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Summary of Discussion of the roundtable on Designing Publicly Funded Healthcare Markets

Annex to the Summary Record of the 66th Meeting of Working Party 2 on Competition and Regulation

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This document prepared by the OECD Secretariat is a detailed summary of the discussion held during the 66th meeting of Working Party 2 on 26 November 2018.

More documents related to this discussion can be found at
http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm

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Summary of Discussion on the Roundtable on Designing Publicly Funded Healthcare Markets

By the Secretariat

The **Chair** introduced the topic of the roundtable: designing competition in publicly funded healthcare markets. He said that for many people, government-funded provision is the only realistic supplier of healthcare services, which are essential inputs into leading a productive, fulfilling, and satisfying life. However, public funding alone, does not incentivise high quality efficient healthcare. Therefore, although there are no guidelines how to use competition mechanisms in healthcare system, most OECD countries have moved towards greater use of market mechanisms, such as competition and consumer choice, aiming to improve the quality and efficiency of these services. However, there are indications that suggest these incentives are often too weak.

Before starting the roundtable discussion, the Chair introduced the panellists: Professor Allan Fels, from University of Melbourne, Monash & Oxford; and Professor Laura Hartman, from Uppsala University, Sweden.

The Chair explained that the discussion would be organised around four main topics: (1) The role of the market when demand is driven by need; (2) How to advance consumer choices in healthcare; (3) How to make sure that capacity meets demands, and (4) Recent processes of reform.

He then gave the floor to **Prof. Allan Fels** to make a presentation on competition and choice in healthcare. Prof Fels started with the proposition that health is a large portion of GDP but there is scope for choice and competition. **Prof. Fels** explained that healthcare is highly government subsidized and the way that subsidies are paid strongly affects the scope for choice and competition. Prof Fels suggested two main explanations why governments intervene in healthcare services: (i) Competitive markets for short-term health insurance cannot protect customers from the risks of long term or chronic health conditions; (ii) Access to healthcare is important for equality of opportunity.

Prof. Fels, then, focused on achieving competition as a tool to deliver greater efficiency and better outcomes for consumers and users of health care and the challenges to be consistent with government objectives. First, he framed the scope of competition in the health care sector: (i) More competition is feasible for most common medical procedures; (ii) Patients are not well-informed and are likely to need assistance in making choices; (iii) It is important that hospital be able to compete and be able to enter and exit the market. However he recognised that there are political difficulties in allowing hospitals to close.

Second, he described several problems with payments in healthcare markets, which have led many countries and systems to use various forms of fee-for-service or prospective payments. The first problem he mentioned was the ***cream-skimming*** problem. This can occur because the cost of serving individual customers can vary from being quiet high to quite low, and so a firm can have an incentive to identify and refuse to serve some patients if the profit from treating them is small relative to the profit available from treating other patients. **Prof. Fels** described two policy approaches to this problem. One approach is to prohibit discrimination. However, there are some easy ways for firms to avoid and evade these restrictions on discrimination. Another approach is to categorise forms of illness, types of patients, and their health problems very precisely, to granulise each service so that

the payment is much more closely related to the likely cost of the service and that means that in many countries, instead of there being a general fee for service there are numerous categories. Even then, however there remains the risk, within each of those categories of cream skimming. Prof Fels explained why in health systems, we use carefully differentiated, categories diagnostic related group (DRG). He described that in Australia, they have an independent hospital pricing authority, whose role in life is to classify all the different forms of health (and mental health) treatment. To do this, it is required to collect data on the costs of serving each category of patient, to derive an average cost, then to set a price based on that average cost, then to allocate funds to hospitals, based on that approach.

The second problem he mentioned, with the fee-for-service payment system, was that it might lead to ***over-service***. As long as the fee paid by government exceeds the fee of providing the service, the supplier has the incentive to provide a medical service even is not needed. Especially in medicine, there is a conflict of interest, when the same doctor or the medical provider can sometimes be both the judge of whether the service is needed and at the same time the economic beneficiary of providing the service. **Prof Fels** said that there are no easy policies for this problem. One of them is instead of paying for a service you pay the doctor per patient, which makes the provision of service independent of the fee paid to the doctor, so it gives the doctor some incentive to economise on the service, but this could lead to underservicing. However, there is a lot of scope for competition between doctors and it is possible that to some extent, competition would sort out that problem. Doctors that underservice lose patients and then as a result, you do get some market correction for that problem. An alternative is to separate diagnosis from treatment as is the case in countries that use general practitioners as gatekeepers to further care.

In addition, the last problem **Prof Fels** mentioned was that there could arise a conflict with other government objectives, especially with the equality of opportunity view that everyone should have equal access to health services. **Prof Fels** mentioned particularly the ***topping up*** problem, which is the problem that many consumers are willing to pay more to get better service or more service from the doctor. Allowing scope for top-ups therefore leads to competition conflicting with the objective of equal access to healthcare.

Prof Fels also discussed some enforcement matters that arise for competition authorities, including anticompetitive restrictions, particularly in the labour market, which arise because many doctors or healthcare providers have exemptions from the competition law or have direct government protection, because many workers in the health services, even the specialists, are classified as employees. However, there is a significant number of people in medicine profession, including specialists, who operate independent businesses and in principle are covered by competition law and so there are numerous questions about price fixing, entry restrictions, market sharing and other unlawful conduct, such as mergers and anticompetitive practices like entry restriction.

Prof Fels concluded that since we want healthcare delivered as efficiency as possible, choice and competition have a roll in enhancing incentives but the pro-competitive reforms have to be done in a way does not undermine the underlying social problem. Attention must be taken to ensure customers are willing and able to make an effective choice and that effective competition can be sustained.

The **Chair** thanked Prof Fels and asked him if whether in Australia there are both public and private hospitals and whether the authority addresses pricing for both public and private providers.

Prof Fels explained that in Australia, they have a very large private sector that is governed by competition law and there is a quite heavy overlay of government intervention in regard to private health insurance which 30-40% of the population take out. There is community re-rating, that is, that if one health insurer manages to attract healthy consumers and others do not, then the government re-arranges the payments that are made to reflect the different costs of these different groups. Regarding the independent pricing authority for the private sector, **Prof Fels** said that overall it works. On the other hand, if you take mental health, the variation is enormous, and the scope for gaming is equally enormous. Therefore, the authority has not been able to apply a pricing system to that.

The **Chair** then asked the UK about the payment by results system. In particular he asked how the prices are identified, whether there is a market price or if it is administratively determined.

The **UK** explained that prices paid by hospitals in the UK are determined by a national tariff system. Before these reforms, hospitals operated under annual budgets and under block contracts, which were negotiated annually. This payment system incentivized hospitals to run at a deficit, since an overspend one year would lead to an increased budget for the hospital the following year, whereas a hospital underspending was not permitted to retain surpluses. However, the national tariff system effectively caps the prices that are paid by commissioners for most forms of healthcare in the UK and those changes are intended to incentives hospitals to compete for patients based on quality rather than on price. Those tariffs are set out in legislation, the most recent round was 2012 Health and Social Care act, and covers most forms of healthcare. The UK explained that there are exceptions and qualifications to the standard approach to setting the tariff. In some instances, the system allows for regional variations, which may better reflect local specific costs. There are also national health services without national prices, in those instances, the commissioners and the providers have to work together to ensure that the price is in the best interest of patients. This can raise competition concerns, but it is intended that those are reached on the basis of transparent criteria following constructive engagement between both sets of parties.

The **Chair** then asked Norway about the Norwegian healthcare system, in which patients have the possibility to choose their general practitioner, and the income of these general practitioners depends on the number of patients they have. In particular, he asked how is entry in the market organized for general practitioners, whether any doctor can become a general practitioner or whether the number is fixed by legislation, and is there a national competition to be a general practitioner or do people just apply.

Norway first mentioned that services are financed by general taxation so for the most part, prices are fixed and they are very low. Then Norway described that patients are free to choose their general practitioner within the national health services as long as that chosen general practitioner has available capacity, and in 2017, only 36% of general practitioners had vacant slots and this may limit patients' choice, especially in local areas where there are few options and perhaps less competition. When it comes to entry, the general practitioner needs a licence and a contract with the municipality and they just need to apply. The number of general practitioners within each municipality is regulated by the Norwegian Directorate Health, who decide the number of general practitioners, and based on demographic figures like the size and age of the population.

The **Chair** asked Norway about hospital funding system, which is fully financed by the government without co-payment. In particular, he asked if patient choice affects the revenue of hospitals both for elective and non-elective treatment.

Norway explained that half of the hospitals' funding comes from a block grant and the other half comes from activity-based, diagnosis related group (DRG) funding. The block grant is unconditional on the number of patients treated and is supposed to give incentives to reduce costs, while the DRG system is supposed to give incentives to compete for patients. The DRG price on the national average costs of a given medical treatment, therefore hospitals are paid conditional on the actual treatment provided so the more patients, the more DRGs the hospital will receive. Because the hospital funding is mixed, patient choice of specialized healthcare affects the revenue of the hospitals.

The **Chair** then turned to Italy to explore how consumer choice in healthcare can be improved. He described an additional problem with competition, that health providers, in order to improve their revenues may strategically change quality or refuse to treat complicated or not well-paid cases. Then he asked Italy about performance of hospitals, that in recent years, hospitals receiving public funding in Italy are obliged to provide data on waiting times and quality, and what are the outcomes of these statistics. In particular, he asked if the statistics help patients to choose according to waiting times and quality or whether they affect the way hospitals are reimbursed, that is whether there is a direct link between these statistics and the payment to the hospital.

Italy explained that the national authority for healthcare services elaborated and published 166 indicators that encompass the outcome of the service, cost, process, and customer satisfaction. However, because some of the indicator are very specific and sophisticated it is unlikely that consumers might get helpful information from that. Therefore, the advocacy intervention, by the competition authority, was to encourage the national agency to simplify this data and make it public in an accessible way through a website. In addition, Italy mentioned that the main task of this regulatory agency is to monitor the quality of the healthcare providers and the first indications are that the mere fact that they introduced this kind of discipline, because healthcare providers felt that they were monitored, had already introduced some positive evolution. This is reflected in results improving despite budgetary cuts.

Italy also put this advocacy intervention into a broader picture. In 1992, the Italian government tried to introduce some competition and consumer choice in the healthcare service. Therefore, the competition authority advocated to the government how to implement these interventions. First, to ensure entry, the authority realized that the regions were organising regulatory barriers to entry in terms of authorization and accreditation of providers, and advocated for the elimination of these barriers. Second, to introduce incentives for the providers. In Italy, local health agencies have had the dual role or purchaser and provider and that hinders incentives. Finally, for consumer choice, the authority advocated for information to be available to consumers.

The **Chair** then asked UK about the proposal by the health service to abandon competition in favour of a collaborative approach. Vertical integration of providers into a single entity that provides a full range of community, mental health and hospital services. However, competition among these vertically integrated entities would then be very limited. In particular, the Chair asked UK to explain why there has been such a change and if the CMA has had any role or voice in it.

The **UK** said that the UK model would be moving elements towards a more collaborative approach as part of the five year plan that was produced by the national commissioning board in 2014 which proposed care models that would integrate care in local areas. One of those models is the multi-specialty community provider (MCP), which brings together large groups of General Practitioners to enable them to offer a broader range of services,

including community and outpatient services. The intention was to create opportunities for providers to innovate in certain elements of the offering, payments, contracting and organisational structures so that the delivery of the services is still provided by the General Practitioners but coming together to collaborate in the broader structure of delivery.

The UK said that this is still in its early stages and needs time to mature and they have not yet seen the new model leading to improvements. However, the competition and markets authority and the regulator of the healthcare sector in the UK are very aware that integration and greater coordination can provide questions on consistency with competition and procurement law, which mean that there will be great sensitivity in the design of those models to make sure they do not breach competition law.

The **Chair** asked if "community providers" mean rural communities, or widespread within the country?

UK replied that community here means across a "local" are, so it could be in rural areas or in parts of cities.

The **Chair** then turned to Romania and asked about the hospitals reimbursements system, which is based on standard costs associated with each treatment, and about the competition authority's suggestion that such a systems of reimbursements might lead providers to reduce quality in order to reduce costs in relation to the fixed price they are receiving. In particular, the Chair asked if the competition authority have evidence that this is happening, or has happened. In addition, he asked what would happen if hospitals would lose patients and bad performing hospitals' patients would prefer especially for elective treatments to go to other hospitals that do not have these bad performances, would hospitals be forced to restructure or leave the market, or would bad performance still have no penalty.

Romania explained that the Health system reforms comes with an element of competition in terms of free competition between suppliers who have contracts with the national health insurer and also patients' freedom to choose between health care providers. Romania described that hospitals are paid based on DRG (diagnosis related group) systems and the national health insurer buys services from public and private providers. However, in 2015, health authorities decided to change the reimbursement formula in favour of the public health units. This change led to the existence of different reimbursement values based only on public/private criteria for the same kind of medical service that was provided. If the hospitals are not paid according to the quantity and quality they provide, they are no longer incentivised to compete for the patients and that led to increased financial pressure on the state budget. Therefore, the equity of the providers' payment system is more important so that patients can benefit from real choice between public and private providers. In addition, Romania assessed the most frequent DRG and their profitability and they found out that both in case of the public and private hospitals, those payments are unprofitable. Therefore, when the level of remuneration is not optimal that can lead to unwanted results such as suppliers only taking on low-cost patients or incentivising them to reduce quality. Instead of advising that the reimbursement reflects efficiently incurred costs, the competition authority said that it has advocated for the introduction of co-payments.

Romania also said that while there is no quality data, there is nevertheless a punishment for hospitals who provide poor quality because if a patient is readmitted to another hospital, the first hospital has to cover the costs incurred by the new hospital.

The **Chair** then turned to Estonia and asked how private hospitals are funded and whether there is private insurance that tops up what the government provides and whether patients can freely choose between private or public hospitals.

Estonia explained that their Health Insurance covers the medical treatment, and when the treatment is funded by the health insurance fund, the treatment is free for the patients. Therefore, a contract with the health insurance fund secures healthcare providers patients and turnover. However, the Health Insurance Fund prefers to use state hospitals. Therefore, private hospitals are funded mostly by private demand from patients, and only to some extent by the health insurance fund. Therefore, the competition authority suggested that the law should be amended to have clear and transparent criteria for the distribution of treatment funding between healthcare institutions.

The **Chair** then turned to Indonesia and asked them to describe the healthcare system in Indonesia.

Indonesia explained that the system only started in 2014 so they still struggling to implement publicly funded healthcare in Indonesia. Many complaints come from people and hospitals because there is limited funding from the government. It also takes a long time for the national health insurance to pay the hospital.

The **Chair** then asked the Netherlands about a statement from their submission: "there are no waiting lists in the Netherlands", in particular he asked how this is possible since the insurer is responsible for the waiting list but is not vertically integrated in the supply-chain. The insurer is therefore not the one that supplies, so how can he make sure that the hospitals indeed are quick so waiting lists are minimised or zero. In addition, he asked if this elimination of waiting lists was achieved through a market mechanism or through some administrative decisions related to capacity.

The Netherlands mentioned first that they have mandatory insurance to combat adverse selection, so that healthy people will not avoid buying health insurance. Moreover, to make sure that this mandatory insurance is meaningful, they determine the size of the basic package, because if you allow people to only insure a little part of the coverage that is the same as selling no insurance at all. The Netherlands said that it could be the same with waiting lists. If you only contract hospitals with very long waiting lists, you offer no insurance. This insurance would definitely be much cheaper, and you will run into the problem of adverse selection. That is the reason why waiting lists in principle are not allowed in the Netherlands. In addition, the Netherlands explained that when they said there are no waiting lists, they mean a waiting list as something that is above the norm of waiting. The sectors themselves agreed on acceptable waiting times and the insurers are obliged to ensure that patients can get care within these norms. In hospital care, that succeeds pretty well although they see some increase in waiting times, but it means that insurers need to make more effort to raise enough capacity, so they have to increase prices. Therefore, this goes hand in hand with liberalisation. For example, suppose that you see waiting lists in one group, you expect that market mechanism would lead to higher prices for the group on the waiting list. However, in mental health sector, prices are regulated for certain groups, and its lead to many waiting lists. That is because the relative prices cannot adjust. They also explained that when hospitals go bankrupt, the insurer has to make sure that someone else in the region will take over and provide timely care for the patient.

The **Chair** asked what happens to an insurer that does not comply with the waiting time limitations that are mandatory, is there a penalty? In particular, what happens if there is a higher waiting time than required?

The Netherlands said that there is a stiff penalty and the Dutch health care authority enforces these rules and they can give these penalties to insurers, but that they have never done that before because the insurers comply with the rules.

The Chair then moved to Argentina and asked about the three-layered insurance system in Argentina. Where one layer was for the needy, 34% of the population; one for the mandatory insured, 53% of the population and one for the privately insured, for the rest of the population. In particular, he asked if these three layers are completely separate, or whether there is just the possibility for everyone to go everywhere, to be treated in any hospitals, and if that is not possible in the system, if there is competition among service providers that is being driven by patient choice. For instance, if patients choose one hospital, would that hospital increase its revenue, and would a hospital that does not have as many patients see decline in revenue?

Argentina explained that they have three groups. Each group has their own providers, for example, the public healthcare sector is universal coverage, so everybody can go to these facilities and these public hospitals. In the social security sector, where there is social insurance, which is a public insurance funded by payroll contributions, there was a reform about 15 years ago that meant that each provider can compete with each other. Private insurance is another issue.

In addition, **Argentina** described three big policies from different areas of the government to give more competition to the healthcare sector. First, the negotiation for the procurement of medicines involved the government, and the business associations and laboratories negotiating on the conditions, prices and commercial issues about how to provide this to the public healthcare sector. Now, the government is reforming this process. One of the big reforms is social security for elderly people, who account for about 40% of demand of these medicines. They will negotiate individually with each medicine producer and not with the cartel of laboratories. The contracts are changing, and this is an issue where the competition authority was involved, advising how to improve the mechanisms and procedures to improve competition. A second reform, is to make competitive tenders and auctions for high-cost medicines and this was another issue where the competition authority gave advice on how to design the auctions and the competition and the first results have delivered 80% savings in procurement of medicines. The third issue is a market investigation into the distribution and logistics of medicines, in all the production chains. The competition authority is going to make recommendations about how to improve the competitive functioning of the sector to create more transparency and more competitive incentives for laboratories (the producers of medicines).

The Chair then turned to Chinese Taipei and asked about their mandatory health insurance system, in which quality is assured by careful review mechanisms. In particular, he asked how public hospitals receive their revenues, are they paid by service or with the government covering their costs. In addition, he asked if public hospitals are still funded when capacity utilisation is low, and whether to open a new hospital you need authorisation and if the authorisation is based on needs.

Chinese Taipei explained that the national health insurance adopted a single payment system, a unified payment standard with healthcare services covered by national insurance, and they do not distinguish between public and private hospitals. In addition, the authority began conducting hospital evaluations to prevent the situation of low capacity. The authority found a low capacity usage rate even in public hospitals. In addition, Chinese Taipei explained that the assessment and authorisation of healthcare institutions, including hospitals and clinic, was approved from the authority of health in accordance with the medical care act. Last, Chinese Taipei said that the goals of the authority of health are to control effectively healthcare expenses without wasting healthcare resource and at the same

time, maintaining healthcare service quality. In order to attain these goals, the authority has started additional reform to avoid bigger healthcare expense abuse of the system.

The **Chair** asked if the employees of public hospitals are state or private employees, and if they can be fired by public hospitals.

Chinese Taipei answered that according to labour laws in Chinese Taipei they cannot fire employees without justifications. Moreover, the State professionals, in general, enjoy a better treatment for employment.

The Chair then turned to Austria and asked about a market study of the pharmacy sector, that was conducted by the Austrian authority. One of the suggestions was to liberalise the sector and the prerequisite for pharmacy to entry to be eliminated. In particular, he asked why the authority did the report and how the report was received, especially by pharmacists, and what were the political reactions to the publications.

Austria replied that the sector enquiry was initiated because of complaints, cases and legal provisions and the authority wanted to have a look at whether they raised competition concerns or not. To clarify the recommendation on the needs' assessment as a prerequisite for the entry, for pharmacies, the authority recommended either eliminating or altering it, if it cannot be eliminated. The reason for that is that in Austria there is a very low pharmacy density of around 15 per 100 000 persons, compared to 25 which is the OECD average for example, and the market could benefit from more pharmacies. Additionally, the reaction of the chamber of pharmacies was very critical, saying that the market gives the opportunity for a higher density and these results and conclusion raised a political discussion in the health committee in the Austrian parliament. In addition, an amendment of the pharmacy act is going on and it will probably clarify section 12 of the pharmacy act, which gives a very high discretion to the responsible authorities for granting a license for a pharmacy. Then probably, this will lead to clearer provisions and clearer enforcement of these provisions by the authorities.

The Chair asked if in Austria are there pharmacists without a pharmacy. Does every pharmacist have a pharmacy, or are some unable to get a pharmacy.

Austria answered that there are many pharmacists unable to get a pharmacy.

Then the **Chair** asked Austria to explain why the authority suggested maintaining the ownership limitation on pharmacies.

Austria replied that the authority see the ownership restrictions as critical, because of the risks of vertical integration and the strong influence of wholesale on pharmacies. The authority do not doubt that the license for running a pharmacy should be granted to a pharmacist only. The authority has recommended that pharmacy chains should not be allowed in order to restrict the influence of wholesalers on pharmacies, and so the authorisation should only be granted to a single person, who can own one pharmacy and two additional branches.

The Chair added that in many countries big chains of pharmacies have emerged because of liberalisation, which are independently owned, not necessarily by pharmacies, or wholesalers. Entrepreneurs own them.

Austria added in this context, that there are grocery stores that tried to gain access to this market. There was issued an application at the Austrian constitutional court, twice in the last three years, it was dismissed in both cases but not on the merits. They suggested that

grocery stores might ensure that the pharmacist is always represented in the pharmacy and that they probably will try an application a third time.

The Chair then turned to Lithuania, which have a negative opinion to a bill that was meant to create hospital pharmacies. In particular, he asked what the economic rationale behind this bill was, and why these hospital pharmacies were created. Was it to expand supply of drugs to the population or to have reduced price of the drugs, because hospitals purchase drugs at much lower prices than pharmacies, or whether the objective was to serve areas where there are no pharmacies.

Lithuania explained that there were several draft amendments to the law. The first draft amendment was registered in May 2017, and suggested that hospital pharmacies should be established not only as a division of healthcare services' institution, which would supply pharmaceuticals to these institutions, but they would also perform the functions of the public pharmacy. Further amendments went even further, in September 2017, it was suggested that hospitals' pharmacies might sell pharmaceuticals to the patients for whom healthcare services were provided in the day stationary, but they may also sell pharmaceuticals remotely. The third amendment was suggested in April 2018, according to which such hospital pharmacies could sell pharmaceuticals to consumers. The concern of the Competition Council was that these amendments suggested the establishment of a chain of State pharmacies which might enjoy privileges that led to more efficient pharmacies being pushed out of the market. The Competition Council was therefore critical with regard to these draft amendments and issued opinions to all three-draft amendments that were registered.

According to the Competition Council, the proposed amendments gave no proper explanation of why the participation of the State in this regard was necessary and what the long-term effect on competition would be. It also said that no cost benefit analysis had been performed on the proposed system. The Competition Council referred to article 46 of the constitution of the republic of Lithuania according to which the freedom of economic activity is guarantee and which states that the State shall regulate economic activity in a way that serves the welfare of its people. Accordingly, the Competition Council said that the constitution states that the basis of the Lithuanian economy, is private ownership and that freedom of economic activity so the role of the State is to promote, support, safeguard and regulate such activity. The Competition Council stressed that in its view only when sufficient data exists about the fact that particular services are necessary in society and cannot be guaranteed by effective competition among private undertakings should the State can take an initiative to promote such services. It suggested that there was no evidence that in the pharmaceuticals retail market there was such a market failure that could be corrected only by the intervention of the State. I considered that the proposals may create risks such including conflict of interests and state-aid concerns.

Therefore, Lithuania noted that the regulation of economic activities should be such that it creates most beneficial conditions for effective competition based on which the benefits may go to consumers, and the State as a whole. Such a regulation should not amount to overregulation and protectionism. Regulation should be clear, transparent and non-discriminatory. The Competition Council therefore opposed the draft amendments. The outcome was that in June 2018 these amendments to the pharmacy law were adopted. They entered into force on November 1st this year. In the final law, it said that hospital pharmacies might provide pharmaceuticals also to the day stationary services, to the services who get the day stationary services, but that they cannot sell pharmaceuticals remotely.

Then the **Chair** moved to discuss the issue of generics, and he turned to Croatia, where the health ministry guide recommended that general practitioners should prescribe the cheapest medicine within the medicine group of the same composition. Therefore, if there is a generic, the General Practitioner is obliged to prescribe it. The **Chair** asked Croatia to explain why the health ministry did not follow the competition authority's suggestion that patients can pay the additional price of the brand of their choice.

Croatia described that the guide of the new referral model was issued by the Croatian health fund and it works out criteria for General Practitioners who are responsible for taking final decisions over prescription drugs and the therapy they propose. The guide recommends that General Practitioners in principle should prescribe the cheapest medicine within the medicine group of the same composition. This guide seems to conflict with the recommendation and therefore it should not be binding. In practice, it defines the practice of General Practitioners in prescribing drugs, and this might indirectly affect the medicine market. Croatia explained that the competition authority holds the view that the application of such a guide may have exclusionary effects on the medicine manufacturers whose products are on the market but are not the cheapest of the particular therapeutic group. The manufacturers of these medicines are excluded from the market despite the fact that they are including in the list covering the drugs that are fully reimbursed. In other words, the final consumer, the patient does not have the right to choose the medicine from this basic list even though he might wish to compensate for the difference between the price of the medicine in question and the reference price of the drug. Moreover, this medicine cannot be in the same place on the supplementary drugs replacement list where it is only available to the final consumers, by her or his direct or indirect contribution on the basis on supplementary health insurance plan. Such a situation significantly reduces the consumers' final freedom of choice relating to the medicines from the basic drugs reimbursement list. This opinion was communicated to the ministry of health and things have changed. Practice has changed, and General Practitioners can prescribe any medicine on the reimbursement list, irrelevant of the price and General Practitioners, doctors cannot be fired anymore for not prescribing the cheapest medicine on this list.

Then the **Chair** moved to the topic of public procurement, by asking Russia about the market for maintenance of medical equipment and their suggestion that when medical devices are purchased, the supplier should also transfer together with the medical device, information and passwords for the electronic part of the medical device. So, that it could be maintained in competition with others.

Russia explained that in the process of healthcare reform in Russia, the Federal Antimonopoly Service faced the issue of insufficient provision of information by producers and distributors of medical equipment. Nowadays, medical equipment are very sophisticated, and the market for maintenance and repair of medical devices remains closed even among businesses that have the appropriate licenses for this type of activity. The reason is that the suppliers of medical devices do not provide the necessary amount of information, keys, passwords and software both to third party contractors for technical maintenance and repair and to buyers themselves, hospitals and owners of medical devices. Thus, the owners and repair organisations depend on the suppliers at whose discretion prices conditions, terms of performance of work provisions of services, and the list of executors for the repair and maintenance of medical products. In order to eliminate this problem, the FAS proposed to fix the obligations of the manufacturer or suppliers to transfer the necessary amount of information thereby insuring the owners the right to fully own, use and dispose of their property as medical devices and to choose a service

organisation to do the maintenance and repair or these devices. Service organisations need access to this information too.

New wording, for a special model contract for the supply of medical devices was approved by the minister of healthcare of the Russian Federation. The producer must organise the transfer of information necessary to work with the equipment, including the provision of keys, access passwords, programs and other information necessary for installation, commissioning, use, operation and maintenance of this type of equipment.

From the demand side of this problem, the FAS proposed to solve the issues of market access for maintenance and service organisation through the mechanism of self-regulation. The competition on the market of medical devices is limited due to a lot of artificial monopolisation of this activity by manufacturers of these devices including through the exclusive rights to provide the technical service for this equipment. The authorised service organisations are not always the best ones and so during the transition to the self-regulation system one of the functions of the newly created self-regulating organisations on this market for servicing medical devices will be monitoring compliance with internal rules and regulations by participants. In cases when the patients are harmed by the use of medical devices that have become unusable or malfunctioning, as a result of bad service that does not comply with the technical and operational documentation of the manufacturer, the damage shall be compensated by the self-regulating organisation. To do this, these self-regulated organisations should establish a special fund for compensation and establish special rules of compensation as well. In this situation, both risks of financial sanctions and reputational risk should be an effective tool to prevent possible violations of contractual obligations as well as governmental rules. Russia noted that the risk of being included on the blacklist of public procurement organisations is a very strong deterrence tool as well.

The Chair asked if the system is in place yet.

Russia replied that it is true that the system is still not in place and that it is in the first part. The part of amendment of the rules for producers and suppliers already exists but the organisation of self-regulation in this sector is in the process of debate now.

The Chair then turned to Singapore and asked about the rotation of baby milk producers as suppliers of hospital nurseries. In addition, the **Chair** described a similar case in Italy, where suppliers of baby milk were rotating their supply of baby milk in nurseries, providing supply for free. One month each, in order to strategically split up the market among themselves so that new-born babies of that particular mother would go home with already having tasted a specific brand of baby milk. Therefore, somehow the system was a strategy of cartel behaviour. In particular, he asked Singapore if they had such an assessment of this rotation strategy, and what it was meant for.

Singapore described that prices of milk formula for babies in Singapore has increased significantly in recent years and this was the impetus to conduct a study into the supply chain of formula milk in Singapore. Among the issues was supply of formula milk to hospitals for new-born babies. Singapore explained that if you put yourselves in the shoes of the parents, once your new-born has already tasted a particular brand of milk without diarrhoea, allergies or problems, when your baby goes home you would not consider switching brand, not taking price into consideration, but rather the safety of the new-born. The formula milk producers all know that and therefore they compete aggressively to be on the default menu of hospitals for new-borns. In addition, in general the hospitals do stock multiple brands of milk for parents to choose, however, only 30% of parents chose specific brands. The other parents, maybe they have no good idea and they defer to the

wisdom of the hospital to choose for them or maybe the mother is still recovering from the delivery and therefore does not have the effort to choose. Moreover, because there is a large proportion of parents that do not have specific choices of brands for the babies, the hospitals have devised this rotation mechanism, different periods for different brands of milk to be the default choice for new-born babies. Unlike the case in Italy, the rotation mechanism is the choice of the hospitals and not an arrangement between the competing formula milk suppliers and therefore is not directly categorised as cartel behaviour in terms of market sharing. However, in the market study, the authority identified potential concerns in that private hospitals in this rotation arrangement accepts sponsors and rebates from the baby milk suppliers and there are two concerns related to this practice. First, competition is potentially distorted. Because it is not only gifts, but also baby milk suppliers positively provide promotion materials and training courses in order that their brand would be chosen for good periods on the rotation schedule and as a result, the choice of brands for babies might not be purely based on merits and may be distorted by the amount of incentives provided to hospitals by the brands. Second, the manufacturers compete aggressively on providing these incentives to hospitals. Subsequently, because of the brand loyalty, they may pass on the cost of such sponsors to parents and to exploit the ex post brand loyalty. Therefore, in the market study report, the authority highlighted these issues and in response, an agency taskforce has been set up in Singapore by the ministry of health to address these issues as part of the ongoing healthcare reform and this process is still ongoing.

The Chair then turned to Israel who wanted to follow up on the interesting input of Singapore on milk formula product.

Israel described a similar problem. The Israeli authority found out that because of the loyalty of parents to the formula that babies are given in the hospitals, the formula companies are paying the hospitals substantial amounts of money in order to become exclusive suppliers of their hospital supply. Formula companies are paying the right to supply free formula to the hospitals and the hospitals could not stand the temptation of getting the substantial amount of money. The authority felt that this is an obstacle to competition on the formula market and reached a decree with the formula companies, in which they agreed to allow all different formula brands to approach parents, so that every hospital had to at least offer three kinds of formulas to the parents of the babies. It was hoped that this will bring more competition in the formula market afterwards. The authority reviewed the outcome of the decree a few years afterwards and found that it really helped to bring competition into the hospitals. The parents were offered indeed a few formulas, but this did not bring more competition to the shelves of the grocery stores afterwards, that there was no reduction in price on formula for babies.

Israel said that it seems that the elasticity of demand here is very strict because a parent is very sensitive to what babies get. The authority saw this when companies tried to promote a higher brand, a parent very easily switch to the higher brand because they would spend whatever is needed on the formula for babies, so this is a very difficult market to put competition into.

Then the **Chair** turned to Korea that asked Prof Fels about information provided for consumers to choose better quality at a low price for healthcare services, he mentioned by his presentation. **Korea** described that in many countries including Korea there are government regulations to restrict or prevent advertising, for the sake of protecting consumers, and asked Prof Fels, if in Australia, they have government regulation to restrict or prevent advertising. What regulation to protect consumers do they have, and, if so, why

did the Australian government introduce government regulation. **Korea** asked Prof Fels to explain, if not Australia, the other countries he found in his research.

Prof. Fels replied first, that in the work of competition, we are extremely suspicious of restrictions on advertising as being anticompetitive. Indeed, there have been cases that restrictions on advertising removed and as a result, there was an increase in competition and a fall in prices. Therefore, it is interesting that we start from that perspective in the world of competition.

Then **Prof. Fels** focused on the health system. Prof. Fels said that there are restrictions on advertisement, in particular in the pharmaceutical sector, because the belief is that consumers should not be left to judge which medicines are best. However, there is side effects. Marketing efforts of pharmaceutical companies, which are devoted to convincing medical practitioners and hospitals of buying their products, has led to a mixture of good and bad effects. The critical perception is that the marketing efforts have been taken too far, the wrong sorts of incentives have been offered to medical practitioners to favour one pharmaceutical company over another, for example attendance at conferences. Therefore, there have been some restrictions not only on primary advertising but also on secondary forms of marketing. Moreover, when you restrict direct advertising to consumers you have to ask, "Where will the marketing effort go? And will it lead to better or worse results?" Prof. Fels described that in general, there are long history among medical practitioners that did not advertise against one another. However, in the last 20 years, there has been quite a lot of advertising and it has had an effect. In Australia when a person goes to a doctor, they have two choices. The doctor may provide services for free and get the money from the government, or the doctor may add on something extra. Therefore, there has been quite heavy advertising by doctors who do not charge a fee and that has had some good impact, probably, on patronage and competition.

Then **Prof. Fels** described other area of the health system. For hospitals, their main market is primary practitioners, doctors and so on. Therefore, there is not much advertising. Specialists also are mainly interested in attracting primary suppliers like General Practitioners to direct people to them. Therefore, there is no public advertising but there are great degrees of subtle and unsubtle self-advertising. For insurers, there is plenty of advertising but it is extremely difficult for consumers to choose between them and especially because there is community rating. Therefore, in a less interfered with market, you would undoubtedly get some insurers trying to attract a maximum of young healthy people and giving very low premiums as an offer. The other insurers who have less healthy and maybe older customers suffer from that competition, so the government tries to equalise by having community rating, something that applies to many countries where it tries to compensate those who are looking after the less healthy with some not very good side effects on how much care they give. Therefore, you have a mixed picture on private health insurance, but there is significant advertising based on brand.

The Chair then turned to Argentina that commented on Austria's contribution on maintaining the obligation of pharmacists to the owners. **Argentina** described a recent cartel case in pharmacies in the province of Argentina. It was a price cartel, the pharmacies agreed to not make rebates more than 10% and some of the ancillary restraints in the agreement where one of them was not to make advertising and the other was forbid pharmacy chains. In fact, there was punishment against some pharmacies that tried to make a chain of pharmacies and break the cartel. Therefore, the authority found that pharmacy chains could be a competitive tool in this market.

The Chair then moved to the final part of the discussion, which is the recent reform in the Nordic countries. The Chair then gave the floor to **Prof. Laura Hartman** to make a presentation on the Swedish and Finish reforms of healthcare, and on develops principles for introducing competition in complex systems that are characterised by government funding, and the coexistence of public and private service providers.

Prof. Hartman started with introducing her main references to the topic of reforms in the healthcare services. First, she mentioned Swedish reforms that open up for competition in the welfare services such as schooling, elderly care and social services. These reforms led, in the last seven years, to questions by politician, in particular, they asked if efficiency and quality in the public sector were improved by the reforms, by introducing competition and other parts of the reforms.

Therefore, looking at consequences of competition in healthcare services, many private operators entered within the primary care market that Sweden has opened. Moreover, private operators do exist within hospital care as well, but are not at all as common. Today, the primary care has a law saying that all 20 counties in Sweden that are responsible for providing healthcare must let patients chose, must give this opportunity to use freedom of choice and must open up for private operators within the healthcare system. However, the main conclusion Prof. Hartman said that opening up healthcare services to competition had not solved everything. Problems and challenges therefore remain within the Swedish system. The system is quite fragmented from the patients' perspective and does not work that efficiently. Swedish doctors, according to some calculations, meet fewer patients than many other doctors in the world, so there is a big government enquiry going on looking at how the resources can move and make the primary care more available and taking up bigger part of the patients' needs.

Prof. Hartman said that the optimal design of a healthcare reform is dependent of two crucial aspects. First, the starting point, which differs very much from country to country, in terms of how health care is provided and organized before the reform. Second is the objectives that are set for the reform, such as cost control, availability, medical results and patients' involvement. The more goals you set, the more conflict there is in these objectives and you will not be able to achieve all of them. In many countries, Sweden as well, the system is not integrated from the patient's perspective. There are also many challenges when you consider the needs of social services.

Another conclusion was that it is important to have the possibility to evaluate the effects of the reform afterwards, and this is very often something that is not done. These are complex systems so it is impossible to know in advance how to do everything perfectly but allowing for refining along the line, by having small-scale testing and systematic evaluation, helps to identify what works and what does not. In addition, it is important to plan this evaluation system from the beginning.

The third overall conclusion was that policy makers should think about employees' rights and patient's rights in advance when they open up the market for private actors and operators. For example, employees' rights are very strong in the Sweden public sector, but they were not so strong among the private operators, and that has been refined and adjusted along the line. Another example from Sweden is patient rights, which were differ between private and public providers. Professor Hartman noted that the government has been trying to close the gap in legislation.

Prof. Hartman explained that cream skimming problems can arise, and the question is how should you design the payment system in order to avoid cream skimming? Prof. Hartman

described the payment system in primary care in Sweden, which they have 20 independent counties who are responsible for healthcare, and most of them have a combination of payment per listed patient for the primary care centres and payment for production. Prof. Hartman suggested that having a public operator alongside private operators is helpful for a system. The main reason is the public operator can be obliged to ensure universal availability for all citizens. Especially, when there are capacity problems, for example when the total capacity among the private operators may be too low to meet the total need, and it also help to smooth exit. In Sweden, availability has improved since the reforms. However there is still a capacity problem and so queues still exist.

The need for a public operator, raises the question of level playing field. If you have public hospitals that are obliged to have extra capacity, then these should not operate under the exact same competitive rules as the private operators who have no public service obligation. Prof. Hartman said that you therefore have to design a system where there are slightly different rules for those operators with public service obligations.

Finally it was important to take a systems perspective. It is important to avoid contradictory or overly detailed management and payment models. In Sweden, the system has become quite administratively heavy, including auditing bureaus, inspections and other kinds of organisations that are controlling the quality and different aspects in the healthcare services, very many details and heavy controlling of the whole sector. Therefore, focusing on patient's perspective, different parts of the healthcare has to communicate with each other, as well as social services, particularly with the elderly who have complex needs. In addition, dialogue and involvement of the healthcare professional, are very important when designing the whole reform. In Sweden for example, the payment system was designed without considering some very basic issues that could have been spotted by involving the medical professionals. Therefore, dialogue and co-operation among staff should be promoted.

Then **Prof**. **Fels** had a comment about the holistic approach and coordinating for the provision of different services to one person that Prof Hartmann addressed. Prof. Fels described the concept of diagonal account. When the health department makes a decision, for instance, about some treatment or provision of a fee for it is weighed up against the benefits within the health system, but actually, there is another column in the accounting represented the benefit of other public services, like prisons, mental health and education. This problem of diagonal accounting with the decision-making being made in one bit of government who are only interested in the cost benefit for themselves. It has also made more complicated by the fact that there are different levels of government.

The Chair then turned to Sweden. In particular, he asked what happens if quality requirements, which are required by the state, are not met and who is responsible. Furthermore, he asked how do you take care of possible excess demand for elective surgery, especially on the hospital side.

Sweden first explained that the competition authority had assignment from the government, when the reform was implemented in 2010, to analyse the preconditions for competition and quality. One of the major findings was that accessibility to primary care in Sweden at the time of the reform was not good. Today, there are among 150 more healthcare centres in Sweden than before the reform, including many small private undertaking that are active in the primary care. In some counties there was not a single private undertaking before the reform, so from the competition perspective, the accessibility for patients to visit a General Practitioner within a certain limit of time is very important. Moreover, this system is continuously evaluated every year. In addition, Sweden

described that there are no fines if the healthcare centre cannot give the patient a time the same day by phone or a fee if the patient cannot visit the healthcare centre the same day. There is no fine if the surgery is not done within 90 days. This is a system that is evaluated by the county councils together and they work together to shorten these times but there are no fines and the responsibility in the long run are for the county councils.

The Chair then turned to Finland and asked about the core of the Finnish reform, which is to transfer the responsibility to the central government from the 18 counties who now have responsibility of healthcare in Finland. Payment would be organised around a two-part tariff with the variable part based on the quality and effectiveness of care. In particular, the Chair asked whether quality is assessed, and how this would translate into remuneration and how Finland identifies the fixed part of the tariff.

Finland said that they do not know if the Finnish reform will be approved by parliament. The final outcome still remains to be seen and the vote will take place sometime late this year or early next year. Finland described that the overall framework for the compensation model of the proprietors has been set in the draft proposal for the reform, but a lot would remain for the counties to decide on. One is the fixed part, a risk-adjusted capitation would become the biggest part of the compensation for the providers and the draft proposal says that the capitation part, this fixed part, paid by the counties shall account for at least two thirds of the total compensation paid to the service providers. In addition, that capitation would be based on national needs-based factors, like age, gender, employment and socio-economic situation, and calculating the correct amount of compensation will require a calculation model, with weighting coefficients and that is currently under preparation. Other parts of the compensation, besides the fixed payment, are performance-based remuneration, which is based on the quality and effectiveness of care and then other remuneration based, for instance, on a remote location. Therefore, it is the counties who would define the quality indicators and assess the quality as well as define how the quality would be translated into remuneration, but there would be a great deal of preliminary work on national level to define quality indicators. In addition, there will be some pilot projects as soon as the reform is approved by parliament, so the model will be tested. The compensation model will be one element in those pilots.

The Chair then gave the floor to Spain that asked to present a brief of them contribution, which refers to different specific problems in bidding processes.

Spain described that in Spain there was a wave of outsourcing of public hospitals in the last decade. The competition authority decided, some years ago, to assess whether this process of outsourcing of the management of the healthcare services in public hospitals was efficient from a competition point of view. The main finding was that in many instances, the procurement was not well designed, and this led to a lack of efficiency and competition. Spain said that if there is bad design of these bidding processes, there could be four main competition problems. One is a lack of competition between bidders, which can lead to higher costs for taxpayers, higher prices for patients, and lower quality for patients. Second is that it can lead to bad design of the incentives and monitoring of the contractor, and this can reduce the efficiency of the contract, for example not giving enough incentives for the contract to invest in new equipment. Third is that long contract duration or lack of transparency on the cash flow of the hospitals, which were subject to this bidding process, can lead to advantages for some bidders, and in the case of repetition of bidding processes can lead to advantages for the incumbent in future bidding processes. Finally, wrong design can lead to advantages for the contractor in related markets, for example, the private provision of healthcare services or in vertically related markets. If there is a

contractor that can use public resources for its own supply in the private market, or if these contractors can also supply some products to the hospital where he or she has been appointed as the contractor.

The Chair then ended the roundtable discussion by saying that competition cannot solve all the problems of healthcare. However, competition it is a useful tool to address some issues and in particular it is a tool for avoiding cost inefficiencies and improving the quality of care. He said that if large numbers of patients do not choose a specific service provider or a hospital it is important that the service provider suffer a loss of revenue that gives it an incentive to restructure or leave the market.