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Designing publicly funded healthcare markets - Summaries of Contributions

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This document reproduces summaries of contributions submitted for Item 4 of the 66th meeting of Working Party No 2 on Competition and Regulation on 26 November 2018.

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

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Designing publicly funded healthcare markets - Summaries of Contributions

This document contains summaries of the various written contributions received for the discussion on Designing publicly funded healthcare markets (66th meeting of Working Party No 2 on Competition and Regulation, 26 November 2018). When the authors did not submit their own summary, the OECD Competition Division Secretariat summarised the contribution. Summaries by the OECD Secretariat are indicated by an *.

Argentina

A series of analysis of the pharmaceutical market in Argentina have concluded that prices for medicines in Argentina are higher than in other countries, even within Latin America. This is particularly the case for, although not restricted to, high cost medicines. In view of this, the Argentine government is redesigning the public procurement system for pharmaceutical products, aimed at reducing the price that both the public sector and individual consumers pay for medicines. Two recent experiences in this area are developed in the following sections. These should be considered as first steps towards a more comprehensive public policy in the pharmaceutical market.

First, in March 2018, for the very first time, four different public entities joined in the organisation of an international tender to procure factor VIII, a treatment for haemophilia A, fully funded by the public sector. The decision to jointly procure factor VIII was made with the goals of achieving coordination among public procurers, achieving public savings for about ARS 800 million, ensuring access to quality, safe and effective medicines, delivered on time and strengthening transparency of procurement processes. On 9 March 2018, nine pharmaceutical companies submitted bids, resulting in a reduction of about 80% in the price of factor VIII compared to the average paid by the four entities in 2017 and savings for ARS 1.4 billion, exceeding by 75% the target savings. Competition advocacy and an appropriate design of the tender documents were key components of this successful story.

Second, in April 2018, the health insurer for the elderly population (PAMI), a public entity and the largest single buyer of medicines in Argentina, accounting for between 35% and 40% of the total market for pharmaceutical products, changed the way it would contract with the pharmaceutical industry. Up to that date, PAMI purchased medicines through an agreement with three trade associations representing most of the pharmaceutical industry, which had several distortions to competition. With the new agreement, PAMI recovers autonomy by keeping the power to set the commercial conditions that would apply individually to pharmaceutical companies and to pharmacists associations. This new agreement should be seen as a first step towards a more competitive and consumer-oriented way of negotiating with the pharmaceutical industry.

Finally, the CNDC has made enforcement efforts in the area of pharmaceuticals and provision of hospital services, by sanctioning two local cartels, one of pharmacists in the province of Tucumán and a second of hospitals in the province of Salta. In addition, it is currently finishing a study of the market for pharmaceuticals, whose conclusions and main recommendations will be soon publicly available.

Austria

Competition in the health care sector is a heavily discussed topic because competition rules need to be applied to a market characterised by asymmetrical information (between patients and doctors), economic interests vs a public interest in the best supply of health services to patients, the difficulty to measure quality and finally in the particularities of different jurisdictions.

The Austrian Federal Competition Authority (FCA) is quite active in the health care sector and launched a sector inquiry in 2017. In May 2018 the FCA published its first interim report focusing on the Austrian pharmacies market. In this report, the FCA identified anti-competitive regulations such as the requirements of a needs assessment that leads to a near monopolistic position of community pharmacies, prohibition of chains and of third party ownership, restriction of the number of branches, restriction of opening hours, restrictions on provision of additional services, restrictions on online sales of OTC medicines, restriction of pharmacy delivery services and the prerogative of pharmacies to sell OTC medicines.

After analysing the market and addressing different stakeholder the FCA made eight recommendations for legal measures in order to strengthen competition in this market and under consideration of the public interest in a reliable supply of medicinal products. Overall an abolition of the needs assessment, retention of prohibition of chains and of third-party ownership and a liberalisation of pharmaceutical distribution and opening hours is proposed.

Finally, in November 2018 a draft of a revised Pharmacy Act will be discussed in the Austrian Parliament and it is likely that an amendment of the Austrian Pharmacy Act will be decided by the end of the year which will probably implement many of the FCA's recommendations.

Bulgaria

The health insurance in Bulgaria is based mainly on the mandatory health insurance provided by a mandated state body - the National Health Insurance Fund (NHIF), which is financed by the state budget. Although there are insurance companies on the market, their role in healthcare insurance is still of limited scope and coverage. The NHIF reimburses the medical services by the healthcare facilities within the scope of the illnesses and medical procedures, set by the law.

The reimbursement level for the services provided by the medical facilities is set annually in the National Framework Contract and is negotiated between the National Health Insurance Fund, the Bulgarian Medical Union and the Bulgarian Dental Association as representatives of the medical practitioners and the dentists. Co-payments by the patients are more widely spread for hospital services. There is an exclusive list what types of payments the hospitals are allowed to ask from the patients.

Healthcare in Bulgaria follows the model of functional separation of the medical services provided to patients into two levels: out-of-hospital healthcare services (primary healthcare and specialized primary healthcare) and hospital services (hospitals and other healthcare facilities). There is regulatory ban on vertical integration of the medical facilities and the functional separation of the healthcare services is further reflected into the legal and organizational separation of the healthcare facilities.

The CPC applies the notion of undertaking to the providers of medical services and the notion of association of undertakings to the professional organizations of the physicians and dentists. As regards the NHIF, on the basis of the CJEU case law, the fund is considered not to be undertaking, but body, managing solidarity based healthcare scheme.

The quality and the funding of the public healthcare system in Bulgaria has been a topic for hot public debates for many years. The main problems articulated during these debates include: continuously increasing total amount of NHIF budget with no obvious increase of quality of medical services; increasing number of private hospitals being established and receiving NHIF funding, especially cardiac units; low level of patients satisfaction of medical services; high level of patients top-up payments; media reports of medical service providers doing unnecessary but well reimbursed procedures. The Ministry of Healthcare and the NHIF tried to remedy the continuous increase of the public spending of the fund for, mainly, hospital services, by regulatory restrictions, limiting the number of new hospitals/hospital units and/or the hospitals/hospital units receiving reimbursement from the NHIF.

The CPC assessed in a number of advocacy decisions the regulatory framework on all levels of healthcare system. The main regulatory restrictions identified originate from the formal prohibition of legal vertical integration and from the attempts of the public bodies to reduce the increased spending of the NHIF by reducing the number of new hospitals/hospital units eligible for funding. The CPC expressed the opinion that the public funding could be efficiently spent if the existing system is changed with selective funding system based on qualitative non-discriminatory criteria. As regards the prohibition of the vertical integration between medical providers of different levels of healthcare, the Commission analyzed its benefits and negatives, but in general considered

that more providers for specific level of healthcare will increase the competition on quality between them and will be of benefit for the patients.

In the last two months the Ministry of Healthcare presented to the public draft strategy with two major scenarios for structural reform of the system- *partial demonopolization* of the NHIF with the introduction of the second pillar private health insurance in addition to the basic coverage by the public insurance of NHIF or *full demonopolization* of the NHIF and competition on the merits between NHIF and private insurers. At a later stage, when there is a clearer concept of the reformed insurance and healthcare systems, the CPC might intervene as appropriate.

Chinese Taipei

Chinese Taipei began implementing National Health Insurance (NHI) in March 1995 as a mandatory social insurance. About 93% of healthcare institutions in Chinese Taipei have joined the NHI, and provide accessible healthcare to citizens. Furthermore, about 99.7% of citizens are covered by the NHI, which is designed with a no gatekeeper system, allowing citizens to freely choose where they want to seek medical attention. Hence, the healthcare market of Chinese Taipei is characterized by fair competition.

As for competition in healthcare services, public and private healthcare institutions in Chinese Taipei can only engage in price competition in relation to the “administrative registration fee” and “healthcare services not covered by the NHI” due to the constraints of the National Health Insurance Act and Medical Care Act, and there are still considerable constraints on such fees. Therefore, there are very few cases of competition law violations in the healthcare service market. In practice, the healthcare service market of Chinese Taipei mainly engages in quality competition

Croatia

In its contribution, Croatian Competition Agency wishes to present its case which is example of advocacy work designed to eliminate possible negative effects on competition.

The *Guide for the new referral model* works out the criteria for general practitioners – who are responsible for taking the final decision with respect to prescription drugs and the therapy they propose. The Guide in question recommends that a GP, in principle, should prescribe the cheapest medicine within the medicines group of the same composition.

The manufacturers of the medicines of the same composition from the basic drugs reimbursement list are excluded from the market despite the fact that they are included in the basic drugs reimbursement list covering the drugs that are fully reimbursed. The adoption of any new rules in the area of health care prescription drugs or any revisions thereof should be carefully studied so as to ensure access to the basic drugs reimbursement lists to all undertakings specified under the valid list that are to some extent excluded from the market by the lowest-price criterion.

Estonia

In 2014 the Competition Authority analysed competitive situation in medical treatment funding. The Health Insurance Act sets out a number of criteria, which the Health Insurance Fund has to consider when concluding a contract for financing medical treatments. Moreover, the Act also prescribes that the Health Insurance Fund has to conclude contracts with hospitals listed in the Hospital Network Development Plan (HNDP), at least within a certain scope.

The Competition Authority has reached the conclusion that there is no transparent and unambiguous regulation in current legislation, which could serve as a basis for the Health Insurance Fund for deciding the distribution of funding between the HNDP hospitals and the rest of the health care providers. The Health Insurance Fund has chosen to solely prefer HNDP hospitals. The current approach of the latter preferring solely the HNDP hospitals distorts competition which would be excluded in a normal competitive situation. This may lead to situations where the more expensive and/ or of lower quality service offered by the HNDP hospital is preferred of the others. According to the Authority, possible counter arguments against free competition should be considered on a case-by-case basis and the HNDP hospital preference should not be automatic in the process of treatment funding. Currently, such a consideration is not carried out. The recommendation covered those specialities, which have been traditionally rendered by health service providers that are not covered by the HNDP (non-HNDP health service providers).

Therefore, the Authority made a proposal to the Ministry of Social Affairs to initiate the draft to amend the Health Insurance Act in order to add clear and transparent criteria for the distribution of treatment funding between health care institutions to the Act. Only in the case of the fulfilment of these criteria, the Health Insurance Fund could have the right to prefer the HNDP hospitals in certain specialties without any restrictions to funding. In case of health care services that do not meet the criteria, all health care providers should have a chance to compete on equal terms.

Finland

The reform process of redesigning publicly funded healthcare and social services system has been going on in Finland for more than a decade now. It is presumed that the Parliament would vote for the reform late in the autumn term 2018 or early 2019 and the result is still to be seen.

In the present system healthcare services are delivered to the population mainly through a municipal-based publicly funded system where public providers are also mainly in charge of the provision of services. Occupational healthcare has an important role in providing primary care services to employees. Also entirely private healthcare services are used, nowadays they are increasingly financed through private insurances.

Problems of the present system concern e.g. the fragmented structure of organizing services, inequality in the access to services and long waiting lists as well. The financial challenges created by the ageing population are also clearly seen. Both OECD and the EU Commission have recommended Finland to take action to adopt the reform.

The reform has several targets: to curb the cost increase, to improve the equality of services and the access to services. More horizontal and vertical integration are among the targets as well. The multisource financing of healthcare and social welfare are also meant to be simplified.

The responsibility for organizing health and social services would be transferred from 190 local authorities to the 18 counties. More Government steering would be introduced as the funding of the services would come entirely from the Government. Primary care services would be provided by public and private organizations equally to promote competition and give the citizens more freedom of choice. That is meant to be the key method to improve the availability of primary services and stimulate client orientation in the service provision.

The concerns and risks pointed out are linked e.g. to the compensation model based largely on the risk-adjusted capitation which could result in under-treatment as well as cost transfers to other providers. Also the risk of adverse selection and cream-skimming based on choices of clients with different needs have been recognized. To tackle these risks the providers would be obliged to accept all listed clients. The details of the risk-adjusted capitation model are still under preparation.

The high level of concentration has also been a concern as only few large companies dominate the market. Also the need to the level playing field for public and private providers has been recognized. Attention should be paid to providing citizens with relevant information on the services and providers so that they can make enlightened choices.

The Finnish Competition and Consumer Authority (FCCA) has been active in taking part in the preparation process by issuing reports and statements. According to the draft legislation the FCCA would have a central role in supervising the neutrality between public and private providers.

After the framework for the reform has been decided, the FCCA is willing to help the counties together with other experts in designing further the compensation mechanism so as to maximize the incentives of the operators to offer good quality services to all clients. The right incentives and restrictions are in a key possession to steer the service provision that meets the targets of both the society and citizens.

Indonesia

Indonesia's national health insurance scheme (*Jaminan Kesehatan Nasional*, or JKN) started in 2014. The goal of the government is to materialize healthy, smart, productive, and having a noble character Indonesians. According to the regulations, the Government shall allocate a health budget of 5% of the State Revenues and Expenditures Budget. But, the number is very small compared to ASEAN countries.

Responding to the demand for health services created through JKN will require strong partnership between the government and the private health sector. How have JKN policies affected the private health sector? Has the private sector's responses expanded access to high-quality healthcare at an affordable cost? Do JKN processes support the private health sector remaining robust and continuing to invest and grow?

The written contribution focus on JKN's impact on pharmaceutical, medical device companies and private hospitals, whether the private sector's products or services have diversified, and whether JKN has motivated healthy competition between companies and hospitals.

Furthermore, based on the data of the Ministry of Health in May 2018, the total number of pharmaceutical companies decreased from previously 210 pharmaceutical companies in 2016 to 174 pharmaceutical companies spreading out throughout the territory of Indonesia. The national pharmaceutical market grew 10% on average per year in the 2010-2015 period. The amount of the national pharmaceutical market in year 2015 was approximately Rp62-65 trillion and would increase to Rp69 trillion in year 2016.

Our assessment indicates that the JKN has developed several elements of the private industry, investment incentives, and improved competition, but has yet to holistically stimulate geographical diversity or larger products. JKN may have larger positive impacts on the private sector if the stakeholders do the following matters:

- Clarification of tariff level setting process, including pharmaceutical and commodity costs calculated in the calculation of tariffs so that private players may make decision based on the information about treatment options.
- Further use of health technology assessment to focus on beyond drugs currently paid to use top-up payment by the Health-Social Security Administering Agency (BPJS Kesehatan), in order to also help inform procedures related to the JKN, drugs and medical devices selection process.
- Improved registration of e-catalogue and bidding process of the LKPP (National Public Procurement Agency), especially to consider several possible bid winners for pharmacy, to develop criteria other than the price, and to enable access to private providers.
- Promote a more collaborative role of the private health insurance market so as to act together with the JKN through a method that is stronger than the current coordination of benefits or top-up to enable access to branded drugs and treatment procedures.

Italy

The advocacy activity of the *Italian Competition Authority* in the health sector has focused on different aspects aimed both at fostering supply, facilitating entry wherever possible, and empowering demand, allowing patients the possibility to make efficient choices. *This contribution provides an overview of the reforms of the National Health System (NHS) of the last two decades and the advocacy intervention of the Authority.*

More specifically, advocacy interventions concerned the following aspects of the Italian NHS: (i) the governance structure of the health sector; (ii) access for private operators to the market for the provision of health services within and outside the NHS; (iii) the criteria for allocating the NHS's budget to accredited (and selected) private operators and (iv) transparency in relation to performance statistics of health structures.

The aim of the Authority's interventions has been to ensure that the benefits, in terms of improved efficiency, better quality and increased innovation, of the two elements introduced by the 1992 reform - free choice for patients and competition on the provision of health-care services – could be realized to the greatest extent possible allowed by the institutional setting of the Italian NHS, without undermining its guiding principles of universal service and solidarity. In this context, the Authority, in its advocacy activity, has invited policymakers to promote market transparency on quality and performance and ensure careful monitoring of access conditions.

Lithuania

In Lithuania, healthcare services are both publically funded and private funded. In the recent years, reforms to the healthcare system were initiated, namely with regard to the establishment of hospital pharmacies and with regard to the conclusion of contracts by the territorial health insurances funds with public and private healthcare institutions respectively. Whereas the former reform has been completed, the latter reform did not go through after the veto of the President of the Republic of Lithuania. The Competition Council of the Republic of Lithuania took an active role, within its competences, by providing its rather critical opinions as regards both reforms.

Norway

The scope for competition within the Norwegian healthcare system is restricted. Health insurance is mandatory and mainly financed by general taxation. Prices are for most parts fixed. Within the last two decades, however, the government has introduced several reforms to encourage competition for patients. These reforms implied two major changes: 1) patient choice, and 2) financial payments linked to the number of treatments or patients. In addition, the use of competitive tenders has increased within specialised healthcare.

For primary healthcare, patient choice implies that patients can choose their preferred general practitioner ("GP") as long as the chosen GP has vacant patient slots on their lists. GPs are not allowed to turn down new patients who want to be enlisted as long as they have vacant slots. The majority of GPs are self-employed with their own private practice and can pocket the profits from the services they provide. Prices are regulated, and the GPs are paid a mix of capitation and fee-for-service. These features are likely to encourage GPs to compete for patients. By providing high quality care, a GP may attract more patients and thereby increase his or her income. However, the number of GPs within each municipality is regulated, and not all GPs have vacant slots. These restrictions may limit patients' choice. Empirical studies tend to find that competition among GPs in Norway has induced more consultations, shorter waiting times, but also more sick listing.

For specialised healthcare, patients can choose their preferred hospital for treatment among all hospitals in Norway. Patients get information on hospitals both from their GP and from a governmental webpage with information about waiting times and quality indicators. While travel cost are refunded, long travel distances may weaken the scope for patient choice. The majority of hospitals are public, but there are also a few private hospitals, both non-profit and for-profit. The public hospitals are organized as state-owned health enterprises with some financial flexibility, such as transfer of surplus (or deficit) across fiscal years. Hospitals are funded by a mix of block grants and activity based diagnosis-related group ("DRG")-funding. In addition, there is a quality based financing scheme where a small proportion (0.4 per cent) of the hospitals' funding is made dependent on the achievement of goals of specified performance targets. While block grant funding gives incentives for the hospitals to reduce costs, the incentive to compete is related to DRG-funding. With patient choice and activity based DRG-funding there is potential for competition on quality and waiting times. However, a partial DRG-funding system (50 per cent), large travel distances, and capacity constraints may limit competition.

There are few empirical studies on the effect of patient choice and activity based DRG-funding on competition in Norway. Although there are some indications of decreases in waiting times and increases in quality and efficiency, these correlations need to be interpreted with caution. Thus, it is uncertain how strong incentives these arrangements give the hospitals to compete for patients in Norway.

To buy short-term private capacity, the government makes use of competitive tenders. Despite an increase in the use of competitive tendering, competitive tenders make up a very small fraction of total costs of specialised healthcare in Norway. For fields that are open to competitive tenders, there is scope for price competition. Although a recent

empirical study indicates that competitive tendering has led to lower prices and as such could potentially lower government spending on specialised healthcare, more studies are needed to draw solid conclusions.

Romania

Health sector represents a priority in the Competition Council's concerns to support a competitive and sustainable economic environment. Therefore, Romanian Competition Council (RCC) seeks protection of competition in the health sector both in a corrective and preventive manner, through all available tools, acting against anticompetitive facts, by control of mergers with potential anticompetitive impact and acting to improve the compatibility between the legal framework governing health and competition rules.

Regarding the market of publicly funded healthcare, RCC conducted in 2017 an investigation¹ which showed that the Ministry of Health (MH) and the National Health Insurer House (NHH) adopted discriminatory regime between public and private healthcare providers regarding the payment mechanism of publicly funded healthcare services. The investigation concluded that the measures adopted by the MH and NHH shaped an unjustified distinction between healthcare suppliers, which did not relate to an objective indicator of medical service evaluation, but only considered the public / private criterion.

¹ Although national competition law is aligned with the principles established in the TFEU, the competition authority has at its disposal an extra tool when public administrative authorities intervene through actions that may restrict competition by discriminating players in the market. In this regard RCC has the power to issue decisions to re-instate the competitive environment.

Russian Federation

The FAS Russia is working to solve the main existing problems in the field of healthcare that have a significant impact on competition, such as issues of substitutability of medicines and medical products, the lack of specialized regulatory legal acts regulating the market of medical products, the distribution of the volume of medical care provided under the compulsory medical insurance program between medical organizations.

The proposals of the FAS of Russia on the development of competition in the field of healthcare are set forth in the Plan of Measures (“road map”) “Development of Competition in Healthcare”, approved by the Order of the Government of the Russian Federation No. 9-p dated January 12, 2017 and include the following measures.

- In the pharmaceutical market:
 - - improvement of state registration of medicines;
 - - ensuring the functioning of the institute of substitutability of medicines;
 - - ensuring the functioning of the institute of substitutability of medicines;
 - -improving the mechanism for regulating the prices of medicines included in the list of vital and essential medicines;
 - - improving the regulatory framework in the procurement of medicines for state and municipal needs;
 - - improvement of legal regulation in the field of intellectual property protection.

In the medical device markets:

- - improving the regulatory framework in the field of circulation of medical devices;
- - improvement of the regulatory framework in the field of procurement of medical devices for state and municipal needs.

In the markets of medical services:

- - improvement of legislation in the field of health care in terms of determining the volumes and types of medical care provided within the framework of regional programs of state guarantees of free medical care to citizens, the annual update of the program of state guarantees of free medical care to citizens when introducing new medical technologies;
- - approval and updating of clinical recommendations (treatment protocols);
- - development of proposals for specifying the conditions under which state (municipal) medical organizations can provide paid medical services;
- - preparation of proposals for improving the mechanism of distribution of medical care among the participants in the implementation of regional programs of state guarantees of free medical care to citizens.

Singapore

Singapore's healthcare market comprises both public and private providers of healthcare services. Primary care is mainly provided by the private sector, while secondary care is mainly provided by the public sector.

Healthcare falls under the purview of the Ministry of Health ("MOH") in Singapore. MOH provides subsidised medical services in the public sector and promotes individual responsibility for healthcare through various co-payment schemes. These are supplemented by private insurance policies.

Singapore's Competition Act is administered and enforced by the Competition and Consumer Commission of Singapore ("CCCS"), which is also responsible for advising the Government and public authorities on competition matters. In recent years, CCCS has promoted competition in the healthcare market through its advisory and enforcement work, as well as through its market studies.

In relation to medical fees, CCCS found that a guideline on fees promulgated by a non-governmental association of medical practitioners was anti-competitive. One of the key reasons for this decision was that the fees in the guidelines were self-reported by the medical practitioners and were not objective. Thus, when MOH set up an advisory committee to design and formulate benchmarks based on objective data, CCCS supported the initiative by providing competition advice to the committee.

As regards health insurance, CCCS has promoted competition in the market through its advocacy and enforcement work. For example, the members of the Life Insurance Association in Singapore removed anti-competitive restrictions in their policies following talks with CCCS. CCCS also conducted an investigation and subsequently penalised a group of financial advisory firms for their conduct that resulted in a new and innovative retailer of life insurance products withdrawing from the online market within days after the launch of the products.

In the area of infant healthcare, CCCS published its findings from its market inquiry into the supply of formula milk for babies, infants and young children and made recommendations to improve the competitive conditions in the market. The Singapore Government took on board CCCS's recommendations and established a multi-agency workforce to review the regulatory framework and implement some of these recommendations.

CCCS recognises that market forces alone may not lead to efficient outcomes in an important market like healthcare and thus works closely with MOH and all relevant stakeholders to ensure that policy goals are realised in a manner that is least restrictive of competition.

*Spain**

In Spain healthcare is highly devolved with regions organising their own systems. Traditionally the regions have directly managed the provision and funding of services. A General Health Act also regulates contracts with private hospitals and gives priority to non-profit organisations. Direct provision. There has been a trend of regions outsourcing direct management of their systems to public-private partnerships such as those in Valencia (the “sistema alzira”). Here the partnership receives all the healthcare funding for the region over an extended period and is then responsible for meeting all the health needs of the population. While patients choosing between different facilities does not carry any financial consequence for the operator of the system, competitive pressure may exist to the extent that in these regions the partnership faces the risk of losing the contract when it is retendered, and hence is incentivised to deliver a good service. However regional governments in Valencia and Madrid have decided against retendering and taken the service back into direct management.

In a 2013 study the CNMC analysed bidding processes over a 13 year period and found 5 bidding processes for healthcare management services, many of which had only one bidder. This could be due to overly restrictive bidding criteria, potential bidders perceiving there to be a risk over future revenues, a lack of data to prepare bids, inadequate time to prepare bids. The study found poor design of payment schemes (which did not incentivise efficiency, quality or investment), substantial advantages for incumbent bidders, and malpractice in the procurement process.

Sweden

The Swedish healthcare system is primarily funded by taxes². There are both public and private providers of healthcare and private providers of healthcare fulfil an important function in Sweden. Privatisation of healthcare services in publicly funded healthcare markets has primarily been implemented through two alternative models, public procurement and systems of choice.

The base of the organisation of Swedish healthcare is primary care and all inhabitants are listed at an approved healthcare centre, regardless of which specific needs the inhabitants have to visit primary care. Since 2010 it has been mandatory for county councils to have a system of choice within primary care, the purpose of which is to increase freedom of choice for patients and to establish quality competition and diversity among providers. With the system of choice, the availability of primary care has been significantly improved. Between 2009 and 2016 the number of healthcare centres in the country increased by almost 15 percent. Most of the new healthcare centres are privately run, often by small undertakings.³

Models of choice increases the possibilities for individual preferences to be met. If the patient is well informed and has the opportunity to choose among providers within a reasonable geographic distance, a system of choice works well.

Competition in hospital care has not occurred to any significant extent in Sweden. In general, patients are not able to choose their provider of hospital care. A major reason is that emergency and university hospitals are in general public run. Only a few county councils have introduced consumer choice within specialist care, and the majority of these systems of choice are found in Stockholm County.

Public procurement has been used for demarcated assignments in hospital care, such as laboratory services, where the price per unit is easy to measure. The Swedish Competition Authority has shown that procured laboratory services reduce the price per unit significantly compared to operations in-house. From a competition perspective, public procurements generate positive synergies, as more stakeholders can establish themselves in the laboratory service market.⁴

² In 2016, 84 percent was funded by public authorities, 15 percent by households themselves and 1 percent by private health insurances, SCB Hälsöräkenskaper 2016

³ Swedish Competition Authority, *Konkurrensen i Sverige 2018*

⁴ Swedish Competition Authority, *Konkurrens inom laboratorietjänster, 2012:5*

United Kingdom

For much of the last twenty-five years, the UK Government has sought through a series of reforms to reorganise the National Health Service (NHS) in order to increasingly embed market-based mechanisms as a way of providing incentives for improvement. In recent years, however, government policy concerning the means to achieve that objective has shifted, in light of the twin pressures of cost cuts and the increasing needs of an ageing population, to favour the use of collaborative approaches to delivering healthcare. This has impacted the role of regulators, commissioners, and providers, which must now attempt to adapt their behaviour accordingly in order to balance the delivery of multiple, sometimes varied, policy objectives.

This submission is structured as follows: first, sets out the background to the provision of healthcare in the UK, including an overview of recent market-based reforms and the current landscape of regulatory bodies for healthcare. It then considers competition within the NHS, in particular patient-driven competition and commissioner-driven competition, noting the NHS' role through its regulator in assessing anti-competitive behaviour and the recent introduction of new care models brought by the NHS' Five Year Forward View in 2014. Finally it highlights some of the work undertaken by the UK's competition agencies in the healthcare sector.