health care law are designed to promote efficiencies, improve quality, and restrain further price increases in the provision of services. But, the market for the provision of hospital services is complex, with competitive forces working to promote efficiencies and restrain prices in several levels of the market, including third-party payors (both government and private payors), hospitals, employers who provide insurance benefits for their employees, and consumer/employees/patients. Consolidation at these levels can have anticompetitive effects and result in higher prices and lower quality services. The FTC's Hospital Merger Retrospective project has informed

[107] See http://www.justice.gov/atr/cases/bcbsmnw.html.

[108] See http://www.justice.gov/atr/cases/bcbsmfn.html.

and strengthened the enforcement actions of the U.S. competition agencies. The project provided further evidence that competition can deliver improvements in the quality of care and restraints on prices for hospital services. Recent efforts by the FTC to stop anticompetitive hospital mergers have met with some success, and the U.S. will continue to make the protection and promotion of competition in the hospital market a high priority.

BRAZIL

1. Introduction

This contribution addresses competition issues related to the health sector in Brazil, in particular those that affect hospital services. First, it presents the general Brazilian regulatory framework in the health sector. Then, it analyses some aspects of market definition for hospitals services, before describing the health insurance market, which is responsible for the main competition concerns in health sector in Brazil. Finally, a few comments on market failure aspects of the sector are made before reaching a brief conclusion of the topic.

2. Regulatory framework

The current Brazilian Federal Constitution from 1988 is the first Brazilian Constitution to provide for a specific constitutional section to the health sector (Articles 196 *et seq.*). It states that health is a right to all individuals and an obligation for the State to provide it, guaranteeing the right to have access to a public health system to all individuals. At the same time, it also sets forth the right for private business to economically exploit the health sector.

For this reason, hospital services may be provided by both public and private hospitals. The health sector regulation is basically set within two regulatory frameworks: the *Sistema Único de Saúde* ("SUS") and the *Agência Nacional de Saúde Suplementar* ("ANS").

Within the SUS, hospital services are provided directly by public funds, and thus access to these services represents no additional or particular financial burden on patients. This can be done through both private and public hospitals. However, long waiting periods for services provided by SUS results in incentives for alternative hospital services, which include private hospitals that are not part of SUS, as well as health insurance companies.

ANS is the governmental agency responsible for the regulation of private supplementary health market. It was created in November 1999 by the Provisory Act nº 1.928, which became Law nº 9.961 from 28 January 2000, after Congressional approval. The legal framework for the private health sector as whole, including health insurance companies, is mainly set forth by Law nº 9.656 from 3 June 1998. Among other items, it provides for a minimum set of services and products that must be included in all health insurance contracts, in order to guarantee the individual constitutional right to access health care.

Finally, a reference must be made to the Brazilian National Health Surveillance Agency (ANVISA – *Agência Nacional de Vigilância Sanitária*), a governmental body responsible for the regulation and surveillance of products related to health in general, such as medical, pharmaceutical, cosmetics and hospital products. One example of ANVISA's regulatory control is the regulation of advertisements relating to products that concern human health.

All three of them – SUS, ANS and ANVISA – are linked to the Brazilian Ministry of Health.

3. Market definition for hospital services

Market definition for hospital services is a difficult topic in both demand and supply perspectives, particularly because of the complexity and diversity of types of treatments and exams. Nevertheless, two major aspects are frequently considered by the Brazilian competition authorities for an initial analysis.[1]

A first general distinction is drawn between hospital services provided or not through SUS. This aims to distinguish the services provided entirely from public funds, with no additional costs to patients, from the services provided by private funds (either from patients themselves or from health insurance companies). If hospital services exist outside of the SUS structure is because there are patients willing to pay for alternative hospital services. This choice may be explained by the existence of a differentiated level of quality services, for instance faster services, better technology for exams and treatments, or higher standard of comfort for patients.

A second and more common approach concerns the geographic dimension of the market definition. The Brazilian experience indicates that consumers are in general willing to move for about 30 to 40 minutes to reach alternative hospitals services, which typically corresponds to a 20km distance. This explains why the geographic dimension of the relevant market is usually considered as the town of the hospital's location, or occasionally a group of small towns.

4. Health insurance companies

In Brazil, the main debate on competition issues relating to the health market is focused on the private supplementary health market and, more precisely, on health insurance activities within this market.

Given the importance of health insurance companies in the Brazilian health sector and after an overview of the general regulatory framework, this paper will now examine two important aspects of health insurance: (i) the legal provision that provides for a minimum set of services and products that must be included in all health insurance activities and (ii) the increase in mergers and acquisitions within this particular market.

4.1. Minimum set of health services and products

As mentioned above, Law nº 9.656 from 3 June 1998 sets forth a minimum set of services and products that must be offered by all health insurance contracts, in order to guarantee the individual constitutional right to access health care. For this reason, it is worth to examine this legal provision:

> "Article 10. The reference-plan for health assistance is created, covering medical-ambulatory and hospital assistance, including birth and treatments, provided exclusively in Brazil, with nursing services, intensive-care unit, or similar standard, when a hospital care admission is necessary, of diseases indicated by the International Statistical Classification of Diseases and Related Health Problems, set forth by the World Health Organization, observed the minimum conditions provided for by Article 12 of this Law, with the following exceptions:
>
> I – experimental clinic treatment or surgery;

[1] For further information, see: Merger file nº 08012.008853/2008-28 from 22 July 2009. The case is also particularly interesting because CADE blocked a hospital merger that would result in the acquisition of a 90% market share on a relevant market analyzed.

II – clinic or surgery procedures for esthetical purposes, as well as orthotics and prosthesis for the same purpose;

III – artificial insemination;

IV – rejuvenation or weight loss for esthetical purposes;

V – to provide medical products imported and not nationalized;

VI – to provide medical products for home treatments;

VII – to provide prosthesis, orthotics, and accessories not related to the surgery act;

VIII – (revoked);

IX – illegal or immoral treatments, as defined by medical standard, or not recognized by competent authorities;

X – cases of cataclysms, wars, and internal disorders, when declared by the competent authority."

ANS periodically publishes administrative resolutions to guide the application of the minimum reference-plan for health services and products. For instance, ANS clarified that the bariatric weight-loss surgery to reduce obesity is not considered an esthetical surgery, and that it must be included in the minimum reference-plan, accordingly to ANS' Resolution RN nº 2011, from 11 January 2010.

The application of the minimum set of health services and products is excluded from certain health domains, including most dental care services, and esthetical services in general, *i.e.* plastic surgery and dermatology.

4.2. Increase in mergers and acquisitions

Over the past recent years, there was a considerable increase in mergers and acquisitions in the health sector, including health insurance companies, hospitals, laboratories and pharmacies. Most of these mergers were horizontal mergers, but some vertical integration was also noticed.[2]

The scheme below shows the evolution of the horizontal mergers that took place in the health insurance market.

[2] For further information about this topic, see: Carlos Emmanuel Joppert Ragazzo; and Kenys Menezes Machado. "Desafios da análise do CADE no setor de planos de saúde". In: Para entender a saúde no Brasil. Perillo, Eduardo; e Amorim, Maria (org.). vol. 4. São Paulo: LCTE, 2011.

Number of Active Health Insurance Companies with Beneficiaries[3] in Brazil

Class of Beneficiaries	1999/12	2001/12	2004/12	2006/12	2008/12
Class 1 to 100	195	141	58	36	34
Class 101 to 1,000	297	251	175	137	109
Class 1,001 to 2,000	164	160	144	111	101
Class 2,001 to 5,000	246	264	255	223	187
Class 5,001 to 10,000	146	172	177	192	178
Class 10,001 to 20,000	84	133	202	191	181
Class 20,001 to 50,000	80	108	160	175	178
Class 50,001 to 100,000	22	41	74	72	78
Class 100,001 to 500,000	20	32	53	56	59
Class Superior to 5,000,000	3	3	7	11	15
Total	1.257	1.305	1.305	1.204	1.120

Source: SEAE (2010). Information from the ANS's database for health insurance companies.

The scheme testifies that there were 1,120 health insurance companies in 2008, whereas 1,257 companies existed in 1999. However, the main structural changes are related to the size and the specific market of these companies. It is possible to notice a considerable reduction of companies that provide services for a small group of beneficiaries and a major increase of those that provide services for a larger class of beneficiaries. Moreover, both the reduction in the number of small companies and the increase in the number of larger companies are present during the past ten years, characterizing a tendency of market concentration for the competition analysis.

Concerning the vertical mergers, it is also possible to notice a trend of concentration of hospitals and health insurance companies. CADE's case law indicates that a significant amount of hospitals in some cities were controlled by one or a few corporate groups. This was the case in the Merger file nº 08012.000229/2008-82 in which CADE acknowledged that 30% of the hospital beds of several Brazilian relevant geographical markets were owned by one single corporate group.

5. Market failures

The health market is usually characterized by market failures that require special attention from competition agencies and explain a strong regulation from regulatory bodies.

A major market failure concerns the asymmetry of information. It exists in different levels, for instance between health insurance companies and health service providers (hospitals, clinics and laboratories), as well as between health service providers and consumers.

[3] Active health insurance companies, with exception to those exclusively intended to dental care and to those without beneficiaries, considering the criterion of the residency of the beneficiary.

In the first case, health service providers retain more information regarding patients than insurance companies. As a result, hospitals, clinics and laboratories may have incentives to make an inefficient use of health services, since the bill will be afforded totally or mainly by the health insurance companies.

In the second case, patients themselves usually do not fully understand their health problem nor the exact extent of the risks. Thus, patients may also have incentives to make an inefficient use of health services because their marginal cost for extra services is close to zero, considering that health insurance covers total or most of the health care costs.

In despite of the asymmetric information problem, ANS only disposes of regulatory powers in the field of health insurances. Hospitals, clinics, and laboratories are not subject to ANS' regulation. However, all these markets are submitted to CADE's jurisdiction on competition grounds and the latter has been working in co-operation with ANS to avoid that anticompetitive practices may harm consumers.

6. Conclusion

The regulation of the Brazilian health sector is basically organized under two main frameworks: one within the *Sistema Único de Saúde* (SUS) and the other by the *Agência Nacional de Saúde Suplementar* (ANS), both linked to the Brazilian Ministry of Health. While services are provided directly by public funds within SUS, the ANS is responsible for regulating health insurance companies.

The main competition debate is held within the second framework, focusing particularly on business activities carried out by health insurance companies. Health insurance companies maintain business relations, on the one hand, with medical professionals and private hospitals, and, on the other hand, with final consumers or patients. In this context, different types of competition tensions may arise from these relationships, in particular those related to the abuse of market power. Nevertheless, CADE has jurisdiction over anticompetitive practices and mergers in all markets related to the health sector in Brazil.

Finally, a topic that requires special attention by both competition agencies and regulatory bodies relates to market failures, in particular asymmetric information. Thus, efforts are continuously made to guarantee a minimum standard of quality in health services to final consumers.

COLUMBIA

1. Introduction

The analysis of the industrial organization on healthcare markets has been a vital importance subject for competition policy makers in Colombia, considering that these markets are characterized by multiple market failures. Its structure and operation is under continued scrutiny by regulators, since its dynamics have important implications for public sector's financial balance and the Country's social welfare.

Colombia has followed different models for the provision of healthcare services. These are: (i) Hygienist, (ii) Supply Subsidies, and, (iii) Regulated Competition. The Hygienist model covered the period from 1886 to 1950. This scheme was focused on public healthcare, orientated to general healthcare events, while individual preventive and curative services were financed directly by users or some charities.[1]

During 1950, the Colombian Social Security Institute (hereinafter ISS for its acronym in Spanish) is created, in order to attend private sector employees with formal employment. Then, from 1970 to 1989, healthcare services became an integral part of the country's socioeconomic planning. The National Healthcare System is also created, under the Supply Subsidies model, in which central government resources for healthcare were transferred to the public hospitals' network. As well as the National Healthcare System, the government developed a financing scheme for the provision of these services to the formal working population, counting with the State, employers and employees[2] participation.

In the early nineties, under the framework of the 1991's Colombian Constitution and, the structural reforms aiming at the privatization of some State Owned Enterprises (SOEs), Social Security began to be conceived as a mandatory public service, in which the healthcare and environmental protection would be provided by the State. Subsequently, there is a legal requirement for healthcare services to be provided by the State and/or delegated agents of the private sector, in order to guarantee to the population these fundamental rights. This, combined with the elimination of State's monopoly in the provision of healthcare services, aiming to free competition by allowing the entry of new companies, would give users the possibility to freely choose a healthcare provider.[3]

Having the latter in mind, market incentives are created so as to promote competition, inspired by the regulated competition model[4] introduced in Colombia by the Act 100 of 1993, or the National Social Security Act. This Act lead to the creation of the Social Security System in Healthcare (hereinafter SGSS, for its acronym in Spanish) and laid the foundation for the services provision, through a network of private and public institutions competing in the health insurance market, under supervision and State regulation.

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1 OROZCO, J. (2006) Caracterización del mercado del aseguramiento en salud para el régimen contributivo en Colombia. See: http://www.consultorsalud.com/biblioteca/e-book/Caracterizacion%20del%20mercado%20del%20aseguramiento%20en%20salud%20para%20el%20RC%20en%20colombia%20-%20jmoa.pdf. p. 23 [consulted the 23th of january 2012].

2 Ibíd., p. 23.

3 Ibíd., p. 24.

4 According to article 1 of Act 789 issued on december the 27th 2002.

In summary, the 1993 healthcare reform was based on an insurance scheme with a competitive market structure, conformed by new healthcare insurance companies: the Healthcare Promoting Companies (hereinafter, EPS for its acronym in Spanish), which serves as intermediaries between the insured and the provider institutions. Service delivery institutions came to be constituted by: (i) private clinics (hereinafter IPS for its acronym in Spanish) and (ii) public hospitals, transformed into State Social Enterprises (hereinafter ESE for its acronym in Spanish). All this institutions were created with the purpose to guarantee that users could exercise their power by choosing the best service among different options, given that premium and the benefit plan are set by the State.[5]

In addition to the above, it is noteworthy that the Act 100 established a mechanism of subsidizing demand, under the principle of solidarity, to facilitate poor people access to healthcare services.

After the enactment of Act 100 the Colombian government found it necessary to make some adjustments to the SGSSS. Pursuant to the foregoing, Act 1122 of 2007 was issued, changing some elements of the system, prioritizing on i) improving and rationalization of the services provision; ii) seeking new funding methods; iii) balancing between actors in the system, and; iv) strengthening public healthcare programs as well as the authority's functions of inspection, supervision, and the networks that provide the service.

Following this reform, in 2011, Act 1438 was issued, having as main target the reinforcement of the system through the implementation the public healthcare service delivery model. That model allows co-ordinated actions between the State institutions and society, improving therefore, users' healthcare. It will also create a safer environment, as well as enabling the entities to serve with greater quality and equity. The reform also included provisions in order to achieve unification of the Benefit Plan for all national residents, the universality of insurance and the guarantee of portability or provision of benefits anywhere in the country, within a framework of financial sustainability.

It is important to mention that, in furtherance of the provisions enshrined by the legal regime of the social security system in healthcare, (Act 100 of 1993, Act 1122 of 2007 and Act 1438 of 2011) State agencies participating in the system, have significantly advanced on regulation and control systems.

This contribution aims to analyze the structure of the healthcare system in Colombia and its related markets, under the scope of free competition rules. For this purpose, the dynamics of the healthcare sector in the country, and the rules of competition will be studied and, highlights on the administrative proceedings conducted by the Colombian competition authority in this sector, will be presented.

The document is divided into seven sections including this introduction. The second section will discuss the market failures that characterize healthcare sector in Colombia. Section three will analyze the structure of the healthcare system in Colombia. The fourth section will present the rules of free competition in the country, particularly those issued for the healthcare sector, while in the fifth section the most outstanding investigations on restrictive practices, merger studies and legal opinions on competition law regarding the rules related to healthcare in Colombia will be presented. Finally, the sixth exposes the conclusions and some recommendations will be made in the last section.

5 ABADÍA, C y OVIEDO, D. (2009). *Itinerarios Burocráticos en Colombia*. see:http://www.elsevier.com/authored_subject_sections/S06/S06_351/misc/ssmlifecycle0909.pdf. p. 2. [consulted on january the 23th 2012].

2. Market failure in healthcare markets

In many theoretical and empirical analyses on healthcare markets, it has been shown that these are characterized by pervasive market failures. As consequence, the free operation of market forces in this sector, does not guarantee an optimum level of service delivery and allocative efficiency. This is of greater importance when analyzing the characteristics of the goods affected by such failures, since access to healthcare services, is constituted as a civil right and it is an indicator of population's social well-being.

Among the market failures in healthcare sector we can find, information asymmetries, moral hazard, inducing demand, adverse selection and agency problems, among others.

The provision of healthcare services involves the existence of asymmetric information between the doctor and the user. While the doctor has a professional training that allows him to know the patient's clinical condition, the latter has no such knowledge and, therefore, depends on the professional to access to the service. These conditions under a market structure, can configure two phenomena: (i) moral hazard, in cases where a patient requests a service and is not provided; or (ii) inducing demand when it corresponds to a third party to fund treatments and when who prescribes the treatment is benefited by its demand.[6]

In turn, adverse selection in healthcare markets occurs when the insurer selects from the group of users, those with lower risks, which represent a lower likelihood of accidents and in this way are less expensive.

Finally, healthcare markets are also affected by agency problems, where information is imperfect and asymmetrically distributed between the principal and the agent, in this case, the regulator and the insurer. Indeed, insurers have more information than regulators, which is why there is some probability that the regulator will be frustrated in its attempt to regulate market mechanisms.

3. General structure of the social security system in healthcare in Colombia

The Colombian Social Security System in Healthcare (SGSS) is based on the belief that state regulation on healthcare's imperfect market forces, would achieve an optimal social benefit.[7] Act 100 was zeroed in on creating the conditions and incentives to lead competition in healthcare markets by allowing the entry of new participants, but under state regulated competition.

Under this scheme, the State seeks to regulate healthcare's market imperfections. The model is based on the State-Market relationship, where the state's share of the system, is comprised of three main entities, all with powers and functions attributed by law as follows:

- Firstly is the Ministry of Social Protection (hereinafter MPS, for its acronym in Spanish)[8] which has as main objectives to dictate the policy guidelines, plans, programs and government priorities for the sector, as well as co-ordinate, execute, control and monitor of the same and the system.

6 Op cit., p. 29.

7 Ibíd., p. 25.

8 Article 170 of the Act 100 established that the direction of the SGSSS would be made under the guidance, regulation, supervision, monitoring and control of the National Government and the Ministry of Health. It will also address the policies, plans, government programs and priorities in the fight against diseases, and the maintenance and education, information and healthcare promotion, in accordance with the economic development plan and social and territorial plans referred to in Articles 13 and 14 of Act 60 of 1993.

- Secondly is the Healthcare Regulation Commission (hereinafter CRES, acronym in Spanish), whose powers includes, among others, designing and updating the contents of the Compulsory Healthcare Plan (hereinafter POS acronym in Spanish) and set the value of the Capitation Payment Unit (hereinafter UPC).[9]

- Thirdly there is the National Healthcare Superintendence, in charge of the system's supervision. It exercises the inspection, supervision and control functions over the public and private entities, responsible for the administration and supply of healthcare services.[10]

- Finally, the decentralized level is organized by departmental and local healthcare administrators, whose jurisdiction corresponds to the municipal and territorial departments. They are in charge of developing and implement healthcare plans for people in their area. These agencies are responsible for the identification of the population unable to pay, recruitment and membership to the EPS of the subsidized regime, and providing healthcare services to low-income population.

The entities above mentioned, are responsible for regulating, monitoring and controlling those agents involved in the two major markets composing the SGSSS, healthcare insurance and healthcare services, described below:

In the health insurance market, the EPS[11] as insurers[12] compete for people seeking to be insured. These entities receive a premium, called the Capitation Payment Unit (hereinafter UPC), in exchange of ensuring the provision of the Obligatory Healthcare Service (hereinafter POS) to the members, who act as service takers, and in turn, as its beneficiaries. Under the present scheme of regulated competition, both the contents of the POS and the value and composition of the UPC[13] are set by the CRES.

For its part, at the healthcare provision market, IPS (regularly low, medium and high complexity hospitals) compete for providing services to EPS, which in turn act as purchasers of services on behalf of its members, selecting and negotiating between providers, public or private, the best possible price-quality combination.

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9 Corresponds to the per capita value recognized by the System to each of the EPS for the organization and ensuring the provision of services included in the POS.

10 Op cit., p. 27.

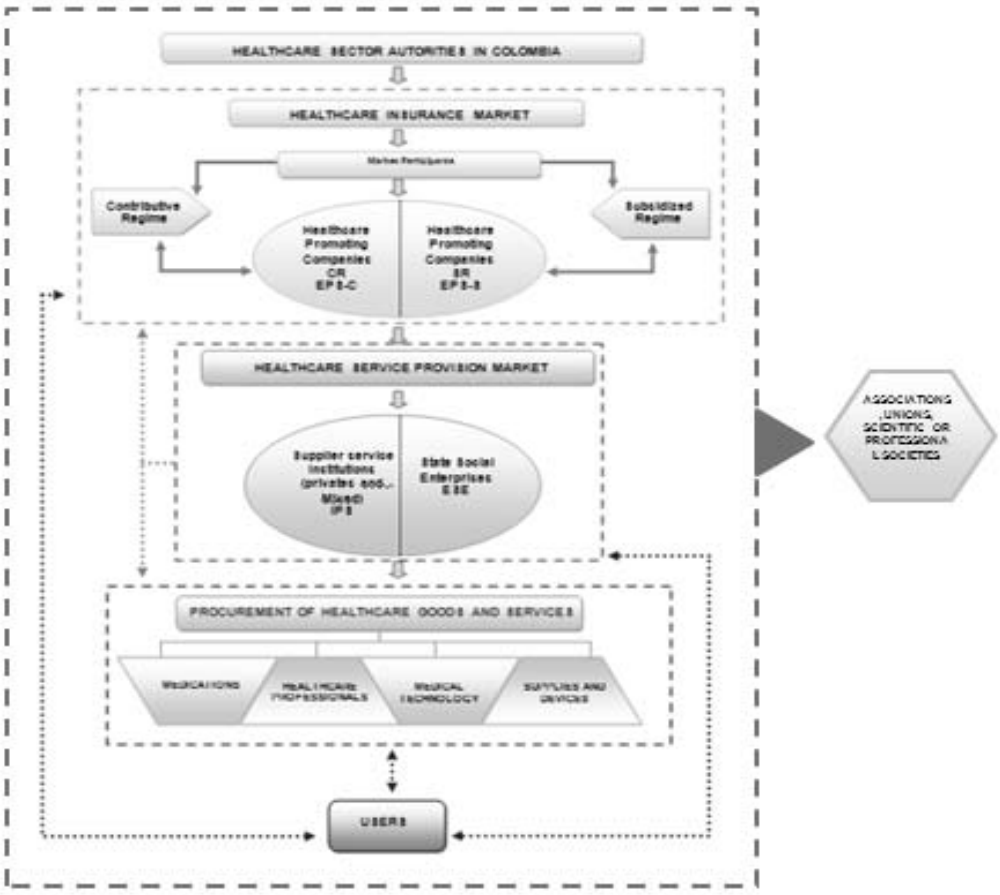
11 According to Article 177 of Act 100, the EPS are "... the entities responsible for membership, and registration of members and collection of quotations, as delegated by the Fund of Solidarity and Guarantee. Its basic function is to organize and secure, directly or indirectly, the provision of mandatory healthcare plan to its members and pay within the terms stipulated in this Law, the difference between income from contributions of its members and the value of corresponding capitation payment units to the Fund of Solidarity and Guarantee, mention in the title III of this Law." The functions, scope and requirements for the constitution of an EPS, are set out respectively in articles 178, 179 and 180 of Act 100, while rates, income and bans, are outlined, in order, in Articles 181, 182 and 183 of the same Act.

12 Constitutional Court. Case T - 760 of July 31, 2008. Magistrate Manuel José Cepeda Espinosa: *In the current regulations, the agencies responsible for ensuring the provision of healthcare services are called Health Promoting Entities, EPS. Before entering into force of Act 1122 of 2007, subsidized entities were called Subsidized Regime Administrators, ARS, at present all are called EPS (art. 14, Act 1122 of 2007).*

13 PULIDO ALVAREZ, Adriana, BOLIVAR VARGAS, Mery, CASTRILLON CORREA, Johanna y ALFONSO, Eduardo Andrés. "*Evaluación del Plan Obligatorio de Salud de los regímenes contributivo y subsidiado en el sistema general de seguridad social en salud colombiano y lineamientos para su reforma – 2008*". Page 4. Ministry of Social Protection of the Republic of Colombia. Bogotá D.C., 2008.

Users have the opportunity, through the principle of solidarity enshrined in Act 100 to access to them, freely choosing the EPS to which they wish to belong to,[14] through membership in one of the insurance regime: i) the contributory scheme[15] (RC), for workers and their families and ii) Subsidized Regime[16](RS), for the population unable to pay.[17]

In Figure 1, is the structure of the SGSS:



14 Numeral 4, Article 153 of the Act 100.

15 The contributory scheme must enroll as a contributor, national or foreigners residing in Colombia which have a labor relationship, independent workers and pensioners. Membership entails the obligation to pay monthly contributions which are made on the employee's salary, based on legal monthly minimum wage in force and as its top, twenty-five legal monthly minimum wage. Health services are provided to members through IPS contracted by the EPS.

16 In accordance with Article 157 of Act 100 "every Colombian will participate in all essential healthcare service that allowed by Social Security System in Health. Some will do so in their capacity as members of the contributory or subsidized scheme, and others will temporarily as participants linked ". (Emphasis away from text).

17 Recent regulation harmonized the subsidized benefit plan with the contributive plan.

As shown in the diagram, the two main SGSSS markets are related to others, which goods or services result necessary in the provision of healthcare, among which we can mention the pharmaceutical, the professionals, the medical technology and the supplies and medical devices market.

Additionally, we highlight that, within the industry, there are multiple professionals associations, trade associations or unions that represents the different actors involved in the market along the healthcare industry in Colombia.

3.1. Healthcare services provision market.

As mentioned above in healthcare services market, service providers, which may be private or public, are competing for services sale to insurers. According to the Colombian Association of Hospitals and Clinics,[18] Colombia in 2010 had a total of 1,135 IPS, 1012 of which were ESE and the 123 remaining belonged to private clinics.

With respect to levels of complexity in health care classified as follows: Level 1: includes outpatient and inpatient services, Level 2 for specialized outpatient care, and Level 3: composed of the super clinical laboratory tests and specialized diagnostic procedures and / or therapeutic, the IPS has to have focused private provision of services in primary care, with 122 clinics, only one in the second level and none in the third, while ESCOs provide their services at all levels of health care, with greater participation in level 1, 83% of public IPS. (See graphic No. 1)

Graphic No. 1. Public and private IPS according to the attention level during 2010 in Colombia[19]

	Providers		
Attention Level	**Private Clinics IPS**	**ESE**	**TOTAL**
1	122	839	961
2	1	142	143
3	0	31	31
TOTAL	**123**	**1.012**	**1.135**

Source: ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. Estadísticas. Véase: http://www.achc.org.co/investigaciones.php?idcat=311. [Fecha de consulta: 1 de febrero de 2012].

Regarding the territorial nature of the IPS, Graph No. 2 shows that the greatest amount of public and private IPS are concentrated on municipal and departmental territories, with 64.9% and 30.6%, respectively, which together account for the 95.5%. The 5% remaining is distributed among the district's, indigenous' and National IPS', the latter having the lowest share (0.4%).

18 ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS (Spanish for Colombian Association of Hospitals and Clinics). Statistics. Consult: http://www.achc.org.co/investigaciones.php?idcat=311. [Consulted on February the 1st 2012].

19 Ibid, http://www.achc.org.co/investigaciones.php?idcat=311.

Graph No. 2. IPS territorial organization during 2010 in Colombia.[20]

Territory	Quantity	Percentage
DEPARTMENTAL	347	30,6%
DISTRICT	29	2,6%
INDIGENOUS	19	1,7%
MUNICIPAL	736	64,9%
NATIONAL	**4**	**0,4%**

With respect to IPS financing and the healthcare spending distribution in the country, the Colombian Association of Hospitals and Clinics estimated that in 2009 the total resources for healthcare amounted to $ 38,611,118 million, 64.5% of which were provided by the SGSS; 3.9% were resources for public health ($ 1,514,145 million), 20.9% came from pocket households spending and 10,7 % remaining, private healthcare services and other healthcare expenses[21.] (See Graph No. 3)

Graph No. 3. SGSSS 2009 Financial Resources (million pesos)[22]

Components	Value	%
Contributive Regime	12.264.255	31,8
Subsidized Regime	7.353.578	19,0
Not Affiliated Poor Population	2.890.541	7,5
Special Regimes	2.380.000	6,2
Subtotal SGSSS	**24.888.374**	**64,5**
Public Healthcare	**1.514.145**	**3,9**
Others (healthcare attention)	**1.316.951**	**3,4**
Private Insurance (including pre-paid healthcare)	2.810.918	7,3
Pocket household expenditure	**8.080.730**	**20,9**
Subtotal Private Resources	**10.891.648**	**28,2**
Total resources	**38.611.118**	**100,0**
As GDP %	**7,9**	

Source: ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. *Alternativas y equilibrios para el sistema de salud Colombiano*. Revista Hospitalaria. No. 72, julio-agosto de 2010. p. 18.

Of the total healthcare expenditure for that year, 75%, ($ 28,958,339 million pesos) were allocated to healthcare, 16% for administrative expenses, other 8% and the remaining 1% to investment. Of the total resources used in healthcare, 34% equivalent to $ 9,845,835 million pesos, were spent in hospitals, which represented in 2009, 25.5% of total healthcare expenditure and 2% of GDP.[23]

20 Ibid, http://www.achc.org.co/investigaciones.php?idcat=311.

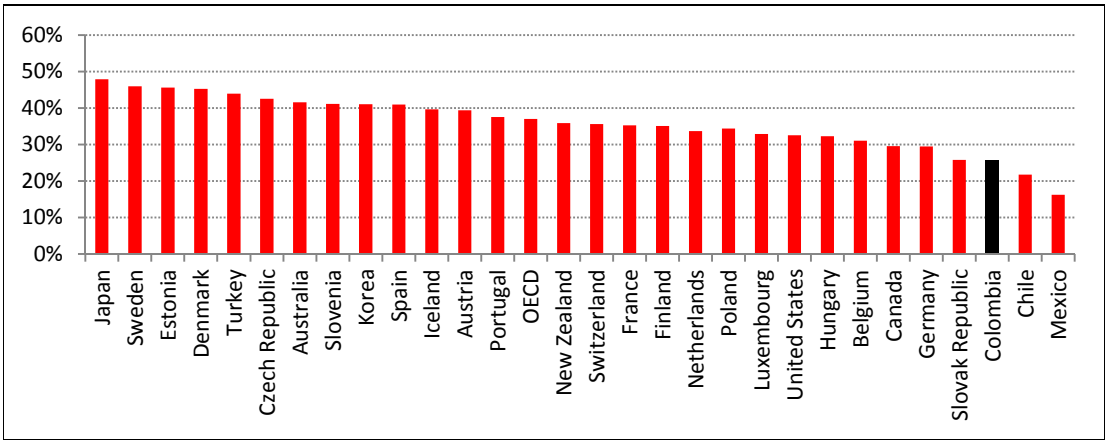
21 ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. *Alternativas y equilibrios para el sistema de salud Colombiano*. Revista Hospitalaria. No. 72, July- august 2010. p. 18.

22 ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. *Alternativas y equilibrios para el sistema de salud Colombiano*. Revista Hospitalaria. No. 72, julio-agosto de 2010. p. 18.

23 Ibíd., pages. 22-23.

The results related to Colombian spending in hospitals, were compared with those obtained in other countries. Bar charts 1 and 2 shows that for Colombia, the outlook in terms of hospitals' expenditure as a percentage of total healthcare investment and as proportion of GDP is not encouraging. As shown No. 1 chart, within the 30 countries under review, Colombia is ranked 27 with a 25.5%, followed by Chile and Mexico, with 21.7% and 16.2% respectively. It is emphasized that the first places are occupied by Japan, Sweden and Estonia with a total of 47.8%, 45.9% and 45.6% respectively expended.

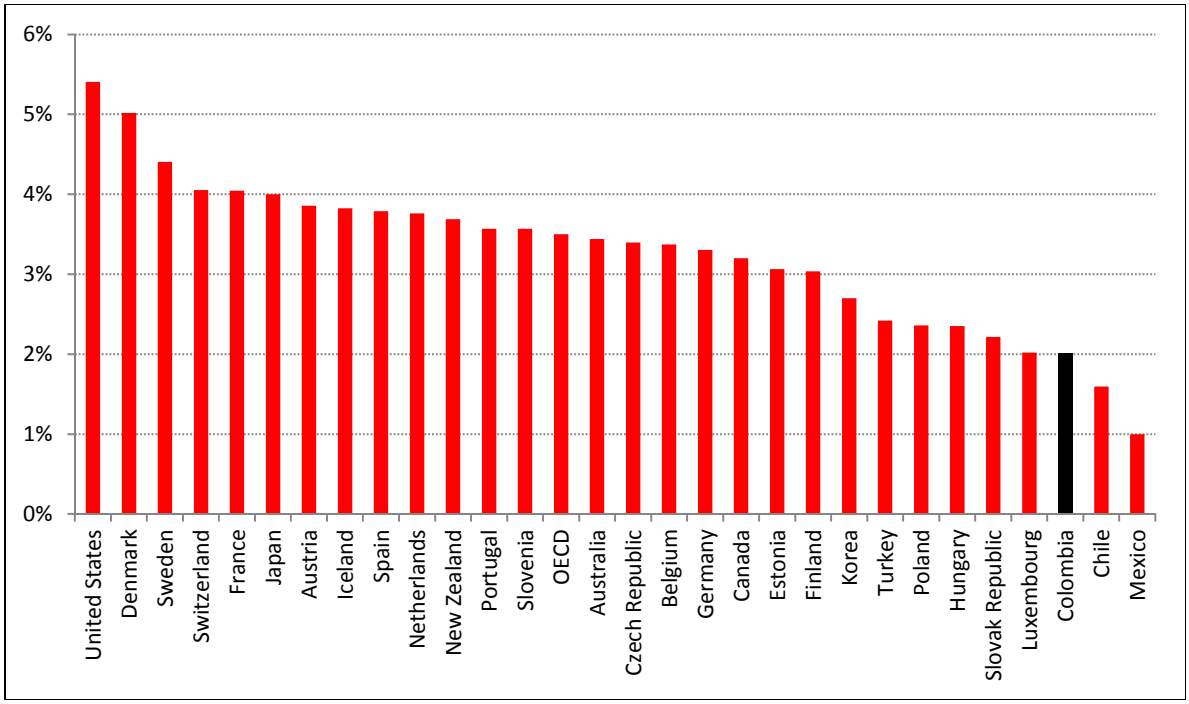
Chart No. 1. Spending on hospitals as a proportion of health expenditure (2009 or earliest available year)[24]



From the budget spent in hospitals as proportion of the GDP, as shown in the following Chart and accordingly to the previously explained, Colombia occupies the 27th among the 29 assessed countries. In this case, the U.S., Denmark and Sweden, stands out for having the largest proportion of hospitals expenditure as a proportion of GDP, with 5.4%, 5% and 4.4% respectively.

[24] ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. *Alternativas y equilibrios para el sistema de salud Colombiano*. Revista Hospitalaria. No. 72, julio-agosto de 2010 and OECD. Statistics. See: http://stats.oecd.org/index.aspx?. [consulted the 1st of february 2012].

Chart No. 2. Spending on hospitals as a proportion of GDP (2009 or earliest available year)[25]



4. Competition rules in the healthcare sector in Colombia

In general, ensuring free competition is a constitutional value, established in Article 333 of the Colombian Constitution. Particularly anti-competitive practices' general clause was defined by Article 1 of Act 155 of 1959 prohibiting agreements which have as purpose or effect limiting the production, supply, distribution or consumption of raw materials, products, goods or national or foreign services; and in general, any practice, procedure or system that restricts competition, and/or maintaining or fixing unfair prices. In addition to the general clause, articles 47, 48 and 50 of the Decree 2153 of 1992, forbade agreements that restrict competition, the commission of acts contrary to free competition, and behaviors that constitute abuse of dominant position of a company in a given market, and punishes them for having unlawful object.

With regard to free and fair competition within the SGSSS, it should be noted that the Act 100 and the Decree 1663 of 1994, established a set of behaviors considered as restrictive of competition. Thus, on the one hand, paragraph 2 of Article 183 of the Act 100 prohibits 'all agreements or arrangements, and concerted practices and decisions that are directly or indirectly aimed at the prevention, restriction or distortion of free choice.

On the other hand, Article 3 of Decree 1663 of 1994 in developing the general prohibition enshrined in the Act 155 of 1959 banned agreements, as well as concerted practices and decisions that, directly or indirectly have the purpose or effect of preventing, restricting or distorting competition in the healthcare market. The same article extends the application of this standard to EPS, IPS, to healthcare professionals, scientific or professional associations and individual legal persons involved in that market.

25 ASOCIACIÓN COLOMBIANA DE HOSPITALES Y CLÍNICAS. *Alternativas y equilibrios para el sistema de salud Colombiano*. Revista Hospitalaria. No. 72, julio-agosto de 2010 and OECD. Statistics. See: http://stats.oecd.org/index.aspx?. [consulted the 1st of february 2012].

In the same way, articles 5, 6 and 8 of the Decree, specially forbade in this sector anti-competitive agreements, the commission of acts contrary to free competition, as well as behaviors that constitute abuse of dominant position of a company in this market.

Furthermore, in line with Article 2 of the 1340 Act which provides that, the rules of competition protection shall apply to anyone engaged in economic activities that affects or may affect its natural development, regardless of form or legal nature in any economic sector. Concerning to healthcare market, this norm is applicable to all those who participate in it, i.e., EPS, IPS, scientific associations, doctors, among others, as much as the competition law, as it embodies the same way Article 3 and 4 of Decree 1663 of 1994.

5. Relevant cases

In order to illustrate the application of competition rules in the healthcare sector in Colombia, set out below are some of the most important administrative proceedings, leading studies and legal opinions developed by the Colombian competition authority in this sector.

5.1. Restrictive trade practices

Over the past eleven years the Superintendence of Industry and Commerce (SIC for its acronym in Spanish) has processed seven investigations related with restrictive practices and "unfair competition" in the healthcare industry; four of which have been sanctioned and the three other still under investigation. Additionally, to date, a total of seven (7) complaints, and four (4) preliminary findings, are been dealt with. The most prominent cases on restrictive practices in this sector in Colombia:

5.1.1. SIC v Colombian Society of Pediatrics and Childcare of Santander Region (Sociedad Colombiana de Pediatría and Puericultura Regional Santander)

On December 12th 2011, SIC, by Resolution 71792 imposed a sanction to the *Colombian Society of Pediatrics and Childcare of Santander Region* for violating the prohibition contained in Article 4 of Decree 1663 of 1994, as well as to their legal representatives for having executed and tolerated anticompetitive conducts undertaken by the company. The association was found to be establishing procurement regulations, decisions and policies, with the purpose to set flat fees for specialized pediatric care services as well as negotiating terms for its members, when contracting with IPS and ESE, private and public hospitals.

5.1.2. SIC v Colombian Association of Integrative Medicine et. al. (14 Healthcare Insurers)

On August 30 of 2011, SIC, by Resolution 46111, imposed a fine to ACEMI (Spanish acronym) and 14 EPS of the Contributive Scheme for violating the prohibition contained in Article 4 of Decree 1663 of 1994, for having set an anticompetitive agreement affecting the healthcare insurance market. Their legal representatives were also fined for having executed and tolerated anticompetitive conducts undertaken by the association and the EPS.

The SIC found that the EPS' members of ACEMI agreed in a concerted manner (i) to affect the levels of healthcare service provision in the insurance market, by defining a list of procedures that should be denied to members, allowing those who made the agreement to stop competing (ii) to prevent the transparency of information required by the regulator to determine the UPC value, as it instructed on the content of the information to be submitted. Moreover, the information was untruthfully presented as it failed to present real data regarding cost structure, frequencies of service and expenses. In turn, within the association, exchanges of sensitive information between competitors were allowed, and (iii) to create a mechanism to set the UPC, therefore, indirectly defining the healthcare insurance price.

The anticompetitive conducts were mostly based on information exchange schemes. The insurers exchanged information regarding which benefits of the plan should not be included due to their cost and therefore, should be passed on the State.[26] [27] This had a double purpose: (i) to shrink the benefits plan in order to assume a lower cost; and (ii) to push the government institution to increase the UPS. The conduct also enabled the EPS to have an additional profit as they charged to FOSYGA for services that according to them were not included in the POS and therefore were not covered by the UPC, but in fact they were.

5.1.3. SIC v Risaralda Hospital Association

In August of 2011, the SIC, by Resolution 41687 imposed sanctions on Risaralda Hospital Association for violating the prohibition contained in Article 4[28] of Decree 1663 of 1994, and to its legal representative for perpetrating and tolerating anticompetitive behaviors made by the association. SIC held that Risaralda Hospital Association had evolved as a cartel of the region's hospitals to impose contractual conditions to insurers (EPS). The association decisions were intended to and with the effect of restricting and distorting competition in the market, by participating directly as a consultant and representative of the ESE in contractual negotiations. The negotiations were conducted with EPS of the Subsidize Sector, setting contractual conditions and agreeing prices upon ESE services standards, offered by the guilds, and thus, exceeding their legally allowed role.

5.1.4. SIC v Colmedica et. al. (12 EPS of the contributive regime)

By Order 26273 of May 20 of 2011, the Delegate for the Protection of Competition, opened an investigation to determine whether twelve EPS and their legal representatives, were engaged in violation conducts of the competition protection regime, embodied in Article 1 of Law 155 of 1959, Article 3 of Decree 1663 of 1994 and sections 1 and 10 of Article 5 of the Decree. Given the analysis of the information provided by the MPS it was established that the inconsistencies found, due to lacking of accuracy in the information supplied by the EPS, makes evidently the interest of the 12 EPS to increase healthcare spending, in order to induce an increase in the UPC, since the calculation of the prime depends on the EPS reporting costs incurred by to the MPS; all of which affects the proper transparency in the insurance market sector.

Some of the inconsistencies reported by the MPS were:

1. Medicine was given to 350.167 affiliates without having received medical attention. Valued at $46.920.013.451 (COP)

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26 The system allows insurers to charge the State for those health risks not included in the plan. Then, the more benefits are excluded from the plan, the more risks are assumed by the State.

27 The values charged by the EPS-C unionized in ACEMI increased from $ 336,647,644,862 (COP) in 2006 to $ 1.798.892.621.322 (COP) in 2009, representing an increase of 434% in four years. This corresponds to 90% of the total amount financed by FOSYGA (Colombian healthcare Solidarity and Guarantee Found) in 2009.

28 Article 4 of Decree 1663 of 1994, prohibits to the scientific and professional associations or societies, and the healthcare sector auxiliaries, to adversely affect competition in the healthcare sector, when developing their activities.
However, under the scope this article, not all decisions or internal policies adopted by an association, have the potential to constitute a violation of the rules of free competition, for the behavior of such entities may be regarded as anticompetitive only when meeting the elements establish in the norm; this is, when it fulfills at least one of the following precepts: (i) prevent, restrict or distort competition, (ii) abuse of a dominant position, and / or (iii) prevent, restrict or suspend the provision of health services.

2. 429.307 people were prescribed medicine without having received the treatment in which the specific medicine is used. i.e. patients receiving x medicine use for cancer treatments without having been diagnosed or treated for it. Valued at $86.938.045.353. (COP)

3. The analysis of 20 of the medicaments provided by the EPS, that had highest increase in supplied quantities and prices, proved not only that the supplied doses exceeded the maximum permitted but also that the prices inexplicably varied from one insurer to the other.

These inconsistencies prevented the CRES from fixing the UPC value for 2011 reason why, it had to be fixed based on the healthcare sector inflation.

5.1.5. SIC v Meta Hospitals

The Delegate for the Protection of Competition, by Resolution 43152 of 2011 opened an investigation to determine whether the 13 ESE in Meta and its legal representatives were engaged in violating conducts of the protection regime. According to the investigation, the ESE (public hospitals) would have been carrying out an anticompetitive agreement, aiming to collectively negotiate with the EPS, contractual terms and conditions; and in the same scenario, would have taken actions to intervene in the process of determining the tariffs for first level healthcare services.[29]

5.1.6. SIC v Hospitals Associations and Social Enterprises of the State

On September the 6th 2010, the Delegate for the Protection of Competition, through Resolution 47786 opened an investigation to determine if ASOHOSVAL, the executive director and legal representative, were engaged in violating conducts of competition regime established in the Article 4 of Decree 1663 of 1994 and paragraph 16 of the Article 4 of Decree 2153 of 1992. Considering that apparently this association in developing their business, took decisions and gave instructions to their members, with the purpose and effect of restricting and distorting competition in the healthcare providers' market, by participating actively in terms and conditions negotiation of contracts related with rates, payment methods, contract subject, induced demand, among others, between associated hospitals and operating EPS in the department of Valle del Cauca.

5.2. Mergers and Acquisitions

With regard to business integrations that have been put into consideration before the SIC in the last eleven years, we have that the competition authority has received a total of sixty six filings, sixteen of which were part of the healthcare market and the fifty remaining, of the pharmaceutical industry. Two of them were conditioned and in three withdrawn. The other operations were approved by the entity.

5.3. Competition Advocacy

In accordance with Article 7 of Law 1340 of 2009 and Decree 2897 of 2010 which conferred on this Superintendence power to exercise functions of Competition Advocacy, under which the entity may submit concept of State regulation projects that may have an impact on markets competition, including those belonging to the SGSS.

Last August the 26th 2011, the SIC presented its opinion regarding the "Agreement Project" sent by the CRES by virtue of which, a factor of adjustment to the UPC for the Benefit Plan Administrators on the

[29] Healthcare service is provided in three different levels, according to the installed capacity of the IPS, being the first level the one in which basic procedures are provided.

contributive regime (EAPB Spanish acronym) with concentration of members in age groups over 50 years, was established. In this matter, the SIC pointed out that there were not sufficient grounds to consider the agreement pro-competitive. According to SIC's recommendation, the CRES should evaluate the minimum threshold parameter of members' concentration in old age (37%) to be able to access to the additional premium, in order to extend this benefit to other EPS, and in this way generate an incentive for competition between EPS for a higher prime because of the age group.

6. Conclusions

It has been shown that healthcare markets are characterized by market failures, which imply that the free operation of market forces in this sector did not ensure optimal service supply and allocative efficiency. Some of these failures are: information asymmetries, moral irrigation, induced demand, adverse selection and agency problems, among others.

The Colombian SGSSS is based on the philosophy that state regulation of healthcare imperfect market forces, would achieve an optimal social benefit. In fact, Act 100 of 1993, which lays the foundation for the structure of the Colombian healthcare system today, created the conditions and incentives that led to competition by allowing the entry of new providers, but under a system of regulated competition, that is, under the regulation, supervision and control of the state.

In the structure of the SGSSS two major markets are highlighted: (i) healthcare insurance and (ii) the provision of healthcare services, which are related to other markets with the necessary goods or services for the provision of healthcare services to users, among which are, the pharmaceutical market, the market for healthcare professionals, the medical technology market and the market for supplies and medical devices. Agents in each market are grouped in associations or unions that represent them.

With respect to administrative actions undertaken by the SIC in the healthcare sector, we have that, in the course of the last eleven years, the competition authority has processed seven investigations for restrictive practices; has approved sixty one mergers and has issued an opinion on competition advocacy addressed to CRES.

7. Recommendations

This section remarks the results of the 'health market regulation study' prepared by Universidad del Rosario and SIC under the program sponsored by the Ministry of Industry and Commerce. The above study was directed especially to propose regulatory changes to encourage competition in the health insurance sector, within four points are highlighted:

- Introducing competition in marginal premiums: it proposes a scheme in which the insurance prime or UPC varies in a range that allows the current competition between EPS, limited to the quality of service and the extension of benefits plans, be extended to certain insurance price competition.

- It is recommended to replace high-cost account for a risk sharing mechanism in which the EPS' shares 5% of the cost of their more expensive members. In this way all the EPS would have to contribute with a premium to finance the group members. The foregoing is intended to limit the incentives of the EPS to select risks.

- It is proposed to develop indicators to measure aspects of the relative efficiency in the provision of healthcare services, pointing to the promotion of competition by comparison in which the UPC received by EPS for each member, would depend also on good resources' management results.

The relative efficiency indicators serve not only to reward the best through the determination of the UPC, but also to convey information to allow users to choose their insurer on the basis of objective criteria.

- We suggest the implementation of a negative benefits plan in the POS instead of positive one, to define the treatments/procedures that will be subject to the implementation of recovery mechanisms, which will gain clarity and transparency in the financing of the system.

PERU

1. Main features of the Peruvian health services sector

1.1. Health service providers

The Peruvian health system is characterized by having various actors (in both service provision and public insurance) whose functions are not necessarily complementary; in fact, they present high degrees of overlap. The system is composed by EsSalud; the Ministry of Health; Regional and Local governments; the health services of the Armed Forces and the Police, and the private sector.

EsSalud is a mandatory medical insurance for salaried workers. By June 2011, 8,97 million people were affiliated to EsSalud, 47% of which belong to care networks of Lima.[1] According to the National Institute of Statistics and Information (INEI), EsSalud concentrates 19,2% of the population.[2]

The Ministry of Health is in charge of decentralized public national institutions which are specialized in maternity, paediatrics, mental health, rehabilitation, ophthalmology, cancer, among others.

During the last decade, functions and resources (human and financial) to provide public health services were transferred to Regional Governments. Furthermore, since 2007 the management of primary care is being transferred to Local Governments.[3]

Armed Forces and the Police also provide health services to their members. Considering holders, beneficiaries and others, these health services cover 1,4% of the population.[4]

Finally, the private sector also plays a role in the Peruvian health system. It includes both non-profit and for-profit organizations and is extremely fragmented.[5] It should be mentioned that most of the biggest private sector institutions (clinics, specialized institutions and laboratories) are affiliated to the Private Clinics Association of Peru.

Public services and those of EsSalud are organized into geographically distributed care networks and by levels of complexity for the member population. They have general and basic hospitals, health centres and posts. The country has all clinical specialties and highly complex equipment but they are not equitably distributed, in fact, they are concentrated in the main cities of Peru and, especially, in Lima and Callao.[6] Table 1 presents the number of health facilities, by institution.

1 Source: National Superintendence of Health Insurance.

2 National Household Survey of 2010.

3 Responsibilities in the areas of water and basic sanitation are also being transferred to Local Governments.

4 National Household Survey of 2010.

5 PAHO (2007).

6 Ibídem.

Table 1. Peru: health facilities, by institution (September, 2011)

Institution	Lima and Callao	Other regions	Total
Ministry of Health and Regional Governments	771	7 084	7 855
EsSalud	64	313	377
Police Health Service	30	125	155
Armed Forces Health Services	139	219	358
Private Sector[1/]	260	207	467
Total	**1 264**	**7 948**	**9 212**

Source: National Superintendence of Health Insurance – Sunasa (2011)

1/ Includes only health facilities that are affiliated to a health plan in a Health Provider Organization. The total number of health facilities in the private sector is higher.

1.2. Insurance

Insurance also plays an important role in the provision of medical services. In the case of Peru, it is important to mention the Comprehensive Health Insurance (CHI), which is a public insurer and financer created in 2002 and designed to facilitate free access to basic health care for poor and extremely poor people who are not covered by any other kind of insurance (in particular, the population under 18 years of age, pregnant women and targeted adult groups). This insurance only finances the cost of health services, patients receive medical care in institutions of the Ministry of Health and Regional Governments. The CHI covers 45,4% of the population (see Table 2).

Table 2. Peru: Health insurance coverage

Health insurance	%
Comprehensive Health Insurance	45,4%
EsSalud	19,2%
Police and Armed Forces Health Insurance	1,4%
Private Health Insurance	1,2%
University Health Insurance	0,4%
Health Providers Organizations	0,3%
Other	0,3%
Not insured	32,9%

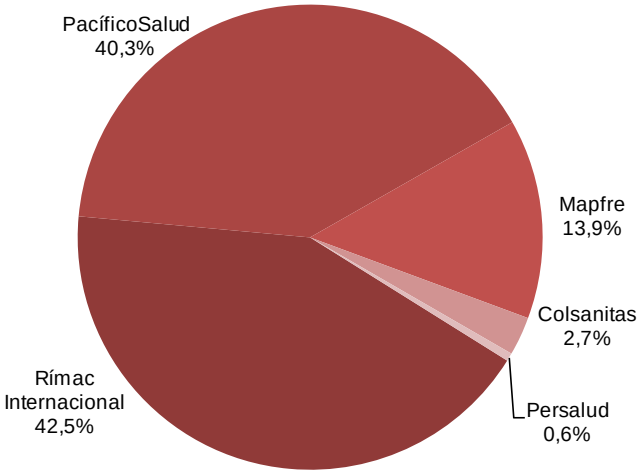
Source: National Household Survey of 2010.

EsSalud is the second biggest insurer in the country. As mentioned before, EsSalud is a mandatory medical insurance for salaried workers and covers 19,2% of the population.

In 1997, a mixed insurance system was established. The reform included the participation of Health Provider Organizations (HPO), private sector organizations which should complement EsSalud through the

provision of health services in their own infrastructure and/or with third party providers. Workers can choose if they are covered entirely in EsSalud or if they want to access a plan offered by a HPO. However, HPO members with catastrophic diseases can still be treated in EsSalud. By 2010, only 0,3% of the population was covered by a HPO. Nowadays, five HPO are operating in Peru and two of them (Rímac Internacional and PacíficoSalud) cover 82,8% of the HPO members (see Graph 1).

Graph 1. Peru: Members of health provider organizations



Source: Sunasa (2011).

The Police and Armed Forces Health Insurance, Private Health Insurance and other account for 3,3% of the population, while the remaining 32,9% of the population is uninsured.

2. Competition and regulation

2.1. Barriers to entry

Licensing and other restrictions on professional services are used to ensure quality when there is asymmetric information. This is the case in the health services sector: if consumers cannot determine the quality of medical care, then they cannot compare the quality of the medical services received and avoid less competent providers. Therefore, in order to avoid market inefficiencies and sub-optimal care, some countries have decided to certify medical applicants in order to ensure that they meet minimal requirements.

Even though some regulation is in place in the health services sector in Peru, there is no systematic registry of performance indicators of physicians (hours of surgery, for instance).

Another aspect that is important to analyse is the nature of demand for health services. Demand for health services is a derived demand: consumers (patients) cannot determine which services will be used for treating a disease; instead, the demand is determined by providers (physicians), who are entrusted with the decision because of their knowledge and experience. As a result, the demand for medical services is deeply influenced by the prestige gained by the medical institution, its equipment and the supporting staff. According to the preliminary results of an investigation carried out by the Economic Research Division of

the National Institute for the Defense of the Competition and the Protection of Intellectual Property Rights – Indecopi[7], this is particularly true in the case of the treatment of catastrophic diseases, such as cancer. In fact, these characteristics may constitute a barrier to entry into the sector.

2.2. Main features of competition in the private sector

As mentioned before, provision of health services in the private sector in Peru is in charge of both non-profit and for-profit organizations. The sector is extremely fragmented, particularly in the case of for-profit organizations.[8]

Private medical institutions (especially clinics) offer their services primarily to the population with higher income, leaving an unmet demand for health services in groups with lower income. Taking this into consideration, one of the main competition strategies of some clinics (such as Clínica San Felipe and Clínica Angloamericana) during the last few years has been to expand their presence in districts with higher average income, especially through small medical units, while the most complex medical services are derived to their bigger facilities. Nonetheless, other clinics (such as Clínica Ricardo Palma and Complejo Hospitalario San Pablo) have decided to expand to districts with lower average income, with quasi-independent service units that provide less complex health services.[9]

Another interesting feature of the competition in the private health sector is that the main source of income for most of the clinics is the sale of drugs.[10] In addition, the sale of drugs represents their source of revenue with highest net margins (14%).

Finally, it should be mentioned that in the last few years, competition in health services in Peru has been characterized by the presence of vertical integration between HPO and clinics. In fact, the largest HPO have been acquiring clinics and medical centres, either directly or through their shareholders (see Table 3). These acquisitions would reflect the fact that the management of insurance provides the amount of customers required to ensure operational self-sufficiency; while the operation of clinics facilitate cost reductions.

7 Indecopi (2011a, 2011b, 2011c, 2011d).

8 PAHO (2007).

9 Apoyo (2005).

10 According to Apoyo (2005), drugs expenses represent 42% of total medical services expenses of HPO.

Table 3. Peru: Vertical integration in the health services sector

HPO	Main shareholder	Clinics
Rímac Internacional	Rímac Internacional S.A. Compañía de Seguros y Reaseguros	Clínica Internacional
PacíficoSalud	El Pacífico – Peruano Suiza Compañía de Seguros y Reaseguros	Clínica El Golf Clínica San Borja [1/] Clínica Galeno[2/] Centro Médico Oncocare[3/] Centro Odontológico Americano[3/]
Mapfre	Mapfre América S.A.	Clínica Italiana[4/]

Source: Apoyo (2011a, 2011b, 2011c, 2011d).

1/ 60% of shares.
2/ Clínica Galeno is located in Arequipa, all the other institutions listed in the chart are located in Lima.
3/ 80% of shares.
4/ Clínica Italiana has not operated since 1997. However, in 2006 its infrastructure was acquired by Mapfre, HPO that has manifested its interest in the construction and operation of medical centres.

2.3. Anticompetitive practices

There is no record of anticompetitive practices among providers of health services in Peru. There is, however, one case of collusive practices among EsSalud's providers of medicinal oxygen. According to the analysis of the Free Competition Commission of Indecopi[11], Praxair Perú S.R.L., Aga S.A. and Messer Gases del Perú S.A. participated in market-sharing agreements during a series of procurement processes organized by EsSalud between January 1999 and June 2004. As a result, Aga S.A. was the winner of public procurement processes in the north of the country, Messer Gases del Perú S.A. in the centre of the country, and Praxair Perú S.R.L. in the south of the country and in Lima, the capital city. Furthermore, prices of the winning bid were set close to 110% of the reference value set by EsSalud, while the competing bidders were always disqualified because they did not meet the price requirements set in the State Procurement Act.[12] Fines were set at US$ 4,89 million (Praxair Perú S.R.L.), US$ 1,70 million (Aga S.A.) and US$ 0,74 million (Messer Gases del Perú S.A.).

It should also be mentioned that a private clinic (Clínica Santa Teresa S.A.) has initiated four procedures in the Overseeing of Unfair Competition Commission of Indecopi against specialized public institutes. According to the claimant, the use of a differential tariff in specialized public institutes would not comply with the subsidiary principle of State's economic activities, as established in the Peruvian Constitution (see Box 1).

11 Indecopi (2010a).

12 According to the State Procurement Act, bids with prices that are higher than 110% of the reference value are disqualified.

Box 1. Subsidiary principle of the State's economic activities in the health service sector

Article 60 of the Peruvian Political Constitution of 1993 allows the participation of the State in the provision of goods and services in cases where market incentives alone are insufficient to ensure that these goods or services would be provided; as long as: (i) the State intervention is authorized by means of a special law, (ii) the Government activity is subsidiary, and (iii) there is an overriding public interest or manifest national benefit supporting the State intervention. The competition authority, through its Overseeing of Unfair Competition Commission, is in charge of guaranteeing the observance of this article.

The Defense of the Competition Chamber Nº1 of Indecopi has analyzed the subsidiary principle and, according to its interpretation, it applies to situations in which the participation of the State in business activities is tolerated because there is no real nor potential private provision of a good or service or because private provision is not sufficient to meet the needs of a certain group of consumers (see: Indecopi, 2010b).

In this context, Clínica Santa Teresa S.A. initiated four procedures against the use of a differentiated tariff in public institutes which are specialized in the treatment of cancer, pediatrics, ophthalmology and maternity and neonatology. These institutions provide their medical services to patients covered by the Comprehensive Health Insurance, patients derived from public hospitals because of the complexity of the disease and uninsured patients at relatively low prices. However, if patients want to receive medical services from these institutions with a lower waiting time, be attended by particular doctor or be hospitalized in a private room, they can get it by paying a higher price: the differentiated tariff. According to the plaintiff, services provided under the differentiated tariff constitute unfair competition from the State to private sector clinics, since they violate the subsidiary principle described above. The cases are currently under investigation.

2.4. Regulation of the pharmaceutical industry

One final aspect that should be reviewed is the pharmaceutical industry since drugs are one of the main inputs in the health services sector. In Peru, there are both producers of drugs (generic and national brand name) and laboratories that import and market drugs in the country. Nonetheless, the sector is highly concentrated.[13]

There is no regulation of drug prices since 1991, although some aspects of their commercialization are regulated. These regulations can be divided into four main categories:

- *Registration and inspections.* The registration of drugs is a requirement for their commercialization. Additionally, inspections to laboratories, importers and storage facilities are conducted in order to verify the compliance with Good Manufacturing Practices and Good Storage and Dispensing Practices, as well as quality controls. Both activities are in charge of the General Office of Medications, Supplies and Drugs. According to some authors, control is relatively small and only a few laboratories comply with Good Manufacturing Practices.[14]

- *Public procurement.* Public procurement of drugs is regulated with the objective of acquiring quality drugs at the lowest possible cost,. Regulations prioritize the use of auctions and include the use of a National Essential Drug Request for all institutions that belong to the public sector (Ministry of Health, Regional and Local Governments, EsSalud and the Police and Armed Forces Health Services).

- *Reduction of taxes and tariffs.* With the aim of reducing the final price of drugs, especially the ones used in the treatment of AIDS, cancer and diabetes, taxes and tariffs on drugs have been

13 Miranda (2004).

14 Ibídem.

reduced. However, according to different studies, these measures have not achieved their goal and, instead, the marketing margin of producers and importers of drugs have increased.[15]

- *Commercialization.* The law also establishes minimum requirements in infrastructure and equipment which must be met by pharmaceutical establishments (pharmacies, drugstores and laboratories) in order to ensure the proper conservation and storage of drugs.

[15] See: Ministry of Health of Peru (2010), Meza (2011).

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SOUTH AFRICA

1. Introduction

The purpose of this submission is to provide a brief overview of the challenges facing the private healthcare market in South Africa and the role played by competition policy. In particular, we discuss the effectiveness of competition in hospital services and the role that competition law interventions and policy have played in this regard. Finally, we assess briefly the challenges faced by the government in attempting to bring about regulatory reform.

South Africa is faced with significant inequalities in access to healthcare services. The national budget on healthcare is significant at 8.6%% of GDP[1]; however public health services are widely thought to suffer from poor quality and inefficiency. A private health sector, mostly financed by medical insurance, exists in parallel to the public system. Private financing as a percentage of total healthcare expenditure stood at 51% in the 2010/2011 financial year.[2] The number of people covered by private medical schemes (or what would be termed insurance in other countries) has remained consistently below 20% of the population over the past decade.[3] This reflects the costs of health care and has implications for the ability of individuals to access private healthcare and also the state to procure services from the private sector.

This paper will focus on competition in the private healthcare sector, which underwent significant liberalisation in the previous decade, and not on the public sector which remains fully state-operated and financed.[4]

2. Background to competition developments in private healthcare

2.1. Regulatory context

Before 1993 the private healthcare industry was regulated by government through the National Health Act ("NHA") and the Medical Schemes Act of 1967 (now the Medical Schemes Act, 131 of 1998 ("MSA"). Within this framework, healthcare tariffs were determined through collective bargaining and co-operation between the medical schemes and the healthcare providers, as represented by their associations.[5] These collective associations were legally recognised as bodies with an interest in determining healthcare tariffs and reimbursement rates for the respective professional services. The resultant tariffs were officially published and binding on the service providers.

1 Council of Medical Schemes (2012), CMS Comments on Proposed Policy on National Health Insurance.

2 Ibid.

3 Council of Medical Schemes submission to the Competition Commission, based on publicly available data.

4 South Africa, unlike countries such as the UK, has not engaged in policy reforms aimed at introducing competition in the public health sector.

5 These included the Representative Association of Medical Schemes (RAMS) (now Board of Healthcare Funders, BHF) and the Medical and Dental Associations (MDA) (now the South African Medical Association) and the Hospital Association of South Africa (HASA).

Although the sector underwent a process of deregulation in 1993, the collective determination and publishing of healthcare tariffs by the medical schemes and health provider associations continued as a standard practice.

2.2. The Competition authorities' intervention on collective bargaining in private healthcare

In 2002, the collective determination of healthcare tariffs became subject to scrutiny by the competition law authorities.[6] This was one of the very early cartel contraventions to be taken on by the authorities. Investigations into per se prohibited conduct generally preclude an examination of the likely effect of the arrangement in question. In this case the associations settled with the competition authorities; thus the possibility of alternative outcomes and remedies was not fully explored.

The trend of consolidation in both private hospitals and medical schemes continued. However, after the Competition Tribunal's ruling there was bilateral negotiation meaning individual bargaining power became more important.

3. Dynamics of competition in the markets for private hospital services

With the cessation of collective bargaining, the differential levels of bargaining power possessed by different groups of market players became apparent. This has been most evident in the case of the three large hospital groups (Netcare, Mediclinic and Life) who have enjoyed substantial price increases. A network of independent hospitals, the National Health Network, was granted an exemption from the Competition Commission to negotiate collectively, reflecting the Commission's recognition of the weak position of independent private hospital in terms of being able to be effective competitors.

It is important to note that the negotiation over prices happens at a national level and the major groups provide national networks to which they have progressively added by acquiring individual hospitals that typically had doctors as the major shareholders. The main hospital groups do have somewhat different profiles, however. For example, Mediclinic tends to have hospitals in smaller towns with only one major private hospital, reinforcing its importance to medical schemes, even though it has a smaller share in most major cities.

Consolidation on the payer side of the market[7] has enhanced insurers' bargaining power though there is debate as to the extent to which the leading medical schemes are able to exercise countervailing power against the hospital groups.

In contrast to the situation between funders and hospitals, with regards to individual medical practitioners (such as general practitioners, optometrists and dentists), large medical schemes like Discovery Health have placed considerable downward pressure on the reimbursement rates paid to these classes of providers. These numerous and fragmented providers have been very vocal in their complaints against insurers pushing down reimbursement rates to levels which they consider to be unacceptably low.[8]

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6 This was three years after the establishment of the competition authorities.

7 According to the 2009/2010 CMS Annual Report there are 110 medical schemes in South Africa representing about 8 million beneficiaries. Most medical schemes are administered by third-party medical scheme administrators. The top four medical administrators hold over 76% market share (Discovery Health 27%, Metropolitan Health 24%, Medscheme Holdings 18%, Momentum Medical Scheme 7%). While administrators should negotiate tariffs on behalf of their medical schemes, it is not clear whether this is happening effectively in practice for the smaller schemes.

8 It is possible that schemes place disproportionate pressure to reduce prices on providers with weaker bargaining power in order to compensate for the higher prices of hospitals and specialists who have

This situation introduced instability into the pricing regime insofar as there were now increasingly greater discrepancies between provider charges and the reimbursement rates of medical schemes. One consequence of this has been the practice of balance billing whereby members are often required to make co-payments to providers whose own fees exceed the stipulated reimbursement rates.

In response to these challenges the Council for Medical Schemes (CMS), with the blessing of the Department of Health, published a National Health Reference Price List (NHRPL).[9] The objective of the NHRPL process was to establish a schedule of prices that would be based on an independent and objective determination of costs. Despite this objective, the NHRPL process was unable to achieve a satisfactory outcome on price. Medical service providers with market power (particularly private hospitals and specialists) deviated from the NHRPL when they wanted to raise prices, often resulting in substantial increases.[10] Medical schemes were forced to condone balance-billing practices so that beneficiaries could have adequate cover.

The NHRPL was beset with controversy as medical schemes challenged the empirical costing basis of the tariffs whilst providers argued that benchmarking exercises were too costly. Managing these tensions proved to be difficult for the Department of Health; in 2010 the regulation was set aside by the High Court following review applications by Netcare, the South African Private Practitioners Forum and others.[11]

3.1. Consolidation and countervailing power in the hospital market

The increasing concentration of the hospital market in the hands of Netcare, Medi-Clinic and Life Healthcare has been cited as a major factor behind these hospitals' ability to achieve allegedly unjustifiable price increases without any competitive constraint.

Competition in the private hospital sector has been largely examined through the lens of particular hospital mergers, several of which have been highly contested.

In the first major transaction to be reviewed under the new competition regime (*Afrox/Amalgamated Hospitals*)[12] the Competition Tribunal held that despite the significant concentration in the local private hospitals market, the merger was unlikely to have a negative effect on competition. The Tribunal stated that a negative effect would arise if the transaction was able to adversely affect the ability of other hospitals to compete for doctors' referrals in the region and/or reduce the countervailing power of the funders, who at the time, negotiated collectively as the Board of Healthcare Funders. They concluded that due to the presence of rival hospital groups in the relevant local market and the countervailing power of funders, this was not likely to happen and thus approved the merger.

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relatively greater bargaining power. It is important to note that most of the debate on this issue has been speculative and not based on hard evidence. It is necessary to investigate the bargaining mechanisms and power relations more thoroughly than has been the case.

9 Circular 10 of 2003 of the Council of Medical Schemes makes reference to the publication of the NHPRL from 2004 onwards.

10 According to the CMS and DoH "Discussion Document: The Determination of Health Prices in the Private Sector", 28 October 2010, prices for certain services increased by as much as 300% of the NHRPL.

11 Decision of the High Court of South Africa, North Gauteng Division, 28 July 2010, Case Number 37377/09.

12 An acquisition by Afrox Healthcare Limited (Afrox) of 76%, over and above the 19.2% it already held in Amalgamated Hospitals Limited (Amalgamated) in 2001. Case No: 53/LM/Sep01.

In the next key transaction (*Prime Cure Holdings/ Medicross*),[13] which involved primary healthcare and the administration of capitated managed care options,[14] the Tribunal found no issues in the primary care market. In the national capitated managed care market, the Tribunal noted the high levels of concentration, high barriers to entry, regulatory uncertainty given that the market was new, and that the merger involved two of the three significant players. It further noted that the claimed efficiency gains did not outweigh the possible anti-competitive effects and thus concluded that the transaction was likely to prevent and/or lessen competition and therefore prohibited the transaction. This matter was taken on appeal at the Competition Appeal Court which found in favour of the merging parties.

The next major transaction involved the acquisition of an additional 56.25% shareholding, on top of the 43.75% it already held, by Netcare Hospital Group (Pty) Ltd (Netcare) in Community Hospital Group (Pty) Ltd (CHG). The main issue related not to the immediate change in control, and therefore any anti-competitive effects arising as a result, but whether the initial un-notified acquisition of control through the 43.75% shareholding would have had such effect. The difficulty with the approach adopted was that a counterfactual scenario demonstrating an independent CHG's competitive conduct outside of Netcare could not be established with the evidence at hand and therefore no potential harm could be determined. As such the merger was approved without conditions save for an adverse finding on prior implementation and co-ordinated conduct.

The practice of the major groups acquiring a minority share in independent hospitals and then implementing management systems and also pricing has arisen in other mergers, including one currently before the Tribunal. The *Netcare/CHG* merger also involved an assessment of rivalry in terms of bargaining at the national level, and the impact of increased concentration at local or regional levels. The merger did not enhance the merged entity's market power at a national level given the quantitative insignificance of CHG at that level (though this insignificance should not obscure the important role that independents could play in introducing and/or enabling innovation). However the Commission argued that regional effects matter. In addition to patient choice and the market for specialists, the Commission in opposing the merger identified the development of designated service provider network options of the medical schemes as introducing rivalry between hospital groups. These networks involve selecting individual hospitals to put together a list to which beneficiaries would be restricted (outside of emergencies). In compiling the lists, the schemes sought to play off hospitals in each area in order to obtain discounts.

The Tribunal approved the merger as it reasoned that competition primarily took place in the form of national level bargaining and that the local bargaining for restricted (low cost) schemes or options was limited. The rules at the time did not allow for the construction of regional schemes open to anyone. In addition, the Tribunal found that CHG presence was not substantial in any of the three regions in which it had hospitals (thus it did not enjoy a must-have status in any locality). The Tribunal also found that low-cost medical plans based on preferred provider networks were still nascent and not enough evidence was provided to support the idea that a lessening of competition in this market segment only could be construed as a substantial lessening of competition. It should be noted that some key witnesses in this matter raised concerns about the structure of the hospital market and the likely resultant market power enjoyed by the big three groups; however this was not an issue that could be addressed within the context of merger review.

13 Tribunal case number 11/LM/Mar05.

14 This refers to arrangements where a fixed fee per patient (or procedure or group of services) is negotiated in advance between the medical scheme and medical provider. The provider takes on the risk of deviation between the fixed fee and the actual cost of service provision.

Subsequent to these major transactions there has been a plethora of other acquisitions by these major hospital groups which largely involved the acquisition of smaller independent hospitals.

In the discussion document on the determination of health prices in the private sector[15] the Department of Health and the Council for Medical Schemes argue that due to the fact that hospital services are covered by insurance, excessive prices are not constrained by a reduction in demand. The hospitals have countered that excessive pricing should be constrained by competition among medical schemes for members. This competition should create a strong incentive to keep scheme prices (premiums and contributions paid by members) down. This, in turn, should translate into a strong incentive for medical scheme administrators to negotiate for the lowest possible prices for provider services.

Although medical aid schemes have incentives to seek reductions in providers' prices, their ability to compel lower prices will depend on their relative bargaining power in relation to providers. If the medical aid scheme (or administrator) has little or no bargaining power over the provider, then the scheme will indeed be forced to accept the price of the provider. The evidence on scheme's countervailing power is mixed.

Rivalry in the private hospital market can emerge through managed care interventions that rely on preferred or designated provider networks to stimulate price competition. But these arrangements depend on the ability of medical insurance providers to select hospitals (or hospital groups) to channel patients towards and to negotiate credibly with specialists. Concentration, and pockets of regional dominance by hospital groups, confer a 'must-have' status on them and eliminates the possibility for crafting selective contractual arrangements.

There have been some developments in managed care since the *Netcare/CHG* merger. Yet both insurers and hospitals have an incentive to discriminate amongst consumers, thus bringing more people into the insured sector while preventing 'buy-downs' into cheaper cover by those already insured. This expands access, but it does not necessarily bring more competitive prices for the majority of those insured.

Though few schemes have introduced such arrangements into the South African market, some important insurers have made inroads in offering low cost medical plans. However, the challenge remains in that less than 10% of the insured population is covered by affordable schemes that rely on managed care initiatives and the growth in medical insurance beneficiaries in general has not kept pace with population growth.

3.2. The role of specialists

Non-price competition, driven by the need for hospitals to attract specialists to their facilities (and hence patient flows), has contributed to upward pressure on costs and also has the effect of enhancing the market power of both parties.[16] Further inquiry in order to understand the nature of this linkage and the implications for costs is needed. It is likely that patients simply accept the recommendations of specialists regarding where and the terms and conditions upon which they receive hospital care. There may be issues of transparency and disclosure with regards to the conduct of specialists affecting the ability of patients (and insurers) to make informed choices.

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15 Council of Medical Schemes (2010), Discussion document on the determination of health prices in the private sector, 28 October 2010

16 A study by the CMS has found that there were more MRI and CT scanners per 1 million people in South Africa's private healthcare market than in Canada, France, Germany, and the Netherlands. Specialist fees have increased by 90% in real terms between 2000 and 2009. The CMS has also stated that specialists have balance billed patients in some instances by as much as 300% of the guideline tariffs.

4. Conclusion and Way Forward

Access to affordable healthcare services is enshrined in South Africa's Constitution[17] as a fundamental human right and the state is obliged to take reasonable measures to achieve the realisation of this right.[18] In this regard the government has expressed concern about high and unconstrained price increases in the private healthcare sector. It appears that competition has failed to contain prices. Efforts at self-regulation have been defeated by the prohibitions of restrictive horizontal practices under the Competition Act 89 of 1998. An attempt by government to introduce a voluntary reference price list was overturned by the High Court on procedural and technical grounds.

The increasing concentration of the hospital market has been cited as a major factor behind the hospitals' ability to extract unilateral price increases. Unconstrained increases in the cost of private healthcare impact negatively on insured patients and also have implications on the extent to which the public sector can procure services from private providers. For example, a comprehensive National Health Insurance (NHI) would have to procure services from both the public and the private sector.

In order to address the challenges discussed above the Department of Health engaged various stakeholders on the need for a regulatory framework for the pricing of private healthcare services. A discussion document was published on 28 October 2010, "*The determination of Health Prices in the Private Sector*", in which the Department of Health motivated for a regulatory framework that included the immediate establishment of a Health Pricing Authority in terms of which prices of private health services would be subject to collective bargaining between the providers and purchasers of those services. The submissions received in response to the discussion document pointed to key stakeholders' concerns about the process taken to initiate these reforms and the factual basis for such reforms.

A comprehensive examination of the factors underlying the observed increases in the costs of private healthcare in South Africa has yet to be undertaken. This will be important for establishing a factual basis upon which recommendations can be made.

17 Section 27(1) (a) of the Constitution of the Republic of South Africa, Act No. 108 of 1996; Minister of Health v New Clicks SA 2006 (2) SA 311 (CC) paras 514 and 704 to 705.

18 Section 27(2) of the Constitution of the Republic of South Africa, Act No. 108 of 1996.

CHINESE TAIPEI

1. Introduction

In preparing the present submission, the Fair Trade Commission (hereinafter "the Commission") consulted with various government agencies, including the agency in charge of health care, disease prevention, as well as food, drug, and cosmetic management and health insurance affairs, the Department of Health, and the Bureau of National Health Insurance responsible for developing and implementing the national health insurance system. This paper will illustrate the issues related to Chinese Taipei's medical industry, healthcare service quality enhancement policy, and measures for promoting competition under the National Health Insurance (NHI) system.

2. Chinese Taipei's Medical Industry

2.1. Implementation of National Health Insurance

Chinese Taipei implemented NHI system, a compulsory social insurance program, in March 1995, providing equitable medical services to all citizens form birth. Chinese Taipei's National Health Insurance is a self-sustained system responsible for its own deficits that employs "pay-as-you-go" financing to balance its account in the short-term. Rather than seeking to accumulate profit, the Bureau of National Health Insurance (BNHI) is required by law to maintain a reserve fund equal to one month of medical expenditures at least. At present the chief source of revenue is premiums paid collectively by the insured, employers, and the central and local governments, and is not derived from general taxation. Any person that pays insurance premiums and acquires an insurance card is eligible to receive medical services provided by any contracted medical care institutions for illness, injury, or maternity upon presentation of the card. Patients need not bear the cost of treatment covered under the scheme, and the contracted medical care institutions then apply for reimbursement from the BNHI under the Department of Health. Medical services provided under the program include: ambulatory and inpatient care, traditional Chinese medicine therapies, dental services, child delivery, physical rehabilitation, home nursing care, and chronic mental illnesses care among others. The program covers most forms of treatment, including diagnosis, examinations, laboratory tests, surgeries, prescription medications, medical supplies, nursing care, certain OTC drugs and insured hospital rooms.

2.2. Medical Institutions Participate in NHI Medical Services

As of 2010 Chinese Taipei had 20,691 medical institutions (hospitals and clinics), with public medical institutions accounting for 2.6% and private medical institutions accounting for 83.9%. Among these, 92% participated in the NHI program. Medical institutions are effectively managed through Regulations Governing Contracting and Management of National Health Insurance Medical Care Institutions, payment system, treatment reviews, and auditing and penalization of violations, impacting physicians' practices to provide high quality, effective medical services. The elimination of financial burdens to health care access for the public through the institutions of NHI and a high participation rate in NHI among medical institutions have resulted in easy access to medical care for the public. Moreover, the NHI system's design does not set restrictions on where people may seek medical attention, nor does it take a gatekeeper approach, allowing the public free choice. Further, having a large number of medical institutions, the majority of which are private, Chinese Taipei's medical market is highly competitive.

2.3. Medical Services Competition for Quality, Not Pricing

With the implementation of NHI, services covered by the National Health Insurance program constitute the chief source of income for medical institutions. National Health Insurance payments follow a third-party payment approach. After citizens obtain medical treatment, the medical institution submits to the BNHI for reimbursement of treatment costs, and the BNHI reimburses the medical institution in accordance with the National Health Insurance Treatment Payment Standards and drug list, establishing uniform payment standards. Accordingly, pricing is not a key factor in competition among medical institutions. The payment system of Chinese Taipei's National Health Insurance program is distinguished by case-payments under a global budget payment system, together with a multiple payment option system. Under the global budget payment system, hospitals compete for quality, not pricing, and the more patients a medical institution can attract, the higher the volume of medical services it provides and the greater the NHI payments it receives.

In addition, although individual medical institutions may set their own standards for medical treatment fees such as administrative registration fees and items not covered by NHI, including differences between room rates or medicines and tests not included under covered items, Article 21 of the Medical Care Act stipulates that municipal or county competent authorities may determine standards for medical fees (cap) charged by medical institutions. Consequently, although price competition exists, it is relatively restricted. That is to say, under the medical fees controls set forth by Chinese Taipei's National Health Insurance Act and Medical Care Act, medical institutions can only engage in price competition in registration fees and items not covered by the NHI scheme. Further, healthcare services competition among both public and private medical institutions largely takes place in areas not related to pricing, such as in expansion of new facilities, attracting professional talent, and achieving higher level hospital ratings, all of which are part of hospitals' strategy for quality competition.

3. Healthcare Service Quality Enhancement Policy – the Hospital Accreditation System

Chinese Taipei has conducted hospital accreditation since 1988 in accordance with the Medical Care Act, designing different ratings indicators for various hospital categories. Examples include accreditation for hospitals and teaching hospitals, mental hospitals and teaching mental hospitals, psychiatry rehabilitation institutions, and psychiatric nursing home institutions. Hospital accreditations are effective for a period of three years. Generally speaking, "patient orientation" and "stress on patient safety" form the core values of the hospital accreditation system. Thus institutions stand out through healthcare service quality, with emphasis on medical staff teamwork, and reconsideration and planning of the operational strategies and systems suited for hospitals with a patient orientation. Whereas in the past a premium was placed on structural demands such as hospital infrastructure, today emphasis is elevated to quality evaluation of process and outcome. Evaluation of teaching hospitals has similarly shifted from initial rating of hospitals' teaching capacities based on structural considerations to focusing on instructional missions and teaching quality.

The hospital accreditation system is strictly voluntary, not compulsory, and most hospitals choose to apply for accreditation, which consists of 238 indicators under the two major categories of operational strategy and medical care. The outcome of the hospital accreditation is divided into two categories: qualified and excellent. Moreover, essential evaluation items are rated by three levels: "above average," "average," and "below average." The competent supervisory authority publishes hospital rating results online for the public to access instantly at any time as reference to guide selection of medical services. Consequently, the majority of hospitals voluntarily apply for accreditation. The high qualification rate and detailed ratings for essential items constitute sufficient incentive for hospitals to elevate overall service quality, so as to compete with other hospitals of similar grade.

4. Measures for Promoting Competition under the NHI System

4.1. Promotion of Multiple Payment System

4.1.1. Quality Assurance Program

National Health Insurance payment system follows a global budget payment system. Prior to the start of each year, the medical community and contributors negotiate the appropriate total amount of the medical payment of this Insurance for the following year. When services exceed this set budget it can lower the value of each point. In order to implement fiscal responsibility while preventing the rapid growth of medical expenses under the fee-for service, the fee-for service payment is combined with a multiple payment system. For instance, the Quality Assurance Program:

1. Safeguards the rights of the insured to receive medical care: medical care service quality satisfaction surveys, complaints disposal mechanisms, monitoring of the insured's access to medical care.

2. Ensures professional medical care service quality:

   - Establishes professional norms for clinical diagnosis procedures, professional reviews, and medical records.

   - Establishes on-going medical care service quality improvement program:

     a) Monitors diagnosis patterns and service quality;

     b) Establishes guidance system for medical institutions;

     c) Establishes medical service quality indicators, make quality information transparent, and publish on the Bureau of National Health Insurance's Web site (www.nhi.gov.tw) as reference for medical institutions' on-going efforts to improve service quality.

4.1.2. Tw-DRGs Reimbursement Boosts Healthcare Service Efficiency

In the effort to boost the efficiency of healthcare services, Chinese Taipei instituted the Diagnosis Related Groups (Tw-DRGs) reimbursement system in 2010. Covering a total of 1029 items and currently being phased in over a period of five years, Tw-DRGs adopts a predetermined uniform reimbursement method for inpatient care on a per-patient basis. The system is intended to raise the quality and efficiency of healthcare services by rewarding hospitals that are able to treat patients quickly and release them. The design of the scheme is based on the following key points: 1) the necessity of hospitalization or main surgery (therapy); 2) the appropriateness of the diagnosis and therapy; 3) the accuracy of diagnoses and treatment coding; 4) diversion of inpatient scope-related fees; 5) appropriateness of medical expenses for outlier cases; 6) stability of release condition; 7) appropriateness of medical quality.

4.1.3. Pay for Performance Program

The pay for performance program utilizes appropriate incentives through adjusted payment of fees to medical institutions to guide healthcare service providers to progress toward integrating and continuing healthcare, and base reimbursement on healthcare quality and performance. For instance, results of the medical care payment improvement initiative introduced in stages from October 2001 based on a pay for performance system for cervical cancer, breast cancer, tuberculosis, diabetes, and asthma indicate that adherence to prescribed treatment procedures for various illnesses increased, resulting in improved

individual indicators such as higher survival rates, steady decrease in the number of emergency and inpatient cases, and alleviation of high blood pressure.

4.2. Review of Medical Expenses Reporting

In order to ensure service quality, the BNHI conducts reviews of the service items, volume, appropriateness, and quality of contracted medical care institutions. BNHI reviews are generally computerized to handle the extensive volume of cases reported. In addition, the BNHI selects medical records randomly for professional review by physicians and targeted management. Contents can be divided between procedural and professional reviews, including the following: 1. Qualifications of the insured; 2. verification of insurance payment scope; 3. verification of insurance reimbursement standards and accuracy of drug list; 4. completeness and accuracy of reported information; 5. completeness of submitted data; 6. initial review of basic treatment items under case-payments method; 7. verification of pre-reviewed cases; 8. review of submission procedures for other healthcare services.

4.3. Open Publication of Healthcare Quality Data

In order that the public make informed choices regarding medical treatment, in the interest of open, transparent information, acting as a mechanism of public participation and oversight, and improving the quality of healthcare services, the BNHI publishes freely accessible healthcare service information on its official website. This includes information on contracted medical care institutions, medical care quality, and scope of coverage to provide the public with highly accessible information on healthcare services.

5. Conclusion

Pursuant to the Medical Care Act and the National Health Insurance Act, in addition to a certain degree of price competition in items not covered by the National Health Insurance program and the scope of administrative registration fees, Chinese Taipei's healthcare services generally engage in competition for quality. Although the Fair Trade Commission has penalized domestic professional association of physicians for its decision to jointly increase registration fees in violation of the Fair Trade Act prohibited concerted actions, few other violations of Fair Trade Act in medical services have been recorded.

Chinese Taipei has instituted a compulsory health insurance system with universal coverage, comprehensive reimbursement scope, high access to medical care, no waiting, greatly reduced administrative costs, low premium rates, and top quality care, earning a high degree of satisfaction among the populace. For instance, under the principles of open access to accreditation information and transparency under the hospital accreditation system set forth by the Medical Care Act, hospitals have considerable incentives to raise the quality of overall services. Moreover, multiple payment methods, case reviews, and open information remain under the global budget payment system, placing healthcare institutions in a state of significant competition.

BIAC

BIAC is pleased to provide the following Discussion Points and Compendium to the OECD Competition Committee Working Party 2 on Competition and Regulation for the Roundtable on Competition and Hospital Services addressing key factors for competition in hospital markets.

1. Key Factors in Hospital Markets – The European Perspective

1.1. Conditions For and Repercussions of Price or Quality Competition

Nowadays, the main challenge for industrialized countries is to introduce entrepreneurial behaviour into healthcare systems, in order to gain the advantages of market efficiency, without neglecting the welfare principles. While all of OECD countries face rising costs in the hospital sector, it is important to stress the necessity of maintaining a balance between the need to preserve the competitiveness of the health care services and to adequately respond to health needs by an equitable access to services provided.

In this perspective, the hospital sector is an important area, as hospital costs still account for the greatest share of total healthcare costs. Nevertheless, it is crucial to consider health facilities' performances not only from the viewpoint of health expenditure, but also from the perspective of the systems global efficiency and of the health protection for citizens, taking into account the costs resulting from an inadequate quality of care. By this reason, it is important to consider also health care economic effects on the global social expenditure, considering that it represents a service intended to preserve the human capital, which is of the greatest importance for modern society.

A kind of competition limited to prices only can be hazardous for the quality of services and, consequentially, for patients. Therefore, any future research with respect to competition in health care services has to analyse competitive mechanisms in a broad manner, which extends to competition on prices, on services provided, on speed of response, and on quality of care, evaluating the productivity and responsiveness of the whole system. By consequent, the problem of cost must not prevail on quality concerns; it is of the highest importance to examine the appropriate connection between these two determinants.

1.2. Demand Side Factors and Effective Competition on Price and Quality

Within EU, citizens' right to freely choose the doctor and the hospital - through the offer of a real alternative set up by a plurality of providers - is a "society choice". In principle, the access to services must depend only on the real need of the treatment, on the speed of obtaining it and on the quality guaranteed. In fact, the majority of European citizens are favourable to a system, in which individual free choice and plurality of providers, in a relationship of competitive collaboration, strives for a constant progress in therapy standards and assistance, within available resources.

In such a framework, the role of the consumer choice has not only to be assured as a fundamental right, but also to be examined in its consequences, because the concrete opportunity to freely choose the doctor and the hospital is a driving force for quality, stimulating providers to improve their performances in order to be chosen by patients.

1.3. Supply Side Factors and the Promotion of Effective Competition on Price and Quality

For the future, it would be important to study competition methods and effects on the supply side, deepening the approach of almost-markets. On the side of services production, particularly within the hospital sector, the connection between cost - quality - benefits must be examined in depth. In fact, the sustainability can be attained also through a better use of the existing wealth of facilities, professionals, health workforce, and technological equipment, promoted by a fair competition. This search for enhanced productivity supposes permanent progress in the hospital sector, supported through relevant reward systems. Therefore, competitive incentives must be evaluated with reference to quality standards and productivity performances, resulting from an efficient management.

Sustained enhanced productivity allows the same results to be obtained with lower costs, and consequently it is the appropriate answer to cost pressure, because it can have a positive impact on expanding resources and finding answers to new needs, within health care systems which have an emphasis on quality and create an environment favourable to new and adaptable schemes of funding.

Improved efficiency and rational allocation of resources are among the most effective tools to achieve better value for money, while questionable cost cuttings and particularly budgets caps have negative effects on equity of access and quality of care. Applying top-down budget caps on spending, without having to renegotiate agreements with hospitals is unfair for providers and it is dangerous for patient safety, risking to lower quality standards.

In this perspective, the separation between purchaser and provider functions within the competent authorities would be essential in order to further health system goals in health delivery, avoiding wastes dues to unfair competition and poor management. To meet this aim, it is crucial to guarantee the parity of rights and duties among all the providers, publics and privates, in regard to accreditation rules, remuneration methods, as DRGs, quality control on the responsibility of a third independent organization – like in France (HAS) and in UK**.**

In the framework of a rigorous analysis of cost, quality and remuneration criteria, competition among providers - on the supply side - and consumer choice - on the demand side - can contribute to maintain a satisfactory quality level, squeezing out wastes caused by inefficiency.

1.4. Institutional Frameworks and Policy Reforms to Enhance Competition in Hospital Services?

The misguided perspective in which health expenditure is conceived only as a cost and not as an investment has conditioned national governments to balance public budgets, through distorted competition. As a result, the rationalization of health expenditure has often resulted in the rationing of health services. In this framework, unfortunately competitive mechanisms were implemented in order to put pressures on providers to constrain expenditure, particularly in the hospital sector. In our opinion, if costs constraint is the major or the only concern, health care sector is considered an unproductive investment and not an important employer, consumers of goods and leader in the field of innovation, research and development, as it is in fact. Although it is necessary to improve the cost efficiency, no OECD country can afford to consider its health system only as a burden and an expenditure to curb or even to cut down, without previous and accurate analysis.

The hospital sector, which responds to the collective health demand, is also an important competitor in the economy, as long as health care services are well managed, productive and quality driven. On the contrary, a possible involution of the policy trends is very dangerous, as long periods of budget restraint may make it more difficult to create conditions for making progress.

At this regard, the industrial and entrepreneurial world, operating in healthcare field, is seriously concerned about a possible regression, highlighting the importance to identify opportunities for:

a) Productivity increase in the health care sector, including improvement of management;

b) Competition in and between both the public and the private segments of the healthcare sector;

c) Enhanced organizational innovation;

d) More efficient health care coverage through a better balance between private and public insurance;

e) Increasing patients' involvement and responsibility for their health; and

f) Regulatory reforms.

The main thread in the reform initiatives implemented by many European countries in the last decades was to introduce entrepreneurial behaviour in healthcare systems, in order to gain the advantages of market efficiency, without neglecting the principles of universality, equity, solidarity, security guaranteed through the policy direction, control and responsibility exercised by the State.

To reach these goals, a policy focused on innovation was pursued:

a) New models of management were implemented;

b) Incentives for competition were injected into public structures, in order to improve their performances;

c) Private hospitals were incorporated into the general health system under public control;

d) Public hospitals' management was entrusted to private operators; and

e) Public-private partnerships came into operation, achieving good results.

Nowadays, despite the differences of national healthcare systems, within EU and other industrialized countries common principles are emerging for a better model of healthcare service, which try to reach a balance between access, quality of treatments and financial viability, taking in due consideration the complexity of healthcare as a sector of considerable social values, but also of economic interest.

In brief, a model of healthcare service, responding to the obligations of a general interest service financially viable, can be based on a public - private mix, fairly managed and able to guarantee:

a) Citizens' right to freedom of choice;

b) Plurality and equality of providers, public or private, that offers citizens concrete alternatives;

c) Abolition of monopolistic (or quasi monopolistic) regimes;

d) Fair competition based on quality, because in periods of budget constraints, institutions offering the best at compatible costs must be supported with stimulating incentives;

e) Effective use of the available resources;

f) Adequate and rapid answer to the demand;

g) Quality improvement; and

h) Independent control institutions (Authorities) in order to guarantee quality standards and a fair and effective competition.

If these conditions are fully respected, competition among a plurality of providers can increase the amount of available resource and stimulate productivity, in order to improve general performances in a viable system.

Continuing attention should be paid to the conditions and the efficiency of competition and the State should play a special role in ensuring that no actor in the hospital sector bypasses the rules relating to competition in order to benefit from various forms of granted privilege. From this viewpoint, the role of the State is to set the rules for a fair competition, facilitating:

a) Equity in access conditions for citizens and in accreditation conditions for providers;

b) Quality through rigorous and equal controls for all providers;

c) Financing, determined by correct and homogenous remuneration criteria for all the contributing providers, private and public hospitals, in order to reach an efficient funding; and

d) Information for citizens about services supply and transparency for the financing agency about services quality and costs of healthcare providers.

These principles can be implemented in a mixed system, composed by a plurality of competing institutions, public and private, for profit and not for profit, among which the citizens can choose, while it is very hard to achieve them in a monopoly regime, as it is demonstrated by the former failure of quasi – monopolistic systems.

If almost- market reforms have not always achieved all the expected results that are due principally to the reason that the experiments with competition were too often discontinued after a relatively short period and more time has been needed for positive results to appear. Moreover, the positive impact of such policies has most often been weakened by continued central control.

2. Issues in Hospital Markets – The U.S. Experience

In the United States, providers of health care services, including hospitals, are reimbursed for their services by commercial health insurance companies, other health coverage plans, government health plans such as Medicare (for seniors and individuals with qualifying disabilities) and Medicaid (for low-income people) (collectively "payors"). The Federal Trade Commission and U.S. Department of Justice Antitrust Division (the "Antitrust Agencies") monitor and regulate competition issues relating to health care providers with the goal of protecting consumers of health services from increased prices or reduced quality or output, and within this structure, a number of competition issues have arisen.[1]

[1] For more background on the U.S. experience, please see the attached Addendum. BIAC extends its appreciation to the American Bar Association's Section of Antitrust Law and, in particular, Section Chair Richard Steuer for this compilation of materials.

2.1. Hospital Mergers

There have been a number of challenges to hospital mergers in the United States in recent years. Mergers of hospitals often can eliminate redundancies and create efficiencies. In some instances, however, the Antitrust Agencies have alleged that a hospital combination results in consolidation that would be harmful to consumers. The issues presented in these instances include how to define markets and measure concentration in hospital services, how much concentration is too much, and how to assess prospects for new entry and the creation of efficiencies. Other issues include the nature of available remedies and the value of undertakings by hospitals to limit price increases.

2.2. Exclusivity

Physicians and groups of physicians commonly become affiliated with one or more hospitals in their locale. In some instances, hospitals require affiliated physicians to agree not to affiliate with competing hospitals. In certain instances, hospitals require that insurers to which they provide services agree not to obtain similar services from competing hospitals in the same region. All of these amount to forms of exclusive dealing arrangements. The issues these arrangements pose are whether other hospitals are unreasonably foreclosed from competing, especially if the other hospitals have less capacity or offer a more limited range of services.

2.3. Most Favoured Nation Provisions

Sometimes, insurers ask hospitals to promise not to charge lower rates to any competing insurer. This provides insurers with assurance that no competing insurer is paying less for the same services. However, such "most favoured nations" provisions allegedly can prevent hospitals from fostering the growth of new insurers, to compete against existing insurers, by offering those fledgling insurers better rates, even temporarily. The Department of Justice has pursued several cases based on such allegations and recently initiated such a case alleging that an insurer demanded better prices than hospitals charged any competing insurer. The issue such cases present is whether most favoured nations provisions are competitively neutral or unreasonably restrain competition in these circumstances.

2.4. Accountable Care Organizations

Recently, Congress passed the *Patient Protection and Affordable Care Act* and the Centres for Medicare and Medicaid ("CMS") issued a Final Rule under the *Act* to facilitate greater accountability for patient care among providers. In response to this legislation and guidance, the Antitrust Agencies issued the *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in Medicare Shared Savings Program* ("Policy Statements") to provide additional guidance to providers seeking to form Accountable Care Organizations ("ACOs"), which permit providers to join together in ventures to negotiate fees and other terms with insurers and other health plans under the new legislation without running afoul of antitrust and competition laws. Under the Policy Statements, if such "ACOs" meet certain criteria, they qualify for limited immunity from antitrust liability. The issues raised by ACOs include how to interpret the new guidelines and how to treat ACOs that do not qualify for immunity.

2.5. Hospital Joint Ventures

Over the years, hospitals in the United States frequently have formed joint ventures to provide particular services. Often, these ventures create efficiencies, permitting more services to be provided at lower cost. Sometimes, however, these ventures may be adopted in situations in which it would be preferable for hospitals to provide such services independently and in competition with one another. The issue raised in these situations is how to distinguish anticompetitive ventures from ventures that are precompetitive or competitively neutral.

2.6. Hospital Group Purchasing Organizations

It has become common for hospitals in the United States to join group purchasing organizations (referred to as "GPOs") or other joint purchasing arrangements. These ventures can enable purchasers of medical supplies and equipment to negotiate lower prices, but also can create concerns about the formation of ologopsony power. There also may be issues as to which hospitals and alternative care facilities are included in or excluded from these groups.

2.7. Information Exchange among Hospitals

A recurrent issue involving competing hospitals in the United States is the extent to which they may exchange information about the rates they charge, the salaries they pay, and the costs they incur. The U.S. Department of Justice and Federal Trade Commission issued a policy on this topic in 1996 and there has been some litigation claiming antitrust violations in particular situations. The issue raised is how to distinguish between anticompetitive exchanges of information and precompetitive or competitively neutral exchanges.

3. Conclusions

In the OECD countries it is fundamental to gain better understanding of health's impact on economic growth and sustainable development, providing guidance on the economic implications of health, for improving the cost efficiency of health care systems. Positioning health as a driver for reaching these goals necessarily implies the promoting of the optimal use of resources in health.

In this perspective, it is of the greatest importance to enhance the effectiveness and efficiency of healthcare systems, providing a solid evidence base, in order to face the challenge of health expenditure, avoiding unfair competition, rationing of health services and waiting lists, caused in many countries by the shortage of services because of economical reasons.

Within public expenditure for health, the contribution of private resources is necessary as capital and human resources provided by private initiative play a key role in the provision of care services. Private hospital sector adds complementary means allowing the State to save capital investment and to impose a tax on earnings; moreover it plays the role of moderator in health expenses, through efficient management. In these circumstances, the contribution of private sector is fundamental in order to balance public budgets**,** because private hospitals takes part in the supply of services for the social insurance or for the national healthcare service, increasing the opportunities of access and allowing a better protection of health.

A rational and effective allocation of the resources - based on a better use of the structural, technological and professional equipment, both public and private - will make health system of the industrialized countries able to guarantee a real improvement of the macroeconomic situation, as considered necessary**.** Private capital could help health care facilities especially if supported in order to build long-term medical infrastructure and not submitted to a short term strategic planning. Effective management and modern entrepreneurial criteria, both in public and private institutions, provides the concrete possibility to guarantee at the same time equity of access and financial sustainability of the system. Besides, the improvement in access to health related services occurs also in conjunction with a greater reliance on private health insurance.

The success of the change to reach a sustainable development depends on the managerial innovation, sustained also by regulatory reforms, and on the correct implementation of pro-competitive incentives within a welfare market. In a healthcare system where the State sets the rules of a fair and collaborative competition the private sector can assure a function of general interest. Private hospitals if they accept the same obligations as public ones are entitled to the same rights in a mix and integrated system.

Without attempting to arrive at a final conclusion, it is suitable to evaluate each local or national health system's trends according to the following general indicators:

a) The degree to which competition between public and private operators is implemented. This indicator depends on the payment system per service, including the equalization for all hospitals, as well as the degree of free choice left up to the users.

b) The right granted to citizens for freely choosing the hospital and the doctor.

c) The ratio between research expenditure and investments versus overall running expenditure.

d) The degree of a health care facility's autonomy, which implies for example that no action has been taken in favour of those hospitals with a deficit position.

These parameters, taken as a whole, give us a pointer as to the system's ability to profitably use available resources.

The industrialized countries are going towards greater running efficiency and encouraging long-term investments within their healthcare systems. For this process to be supported by the market, the hospital sector must acquire even greater competitive abilities.

Finally, talking about competition is not enough. It is necessary to find out and concretely implement the conditions for an impartial management of the public-private mix at the basis of most western health care systems. Only in this way the competitive mechanisms will be able to improve the overall performance of the health care services. As a result the same mechanisms can contribute to ensure not a formal, but a real protection of welfare principles, progressing from a theoretical declaration of rights to an adequate answer to citizens' concrete needs, through the best possible use of the available resources, in the perspective of a sustainable growth.

ADDENDUM

COMPENDIUM OF MATERIALS ON HOSPITALS AND COMPETITION IN THE UNITED STATES

Prepared by American Bar Association
Section of Antitrust Law

The aforementioned competition issues in the U.S. have been addressed in materials published by the Section of Antitrust Law. These materials reflect the views of their individual authors and should not be construed as representing the position of either the American Bar Association or the Section of Antitrust Law. Nevertheless, these materials may provide useful background to policymakers outside the United States as they consider options for designing efficient policies for hospital competition within their own jurisdictions.

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THE VERY ENGLISH EXPERIENCE WITH COMPETITION: LESSONS FROM BRITAIN'S NATIONAL HEALTH SERVICE

Paper by Mr. Zack Cooper[*]

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1. Introduction

Over the last decade, there has been a wave of market-based health care reforms across Europe and North America. These reforms have been prompted by a combination of rising demand for health care services, increasing expectations for quality, and significant pressure to slow the growth of health care spending. Often, at the core of these market-based reforms have been efforts to expand patient choice and introduce competition between health care providers.

Despite the growing interest in the potential of competition to stimulate providers to improve their performance, the empirical evidence on the effect of competition is ambiguous (Gaynor and Town, 2011). This ambiguity stems, in part, from the difficulty of empirically establishing the causal effect of competition on hospital performance. To test the effect of competition, in an ideal world, researchers would want to design a randomized control trial and expose some hospitals, at random, to competition and compare their performance to a group of 'control' hospitals that were left in monopoly markets. However, this sort of large-scale research design would clearly be inappropriate.

However, recent reforms in the English National Health Service (NHS) provide an ideal opportunity to examine the effect of competition on quality, productivity and equity. In 2006, the Blair Government in England introduced substantial reforms to the NHS, which gave patients a choice over where they received care and prompted public hospitals to compete with each other, and eventually with private sector providers, to deliver care to publicly funded patients (Cooper et al., 2011). These substantial reforms injected competition into a health system that historically contained few financial incentives for hospitals. More than that, these reforms, from an empiricist's perspective, provide an ideal opportunity to assess the impact of hospital competition. Indeed, in the five years since these reforms were introduced, a body of literature has developed, which has assessed the impact of competition on quality, productivity, hospital management performance and equity (Cooper et al., 2009, Bloom et al., 2010, Cookson et al., 2010, Cooper et al., 2011, Gaynor et al., 2010, Gaynor et al., 2011, Cookson et al., 2009).

This paper examines the English experience implementing with introducing competition into the English National Health Service and reviews the evidence that these reforms have had on equity, hospital efficiency and hospital quality. More than that, this paper uses English experience to serve as a vehicle for examining the institutional elements necessary to support hospital competition and exploring the policy options for promoting productive competition that raises hospital quality without undermining equity.

On balance, the introduction of competition in the English NHS has been successful. Empirical evidence suggests that the introduction of competition in the NHS has led to reductions in death rates, improvements in hospital quality, management and productivity and has not harmed equity (Bloom et al., 2010, Cooper et al., 2011, Cooper et al., 2009, Gaynor et al., 2010, Gaynor et al., 2011). However, as with all policies, there remains room for improvement. Prospectively, as with other countries that are going down the road of using hospital competition to stimulate providers to improve their performance, policy-makers in England need to continue to promote publication of meaningful, risk adjusted data on hospital performance, expand the role of agents in assisting patients making choices, and continue to refine the payment system for hospitals to encourage clinical improvements, innovation and productivity gains.

There is a great irony to the NHS reforms, which has important implications for other nations. In many ways, it was the centralized policy environment in England that allowed the government to succeed with their market-based reforms. It was the centralization that created an environment where policy-makers could build an edifice of other policies to support competition in the NHS. These competition supporting policies included central policies that rewarded hospitals running surpluses, efforts to publish information on providers' performance on a centrally run website, and rewarding general practitioners to

server as patients' agents and assist them making choices. This is a lesson from England that should not be lost.

This paper will be structured as follows. The first section will examine the reforms introduced in England and examine the arguments made in the UK for and against these reforms. The second section will examine the evidence on the effect of these reforms including examining whether patients were willing to exercise choice and if hospital competition created incentives for providers to improve their performance. The third section of this paper will examine the ways that these English reforms could be improved and will draw out lessons that the British experience suggests for other countries interested in increasing the role for competition in their hospital sector.

2. The NHS Reforms, The Government's Argument for Change, and the Criticisms of Competition in the NHS

2.1. Competition and Hospital Markets

There is stunning variation in hospital performance. The NHS Atlas documented widespread, unexplained variation in the quality of services across England (Right Care Team, 2011). In the US, there is evidence that, within hospitals and across states, there is frequently almost no correlation between spending and outcomes (Orszag, 2007). In short, there are many good health care providers, but there are also plenty of bad providers who deliver outcomes that fall far short with respect to quality and productivity. As a result, the basic question for policy-makers in the US, the UK and abroad is how to reduce this variation in performance and improve the quality and productivity of care delivered.

The value of competition is best considered by contrasting it with the drawbacks of monopoly. In the absence of competition, a lone provider has few financial incentives for attracting patients or improving quality. In this monopoly environment, policy-makers need to rely on central control (performance management) or providers' altruistic motivations to create incentives for providers to improve performance (Le Grand, 2007). In contrast, at its core, according to micro-economic theory, perfectly competitive market, in the long run, will lead to both allocative and productive efficiency. Applied to the hospital sector, competition will create financial incentives for providers to raise quality and reduce prices in order to maintain their market share, generate surpluses and expand.

10. However, it is vital to point out that markets in health care differ substantially from the stylized world of perfect competition. Health care has been a sector long considered to significantly diverge from highly stylized, perfectly competitive markets (Arrow, 1963). Health care is marked by substantial information asymmetries between doctors and patients. The services, surgeries for example, are highly differentiated. Indeed, within many systems, hospitals are not-for profit and there are extensive government barriers to entry and political constraints on exit.

Nevertheless, the fact that health care markets do not mimic textbook perfectly competitive markets does not mean that hospital competition cannot play a productive role and prompt improvements in providers' quality and productivity. Indeed, many markets tend to diverge from textbook perfectly competitive markets. Instead, the fact that health care markets are not perfectly competitive suggests that the challenge for policy-makers is ultimately to create an environment where the basic conditions necessary to support competition can be so that hospital markets function effectively. These conditions include that:

- Hospital staff, including senior management, must be responsive to financial incentives;
- Patients must be interested in making choices;

- Patients must have alternative providers that they can access;
- There must be information in the market to inform patients' and purchasers' choices;
- Patients must be responsive to quality signals.

In addition, Gaynor (2006) has suggested that the expected impact of competition in hospital markets very much depends on how prices are determined. In markets with price competition, where hospitals can set their own prices, increasing the number of competitors (competition) could be predicted to improve or harm clinical quality depending on the ability of patients to perceive both quality and price. In short, because hospital quality is often so difficult to measure and observe, competition on prices and quality in the hospital sector may very well lead to reductions in prices and quality if consumers are more able to observe price than they are quality.

In contrast, the impact of quality competition in hospital markets where prices are fixed by a regulator is unambiguous (Gaynor, 2006). In these markets, as long as the reimbursement rate is higher than hospitals' marginal costs, increased competition should improve hospital quality. Facing competition in these markets, hospitals will, in the long run, increase quality until their profits approach zero. In other sectors, there are concerns that regulated prices will lead to excessive quality. However, in a health care setting, gains in quality are generally so valuable (i.e. it reduces death) that improvements in quality are generally viewed as improvements in overall social welfare (Gaynor and Town, 2011).

2.2. The English NHS Reforms

From 1997 to 2010, the English National Health Service (NHS) went through a period of profound flux. During their thirteen years in office, the Labour government dramatically increased spending on the health service and introduced several waves of substantive reforms across the NHS. The 1997-2010 period in the English NHS was marked by several substantive shifts in policy. More than anything else, the most momentous change during this period was a shift in thinking of senior policy-makers and the Prime Minister himself, all of whom, over time, came to believe that incentives, rather than pure altruism, were vital to improving the performance of the NHS.

More specifically, in the early days of the government, there was a consensus that relying largely on the public service ethos – trusting in doctors' altruistic motivations – was enough to improve hospital performance (Le Grand, 1999). However, after watching performance stagnate and increasing funding, which was not paired with incentives, fail to deliver significant improvements, the government came to the conclusion that more direct incentive structures had ultimately to play a key role in English health policy (Stevens, 2004).

From mid-2000 until 2010, the Blair government replaced the trust model of delivery with a series of policies that wed information on performance with financial and non-financial incentives for providers. These information and incentives reforms began with a performance management program for secondary care providers, directed from the centre and heavily reliant on doling out heavy punishment for underperformers (Propper et al., 2010). The government also introduced a pay-for-performance scheme for primary care, making the income of general practitioners (GPs) partly contingent upon achieving a certain level of performance on range of clinical practice, patient experience and patient outcomes measures (Campbell et al., 2009). Finally, the government introduced patient choice and (fixed price) hospital competition in the market for secondary care for NHS funded patients, in an effort to prompt providers to compete on clinical performance (Klein, 2006b).

After distancing themselves from the regulated market introduced by the previous government, this return to using a quasi-market to drive performance represented a profound shift in policy. After initially piloting patient choice schemes across the country from 2002 through 2005, the policy became fully operational in 2006 (Department of Health, 2005a). The aim of the policy was to maintain incentives for hospitals to improve their quality and efficiency, but additionally also to separate the central government from the day-to-day running of the health service.

These market-based reforms were introduced on a rolling basis from 2002 through 2008. During this period, the government introduced a range of policies designed to foster a more competitive environment. This included introducing a new fixed-price, prospective payment system, modelled on the Medicare prospective payment system from the United States (Department of Health, 2011). This payment system, known as Payment by Results (PbR), paid hospitals a fee determined by the government, on the basis of patients' diagnoses, with adjustments for local economic wage rates, hospital characteristics and some elements of illness severity. In addition, the government encouraged new private providers to enter the market and gave hospitals additional fiscal and managerial autonomy (including the ability to retain surpluses). These pro-competition policies were set against a backdrop of regulatory reforms designed to guarantee minimum standards of hospital performance.

The key element of the NHS reforms was to give patients a formal choice over where they received secondary care. Together with a reimbursement system where money followed patients around the system, the introduction of choice created financial incentives for hospitals to compete for market share. Beginning in 2002, the government introduced choice pilot programs around the country and gave patients who were waiting for over a year for care (later lowered to nine months) the ability to go to an alternative provider with spare capacity. On January 1, 2006, the government required that all NHS patients referred for elective care be offered a choice of four or more providers (Department of Health, 2009a). This was the first point at which the new payment system and patient choice worked in tandem to create financial incentives for hospitals to attract patients. We regard this as the 'policy-on' date where public hospitals faced competition from other public providers in the context of a revenue system rewarding them for higher volume.

The introduction of patient choice was accompanied by the development of a paperless hospital referral system that allowed patients and their GPs to book hospital appointments online or over the phone. The main online interface for the referral system allowed patients and their referring physicians to search for nearby hospitals and included information on providers' performance and information on average waiting times at each facility.

Over time, policy-makers sought to allow patients to access care in the private sector in order to prompt public hospitals to compete with new private entrants. This push for more private provision that is funded by the NHS began with a centrally run program to create privately managed, specialty surgical centres, known as Independent Sector Treatment Centres (ISTCs). These facilities were focused on elective care and were frequently co-located on the grounds of existing NHS facilities (Department of Health, 2005b). However, the ISTC program was fraught with problems and by mid-2006, there were only 21 ISTCs established to deliver care to NHS patients (Department of Health, 2006), and the program was eventually heavily curtailed.

Following the limited ISTC program, the government launched a more ambitious push to allow private providers to deliver care to NHS funded patients. This program allowed private providers in England who registered with the government quality regulator[1] to provide care to NHS funded patients. This meant that beginning on a limited basis in July 2007, and in full force from 2008 onwards, all of the

[1] http://www.cqc.org.uk/

162 private hospitals in England offering elective secondary care with overnight beds were potentially accessible to NHS-funded patients at no charge, if the hospitals agreed to the be paid based using standard NHS tariffs (Cooperation and Competition Panel, 2011).

2.3. The Government's Argument for Reform

The Government argued that hospital competition in a market with fixed prices would catalyse providers to become more efficient, more responsive to patients and improve the quality of care hospitals delivered. Along those lines, in a 2005 speech then Health Secretary Patricia Hewitt said:

> "If a hospital fails to provide the service that people want and expect, some patients will choose to go elsewhere. And under payment by results – which we've started to introduce this year – money will follow the patient. All this creates very sharp incentive for hospitals to improve the quality of care they provide – and an equally sharp challenge to the medical profession to change old vested interests and protective practices if they are holding back patient care" (Hewitt, 2006).

The basic argument that underpinned the reforms was that if providers faced a real financial risk of not being chosen and there was increasingly available information available to inform patients' choices (i.e. an increase in patients' elasticity of demand), this combination would create a financial incentive for them to appeal to patients. In addition, the new fixed price reimbursement system would create further incentives for providers to increase their throughput and maximize their technical efficiency in order to generate additional profits.

The Government and its advisers also argued that, in addition to driving improvements in quality and efficiency, formalizing patient choice would make the NHS more equitable (Department of Health, 2003). Given the common perception that competition would lead to an equity/efficiency trade-off, this was a bold claim. Nevertheless, the government consistently placed strong emphasis on the potential for choice to improve the quality of care delivered to the poor. To that end, former Health Secretary Alan Milburn said in 2003:

> "For half a century, uniformity of provision has not guaranteed equality of outcome. Too often, even today, the poorest services are in the poorest communities. The hard fact is that for over fifty years it is poorer people and poorer communities who have lost out from poorly provided public services…Take choice, which the Left has mistakenly conceded to the Right. For too long choice in health care has only ever been available to those with the means to pay for it. Those with more money have been" (Milburn, 2003).

The same year, his successor as Health Secretary, John Reid, said:

> "These choices will be there for everybody…not just for a few who know their way around the system. Not just for those who know someone 'in the loop' – but for everybody with every referral. That's why our approach to increasing choice and increasing equity go hand in hand. We can only improve equity by equalizing as far as possible the information and the capacity to choose" (Reid, 2003)

And finally, speaking about his party's reforms in public services, Tony Blair said:

> "People should not forget the current system is a two-tier system when those who can afford it go private…choice mechanisms enhance equity by exerting pressure on low-quality or incompetent providers. Competitive pressures and incentives drive up quality, efficiency, and responsiveness in the public sector. Choice leads to higher standards. The overriding principle is clear. We

> should give poorer patients…the same range of choice the rich have always enjoyed" (Blair, 2003).

The Government's argument was based on the idea that even in an NHS without formal choice for users, choice still existed, though it was vastly more prevalent for middle and upper class patients (Department of Health, 2003, Le Grand, 2006). They argued that choice in the pre-reform NHS was available for middle and upper class NHS users who had a greater capacity to: 1) negotiate with their GPs for more choices using a louder voice; 2) move to areas with better local services; and 3) opt out of public services and pay for care in the private sector (Cooper and Le Grand, 2008). This idea that informal choice was present and being exercised by the well-off was supported empirically by a 2006 study that found that prior to the introduction of formal choice in 2006, less wealthy travelled a shorter distance for care than wealthier patients, controlling for the location of patients and hospitals (Propper et al., 2006).

2.4. Criticisms of the Government's Market-Based Reforms

However, just as the government argued that expanding patient choice and hospital competition would improve quality, efficiency and equity, critics opposed the reforms on roughly the same grounds. On the quality and efficiency front, critics argued that the market-based reforms would fragment the supply-side in England, raise transaction costs, and financially destabilize the incumbent NHS providers (Appleby and Dixon, 2004, Hunter, 2009). The three most common themes to this argument were 1) that patients would not be able to differentiate between providers based on clinical quality; 2) that the government would not be able to effectively regulate the competitive markets; and 3) that introducing private sector competitors would lead to cost increases and risk-segmentation as private providers would target the patients that appeared ex ante less costly to treat. (Appleby and Dixon, 2004, Hunter, 2009).

Speaking about market-based reforms, former Labour Health Secretary Frank Dobson said, "The whole concept of trying to raise standards by introducing competition between different parts of the NHS is stupid and damaging" (Dobson, 2005). The fact that he gave that quote only five years he had been Health Secretary himself in the same Government highlights just how far the government travelled from 1996 to 2007. Equally critical of the reforms, in an editorial that appeared in the British Medical Journal, Wollhandler and Himmelstein wrote, "market theorists argue that although competition increases administration, it should drive down total costs. Why hasn't practice borne out this theory?" (Wollhandler and Himmelstein, 2007). They continue, "…only a dunce could believe that market based reform will improve efficiency or effectiveness. Why do politicians – who are anything but stupid – persist on this track?" (Wollhandler and Himmelstein, 2007).

Indeed, there Were broader concerns that the market-based reforms were sullying the public service ethos of the NHS (Le Grand, 2007). This belief was summarized by David Marquand, who wrote,

> The language of buyer and seller, producer and consumer does not belong in the public domain; nor do the relationships which this language implies. People are consumers only in the market domain; in the public domain they are citizens. Attempts to force these relationships into a market would undermine the service ethic, with is the true guarantor of quality in the public domain" (Marquand, 2004).

On the equity front, many believed that increasing patient choice and hospital competition would adversely impact the less well off. This harm to equity, they argued, would run directly against the founding principles of the health service. Here, critics argued that the reforms would accentuate differences in individuals' capacity to make informed decisions and that the reforms would necessarily create winners and losers. To that end, Labour peer Roy Hattersley said, "[C]hoice is an obsession of the

suburban middle classes. But when some families choose, the rest accept what is left. And the rest are always disadvantaged and dispossessed" (Hattersley, 2003).

Similarly, analysts from Kings Fund wrote, "while increased choice may put pressure on poorly performing providers to improve their services, there is no reason to think that this will ensure equal treatment for equal need. Hence extending choices puts at risk a key object of the NHS – equal access for equal need" (Appleby et al., 2003). And, in a scathing editorial in the Journal of Medical Ethics, Barr et al. wrote, "while adopting this policy program, new Labour has appended the claim that choice – and the market mechanisms this fill facilitate – will make the NHS fairer. This claim has not developed prospectively from an analysis of the causes of health care inequity, or even with a consistent normative definition of equity…As patient choice is rolled out in England, the equity impacts should be monitored by an independent body, so that the government may be held to account for its novel claim" (Barr et al., 2008).

The various doctors and nurses unions also attacked the reforms. The British Medical Association (BMA) led the charge against introducing choice and competition into the NHS and has taken every opportunity to argue against the reforms publicly. According to the BMA's website, "the BMA has opposed the increased commercialization and competition imposed on the NHS in recent years and there is little evidence of any benefits to patients. It brings with it additional costs as well as disincentives for collaboration and cooperation" (British Medical Association, 2010). According to the Chairman of the BMA, "the BMA, like many other groups, has long been concerned that the costs and perverse incentives resulting from the market structure that has been imposed on the NHS. Many of the reforms of recent years threaten to erode the principles of free access, care based on need and risk-pooling" (Meldrum, 2010).

3. Evidence from the English Experience with Patient Choice and Provider Competition

Competition between hospitals in the English NHS took force in January 2006. As Nick Timmins, Public Policy Editor of the Financial Times wrote on December 31, 2005, the evening before the NHS reforms were introduced, "The arrival of 'patient choice' – the right to choose, initially from at least four hospitals, and by 2008 from any hospital prepared to meet NHS standards and prices – is a symbolic moment in the government's endeavour to use market forces to drive up health service performance" (Timmins, 2005).

These reforms provide an ideal opportunity to examine the rollout of the reforms and answer questions about the effect of competition and the response of patients to being given the ability to choose their provider. Earlier, we mentioned the conditions necessary for competition to improve hospital performance. These included:

- Hospital staff, including senior management, must be responsive to financial incentives;
- Patients must be interested in making choices;
- Patients must have alternative providers that they can access;
- There must be information in the market to inform patients' and purchasers' choices;
- Patients must be responsive to quality signals.

In what follows, I will discuss how policy-makers in England addressed these conditions for productive competition.

3.1. Hospital staff, including senior management, being responsive to financial incentives

Nearly all hospitals offering care to NHS patients are publicly owned and not-for profit. Prior to 1992, NHS hospitals were centrally run and given annual budgets (Klein, 2006a). This encouraged hospitals to run deficits because an overspend in 1989 meant an increase in the size of the annual budget for 1990. Indeed, during this period, the central government clawed back surpluses from productive hospitals and used those funds to pay down the deficits in hospitals that ran a loss.

In the 1990s and early 2000s, NHS hospitals were remunerated using annual block contracts that paid facilities for delivering care a range of services to predefined populations (here the contracts often had no stipulations for the volume of care delivered) (Chalkley and Malcomson, 1998). While this form of contracting added an element of contestability – purchasing organizations could decide to no longer contract with a hospital – it still provided few incentives for quality or responsiveness. Crucially, during this period, hospitals were not allowed to retain surpluses.

In the most recent NHS reforms, a crucial element for introducing competition was altering how hospitals were paid and allowing hospitals to retain surpluses. Indeed, to sharpen pressure on hospitals improve their financial performance; hospitals were judged by the central government (who had the power to remove hospital CEO) on their surpluses and deficits. When both for-profit and not-for-profit hospitals are allowed to retain surpluses, there is a growing body of research, which suggests that both forms of hospitals behave similarly with respect to pricing, market structure and the provision of uncompensated care (Capps et al., 2003, Dranove and Ludwick, 1999, Gaynor and Vogt, 2003). Indeed, even in the United States, which many view as the most pro-market health system in the world, only 19.9% of hospitals are for-profit.

3.2. Patients must be interested in making choices

There is strong evidence that patients in the English NHS want to have a choice about where they receive hospital care. Evidence from the British Social Attitudes Survey shows that when asked, 75% of the British public say they want the ability to select their hospital (Appleby and Phillips, 2009). This is echoed by findings from a recent report by the Kings Fund, which also found that 75% of patients said they supported having choice of their secondary care provider (Dixon et al., 2010). Indeed, patients are particularly positive about the ability to select their provider if they were previously dissatisfied with the performance of their provider (Barnet et al., 2008).

In addition, both the British Social Attitudes Survey and the work done by the Kings Fund found that it was generally the less wealthy and less educated patients who wanted choice more than the wealthy (Dixon et al., 2010). This is similar to evidence from the US, which suggests that less wealthy and minority parents generally want choice over their children's' school more than wealthy white parents (Bositis, 1999), as well as evidence reflecting the same pattern for school choice surveys in New Zealand (Thomas and Oates, 2005). These results likely stem from the fact that upper class and educated parents and patients are likely already satisfied with the services that they currently receive (Le Grand, 2007).

In 2004, the British Government launched a series of patient choice pilots where patients waiting over six months for care were offered the ability at choose to attend an alternative provider with a shorter wait for care (Coulter et al., 2005). In the pilots, 83% of patients suggested that they would be open to going to a non-local provider and 63% of patients, when offered, decided to go to a non-local provider for care. In addition, consistent with results from Dixon et al. (2010) and Appleby and Phillips (2009), there was no difference in the uptake of choice according to social class, race, gender or education. However, it should be noted that in the pilots, the British government provided patients with "patient choice advisors" who were available to offer assistance and the government also subsidized transport costs.

Burge et al. (2004) looked at the factors that influenced patients' choice of provider. They found that there was a strong anchoring effect and that patients often preferred to attend their nearest provider (Burge et al., 2004). However, they noted that when there were large differences in quality, patients were generally willing to travel longer distances for care (Burge et al., 2004). Evidence from the London Patient Choice Pilots suggests that hospital cleanliness and hospital waiting times were the two most influential factors over whether or not patients went to a non-local provider (Coulter et al., 2005). However, this finding likely reflects the fact that at the time of the pilots, waiting times and cleanliness were two issues that were constantly featured in the popular press. Additional evidence generated after the NHS reforms were introduced in 2006 suggests that over time, as waiting times in the NHS dropped, patients began to rank hospital quality as the strongest determinant of their hospital choice (Audit Commission and Health Care Commission, 2008). Other evidence highlights the impact that one's previous experiences and the experience of family members strongly influence choice, perhaps above and beyond objective data on hospital quality (Dixon et al., 2010).

3.3. Patients must have alternative providers that they can access

While the reforms were being introduced, some expressed concern that introducing hospital competition would require significant spending to increase the number of alternatives for patients. However, it turned out that most patients in England had access to two or more hospitals and that, prior to the reforms, there was significant unused capacity. To that end, a 2005 study found that over 90% of people in England had two or more hospitals within a 60-minute travel time and that there was a large amount of spare capacity in the NHS (Damiani et al., 2005). Damiani et al. (2005) found that 98% of people in England have access to 100 unoccupied NHS beds within a 60-minute travel time, and 76% of people have access to up to 500 unoccupied beds. It is worth noting all this observed spare capacity existed at a time when the NHS was experiencing the longest waits in its history.

However, in addition to using the capacity that already existing, the government introduced new private providers, as discussed earlier. These independent sector treatment centres (ISTCs) were meant to expose traditional incumbent NHS providers to even more outside competition. These ISTCs ended up being one of the most controversial and least successful elements of the reform package.

In order to induce private companies to enter the market for NHS care, the government had to guarantee minimum activity levels and some of the new treatment centres were paid, in advance, for a significant number of procedures that they ended up not completing. Likewise, differences in staffing costs (i.e. needing to account for NHS staff pensions) meant that the government needed to pay private hospitals more to do the same procedures.

After the ISTC programme failed to launch, the government shifted their focus and began to pay for NHS patients to attend existing private providers in England that had historically only treated privately funded patients. This liberalization of the market, introduced from 2007/2008 onwards opened up significantly more spare capacity in the NHS and exposed incumbent hospitals to more competition.

In general, approximately 50% of patients in the mid-2000s were aware that they could choose their provider (Dixon et al., 2010) According to the Department of Health, the percentage of patients aware that they could choose rose from 29% in 2006 to 50% in 2009. Indeed, of patients offered a choice, 91% indicated that they went to the hospital that they wanted to attend, compared to 52% of those who were not offered a choice (Dixon et al., 2010). Here, older patients tended to be more informed about their ability to select a provider, and there was no significant difference in awareness by ethnicity, gender or education levels. Indeed, older patients, according to NHS data, were more likely to travel for care. According to patient feedback, 29% of patients', after 2006, reported receiving care at a non-local NHS provider (Dixon et al., 2010).

3.4. There must be information in the market to inform patients' and purchasers' choices;

In an effort to promote the use of information, the NHS created NHS choices (http://www.nhs.uk/Pages/HomePage.aspx), a website which presents information on the quality of NHS hospitals. At present, it includes information on hospitals' facilities, waiting times, activity rates, infection rates, mortality rates and readmissions rates. In addition, it includes comments and recommendations from individual patients. However, in a survey by Dixon et al., only 4% of patients offered a choice consulted this website. A similar Department of Health survey found that only 5% of patients consulted the website and 7% looked at printed information provided by their GPs (Department of Health, 2009b).

Patients indicated that a key source of information for their decisions on where to be treated was their own previous experience at the hospital and the experience of their family and friends. Here, 56% of patients indicated that they relied on their own previous experience with the hospital, 52% indicated that they were informed by their experience of family and friends and 50% used information gleamed from media reports (Dixon et al., 2010). Nevertheless, 60% of patients offered a choice indicated that the amount of information they received was 'about right'.

During this period, patients' general practitioners were meant to act as patients' agents and help to narrow information asymmetries and aid patients in the decision-making process. According to a recent King's Fund report, 40% of patients reported receiving advice from their GP and 35% received advice from family and friends (Dixon et al., 2010).

3.5. Patients must be responsive to quality signals

If competition in England materialized then patient flows in the needed to shift after choice in the NHS was introduced. Here, both Gaynor et al. (2010) and Cooper et al. (2010) demonstrate that hospital markets in England became more competitive (less concentrated) after the reforms took force in 2006. However, the real question is not just whether or not patient flows changed, but whether or not patients became more elastic to quality. Indeed, consistent with an increase in elasticity, Gaynor et al. (2010) illustrates that better hospitals tended to draw a higher number of patients after the reforms.

To that end, Gaynor et al. (2011) looked directly at whether patients' elasticity with respect to quality increased. To do that, they investigated patients' revealed preferences to determine whether patients became more responsive to quality and waiting times after they were given the ability to choose their provider in 2006. Gaynor et al. (2011) investigated patients' choice of where to undergo a coronary artery bypass graft (CABG) before and after choice was introduced. They found that while the average patient made similar choices before and after the reforms, sicker patients (defined as older and with more comorbidities) became significantly more responsive to quality from 2006 onwards. Likewise, they also found that English patients with lower incomes become significantly more responsive to waiting times after the reforms.

4. Empirical evidence on the impact of competition on quality, productivity and equity

Within the broader economics literature, it has been difficult to assess the impact of hospital competition on providers' performance. That is because, in the cross section, hospital market structure is likely heavily influenced by hospital quality. So, for example, better hospitals may deter other competitors from entering their market. However, the rollout of competition in the NHS provides an ideal environment to determine the causal effect of competition on hospital quality and build on earlier work from the United States. Using the NHS as a quasi-experimental setting, investigators can determine whether NHS hospitals located in more competitive areas prior to the reforms performed better after competition was introduced. The argument behind this research strategy is hospitals market structure before competition is unrelated to

their performance, but it will also determine how sharply these hospitals feel pressure to compete after the reforms in England were introduced.

There are four studies that have looked directly at whether hospital competition in England prompted providers to improve their performance. Two studies looked directly at whether NHS hospitals facing more competition lowered their death rates after competition was introduced. Cooper et al. (2011) found that after competition was introduced, the death rates for patients with heart attacks declined more rapidly in competitive areas. Indeed, Cooper et al. (2011) found that an increase in the number of hospitals in a market by 2 was associated with a 6.7% relative reduction in heart death rates. In a related study, Gaynor et al. (2010) also looked at the impact of competition on hospital death rates in England. They too found that hospitals facing greater competition lowered their heart attack mortality rates and overall mortality rates and found that the magnitude of the effect was nearly identical to that which was measured by Cooper et al.

It is worth noting that consistent with the wider literature assessing the impact of policy changes on hospital performance, both Cooper et al. and Gaynor et al. measure quality using risk-adjusted mortality rates for acute myocardial infarction and control for the introduction of new technologies during their period of analysis. As Cooper et al. note, both studies use AMI mortality as a quality indicator, in part because patients have little choice over where they receive care, which means that patient outcomes are a function of hospital performance, rather than patients' ability to select high quality providers or certain providers' ability to avoid delivering care to high risk-patients. In addition, Cooper et al demonstrate that hospitals that have lower AMI mortality have higher patient satisfaction, lower overall death rates, lower length of stay and lower waiting times. Likewise, Gaynor et al. also illustrate that hospitals facing substantial competition also lower their overall mortality.

In a separate study, Bloom et al. (2010) assessed the impact that hospital competition in the NHS had on hospitals' management quality in 2007. They relied on a management survey of 182 hospitals covering 61% of the NHS and one year of data (Bloom et al., 2010). Bloom et al. (2010) have three principle findings. First higher management quality was associated with higher hospital survival rates from heart attacks and better financial balance sheets for hospitals. Second, they found that public hospitals in England had significantly lower management quality than their private sector competitors. Finally, after instrumenting for competition, Bloom et al. (2010) found that hospitals located in more competitive markets tended to have higher quality management. This study is vital because, in many ways, it provides the mechanism that is likely driving the improvements in mortality observed by Gaynor et al. and Cooper et al. That is, hospital competition in the English NHS led to an improvement in hospitals' management quality, which resulted in improvements in clinical care.

More recently, Cooper et al. (2012) investigated the impact of competition on the productivity of NHS hospitals. To measure hospital productivity, Cooper et al. looked at hospitals length of stay and focused on the rate at which hospitals performed elective surgery on the day that patients were admitted for care. In addition to looking at the impact of competition between public hospitals, Cooper et al. (2012) also looked at whether the opening of the market for NHS patients to private providers in 2008 also induced productivity gains. Cooper et al. observed that from 2006 onwards, each additional hospital was associated with a productivity gain of approximately 5%. In contrast, the entrance of private providers was not associated with any improvements. Instead, Cooper et al. (2012) found evidence that the entrance of private providers was associated with risk selection and that incumbent NHS hospitals located in areas with more private providers tended to treat an older, and less wealthy mix of patients after the NHS market was liberalized in 2008. This suggests that policy-makers need to do more to risk-adjust patients, so that hospitals are more generously compensated for treating riskier patients with higher costs.

Prior to the introduction of choice and competition in the NHS, a number of analysts raised significant concerns that the reforms had the potential to adversely impact the equity of the NHS. However, there has been no evidence thus far that the NHS reforms harmed equity. Cookson et al. (2011) examined whether competition led to differences in the utilization rates of care across social classes. Indeed, rather than finding that the increase in competition undermined equity, they actually found evidence that it may have been associated with small improvements in access for underserved populations. Their work is consistent with earlier evidence from Cooper et al. (2009) which found that from 1997 through 2007, the equity of the distribution of waiting times across social group improve substantially. They found that in 1997, lower income patients waited substantially longer for elective care than wealthier patient, but that by 2007, that variation had disappeared.

5. Learning from the English Experience and Steps Forward

In most respects, the NHS reforms in the mid-2000s have been successful. During that period, waiting times fell substantially, hospital quality improved and the NHS became more equitable. A number of national policies clearly played a role in the improvement in NHS performance during that period. Indeed, from 2000 – 2010, funding in the NHS went up substantially, the government introduced a rigid performance management program for hospitals and primary care physicians and there were a number of centralized programs designed to improve stroke and heart attack care. Nevertheless, against the backdrop of improvements from national policies, more recent evidence suggests that hospital competition during that period led to improvements in hospitals' quality, productivity and management performance and it did so without harming equity. As a result, the English experience profound implications for other health systems.

However, the implications from the NHS reforms are not simply that competition is good and therefore that other should liberalize their markets or than the NHS should necessarily go further and faster. The NHS reforms, particularly when they are contrasted with evidence of competition failing to produce welfare gains elsewhere, illustrates that in order to have competition improve performance, it must occur in the presence of other concurrent policies. Indeed, in many ways, it was the high degree of centralization in England, which allowed policy-makers to put parallel policies in place that mitigated against some of undesirable consequences of competition and assure that competition led to positive gains.

In what follows, I will briefly discuss the policy steps taken in England, which made hospital competition successful in the NHS and examine the implications this has for other health systems.

5.1. Information

First, there was a concerted effort by the central government in England to publicly publish information on providers' performance. Indeed, as the NHS reforms were being rolled out, the NHS launched a website providing information and many aspects of clinical performance to inform patients' choices.

However, there is a large body of evidence that suggests that a large share of consumers do not use information on providers' performance to inform their choices. Indeed, in England, there is some evidence that patients rarely utilized to this webpage.

So why then did the information matter?

It mattered for two reasons. First, there is ample reason to believe that when information is published in a competitive environment, it will induce changes in behaviour in hospital performance, irrespective of patients' responsiveness, so long as hospital CEOs and members of hospital boards have a fear that it might. Likewise, Gaynor et al. (2011) illustrate that a small share of patients were indeed responsive to

quality. Given the huge pressure hospital CEOs were under at that time to maintain surpluses, even small losses in their share of elective activity would have sizeable implications for their financial balance sheets. As a result, it is likely that in this market, even a small share of well-informed patients was enough to induce changes in activity.

Second, as I shall discuss in more detail to follow, patients' general practitioners played an integral role in informing patients' choices and suggesting where they should receive care. As a result, even if patients remain uniformed, so long as performance information is public and general practitioners can use it to inform patients' choices, then this information could still be beneficial.

Prospectively, the NHS needs to continue to publish more information on providers' performance. This includes data above and beyond mortality rates, including patients' reported outcomes (i.e. perceived health improvement), patient satisfaction and more detailed data on the outcomes for individual procedures. At present, most data is at a whole hospital level. Going forward, the NHS, and other systems should strive to publish data at a procedure level and illness level to inform choice.

5.2. Agency

A second crucial factor in the success of the NHS reforms was the role that GPs played in the referral process. Because each referral was generally made in the company of the GP, GPs' had tremendous power to influence patients' referrals. Indeed, this hypothesis is born out of survey work by Dixon et al. (2010) illustrating that GPs were one of the most important sources of information used to inform patients' choices. In the market for hospital care in England, GPs served as agents for patients, narrowing the typical information asymmetries that often exist in markets for health care services.

More than that, GPs often made the same referral for multiple patients which put them in a position to perceive quality *ex post* and use the information gleamed from previous patients to inform future patients. Elsewhere, Klein and Leffler (1981), Shapiro (1983) and Allen (1984), have found that even in markets with imperfect information, there is likely to be an equilibrium with optimal quality if consumers can perceive quality ex post and providers have an interest in attracting repeat business.

This too has important implications for other health systems experimenting with competition. Having an agent to help inform patients' choices is vital to creating meaningful incentives. In the face of substantial evidence that the majority of patients do not use information on providers' performance to inform their decisions, agents, like GPs, are crucial elements in ensuring that participants in the market are elastic to quality.

It is also vital to note that in England, GPs did not have the opportunity to gain financially from making certain referral decisions. This lack of a pecuniary interest on the part of GPs is vital to ensuring adequate levels of trust and a successful agency relationship. Prospectively, policy-makers in England are giving GPs budgets and making them de facto insurers. This change in policy substantially raises the risk that patients will lose trust their GPs' advice and it could undermine the agency relationship.

That said, there are other players in health care markets who should have a role shaping patients' choice sets and informing their decisions. Crucially, purchasers have the power to decide who is included in the patients' choice set and who they will reimburse. Here, purchasers have the power to use cost-sharing and financial incentives to 'tier and steer' patients. That is, they could create financial incentives to steer patients towards the most cost-effective providers or to providers who demonstrate that they use evidence-based guidelines for care. In England, demand side cost sharing is not politically viable, but it remains a strong policy tool to direct patients to hospitals with better outcomes (i.e. by imposing a cost to

patients for attending hospitals that do not follow evidence-based guidelines or who have above average complication rates).

5.3. Pricing

Third, it is also vital to note that competition in England operated in a market with fixed prices that were determined by a regulator. As mentioned earlier, empirical evidence tends to suggest that competition in fixed price markets is generally associated with improvements in quality whereas competition in markets with price competition may harm quality. Indeed, in the 1990s, England also experimented with price competition and allowed hospitals to compete for annual contracts with local purchasing bodies. Evidence from this period suggests that competition lowered prices but also harmed quality.

This is not to say that price competition has no role in health care. As outlined in Charlesworth and Cooper (2010), price competition has a place, but it must be introduced carefully. Crucially, before health systems and regulators start experimenting with price competition, they must ensure that there is sufficient information for patients and their agents to observe quality. Indeed, prospectively, there is certainly scope for England to open the NHS up to price competition, but it should only occur for procedures where quality is easily observable and where the impact of potential reductions in quality are not fatal.

However, competition between hospitals in fixed price markets is not guaranteed to improve quality. Here, setting the tariff price is vital to ensuring that competition leads to quality gains. If regulators set prices below providers' marginal costs, competition will tend to reduce quality and lower the provision of services. Likewise, setting prices far too high will result in supernormal levels of quality and over provision. In England, regulators had access to data on hospital costs. This information was crucial for their rate setting. In other countries, like the Netherlands, price setting has typically occurred in negotiations between insurers and providers. These sorts of negotiations, which include hospital representatives, are also sensible since they also will be informed by inside information on hospital costs.

5.4. Concluding Thoughts

From 2000 onwards, the English National Health Service went through a series of profound reforms that injected hospital competition into a health system that historically had few financial incentives for health care providers. These reforms have proven largely successful and they provide an opportunity for outside observers to learn from the English experience with competition. Within England, policy-makers took specific steps to address the commonly known ways that health care markets differ from textbook, perfectly competitive markets which form the backbone of micro-economic theory. In order to make the hospital markets in England function, policy-makers introduced competition on quality (not price), created a substantial role for patients' general practitioners to act as patients agents, and worked to publish information on providers' performance in order to inform patients' choices. In addition, policy-makers took advantage of the historical centralization of the NHS, which allowed those setting prices in England to, for instance, have access to hospital cost information.

The story that emerges from the recent NHS reforms is not that competition is unambiguously good and that centralization is unambiguously bad. The story is that competition can be an effective tool to create financial incentives for health care providers to improve their performance as long as certain conditions are met. More than that, a second key finding to emerge from the English experience with competition is that the historical centralization of the NHS was likely hugely advantageous to policy-makers working to create a dynamic hospital market. This historical centralization allowed policy-makers to introduce measures designed address some of the commonly known pathologies present in health care

markets and create an environment where hospital competition could improve providers' clinical quality and increase their productivity.

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REFORM, COMPETITION, AND POLICY IN HOSPITAL MARKETS

Paper by Mr. Martin Gaynor[*]

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1. Introduction

1.1. Health Care Costs, Quality

Health care costs have been rising on a sustained basis over the past 30-plus years in Europe, Canada, and the United States (OECD, 2011). There has been growing concern about benefits generated by health care relative to the costs, and the ability to finance this sustained growth in spending. These concerns have been accentuated recently by the global economic situation and the realization that long term fiscal realities require substantial reductions in public spending. Somewhat more recently, starting in the late 1990s, there have been parallel concerns about the quality of care. Despite the substantial sums of money spent on health care, especially in the U.S., quality of care is uneven, with some glaring deficiencies, such as medical errors.

The hospital sector is an area of major concern. This is generally where the sickest patients are treated, and accounts for a large share of the costs. Hospital inpatient care on average accounted for 29 percent of health spending in OECD countries in 2009 (OECD, 2011), and about 2.8 percent of GDP. In addition, hospital markets generally are served by a small number of firms, and are thus susceptible to the exercise of market power if competition is not maintained.

1.2. Health Reforms

As a consequence, cost control has emerged as a key issue for most developed countries' health systems. The development of most countries' health systems was initially guided by equity goals, not efficiency.[1] This led to common features such as universal coverage and no price rationing. However, health care spending has increased rapidly over time --- the percent of GDP devoted to health care has more than doubled in OECD countries since 1960. This has led to health system reforms aimed at combating the increase in health care costs. In addition, quality problems have recently emerged as another area of concern. While the problems confronting health systems have not changed in any fundamental way, the policy approaches have (Dixon and Poteliakhoff, 2012).

Initially (1970s and 1980s), approaches to cost control were regulatory, e.g., fee reductions to health care providers and rationing access (especially to new technologies). These approaches did seem to slow the growth in costs, but only temporarily. As a consequence, continuing to contain costs would require continually tightening regulatory limits. Such an approach leads to the politically unattractive prospect of more visible and onerous rationing.

At present, market oriented approaches are being adopted or considered in a number of countries.[2] This has the attraction of reducing costs without public cuts in entitlements.

1.2.1. United States

The U.S. is the country with the most experience with competition in health care markets. It has always relied on markets to some extent, however, some key policy changes intensified the role of competition in hospital markets. First, in 1983, the Medicare program changed the way it paid hospitals. Previously hospitals had been paid on a retrospective cost-plus basis. From 1983 onwards hospitals were paid on a fixed price prospective basis (the Prospective Payment System, PPS, often referred to as ``DRG payment."). As a consequence, hospitals now had an incentive to compete for patients (at least those with

[1] The United States may be an exception.

[2] For example, the U.K., France, the Netherlands, Germany, and Sweden.

profitable conditions). Second, in the 1990s, U.S. states began allowing private health insurance companies to engage in selective contracting with health care providers. This change allowed insurers to engage in serious price negotiations with hospitals, leading to substantially tougher price competition. Antitrust enforcement agencies, however, lost 8 straight hospital merger cases during the 1990s, concurrent with a substantial amount of consolidation in the industry. The majority of urban areas in the U.S. are now highly concentrated.[3] The HHI for hospital markets rose by over 900 points from 1987 to 2006 (Gaynor and Town, 2012).

1.2.2. England

The English N.H.S. (not Scotland, Wales, or Northern Ireland) introduced a set of reforms in 2006 designed in introduce non-price competition among hospitals. The reforms had three moving parts. Hospitals went from negotiating reimbursement with local health authorities (PCTs) to ex ante fixed prices based on diagnosis (Payment by Results, PbR). It was also required that patients be given the choice of 5 hospitals. Hospitals designated as Foundation Trusts could keep their surpluses, and good performance allowed ordinary hospitals to achieve Foundation Trust status.

1.2.3. The Netherlands

The Netherlands has gradually been moving to allowing hospital prices to be market determined. Beginning in 2006 health insurers and hospitals were allowed to freely negotiate prices for an increasing subset of services (the "B-segment"), comprising approximately 1/3rd of services at present.

1.3. Issues with Competition in Health Care

1.3.1. Is Health Care Different?

It is often alleged that health care is different from other goods, and as a consequence markets don't work in health care. In discussing this first let me enumerate the ways in which health care is different from a perfectly competition market. While there are few truly perfectly competitive markets in the real world, perfect competition does serve as the benchmark for market performance, so it's worth considering how health care compares.

The conditions for a market to be perfectly competitive are as follows (Perloff, 2012).

- Homogeneous products
- Large number of firms
- Free entry and exit
- No transaction costs
- Perfect information
- No externalities or public goods

Hospital markets deviate from these conditions in several fundamental ways. First, the product is differentiated, not homogeneous. Hospitals differ in their characteristics, including location and quality of

[3] Herfindahl-Hirschmann Index (HHI = sum of squared market shares) greater than 2,500.

care. Second, hospital markets are oligopolies, characterized by a small number of firms. Third, entry and exit are costly, although technological advances have somewhat changed this. For example, many surgeries can now be performed on an outpatient basis at free standing independent surgery centres. Nonetheless, many procedures can only be performed on an inpatient basis. Constructing an entirely new inpatient facility is extremely costly. Exit is also costly, because of the specialized nature of the facility. Hospital facilities can be converted to other uses, but at a nontrivial cost. Fourth, there are transactions costs. Travel costs to obtain care can be substantial (one may also regard location as a product characteristic). Purchasing is often done by a third party (a private health insurer or a government agency) via negotiations, which can have nontrivial transactions costs. Fifth, one of the characteristic features of health care is imperfect information. There is asymmetric information between patients and providers and purchasers and providers along a number of key dimensions, for example appropriate treatment and provider effort. Last, while there are some externalities in health (e.g., infectious disease), most of what is bought and sold in hospital markets in developed countries is not subject to externalities nor does it have a substantial public good character (e.g., heart surgery).[4,5]

The fact that health care markets do not conform to the theoretical conditions for perfect competition is not very significant. Very few real world markets come very close to these conditions. Indeed, many markets deviate from the conditions for perfect competition in ways that are similar to health care.

The vast majority of products sold in modern economies are differentiated. Automobiles, ready-to-eat breakfast cereals, computers, restaurant meals, even retail gasoline are all differentiated (gasoline primarily via location). This is a common feature of many markets, and it poses issues for competition. However, much of modern industrial organization has been devoted to understanding the workings of such markets. While it is understood that product differentiation can soften competition, that doesn't mean that competition can't "work" in these markets (see, e.g., Tirole, 1988; Carlton and Perloff, 2005; Pepall et al., 2005).

The same description also holds for oligopoly. Many markets in the economy are oligopolies. These include automobiles and ready-to-eat breakfast cereals, as mentioned above, plus other markets like airlines and personal care products like toothpaste, shampoo, etc. Again, having a small number of firms in a market presents challenges to competition, but in general we let markets serve as the mechanism for organizing exchange even when there are oligopolies.

The issue of entry and exit costs is related. Oligopoly markets are typically characterized by high entry (and often) exit costs – that is why there are few firms serving these markets. Of course in some cases entry costs are high enough that only one firm serves a market. That amounts to a "natural monopoly." Economic theory indicates that (price) regulation is warranted in such a case.

Transactions costs are also a pervasive feature of markets. All markets require some time expenditure in order to obtain goods, whether it's travel time or time spent on a website. Most retail goods are sold with posted prices, so beyond the time cost, transactions costs are typically low. For some good, like automobiles or houses, price is typically determined via negotiation. In these markets transactions prices can be significant. Nonetheless, there are few allegations that these markets are fundamentally flawed and should be replaced by another method of allocation.

Economists agree that the defining feature of health care markets is imperfect information, specifically asymmetric information. Asymmetric information presents a significant challenge to the

4 There will usually be pecuniary externalities, since care is financed via private insurance or public funding.

5 It is important to note that there may be externalities if individuals are concerned about others' health. In that case others' consumption of health care will constitute a (positive) externality.

functioning of markets. Most of the concern with health care (as opposed to health insurance) is moral hazard. Health care providers (e.g., physicians) know more about the patient's problem, the technology of treatment, and their own effort, than does the patient. In short, physicians are selling an "expert service." Patients are buying both diagnosis and treatment. This puts the physician in a position to exploit the information asymmetry to their advantage, for example, recommending more profitable services or providing less effort. Health care, however, is not the only expert service. Automobile repair, plumbing, dentistry, and financial advising are all examples of expert services. Consumers in markets like this are often subject to exploitation by sellers (automobile repair is a canonical example). However, adjustments to the information asymmetry allow these markets to function, for example, seller reputations, warranties, 3rd party ratings of sellers, etc.

There can be other effects of imperfect information. If few consumers are well informed, then sellers don't have to compete intensively with each other. For example, if few consumers have information about quality, then hospitals will not need to compete with each other over quality.

As I mentioned previously, hospital services are mostly private goods, hence there are no significant externalities or public good aspects in these markets. As I also mentioned, individuals may have concerns over the health of others, which can be expressed as a positive externality of others' consumption of hospital care. If this is the case it will have the usual impact of an externality – in the case of a positive externality the market will produce too little of the good. I think it's more productive to talk about equity explicitly, as opposed to couching equity concerns as efficiency in the form of an externality.

1.3.2. Conditions for Competition to Work

In order for competition to work in hospital markets, what do we need? Some of the things we need correspond to factors discussed above, but there are some additional factors due to the institutional characteristics of hospital markets. The conditions that must hold for competition to work in hospital markets are as follows.

- "Enough" hospitals
- Incentives for hospitals to attract patients
- Demand responsiveness to differences across hospitals
- "Enough" information

We know from economic theory that competition in oligopolistic markets gets tougher as the number of firms increases. In fact, competition can increase substantially even with only a small number of firms, e.g., moving from 1 firm to 2, or from 2 firms to 3. There is empirical evidence on this. Bresnahan and Reiss (1991) find evidence that competition increases substantially as the number of competitors increases for doctors, dentists, druggists, and tire dealers (they find no change for plumbers). Abraham et al. (2007) perform a similar analysis for hospitals. They find that hospital competition gets substantially tougher as more hospitals are in a market, up to 3 hospitals. As a consequence, even two hospitals in a market can be enough to have fairly tough competition.[6]

In economics in general it is presumed that firms want to attract customers. Firms are profit maximizers and make money by selling their products. However, that is not necessarily the case in all

[6] Of course competition will be tougher with more hospitals. Collusion is also more of a concern the fewer firms there are in a market.

health care systems. If hospitals' budgets are not directly related to their patient volume then they have little or no incentive to attract patients. It is necessary that hospitals' revenues increase with the number of patients, and that they retain (at least some) of those revenues.[7] For example, in the English NHS, hospitals are paid a fixed price based on the patient's HRG (a DRG like categorization). Assuming the price is above marginal cost, it is profitable for the hospital to treat the patient. However, unless the hospital can retain the profits generated by admitting the patient, there is no incentive do so. Another key factor is that Foundation Trusts keep their financial surpluses, and "ordinary" trusts are evaluated on the basis of their financial performance and have the ability to be designated Foundation Trusts if their performance is deemed sufficiently good.

A key condition for making competition work is that demand is responsive to differences across hospitals in the key competitive variable(s). For example, if price is market determined, then demand must be responsive to price differences across hospitals – otherwise there is no reason for hospitals to compete on price. The same is true of quality, or any other characteristic. It will often be the case that quality is the key competitive variable, since price is administered, rather than market determined. It will not necessarily be the case that the patient is the only one involved in decision making, indeed, that may not even be desirable. Clearly demanders must be able to perceive differences across sellers and value them properly. This can be difficult for individual consumers in health care, with respect to say, quality, or even price.[8] Consumers may have difficulty gathering information themselves or evaluating information properly even if they have it. Patients' physicians can in principle act as their agents, however physicians may not have strong incentives to act on patients' behalf. A 3rd party, whether government or private, can help to provide information and decision assistance. A non-trivial difficulty here is measuring quality. A great deal of progress has been made in measuring health care quality, but the measures are still quite imperfect. Another alternative is more active patient steering, as occurred in managed care in the US. Hospitals have to compete to be included in provider networks, which can be on the basis of price or quality. Patients who wish to go to a provider outside the network pay substantially more. Managed care plans in the US did this on the basis of price, but in principle it could be done on the basis of quality as well.

I have already discussed information above. However, it is not necessary for all consumers in a market to be well informed for information to be effective. It is sufficient that "enough" buyers be well informed and that sellers can't discriminate among well informed and poorly informed customers. If a sufficient number of buyers are well informed then sellers will have to respond as if everyone is well informed. They can't shade quality or raise price because the well informed buyers will go elsewhere. Sellers also know that the other sellers know this and thus all sellers have strong incentives to provide high quality or low prices for fear that others will steal their customers. While buyer information is a significant issue, it is a less formidable obstacle to have a fraction of buyers well informed.

2. Evidence

2.1. Economic Theory

Economists, antitrust scholars, and the courts intuitively think that competition is a good thing. Indeed, this is the presumption of antitrust law. Economic theory, when there are differentiated products, however, is not so clear. In what follows, I briefly summarize the state of knowledge on this issue from economic theory. I divide this into situations where price is administered (e.g., set by a central authority) versus those where price is set by firms. These situations have very different results.

7 This is sometimes referred to as "activity-based funding." See O'Reilly et al. (2012) for documentation on this in 5 European countries.

8 In many health systems patients bear little or none of the cost, or there are no price differences between hospitals due to administered pricing, so quality, not price is relevant.

2.1.1. Administered Prices

Economic theory is fairly straightforward with regard to competition when there are administered prices. Since a regulator sets the prices firms compete over non-price dimensions to attract consumers. I will refer to this as "quality." If price is set above marginal cost, then attracting another patient is profitable for a hospital. In that case, hospitals will compete for patients. Competition will become more intense as the number of hospitals in a market increases, assuming that the demand faced by an individual hospital becomes more responsive to hospital quality.[9,10]

Another clear implication of the theory is that the level at which the administered price is set is critical. If the price is set below marginal cost then firms will reduce quality, or if they can't, try to avoid patients. If the price is set too high above marginal cost then the resulting level of quality will be too high.

In standard economic models competition of this sort (with price above marginal cost) can be inefficient. Firms steal demand from each other, rather than expanding total market demand, as a consequence, competition can lead to excessive levels of quality. In health care, however, the value that patients derive from consuming the same quantity of care can be dramatically enhanced by improved quality. As a consequence, it's less likely that such quality competition in wasteful, even if it only results in demand stealing.

2.1.2. Market Determined Prices

In the case where both prices and quality are market determined theory is unclear about the impacts of competition. There is no general result here – the results tend to be model specific. However, there are still some general insights available. The model developed by Dorfman and Steiner (1954) is very useful for this purpose. Their model is nominally about choice of price and advertising, but can also be interpreted as about price and quality. The model yields the following equation, known as the Dorfman-Steiner condition (z is quality, p is price, d is the marginal cost of quality, ε_z is the quality elasticity of demand, and ε_p is the price elasticity of demand).

$$z = \frac{p}{d}\frac{\varepsilon_z}{\varepsilon_p}$$

This says that quality will go up if the quality elasticity of demand increases or the price elasticity of demand declines, and vice versa. It also offers some other insights.

Presume that there exist "optimal" values of the price and quality elasticities, that is, there exist unique values which induce the monopolist to choose the socially optimal price and quality. Then if market power over price increases, i.e., ε_p goes down, price will increase above the optimum. Quality will also increase. Alternatively, if the quality elasticity decreases, quality will fall to a sub-optimal level, even if the price elasticity is at its optimal value. If an increase in market power reduces both the price and quality elasticities, the effect on quality is unclear. Price will certainly rise. If the price and quality elasticities fall by the same proportion, so that their ratio is unchanged, price will still rise and as a consequence quality will also rise above its optimal level. If the ratio of the quality elasticity to the price elasticity falls by more than price increases, quality will fall below the optimal level.

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[9] If demand is responsive to quality differences across hospitals, then demand for any hospital will become more elastic as the number of hospitals increases, since consumers now have more choices. The assumption here is that hospitals become closer substitutes the more of them there are.

[10] See Gaynor (2006) or Gaynor and Town (2012) for a more complete exposition.

Dranove and Satterthwaite (1992) consider the effects of information on price and quality when consumers are imperfectly informed about both. They find that if consumers have better information about price than about quality, then this can lead to an equilibrium with sub-optimal quality. Intuitively, this is similar to what happens in the Dorfman–Steiner framework with an increase in the price elasticity of demand, with no increase in the quality elasticity. The price-cost margin will fall, leading to a decreased payoff to quality, and a decrease in the quality–price ratio.

Kranton (2003) examines the impact of competition on quality when consumers have imperfect information about quality. A number of papers have considered the question of whether there is an equilibrium at which the socially optimal quality is produced in a market where consumers are imperfectly informed about quality (but not about price) (Allen, 1984, Klein and Leffler, 1981, Shapiro, 1983). These papers demonstrate that there is an equilibrium with optimal quality if consumers can learn about quality *ex post* and if firms care enough about (future) repeat business. In this equilibrium there is a "quality-assuring price" that is above marginal cost and supports the optimal quality. Kranton shows that this result does not necessarily hold if firms compete in price for market share (a feature that is absent from the prior models). If a firm can increase (and sustain) its market share by cutting price, then there cannot be an equilibrium at the socially optimal quality level. One may apply the intuition from the Dorfman and Steiner model to Kranton's result. The ability to increase market share via price cuts is analogous to a large price elasticity of demand in the Dorfman–Steiner model, which leads to a lower quality–price ratio. If the reference point is an equilibrium with optimal quality, as in Kranton's model, then the lower quality is suboptimal.

Allard *et al.* (2005) explicitly consider competition in the physician services market. They consider a repeated game between physicians and patients. The patient's health is determined by observable medical care and physician effort. Physician effort is anything physicians do that affects patient health. It can be thought of as quality. The patient observes his health *ex post*, so physician effort is observable, but is non-contractible. In the static game physicians will supply sub-optimal effort. However, in the repeated game there is an equilibrium in which physicians supply optimal effort. This equilibrium obtains under certain conditions, in particular, if patient switching costs are not too high and there is an excess supply of physicians. If switching costs are high then effort will be suboptimal, but competition will result in effort levels above the minimum.[11] Again, there are parallels to the Dorfman and Steiner intuition. In the Allard *et al.* model optimal effort occurs when patient switching costs are not too high. This is similar to the quality elasticity of demand being sufficiently high in the Dorfman and Steiner model. Sub-optimal effort occurs when switching costs are high, analogous to a low quality elasticity of demand.

While there are still no determinate conclusions from this framework, it does offer some useful guidance for thinking about issues of competition in health care markets. For example, if buyers in health care markets become better informed about quality, either through better information dissemination or increased emphasis on quality and medical errors then the quality elasticity of demand may increase. Quality will then increase. If the price elasticity remains unchanged this will increase price (since the increase in quality increased marginal cost), but price cost margins will remain unchanged. As an alternative example, the advent of managed care in the US in the 1990s is commonly thought to have increased the price elasticity of demand facing health care firms (hospitals in particular). This should have

[11] In addition, if there is uncertainty in the relationship between patient health and physician actions, then physicians face some risk of patients switching even if they have supplied optimal effort. In this case, the physicians will supply supra-optimal effort.

led to decreased prices, and indeed seems to have done so.[12] If there was no sufficiently countervailing increase in the quality elasticity, then quality should have fallen.[13]

2.2. Empirical Evidence[14]

There is a well-established empirical literature on competition and prices in hospital markets. The empirical evidence in this area comes almost entirely from the US (there is one recent paper from the Netherlands). There is also a newer literature on hospital competition and quality. While the majority of the evidence here is also from the US, there is a rapidly growing literature with evidence from other countries, such as the UK and the Netherlands.

In what follows, I first review the evidence on the impacts of competition on quality. I then discuss the evidence of the impact of competition on price. I also then review the evidence on costs/efficiencies from merger, and last, I review the small literature on vertical integration.

2.2.1. Quality

A number of research studies have examined the impacts of hospital consolidation on various measures of quality, although the most commonly used measure of quality is mortality (adjusted for patient severity of illness). The results in this literature are mixed, although the results are strongest for markets with administered prices (see Gaynor, 2006; Vogt and Town, 2006; Gaynor and Town, 2012, for surveys).

The evidence from markets with administered prices is fairly clear – competition among hospitals leads to better quality. While not every single paper in the literature has this finding, this is the case for the majority of the studies, and the strongest studies. The evidence comes from the US Medicare program, the UK (English NHS), and the Netherlands.

A number of studies have examined the impact of market concentration on patient mortality for Medicare patients. There are a variety of findings, but the strongest studies find that market concentration significantly increases mortality (Kessler and McClellan, 2000; Kessler and Geppert, 2005). Kessler and McClellan find that risk-adjusted one year mortality for Medicare heart attack (acute myocardial infarction, or AMI) patients is significantly higher in more concentrated markets. In particular, patients in the most concentrated markets had mortality probabilities 1.46 points higher than those in the least concentrated markets (this constitutes a 4.4% difference) as of 1991. This is an extremely large difference - it amounts to over 2,000 fewer (statistical) deaths in the least concentrated vs. most concentrated markets.

The English National Health Service (NHS) adopted a set of reforms in 2006 that were intended to increase patient choice and hospital competition, and introduced regulated prices for hospitals based on patient diagnoses (analogous to the Medicare Prospective Payment System). Two recent studies examine the impacts of this reform (Cooper et al., 2010; Gaynor et al., 2010) and find that, following the reform, risk-adjusted mortality from heart attacks fell more at hospitals in less concentrated markets than at hospitals in more concentrated markets. Gaynor et al. (2010) also look at mortality from all causes and find that patients fared worse at hospitals in more consolidated markets.

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12 See Dranove and Satterthwaite (2000), Gaynor and Vogt (2000), Vogt and Town (2006), and Gaynor and Town (2012) for reviews of the evidence.

13 It is important to bear in mind here that if the starting point was one where hospitals possessed market power, then the model predicts that quality should have been at supra-optimal levels. Thus a decrease in quality could be welfare improving (assuming it did not fall below the optimal level).

14 I only refer here to papers published in English, due to my rudimentary knowledge of most other languages.

The results of studies which examine impacts of competition for privately insured patients are more mixed. A number of studies find that quality is positively affected by competition, a number find that it is negatively affected by competition, and some find no effect. As a consequence, there is no clear general impact of the impact of hospital consolidation on quality for privately insured patients that can be ascertained from the current research literature.

A recent study by Cutler et al. (2010) examines not only the impacts of competition on quality, but also impacts on costs. Cutler et al. use the repeal of entry restricting regulation (hospital certificate of need regulation; CON) in Pennsylvania to examine the effect of entry of hospitals into the CABG surgery market. They find that entry led to increased quality, but that the gains from reduced mortality due to entry are approximately offset by the additional costs incurred by entering firms.

A recent paper by Romano and Balan (2011) attempts to directly assess the impacts of hospital mergers on quality. Romano and Balan study the impact on quality of care of a consummated merger between two hospitals in the Chicago suburbs (Evanston Northwestern Hospital and Highland Park Hospital). This merger was the subject of an antitrust suit by the Federal Trade Commission, and the authors provided evidence on the case. They find no significant impact of the merger on many quality measures, but there is a significant negative impact on some and a few with positive impacts. They estimate that the merger led to heart attack, pneumonia, and stroke mortality going up at Evanston Northwestern Hospital, although not at Highland Park. There was some improvement in quality for some nursing-sensitive quality measures: the incidence of decubitis ulcers (bedsores) fell at both merged entities, as did infections at Evanston Northwestern. Conversely, the incidence of hip fractures rose at Evanston Northwestern. Last, they found increases in some measures of obstetric outcomes (birth trauma to the new-born, obstetric trauma to the mother), and decreases in some other measures. They conclude that overall there is no reason to infer that the merger had salutary effects on quality.

Bijlsma et al. (2010) examine the impacts of hospital competition in the Netherlands on process indicators (e.g., share of operation cancellations on short notice and share of diagnoses within 5 days) and outcome indicators (e.g., mortality rates) of hospital quality. They find that competition explains differences in process indicators, but not outcome indicators, i.e., hospitals facing more competition did better on process, but no differently with regard to outcomes than hospitals in less competitive markets.

Overall, the research evidence suggests that hospital consolidation can have a negative impact on quality in markets with regulated prices, like Medicare. However, the current research evidence where prices are market determined (the privately insured) does not indicate a clear impact of consolidation on quality in those markets in general.

2.2.2. Prices

There has been a lot of research on the impact of hospital market consolidation on prices paid by private payers, mostly in the US, because price is set administratively in most other systems. There is, however, some recent evidence from the Netherlands, which has allowed prices for some hospital services to be market determined. The overwhelming finding in the literature is that consolidation leads to higher prices (see Dranove and Satterthwaite, 2000; Gaynor and Vogt, 2000; Vogt and Town, 2006; Gaynor and Town, 2012, for reviews of the evidence).

Examining the distribution of realized hospital prices (for the privately insured) alone is informative about the functioning of hospital markets. Ginsburg (2010) uses administrative claims data for 8 geographic areas from 4 large private insurers to construct inpatient hospital prices. He finds that there is significant variation both within and across regions in hospital prices. For example, San Francisco has the highest average hospital prices in 2008, with prices equal to 210% of the Medicare reimbursement rate.

The lowest rate is Miami-South Florida with mean prices that are 147% of Medicare rates - the mean price in San Francisco is 43% higher than Miami. Within San Francisco, the interquartile range is 116% of the Medicare price. Of course, there are a number of possible reasons for this variation. Cost, quality and demand differences will generally imply price differences. However, it seems unlikely that there is enough variation across those factors to generate such wide variation in price.

There are a number of different methods that have been used to estimate the impact of hospital consolidation on prices. The most direct approach compares price increases at merging hospitals with those at similar hospitals which did not merge (see Capps and Dranove, 2004; Dafny, 2009; Haas-Wilson and Garmon, 2011; Kemp and Severijnen, 2010; Krishnan, 2001; Spang et al., 2001; Sacher and Vita, 2001; Tenn, 2011; Thompson, 2011). The vast majority of these studies find price increases of at least 10 percent due to merger, with some estimates of price increases due to merger of 40 percent or greater.

For example, Haas-Wilson and Garmon (2011) evaluate the Evanston Northwestern and Highland Park hospitals in the northern suburbs of Chicago. They find a price increase of 20 percent due to that merger. Tenn (2011) examines the merger of two hospitals in California: Summit and Alta Bates. He finds that prices at Summit hospital increased between 28 and 44 percent after the merger. Kemp and Severijnen (2010) estimate the impacts of two hospital mergers in the Netherlands on the price of hip surgery. For the merger that raised more serious concerns, between Ziekenhuis Gooi-Noord and Ziekenhuis Hilversum, they find price increases of 3.5 per cent for Ziekenhuis Gooi-Noord and 5.1 per cent for Ziekenhuis Hilversum due to their merger.

Another source of information on the impacts of hospital consolidation comes from studies which examine the impact of hospital market concentration (measured as the HHI) on price. These studies don't examine the effects of mergers directly, but allow one to calculate the expected impact of a merger based on its impact on market concentration. Vogt and Town (2006) calculate the average estimated impact of a merger of two equal sized hospitals in a five hospital market (a "5 to 4" merger).[15] They find that such a merger is estimated to increase prices by 5 percent. Halbersma et al. (2010) find hospital prices are positively correlated with hospital concentration and negatively correlated with insurer concentration after the introduction of market-based health care reforms in the Netherlands in 2004.

Last, a few research papers have estimated the impacts of hospital mergers using simulation. These papers estimate models of hospital competition, then use the estimated parameters of those models to simulate the impacts of mergers (Town and Vistnes, 2001; Capps et al., 2003; Gaynor and Vogt, 2003; Brand et al., 2011). These papers find estimated impacts of mergers ranging from 5 to 53 percent increases in price. Town and Vistnes (2001) examine mergers among hospitals in Los Angeles and Orange Counties, California, where there are more than 120 hospitals between the two counties. They find that many of the mergers they examine would result in price increases of 5 percent or greater, in spite of the large number of hospitals in these counties. Capps et al. (2003) examine a 3 hospital merger in the southern suburbs of San Diego County, California, and find a price increase due to the merger of over 10 percent. Gaynor and Vogt (2003) find that a three-to-two hospital merger in San Luis Obispo, California (which was attempted, but blocked by the FTC) would have raised prices by over 50 percent. Brand et al. (2011) consider the recent proposed acquisition of Prince William hospital in Manassas, Virginia by Inova health system in Northern Virginia. They estimate that the acquisition would have led to price increases at Prince William hospital of anywhere from 19 to 33 percent.

[15] This results in an 800 point increase in the HHI, from 2000 to 2,800. The average HHI rose by about this amount from 1997 to 2002, albeit from a higher base.

Overall, these studies consistently show that hospital consolidation raises prices, and by nontrivial amounts. Consolidated hospitals that are able to charge higher prices due to enhanced market power are able to do so on an ongoing basis, making this a permanent rather than a transitory problem.

2.2.3. Not-for-Profit/Public Firm Behaviour

The hospital sector is characterized by the fact that in most countries the firms are either public or not-for-profit. In the US there is a mixture of firms with different ownership types. Not-for-profits are the most common, but there are substantial numbers of for-profit hospitals and public hospitals. One question that is relevant in this setting is whether not-for-profit hospitals behave any differently with regard to their competitive conduct.

A number of studies (e.g., Keeler et al., 1999; Simpson and Shin, 1997; Dranove and Ludwick, 1999; Capps et al., 2003; Gaynor and Vogt, 2003) have addressed the issue of not-for-profit/for-profit differences in competitive conduct. Those studies do not find any significant differences in pricing behaviour. In particular, the effects of consolidation on pricing do not appear to differ depending on whether a hospital is not-for-profit.

A recent study by Capps et al. (2010) examines whether not-for-profit hospitals are more likely than for-profit hospitals to offer more charity care or unprofitable services in response to an increase in market power. The implication is that if there were such a difference, not-for-profits would be spending their profits from market power on socially beneficial activities. Capps et al. examine 7 years of data on California hospitals and find no evidence of any such differences - not-for-profits do not engage in any more socially beneficial activities than do for-profits when they possess market power.

2.2.4. Costs

It is clear that mergers can result in efficiencies because of economies of scale, increased purchasing power, the ability to consolidate services, or the transfer of managerial techniques and skill to the acquired hospital. However, mergers also have the potential to increase costs. Larger systems imply larger bureaucracies. In addition, hospital costs are not necessarily exogenous to market structure. Hospitals that are able to bargain for higher prices may have the incentive to use the resulting profits for the benefit of physicians and hospital executives (e.g., through capital expenditures that benefit physicians or increases in executive compensation or perks). This is particularly likely if there is no residual claimant (as is the case for not-for-profit or public organizations) or monitoring by the residual claimant is costly. Thus, the analysis of cost impacts is central to understanding the impact of hospital mergers. The evidence presented above suggests that, on average, hospital mergers result in increases in price. Consequently if there are significant cost reductions associated with mergers they are not passed onto the purchasers of hospital services in the form of lower prices.

A few studies do directly examine the impact of hospital mergers on costs. Dranove and Lindrooth (2003) examine mergers of previously independent hospitals that consolidate financial reporting and operate under a single license post-merger. They find that, on average, these hospitals experience post-merger cost decreases of 14 percent. System mergers in which the hospitals were not as fully integrated (as measured by the use of multiple licenses) did not realize cost savings. These findings suggest that integration of merging hospitals is necessary to achieve meaningful efficiencies. A recent study by Harrison (2010) finds that immediately following a merger costs declined, but eventually rose to pre-merger levels. This finding is difficult to reconcile with the view that mergers require significant upfront costs but have benefits accrue in later years. The circumstances in which mergers are most likely to result in meaningful cost decreases are those in which the merging facilities operate as a more fully integrated

entity. To be clear, however, the presence of any cost savings does not mean that they are necessarily passed on to consumers.

The UK government pursued an active policy of hospital mergers in the late 1990s to mid-2000s, arguing that such consolidations would bring improvements for patients. Between 1997 and 2006 in England around half the short term general hospitals were involved in a merger Gaynor et al. (2011) examine the impact of these hospital mergers on financial performance, productivity, waiting times and clinical quality and find little evidence that mergers achieved any gains other than a reduction in activity.

2.2.5. Vertical Integration

Vertical integration between hospitals and physicians or insurers and providers can in principle provide efficiencies by aligning incentives, allowing for better co-ordination of care and joint investments which enhance efficiency or the quality of care. At the same time, integration can potentially harm competition by foreclosing rivals from access to key inputs. An integrated system which has locked up all the orthopaedists in town, for example, may make it difficult to impossible for another hospital to offer orthopaedic services or for a freestanding ambulatory surgery centre to enter the market and compete on orthopaedic services. Separately, integration may eliminate competition among previously independent providers. For example, physicians who had previously been in competition all become members of the same firm once they integrate with a hospital system (or an insurer).

There is very little evidence at present on the impact of vertical integration on market power. In part, that is because vertical integration has not been that common in health care. It was quite rare until the mid-1990s, and then declined rapidly thereafter. Integration between hospitals and physician practices peaked in 1996 at approximately 40% of all hospitals, and declined thereafter (Burns and Pauly, 2002; Ciliberto, 2005). This pattern was repeated with vertical integration of hospitals into the insurance market, although the extent of vertical integration was never as great as between hospitals and physicians (Burns and Pauly, 2002). This growth coincided with the growth of managed care, and in particular with the perceived growth in managed care organizations' negotiating power with hospitals. Burns et al. (2000) find that hospital-physician alliances increase with the number of HMOs in the market. They infer that providers may be integrating in order to achieve or enhance market power. More recently, Berenson et al. (2010) conducted 300 interviews with health care market participants, and report that increased bargaining power through joint negotiations listed as one of several reasons for hospital-physician alliances.

Certain types of vertical relations in health care have been the subject of significant antitrust scrutiny exclusive dealing between physician practices and hospitals (usually for a specialized service, e.g., radiology, anaesthesiology, or pathology), and most-favoured-nations clauses between insurers and providers, which require the provider to give the insurer a rate as low as it gives to any buyer (see Gaynor and Haas-Wilson, 1998; Haas-Wilson, 2003, for reviews of vertical issues in health care).

In spite of the interest in this topic, there is relatively little evidence on the effects of vertical restraints in health care. Ciliberto and Dranove (2005) and Cuellar and Gertler (2005) are the only two papers (of which I am aware) which examine the competitive impacts of vertical integration in health care. Both papers look at the effects of hospital-physician practice integration on hospital prices. The two studies find opposite results - Cuellar and Gertler find evidence consistent with anticompetitive effects of physician-hospital integration, while Ciliberto and Dranove find no such evidence.

Research on effciencies from integration does not find much evidence of positive gains from integration. Burns and Muller (2008) review the empirical evidence on hospital-physician relationships. They find little evidence of an impact of integration on costs, quality, access or clinical integration. Madison (2004) investigates the relationship between hospital-physician affiliations and patient treatments,

expenditures, and outcomes using data on Medicare heart attack patients. She finds little evidence of any impacts of hospital-physician relationships.

3. Summary and Conclusions

3.1. What do we know about competition in hospital services?

In summary, it is clear that hospital competition leads to lower prices and to higher quality when prices are fixed by administrative fiat. The research does not find evidence of efficiencies due to merger. It is less clear what the impact of competition on quality is when price is market determined.

The evidence thus far is supportive of competition improving quality when prices are set administratively. For this to happen hospitals have to have an incentive to try to attract more patients and patients, or someone choosing on their behalf, has to be able to observe and respond to hospital differences in quality.

When price is market determined, the evidence also supports competition reducing prices. This is important, but it is less clear what the impacts are on quality. As stated above, hospitals must have strong incentives to try to attract more patients, and patients (or someone choosing for them), must observe prices and respond.

Thus, there are important conditions for competition to work. The market must not be so concentrated that hospitals don't have to work to attract patients. Hospital payment must provide them with strong incentives to attract patients. There must be sufficient information in the market that it is possible to observe relevant differences across hospitals (quality, price) and respond. Last, consumers have to be responsive to quality or price in order to drive hospitals to compete. This may be through their own direct choices, or with a 3rd party playing a role in assisting choice.

3.2. Role for government

3.2.1. Competition authority (antitrust)

If markets are going to be employed for the organization and delivery of hospital care, then competition is important for adequate performance in these markets. As a consequence, competition policy looms large, and monitoring and enforcement are critical. This is particularly important in some countries where there has been a great deal of consolidation in hospital markets. It's important to emphasize that competition policy is still vital for the effective functioning of hospital markets, even if price is set administratively. As reviewed above, hospital competition can have substantial effects on quality under administered prices. A competition authority thus plays an important role in assuring the quality of care in such a setting.

a) Hospital Market Structure Trends

Table 1 presents numbers for the US population-weighted Herfindahl-Hirschmann Index (HHI) for selected years from 1987 to 2006.[16] Two things are clear from this table. U.S. hospital markets are highly concentrated and have become even more concentrated over time. Figure 1 displays the trends in the

[16] The HHI is the sum of squared market shares in the market. It is the most commonly used measure of market structure. We present population weighted, averages for Metropolitan Statistical Areas (MSA)(based on admissions). We limit the sample of MSA to those with a population less than 3 million in 1990. We do this because it is likely that in MSAs with more than 3 million, there are multiple hospital markets and the HHI of that MSA is likely mismeasured.

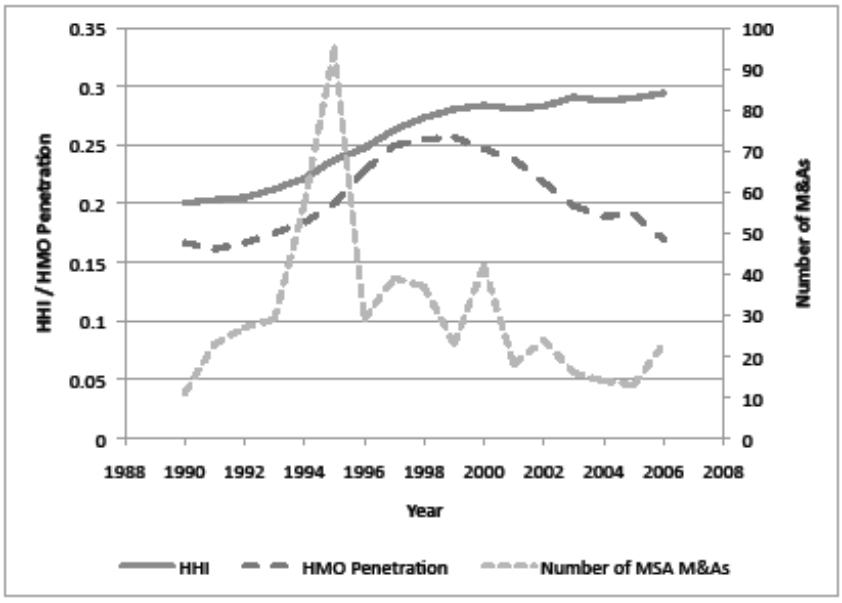
hospital HHI, the number of within market hospital mergers and acquisitions, and the percentage of the population enrolled in an HMO from 1990-2006. From the table and figure it is easily seen that hospital markets have become significantly more concentrated. In 1987, the mean HHI was 2,340 and by 2006 the HHI was 3,161 - an increase of over 900 points. In 1992, the mean hospital concentration levels (2,440) were (barely) below the recently updated Federal merger guidelines' (FTC/DOJ, 1992) cut-off point for classifying a market as "Highly Concentrated" (HHI ≥ 2,500), but by 2006 the mean concentration level (3,261) rose to well above this threshold. Town et al. (2006) note that mergers and acquisitions are the primary reason for the increase in hospital concentration over this period.

Table 1. Hospital Market Concentration, U.S., 1987-2006[a]

Year	Mean HHI[b]	Change[c]
1987	2,340	—
1992	2,440	100
1997	2,983	543
2002	3,236	253
2006	3,261	25

[a] Source: American Hospital Association. Data are for U.S. Metropolitan Statistical Areas with population < 3 million.
[b] Herfindahl-Hirschmann Index. Means weighted by MSA population.
[c] Total change from the previous year in the table.

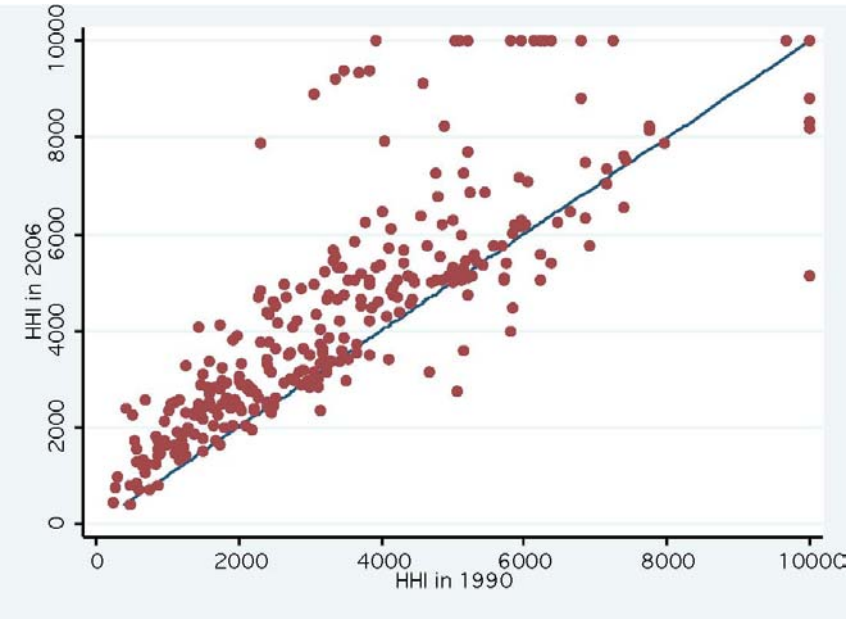
Figure 1. Trends in Hospital Concentration, M&A Activity and HMO Penetration: 1990-2006



While hospital markets are highly concentrated on average, there is also wide variation in concentration. Figure 2 shows a scatterplot of the MSA level market concentration in 1990 and in 2006.

This figure displays two phenomena. First, it shows the distribution of HHIs across MSAs. Most MSAs are "Highly Concentrated." In 2006, of the 332 MSAs in the U.S., 250 had HHIs greater than 2,500. Second, it is clear from Figure 2 that the increase in hospital concentration was a broad phenomenon – the vast majority of MSAs became more concentrated over this period. Particularly striking is the number of moderately concentrated MSAs in 1990 that by 2006 had become highly concentrated. By 2006, most health insurers now had to negotiate with hospital systems in highly concentrated markets, which likely reduced their bargaining clout.[17]

Figure 2. Scatterplot of MSA HHI in 1990 and HHI in 2006



The trend toward increasing concentration in hospital markets is not confined to the U.S. Tables 2 and 3 provide information on market structure levels and trends in England and the Netherlands. We see that the trends in these countries are very similar to the U.S. - the total number of hospitals in both countries declined substantially over time. For England there are HHIs for local hospital markets for a number of years. Those reflect substantial concentration, although declining slightly over time. Figure 3 illustrates the change in the distribution of the HHI between 2003/04 and 2007/08 (fiscal years). It can be seen that there is a shift of the distribution from more concentrated to less concentrated markets. Most of the shift is in the middle of the distribution, as opposed to the tails. The decline in the hospital HHI in England documented here is most likely due to pro-competitive reforms of the English National Health Service that occurred in 2006 (see Gaynor et al., 2010).

[17] Changes in Health Care Financing and Organization (http://www.hschange.com/index.cgi?func=pubs&what=5&order=date) present a number of market-by-market case studies that highlight the increase in hospital bargaining leverage over the last several decades.

Table 2. Hospital Market Structure, England, National Health Service, 1997-2007

Year	# NHS Hospitals[a]	#Mergers	HHI	# Private Hospitals[b]
1997	227	26	—	—
1998	214	21	—	—
1999	202	17	—	—
2000	193	23	—	—
2001	188	25	—	—
2002	174	6	—	—
2003	171	0	5,573	—
2004	171	0	5,561	3
2005	171	3	5,513	21
2006	168	3	5,459	32
2007	167	0	5,461	—
Total	—	124	—	—

[a] Source: U.K. Department of Health. Hospitals with fewer than 5,000 consultant episodes per year are excluded.
[b] Independent Sector Treatment Centres. These are private hospitals with contracts with the NHS.

Figure 3. Kernel density estimates for the distribution of HHI (all elective services)

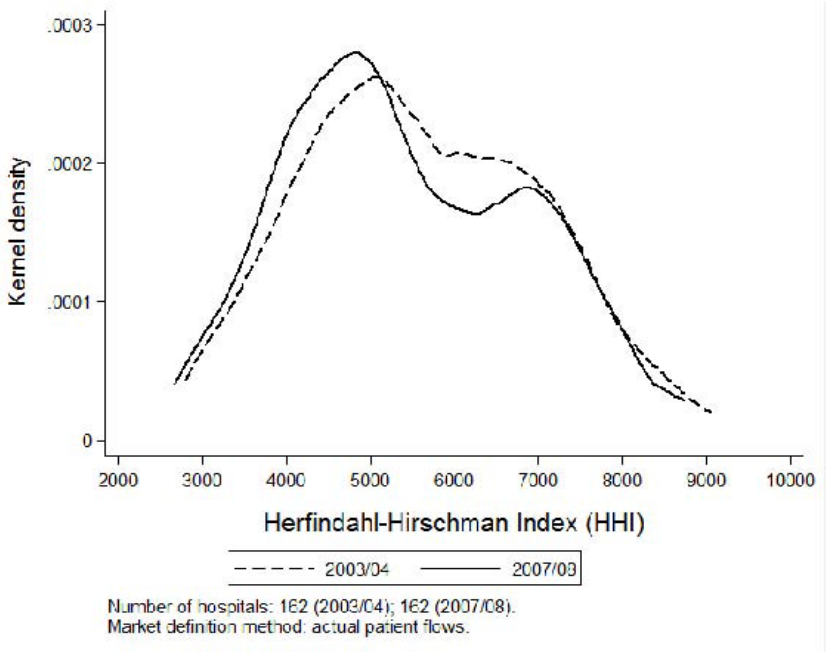


Table 3 provides information on the total number of hospitals and independent outpatient treatment centres in the Netherlands by year. There is a clear downward trend in the number of hospitals - there were 23 fewer hospitals in 2010 than in 1997. More recently, there has been a large increase in the number of independent outpatient treatment centres. The number grew from 37 in 2005 to 184 by 2010.

Table 3. Hospital Market Structure, The Netherlands, 1997-2010[a]

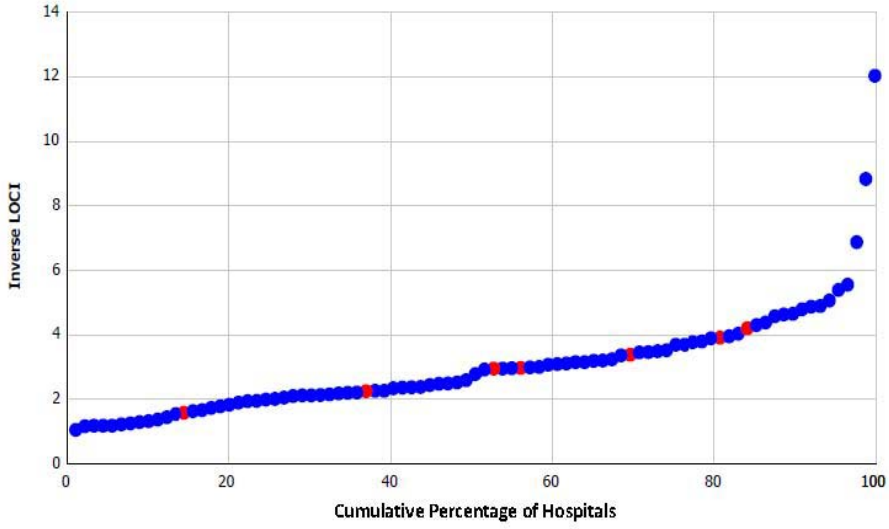
Year	# Hospitals[b]	Outpatient Treatment Centers[c]
1997	117	—
1998	117	—
1999	115	—
2000	111	—
2001	104	—
2002	102	—
2003	102	—
2004	101	—
2005	99	37
2006	98	57
2007	97	68
2008	97	89
2009	95	129
2010	94	184

[a] Source: Netherlands Healthcare Authority.
[b] Total # of hospitals, including general hospitals, specialty hospitals, and university medical centers. The vast majority are general hospitals.
[c] Independent Treatment Centers (ZBCs). These are freestanding outpatient treatment centers, not part of hospitals.

Figure 4 shows the distribution of an alternative measure of market structure, LOCI (for Logit Competition Index),[18] for the Netherlands in 2010. LOCI is a measure of how much competition a firm faces in a differentiated products market. It varies between zero and one, where zero is pure monopoly and one is perfect competition. The graph shows the cumulative distribution of hospitals in the Netherlands by their values of the inverse of LOCI. As can be seen, approximately 20 percent of hospitals have values of inverse LOCI of 2 or below. A value of 2 implies the market isn't very competitive - for example a hospital in a duopoly that equally split the market with its rival would have a LOCI value of 1/2, i.e., an inverse LOCI of 2. One half of all hospitals have inverse LOCI values of 3 or less. This implies that half of Dutch hospitals operate in markets where they face competition from the equivalent of a triopoly or less.

[18] This is a competition index for differentiated products Bertrand oligopoly with logit demand. See Akosa Antwi et al. (2006).

Figure 4: Cumulative Distribution of LOCI, Netherlands, 2010



b) Enforcement

Clearly enforcement is critical in hospital markets. In practice, most of the concerns have been over hospital mergers. Since hospital markets are oligopolies, mergers can have substantial impacts on market structure, and consequently on conduct. The empirical evidence on hospital markets demonstrates that market structure can have large effects on price or quality. A number of papers have estimated the impact of actual hospital mergers on price. These studies generally find large and significant increases in hospital prices due to the merger (see Gaynor and Town, 2012 for a comprehensive review).

For example, Tenn (2011) finds that the prices at Sutter hospital in California increased between 28 and 44 percent after its merger with Alta-Bates hospital (another local hospital), relative to the control group. Kemp and Severijnen (2010) estimate the impacts of two hospital mergers in the Netherlands on the price of hip surgery and find price increases of 3.5 per cent for Ziekenhuis Gooi-Noord and 5.1 per cent for Ziekenhuis Hilversum due to their merger (relative to the control hospitals). Gaynor and Vogt (2003) find price increases of over 50 percent in a simulation of a hospital merger (to monopoly).

These impacts are not limited to price, but also affect quality. For example, Kessler and McClellan (2000) estimate that a move from the top quartile to the bottom quartile of the HHI in their sample will lead to a 3.37 percentage point fall in the AMI death rate for the US Medicare population. Gaynor et al. (2010) find a similar effect of 2.26 percentage points for the English NHS.

As a consequence, enforcement can have a profound impact by preventing hospital mergers that would lead to worsened quality or higher prices.

Antitrust enforcement has been a serious problem in the US. The US antitrust enforcement agencies lost every single action they brought against hospital mergers in the 1990s (8 cases). As a consequence, consolidation was virtually unimpeded during this time, leading to massively concentrated hospital markets, as noted earlier. Fortunately this trend has recently been reversed, with the Federal Trade Commission winning a victory in a consummated merger case (FTC v. Evanston Northwestern Healthcare

Corp.).[19] This has been followed by a merger which was dropped when challenged (Prince William and INOVA), and a consent decree.[20]

There has not been nearly as much antitrust activity towards health care outside of the US. This is mostly due to health care systems in other countries being more centrally controlled and heavily regulated. However, a number of countries have pursued decentralization and competition in reforms of their health systems. The Netherlands, Germany, and the United Kingdom (England in particular) are notable in this regard. Varkevisser and Schut (2009) review antitrust policy towards hospital mergers in the Netherlands, Germany, and the US.

The Netherlands has had a few antitrust matters arise over the past few years. They have had concerns about hospital mergers, as in the US, and also have had concerns about vertical restraints, including vertical integration, between insurers, hospitals, and doctors. As Canoy and Sauter (2009) note, there was an uptick in merger activity following market liberalization, and a consequent need for greater merger control. The NMa has reviewed nine hospital mergers. All were approved, although some were subject to extensive review. Netherlands).

In 2009 the UK established an agency charged with oversight of competition in the NHS, following their reforms (in England) in 2006 designed to promote competition. The establishment of a new agency was necessary, because the conduct of NHS entities was exempt by fiat from oversight by the UK's competition authority (the Office of Fair Trading). The Cooperation and Competition Panel (CCP) is the agency that has been established for the oversight of competition in health care and has fairly broad authority to regulate mergers and general conduct. Since beginning operations in 2009, the CCP has reviewed over 50 merger cases and a number of conduct cases.

3.2.2. Regulation

Governments are heavily involved in regulating the health care sector. There are some particular aspects of regulation that are relevant here.

a) Administered prices

As mentioned previously, if prices are administered, the level at which the price is set has a profound impact on quality and competition. If price is set too low then quality will suffer. Conversely, it is possible to have an excessive level of quality if the price is set too high.

b) Selective contracting

Selective contracting by private payers is a mechanism which helps to create an environment where competition among providers is possible. If payers contract with every provider in a market, then they have very little bargaining power. Policies that enhance the ability of payers to selectively contract with providers are important, but they will only be effective if there is sufficient choice among providers.

c) Information/"Transparency"

[19] Evanston Northwestern Healthcare Corp., FTC Docket No. 9315, Initial Decision (Oct. 20, 2005), available at http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf.

[20] United States of America Federal Trade Commission Office of Administrative Law Judges, Docket No. 9346, In The Matter Of Promedica Health System, Inc., December 12, 2011

Transparency, providing information about prices or quality to the public, is a policy that has received substantial attention. In principle, it seems as more information should be better. However, this is not necessarily the case. Making pricing information public can make it easier for firms to collude (this also may apply with regard to quality information). In addition, it's not clear that heavily insured consumers have sufficient incentive to pay attention to price differences. Even consumers who have policies with a lot of cost sharing will not face much of the impacts of price differences if they obtain an expensive treatment. Expensive treatments put most consumers well beyond their deductibles and copays so that they bear little to none of any price differences across providers.[21] Of course, expensive treatments account for the majority of medical spending.

Consumers should, in principle, be responsive to quality information, since they directly bear the consequences of better or worse quality. Providing clear and understandable information about products (providers' and insurers') so consumers can understand what they are obtaining can facilitate competition (again, conditional on sufficient alternatives). If consumers have little information or don't understand the information they have, they tend to rely on reputations, brand names, etc. This tends to decrease the responsiveness of demand to prices or other factors and enhances firms' market power.

If there is patient cost-sharing, it is possible to use “tiering,” that is consumers pay more of the costs of less desirable hospitals, where less desirable can mean either higher prices or lower quality.

[21] This doesn't mean that being insured against large losses is bad { it isn't. Consumers should be insured against large risks. It just means that it's not realistic to expect them to pay attention to prices in such a situation.

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SUMMARY OF DISCUSSION

By the Secretariat

1. The introduction of the roundtable on competition in hospital services

The Chair, Professor Alberto Heimler, opened the roundtable discussion on competition in hospital services by welcoming delegates, in particular the delegates of the Health Committee, and presented the roundtable as a follow-up to the one held in October 2005. Hospital expenditures represent around 38% of OECD member countries' healthcare budgets (with a significant variance from 12% in Mexico to 48% in Japan) and are placing an ever-increasing stress on public finances. Many scholars, among which attendees Zack Cooper from the London School of Economics and Martin Gaynor from Bristol University and Carnegie Mellon, have argued that there are considerable margins to increase productivity in health care services, and in particular in hospital services, in almost all countries. In the Chair's view, markets can play an important role in the provision of hospital services as demonstrated for example by the United Kingdom. Whilst countries relying on market mechanisms in hospital services were limited to the United States, the United Kingdom, the Netherlands and a few other countries in 2005, the number has rapidly increased, although the models of competition differ across countries.

The Chair further commented that an incentive structure coherent with the objectives pursued is needed to make competition work to the benefit of consumers, tax payers and insurance holders, which is seldom the case in hospital services. In some countries, shifts in demand do not seem to influence the incomes of stakeholders and there is not enough capacity to exercise choice. Furthermore, for competition to be effective, customers (or their agents) must be informed of the relevant dimensions of the quality of the services provided by different hospitals. In other words, competition needs to be present both on the supply side and on the demand side.

Next, the Chair proposed to divide the discussion into three main topics. The first topic would address the governance of the hospital sector. The second would consider the role of market mechanisms in favouring good performance. The third topic would address national experiences with antitrust enforcement.

The Chair acknowledged that the OECD Secretariat has long been active on strengthening health care quality while keeping costs under control and invited Frank Maier-Rigaud from the Competition Division, the author of the background paper, and Ankit Kumar, from the Health Division, to deliver a joint presentation on the scope of competition as an instrument to achieve better outcomes in hospital services.

Frank Maier-Rigaud began the presentation, noting that there are different views on the impact of competition, which range from compromising public health objectives and deteriorating health outcomes to spurring dynamic innovation and better outcomes for consumers. Undesirable outcomes may occur if there is not enough competition but also under intense competition in the presence of inadequate regulatory frameworks. The latter can be addressed in the realm of traditional competition law enforcement, and the former emphasizes the importance of taking into consideration the scope for competition when setting up the regulatory framework. The design of healthcare systems has an impact on incentives, market structure and, consequently, outcomes.

Ankit Kumar then highlighted the importance of bringing together health and competition policymakers. He commented on the three policies that have figured more prominently over the last decade and a half: fixed prices, patient choice and information, and hospital autonomy. Fixed prices, which are also referred to as Diagnostic Related Group financing (DRG, hereafter), is the finance system adopted (or under consideration) in the majority of OECD countries. By setting a fixed price, money follows the patient and introduces contestability, which is expected to occur on the grounds of quality. In terms of budgeting tools, DRG systems are better than fixed budgets, which do not introduce competition, and reimbursing fees, which increase fiscal exposure. In spite of this, a study in France found a disconnection between how fixed prices are set at the central level and how they actually work in hospitals. This suggests that hospital management is key to ensure that those who are actually delivering the services feel the need to compete and are continuously seeking improvements in efficiency or quality. He also pointed out that by fixing prices, competition may only occur on quality instead of productivity.

The Chair then inquired as to the existence of a common standard DRG across countries. To answer this question, Ankit Kumar indicated that while the theory behind DRG is common to all countries, its application is unique and most countries adopt one of a handful of models and tailor it to their own needs.

Ankit Kumar continued his presentation by stating that enhanced choice and information do not worsen outcomes, but rather that the magnitude of their positive effect is subject to discussion. Despite the increasing trend to devolve management, hospitals may not have the autonomy to influence their operations and the resource allocation to operate on a more competitive basis. Boards need to be politically independent to be able to make tough and relevant decisions. Finally, he remarked that the scope for competition is also limited since not all hospital services are suited for competition, such as emergency departments or highly specialised services that require a certain scale, and there might be cross-subsidisation between them.

The Chair continued the discussion by referring to Professor Martin Gaynor's paper that addresses the prerequisites for more competition and the outcomes to be expected in terms of rewards and punishments. In this context, the Chair asked for the counterfactual of competition to be used in measuring success of greater competition in hospital services.

Professor Gaynor started by providing a brief overview of the current knowledge on competition in hospital services. He stated that healthcare markets are not perfectly competitive, but can work reasonably well under certain conditions. These consist of incentives for hospitals to attract patients, demand responsiveness to key differences across hospitals, enough choice alternatives and information about the relevant dimensions, and the inability of hospitals to discriminate their patients. Economic theory predicts that under administered prices, quality increases if prices are above marginal costs. In contrast, when prices are determined in the market, the effects on overall welfare are uncertain. However, if quality elasticity increases or price elasticity decreases both price and quality increase, suggesting that achieving a proper balance between prices and quality is critical.

Empirical evidence on the effects of competition on the provision of hospital services is limited to a small number of countries. In markets with administered fixed prices, competition improves quality as measured by mortality rates and the impact can be substantial and long lasting. In market-determined prices, the evidence is mixed. Mergers between hospitals can lead to significant price increases ranging from 3.5 to 53% depending on the availability of close substitutes. Therefore, competition authorities play an important role. In the United States, hospitals with market power are able to charge higher prices on some permanent basis and consumers fully bear the costs, even in the case of not-for-profit hospitals. There is little evidence that efficiencies are achieved through mergers and these are typically not to the benefit of consumers. The complexity of setting administered prices has led in any case to the introduction

of selective contracting by payers, which facilitate price competition, or tiering. Tiering consist of contracting a subset of hospitals and charging higher prices to patients opting for other hospitals.

Noting the importance of information, the Chair asked Martin Gaynor who should be responsible for providing information, which types of information should be made available and which countries could be considered exemplary. Martin Gaynor responded that placing the responsibility in a central public authority is a very common model in the United States. He discussed the difficulty of measuring quality, which has been addressed with risk-adjusted indicators, and providing the information to decision-makers, mentioning Cooper's presentation on the United Kingdom. Zack Cooper then confirmed Gaynor's views and added that hospital market liberalisation will open up markets for information.

2. The governance of the hospital sector

The Chair started the discussion on the governance of the hospital sector noting that competition in hospital services can also be introduced when the payment and the supply are mainly public. This is the case in most countries, and in this way it is similar to education. The Chair first gave the floor to the Netherlands and explained that in the Dutch healthcare system individuals buy one of several insurance policies and insurance companies negotiate with hospitals on behalf of their customers. In this context, the Chair asked how adverse selection is prevented and whether premiums are based on the health status or set by the government.

The delegate from the Netherlands explained that the new system, which was first enforced in 2006, seeks to avoid adverse selection in two ways. First, insurance premiums are determined by insurers, but an insurance plan with a government-set minimum standard level of coverage must be offered. Subscription of at least this basic coverage is mandatory for adult residents and insurance companies are not allowed to refuse any individual willing to contract this minimum. Second, a risk equalisation pool funded through salary-based contributions from employers has been created to split risks. Funding from the pool is distributed to insurers for each individual insured under the mandated policy, additional amounts are provided for high risk individuals and the insurance of both low income individuals and children under 18 is funded entirely from the pool. Therefore, insurers who take on high risk clients do not have to charge higher premiums and may even profit from attracting and specialising on certain patients. Insurers receive 45% of total revenues from premiums, 50% from the equalisation pool and the additional 5% is provided by the State to cover individuals that cannot afford the premium. The basic insurance plan can be supplemented but additional coverage is not publicly funded.

The Chair sought clarification on the extent of competition. In his view, it would seem as if markets only operate on 45% of the total revenue and the government still plays an important role. He asked the reasons behind the Minister of Health reaching an administrative framework agreement with the trade association of hospitals and health insurers on cost control in healthcare. Furthermore, the Chair asked whether the co-ordination involved in reaching these decisions raised any concern to the competition authority.

The delegate from the Netherlands confirmed that of the health insurers' total income, 45 per cent comes from the premiums their clients pay them. However, health insurers compete with their competitors for almost 100 per cent of their total income, as they vie for resources from the three different funds. Insurers compete for every client, and the share that insurers are allocated from the fund is directly linked to the insured and their health characteristics, so health insurers compete with one another with regard to this fund as well. Only with respect to the 5 per cent contribution that is linked to the total number of uninsured, can it be said that insurers partially do not compete with one another, with regard to insured adults. To put an end to frequent overspending by healthcare providers, an agreement with the principal stakeholders was reached in 2011 whereby insurers share responsibility for closely monitoring

expenditures to prevent budgetary shortfalls but are ultimately not liable if expenditure exceeds a 5.25% ceiling. Concerns about this agreement led to the involvement of the competition authority in advising the Ministry. The agreement only sets goals and the parties retain discretion on how to achieve efficiencies and prevent budgetary shortfalls within the boundaries of competition law.

The Chair followed up by asking whether there is any variance across the premiums charged by the six insurance companies. The delegate indicated that premiums are similar and, although the system has been running for a couple of years, more differentiation would be welcomed.

Next, the Chair highlighted the case of the United Kingdom, where general practitioners play an important role in overcoming information asymmetries. The Chair asked how general practitioners' incentives are aligned with those of the government on cost minimisation and why this redundancy is accepted to allow the exercise of choice.

The delegate from the United Kingdom explained that currently there are two key issues in the debate. On the demand side, the debate concerns the role of information in overcoming market failures. On the supply side, it refers to the compatibility of competition and integrated care. The majority of hospital services are provided by the National Health Service (NHS), which is publicly funded. There is a fixed price finance system for elective care, which means that hospitals compete on quality dimensions to attract patients and can retain surpluses. In the private healthcare market, there are private hospitals that provide services through private insurances or through self-pay patients.

The Chair asked whether the NHS is administered centrally or locally. The delegate responded that the governance structure was complex, with a central administration setting central budgets and allocating these to local areas. Decisions are taken locally within central constraints and patients have free choice within this system.

The majority of patients have choice within a reasonable travel distance and 40% of patients do not choose the nearest hospital, indicating that other dimensions such as quality are also relevant. General practitioners are informed agents with better clinical knowledge that can provide impartial advice on the choice of hospital. The alignment of general practitioner's incentives becomes more complex as the system evolves and changes but recommendations have been made to ensure their impartiality. For example, in mergers these include ensuring that patients have sufficient choice of general practitioner and that there is full disclosure of potential conflicts of interest.

The government has made information available through multiple ways, such as a website that contains comprehensive information on NHS choices and there is a private website that produces a hospital guide and ranks hospitals according to their clinical quality. The Chair followed up by asking who pays for this private website. The delegate responded that the site is a joint venture between the Department of Health and a private information company, as part of the government's push for more information providers and under the trend of publishing raw data. A private healthcare market study undertaken by the Office of Fair Trading outlines the existence of information asymmetries due to a lack of comparable information. In addition, the study indicates that there are barriers to enter the private market. New hospitals need to contract with multiple insurers before the quantity of patients is sufficient to operate efficiently, while medical staff prefers to work in a single facility rather than in multiple hospitals.

On the supply side, the question is whether competing hospitals can have the right incentives to provide the joint care that patients need. In the view of the competition authority, these are not mutually exclusive as the case of cancer networks has shown but caution is needed in order to avoid conflicts of interest and exclusionary behaviours.

Next, the Chair turned to Germany and commented that the Monopolkommission, who unfortunately mostly publishes in German, suggested that elective treatments should be provided under free market conditions. The Chair invited the delegate to provide a workable definition of elective treatments.

The delegation from Germany started her intervention by stating that, in reaction to the increase of healthcare expenditures, reforms to increase competition have been introduced. In 2003 a DRG system based on the Australian model was introduced to calculate hospital remuneration and prices for treatments. A report by the Monopolkommission published in 2008 revealed that the legal framework in place was insufficient to lower the costs of hospital services. The report described a model that would introduce more elements of price competition in the market by allowing health insurers to conclude selective contracts with hospitals for elective treatments. Patients are offered a cheaper option tariff that narrows the choice to contracted hospitals. Insurance companies contract with hospitals that offer the best price performance ratio, which puts pressure on hospitals to offer better or lower cost services. With regard to the definition of elective treatments, the delegate noted that in the report these are understood in a broad sense, excluding only emergency treatments. The fact that elective treatments may become urgent at a certain time is not discussed within the report. Also, the report states the need to regulate the distance that patients can be required to travel by the insurance company with regard to the described option tariff model.

The Chair asked about the funding of hospital capacity, as Germany is the only country referring to it in its submission. Supply has to be equal to potential demand all the time, which implies leaving some capacity available to accommodate peak demand. The Chair asked whether capacity is the reason for funding capital investments. In this regard, the Chair went on to ask if productivity improvements, which shorten the length of stay in a hospital and therefore free up capacity, are taken into consideration in the management of capacity.

The delegate from Germany clarified that capital investments are funded on the basis of a capacity plan that is prepared and adapted on an annual basis. The provision of reserve capacity on peak demand is taken into account in the annual plan. Improvements in productivity are also considered, although balancing increases in productivity with overall increases in demand for hospital services and sufficient quality treatment is an on-going and complex task.

Next, the Chair addressed Brazil and noted that the right to health protection is enshrined in the constitution, guaranteeing the right of access to public hospitals. As a result, these hospitals are overcrowded and operate on a first-come-first-served principle with long waiting periods for all treatments. The Chair invited the delegate to explain the measures that the State has undertaken to reduce waiting times.

The delegate from Brazil clarified that the constitutional commandment is understood as a programmatic rule rather than a right, with efficacy limited to the availability of resources. The constitution obliges each level of the public administration to spend a certain amount of public resources in healthcare services and each authority is competent to decide when, where and if to invest. Decentralisation limits the capacity of the federal government to address concerns in public healthcare services. The national strategy consists in investing in less served areas, by creating incentives for both the private sector to build more hospitals and medical staff to study and stay there, under the belief that by enhancing access, waiting times will be reduced.

The Chair invited the delegate to provide a brief description of private insurance policies, including the existence of a mandatory minimum content established by law, the differences between the 1,100 health insurance companies active in the market and the reason for not choosing bigger insurers, which probably provide better and more articulated services.

The delegate responded that only about 25% of the Brazilian population is covered by private health insurance, but private services are considered a necessity as long as the public system is not able to offer the needed care to all individuals. With regard to the law establishing minimum standards for private insurance plans, the government established three levels of coverage because the average consumer is not able to identify and compare quality and content of healthcare services. Finally, the delegate explained that the large number of insurance companies results from the presence of many small companies in locations where big companies have no interest to go and also from small companies offering joint services. Whilst the presence of many small insurance companies is characteristic of the Brazilian health system, it does not conflict with the preference for major companies, which offer better and wider services.

With reference to the Chilean submission, the Chair sought clarification on whether the working population is allowed or obliged to be privately insured. In addition, the Chair inquired as to the measures in place to ensure that insurance premiums do not skyrocket, as there are 6 competing insurance companies. Whilst in the Chair's view, product differentiation is necessary for competition, homogenisation of insurance plans has been discussed in Chile. The Chair suggested that homogenisation can lead to collusion and the lack of innovation and invited the delegate to provide an overview of the situation in Chile.

The delegate from Chile started his intervention by stating that the working population pays a monthly minimum of 7% of their gross income for health insurance, either from the public system or one of six private insurance companies. Most prefer the latter and there is little substitution between the two sectors. The Chair followed up by asking whether the two sectors are independent. To clarify, the delegate stated that a choice between the public and the private is to be made and pointed out the absence of price regulation on private insurance premiums. The delegate noted that a complaint of collusion in insurance plans submitted in 2007 was rejected by both the Competition Tribunal and the Supreme Court. In addition, there have also been issues of price concerns and many rulings by courts of appeal have stopped premium increases for specific groups of insured clients. A proposal to establish a general plan, similar to the banking industry with respect to universal credit, was recently discussed in Congress.

Next, the Chair turned to Colombia, where the 1993 reform introduced a competitive system organised around healthcare insurance companies and service delivery institutions. However, benefit plans for all citizens were unified and a mandatory obligation of insurance was introduced in 2011. The Chair invited the delegate to explain how this recent reform relates to the market oriented approach adopted in 1993. The Chair also asked for clarification on the role of private hospitals in the most specialised and complicated areas of health care.

The delegate from Colombia explained that before 1993 the system was publicly handled, but then a dual system was introduced with private health insurances for the employed and a publicly subsidised system usually for the unemployed. Following a constitutional court order to harmonise the benefits of the subsidised and the contribution-based system, the government put an end to the dual system in 2011. With regard to the role of private hospitals, the delegate clarified that these are focused on highly complex diseases, while public hospitals are a last resort and are located in areas where private hospitals are reluctant to operate.

Referring to the submission of Chinese Taipei, the Chair highlighted that 84% of hospitals are private and health services are paid by the National Health Insurance which is funded by compulsory insurance premiums. The Chair asked why application for hospital accreditation is strictly voluntary.

The delegate from Chinese Taipei explained that it is a compulsory social insurance programme created in 1995 and designed to be a self-sustained pay-as-you-go system with responsibility for its own deficit. At present the main source of revenues are premiums paid by insured patients, employers as well as

local and central government, and are not derived from general taxation. The delegate indicated that 92% of the medical institutes are participating in this programme. It covers most of the formal treatments and any insured person is eligible to receive medical service from the contracted provider of their choice. This is a fixed price system and services covered by the programme constitute the bulk of revenues for medical institutions. About 84% of institutions are private, resulting in a highly competitive health market on the grounds of quality. The accreditation system was introduced in 1988 and only applies to hospitals. While accreditation is voluntary, the vast majority of hospitals apply for it. It consists of a large number of indicators and the results are made available online by the Department of Health as a reference guide for selection of hospital services.

The Chair followed up by asking why the accreditation is voluntary instead of mandatory. The delegate from Chinese Taipei responded that it was designed to be voluntary because hospitals are willing to participate in the programme as more patients lead to a higher volume of medical services and, consequently, to higher reimbursement. In addition, the rating obtained can help hospitals in the application for research grants from other sectors of government. The Chair went on to ask whether low quality hospitals also participate. The delegate acknowledged that very few of them apply for accreditation.

Then, the Chair turned to Ireland and commented that the system is mixed. There are 50 public hospitals, with 20% of private beds, and 20 private hospitals. The Chair cited that about 50% of the population has a private insurance and asked whether private insurance complements public insurance. In addition, the Chair raised a question on market concentration, given that there are only three insurers and one of them has a market share of 65%, and went on to ask if this was due to exclusive contracts.

The delegate from Ireland clarified that, private insurance is optional; access to the public system is available to everyone; it is free to those below a certain income threshold and those above this threshold pay a small fee. Alternatively, people can buy private insurance; this covers care in public hospitals as well as care in private hospitals that are covered by the insurer. The principal benefits of private insurance are that it provides a greater choice of facilities and quicker access to elective procedures. With regard to market structure, the concentration is due to the fact that the state-owned private health insurer was a monopolist until mid-1990s. While other insurers have since entered the market, the state insurer's market share has remained high; this is due to, among other things, different regulatory rules being applied to the different insurers resulting in the state insurer having a regulatory advantage, uncertainty in the market over risk equalisation and the consumers' historical perception that the services delivered by this insurer are the safest, especially among older age cohorts. Also, the delegate noted that although the state-owned company has a 65% market share, it purchases 80% of privately provided hospital services since this insurer has a higher share of older and less healthy individuals. To answer the Chair's question on exclusive contracts, the delegate stated that hospitals try to contract with the three insurers; however they particularly try to contract with the state-owned insurer. The high market share on the purchasing market gives the state insurer the role of being a gatekeeper into the privately-provided hospital services.

The Chair noted that the existence of a former monopoly explains this high concentration. He followed up by asking about the relationship between public hospitals and private insurance companies and the coverage of the insurance.

The delegate responded that insurers negotiate prices with the private hospitals individually. By contrast, in public hospitals the cost to the insurer for its policyholders depends on the type of bed occupied. Assignment to a public bed entails low costs equal to fees paid by publicly insured patients. Fees charged for private beds in public hospitals are set by the government and, while higher than occupying a public bed, do not cover the full economic cost of the services provided. Therefore, there is an incentive for private health insurers to have their patients treated in public hospitals. The government intends to increase

the fees for treatment of private patients in public hospitals to move them closer to the economic costs and to charge them irrespective of whether assignment is to a public or private bed.

Next, the Chair turned to Peru, where the Ministry of Health is the main provider of hospital services with 86% of all facilities. EsSalud is the state-owned company of paid workers and insures 19% of the population, while 45% is covered by Comprehensive Health Insurance and 32.9% is not insured at all. The Chair invited the delegate to explain who is not insured and why. Private hospitals only account for 5% of the total and focus on high income individuals. Finally, the Chair asked why the main source of income for hospitals is the sale of drugs and whether the 14% margin on these sales is a result of the regulation and is related to entry in the pharmacy sector.

The delegate from Peru noted that their health system is similar to the one in Chile and Colombia. Employees are obliged to choose between the state-owned insurance (EsSalud) or a private health insurance. The public insurer runs its own hospitals and has its own insurance plans. There are five private insurance companies; two of them concentrate around 80% of the market share. With regard to the Comprehensive Health Insurance, it covers for free the more vulnerable share of the population, considered as living in poverty, as well as individuals less than 65 years-old with limited payment capacity for a semi-subsidised or minimum cost insurance. A high percentage of the population is not covered because insurance is not mandatory for unemployed and independent workers. The delegate clarified that the percentage of private hospitals mentioned only refers to clinics or big hospitals and does not include small private hospital providers. The reduction of margins in the provision of health services prompted the sale of drugs, but there is no drug-sale regulation and legal requirements to enter the pharmacy sector are not strong.

The Chair turned to Finland and commented that the healthcare system was fully publicly subsidised. In the absence of pricing, waiting times balance supply and demand resulting in long queues. Maximum waiting times were established by law, but this is not an effective solution in the Chair's view. In May 2011, free choice of hospitals for patients was introduced. However, hospitals are funded by local taxes and free choice may lead to hospitals providing services to patients outside of the local area, who do not contribute to the costs and subsequently may crowd out locals. The Chair noted that this is a non-sustainable situation and suggested that making payments follow the patient could be a suitable solution.

The delegation from Finland confirmed that the public healthcare system is decentralised and responsiveness to demand is low compared to similar systems in other countries. The maximum waiting times introduced by law have resulted in a substantial decrease in the number of patients who had waited longer than 6 months for specialist care. In 2011, the maximum waiting times (180 days for non-urgent hospital treatments) were exceeded for about 1000 patients. Hospital districts have taken special measures to reduce waiting times, including enhancing the use of personnel, using additional personnel, offering treatment abroad to a few patients, and providing vouchers for private service providers, thereby increasing the share of the private sector. The decrease in waiting times has been boosted by a supervisory authority that has imposed a number of decisions on the hospital districts for exceeding waiting times, some accompanied by a threat of conditional fines. In addition, a supervisory authority has imposed conditional fines for exceeding waiting times. Concerning taxation, the delegate clarified that in urgent care, hospital districts already charge from other hospital districts for patients with residence in the latter's' territory, but there is no general price regime and every hospital district determines its own pricing policy. The delegate agreed that payments will have to follow the patient and that a generalised system will need to be devised. The delegate added further that an introduction of a capitation system is being discussed in Finland. Such a system would be more likely in the case of primary care, concerning which the first measures to open up the sector to free choice have been taken, further opening-up being scheduled for the beginning of 2014.

Next, the Chair noted that the submission of Israel suggests that payment for hospital services is case by case and cannot be planned in advance. Many jurisdictions, however, have implemented a system of cost calculations based on a standard reference (DRG) and the Chair asked whether this approach is considered to put payment planning more under the control of the hospital itself. The Chair went on to ask if the system of hospital evaluation by an independent body mentioned in the submission had already been implemented and invited the delegate to briefly describe its institutional setting.

The delegate from Israel responded to the Chair's first question by stating that payment for hospital services differ by service. There is fixed payment per day of hospitalisation, which is calculated as an average price for each day and over the years has been differentiated by type of hospitalisation areas and type of admission. The second payment method is a sort of DRG based on medical procedures rather than diagnostics. The delegate clarified that a programme to create and systemize standardised quality assessment mechanisms still needs to be devised and introduced to the hospital healthcare system. An independent professional body will conduct data collection and analysis, and will provide customers with transparent and certified comparable data on hospital performances and will provide hospitals with feedback. It will also improve costing mechanisms, by introducing information related to the case-mix of patients instead of average costs and independent of quality, which encourages prolonged hospital stays. A possible model suggested for such an organisation is the Leapfor Group. The delegate acknowledged that the establishment of appropriate quality and cost performance assessment mechanisms is likely to face a number of organizational and practical challenges.

The Chair asked who is devising the independent institute. The delegate responded that it is under the lead of the Ministry of Health. Additionally, the Chair noted that around 95% of capacity is used, which limits choice and competition. The delegate responded that the problem of capacity is more acute in internal medicine and still needs to be addressed, in addition to improving quality and strengthening transitions between hospitalisation and community care.

Turning to the Norwegian submission, the Chair noted that the system is fully publicly funded and travel costs are reimbursed in order to encourage patients' free choice. The Chair asked what the consequences are for a hospital that incurs financial deficits, since the DRG payment structure is based on performance of the best hospitals. Referring to the submission, the Chair commented that widespread use of public procurement for medical services can be challenging as quality standards are difficult to define in a procurement bid.

The delegate from Norway started his presentation by saying that the State has the overall responsibility for health services financing and provision. Treatments are free, including medicine, but there is as a mandatory fee for the health insurance scheme equivalent to 7.8% of income. The structure of the Norwegian health enterprise model consists of four regional health enterprises. Patients are free to choose the hospital in which they wish to receive their elective treatment (public or private with an agreement) and travelling costs are reimbursed. With regard to information, an evaluation presented in 2011 by the Auditor General concluded that there is room for improvement as more relevant and up-to-date information should be published and only 50% of the patients visiting with a general practitioner were informed of the possibility of choice.

To answer the Chair's question on financing, the Norwegian delegate indicated that it is an activity-based system and that regional health enterprises receive 40% of the calculated DRG price for the scheduled treatment, which is equivalent to the average operating costs for each DRG. He noted that this system has positive effects on efficiency and length of stay, but inefficient hospitals in financial difficulty cannot go bankrupt. Mechanisms to prevent or address financial imbalances include carry-forward of deficits, reduction of investment budgets, warnings or withdrawing from the board of the regional enterprise. With regard to the definition of quality in public procurement, the delegate clarified that the

extent of procurement is not widespread and quality is of utmost importance. Although there is no evidence of declining quality in private hospitals, the competition authority has raised concerns related to quality based on the fact that contracts of certain private specialists are awarded by seniority and expire at the age of 70 and there will be an assessment of this scheme.

Next, the Chair commented that a system based on free consumer choice has also been developed in Sweden. Since patients can freely choose between public and authorised private hospitals, the Chair asked whether large shifts to the private sector could pose a challenge on financing of universal services. The Chair also invited the delegate to explain how capacity is determined.

The delegate from Sweden explained that the State has shared responsibility of the provision of social services with local authorities and responsibility of hospitals with regional authorities. The healthcare system is financed through taxes and there are no private health insurance companies. The delegate noted that previous concerns of too few private operators in public procurement, led to the creation of a system of choice where interested suppliers submit an application and are awarded the service concession if requirements are fulfilled. There is no limitation on the number of contracts; there are no deadlines for application; contracts are published and this system brought in hundreds of new private operators, including many SMEs. However difficulties in defining the quality have resulted in some care scandals. The level of economic compensation is decided by the authority, but it is not based on the lowest price and varies across the country.

The Chair asked the delegate to further elaborate on the criteria of award and the calculation of economic compensation. The delegate responded that fulfilment of requirements and acceptance of the compensation level are enough to qualify. The economic compensation is estimated considering the average costs of in-house provision, but private operators are only remunerated for the number of consumers attracted. The delegate added that other aspects can also be considered, including R&D spending, education or financial capacity. Contracts can be reviewed and challenged in courts and the competition authority supervises the legislation. Local and regional authorities are responsible for providing information to the citizens. Differences with respect to the previous public procurement system include continuous advertisement, contacts with all applicants, free choice of providers, equal compensation for all suppliers and the absence of financial guarantees to suppliers. The delegate also identified four key challenges of this system of choice: defining the level of economic compensation, maintaining fair competition between private and public operators, increasing administrative costs and monitoring contract performance.

Regarding shifts to the private sector, the Chair went on to ask about the impact on the public sector. The delegate responded that these shifts force the public sector to improve the quality of the services provided. Indeed, the market share of private operators is increasing: in two local authorities, in-house providers have been closed down because private operators provided higher quality services.

The Chair drew to a close the first part of the Roundtable discussion and opened the floor for questions and comments. Responding to the Chair’s invitation for comments, Professor Gaynor commented on several issues that had arisen. With regard to integration of various kinds of providers and insurance companies, there are potential efficiencies but also dangers of foreclosure. With regard to information, all consumers need not be well informed but hospitals need to bear in mind that information about other hospitals’ quality influences their revenues. Finally, there is scope for competition in elective care given certain conditions but not so much for emergency care. There are, however, positive spillovers.

3. Good performance in the provision of hospital services: the role of competition

The second part of the discussion started with a presentation by Professor Zack Cooper on the tensions that emerged in the introduction of competition in health care markets in the United Kingdom. In his paper Cooper listed institutional, regulatory and political conditions for anticipating the role that competition can play in controlling costs and raising the quality of hospital services.

Zack Cooper began his presentation by explaining the reforms introduced in 2006 that provided patients with free hospital choice in a very centralised system. He then introduced five minimum conditions for meaningful competition. First, hospitals need to be responsive to financial incentives. The funding system switched from bulk contracts, which were independent of volume, to DRG with an individual price for each individual service. The availability of detailed costing data enabled the government to set the tariffs effectively. Also, significantly more clinical, fiscal and managerial autonomy as well as the ability to retain surpluses was granted to hospitals depending on their financial stability.

Second, patients need to be interested in making choices. Surveys indicate that 75% of patients want to choose where they receive their care and, granted the choice, 30% of patients deviated from the default option. Patients from less wealthy backgrounds want choice more because without formalised choice they could only access lower quality services. Third, patients must have alternatives. In England, virtually everyone has access to two or more hospitals within a one hour radius. In addition to free choice within the public system, in 2008 government encouraged private sector providers to offer care to NHS patients, which was the least successful part of the reforms. Fourth, there must be information on providers' performance. Information was provided through a central website and, although only 4% of patients reported using this data, 60% of the patients argued that they had enough information to inform their choices. Fifth, patients must be responsive to quality. Evidence shows that patients are fairly quality elastic with respect to waiting times and mortality rates. This implies that patients are informed and in information asymmetries *ex post* information is key. General practitioners are the ones that can use past information to inform future referrals.

Markets with fixed-price competition resulted in lower mortality rates and reduced pre-surgery length of stay. Management improved under competition and non-clinician leadership. Efficiency was not sacrificed with equity, which slightly improved. Hospitals in more competitive areas reportedly tended to take less advantaged patients after the reforms, although competition from the private sector actually increased selection risks. Competition requires a very active role for government; the role of patients' agents is imperative to solve information asymmetries; fixed prices competition improves quality, but this doesn't resolve the question of how to use competition to lower healthcare spending.

The Chair moved the discussion to Turkey indicating that the 2008 Social Security reform allows patients to receive health services from any hospital with an SSI contract, both public and private. As a result, the number of private hospitals in Turkey increased quite substantially. The Chair asked how payments to hospitals are calculated, and whether it was a DRG or cost plus system. Since Turkey is the only submission referring to public-private partnerships, which allow private expertise to be used, the Chair asked how future revenues are estimated because cost plus systems would provide all profits to the private sector while incentives can work to the public benefit.

The delegation from Turkey explained that the Pricing Commission sets the prices for each type of healthcare services financed by SSI considering the cost of the healthcare service, regional cost structure and development levels, cost-effectiveness of diagnostics and treatments, general health insurances budget and subsidies given by the government. The SSI establishes appropriate payment mechanisms based on the scope of services provided. Universal health insurance law allows extra billing and private providers can charge additional fees to patients covered by the universal health insurance and the amount depends on the

hospital ranking system. For example top-rated hospitals can charge up to 70% more than the SSI prices. Hospitals are categorised based on service quality, service standards, capacity and scope of the services provided. Since 2006 a pilot project on paying hospitals based on the Australian model of DRG has been in place, but more time is needed for a final assessment of the results. With regard to public-private partnerships, the delegate clarified that new facilities are constructed based on a predetermined leasing grade and leasing duration. Until premises become operational, the private sector does not generate revenue. Although the law was enacted in 2005, no project has been finalised but a substantial number of investments have been made.

The Chair moved the discussion to the United States noting that 55% of hospital revenues originate from the Government, 22% of hospitals are public and only 20% are for profit. Nonetheless hospital services evolve according to market incentives and, as a result, there are permanent challenges for regulators and competition authorities. An issue already mentioned by Professor Gaynor is tiering, the role of co-payments aligning the incentives of patients and hospitals. The Chair asked whether co-payments are a good solution in the case of credence goods, in which patients are neither able to assess quality before the service nor after.

The delegate from the United States (on behalf of the FTC) clarified that the Government is the single largest payer through its Medicare and Medicaid programs, but the lion's share of hospital services are provided at private facilities, with the largest proportion at private not-for-profit facilities. With regard to co-payment and quality, he noted that information asymmetries are a key challenge, particularly regarding quality, as it is hard to measure and even harder to evaluate. With regard to the relationship between quality and price, consumers almost never fully appreciate the total costs of services, while co-payment increases financial responsibility. Tiering is a way to align incentives between patients and health insurers rather than between patients and providers. Insurers influence patients' choice by offering the most economic option but allowing them to choose another hospital by incurring a larger co-payment. Desirability is more based on price than quality as insurers already evaluate costs and quality in designing tiered offers. With regard to integrated care, the delegate commented that the US health care reform legislation enacted two years ago aims at reinforcing the value of integrated care and preserving competition, which are not mutually exclusive. To this end, there are provisions on accountable care organisations, which are intended to promote integrated delivery and the adoption of best practices. Antitrust enforcement has an important role in preventing unintended anticompetitive consequences, particularly for private providers.

The Chair followed up by asking a question related to certificates of need, which are required by some states to authorise new capacity to be built. While certificates of need ensure that past investments of incumbents are not under-rewarded, these have little effect on cost containment. The Chair asked whether the government should identify the optimal level of capacity in the hospital sector.

The US delegate responded that the antitrust enforcement agencies in the US have a uniform view on certificates of need, which is that market forces are better equipped to allocate and inform decisions about capacity than the government. States with certificates of need in place have been encouraged to reconsider these certificates as the original rationale is no longer in place; cost reimbursement was replaced by DRG. Certificates of need impose substantial costs on consumers and health care markets by creating barriers to entry and are subject to abuse. The Chair then asked whether states that have certificates of need have lower capacity of hospital services and whether certificates of need therefore further restrain capacity. The delegate replied that it may not follow that certificates of need create inefficiencies in terms of capacity, but judgements on capacity should rely on market forces. The Chair questioned whether market forces are able to provide adequate capacity levels in the hospital sector, as capacity is to be equal to peak demand rather than average. The delegate responded that it is not obvious that certificate of need regulation leads to an efficient level of capacity.

Next, the Chair turned to South Africa and its large public sector system. As in many other countries, the state-owned sector is largely inefficient. The private sector is more efficient and effective and half the health care budget of the country is managed by the private sector. The two sectors do not interact and competition is only developing in the private sector. The Chair invited the delegate to clarify the regulatory structure for the public and private provision of services and the involvement of the Department of Health in setting up the National Health Reference Price List.

The delegate from South Africa started his presentation by providing a brief description of the healthcare system and the extent of competition. The constitution provides for public healthcare services for those that do not have a medical insurance and the public sector is funded by general taxes and decentralised in each province. In contrast, the private sector is regulated at the national level, with a strong regulatory framework for insurance which includes non-refusal of patients. There is a community rating. Refusal due to diseases is not allowed and these patients cannot be subject to higher premiums. There are also mandatory minimum benefits. Risk pools are not split between medical schemes. Health professionals and hospitals are regulated at the provincial level in terms of facility standards and licences.

An important share of healthcare expenditures is based on voluntary private health insurance. The degree of high-tech equipment and expenditures are high relative to the level of development, while health outcomes are poor. The private hospital market is highly concentrated; mergers in the late nineties resulted in only three major companies, and since 2000 premiums have been steadily increasing. The delegate identified five key challenges: market power imbalances, vertical relationships between hospital groups and their supply chain, conflicts of interest, employment of specialists and general practitioners in private hospitals and improved hospital licensing to reduce market concentration in the major metropolitan areas. Finally, the delegate pointed to the establishment of a statutory pricing authority as a possible solution.

The Chair asked for clarification of the relationship between public and private sectors. The delegate responded that the roles are separated, but many specialists in the public sector also work in the private sector on a fee for service basis. The Chair further inquired as to the reason for the high concentration in the private hospital market. The delegate responded that many of the mergers and acquisitions that occurred in the 1990s led to a concentrated market over time and were challenged by the competition authority, but cleared in the courts due to incomplete evidence and an optimistic view of the role that private insurers could play in containing costs.

Finally, the Chair posed a question on the impact of these mergers and internal growth on capacity. The delegate responded that currently there is excess capacity with around 70% occupancy rates in the private sector, which provides incentives to overprovision.

The Chair referred to the Business Industry Advisory Committee (BIAC) submission which promotes the role of the private sector in spurring innovation, diversity and cost effectiveness in hospital services in Europe and the US. However, in Europe the private sector has a small market share, mainly in less sophisticated treatments. The Chair asked whether BIAC considers provisions on universal service in the hospital sector to be important and whether some public intervention is deemed necessary. In addition, the Chair asked whether privatisations in the hospital sector should be encouraged, although he noted that this had not been suggested in the discussion.

In his presentation, the representative indicated that BIAC has a unique perspective with a real interest in human capital, while often being a payer of hospital services. In terms of privatisation, the representative acknowledged that it may not be the most appropriate solution in all countries. With regard to universal service provision, BIAC supports universal care but the way it is achieved depends on the economy and the culture of the country. Then, the representative provided an overview of the benefits of private involvement in hospital services. First, competition will result in the encouragement of entrepreneurial

behaviour in price and quality. To this end, purchaser and provider functions need to be separated and fair competition between public and private providers need to be ensured. This includes impartial management of the public-private mix, equal remuneration and not favouring hospitals running a deficit. Second, private capital can contribute to building facilities and, indeed, many private hospitals are due to new construction rather than privatisation. Third, for-profit sector is taxable and, therefore, contributes to economies as well. BIAC supports patients' rights to choose doctors and hospitals rather than rationing. Fourth, private health insurance can help improve access for all. Finally, he referred to a literature review on the US experience provided in the submission for further information.

Next, the Chair turned to France and commented that a DRG system to remunerate hospital services is used. The Chair asked about the consequences for the least efficient hospitals if costs are not covered. He went on to ask why no private system has developed if DRG also covers the fixed costs.

The delegate from France confirmed that the system in place since 2005 is the remuneration by activity (DRG). After implementing this payment method, a system to monitor budgetary deficits was put into place and the regional health agency is responsible for monitoring the financial situation of hospitals. First, within hospitals, the monitoring commission, a kind of administration board, can ask for an internal audit if there is evidence of inadequate financial management and adopt a turnaround plan for the hospital. The delegate pointed out that this system is similar to the Norwegian one because in case the turnaround plan fails to redress the situation and deficit exceeds 2.5%, the hospital can be placed under provisional administration by experienced officials. Debt of public hospitals has diminished in recent years and is not perceived as a concern for the provision of health services. The delegate also noted that provisional administration also occurs when managers fail to secure a high quality provision of services. With regard to the last question, the delegate indicated that there is a public system of hospitals with public service responsibilities, and a private for-profit and not-for-profit hospital market. The Law on Funding of Social Security aims at narrowing the gap between the price levels for the public and private sector, although there are difficulties. For example, private operators do not provide public services and tend to specialise in the most profitable services rather than an integrated offer.

4. Antitrust enforcement in hospital services

Next, the Chair opened the discussion on antitrust enforcement with reference to the Norwegian submission. Norway reports on a number of bid rigging cases involving transport services for hospital patients and also health services. Identifying the very common practice of bid-rigging is difficult, because it requires information across bids and the bidding administration has no incentive to report. The Chair asked how the cases described were discovered.

The delegate from Norway confirmed that in recent years there had been a few cases of collusion related to tenders for patient transport and explained that the two cases described in the submission were not difficult to discover because there was only one bidder. These cases underline the importance of effective competition in procurement and, as an example the delegate indicated that an *ex post* assessment of one of these cases estimated public cost savings of up to NOK 2 million each year. The delegate added that the Norwegian Competition Authority recently sent out information to public procurers on how to detect bid-rigging and how to design less vulnerable tenders and report these to the competition authority.

Then, the Chair continued with the United States and noted that this country has a long tradition in controlling mergers in hospital services. A major review undertaken in 2002 found that a loose definition of the relevant market had been used to clear several mergers and market power was being exercised. As a consequence, the FTC took a more rigorous approach with a more direct estimation of market power that is coherent with the new merger guidelines. In this context, the Chair noted that the data requirements for this estimation were very high and asked if enough data was available. A second finding from this review is

that for-profit hospitals do not behave differently than any other hospital with respect to the exercise of market power and the Chair asked how this concept had been defined.

The delegate from the United States clarified that the FTC tried to block these 1990s mergers, but these challenges were rejected by the Courts due to the scope of geographic markets and a presumption that not-for-profit facilities would not impose price increases in their communities. The study concluded that they had exercised market power and this animated a renewed enforcement effort. A careful study and modelling was undertaken to measure the intensity of competition between the two merging parties based on patient discharge data collected by most states.

The Chair turned to Japan, where the Japan Fair Trade Commission (JFTC) has been engaged in advocacy and in enforcement with respect to health care. Referring to the written submission prepared by Japan, the JFTC mentions the existence of advertising limitations for hospitals and the Chair asked whether they still exist and apply to both public and private hospitals. He also asked for the reasons behind these limitations as informed advertisement is usually allowed since it constitutes a way to inform patients.

The delegate from Japan explained that the JFTC convened a study group on government regulations of hospital services under competition policy and published a report in 2002. The report made three points. First, patients should have a choice and hospitals should compete with each other. Second, the negotiation power of patients and insurers should be enhanced. Third, regulations at both the supply and demand side should be reviewed in order to promote competition. With regard to advertising limitations, the report indicates that to enable patients to make better-informed choices and to ensure fair competition, advertising should be liberalised. For many years the Japanese Medical Care Act had adopted a system that allowed only information that was objective and verified to be advertised, but in 2007 the scope of advertising content was enlarged. In December 2010, a draft reform to lift advertisement restrictions for both public and private hospitals was proposed in the working group established under the subcommittee of "the Government Revitalization Unit".

The Chair summarised the roundtable by saying that for competition to work incentives are needed on both the supply and demand side. Supply needs to be responsive to demand, particularly in publicly funded systems. When insurance companies are involved, patients' choice needs to affect revenues of hospitals and income of stakeholders. In a few countries such as France and Germany, measures are undertaken in the event of hospital deficit, but these do not include bankruptcy. Also, the Chair pointed to the fact that hospitals generally do not have the flexibility to impose cost-cuts to stakeholders, such as dismissals and wage cuts.

The Chair also highlighted the importance of informing patients' decisions and promoting competition between hospitals. Surveys show that there is a real demand for choice and, in countries where choice has been introduced; it has been particularly beneficial for low-income individuals.

Finally, the Chair stated that hospital management is very important and warned that doctors may not possess adequate management skills, in particular within the public sector. Also, intermediaries play a key role and their incentives should be aligned with both patient and government needs.

COMPTE RENDU DE LA DISCUSSION

par le Secrétariat

1. Introduction de la table ronde sur la concurrence dans les services hospitaliers

Le Président, le professeur Alberto Heimler, ouvre la table ronde sur la concurrence dans les services hospitaliers en souhaitant la bienvenue aux délégués, notamment ceux du Comité de la santé, et précise qu'elle s'inscrit dans le prolongement de celle tenue en octobre 2005. Les dépenses hospitalières représentent environ 38 % du budget de la santé des pays membres de l'OCDE (avec des écarts considérables entre les pays, cette part atteignant pas moins de 48 % au Japon, contre seulement 12 % au Mexique) et font peser des contraintes toujours plus lourdes sur les finances publiques. Plusieurs universitaires, parmi lesquels Zack Cooper, de la London School of Economics, et Martin Gaynor, des universités de Bristol et de Carnegie Mellon, avancent que la quasi-totalité des pays disposent d'une marge considérable d'augmentation de la productivité dans les services de santé, et notamment les services hospitaliers. Le Président est d'avis que les marchés peuvent jouer un rôle important dans la prestation de services hospitaliers, comme c'est le cas au Royaume-Uni par exemple. Alors que les États-Unis, le Royaume-Uni, les Pays-Bas et quelques autres pays étaient les seuls à s'appuyer sur les mécanismes du marché dans les services hospitaliers en 2005, ils ont rapidement été rejoints par d'autres, bien que les modèles de concurrence varient selon les pays.

Le Président ajoute qu'une structure incitative compatible avec les objectifs visés est nécessaire pour que la concurrence profite aux consommateurs, aux contribuables et aux assurés, ce qui est rarement le cas dans les services hospitaliers. Dans certains pays, l'évolution de la demande ne semble pas influencer les revenus des parties prenantes, et les possibilités de choix sont insuffisantes. En outre, pour que la concurrence soit efficace, les clients (ou leurs agents) doivent avoir connaissance des dimensions pertinentes de la qualité des services fournis par les différents hôpitaux. En d'autres termes, la concurrence doit être présente du côté de l'offre comme de la demande.

Ensuite, le Président propose d'axer les débats sur trois grands thèmes, à savoir la gouvernance du secteur hospitalier, le rôle des mécanismes du marché dans l'amélioration des performances et les expériences nationales dans la mise en œuvre du droit des pratiques anticoncurrentielles.

Le Président reconnaît que le Secrétariat de l'OCDE travaille depuis longtemps au renforcement de la qualité des soins de santé tout en veillant à maîtriser les coûts, et invite Frank Maier-Rigaud, de la Division de la concurrence, l'auteur du document de référence, et Ankit Kumar, de la Division de la santé, à présenter conjointement la portée de concurrence en tant qu'instrument d'amélioration des résultats dans les services hospitaliers.

Frank Maier-Rigaud débute la présentation en remarquant que l'impact de la concurrence fait l'objet d'avis divergents, certains la considérant comme un obstacle à la réalisation des objectifs de santé publique et un facteur de dégradation des résultats médicaux, alors que d'autres estiment qu'elle est synonyme de dynamisme en matière d'innovation et d'amélioration des résultats pour les consommateurs. Des résultats indésirables peuvent survenir si la concurrence est insuffisante, mais également en cas de concurrence intense dans un environnement réglementaire inadapté. Dans ce dernier cas, les mesures à prendre relèvent classiquement de l'application du droit des pratiques anticoncurrentielles, alors que le premier cas de figure

souligne l'importance de tenir compte des possibilités de concurrence lors de la définition du cadre réglementaire. La conception des systèmes de santé a un impact sur les incitations, la structure du marché, et donc sur les résultats.

Ankit Kumar souligne ensuite l'importance d'un rapprochement entre les responsables des politiques de la santé et de la concurrence. Il commente les trois politiques qui ont dominé au cours des quinze dernières années : prix fixes, choix et information des patients, et autonomie des hôpitaux. Le système de prix fixes, qui est également désigné sous le nom de Groupes homogènes de malades (ci-après GHM), est le système de financement adopté (ou envisagé) par la majorité des pays de l'OCDE. En présence de prix fixes, « l'argent suit le patient » et introduit une possibilité de contestation sur le plan de la qualité. Les systèmes de GHM sont de meilleurs outils budgétaires que les budgets fixes, qui n'instaurent pas de concurrence, et le remboursement des coûts, qui augmente le risque budgétaire. Malgré tout, une étude menée en France a mis en évidence une absence de corrélation entre la manière dont les prix fixes sont définis au niveau central et leur impact concret sur les hôpitaux. On peut en conclure que la direction de l'hôpital a un rôle essentiel à jouer pour garantir que les prestataires de services ressentent le besoin de se livrer concurrence et cherchent continuellement à améliorer l'efficience ou la qualité. Il souligne également qu'en établissant des prix fixes, il est possible que la concurrence porte uniquement sur la qualité et non sur la productivité.

Le Président s'enquiert ensuite de l'existence d'un système standard de GHM commun à tous les pays. Pour répondre à cette question, Ankit Kumar indique que bien que le principe des GHM soit effectivement commun à tous les pays, sa mise en œuvre est propre à chacun, et la plupart d'entre eux adoptent l'un des nombreux modèles existants et l'adaptent à leurs besoins respectifs.

Ankit Kumar poursuit sa présentation en déclarant que l'amélioration du choix offert aux patients et des informations mises à leur disposition ne se traduit pas par une dégradation des résultats, mais que l'ampleur de ses effets bénéfiques est sujette à débat. Bien qu'ils aient de plus en plus tendance à déléguer les fonctions de gestion, les hôpitaux pourraient ne pas disposer de l'autonomie nécessaire pour influencer leurs activités et l'affectation des ressources et fonctionner ainsi sur une base plus concurrentielle. Les conseils d'administration doivent être indépendants politiquement afin d'être en mesure de prendre des décisions fermes et pertinentes. Enfin, il remarque que les possibilités de concurrence sont également limitées puisque les services hospitaliers ne sont pas tous adaptés à un cadre concurrentiel, comme les urgences ou les services très spécialisés, qui doivent faire une certaine taille. En outre, ils peuvent avoir recours à des subventions croisées.

Le Président fait ensuite référence au rapport du professeur Martin Gaynor sur les conditions nécessaires à un accroissement de la concurrence et aux résultats à attendre en termes de récompenses et de sanctions. Dans ce contexte, le Président demande d'utiliser le contre-scénario de la concurrence pour mesurer l'efficacité d'une concurrence accrue dans les services hospitaliers.

Le professeur Gaynor commence par donner un bref aperçu des connaissances actuelles en matière de concurrence dans les services hospitaliers. Il déclare que les marchés de la santé ne sont pas parfaitement concurrentiels, mais peuvent fonctionner raisonnablement bien sous certaines conditions, à savoir : incitation des hôpitaux à attirer les patients, réactivité de la demande aux principales différences entre les hôpitaux, choix suffisamment varié, informations relatives aux dimensions pertinentes de la qualité en nombre suffisant, et inaptitude des hôpitaux à discriminer leurs patients. La théorie économique prédit que dans un contexte de prix administrés, la qualité augmente si les prix sont supérieurs aux coûts marginaux. En revanche, lorsque les prix sont déterminés par le marché, les effets sur le bien-être global sont incertains. Toutefois, si l'élasticité par rapport à la qualité augmente ou que l'élasticité par rapport au prix diminue, le prix et la qualité augmentent, ce qui donne à penser qu'il est essentiel de parvenir à un bon équilibre entre le prix et la qualité.

Les données empiriques relatives aux effets de la concurrence sur la prestation de services hospitaliers portent sur un petit nombre de pays. Sur les marchés où les prix sont fixes et administrés, la concurrence améliore la qualité mesurée par le taux de mortalité, et peut avoir un impact substantiel et à long terme. Lorsque les prix sont déterminés par le marché, les données sont mitigées. Les fusions hospitalières peuvent conduire à des hausses de prix significatives comprises entre 3.5 et 53 %, en fonction de la disponibilité de substituts proches. Ainsi, les autorités de la concurrence jouent un rôle important. Aux États-Unis, les hôpitaux disposant d'un pouvoir de marché peuvent faire payer des prix plus élevés sur une base permanente, et les coûts sont entièrement supportés par les consommateurs, même dans le cas d'hôpitaux à but non lucratif. Rien ou presque n'indique que les fusions aboutissent à des gains d'efficience, et elles ne profitent généralement pas aux consommateurs. Dans tous les cas, les difficultés liées à l'établissement de prix administrés ont conduit les payeurs à recourir à la contractualisation sélective, qui favorise la concurrence sur le plan des prix, ou à une différenciation *(tiering)*. Cette différenciation consiste à passer un contrat avec un sous-ensemble d'hôpitaux et à faire payer plus cher les patients qui choisissent d'autres hôpitaux.

Mettant l'accent sur l'importance des informations, le Président demande à Martin Gaynor qui devrait être en charge de fournir ces informations, quels types d'informations devraient être mis à disposition, et quels pays pourraient être cités en exemple. Martin Gaynor répond qu'il est très courant aux États-Unis de confier cette responsabilité à une autorité publique centrale. Il évoque la difficulté de mesurer la qualité, résolue à l'aide d'indicateurs ajustés en fonction du risque, et de communiquer ces informations aux responsables politiques, citant la présentation de Cooper sur le Royaume-Uni. Zack Cooper confirme le point de vue de Gaynor et ajoute que la libéralisation du marché hospitalier permettra l'ouverture de marchés de l'information.

2. La gouvernance du secteur hospitalier

Le Président ouvre le débat sur la gouvernance du secteur hospitalier en remarquant qu'une concurrence peut également être instaurée dans les services hospitaliers lorsque les payeurs et les prestataires sont essentiellement publics. C'est le cas dans la plupart des pays, et à cet égard la situation est similaire à celle de l'éducation. Le Président donne d'abord la parole aux Pays-Bas et explique que dans le système de santé néerlandais, les individus doivent souscrire une assurance auprès d'un des nombreux opérateurs privés, et les assureurs négocient avec les hôpitaux pour le compte de leurs clients. Dans ce contexte, le Président demande quelles sont les mesures prises pour éviter la sélection défavorable, et si les primes sont déterminées en fonction de l'état de santé ou fixées par les pouvoirs publics.

Le délégué des Pays-Bas explique que le nouveau système, entré en vigueur en 2006, cherche à éviter la sélection défavorable de deux façons. Tout d'abord, le montant des primes d'assurance est fixé par les assureurs, mais un plan d'assurance prévoyant des prestations élémentaires déterminées par les pouvoirs publics doit être proposé. Les résidents adultes ont l'obligation de souscrire au minimum cette couverture de base, et les sociétés d'assurance ne peuvent leur opposer aucun refus. Ensuite, un fonds de péréquation, financé par des cotisations liées aux revenus et perçues à la source, a été créé pour limiter les risques encourus par les assureurs. Une compensation est versée aux assureurs en fonction des caractéristiques de leurs assurés, une compensation plus importante leur étant accordée pour les individus à haut risque. L'assurance des individus à faible revenu et des enfants de moins de 18 ans est entièrement prise en charge par le fonds. Ainsi, les assureurs qui acceptent des clients à haut risque n'ont pas besoin de leur facturer des primes plus élevées, et peuvent même tirer profit du fait d'attirer certains patients et d'acquérir ainsi une spécialisation. 45 % des revenus des assureurs proviennent des primes nominales versées par les assurés et 50 % du fonds de péréquation, les 5 % restants étant versés par l'État au titre de la prise en charge des individus qui n'ont pas les moyens de payer les primes. Il est possible de souscrire une couverture supplémentaire, qui n'est pas prise en charge par l'État.

Le Président demande des éclaircissements quant à la situation concurrentielle. De son point de vue, il semblerait que la concurrence ne joue que sur 45 % des recettes totales et que les pouvoirs publics soient encore grandement impliqués. Il s'interroge sur les raisons qui ont conduit le ministre de la Santé à conclure un accord-cadre administratif relatif à la maîtrise des coûts de santé avec l'Association néerlandaise des hôpitaux et les assureurs. En outre, le Président demande si la coordination nécessaire pour parvenir à ces décisions a causé de quelconques inquiétudes à l'autorité de la concurrence.

Le délégué des Pays-Bas confirme que 45 % de l'ensemble des revenus perçus par les assureurs proviennent des primes que leur versent leurs clients. Toutefois, ils se livrent concurrence sur la quasi-totalité de leur recettes puisqu'ils se disputent les ressources provenant de chacune des trois sources de financement. Les assureurs se livrent concurrence pour chaque client, et les compensations qui leur sont versées par le fonds de péréquation sont directement fonction des assurés et de leur état de santé. Ainsi, les assureurs se livrent également concurrence vis-à-vis de ce fonds. Seule la contribution publique de 5 %, liée au nombre total de personnes non assurées, permet d'affirmer que les assureurs ne se livrent pas concurrence à l'égard d'une partie des adultes assurés. Pour mettre fin aux dépenses souvent excessives des prestataires de santé, un accord a été conclu avec les principales parties prenantes en 2011, en vertu duquel les assureurs doivent surveiller de près leurs dépenses afin d'éviter les déficits budgétaires, mais ne voient pas leur responsabilité engagée en définitive si les dépenses excèdent un plafond de 5.25 %. Les inquiétudes soulevées par cet accord ont conduit l'autorité de la concurrence à jouer un rôle consultatif auprès du ministère. L'accord en question se contente de définir des objectifs et les parties restent décisionnaires quant à la manière d'engendrer des gains d'efficience et de prévenir les déficits budgétaires, dans les limites du droit de la concurrence.

Le Président poursuit en demandant s'il existe des différences entre les primes facturées par les six sociétés d'assurance. Le délégué indique que ces primes sont équivalentes et que bien que le système soit en place depuis quelques années, une plus grande différenciation serait bienvenue.

Ensuite, le Président souligne le cas du Royaume-Uni, où les médecins généralistes contribuent grandement à la lutte contre les asymétries d'information. Le Président demande de quelle manière les incitations à la réduction des coûts visant les médecins généralistes sont harmonisées avec celles visant les pouvoirs publics, et pourquoi cette redondance est acceptée pour permettre l'exercice d'un choix.

Le délégué du Royaume-Uni explique que deux questions majeures font actuellement débat. Du côté de la demande, ce débat porte sur le rôle des informations dans la lutte contre les défaillances du marché. Du côté de l'offre, il porte sur la compatibilité de la concurrence et des soins intégrés. La majorité des services hospitaliers sont fournis par le National Health Service (NHS), financé par l'État. Un système de prix fixes est en place pour les soins non urgents, ce qui signifie que les hôpitaux se livrent concurrence sur des critères de qualité pour attirer les patients, et peuvent conserver leurs excédents. Sur le marché des soins privés, certains hôpitaux privés fournissent des services dont le coût est pris en charge par des assurances privées ou par les patients eux-mêmes.

Le Président demande si le NHS est administré au niveau central ou local. Le délégué répond que la structure de gouvernance est complexe, le budget étant défini par l'administration centrale, qui le répartit ensuite entre les autorités sanitaires locales. Les décisions sont prises localement dans le respect des contraintes définies au niveau central et les patients bénéficient d'une liberté de choix totale au sein de ce système.

La majorité des patients ont le choix entre plusieurs établissements dans un rayon raisonnable autour de leur domicile, et 40 % d'entre eux ne choisissent pas l'hôpital le plus proche, ce qui indique que d'autres critères, tels que la qualité, entrent en jeu. Les médecins généralistes sont des agents informés bénéficiant de meilleures connaissances cliniques, qui peuvent donner un avis impartial sur le choix d'un

hôpital. L'ajustement des incitations des médecins généralistes se complexifie à mesure que le système évolue, mais des recommandations ont été formulées afin de garantir leur impartialité. Par exemple, en cas de fusion, il convient de s'assurer que les patients aient le choix entre un nombre suffisant de médecins généralistes, et que les éventuels conflits d'intérêts fassent l'objet d'une transparence totale.

Les pouvoirs publics mettent des informations à disposition par de nombreux biais, comme le site NHS Choices, qui fournit des informations complètes sur les hôpitaux. Par ailleurs, un site privé propose un guide hospitalier et établit un classement des hôpitaux sur la base de leur qualité clinique. Le Président demande qui finance ce site privé. Le délégué répond que ce site est géré conjointement par le ministère de la Santé et une société d'information privée, dans le cadre des efforts entrepris par les pouvoirs publics pour accroître le nombre de sources d'information, et s'inscrit dans la tendance actuelle à la publication de données brutes. Une étude du marché des soins de santé privés entreprise par l'*Office of Fair Trading* révèle l'existence d'asymétries d'information imputables à un manque d'informations comparables. En outre, l'étude indique qu'il existe des obstacles à l'entrée sur le marché privé. Les nouveaux hôpitaux doivent passer des contrats avec nombre d'assureurs avant de pouvoir accueillir suffisamment de patients pour fonctionner efficacement, tandis que le personnel médical préfère travailler dans un seul établissement plutôt que dans plusieurs hôpitaux.

Du côté de l'offre, la question est de savoir si des hôpitaux concurrents peuvent être incités à dispenser conjointement les soins dont les patients ont besoin. Du point de vue de l'autorité de la concurrence, ils ne s'excluent pas mutuellement, comme l'a montré le cas des réseaux oncologiques, mais la prudence reste de mise afin d'éviter les conflits d'intérêts et les comportements d'exclusion.

Le Président passe ensuite à l'Allemagne et déclare que la Commission allemande des monopoles *(Monopolkommission)*, dont la plupart des publications sont malheureusement en langue allemande, a suggéré que les traitements non urgents devraient être dispensés dans les conditions du marché libre. Le Président invite le délégué à donner une définition satisfaisante des traitements non urgents.

La délégation d'Allemagne débute son intervention en déclarant qu'en réaction à la hausse des dépenses de santé, des réformes ont été entreprises afin d'accroître la concurrence. En 2003, un système de GHM inspiré du modèle australien a été instauré aux fins du calcul de la rémunération des services hospitaliers et du prix des traitements. Un rapport publié par la *Monopolkommission* en 2008 a révélé que l'environnement législatif en vigueur était insuffisant pour faire baisser le coût des services hospitaliers. Ce rapport propose un modèle introduisant davantage d'éléments de concurrence tarifaire sur le marché, en permettant aux caisses d'assurance maladie de conclure des contrats sélectifs avec les hôpitaux pour ce qui concerne les traitements non urgents. Les patients se voient alors proposer un tarif plus avantageux, mais en contrepartie leur choix est restreint à des hôpitaux sous contrat. Les caisses d'assurance passent des contrats avec les hôpitaux offrant le meilleur rapport prix/performances, ce qui incite les hôpitaux à offrir des services de meilleure qualité ou à moindre coût. En ce qui concerne la définition des traitements non urgents, le délégué fait remarquer que le rapport emploie ce terme au sens large, excluant seulement les traitements urgents. Le fait que les traitements non urgents puissent acquérir un caractère urgent à un moment ou à un autre n'est pas évoqué dans le rapport. De même, le rapport évoque la nécessité de réglementer la distance que la caisse d'assurance maladie peut imposer de parcourir aux patients dans le cadre de ce modèle.

Le Président pose la question du financement des capacités des hôpitaux, puisque l'Allemagne est le seul pays à y faire référence dans sa note. L'offre doit toujours être égale à la demande potentielle, ce qui implique de laisser toujours des lits libres afin de pouvoir faire face aux pics de demande. Le Président demande si le financement des dépenses d'équipement est motivé par les capacités. À cet égard, le Président poursuit en demandant si les améliorations de la productivité, qui raccourcissent la durée des

séjours hospitaliers et permettent donc de libérer des capacités, sont prises en compte dans la gestion des capacités.

Le délégué de l'Allemagne explique que les dépenses d'équipement sont financées sur la base d'un plan de capacité préparé et adapté tous les ans. Ce plan annuel prévoit la mise à disposition de capacités de réserve en cas de pic de la demande. Les améliorations de la productivité sont également prises en compte, bien que jongler entre les hausses de productivité et les augmentations globales de la demande de services hospitaliers tout en maintenant une qualité de traitement suffisante soit une tâche complexe et de longue haleine.

Le Président passe ensuite au Brésil et remarque que la protection de la santé est un droit inscrit dans la constitution, garantissant un droit d'accès aux hôpitaux publics. Par conséquent, ces hôpitaux sont surpeuplés et fonctionnent selon le principe du « premier arrivé premier servi », d'où des délais d'attente très longs dans tous les services. Le Président invite le délégué à détailler les mesures mises en œuvre par l'État pour réduire ces délais.

Le délégué du Brésil explique que ce commandement constitutionnel est davantage perçu comme une règle administrative que comme un droit, et que son efficacité est fonction des ressources disponibles. La constitution oblige chaque niveau de l'administration publique à consacrer une certaine part des ressources publiques aux services de santé, et chaque autorité est compétente pour décider quand et où investir, et évaluer la pertinence d'un tel investissement. La décentralisation limite la capacité du gouvernement fédéral à régler les problèmes des services de santé publics. La stratégie nationale consiste à investir dans les régions les moins favorisées, en incitant le secteur privé à y construire davantage d'hôpitaux et le personnel médical à y étudier et s'y installer, selon l'idée qu'en améliorant l'accès aux soins hospitaliers, les délais d'attente diminueront.

Le Président invite le délégué à décrire brièvement les polices d'assurance privées, et notamment les éventuelles garanties minimales obligatoires définies par la loi, les différences entre les 1 100 sociétés d'assurance maladie actives sur le marché, et les raisons qui poussent à ne pas choisir de plus gros assureurs, qui fournissent probablement des services de meilleure qualité et mieux articulés.

Le délégué répond que seulement 25 % de la population brésilienne est couverte par une assurance privée, mais que les services privés seront considérés comme nécessaires aussi longtemps que le système public ne sera pas en mesure de dispenser les soins nécessaires à chaque individu. En ce qui concerne la définition par la loi de prestations minimales dans le cadre des plans d'assurance privés, les pouvoirs publics ont établi trois niveaux de couverture, parce que le consommateur moyen n'est pas en mesure d'identifier et de comparer la qualité et la teneur des services de santé. Enfin, le délégué explique que la multiplicité des sociétés d'assurance résulte de la présence de nombreuses petites entreprises dans les zones où les grosses sociétés n'ont pas intérêt à s'établir, et également du fait que ces petites entreprises offrent des services conjoints. Bien que la présence de nombreuses petites sociétés d'assurance soit caractéristique du système de santé brésilien, elle n'empêche pas de préférer les grandes entreprises, qui offrent une plus large palette de services de meilleure qualité.

Faisant référence à la note du Chili, le Président demande des éclaircissements quant à la question de savoir si la population active est autorisée à souscrire une assurance privée ou si elle en a l'obligation. En outre, le Président demande si des mesures sont en place pour éviter que les primes d'assurance augmentent trop, dans la mesure l'on dénombre six sociétés d'assurance. Bien que de l'avis du Président, la différenciation des produits soit nécessaire à la concurrence, une homogénéisation des plans d'assurance a été débattue au Chili. Le Président laisse entendre que l'homogénéisation peut conduire à la collusion et freiner l'innovation, et invite le délégué à donner un aperçu de la situation régnant dans son pays.

Le délégué du Chili déclare que la population active consacre chaque mois au moins 7 % de son revenu brut à l'assurance maladie, qu'elle soit couverte par le système public ou par l'une des six sociétés d'assurance privées. La plupart des actifs préfèrent ces dernières et il y a peu de substitution entre les deux secteurs. Le Président demande si les deux secteurs sont indépendants. Le délégué explique qu'un choix doit être fait entre le public et le privé, et souligne l'absence d'encadrement des primes réclamées par les assurances privées. Il fait remarquer qu'une plainte pour collusion entre les sociétés d'assurance, déposée en 2007, a été rejetée par le Tribunal de la concurrence et la Cour suprême. En outre, il y a également eu des inquiétudes au sujet des prix et de nombreux arrêts bloquant la hausse des primes pour certains groupes spécifiques d'assurés ont été rendus par les cours d'appel. Une proposition d'établissement d'un plan général, similaire à celui adopté par le secteur bancaire en matière de crédit universel, a récemment été débattue au Congrès.

Le Président se tourne ensuite vers la Colombie, où la réforme de 1993 a instauré un système concurrentiel organisé autour des sociétés d'assurance et des institutions prestataires de services. Toutefois, les régimes de prestations de l'ensemble des citoyens ont été harmonisés et une obligation d'assurance a été instaurée en 2011. Le Président invite le délégué à expliquer dans quelle mesure cette réforme récente s'inscrit dans le sillage de l'approche axée sur le marché adoptée en 1993. Le Président demande également des éclaircissements quant au rôle des hôpitaux privés dans les secteurs les plus spécialisées et les plus complexes de la santé.

Le délégué de la Colombie explique qu'avant 1993, le système était administré par les pouvoirs publics, mais qu'un système dual a été instauré par la suite, avec des assurances maladie privées pour les salariés, et un système financé par les pouvoirs publics pour les chômeurs. À la suite d'une ordonnance de la cour constitutionnelle relative à l'harmonisation des prestations du système subventionné et du système financé par les cotisations, les pouvoirs publics ont mis fin à ce système dual en 2011. Quant au rôle des hôpitaux privés, le délégué explique que ces derniers se concentrent sur les cas extrêmement complexes, tandis que les hôpitaux publics représentent une solution de dernier recours et sont situés dans des zones où les hôpitaux privés sont réticents à s'installer.

Faisant référence à la note du Taipei chinois, le Président souligne que 84 % des hôpitaux sont privés et que les services de santé sont payés par l'Assurance maladie nationale, financée par des primes d'assurance obligatoires. Le Président demande pourquoi la demande d'accréditation des hôpitaux est strictement facultative.

Le délégué du Taipei chinois explique qu'un programme d'assurance obligatoire conçu comme un système de répartition autofinancé, responsable de son propre déficit, a été instauré en 1995. Aujourd'hui, les fonds nécessaires à son financement proviennent principalement des primes versées par les assurés, les employeurs et l'administration centrale et locale, et non de l'impôt. Le délégué indique que ce programme englobe 92 % des établissements médicaux. Il couvre la plupart des traitements formels, et les assurés peuvent s'adresser au prestataire de services médicaux de leur choix, sous réserve qu'il ait conclu un contrat avec l'Assurance maladie nationale. Il est fondé sur un système de prix fixes, et les services couverts génèrent la majorité des revenus des établissements médicaux. Près de 84 % de ces établissements sont privés, d'où un marché de la santé très concurrentiel sur le plan de la qualité. Le système d'accréditation a été instauré en 1988 et concerne uniquement les hôpitaux. Bien que l'accréditation soit facultative, une majorité d'hôpitaux la demandent. Elle repose sur une multitude d'indicateurs, et les résultats sont publiés en ligne par le ministère de la Santé pour servir de guide de référence dans le choix des services hospitaliers.

Le Président poursuit en demandant pourquoi l'accréditation est facultative et non obligatoire. Le délégué du Taipei chinois répond qu'elle est facultative parce que les hôpitaux sont tout à fait disposés participer au programme, dans la mesure où le fait d'accueillir davantage de patients permet d'accroître le

volume des services médicaux, et par conséquent, d'obtenir des remboursements plus élevés. En outre, la note obtenue permet aux hôpitaux d'obtenir plus facilement des bourses de recherche auprès d'autres secteurs du gouvernement. Le Président demande alors si les mauvais hôpitaux participent également. Le délégué admet qu'une minorité d'entre eux font une demande d'accréditation.

Le Président se tourne ensuite vers l'Irlande, dont le système est mixte. Le pays compte 50 hôpitaux publics, avec 20 % de lits privés, et 20 hôpitaux privés. Le Président précise que près de 50 % de la population est titulaire d'une assurance privée et demande si cette dernière vient en complément de l'assurance publique. En outre, le Président pose la question de la concentration du marché, dans la mesure où le pays ne compte que trois assureurs, dont l'un détient 65 % du marché. Il termine en demandant si cela est dû à des contrats exclusifs.

Le délégué de l'Irlande explique que l'assurance privée est facultative ; le système public est accessible à tous ; il est gratuit pour les personnes dont les revenus se situent en dessous d'un certain seuil. Les personnes dont les revenus dépassent ce seuil versent une petite contribution. Il est également possible de souscrire une assurance privée ; elle couvre les soins dispensés par les hôpitaux publics ainsi que les soins privés pris en charge par la formule souscrite. Le principal avantage de l'assurance privée réside dans le fait qu'elle offre un plus grand choix d'établissements et permet d'accéder plus rapidement aux procédures non urgentes. En ce qui concerne la structure du marché, la concentration est due au fait que jusqu'au milieu des années 1990, il n'y avait qu'un seul opérateur sur le marché de l'assurance maladie privée, et qu'il était la propriété de l'État. Bien que d'autres assureurs soient entrés sur le marché depuis, la part de marché de l'assureur public est demeurée élevée ; cela est dû, entre autres, aux régimes réglementaires distincts s'appliquant aux assureurs, qui ont pour effet de conférer un avantage réglementaire à l'assureur public, à l'incertitude quant à la péréquation des risques, et au fait que les consommateurs, et notamment ceux des tranches d'âge supérieures, ont toujours eu l'impression que les services fournis par cet assureur étaient les plus sûrs. De même, le délégué remarque que bien que l'assureur public détienne 65 % du marché, il achète 80 % des services hospitaliers privés puisqu'il compte une part plus importante de personnes âgées et en moins bonne santé parmi ses assurés. Pour répondre à la question du Président sur les contrats exclusifs, le délégué déclare que les hôpitaux cherchent à passer des contrats avec les trois assureurs, mais plus particulièrement avec l'assureur public. Il détient une part importante du marché de l'achat, ce qui lui confère un rôle de filtre en ce qui concerne l'accès aux services hospitaliers privés.

Le Président note que l'existence d'un ancien monopole explique cette concentration importante. Il poursuit en interrogeant le délégué au sujet de la relation entre les hôpitaux publics et les sociétés d'assurances privées et la couverture d'assurance.

Le délégué répond que les assureurs négocient les prix avec les hôpitaux privés individuellement. À l'inverse, dans les hôpitaux publics, le coût supporté par l'assureur dépend du type de lit occupé par le titulaire du contrat. Un lit public génère des coûts faibles équivalents aux frais payés par les patients assurés dans le public. Les frais hospitaliers facturés pour les lits privés dans les hôpitaux publics sont fixés par les pouvoirs publics, et bien qu'ils soient supérieurs à ceux facturés pour les lits publics, ils ne couvrent pas en totalité le coût économique des services fournis. Ainsi, les assureurs privés sont incités à envoyer leurs patients dans les hôpitaux publics. Les pouvoirs publics entendent augmenter les frais hospitaliers facturés aux patients privés dans les hôpitaux publics afin de les rapprocher du coût économique, et ne plus prendre en compte l'affectation à un lit public ou privé dans la facturation.

Ensuite, le Président se tourne vers le Pérou, où le ministère de la Santé, qui gère 86 % de tous les établissements, est le principal prestataire de services hospitaliers. EsSalud est la caisse publique des travailleurs salariés et assure 19 % de la population, alors que 45 % est prise en charge par l'Assurance maladie intégrale *(Seguro Integral de Salud)* et 32.9 % n'est pas du tout assurée. Le Président invite le

délégué à expliquer qui n'est pas assuré et pourquoi. Les hôpitaux privés représentent seulement 5 % de l'ensemble des établissements et accueillent principalement des personnes à très haut revenu. Enfin, le Président demande pourquoi la vente de médicaments est la principale source de revenus des hôpitaux, et si la marge de 14 % réalisée sur ces ventes est prévue par la réglementation et est liée à l'entrée dans le secteur pharmaceutique.

Le délégué du Pérou fait remarquer que le système de santé de son pays est comparable à celui du Chili et de la Colombie. Les salariés sont obligés de choisir entre la caisse publique (EsSalud) ou une assurance privée. La caisse publique gère ses propres hôpitaux et dispose de ses propres plans d'assurance. On compte cinq sociétés d'assurance privées ; deux d'entre elles se partagent près de 80 % du marché. En ce qui concerne l'Assurance maladie intégrale, elle couvre gratuitement les pans les plus vulnérables de la population, à savoir les personnes considérées comme pauvres. Elle comprend également un régime semi-subventionné (*Seguro semisubsidiado*) destiné aux personnes de moins de 65 ans dont le revenu est inférieur à un certain seuil, moyennant une petite contribution mensuelle. Une large proportion de la population n'est pas couverte, l'assurance maladie n'étant pas obligatoire pour les chômeurs et les travailleurs indépendants. Le délégué précise que le pourcentage d'hôpitaux privés mentionné intègre seulement des cliniques ou des gros hôpitaux et ne tient pas compte des petits prestataires privés. La diminution des marges dans la prestation de services de santé a entraîné une hausse de la vente de médicaments, qui n'est pas réglementée. En outre, les conditions juridiques pour entrer dans le secteur pharmaceutique ne sont pas strictes.

Le Président se tourne vers la Finlande et déclare que le système de santé est entièrement financé par les pouvoirs publics. En l'absence de tarification, l'offre et la demande sont équilibrées par les délais d'attente, d'où des listes d'attente interminables. La législation a défini des délais d'attente maximum, mais ce n'est pas une solution efficace de l'avis du Président. Depuis mai 2011, les patients peuvent choisir librement leur hôpital. Toutefois, les hôpitaux sont financés par les impôts locaux et le libre choix peut conduire les hôpitaux à fournir des services à des patients résidant en dehors de leur région, qui ne participent pas au financement et risquent de supplanter les résidents locaux. Le Président estime que cette situation n'est pas tenable et qu'une solution convenable pourrait consister à faire en sorte que les paiements suivent les patients.

La délégation de la Finlande confirme que le système de santé publique est décentralisé et peu réactif à la demande comparé aux systèmes d'autres pays. La définition de délais d'attente maximum par la loi a permis de réduire considérablement le nombre de patients attendant plus de 6 mois avant de pouvoir consulter un spécialiste. En 2011, les délais d'attente maximum (180 jours pour des traitements hospitaliers non urgents) ont été dépassés pour un millier de patients. Les districts hospitaliers ont pris des mesures spécifiques afin de réduire les délais d'attente. Ces mesures ont notamment consisté à mobiliser leur personnel, à augmenter leurs effectifs, à proposer à quelques patients de suivre leur traitement à l'étranger, et à remettre des coupons donnant accès à des prestations de services privées, augmentant ainsi la part du secteur privé. La réduction des délais d'attente a été accélérée par une autorité de contrôle qui a imposé un certain nombre de directives aux districts hospitaliers concernant le dépassement des délais d'attente réglementaires, assorties pour certaines de la menace de pénalités. Quant à la tarification, le délégué précise qu'en ce qui concerne les soins urgents, les districts hospitaliers facturent déjà les autres districts lorsqu'ils reçoivent des patients résidant sur le territoire de ces derniers, mais qu'il n'existe pas de régime de tarification général et que chaque district hospitalier applique sa propre politique de tarification. Le délégué est d'accord avec le fait que les paiements doivent suivre le patient, et qu'un système général doit être mis au point. Il ajoute que l'instauration d'un système de capitation est en cours de discussion en Finlande. Un tel système s'appliquerait plus vraisemblablement aux soins primaires ; des mesures ont déjà été prises afin d'instaurer le libre choix dans ce secteur, la prochaine étape de l'ouverture étant prévue pour le début de l'année 2014.

Ensuite, le Président remarque que la note d'Israël suggère que le paiement des services hospitaliers doit être déterminé au cas par cas et ne peut être planifié à l'avance. Toutefois, de nombreux pays ont adopté un système de calcul des coûts fondé sur une référence standard (GHM) et le Président demande si cette approche est considérée comme permettant à l'hôpital de mieux maîtriser la planification des paiements. Le Président poursuit en demandant si le système d'évaluation des hôpitaux par un organisme indépendant mentionné dans la note a déjà été mis en œuvre, et invite le délégué à présenter brièvement son cadre institutionnel.

Le délégué d'Israël répond à la première question du Président en déclarant que la rémunération des services hospitaliers varie en fonction du service. Un prix fixe par jour d'hospitalisation est en vigueur, calculé sur la base d'un coût journalier moyen. Au fil des ans, il a fait l'objet d'une différenciation par type de chambres et d'admission. La seconde méthode de rémunération est une sorte de système de GHM fondé sur les procédures médicales plutôt que sur le diagnostic. Le délégué explique qu'un programme visant à créer et systématiser des mécanismes standardisés d'évaluation de la qualité doit encore être conçu et intégré au système de soins hospitaliers. Un organisme professionnel indépendant sera chargé de la collecte et l'analyse des données, fournira aux clients des données comparables, transparentes et certifiées sur les performances des hôpitaux et fera un compte rendu auprès de ces derniers. Il améliorera également les mécanismes de calcul des coûts, en introduisant des informations relatives au profil des patients plutôt qu'aux coûts moyens, et indépendantes de la qualité, ce qui favorisera la prolongation des séjours hospitaliers. Cet organisme pourrait prendre modèle sur le Leapfrog Group. Le délégué reconnaît que l'établissement de mécanismes appropriés d'évaluation des performances en matière de qualité et de coût risque de se heurter à un certain nombre de difficultés organisationnelles et pratiques.

Le Président demande qui est chargé de la création de cet institut indépendant. Le délégué répond qu'elle est sous la responsabilité du ministère de la Santé. En outre, le Président remarque que près de 95 % des capacités hospitalières sont utilisées, ce qui limite le choix et la concurrence. Le délégué répond que le problème des capacités concerne davantage la médecine interne et qu'une solution reste encore à trouver, outre l'amélioration de la qualité et le renforcement des transitions entre l'hospitalisation et les soins communautaires

Passant à la note de la Norvège, le Président remarque que le système est entièrement financé par l'État et que les frais de transport sont remboursés afin d'encourager le libre choix des patients. Le Président demande quelles sont les conséquences pour un hôpital en déficit, dans la mesure où la structure tarifaire fondée sur les GHM repose sur les performances des meilleurs hôpitaux. En se référant à la note, le Président ajoute que le recours généralisé aux marchés publics pour les services médicaux peut s'avérer problématique dans la mesure où les normes de qualité sont difficiles à définir dans le cadre d'un appel d'offres.

Le délégué de la Norvège commence par déclarer que la responsabilité générale du financement et de la prestation des services de santé revient à l'État. Les traitements sont gratuits, les médicaments aussi, en contrepartie du versement d'une cotisation de sécurité sociale équivalant à 7.8 % du revenu. La modèle norvégien est fondé sur quatre entreprises régionales de santé. Les patients sont libres de choisir l'hôpital dans lequel ils souhaitent recevoir leur traitement non urgent (public ou privé sous contrat) et les frais de transport sont remboursés. En ce qui concerne les informations, une évaluation présentée en 2011 par le Contrôleur général conclut que des améliorations sont encore possibles dans la mesure où les informations publiées pourraient être plus à jour et plus pertinentes, et où seulement 50 % des patients consultant un médecin généraliste ont été informés qu'ils avaient la possibilité de faire un choix.

Pour répondre à la question du Président sur le financement, le délégué norvégien indique qu'il s'agit d'un système fondé sur l'activité et que les entreprises régionales de santé reçoivent 40 % du tarif calculé en points GHM pour le traitement programmé, qui équivaut aux coûts d'exploitation moyens de chaque

GHM. Il remarque que ce système a des effets positifs sur l'efficience et la durée de séjour. Toutefois, les hôpitaux inefficients en difficulté financière ne peuvent pas faire faillite. Les mécanismes visant à prévenir ou réguler les déséquilibres financiers incluent des reports de déficits, la réduction des budgets d'investissement, des avertissements ou l'éviction du conseil d'administration de l'entreprise régionale de santé. En ce qui concerne la définition de la qualité dans les marchés publics, le délégué explique que les marchés publics ont une envergure limitée et que la qualité revêt une importance cruciale. Bien qu'aucune donnée probante ne mette en évidence un déclin de la qualité dans les hôpitaux privés, l'autorité de la concurrence a exprimé des inquiétudes vis-à-vis de la qualité du fait que les contrats de certains spécialistes privés sont attribués en fonction de l'ancienneté et sont soumis à une limite d'âge de 70 ans. Une évaluation de ce système est prévue.

Le Président poursuit en déclarant qu'un système fondé sur le libre choix du consommateur a également été mis en œuvre en Suède. Dans la mesure où les patients peuvent choisir librement entre les hôpitaux publics et les hôpitaux privés conventionnés, le Président demande si d'importants transferts vers le secteur privé pourraient compromettre le financement des services universels. Le Président invite également le délégué à expliquer comment sont déterminées les capacités.

Le délégué de la Suède explique que l'État partage la responsabilité de la prestation des services sociaux avec les autorités locales et la responsabilité des hôpitaux avec les autorités régionales. Le système de santé est financé par l'impôt et il n'existe pas de caisses d'assurance maladie privées. Le délégué remarque que les précédentes préoccupations quant au nombre trop restreint d'opérateurs privés participant aux marchés publics ont conduit à la création d'un système de sélection dans lequel les fournisseurs intéressés soumettent leur candidature et remportent la concession de services si les conditions sont remplies. Le nombre de contrats est illimité ; le dépôt des candidatures n'est soumis à aucun délai ; les contrats sont publiés et ce système a permis d'introduire des centaines de nouveaux opérateurs privés, dont de nombreuses PME. Toutefois, les difficultés liées à la définition de la qualité ont donné lieu à certains scandales dans le domaine des soins. Le niveau de compensation financière est fixé par l'autorité, mais n'est pas fondé sur le prix le plus bas et varie à travers le pays.

Le Président demande au délégué de donner davantage de précisions sur les critères d'attribution et le calcul de la compensation financière. Le délégué répond que le respect des conditions et l'acceptation du niveau de compensation financière suffisent à se qualifier. La compensation financière est estimée sur la base des coûts moyens de la prestation en interne, mais les opérateurs privés sont rémunérés uniquement en fonction du nombre de consommateurs attirés. Le délégué ajoute que d'autres aspects peuvent également être pris en compte, comme les dépenses de R-D, la formation ou la capacité financière. Les contrats peuvent être examinés et contestés devant les tribunaux, et l'autorité de la concurrence encadre la législation. Les autorités locales et régionales sont chargées d'informer les citoyens. Les différences par rapport à l'ancien système de passation des marchés publics incluent la publicité continue, les contacts avec tous les candidats, le libre choix des prestataires, le niveau égal de rémunération de tous les prestataires, et l'absence de garanties financières pour les prestataires. Le délégué a également identifié quatre difficultés majeures dans le cadre de ce système de sélection : la définition du niveau de compensation financière, le maintien d'une concurrence loyale entre les opérateurs privés et publics, la hausse des coûts administratifs et le suivi de l'exécution des contrats.

En ce qui concerne les transferts vers le secteur privé, le Président s'interroge sur leur impact sur le secteur public. Le délégué répond que ces transferts obligent le secteur public à améliorer la qualité des services fournis. En effet, la part de marché des opérateurs privés ne cesse d'augmenter : dans deux autorités locales, des fournisseurs internes ont cessé leur activité parce que les opérateurs privés fournissaient des services de meilleure qualité.

Le Président clôt la première partie du débat de la Table ronde et demande s'il y a des questions ou des commentaires. En réponse à l'invitation du Président, le professeur Gaynor revient sur plusieurs questions soulevées. En ce qui concerne l'intégration des différents types de prestataires et de sociétés d'assurance, il existe des gains d'efficience potentiels mais également des risques d'éviction du marché. En ce qui concerne les informations, tous les consommateurs n'ont pas besoin d'être bien informés, mais les hôpitaux doivent garder à l'esprit que les informations relatives à la qualité des autres hôpitaux influent sur leurs revenus. Enfin, il existe des possibilités de concurrence dans les soins non urgents sous certaines conditions, ce qui n'est pas vraiment le cas dans le domaine des soins urgents. Il y a, toutefois, des retombées positives.

3. Bonnes performances dans la prestation de services hospitaliers : le rôle de la concurrence

La deuxième partie du débat s'ouvre sur une présentation du **professeur Zack Cooper** relative aux tensions qui ont émergé lors de l'instauration de la concurrence sur les marchés des soins de santé au Royaume-Uni. Dans son document, Cooper dresse la liste des conditions institutionnelles, réglementaires et politiques nécessaires pour que la concurrence puisse jouer un rôle dans la maîtrise des coûts et l'amélioration de la qualité des services hospitaliers.

Zack Cooper commence sa présentation en détaillant les réformes instaurées en 2006, qui ont permis aux patients de choisir librement les hôpitaux dans un système très centralisé. Il présente ensuite cinq conditions minimales nécessaires à l'instauration d'une concurrence utile. Premièrement, les hôpitaux doivent réagir aux incitations financières. Le système de financement est passé des contrats forfaitaires, indépendants du volume, aux GHM, avec un prix individuel défini pour chaque service. Les pouvoirs publics disposaient de données détaillées sur les coûts, ce qui leur a permis de fixer les tarifs efficacement. Ainsi, les hôpitaux ont acquis une autonomie clinique, budgétaire et de gestion bien plus importante, et ont désormais la possibilité de conserver les excédents, en fonction de leur stabilité financière.

Deuxièmement, il faut que les patients éprouvent l'envie de faire des choix. Les enquêtes montrent que 75 % des patients veulent choisir l'établissement où ils sont soignés et, lorsqu'ils ont cette possibilité, 30 % s'écartent de l'option par défaut. La raison pour laquelle les patients moins nantis veulent avoir le choix tient davantage au fait qu'en l'absence d'une possibilité de choix bien codifiée, ils n'auraient accès qu'à des services de moindre qualité. Troisièmement, les patients doivent avoir des alternatives. En Angleterre, la quasi-totalité de la population a accès à deux hôpitaux ou plus à moins d'une heure de route. Outre le libre choix accordé par le système public, les pouvoirs publics ont encouragé en 2008 les fournisseurs privés à proposer des soins aux patients du NHS, ce qui a été l'aspect le moins heureux des réformes. Quatrièmement, des informations relatives aux performances des prestataires doivent être disponibles. Les informations étaient mises à disposition par le biais d'un site Internet et, bien que seuls 4 % des patients aient déclaré utiliser ces données, 60 % ont affirmé avoir eu suffisamment d'informations pour faire un choix éclairé. Cinquièmement, les patients doivent être sensibles à la qualité. Certaines données révèlent qu'ils font preuve d'une certaine élasticité par rapport à la qualité en ce qui concerne les délais d'attente et les taux de mortalité. Cela implique qu'ils sont informés, et dans les asymétries d'information, les informations *ex post* sont essentielles. Les médecins généralistes sont ceux qui sont en mesure de s'appuyer sur des informations relatives au passé pour formuler leurs futures recommandations.

Les marchés concurrentiels à prix fixes ont enregistré une réduction des taux de mortalité et de la durée de séjour préopératoire. La gestion s'est améliorée sous l'effet de la concurrence et de l'exercice des fonctions de direction par des non-cliniciens. L'efficience n'a nullement été sacrifiée avec l'équité, qui s'est légèrement améliorée. Les hôpitaux des zones plus concurrentielles auraient eu tendance à accepter des patients moins avantagés après les réformes, bien que la concurrence exercée par le secteur privé ait en réalité augmenté les risques de sélection. Pour les pouvoirs publics, la concurrence doit jouer un rôle très actif : le rôle des agents des patients est essentiel pour remédier aux asymétries d'information ; la

concurrence sur le plan des prix fixes améliore la qualité, mais cela ne résout pas la question de savoir comment utiliser la concurrence pour abaisser les dépenses de santé.

Le Président oriente ensuite la discussion vers la Turquie en indiquant que la réforme de la Sécurité sociale de 2008 permet aux patients de bénéficier des services de n'importe quel hôpital sous contrat avec la SSI, qu'il soit public ou privé. Par conséquent, le nombre d'hôpitaux privés a augmenté assez considérablement en Turquie. Le Président demande comment est calculée la rémunération des hôpitaux, et si elle se fonde sur un système de GHM ou de coût majoré. Dans la mesure où la note de la Turquie est la seule à faire référence aux partenariats public-privé, qui permettent le recours à une expertise privée, le Président demande comment sont estimés les futurs revenus puisque tous les bénéfices des systèmes de coût majoré reviendraient au secteur privé, alors que les incitations sont susceptibles de bénéficier au public.

La délégation de la Turquie explique que la Commission de tarification fixe les prix de chaque type de service de santé financé la SSI en tenant compte du coût du service de santé, de la structure des coûts et des niveaux de développement régionaux, du rapport coût-efficacité des diagnostics et des traitements, du budget général des caisses d'assurance maladie et des subventions accordées par les pouvoirs publics. La SSI établit des mécanismes de rémunération appropriés en fonction de l'envergure des services fournis. La loi sur l'assurance maladie universelle autorise les dépassements d'honoraires et les prestataires privés peuvent facturer des frais supplémentaires aux patients couverts par l'assurance maladie universelle, dont le montant dépend du classement des hôpitaux. Par exemple, les hôpitaux en haut du classement peuvent facturer jusqu'à 70 % de plus que les prix de la SSI. Les hôpitaux sont classés en fonction de la qualité de leurs services, des normes de services, de la capacité et de l'envergure des services proposés. Depuis 2006, un projet pilote relatif à la rémunération des hôpitaux fondé sur le modèle australien des GHM est en place, mais il faudra attendre encore avant de pouvoir procéder à une évaluation finale des résultats. En ce qui concerne les partenariats public-privé, le délégué explique que les nouveaux établissements sont construits sur la base de modalités et d'une durée de location définies à la l'avance. Le secteur privé ne génère pas de recettes tant que les locaux ne sont pas opérationnels. Bien que la loi ait été promulguée en 2005, aucun projet n'a été finalisé mais un nombre substantiel d'investissements ont été effectués.

Le Président passe ensuite aux États-Unis, et fait remarquer que 55 % des revenus hospitaliers proviennent des pouvoirs publics, 22 % des hôpitaux sont publics et seulement 20 % sont à but lucratif. Néanmoins, les services hospitaliers évoluent en fonction des incitations du marché et par conséquent, les autorités de réglementation et de concurrence font face à des défis permanents. La différenciation *(tiering)*, un aspect déjà évoqué par le professeur Gaynor, pose question, le rôle du ticket modérateur ajustant les incitations des patients et des hôpitaux. Le Président demande si le ticket modérateur est une solution adéquate dans le cas des biens de confiance, les patients étant incapables d'évaluer la qualité du service, que ce soit avant ou après sa délivrance.

Le délégué des États-Unis (intervenant au nom de la FTC) explique que les pouvoirs publics sont les principaux payeurs, via leurs programmes Medicare et Medicaid, mais que la majeure partie des services hospitaliers sont fournis par des établissements privés, principalement à but non lucratif. En ce qui concerne le ticket modérateur et la qualité, il remarque que les asymétries d'information représentent un défi majeur, notamment sur le plan de la qualité, étant donné qu'elle est difficile à mesurer et encore plus difficile à évaluer. En ce qui concerne la relation entre la qualité et le prix, les consommateurs n'apprécient quasiment jamais pleinement le coût total des services, tandis que le ticket modérateur augmente la responsabilité financière. La différenciation est un moyen d'ajuster les incitations des patients et des assureurs plutôt que celles des patients et des prestataires. Les assureurs influencent le choix des patients en leur proposant l'option la plus économique mais en leur laissant la possibilité de choisir un autre hôpital moyennant un reste à charge plus élevé. L'attractivité est davantage fondée sur le prix que sur la qualité dans la mesure où les assureurs évaluent déjà les coûts et la qualité lorsqu'ils différencient leurs offres. En

ce qui concerne les soins intégrées, le délégué déclare que la législation réformant le système de santé adoptée il y a deux ans vise à renforcer la valeur des soins intégrés et à préserver la concurrence, qui ne s'excluent pas mutuellement. À cette fin, elle contient des dispositions sur les ACO (*Accountable care organisations*), qui visent à promouvoir la fourniture intégrée et l'adoption de bonnes pratiques. L'application du droit des pratiques anticoncurrentielles joue un rôle important dans la prévention des conséquences anticoncurrentielles inattendues, notamment pour les prestataires privés.

Le Président poursuit par une question relative aux « certificats de besoins » exigés par certains États pour autoriser la construction de nouveaux établissements. Bien que ces certificats de besoins garantissent que les établissements existants bénéficient d'un retour sur investissement correct, ils n'ont que peu d'effets sur la maîtrise des coûts. Le Président demande si les pouvoirs publics devraient identifier le niveau optimal des capacités dans le secteur hospitalier.

Le délégué des États-Unis répond que les autorités chargées de l'application des lois sur la concurrence aux États-Unis partagent le même avis sur les certificats de besoins, à savoir que les forces du marché sont mieux armées que les pouvoirs publics pour prendre et justifier des décisions relatives aux capacités. Les États ayant mis en place une certification des besoins ont été encouragés à la reconsidérer dans la mesure où sa justification initiale n'est plus à l'ordre du jour ; le remboursement sur la base du coût a été remplacé par les GHM. Les certificats de besoins font peser des coûts considérables sur les consommateurs et les marchés de la santé en créant des obstacles à l'entrée, et font l'objet d'abus. Le Président demande ensuite si les services hospitaliers des États ayant recours aux certificats de besoins se caractérisent par une moindre capacité, et donc si les certificats de besoins ont pour effet de restreindre encore davantage les capacités. Le délégué répond que les certificats de besoin ne créent pas forcément des inefficiences en termes de capacités, mais que les évaluations des capacités devraient s'appuyer sur les forces du marché. Le Président demande si les forces du marché sont en mesure de garantir des niveaux de capacité adéquats au secteur hospitalier, dans la mesure où les capacités doivent permettre de répondre aux pics de demande et non se fonder sur la demande moyenne. Le délégué répond qu'il n'est pas certain que la certification des besoins permette d'atteindre un niveau de capacité efficient.

Le Président se tourne ensuite vers l'Afrique du Sud et son secteur public de grande envergure. Comme dans de nombreux autres pays, le secteur public est largement inefficient. Le secteur privé est plus efficient et gère près de la moitié du budget du pays consacré à la santé. Les deux secteurs n'interagissent pas et la concurrence ne concerne que le secteur privé. Le Président invite le délégué à présenter de manière plus détaillée la structure réglementaire de la prestation publique et privée de services et l'implication du ministère de la Santé dans l'élaboration de la liste nationale des prix de référence dans le secteur de la santé *(National Health Reference Price List)*.

Le délégué de l'Afrique du Sud commence sa présentation par une brève description du système de santé et de l'envergure de la concurrence. La constitution prévoit la prestation de services de santé publique pour ceux qui n'ont pas d'assurance maladie. Le secteur public est financé par l'impôt et décentralisé dans chaque province. À l'inverse, le secteur privé est réglementé au niveau national, l'assurance maladie s'inscrivant dans un cadre réglementaire solide, qui interdit toute sélection des patients. Un système de tarification mutualisée au niveau d'un groupe *(community rating)* est en vigueur. Il interdit de refuser des patients sur la base de leur état de santé, et les patients malades ne peuvent pas non plus faire l'objet de surprimes. Des prestations minimales obligatoires sont également en place. Les groupes à risque ne sont pas répartis entre les régimes médicaux. La réglementation applicable aux professionnels de santé et aux hôpitaux en ce qui concerne les normes relatives aux installations et les licences est définie au niveau des provinces.

Une part importante des dépenses de santé relèvent d'une assurance maladie privée volontaire. Le niveau des équipements et des dépenses de haute technologie est relativement élevé par rapport au niveau

de développement, alors que les résultats médicaux sont mauvais. Le marché des hôpitaux privés est fortement concentré ; en raison des fusions menées à la fin des années 1990, on ne compte que trois grandes sociétés d'assurance, et les primes n'ont cessé augmenté depuis 2000. Le délégué identifie cinq difficultés majeures : déséquilibres du pouvoir de marché, relations verticales entre les groupes hospitaliers et leur chaîne d'approvisionnement, conflits d'intérêts, emploi des spécialistes et des médecins généralistes dans les hôpitaux privés et augmentation du nombre de licences hospitalières octroyées afin de réduire la concentration du marché dans les grandes zones métropolitaines. Enfin, le délégué cite la création d'une autorité légale de réglementation des prix comme une solution possible.

Le Président demande des éclaircissements quant à la relation entre les secteurs publics et privés. Le délégué répond que les rôles sont séparés, mais que de nombreux spécialistes du secteur public travaillent également dans le secteur privé et sont rémunérés sur la base d'honoraires. Le Président demande ensuite la raison de la forte concentration du marché hospitalier privé. Le délégué répond que la plupart des fusions et acquisitions des années 1990 ont conduit à une concentration du marché au fil du temps et ont été contestées par l'autorité de la concurrence, mais validées par les tribunaux en raison d'une insuffisance de preuves et d'un avis positif sur le rôle que les assureurs privés seraient susceptibles de jouer dans la maîtrise des coûts.

Enfin, le Président pose la question de l'impact de ces fusions et de la croissance interne sur les capacités. Le délégué répond qu'il existe actuellement un excédent de capacité avec un taux d'occupation de près de 70 % dans le secteur privé, ce qui encourage une prestation excessive de services de santé.

Le Président fait référence à la note du Comité consultatif économique et industriel auprès de l'OCDE (BIAC), qui salue le rôle du secteur privé dans la promotion de l'innovation et l'amélioration de la diversité et du rapport coût-efficacité dans les services hospitaliers en Europe et aux États-Unis. Toutefois, le secteur privé européen ne détient qu'une petite part de marché, principalement dans les traitements les moins pointus. Le Président demande si le BIAC attache de l'importance aux dispositions sur les services universels dans le secteur hospitalier, et si une intervention publique est jugée nécessaire. En outre, le Président demande si les privatisations devraient être encouragées dans le secteur hospitalier, bien qu'il remarque que ce point n'a pas été abordé au cours du débat.

Dans sa présentation, le représentant indique que le BIAC a un point de vue très particulier et porte un intérêt réel au capital humain, tout en étant souvent un payeur de services hospitaliers. En ce qui concerne la privatisation, le représentant reconnaît qu'il ne s'agit pas forcément de la solution la plus adaptée pour tous les pays. En ce qui concerne la prestation universelle de services, le BIAC est favorable aux soins universels, mais les moyens de mise en œuvre dépendent de l'économie et de la culture du pays. Ensuite, le représentant présente les avantages d'une implication du secteur privé dans les services hospitaliers. D'abord, la concurrence encouragera le comportement entrepreneurial en termes de prix et de qualité. À cette fin, les fonctions d'acheteur et de fournisseur doivent être séparées et une concurrence loyale entre prestataires publics et privés doit être garantie, d'où la nécessité d'une gestion impartiale de la répartition public-privé et d'une rémunération égale. Il convient également de s'abstenir de favoriser les hôpitaux en déficit. Deuxièmement, les capitaux privés peuvent être investis dans la construction d'installations, et en effet, de nombreux hôpitaux privés découlent de constructions nouvelles plutôt que de privatisations. Troisièmement, le secteur à but lucratif est imposable et contribue par conséquent à l'économie. Le BIAC est plus favorable au droit des patients à choisir les médecins et les hôpitaux qu'au rationnement des soins. Quatrièmement, les assurances privées peuvent contribuer à améliorer l'accès pour tous. Enfin, il fait référence à une analyse de publications antérieures relatives à l'expérience des États-Unis, qui figure dans la note à des fins d'information.

Le Président se tourne ensuite vers la France et déclare qu'un système de GHM est en vigueur pour la rémunération des services hospitaliers. Le Président s'enquiert des conséquences pour les hôpitaux les

moins efficients si les coûts ne sont pas couverts. Il demande également pourquoi aucun système privé ne s'est développé si les GHM couvrent également les coûts fixes.

Le délégué de la France confirme qu'un système de tarification à l'activité (GHM) est en vigueur depuis 2005. Après la mise en œuvre de cette méthode de rémunération, un système de surveillance des déficits budgétaires a été mis en place. En outre, les agences régionales de santé sont chargées de contrôler la situation financière des hôpitaux. Tout d'abord, au sein des hôpitaux, la commission de surveillance, une sorte de conseil d'administration, peut demander un audit interne en cas de mauvaise gestion financière avérée et adopter un plan de redressement. Le délégué souligne que ce système est similaire au système norvégien. En effet, si le plan de redressement ne parvient pas à améliorer la situation et que le déficit excède 2.5 %, l'administration de l'hôpital peut être confiée provisoirement à des agents chevronnés. La dette des hôpitaux publics a diminué au cours des dernières années et n'est plus considérée comme préoccupante pour la fourniture de services de santé. Le délégué remarque également qu'une mise sous administration provisoire est également d'actualité lorsque les dirigeants ne parviennent pas à garantir des prestations de services de haute qualité. En ce qui concerne la dernière question, le délégué indique qu'il existe un système public hospitalier avec des responsabilités de service public, et un marché hospitalier privé à but lucratif et non lucratif. La Loi sur le financement de la Sécurité sociale vise à combler les écarts de prix entre les secteurs public et privé, malgré les difficultés. Par exemple, les opérateurs privés ne fournissent pas services publics et tendent à se spécialiser dans les disciplines les plus rentables plutôt que de proposer une offre intégrée.

4. Application du droit des pratiques anticoncurrentielles aux services hospitaliers

Ensuite, le Président ouvre le débat sur l'application du droit des pratiques anticoncurrentielles en faisant référence à la note norvégienne. La Norvège évoque un certain nombre d'affaires de soumissions concertées dans le secteur des services de transport des patients des hôpitaux ainsi que des services de santé. La soumission concertée, une pratique très répandue, est difficile à identifier, car elle nécessite des informations relatives aux soumissions, et l'administration soumissionnaire n'est nullement incitée à la transparence. Le Président demande comme les affaires décrites ont été découvertes.

Le délégué de la Norvège confirme qu'au cours des dernières années, quelques cas de collusion liés à des appels d'offres dans le secteur du transport des patients ont été recensés, et il explique que les deux cas décrits dans la note n'ont pas été difficiles à découvrir dans la mesure où il n'y avait qu'un seul soumissionnaire. Ces cas soulignent l'importance d'une concurrence efficace dans les marchés publics, et pour illustrer son propos, le délégué indique que l'évaluation *ex post* d'une de ces affaires a estimé le montant des économies publiques à près de 2 millions NOK par an. Le délégué ajoute que l'autorité norvégienne de la concurrence a récemment envoyé des informations aux acquéreurs publics quant aux procédures à mettre en œuvre pour détecter les soumissions concertées et concevoir des appels d'offres moins vulnérables, et informer l'autorité de la concurrence.

Le Président passe ensuite aux États-Unis et remarque que le pays a une longue tradition de contrôle des fusions dans les services hospitaliers. Une analyse majeure entreprise en 2002 a mis en évidence qu'une définition imprécise du marché concerné a été utilisée pour annuler plusieurs fusions et qu'un pouvoir de marché était exercé. Par conséquent, la FTC a adopté une approche plus rigoureuse avec une estimation plus directe du pouvoir de marché cohérente avec les nouvelles lignes directrices relatives aux fusions. Dans ce contexte, le Président remarque que les exigences relatives aux données nécessaires pour cette estimation étaient très strictes et demande si les données disponibles étaient suffisantes. Deuxième résultat de cette analyse, les hôpitaux à but lucratif ne se comportent pas différemment des autres hôpitaux en ce qui concerne l'exercice du pouvoir de marché, et le Président demande comment ce concept a été défini.

Le délégué des États-Unis déclare que la FTC a tenté d'empêcher les fusions dans les années 1990, mais que ses recours ont été rejetés par les tribunaux en raison de l'envergure des marchés géographiques et d'une présomption selon laquelle les établissements à but non lucratif n'imposeraient pas de hausses des prix à leurs communautés. L'étude conclut qu'ils ont exercé un pouvoir de marché et que cela a renouvelé les efforts de mise en œuvre. Une étude et une modélisation soigneuses ont été entreprises pour mesurer l'intensité de la concurrence entre les deux parties à la fusion sur la base des données relatives aux sorties des patients collectées par la plupart des États.

Le Président se tourne vers le Japon, où la Commission japonaise des échanges équitables (JFTC) s'est engagée en faveur de la défense et du respect du droit des pratiques anticoncurrentielles dans le domaine des soins de santé. Faisant référence à la note écrite préparée par le Japon, la JFTC mentionne l'existence de restrictions en matière de publicité pour les hôpitaux et le Président demande si elles sont toujours en vigueur et s'appliquent à la fois aux hôpitaux publics et privés. Il demande également les raisons motivant ces restrictions dans la mesure où la publicité est généralement autorisée puisqu'elle est considérée comme un moyen d'informer les patients.

Le délégué du Japon explique que la JFTC a réuni un groupe d'étude sur la réglementation des services hospitaliers dans le cadre de la politique de la concurrence et a publié un rapport en 2002. Ce rapport souligne trois points. Toute d'abord, les patients doivent avoir le choix et les hôpitaux doivent se livrer concurrence. Ensuite, le pouvoir de négociation des patients et des assureurs doit être amélioré. Enfin, les réglementations du côté de l'offre et de la demande doivent être revues afin de promouvoir la concurrence. En ce qui concerne les restrictions en matière de publicité, le rapport indique que la publicité doit être libéralisée, afin de permettre aux patients de faire des choix plus éclairés et de garantir une concurrence loyale. Pendant de nombreuses années, le système entériné par la Loi japonaise sur les soins médicaux permettait uniquement la publication d'informations objectives et vérifiées, mais en 2007, l'étendue du contenu publicitaire a été élargie. En décembre 2010, un projet de réforme visant à lever les restrictions publicitaires pour les hôpitaux publics et privés a été proposé par le groupe de travail établi dans le cadre du sous-comité de « l'Unité de revitalisation du gouvernement ».

Le Président résume les débats de la table ronde en indiquant que pour que la concurrence fonctionne, des incitations sont nécessaires du côté de l'offre comme de la demande. L'offre doit répondre à la demande, notamment dans les systèmes financés par les pouvoirs publics. Lorsque des sociétés d'assurance sont impliquées, le choix des patients doit affecter les revenus des hôpitaux et des parties prenantes. Dans un nombre restreint de pays, telles la France et l'Allemagne, des mesures sont prises en cas de déficit hospitalier, mais excluent la mise en faillite. De même, le Président souligne que les hôpitaux n'ont généralement pas la flexibilité nécessaire pour imposer des baisses de coûts aux parties prenantes, comme des licenciements ou des baisses de salaires.

Le Président souligne également l'importance d'éclairer les décisions des patients et de favoriser la concurrence entre hôpitaux. Les études montrent qu'il existe une réelle demande des patients en faveur du choix, et que dans les pays où des possibilités de choix ont été instaurées, elles ont été particulièrement bénéfiques pour les individus à faible revenu.

Enfin, le Président déclare que la gestion des hôpitaux revêt une importance majeure et avertit que les médecins ne sont pas forcément compétents en la matière, notamment dans le secteur public. De même, les intermédiaires jouent un rôle essentiel et leurs incitations doivent être ajustées à la fois aux besoins des patients et à ceux des pouvoirs publics.