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Challenges in designing publicly funded healthcare markets – Paper by Laura Hartman

Roundtable on Designing Publicly Funded Healthcare Markets

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More documents related to this discussion can be found at

www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm

Please contact Mr Chris PIKE if you have questions about this document [Chris.PIKE@oecd.org].

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Report on challenges in designing publicly funded healthcare markets

by Laura Hartman*

1. Main references

1. My main reference for addressing these questions is economic theory and Swedish experience from opening the primary care for competition. I have written two books that closely relate to these questions: "*The consequences of competition – what happens to Swedish welfare state?*" (In Swedish: Konkurrensens konsekvenser – Vad händer med svensk välfärd?) from 2011, and "Chasing the perfect payment model – What happens to the employees room of action?" from 2017 (Jakten på den perfekta ersättningsmodellen – Vad händer med medarbetarnas handlingsutrymme?). The first report summarizes evaluation studies on opening Swedish primary care (and other welfare state services) for competition; the second discusses how the best payment model should look like in order to achieve best service quality; working environment; and use of human capital in social and health care services. I have also been involved as an expert in the early planning phase in 2016 of the Finnish social and health care reform ("SOTE" reform), so some of the conclusions are related to that work.

2. Overall conclusions

2. The design of the optimal system or model is dependent of two crucial aspects: (i) *the starting point*, i e how health care is provided and organized before the reform; and (ii) *the objectives that are set for the reform*, i e the desired effects that one wants to achieve by opening for competition. Often there are several sub-objectives such as reduced costs, increased accessibility or medical results, equality aspects, or freedom of choice as a value by itself. Sometimes even industrial policy goals are set, such as making it easier for small and middle-sized companies to enter the market. Thus it is impossible to give general recommendation for an optimal design without considering these aspects. A reasonable assumption is that the more sub-objectives there are, the higher the risk that not all goals are met; and that the system becomes very complex (which in turn increases the risk that the goals are not met and/or that indirect effects will occur).

3. Health care in basically all developed countries is a complex system. Moreover, how well the system function depends on the function of other closely related welfare state systems such as social services. When reforming health care by opening it for competition, (unexpected) effects may occur in the complex health care system as well as within other parts of the social safety net. This contributes to the difficulties in designing the optimal competitive model in detail in advance. There are simply many unexpected aspects that may show up along the implementation process. Thus, *how the reform is implemented* is an important aspect. In general, implementation scheme that allows for small-scale testing, continuous and systematic evaluation, and adjustments along the line are preferable as

* Associate Professor in Economics, Uppsala University

compared to a complex reform that is rushed though quickly and where evaluation is not a central part of the design. *Systematic monitoring and evaluation should be planned for from the beginning.* Questions such as who should take responsibility for doing it, which data should be gathered; are how it is financed are important to answer in advance. It is not to be expected that the research community "voluntarily" will make sure that all the aspects important for political decision-making are evaluated. This is one of the key conclusions regarding the Swedish reforms from the 1990s. Evaluation of these reforms were not systematically guaranteed.

4. Legislation regarding the activities of companies must be made so *that business secrets do not become an obstacle to systematic monitoring, control and citizens' access to information* . In Sweden these communications and the rights of workers (anonymous right to report disadvantages to the media) have been clarified in the 2010s and, the new Patient Act (2015) is designed to strengthen the status of patients based on systematic information. Efforts have been made to harmonize the role of private and public care providers right from the patient's point of view.

5. For many reasons, the competitive health care system should include a *relatively large public operator*. The main reason is to ensure universal availability for all patients/citizens. Especially in a quasi-market where prices are set by politicians rather than by market forces, there is often certain inertia and the total capacity among the private operators many be too low to meet the total need.

6. The quality and functionality of health care are guided by many factors other than compensation systems and organizational charts. The quality of the services is ultimately defined in the meeting between the patient and the healthcare worker. It is therefore important for *healthcare professionals to be included in the design and implementation of the new system and to* communicate the key incentives and principles of the plan throughout the whole line. It is also important that data collection related to the compensation system is carefully planned so that employees do not experience it as a burden but see it as necessary and beneficial. It is therefore from the beginning to make sure that there is a well-functioning feedback-loop between the top management and the professionals. Effective use of information creates the conditions for the continuous development of services and the calibration of the compensation system.

7. It is important to get the economic intensives in designing the contracts and the payment model. However, what effects payment models have on services depends on the other management of them. Laws and regulations, financial management, performance management provide, along with leadership, values and culture, management signals that interact mutually and affect one another. Generally, a complicated payment model with many goals and details is often less effective than a simple one, combined with other steering methods. Placing too much focus on the formal contracts and payment models does not produce the desired result. Culture, values, leadership and co-leadership should be given a much more prominent role at the same time as management via finances and results-based management are made less detailed and therefore more enabling. The ability to have a holistic perspective, a systems perspective, in designing new management signals is important in order to avoid contradictory or overly detailed management.

3. Addressing the specific questions

3.1. Whether to encourage competition for patients, or for contracts?

8. I would say that it impossible to say in general terms whether competition for patients or for contracts is preferable. It depends on how the contracts and the system for patient competition is formed. But most importantly, it depends on what is expected to be achieved by competition. If the main objective is to increase cost-control, competition for contracts is generally better. It is also preferable for complex health care services, where the patient needs an integrated chain of treatment. This kind of integrated services are difficult to design in a for-the-patient-efficient way anyway, but my impression is that it still is easier to combine these services into the same contracts than to achieve it within a voucher model with many independent operators. On the other hand, if the goal is increased freedom of choice for the patient and various quality gains, competition for patients is preferable.

9. Sweden's experiences from opening the primary care for competition show some increase in availability and cost control of basic health care but not cost savings. Productivity, measured at health center visits per day and labor input, has increased, but systematic research as to whether the increase in visits has led to a better (medical) outcome is not available. How the reforms have affected inequality has been difficult to study because of the lack of detailed information on medical effects. There is also a concern that more socio-economically strong groups that are "pooled" into private healthcare centers and thus allow these centers to offer better quality care and availability if reimbursement systems do not compensate for the socio-economical mix of patients. There is also evidence of a certain regional inequality; new health centers have, above all, been created in heavily populated areas.

10. In the county of Stockholm, some of the specialized health care services have been opened up for competition. This seems to have led to a significant increase of costs. Another problematic consequence of the primary care reform according to an evaluation by the Swedish Inspectorate for Social Insurance is an increase in sickness insurance use. Norwegian evidence point in the same direction – when patients can choose their doctor, the doctor’s willingness to grant a certificate advocating a period with sickness benefits is one important criteria for the patient’s choice. Similar indications have been found for prescription for antibiotics.

3.2. The advantages and disadvantages of creating competition between insurers as well as providers of healthcare services?

11. There is no Swedish experience of competition between health care insurers. I have no detailed experience of studying the existing competitive insurer models in this area. But in theory, one could argue that competition between insurers would imply incentives to put effort on preventive measures.

12. One close parallel is the Finnish occupational health care system where employers insure the employed workers and provide integrated occupational and primary care services. It has been noted to provide efficient care for the employees and keeping sickness absence low. However, in that kind of system inequality issues become more of an issue. The gap in health care availability and quality between employed and non-employed is wider than in other comparable countries such as Sweden.

3.3. How to avoid competitive distortions from 'cream-skimming'?

13. To design a competition for patient model that manages to fully deal with cream skimming has, according to my experience, shown to be difficult in practice. One reason is probably the behavior of the patients – socioeconomically strong individuals are better in demanding (good) health care. In other words, it is not only the incentives laid on the operators that matter. Having said that, the economic incentives of the payment model are of course crucial. In a capitation model (payment according to the number of listed patients at the health care center), the payment per patient should be adjusted for as many characteristics as possible that determine the risk level and the complexity of the patient. Former sickness history is one example of such characteristics. An alternative is of course to compensate for health care production, such as paying per visit, which in principle promotes patients with larger needs. In general, research from Sweden recommends a combination of these models. Putting too much weight on production, such as visits, implies a risk for sub-optimization as it gives incentives to split one problem into several visits, which most probably is not the best for the patient.

3.4. Whether to allow for-profit providers where quality is difficult to observe?

14. A short answer is no. But the question is of course how difficult it is to observe the quality for the principal making the choice (patient in a voucher model, or the civil servant responsible for the contract). In a competition-for-contract system, the problem is to find best balance between detailed quality criteria and openness for innovative ways to provide the services. One alternative then is to use continuation clauses as options. That is, using contracts that express high ambitions for quality but not very detailed criteria, and are based on a long contract period but with "control stations" along the where quality is observed. The idea is that quality is easier to observe after a while, when the services have been delivered for a while.

15. In general, my impression is that there still is a potential to create better quality indicators by acknowledging the importance of qualitative methods to gather information, enhancing dialogue between the operators and the principal, and by adopting the patient's perspective for quality.

16. In comparison with another publicly funded welfare state service, schooling, I would also say that the potential problem with quality measurement is smaller with health care services. The reason is that quality criteria from the society's perspective is more alike quality criteria from the individual perspective. Individual patients want good care that cures their ill health. The societal goal of a good health care is basically the same: to provide as good health care as possible to as many as possible (the whole population). The individual goals with education are somewhat more complex. High grades open doors to higher education and good jobs, independent on how much the student has gained knowledge. Thus, in a competitive model with for-profit providers, grades easily inflate, at least as long as it is up to the school principal to steer the grading (no systematic national testing and grading). This is deeply problematic from the society's point of view. There is Swedish evidence on exact this phenomenon in the schools.

17. Of course, the consequences of competition on sickness insurance use and prescription of antibiotics indicate that such a gap between the best for the society and the best for the individual might exist even in health care systems.

3.5. How to give state-owned operators the necessary autonomy and incentive to compete?

18. As soon as you introduce competition, both state-owned and private actors start acting according to market logic. Given that both type of operators are included in the competitive model by *approximately* same conditions (I will come back to this later on), both type of operators should experience the competitive pressure. So then the important question is whether the public operators have enough room for action, autonomy, to respond to the increased pressure implied by competition.

19. This is a question of how narrowly regulated the public operators are, i.e. how constraining the steering and management is of the public operators. That depends on several issues. One is laws and formal (state) regulations. Most of them affect the private operators as well, even though there might be a difference e.g. in terms of how much information the public operators must provide as compared to the private. This might cause a competitive burden on the public operators. On the other hand, assuring transparency among the private operators is important as well. Some reforming of the Swedish laws regulating transparency and openness among the private operators has been done to strengthen the patient safety and the possibilities for independent supervision.

20. I would say that in Sweden the main issue is not laws and formal regulation by state, rather than the culture and internal steering and management on the county level. In general, there is potential for a more trust-based, enabling steering and management. Culture, values, leadership and co-leadership should be given a much more prominent role at the same time as management via finances and results-based management are made less detailed and therefore more enabling.

21. One important and somewhat controversial question is that of "level playing field" among public and private operators. From an efficiency and fair competition point of view, one could argue for same rules and conditions. However, as I will argue on several places in the report, in a universal system that needs to provide services for all, and with varying demand, the system must contain some surplus capacity. It is natural to make the public operator provide that. If private operators go bankrupt, or decide on constraining their size or the target group, some other operator must be able to give services to those patients. When this obligation is put on a public operator, the conditions immediately differ. Thus, there is an argument for making other conditions differ as well. It is not obvious why same profitability conditions should yield for both operators, if only one of them is obliged to have surplus capacity.

3.6. How to discipline the cost of publicly funded health care services?

See chapter 3.1.

3.7. Whether to allow topping-up (allowing patients to top-up the government contribution in order to purchase a higher quantity or quality of service)?

22. Advocates of that type of system argue that more resources can be directed to the public system when the rich pay more by themselves. Topping-up increases the freedom of choice of the patient, as well. An argument against is that this leads to inequalities in service. I am not an expert on this issue, but having read and listened to some of them, I believe that it is difficult to design a long-term sustainable system with high level of good quality public services if you allow for topping-up. Especially in times of economic

downturn, the willingness among high income earners to maintain the publicly provided system is fragile. It may become a saving object and thus the share of private “top-up” steadily grows. That in turn may finally lead to an erosion of the legitimacy of the public system. There is a parallel to the Swedish sickness insurance system. It builds on a principle has become a double structure with private (collectively provided) complementary insurance on top of the public.

23. In the end, it is an ideological question which of these arguments one values the most.

3.8. How to ensure efficient exit by failing providers while preserving continuity of service?

24. The Swedish experience of competition within primary health care has not shown any large exits thus far. Thus, this question has not any significant relevance for the Swedish context. In the schooling market, however, a few schools have gone bankrupt.

25. In general, a significant challenge in this type of publicly provided, universal services where continuity is one of the important quality aspects is to find ways of making the operators improve their quality before forcing to exit. At least as long as *all* the patients have not left voluntarily. Many exits are not necessarily a sign of well-functioning (quasi)market.

26. However, in the case of exit, surplus capacity is again important to ensure that the patients are taken care of. Information about relevant alternatives should be easily found for the patient, and rules for where the patient is directed in the case that he or she does not make an active choice. I believe that the easiest way to provide this is to have a large public provider that is allowed to have surplus capacity. Another key aspect is that there are information systems that communicate with each other. The easier it is for a new care provider to observe all relevant information about the patient, the smoother the transfer.

3.9. How to address information asymmetries and empower patients to choose?

27. To ensure system monitoring and evaluation and, on the other hand, to empower patients to choose, national comprehensive registers should be available for both citizens and operators. However, Swedish evidence suggests that in spite of ambitious investments in making data available it is not all clear how much the patients base their choices on these data. On the contrary, surveys suggest that they base their choices to a high extent on recommendations from relatives and friends and a “general reputation". But on the other hand, the comparative registers are primarily used by service providers to compare themselves with competitors. This can of course have a quality enhancing effect even if citizens do not use registers. The "general reputation" of producers may also be based on the scale registers (through e.g. media), where the registers affect the choices of citizens, albeit indirectly. In addition to the content of the graduate registers, consideration should be given to how good conditions for usability can be created. In creating digitized solutions, care must be taken to ensure that the provinces do not start building their own information systems that do not "talk" with each other. *Uniform information systems, and thus comparing materials, are an important prerequisite for effective guidance as well as national monitoring*. This, such as the creation of scale clusters, will take time, which in turn motivates a gradual and moderate implementation timetable.

28. Another aspect that should matter, at least in the case of patients with chronic illnesses, is the patient's knowledge of good care and his or her participation in the care process. The more the patient knows about different aspects of the care process, the better he or she should get in demanding the right type of care and knowing the difference. Considering patients participation as an important quality criterion is thus important also in this respect.

3.10. Whether to have a regulator set fixed prices, and if so what principles should drive this?

See e.g. 31 and 3.12.

3.11. How to manage capacity constraints (for example the setting of caps and catchment areas)?

29. One obvious argument for capacity constraints such as maximum number of listed patients is the work load and working environment of the doctors. To my knowledge, such rules are applied in Norway. These have been discussed in the county of Stockholm, as well. In practice this might lead to difficulties for patients to find a care provider. However, in choosing between cap per doctor and cap per heath care center, the former should imply at least somewhat more flexible system. However, this kind of caps should be much easier to deal with if there is a large public operator with surplus capacity who can handle the variation in demand.

30. One could also argue that among private operators, for-profit is more sensitive to changes in demand, compared with non-profit. The latter have not as strong incentives to grow, as exclusivity may be part of the attraction.

3.12. How to ensure that competing services also cooperate to offer an integrated service when patients move between them?

31. To provide integrated services has shown to be one of the clear relative weaknesses of the Swedish health care system. In the end, it is a question of steering and management, with far more complicated reasons than simply the degree of competition. That is, competition has not created this problem, but it has not helped it either. Having said that, obviously the economic incentives applied on the providers play a role for how much room for action there is for cooperation and creating value for the patient. In theory, different value-based care models (bundled price models) could be one way to enhance integrated service. I am not convinced though that we yet have enough empirical evidence to draw strong conclusions. The models easily become quite complicated and data-demanding, and it is far from trivial to design the payment correct with response to the value for the patient. An alternative advice would be to build on more "soft" values in the management where the professional autonomy, holistic view, and a culture based on trust and cooperation are key words.

3.13. How to make sure that capacity of healthcare services is sufficient to cope with the demand?

32. A well-functioning, flexible and quickly adjusting system needs a relatively large public provider that is able to take care of varying demand. Or rather varying needs. I claim

that it is important to make a difference between the demand ("what individual patients wish") and their needs (what we tax-payers and citizens, though democratic processes, choose to include in the publicly funded system). In order for the public provider to be flexible and capable of having surplus capacity, the payment system and other conditions may have to differ somewhat between the private and public providers.

33. To my knowledge, some municipalities in Sweden have tested payment models directed to both private and public operators within elderly care, where the payment is divided in two: one part for the patient, and one part for providing a bed/place. This is one way of providing financial incentives to keep surplus capacity. I have not found calculations showing whether this is a more cost-efficient way of doing it, compared to financing surplus capacity at a public provider.