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Executive Summary 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

26 November 2018

This Executive Summary by the OECD Secretariat contains the key findings from 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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Executive Summary of the Roundtable on "Designing Publicly Funded Healthcare Markets"[*]

Working Party No. 2 of the OECD Competition Committee held a Roundtable on the subject of *Designing Publicly Funded Healthcare Markets* on 26 November 2018. Based on the background paper prepared by the OECD Secretariat, written submissions from delegates, and the contributions by expert panellists and delegates to the discussion, the following key points emerged:

1. Public funding for healthcare is necessitated by the inability of free markets to provide adequate healthcare. However, publicly funding healthcare services without creating incentives for those entities providing those services appears to create services that are not as efficient, innovative or responsive to users' needs as we would like. Publicly funding healthcare markets allows competitive incentives to be used to deliver the services that patients need, rather than the services they can afford to show a willingness to pay for. Advocacy by competition agencies can help to develop market mechanisms that deliver those goals.

Left to their own devices free markets in healthcare can be expected to result in insurance markets in which those with pre-existing conditions are unable to purchase coverage, and in which those on low-incomes or at low-risk are underinsured or decide not purchase. This lack of insurance can result in huge personal cost, as well as considerable negative externalities in terms of the effect on the health of others, lost labour and lost taxes, it also contradicts important policy objective that voters have bestowed upon governments such as equality of access to a good standard healthcare.

However, publicly funding healthcare services is not enough, providers need to be incentivised if we want them to provide the services that are efficient, innovative and responsive to users' needs. One option is to incentivise providers by setting performance targets and regulating to drive up the minimum standard. Most OECD countries have adopted this regulatory approach to guarantee minimum standards, however they have turned to choice, competition and market mechanisms to empower users and incentivise providers to do more than the regulated minimum. However by providing public funding for users, governments successfully break the link that free markets create between a user's ability to pay and their demand, and ensured instead that the service that the market provides is based on need. This ensures that competitive incentives contribute to achieving this important public policy objective, rather than contradicting it. Such a contribution helps to secure the legitimacy of competition as a public policy tool in healthcare and hence allows it the opportunity to increase efficiency.

Competition is therefore a delivery mechanism - not an objective in and of itself. There is therefore a particularly strong role for knowledgeable and nuanced advocacy by competition agencies that goes beyond simply cheerleading for more competition, deregulation, and lower barriers to entry. In some cases agencies have been active in advocating against anti-competitive distortions that policymakers and regional

[*] This Executive Summary does not necessarily represent the consensus view of the Competition Committee. It does, however, encapsulate key points from the discussion at the roundtable, the delegates' written submissions, the panellists' presentations and the background note.

governments have proposed, and in favour of pro-competitive reforms. This has extended to the use of powers to challenge in court anticompetitive proposals made by regional authorities. However in other cases healthcare policymakers have sought to blur the division between purchaser and provider and there is a risk that the market mechanism itself would be dismantled. Authorities therefore identified the need to be vigilant in their advocacy on these issues.

2. There is a trend across the OECD towards increased competition for patient choice, rather than competition for concessionary rights, though there remain challenges in making these choices meaningful. Moreover there are some healthcare services in which patient choice is not feasible, and in such cases the funding and organisation of these services needs to avoid distorting competition in those services where it is. The information that is given to patients to inform their choice, and the structure of payments that providers receive, will together determine what competitive incentives can achieve in a given service and hence are areas ripe for competition agencies to advocate upon.

There is a trend across the OECD towards the increased use of competition for patient choice. In some cases, countries have also introduced competition for contracts or concessions, however these often appear to have struggled to attracted bidders. Where informed patient choice is feasible it is likely to be more effective at improving services than competitive tendering. However it requires that patients have access to comparative information on services; that patients are aware of the difference in the services available; and that they would consider switching when poor quality is provided. Many countries therefore provide comparative information on outcomes across different providers, while some provide independent choice advice and subsidies for those wishing to travel further for better care.

However user choice is not feasible for some healthcare services. For example, providers of emergency care need to be contracted and paid to provide a certain capacity of care in a location, rather than having contracts and payments that encourage them to compete to be chosen by patients. Competition is in some cases used to determine who provides that capacity, however such tenders have struggled to attract bidders, and policymakers are often concerned at the prospect of incurring large transaction costs attempting to write complete contracts that can adequately hold providers to the delivery of promises made in their bids. It may therefore be that competition is not a solution for such services. In any case, to avoid contracts for competitively tendered or non-competitively allocated services distorting competition in patient choice markets, policymakers may need to introduce structural or accounting separation between the services.

The type of information that is offered to patients and the payments that are offered to providers will also help to determine the type of competitive incentives that are created. For instance, information on, or payments that depend on, the effectiveness with which a healthcare service interacts with social care or other healthcare services will help to incentivise providers to compete to better cooperate with those services. In addition, patients that develop multiple long-term conditions might be allocated a year of care budget and asked to select a coordinator to arrange for the coordinated delivery of all the necessary services. Such competitive incentives to cooperate and coordinate care offer an economically literate alternative to healthcare systems' tendency to focus on organisational boundaries rather than incentives and hence to merge all services that need to cooperate into a single behemoth.

3. For competition to improve publicly funded healthcare systems, prices need to be set at a level that incentivises providers to work to attract patients. Where prices are unregulated and set by providers this can create a topping-up problem that risks conflicting with the often important public policy objective of equal access, and thereby delegitimising competition as a policy tool. Meanwhile when prices are set by an independent regulator, the risk is that setting the wrong regulated price can result in cream-skimming problems and potentially additional competitive distortions.

Where prices are not regulated, and are paid by users (with the help of state subsidies), providers can charge higher prices for treating patients with more complex needs but can also charge higher prices to users that are willing to pay more to top-up the care they receive. Publicly funding such a system will therefore not help to address health inequalities. Competition agencies that advocate for the removing of restrictions on top-ups as a 'pro-competitive' measure therefore risk bringing competition as a policy tool into conflict with the common public policy objective of equal access to publicly funded healthcare. In contrast, those agencies that support the application of non-discrimination obligations on providers (e.g. prohibiting restrictions on pre-existing conditions), and the prohibition of top-ups on publicly funded services, will be able to then advocate for pro-competitive measures that help policymakers to achieve their goals of equal access to a more efficient healthcare service.

In most publicly-funded systems prices are instead regulated, and prices are set for each bundle of healthcare services that might be required to treat a certain condition. This is because; a) there is a concern that inadequate quality information will lead to competition to cut costs without reference to the impact on quality and value, and b) there is little confidence that insurers will successfully bargain down prices on behalf of patients. However where prices are regulated there is a risk that regulators will set prices at which it is unprofitable for an efficient provider to treat some patients. In such cases the incentive for the provider is to attract the most profitable patients (cream-skimming or cherry-picking), and to refuse to treat those that are unprofitable, or to discourage demand from those patients, for instance by deteriorating the quality of the treatment (e.g. allowing the waiting list to grow).

Where all providers face the same public service obligation (in that they are all prohibited from selecting patients), this can be expected to result in poor outcomes for patients with those conditions that it is unprofitable to treat. However, there is the possibility of an additional competitive distortion where there are asymmetric public service obligations, that is, where some providers are allowed to refuse to treat those patients whilst other providers cannot (e.g. on the basis of complexity or their location within a catchment area). Such a distortion can arise if treating unprofitable patients has an impact on the rival's cost of treating – or its ability to attract - profitable patients, and hence reduces the competitive constraint they impose. However, unlike education services, in healthcare there would not appear to be any intrinsic reason why there should be such an impact. Instead, the possibility of an impact will depend on how the shortfall in funding is treated (e.g. whether the rival has to redirect staff or resources from profitable service lines to cover the shortfall).

4. Advocacy has helped to support the dismantling of unnecessary barriers to entry into the provision of healthcare services. Such barriers are often implemented as crude solutions to nuanced problems, and so advocacy can be most effective when it is pro-active and constructive in identifying alternative pro-competitive solutions to those issues. While barriers to entry can prevent some new providers from accessing

the market, barriers to exit in the form of bail-outs for failing providers can entirely undermine competition within the market. Developing a reliable administration process for unviable healthcare providers is therefore a necessary condition for effectively advocating for the removal of access to such bail-outs.

There are often significant barriers to entry in healthcare services due to the sunk costs of setting up new purpose built facilities with limited resale value. However these are often overlaid by unnecessary additional barriers that advocacy efforts can address. For example these can include public purchasers requiring certificates of need from some form of central planner before permitting entry or expansion. Such restrictions appear to reflect concerns that once built, capacity will be filled and hence will incur additional cost, either because the better access that results from additional capacity will stimulate additional demand from patients, or because providers will use their informational advantage to fraudulently increase the number of units of a profitable service that they provide. The first is an unavoidable consequence of having a high quality healthcare system. The second is an issue that countries have sought to address through less anticompetitive approaches including the use of clinical audits and general practitioners as a gatekeepers to specialised care.

In many countries there remains a debate about the advantages and disadvantages of allowing profit-making firms to compete to provide publicly-funded healthcare services. This is particularly true where, as in most countries, there remains little confidence that there is sufficient information on quality to deny profit-making firms the opportunity to cut costs in ways that damage quality but cannot be easily observed by patients. Many countries have therefore recognised the advantages of maintaining a state-owned option. However, the role of charities and employee-owned mutuals as providers of services is less controversial, as is the potential for profit-making firms to sell advice or consultation services to non-profitmaking providers. The advantages of adopting market mechanisms may therefore usefully be separated from the case for or against introducing profit-making into the delivery of these services.

More important than entry by new providers is the facilitating of exit by inefficient incumbents. While some countries allow such providers to go bankrupt and exit the market, it is more common that inefficient poor quality providers are bailed out and protected, and the role of local politics in this was recognised. However such protectionism can be damaging as it undermines the incentives for more efficient providers to compete to increase market share or to innovate. Advocacy that recognises and addresses the legitimate public policy concern that exit needs to be managed smoothly so as not to interrupt the treatment of patients, is therefore more likely to be successful with healthcare policymakers.