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FOREWORD

This document comprises proceedings in the original languages of a Roundtable on Competition to Promote Efficiency in the Provision of Hospital Services, held by the Working Party n°2 of the Competition Committee in October 2005.

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

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

PRÉFACE

Ce document rassemble la documentation dans la langue d'origine dans laquelle elle a été soumise, relative à une table ronde sur la concurrence pour promouvoir l'efficacité dans la prestation de services hospitaliers, qui s'est tenue en octobre 2005 dans le cadre du Groupe de Travail n°2 du Comité de la concurrence.

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

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

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EXECUTIVE SUMMARY

By the Secretariat

In the light of the written submissions, the background note and the oral discussion, the following points emerge:

Role of Rivalry for Provision of Hospital Services

1. *Market-oriented mechanisms can help to reduce costs of provision of hospital services, thus making limited health care funds have more impact, even systems with hospitals that are primarily government-operated.*

Increasingly, OECD members are seeking to increase the output from the limited financial resources that the state or private sector contributes to health care. Given that hospitals constitute 41% of Member country health care spending, increasing productivity and reducing unnecessary care is of great importance. Studies suggest that significant room exists to improve efficiency in the delivery of health care services. While the health care sector is one that involves many public-spirited motives, financial incentives do nonetheless have a significant influence on outcomes; appropriate incentives can increase outputs from a given level of spending, thus ensuring that public and private funds are used effectively. A number of countries that previously have not had significant market-based mechanisms for hospital services have taken steps to introduce stronger market mechanisms, including France, Germany, the Netherlands, Sweden and the United Kingdom. The introduction of market mechanisms is fully consistent with broad and equitable access to health care; it does not necessarily imply privatization or non-governmental control of facilities, but can take a variety of forms, including increased rivalry between government-operated suppliers of hospital services.

Pre-Conditions for Market Mechanisms

2. *A number of conditions must be met in order for market forces to have an effect in the health care sector.*

Some of the most important pre-conditions for market mechanisms to work are that (1) financial support for a hospital is related to the number of patients treated and their treatments, so that hospitals have an incentive to seek to treat more patients; (2) selective contracting is permitted, so that hospital service purchasers do not have to purchase from all hospitals or that hospitals offering higher levels of services for a given level of funding can receive greater numbers of patients; (3) feasible alternative suppliers must be present and they must have the capacity to take increasing volumes of patients, otherwise providers will have monopoly power and rivalry will have little impact; and (4) sufficient information is collected to judge exactly what services are provided by hospitals, ideally, including indicators of quality of care.

Ensuring that hospitals that perform well are rewarded for good performance is critical to providing incentives for efficient use of funds. In some systems where hospitals have received global budgets, introducing payments for outputs has led initially to greater funding for the more successful hospitals, but then been followed by a reduction in “base” hospital funding in order to help other hospitals that face financial difficulties as a result of being less successful. Incentives like this will not work because management will not perceive long-term advantages from good performance or detriment from bad performance. Consideration should be given to closing or changing management for hospitals that continually fail (compared to their peers) to provide a good set of outcomes in relation to resources used.

One common form of payment is based on prospective payment, where payments are based on costs in an “average” or an “exceptional” hospital. This form of payment is based on benchmark competition; the benchmark changes over time as hospitals increase their productivity.

If all capacity is fully used and no new capacity is built, direct rivalry could have much reduced impact because providers will know that, even if they do not improve services, they will not lose significant business. This does not necessarily mean that new hospitals must be built. One of the impacts of rivalry and benchmarking can be that hospitals reduce often-excessive lengths of stay, hence freeing capacity, as was the case with the introduction of prospective payment in the United States in 1982, which resulted in reduced patient lengths-of-stay and shifting surgeries to outpatient settings so that hospital occupancy rates fell from 74.6% in 1982 to 63.6% in 1986. Improved surgical technology (with shorter recovery times) has led to a reduction in lengths of stay as well, freeing capacity. Even hospitals that are apparently full may have the ability to increase capacity. For example, in France, some hospitals provide the option of private rooms (with patients paying a premium for private rooms) but eliminate this option when patient numbers are high.

One of the most basic ways to reward efficient providers is by giving them more patients, which typically implies giving less efficient providers fewer patients. Selective contracting is one way to ensure these rewards, meaning that, in systems with multiple purchasers of services (such as insurance companies or physicians) the purchasers are not obliged to contract with all potential providers of a service, but can selectively contract with a limited number of providers. In systems with only one purchaser of services (such as the state), absolute selective contracting may be more difficult, because it could imply that a hospital without a contract would go out of business, but partial selective contracting, in which “preferred” hospitals receive a higher percentage of patients for certain types of care, may be feasible.

In some health care systems, hospitals have not kept records of treatment in a consistent manner that is comparable across hospitals. In absence of such information, benchmarking and effective use of resources is difficult to ensure and manage, whether for government or private payors. Collecting detailed comparable information on treatments may help to promote rivalry and identification of best practices.

Heterogeneity of Hospital Services

3. *Some hospitals services benefit more from competition than others and this competition need not always come from hospitals themselves.*

Hospital services are a complex set of products and services that encompass many different types of patient-oriented activities. In addition to surgical, maternity and inpatient care, hospitals typically offer emergency care, a variety of diagnostic services and pharmacies. For some

services, such as emergency services, a hospital may have few, if any, competitors because ambulances with patients needing critical care must go to the nearest hospital to ensure fast treatment. For other services, such as surgeries, hospitals may compete with other hospitals and ambulatory surgery centers and, for diagnostic and pharmacy services, hospitals may compete with a variety of non-hospital providers. Typically, more advanced surgical services will be provided by fewer hospitals and may be less competitive.

Health care services, including hospital services, combine unusual features that could result in excessive spending from the adoption of a pure free-market approach. In particular, health insurance implies that consumers pay a much lower cost than the marginal cost of services they receive, so they will demand services even when the cost of the service is higher than the patient's expected gain. An information problem also exists, because consumers have difficulty assessing the quality of care both before and after the delivery of services, which could permit revenue maximizing health care providers to provide excess and low-quality services. As a result, most countries reasonably place constraints on the extent to which a complete free-market operates.

Different Effect of Competition for Rural Hospitals and Highly Sophisticated Services

4. *When hospitals are located in rural areas or services in question are highly sophisticated and provided by few hospitals, competition with other hospitals is likely less effective for encouraging better use of resources; when hospitals are located in areas with multiple competing service providers, competition will reward those who use resources better.*

Not all hospitals are equally susceptible to benefits of market forces. Canada stated that "Careful consideration is required of the feasibility of competition with respect to different hospital services and for different regions of the country. While it may be feasible in relation to relatively standardized services in densely populated areas, for other more complicated or rare services, teaching hospitals and less densely populated areas, the potential for competition may be limited." For rural hospitals, for example, direct competition cannot be expected to provide a strong incentive for improvement in the provision of services. However, even for such rural hospitals, benchmark competition (based on prospective payment) can provide significant incentives for improvement. Benchmark competition may be difficult to implement, however, outside of a state-operated payment system. When a state-operated payment system co-exists with a non-state system, hospitals with market power because of limited direct competition may seek to set higher prices to non-state payors in order to make up for shortages from state reimbursement. Often, in a mixed payor system, market mechanisms cannot be fully relied upon to provide a strong incentive for rural hospitals to improve service.

Anti-Competitive Restrictions on Labour Use

5. *Anti-competitive restrictions by professionals and other staff can be reduced to permit more flexible uses of resources, according to patient needs and hospital resources.*

Professional and staff restrictions can result in significantly lowered hospital productivity, as when nurses are not permitted to perform certain tasks for which they are or could be easily trained, or when strict rules determine whether a person working in one area of the hospital can, in case of need, perform work in another part of the hospital. Such restrictions are sometimes put in place by professional rules that have the effect of limiting the ability of otherwise qualified personnel to perform tasks. Greater flexibility over tasks can greatly enhance productivity of personnel. Restrictive rules, particularly those developed by self-regulating professions, should

be carefully examined to see whether their impact is beneficial to the health care system as a whole.

Non-governmental Provision of Hospital Services

6. *Non-governmental operation of hospitals or non-hospital service providers will often result in better outcomes and, consequently, it is valuable to have such options present.*

Many countries have non-governmental hospitals, including Australia, Canada, Denmark, France, Germany, the Netherlands, Switzerland, the United Kingdom and the U.S.. Many owners are non-profit organizations, while others, in some cases, are for-profits. For-profit hospitals often can serve both private and, increasingly, public patients. In the United Kingdom, a number of new hospitals are being constructed under private contracts in part because private hospital operators are able to construct new facilities more quickly than under government operation. In Denmark, as of 2002, a system was implemented that gave patients the option to receive funded care from private hospitals in Denmark or other countries if their home county hospital was not able to guarantee treatment within two months, provided that a contract exists between the society of Danish counties and the private service provider. Of the 160 private care providers with whom agreements have been struck, 20 are located in Germany and Sweden.

Better outcomes from non-government control are much less likely to occur when physicians are major financial beneficiaries of hospital profits, whether through direct ownership or other means. As in Sweden, hospital facilities themselves can continue to be run by the state even after some hospital operations are run by private operators. Some countries, such as France and the U.S., have introduced rules that restrict the ability of physician-owned facilities to serve patients who are paid by government funds. There is evidence that such hospitals will seek to siphon the less complicated cases for themselves while leaving more complicated cases for the public hospital system, raising the average cost for treating a condition in public hospitals.

Benchmark Competition

7. *Benchmark competition can be particularly effective for providing incentives for hospitals to achieve better performance.*

Prospective payment is often adjusted based on performance of median or best practice hospitals. Many countries are introducing prospective payment systems in order to encourage hospitals to improve their outputs for the funds they receive. When hospitals are paid based on the number of days of care they provide, they can have an incentive to increase lengths of stay unnecessarily. For example, a number of jurisdictions have recently introduced prospective payment systems including Denmark, Germany, France, Japan, Norway and parts of Sweden and Switzerland.

Benchmarking can also be used to provide incentives for hospitals to deliver higher quality care. In the United States, hospitals are given financial incentives to report data that provides indicators of quality of care. Those hospitals that are deemed to provide among the highest quality of care (compared to others) then receive extra payments from many government-reimbursed patients.

Purchasing with Budgets

8. *Physician-led or insurer-led purchasing can yield significant improvements in total hospital services received from given resources.*

Physician led purchasing by primary care physicians has been introduced in the UK. Physicians or physician groups are given a budget for their patients, based on expected costs of their register of patients. If there are catastrophic cases, these can be excluded from the overall budget, to provide better incentives for physicians to carefully select both which patients receive care and where they go for their care. Studies suggest that such approaches lead to better use of resources even when the physicians do not receive direct payments.

Consumer Mobility and Choice

9. *When waiting lists are long, permitting funds to follow patients will help to reduce length of waiting lists and increase output.*

Many countries have suffered from long waiting times for scheduled surgeries. One approach that can be adopted in such situations is to give physicians or patients the right to choose where they will receive care. In Sweden, where counties are responsible for providing care, if patients waited more than a certain amount of time, they were permitted to go outside of their county to receive care, and the counties would then have to pay hospitals outside of the county for the care that was provided. For cataract procedures, for example, the introduction of this law was related to a significant increase in the total number of procedures performed and a reduction in average waiting time. Long waiting times may have been discouraging physicians from proposing surgeries that they felt would be valuable for patients. However, relatively little switching occurred, in part because of poor information available to consumers and physicians about wait times in different hospitals. This lack of widely accessible information has led the Swedish Federation of County Councils to begin a project to collect and distribute information about wait times over the Internet.

Centres of Excellence

10. *While in general, limiting the number of hospitals that can perform a service will not promote best use of resources, for certain intensive, high-end services with large economies of scale, focusing on the creation of centers of excellence can help to increase both the quantity and quality of services.*

Open-heart surgeries and organ transplants have been shown to benefit from significant economies of scale in operation. This means that focusing patient care in a limited number of facilities can actually have significant benefits for reducing costs. Moreover, it has been shown that centers of excellence can increase quality of care, because the personnel have more regular practice in dealing with a given condition and its complications. An open-heart surgery unit that deals with more than 5 cases per week will often have much better results, per patient, than a unit that deals with just one case per week. Competition for open-heart surgery can result in more hospitals having lower numbers of patients, largely because hospitals perceive it is prestigious to have an open-heart surgery center, even when few procedures are performed. This illustrates how competition with no entry constraints for certain very expensive and high-end services may actually increase system costs, and in these limited instances, restrictive entry may yield better outcomes.

Competition Policy Applied to Hospitals

11. *Introduction of market mechanisms requires that governments pay attention to structural conditions in the market (through merger control) and co-ordination among suppliers (through anti-cartel programs.)*

Many countries now have experience with competition law investigations or enforcement in the health sector, including Argentina, Australia, Brazil, Chinese Taipei, Germany, Italy, Korea, Mexico, the Netherlands, New Zealand, South Africa, Switzerland and the U.S.. At least four of these countries had hospital merger cases in 2005. Largely because of longstanding existence of private markets in health care, the U.S. has had the longest experience of competition cases in this area and has actually had groups of attorneys dedicated to health care issues for decades. Cases related to hospitals can involve hospital mergers, planning licenses, system-wide negotiation, joint hospital and physician negotiations, hospital exclusivity and most-favoured supplier contracts. Hospital merger enforcement by competition authorities is complex, largely because of the necessarily predictive nature of merger enforcement, the public service nature of hospitals, the complications of defining geographic market appropriately and the complicated nature of hospital services. After a number of lost merger challenges by U.S. agencies, in a recent case, the U.S. FTC challenged a previously consummated merger with the allegation that prices had increased substantially after the merger. The judge's decision found for the U.S. FTC, finding that prices had risen significantly as a result of hospital merger in a major metropolitan area with a number of non-merging hospitals nearby. Other countries have recently successfully challenged mergers or reached divestiture agreements in system mergers.

SYNTHESE

par le Secrétariat

Les points suivants ressortent des contributions écrites, du document de référence et des débats oraux :

Rôle de la concurrence dans l'offre de services hospitaliers

1. *Des mécanismes de marché peuvent aider à réduire les coûts de l'offre de services hospitaliers, de sorte que les fonds limités consacrés aux soins de santé peuvent avoir plus d'impact, même dans les systèmes où les hôpitaux sont principalement à gestion publique.*

De plus en plus, les pays membres de l'OCDE cherchent à accroître le rendement des ressources financières limitées que consacrent l'Etat ou le secteur privé aux soins de santé. Etant donné que les hôpitaux représentent 41% des dépenses en soins de santé dans les pays membres, l'augmentation de la productivité et la réduction des soins inutiles revêtent une grande importance. Des études tendent à prouver qu'il existe une marge significative d'amélioration de l'efficacité dans la fourniture des services de santé. Même si le secteur de la santé met en jeu de nombreuses considérations d'intérêt général, les incitations financières n'en ont pas moins une incidence sur les résultats ; des incitations appropriées peuvent accroître le rendement d'un niveau donné de dépenses, garantissant ainsi une utilisation efficace des fonds publics et privés. Un grand nombre de pays qui précédemment n'avaient pas mis en place des mécanismes de marché d'une certaine ampleur pour leurs services hospitaliers ont pris des mesures pour les renforcer, notamment la France, l'Allemagne, les Pays-Bas, la Suède et le Royaume-Uni. L'introduction des mécanismes de marché est pleinement compatible avec un accès large et équitable aux soins de santé ; elle n'implique pas nécessairement une privatisation ou un contrôle non public des établissements, mais peut prendre diverses formes, notamment une concurrence accrue entre prestataires de services hospitaliers à gestion publique.

Conditions préalables nécessaires à la mise en place de mécanismes de marché

2. *Un certain nombre de conditions doivent être remplies pour que les forces du marché aient un effet dans le secteur des soins de santé.*

Pour que les mécanismes de marché fonctionnent, il faut qu'un certain nombre de conditions préalables soient remplies : (1) le soutien financier dont bénéficie un hôpital doit être lié au nombre de patients traités et aux traitements proposés, de sorte que les hôpitaux soient incités à chercher à traiter davantage de patients ; (2) le contrat sélectif doit être autorisé, de façon que les acheteurs de services hospitaliers ne soient pas obligés d'acheter des services à tous les hôpitaux et que les hôpitaux offrant des services de plus haut niveau pour un niveau de financement donné puissent accueillir davantage de patients ; (3) d'autres fournisseurs possibles doivent être présents et ils doivent avoir la capacité d'absorber des volumes croissants de patients ; sinon les prestataires auraient un pouvoir de monopole et la compétition n'aurait guère d'impact ; et (4) des informations suffisantes doivent être rassemblées pour juger précisément des services fournis par les hôpitaux, y compris, idéalement, des indicateurs de la qualité des soins.

Il est essentiel de veiller à ce que les hôpitaux qui ont de bons résultats soient récompensés pour leurs performances afin d'inciter à une utilisation efficiente des fonds. Dans certains systèmes où les hôpitaux ont reçu un budget global, l'introduction du paiement aux résultats a conduit initialement à une augmentation du financement accordé aux hôpitaux qui obtiennent de meilleurs résultats, mais cette phase a été suivie d'une réduction du financement "de base" afin d'aider d'autres hôpitaux qui ont des difficultés financières parce qu'ils réussissent moins bien. Des incitations de ce type ne fonctionneront pas, parce que la direction ne percevra pas les avantages à long terme de bonnes performances – ou les inconvénients de mauvais résultats. Il faudrait envisager des fermetures ou des changements de direction d'hôpitaux qui ne réussissent pas (contrairement à leurs pairs) à fournir durablement une bonne palette de résultats en rapport avec les ressources employées.

Une forme courante de paiement est le paiement prospectif, basé sur les coûts des soins dans un hôpital "moyen" ou "exceptionnel". Cette forme de règlement se fonde sur la concurrence par étalonnage ; le critère de référence appliqué évolue avec le temps, à mesure que les hôpitaux accroissent leur productivité.

Si toutes les capacités sont pleinement utilisées et aucune capacité nouvelle n'est créée, la concurrence directe peut avoir beaucoup moins d'impact car les prestataires sauront que même s'ils n'améliorent pas les services, ils ne perdront pas grand chose. Cela ne signifie pas nécessairement qu'il faille construire de nouveaux hôpitaux. L'un des effets de la concurrence et de l'analyse comparative peut être que des hôpitaux réduisent la durée souvent excessive des séjours, libérant ainsi des capacités, comme cela a été le cas avec l'introduction du paiement prospectif aux Etats-Unis en 1982 : il s'est traduit par une réduction de la durée des séjours et par un transfert d'actes chirurgicaux à des centres de soins ambulatoires, de sorte que les taux d'occupation dans les hôpitaux sont tombés de 74.6% en 1982 à 63.6% en 1986. L'amélioration des techniques chirurgicales (avec diminution des temps de récupération) a conduit également à une réduction de la durée des séjours, libérant des capacités. Même des hôpitaux qui apparemment pleins sont susceptibles d'augmenter leur capacité. En France, par exemple, certains hôpitaux offrent des chambres individuelles (les patients payant pour cela un supplément), sauf lorsque le nombre de patients est élevé.

L'un des moyens les plus simples de récompenser les prestataires efficaces est de leur donner plus de patients, ce qui implique habituellement d'en donner moins aux prestataires moins efficaces. Le contrat sélectif est une forme de récompense : dans les systèmes à acheteurs multiples de services (par exemple les sociétés d'assurance ou les médecins), les acheteurs ne sont pas obligés de contracter avec tous les fournisseurs potentiels d'un service ; ils peuvent choisir un nombre limité de fournisseurs. Dans les systèmes à un seul acheteur de services (tel l'Etat), le contrat sélectif absolu peut être plus difficile à mettre en œuvre, car il impliquerait qu'un hôpital sans contrat fasse faillite ; en revanche, un régime partiellement sélectif avec lequel des hôpitaux préférés reçoivent un pourcentage de patients plus élevé pour certains types de soins semble possible.

Dans certains systèmes de soins de santé, les hôpitaux n'ont pas gardé trace des traitements d'une manière suffisamment cohérente pour permettre des comparaisons. En l'absence de telles informations, l'analyse comparative et l'utilisation efficace des ressources sont difficiles à assurer et à gérer, tant pour l'Etat que pour les bailleurs de fonds privés. La collecte d'informations comparables détaillées sur les traitements peut aider à promouvoir la concurrence et l'identification des meilleures pratiques.

Hétérogénéité des services hospitaliers

3. *Certains services hospitaliers bénéficient davantage de la concurrence que d'autres, et cette concurrence ne vient pas nécessairement toujours des hôpitaux eux-mêmes.*

Les services hospitaliers sont un ensemble complexe de produits et services qui englobent de nombreux types différents d'activités en direction des patients. En plus des soins chirurgicaux, de maternité et d'hospitalisation, les hôpitaux offrent généralement des soins d'urgence, divers services de diagnostic et des services de pharmacie. Pour certains services, comme les urgences, un hôpital peut avoir peu ou pas de concurrents, parce que les ambulances qui transportent les patients ayant besoin de soins intensifs doivent se rendre à l'hôpital le plus proche pour qu'ils soient traités le plus rapidement possible. Pour d'autres services, tels ceux de chirurgie, les hôpitaux peuvent être en concurrence avec d'autres hôpitaux et centres de chirurgie ambulatoire et, pour les services de diagnostic et de pharmacie, ils peuvent avoir comme concurrents toute une gamme de prestataires non hospitaliers. En général, les services chirurgicaux les plus avancés seront proposés par un petit nombre d'hôpitaux et risquent d'être moins soumis à la concurrence.

Les services de santé, y compris les services hospitaliers, combinent des caractéristiques inhabituelles qui pourraient entraîner des dépenses excessives si l'on adoptait une approche de marché totalement libre. L'assurance maladie, en particulier, implique que les consommateurs paient un coût très inférieur au coût marginal des services qu'ils reçoivent, de sorte qu'ils vont exiger des services même lorsque le coût en est plus élevé que le gain qu'ils en attendent. Il existe aussi un problème d'information, car les consommateurs ont du mal à évaluer la qualité des soins aussi bien avant qu'après la fourniture des services, ce qui pourrait permettre à des prestataires de soins de santé souhaitant maximiser leurs recettes de fournir des soins en excès et de mauvaise qualité. En conséquence, la plupart des pays ont raison de mettre des freins au développement d'un marché complètement libre.

Effet différent de la concurrence pour les hôpitaux des zones rurales et pour les services extrêmement complexes

4. *Lorsque les hôpitaux sont situés en zone rurale ou que les services considérés sont extrêmement complexes et fournis par un petit nombre d'hôpitaux, la concurrence avec d'autres hôpitaux risque d'être moins efficace pour encourager une meilleure utilisation des ressources ; lorsque les hôpitaux sont situés dans des zones où opèrent de multiples prestataires de services concurrents, la compétition récompensera ceux qui font le meilleur usage des ressources.*

Les hôpitaux ne sont pas tous susceptibles de bénéficier également des forces du marché. Comme l'indique le Canada : "Il faut examiner soigneusement la « faisabilité » de la concurrence pour différents services hospitaliers et pour différentes régions du pays. Si la concurrence semble possible pour ce qui est des services relativement standardisés dans des zones à forte densité de population, pour d'autres services plus compliqués ou plus rares pour les centres hospitaliers universitaires et les zones moins peuplées, les possibilités de concurrence peuvent être limitées." Pour les hôpitaux en zone rurale, par exemple, on ne peut pas s'attendre à ce qu'une concurrence directe incite fortement à améliorer la prestation des services. Cependant, même pour ces hôpitaux, la concurrence par étalonnage (basée sur le paiement prospectif) peut grandement inciter à l'amélioration. La mise en concurrence par étalonnage des performances peut néanmoins être difficile à mettre en œuvre en dehors d'un système de paiement étatique. Lorsqu'un système de paiement étatique coexiste avec un système non étatique, les hôpitaux détenant un pouvoir de marché à la faveur d'une concurrence directe limitée peuvent chercher à

facturer des prix plus élevés aux payeurs autres que l'Etat afin de rattraper les remboursements insuffisants de l'Etat. Souvent, dans un système mixte, on ne peut se fier totalement aux mécanismes de marché pour inciter fortement les hôpitaux des zones rurales à améliorer leurs services.

Restrictions anticoncurrentielles à l'utilisation de la main d'oeuvre

5. *Il est possible de réduire les restrictions anticoncurrentielles appliquées par les professionnels et autres personnels pour permettre une utilisation plus flexible des ressources, conformément aux besoins des patients et aux ressources hospitalières.*

Les restrictions appliquées par une profession ou applicables au personnel hospitalier peuvent entraîner une productivité nettement moindre ; ainsi lorsque les infirmières ne sont pas autorisées à exécuter certaines tâches pour lesquelles elles peuvent ou pourraient facilement être formées, ou lorsque des règles strictes déterminent si une personne travaillant dans un secteur de l'hôpital peut, en cas de besoin, intervenir dans une autre partie de l'hôpital. De telles restrictions sont parfois mises en place par des réglementations professionnelles qui ont pour effet de limiter la possibilité qu'auraient des personnels autrement qualifiés d'accomplir certaines tâches. Une plus grande flexibilité pour certaines tâches peut améliorer grandement la productivité du personnel. Les réglementations restrictives, notamment celles qui sont établies par des professions auto-réglementées, devraient être soigneusement examinées afin de déterminer si leur impact est bénéfique pour le système de santé dans son ensemble.

Fourniture non publique de services hospitaliers

6. *Des hôpitaux à gestion non publique ou des prestataires de services non hospitaliers donnent souvent de meilleurs résultats et il est utile, par conséquent, d'avoir de telles options présentes à l'esprit.*

Beaucoup de pays ont des hôpitaux non publics, notamment l'Australie, le Canada, le Danemark, la France, l'Allemagne, les Pays-Bas, la Suisse, le Royaume-Uni et les Etats-Unis. Beaucoup de leurs propriétaires sont des organisations sans but lucratif, tandis que d'autres, dans certains cas, sont à but lucratif. Les hôpitaux à but lucratif peuvent souvent accueillir à la fois des patients privés et, de plus en plus, des patients du système public. Au Royaume-Uni, de nombreux hôpitaux sont construits actuellement sous contrat privé, en partie parce que les opérateurs privés sont capables de construire de nouveaux établissements plus rapidement que les opérateurs publics. Au Danemark, depuis 2002, on donne aux patients le choix de recevoir des soins dans des hôpitaux privés au Danemark ou dans d'autres pays si l'hôpital de leur comté d'origine n'est pas en mesure de leur garantir un traitement dans un délai de deux mois, à condition qu'un contrat ait été conclu entre l'association des comtés danois et le prestataire privé. Parmi les 160 fournisseurs de soins privés avec lesquels des contrats ont été conclus, 20 sont situés en Allemagne et en Suède.

De meilleurs résultats en cas de contrôle non public ont beaucoup moins de chances de se produire lorsque les médecins sont les principaux bénéficiaires des profits hospitaliers, soit du fait qu'ils sont directement propriétaires, soit par d'autres moyens. Comme en Suède, les établissements hospitaliers eux-mêmes peuvent continuer à être gérés par l'Etat même après que certaines fonctions aient été confiées à des opérateurs privés. Certains pays, comme la France et les Etats-Unis, ont introduit des règles qui limitent la possibilité pour les établissements appartenant à des médecins d'accueillir des malades qui sont pris en charge sur fonds publics. On constate que ces hôpitaux chercheront à attirer les cas les moins complexes pour laisser les plus

difficiles aux hôpitaux publics, augmentant le coût moyen de traitement d'une pathologie dans les hôpitaux publics.

Concurrence par étalonnage

7. *La concurrence par étalonnage peut être particulièrement efficace pour inciter les hôpitaux à réaliser de meilleures performances.*

Le paiement prospectif est souvent ajusté en fonction des performances de l'hôpital médian ou des meilleures pratiques. Beaucoup de pays introduisent les systèmes de paiement prospectif pour inciter les hôpitaux à améliorer leurs résultats par rapport aux financements qu'ils reçoivent. Lorsque des hôpitaux sont payés sur la base du nombre de jours de soins qu'ils fournissent, ils peuvent être incités à augmenter inutilement la durée des séjours. Par exemple, un certain nombre de pays ont introduit récemment des systèmes de paiement prospectif, dont le Danemark, l'Allemagne, la France, le Japon, la Norvège et certaines parties de la Suède et de la Suisse.

La concurrence par l'étalonnage peut aussi être utilisée pour inciter les hôpitaux à fournir des soins de meilleure qualité. Aux Etats-Unis, les hôpitaux reçoivent des incitations financières pour fournir des données contenant des indicateurs de la qualité des soins. Les hôpitaux qui sont réputés assurer la plus haute qualité de soins (par rapport aux autres) reçoivent des paiements complémentaires de la part de nombreux patients remboursés par le système public.

L'achat avec budget

8. *L'achat déterminé par le médecin ou l'assureur peut entraîner de nettes améliorations par rapport au total des services hospitaliers obtenus pour des ressources données.*

L'achat déterminé par le médecin généraliste a été introduit au Royaume-Uni. Des médecins ou groupes de médecins reçoivent un budget donné pour leurs patients, basé sur les coûts prévisibles au vu des patients inscrits aux cabinets des praticiens. Les pathologies extrêmement graves peuvent être exclues du budget général, ceci pour mieux inciter les médecins à choisir soigneusement à la fois les patients qui reçoivent des soins et l'établissement qui les accueillera. Des études donnent à penser que de telles formules permettent de mieux utiliser les ressources, même lorsque les médecins ne reçoivent pas de paiements directs.

Mobilité et choix des consommateurs

9. *Lorsque les listes d'attente sont longues, adopter le principe « l'argent suit le patient » contribue à réduire les listes d'attente et à accroître la production.*

Beaucoup de pays ont connu de longs délais d'attente pour des interventions chirurgicales programmées. Une solution susceptible d'être adoptée dans de telles situations consiste à donner aux médecins ou aux patients le droit de choisir où ils veulent recevoir des soins. En Suède, où les comtés sont responsables de l'offre de soins, si les patients ont attendu plus qu'un certain délai, ils sont autorisés à être soignés hors de leur comté, celui-ci devant ensuite rembourser aux hôpitaux extérieurs les soins qu'ils ont prodigués. Pour la cataracte, par exemple, cela s'est traduit par une forte augmentation du nombre total d'interventions et une réduction du temps d'attente moyen. De longues attentes ont pu décourager certains médecins de proposer des interventions chirurgicales utiles à leurs patients. Cependant, il y a eu relativement peu d'interventions hors comté, en partie à cause d'une information insuffisante des patients et des médecins sur les délais à prévoir dans les différents hôpitaux. Ce manque d'informations

largement accessibles a conduit la Fédération suédoise des Conseils des comtés à lancer un projet de collecte et de diffusion sur Internet d'informations sur les délais d'attente.

Centres d'excellence

10. *Alors qu'en général limiter le nombre des hôpitaux qui peuvent assurer un certain service n'encouragera pas une meilleure utilisation des ressources, pour certains services intensifs à haute valeur ajoutée comportant d'importantes économies d'échelle, privilégier la création de centres d'excellence peut aider à augmenter tant la quantité que la qualité des services.*

Les opérations à coeur ouvert et les greffes d'organes semblent avoir bien tiré parti d'importantes économies d'échelle. Autrement dit, concentrer les soins aux malades dans un nombre limité d'établissements peut effectivement être très bénéfique du point de vue de la réduction des coûts. De plus, il est prouvé que des centres d'excellence peuvent améliorer la qualité des soins, parce que le personnel a plus l'habitude de traiter certaines pathologies et leurs complications. Une unité de chirurgie cardiaque qui effectue plus de 5 opérations à coeur ouvert par semaine aura souvent des résultats bien meilleurs, par malade, qu'une unité qui ne traite qu'un cas par semaine. La concurrence pour les opérations à coeur ouvert peut se traduire par une situation dans laquelle plus d'hôpitaux ont moins de patients, essentiellement parce que les hôpitaux estiment prestigieux d'avoir un centre de chirurgie cardiaque, même s'ils effectuent peu d'opérations de ce type. Ceci illustre comment la concurrence sans contraintes à l'entrée pour certains services très onéreux et à forte valeur ajoutée peut effectivement accroître les coûts du système, alors qu'en l'occurrence des restrictions à l'entrée peuvent produire de meilleurs résultats.

La politique de la concurrence appliquée aux hôpitaux

11. *L'introduction de mécanismes de marché exige que les pouvoirs publics prêtent attention à la structure du marché (par le contrôle des fusions) et à la coordination entre fournisseurs (par des mesures de lutte contre les ententes).*

De nombreux pays ont acquis une certaine expérience des enquêtes et de l'application du droit de la concurrence dans le secteur de la santé, notamment l'Argentine, l'Australie, le Brésil, le Taipei chinois, l'Allemagne, l'Italie, la Corée, le Mexique, les Pays-Bas, la Nouvelle-Zélande, l'Afrique du Sud, la Suisse et les Etats-Unis. Au moins quatre de ces pays ont connu des affaires de fusion d'hôpitaux en 2005. C'est en grande partie parce qu'il existe aux Etats-Unis depuis longtemps des marchés privés pour les soins de santé que ce pays a la plus longue expérience d'affaires de concurrence dans ce domaine et qu'il possède depuis plusieurs années des cabinets d'avocats spécialisés dans ces questions. Les affaires en rapport avec les hôpitaux peuvent concerner des fusions d'hôpitaux, les autorisations d'urbanisme, la négociation à l'échelle du système tout entier, les négociations communes hôpital/praticien, l'exclusivité et les contrats avec clause du fournisseur le plus favorisé. Pour les autorités de la concurrence, l'application de la loi dans les cas de fusions d'hôpitaux pose des problèmes complexes, notamment en raison de son caractère nécessairement prédictif, de la mission de service public des hôpitaux, des difficultés qu'il y a à bien définir géographiquement le marché et de la complexité inhérente aux services hospitaliers. Après un certain nombre de procès perdus par des autorités américaines de la concurrence, la FTC a contesté dans une affaire récente une fusion déjà réalisée en faisant valoir que les prix ont considérablement augmenté après la fusion. Le juge s'est prononcé en faveur de la FTC, considérant que les prix avaient considérablement augmenté à la suite d'une fusion d'hôpitaux dans une grande zone métropolitaine par rapport aux prix pratiqués par des hôpitaux proches

n'ayant pas fusionné. D'autres pays ont récemment réussi à remettre en cause des fusions ou sont parvenus à des accords de démantèlement à l'occasion de fusions d'établissements de santé.

BACKGROUND NOTE

COMPETITION AND RELATED MECHANISMS TO ENHANCE EFFICIENCY IN THE PROVISION OF HOSPITAL SERVICES

1. Introduction

Hospital services constitute a significant portion of total health spending and government spending in OECD countries. As of 2002, inpatient care accounted for 41% of OECD Member country health-care spending. Moreover, OECD governments were responsible for 85% of inpatient care expenditures.¹ Over the last 10 years, spending for hospital services has increased at a rate substantially in excess of CPI inflation. With the demographic trends resulting from an aging population, this trend is expected to continue. Because of the high percentage of national income and government budget typically associated with the provision of hospital services, ensuring efficiency of their delivery is a matter of great policy importance in most OECD countries, particularly because there is substantial evidence that hospital services are not always delivered as efficiently as they could be. One increasingly common approach for increasing efficiency is to enhance the degree of competition that operates for the provision of hospital services. The purpose of this paper is to identify, describe and provide a preliminary assessment of the different competitive mechanisms that are being adopted to increase the efficiency of hospital care delivery.

Market-based mechanisms within the health care system are in place or being considered in many countries including those with national health care systems. A number of countries are introducing contracting mechanisms that have competitive features and reward good performance. In the UK, for example, a new system of purchasing of hospital services by physicians was announced in October, 2004. In Germany, a new prospective payment system has been introduced. In the US, there is an increased willingness to award a bonus to providers based on quality comparisons. While competitive approaches are becoming more common, competition for provision of hospital services is often limited through government regulations and payor standards for reimbursements. These limits substantially influence the provision of hospital services.

Competition between providers of hospital services can have a number of impacts, including reducing excessive hospital stays, reducing costs of providing care and improving quality of care.² Overall, experience suggests:

- Providers and purchasers of hospital services do respond to financial incentives for more efficient provisions.
- Competition among hospitals or other hospital-service providers can, for many services, lead to more efficient delivery of hospital services, encompassing lower costs, higher quality or a combination of both.

1 Source: OECD Health Data 2005. For related statistics, see Table 1.

2 Previous OECD work that focuses on benefits that can arise from increased competition for hospital services includes Oxley and MacFarlan (1994) and Docteur and Oxley (2003).

- When competition operates only in the “quality” dimension and supply is variable, the result can, at times, be higher costs without compensating benefits.
- Even in systems in which the provision of hospital services is provided largely by the government, there may, nonetheless, be a valuable role for competition either within the public sector itself or with private hospitals. The real challenge is to identify the ways and means by which competition affects the incomes of publicly run hospitals.
- Unrestricted freedom of choice by patients who bear only a small cost of care may increase system costs because such patients do not bear the costs of their choices; choice over a limited network of hospital service providers or by other actors who face a budget constraint (such as doctors) may be more effective for providing an incentive to reduce costs and prices.
- Effective price competition requires excess capacity in order to ensure that the purchaser has a credible threat to move purchases elsewhere.
- Once competitive incentives are in operation, governments need to pay attention to structural conditions in the market (through merger control) and co-ordination among suppliers (through anti-cartel programmes).

Hospital services themselves are a complex set of products and services that encompass many different types of patient-oriented activities. In addition to surgeries, maternity and inpatient bed care, hospitals offer emergency care, a variety of diagnostic services, pharmaceuticals and other support services. For some services, such as emergency services, a hospital may have few, if any, competitors. For other services, such as inpatient scheduled surgeries, a hospital may compete for patients with other hospitals that offer comparable care. High-level services (sometimes called tertiary services), such as open heart, transplant, burn unit and neonatal services, may not be offered by many hospitals. Finally, for some services such as diagnostic services, specialist consultations and outpatient services, hospitals may at times compete with diagnostic centres, doctors’ offices and ambulatory surgery centres. None of these alternative non-hospital providers are able to provide the broad range and depth of services as a general acute-care hospital and thus cannot be considered as full substitutes to a hospital. To the extent that these services are substitutes for certain hospital services, efficiency may sometimes be enhanced through their provision outside of a hospital setting.³

Health care services, including hospital services, combine a number of unusual features that could result in excessive spending from the adoption of a pure free-market approach. These features include (1) an insurance effect, arising from the fact that consumers often pay a price that is much lower than the marginal cost of the services they receive (and so demand services even when the cost of the service is higher than the expected gain) (2) an information effect because consumers have difficulty assessing the quality of care both before and after the delivery of services and (3) a distributional welfare goal of broad health care coverage that includes coverage for the disadvantaged and the poor. Taking into account these features of the health care sector, there are circumstances in which competition is associated with increased efficiency.

This paper will identify a number of mechanisms for enhancing the efficiency of the provision of hospital services. Each mechanism has been tried in at least one OECD Member country. Even relatively weak financial incentives can have substantial cost reducing impacts or quality increasing impacts. If appropriate mechanisms were introduced across the OECD, substantial savings and quality improvements

3 The multi-product nature of hospital services can make the estimation of costs for providing particular services especially difficult.

could be achieved. If inpatient costs were reduced by 1.0% in all OECD countries, more than 8 billion USD would be saved on an annual basis.

Mechanisms for increasing competition or market forces identified in this paper include:

- Collecting and distributing improved information on provider performance;
- Supporting new entry when entry and exit costs are low;
- Encouraging increasingly independent and private operation of facilities;
- Improving allocation of human resources, particularly through assessment of anti-competitive restrictions by professionals;
- Introducing contracts that reward performance and output;
- Providing for greater consumer choice, particularly when waiting lists are long;
- Emphasizing regional centres for complex procedures;
- Considering permits for outpatient ambulatory care centres and specialty hospitals;
- Introducing contestable management of hospitals; and
- Applying competition law.

Overall, this paper finds that there is great potential for the use of competitive and market-oriented incentive mechanisms to increase efficiency of the production of hospital services. In a number of instances, substantial savings or quality improvements have followed from such mechanisms. Competition and market-oriented mechanisms have had substantial benefits. For example, evidence reviewed in this paper suggests that, at least in some circumstances:

- Competitive tendering of laboratory services can save 30% or more;
- Price competition between selectively contracted hospitals can lead to price reductions of 7% or more;
- Benchmarking of payment levels against most efficient hospitals can lead to 6% reduction in costs at less efficient hospitals;
- Physician budgets can result in reductions of admissions by 3.3%;
- Per case payments can save 10% or more compared to hospital financing that is based primarily on previous spending; and
- The presence of for-profit hospitals can be associated with 2.4% lower hospital payments in a geographic area.

But broad generalizations about the benefits of competition in the provision of hospital services are not always appropriate. The impact of the introduction of competition depends on the form of competition, the health care financing system, the hospital payment system, the types of services in question, the types

of provider, the possibility for entry of new providers, the regulatory system and the social mores that govern the provision and demand for health care. A competitive mechanism that might work in one system will not necessarily transfer well to another one.

The United States has, in the last two decades, experienced the greatest degree of direct competition for the provision of hospital services in the OECD. The per capita costs of health care in the U.S. are among the highest in the OECD, but the introduction of price competition between hospitals did result in a reduction in the increase of prices for the delivery of hospital services at least during the 1990s.⁴

Other countries that are introducing market-like mechanisms are unlikely to adopt the same direct competition system as the U.S.. Less direct mechanisms may, nonetheless, have beneficial effects. It is perhaps in the area of competition law application that the greatest potential similarities arise between the U.S. and other OECD countries. Many different governments may be examining hospital mergers and hospital contracting activities in the future, and there may be much to learn, particularly from the wide-ranging U.S. experience of competition law enforcement in this area.

2. Defining the issues

Before analyzing the mechanisms identified above, it is important to consider:

- Objectives of competition in the hospital services sector;
- Key features of hospital service markets; and
- Regulatory constraints.

2.1 *The objectives of competition in the hospital sector*

Competition for the provision of hospital services covers a number of different incentive mechanisms, ranging from free markets – in the U.S.-style approach in which multiple insurers negotiate with multiple hospitals over price and other conditions of care – to “weaker” forms that attempt to harness the power of markets in other institutional settings. These forms could include benchmark competition, selective contracting, physician purchasing as well as, more generally, mechanisms that create rivals or force hospitals to act as though they have rivals. These strong and “weak” mechanisms can have a number of beneficial impacts.

The benefits from introducing competition for hospital services arise primarily from a potential increase in the technical and allocative efficiency of provision of services, improving the quality of provided services and, ultimately, helping to control system-wide costs. Controlling system-wide costs can help to ensure that the social objective of a broad availability of health care is achieved and that increased quality of care is affordable to the government.

When evaluating the impacts of introducing competition, benefits of competition must be weighed against potential costs. Such costs can take a variety of forms, and could include investment costs related to excess capacity as well as administrative costs. Effective direct competition between rivals requires the presence of excess capacity so that purchasers of hospital services have an effective threat to move patients

⁴ The subsequent change in supply conditions, especially through hospital mergers, combined with tighter state regulations governing the constraints that insurers can place on suppliers and on patients, may have contributed to increasing overall costs and rising premiums despite the ability to negotiate hospital service prices.

from one institution to another. This excess capacity can be costly, however, to the extent that it requires investment and ongoing maintenance. Thus excess capacity represents one cost of competition.

The introduction of competition can increase administrative costs related to reimbursement of services. In the United States, for example, overall administrative costs, including those of hospitals and doctors' offices, are estimated to account for 31% percent of health care spending, or 1059 USD per capita, while in Canada, with a single public insurer, there are much lower administrative requirements estimated to account for 16.7% of health care spending, or 307 USD per capita. (Woolhandler, Campbell and Himmelstein 2003) These lower costs to some extent reflect the virtually entire absence of competition.⁵ The results of a cost-benefit analysis between competitive provision and administrative costs are not always clear and may depend substantially on the types of information systems that already exist.

Increasing efficiency of provision

One of the most commonly cited benefits of introducing market-based processes is that they help to improve incentives for efficient production. For such a benefit to materialize, some inefficiency would likely need to be present in the pre-introduction system. There is significant evidence that hospitals operate in many countries with a high degree of inefficiency. For example Zuckerman, Hadley and Iezzoni (2002) find that inefficiency accounts for 13.6% of total hospital costs in the United States. Cellini, Pignataro and Rizzo (1996) find that only 3.4% of hospitals in their sample from Italy operate on the cost frontier. This suggests that as much as 96.6% of Italian hospitals could potentially improve long-run efficiency.⁶

The technical efficiency of provision of health-care services is increased when the quantity of services provided for a given amount of spending increases or when the quality of services provided increases without an increase in spending. Rivalry between alternative suppliers is one of the best mechanisms for increasing the incentive to operate efficiently. Technical efficiency can arise both from slack and the economies of scale. As new technologies have been introduced that reduced the length of stay in necessary after surgical procedures, hospitals have increasingly begun operating below their optimum scale. Keeler and Ying (1996) and Gaynor and Anderson (1995) emphasize that an optimal occupancy rate for hospitals and must take account of the daily statistical variation in demand and their obligation to provide care so that a 100% occupancy rate would actually be unlikely to be efficient because patients would then be turned away frequently.⁷ But actual occupancy rates in some OECD members have fallen to below 70% in some cases, which is likely to be below efficient scale, as shown in Table 1. Wide variation in average lengths of stay in acute care beds is an additional indicator of the potential for cost savings.

Improving efficiency of provision can help to achieve government objectives to control system-wide costs. This has particular importance given that governments themselves pay for 85% of inpatient care spending.

5 However, it should be noted that part of the differences include costs of gathering information on provider behaviour which is probably more prevalent in the U.S. than in Canada. This information may serve, in turn, to place pressure on hospitals to reduce costs and improve performance.

6 The interpretation of results of envelope analyses may be somewhat complicated by an inability to distinguish high and low performers, once statistical significance is taken into account.

7 This is a peak and off-peak problem. Note that the social objective of maintaining excess capacity will not be shared by a for-profit hospital, that, if it were paid by the patient day, would likely want to be full.

Improving quality and responsiveness to patient expectations

Competition can play a substantial role in increasing the quality of services provided to patients. But not all forms of quality have the same value.⁸ When competition results in substantially reduced waiting times for the provision of surgical services, patients receive a direct patient benefit. In contrast, when competition results in excess capital investment, such as “gold-plating” of waiting rooms or duplicative diagnostic machinery, such as MRI scanners or x-ray equipment that is little used, the impact of non-price competition may not substantially improve the health condition of the population and may instead be considered a Medical Arms Race (MAR), as described in Box 1.

Box 1. Does Hospital Competition Lead to a Medical Arms Race?

Many policymakers have suggested that hospital competition is wasteful and that as a result introducing competition into the market for the provision of hospital services would raise health-care spending. There is mixed evidence on this question and much of the response depends on the characteristics of the health care system as a whole. There is, nonetheless, an increasing consensus that, while hospital competition may promote a medical arms race, this is likely to account for a very small percentage of costs, to the extent it occurs at all.

Robinson and Luft (1985) suggest that hospitals in more competitive markets will invest in duplicative services that are in excess of what would be demanded by the market. “While hospitals obtained some of their patients directly from emergency rooms and ambulatory care clinics, the majority are admitted by community-based physicians affiliated with the institution....the hospital is dependent on its affiliated physicians for clients; conversely, the physicians are dependent on the hospital for those types of services that physicians cannot profitably and conveniently provide in their own offices.” (Robinson and Luft) The MAR hypothesis is based on the idea that, in absence of price competition, hospitals will compete for physicians because the physicians determine admission patterns. One way to attract physicians is to offer high technology services. For example if a geographic area has sufficient population in demand to support the use of one MRI scanner, but has two hospitals, once one hospital obtains an MRI scanner, the other may also seek a scanner in order to be equally attractive to physicians. But the result can be that an area with an intrinsic need for one MRI scanner ends up with two partially utilized scanners. Another rationale for the MAR hypothesis is that hospitals will raise quality in order to attract patients who do not have to bear the full costs of that quality, owing to insurance.

Robinson and Luft examined U.S. hospitals in 1972, a period before significant price competition was present in U.S. hospital markets. They find that, in comparison to monopoly hospitals, the average cost per patient day was 5.6% higher for hospitals with one neighbour, 9.1% higher for hospitals with two to four neighbours, 16.3% higher for hospitals with five to 10 neighbours and 20.5% higher for hospitals with 11 or more neighbours. (p.347) note that these estimates do not actually directly test for technological intensity and could arise for reasons not related to the MAR hypothesis.

None of these studies provide a direct test of the presence of high technology over-investment that is consistent with the MAR hypothesis. Dranove, Shanley and Simon (1992) perform a careful analysis of 11 high-tech hospital service categories provided in 1983 at a time before aggressive price competition grew common between hospitals. The services they study are open-heart surgery, full body CT scans, radiation therapy, and radioisotope therapy and seven groupings of services along clinical or technological lines, focused on cardiology, deliveries, diagnostics, emergency, neonatology, pediatrics and teaching. They find that there is an identifiable MAR effect but that it is small in economic import. Most hospital mergers would not be predicted to reduce capital spending from the elimination of the MAR.

Dranove et al. conclude that the MAR is relatively unimportant by examining plots that show the number of

⁸ Ultimately, it would be valuable to measure quality improvements as they relate to health status of individuals rather than the process of delivering particular types of care, measurement of health status is even more difficult than measurement of the quality of a given service. One major step in this direction has been the consideration of quality-adjusted life years (QALYs) that take into account restrictions to full mobility and potential health as for the purpose of evaluating alternative investments of limited health funds. (See Williams (1995))

service providers per capita against the number of hospitals. For cardiology the first specialized provider enters when the local population is roughly 62 000, the second provider enters at 277 000 in additional providers enter in population increments of 680 000 to 830 000. "If the MAR was the dominant determinant of specialized service supply, and we would expect to these plots to show a general upward trend -- as more hospitals appeared in the market, competition would drive them to add services beyond the level demanded by the population. In fact, the plots show a downward trend. This suggests that as markets grow and more hospitals enter, the dominant effects are probably scale and scope economies, with the MAR having its effect only on the margin." (p.257)

2.2 *Some key features of hospital services*

The market for hospital services exhibits a number of distinct characteristics that are important to recognize when considering the introduction or modification of competition-enhancing mechanisms, including:

- Complexity of production;
- Asymmetry of information;
- Local market power;
- Lumpy investments;
- Large employer; and
- Payment systems that fail to encourage search for efficiency gains.

Complexity of the production and rapid technological change

The product produced when providing hospital services is highly complex. It is sometimes patient specific because even within the same diagnosis, patients often require different sets of services and as a result the services provided are difficult to standardize.

Rapid technological change is a dominant feature of the provision of hospital services. For example, blocked veins near the heart that once required open-heart surgery can now often be treated by cardiac catheterization. New surgical methods, medical devices, standards of treatment and diagnostic devices have the potential to change the markets for particular hospital services substantially and quickly. One impact of technological change can be to reduce the length of time required for recovery from surgery. This in turn can reduce the number of beds that are needed to serve a given population. However since most hospitals are constructed for the long term, technological change may result in lower utilization rates of facilities. This in turn makes recovery of sunk capital investment more difficult.

Asymmetry of information between payers, patients and providers of care

In most OECD countries, the vast majority of patients are insured for their use of hospital services. While at times modest co-payments are necessary, patients usually pay only a modest fraction of the cost of the care they receive if they pay anything. Both patients and payers typically have a difficult time judging the appropriateness of care. As a result, if hospital services are reimbursed for each unit of service, hospitals will have an incentive to over-provide their services. Similarly, patients may have an incentive to over-consume services since the cost of the services to them is typically much lower than the real cost. They may seek services whose true marginal benefit to the patient is lower than the cost to the payer. In short there is asymmetric information about:

- The extent of care needed;
- The true cost of such care; and
- The value of such care in terms of health outcomes.

Local market power due to economies of scale and costs of travel

Economies of scale are substantial for many hospital services but not for all services. This is one reason that rural hospitals generally provide a much smaller set of services than large secondary or tertiary urban hospitals. The population served by the hospital is not sufficient to support the scale that would be needed to provide an economic service in many areas. Nonetheless, certain services do not exhibit high levels of return to scale. For example, laboratory services may have a relatively small minimum efficient scale and limited returns to greater scale.

The distance of a hospital from a patient's home or workplace has a substantial effect on the patient's willingness to use a given hospital, as established by McGuirk and Porell (1984) and Dranove, White and Wu (1991) who find that distance to hospitals within the local market is an important determinant of hospital choice and that patients who cannot satisfy their health care needs within their own market will typically travel to the nearest market that does meet their needs. In a recent Canadian survey from December 2004, "one out of three adult Canadians said that it would be "extremely important" that surgery take place at a hospital close to their home." (CIHI, 2005) This is a natural result of patients and their doctors imputing a cost to travel time and distance. The result is that hospitals offering comparable services may be geographically differentiated. This differentiation means that such hospitals may not be close substitutes and suggests that hospitals may have market power.⁹

There is extensive debate among legal and economic practitioners about the appropriate geographic market definition for the provision of hospital services. On the one hand, it is relatively sure that there is a high degree of substitutability between hospitals in dense urban areas. Some researchers would argue that the hospital services market in large urban areas such as Los Angeles would cover the entire metropolitan area. But this is inconsistent with observations of a price increase by a hospital in Santa Monica after its closest competitor was closed or operating at reduced capacity for more than a year as result of earthquake damage in 1994 despite the presence of a number of other hospitals within a 5 mile radius that had excess capacity.¹⁰ The evidence from this temporary hospital closure suggests that the geographic market definition for providers of hospital services can actually be quite narrow, even in large metropolitan areas.

Consistent with the idea that geographic markets may be narrower than a metropolitan area, there is an increasing body of evidence, described below, that hospital mergers in metropolitan areas can be followed by price increases.

9 The presence of market power need not necessarily mean that prices will rise above a "competitive" level. There has been an ongoing debate among policy analysts about whether non-profit hospitals will take advantage of market power.

10 Ennis (1995) finds that hospital prices at Santa Monica Hospital rose by between 15 - 25% during the roughly year-long period in which, of the two hospitals in Santa Monica, one hospital close to the other was closed or operating with very few beds. (Santa Monica is located within the Los Angeles metropolitan area and contains just two of the more than 100 hospitals in the metropolitan area.)

In this context, there are many OECD countries that have large areas where the population is highly dispersed and of low density, considerably restricting the scope for competitive markets for hospital services.¹¹

Lumpy investments of a long-term nature

The fact that hospitals consist of lumpy investments of a long-term nature and that sunk costs are a significant part of this investment means that hit and run entry is not a feasible strategy in the face of anticompetitive price increases by hospitals. While new hospitals are constructed in areas experiencing high population growth or inadequate supply, full service acute care hospitals are rarely constructed in stable markets, in large part because the improved surgical technology has reduced lengths of stay resulting in high excess capacity for many hospitals. While entry is not a very common occurrence, the presence of excess capacity has led to many hospital closures in some OECD countries. In the United States for example where hospital occupancy rates stood at 66.2% in 2002, more than 500 hospitals closed between 1980 and 2000. In Canada, the number of active hospitals has fallen from 1194 in 1992-93 to 744 in 2002-3. In contrast, in the United Kingdom, where occupancy rates stood at 85.1%, a number of new hospitals have recently been built and will be built in the near future. The excess capacity exemplified by the U.S. experience lies in contrast to the experience in the UK, where inadequate capacity has been identified in certain regions of the country.

Large employer and important local public service

Maintaining a broad accessibility to health care services provided by hospitals is a high priority for OECD governments. Some policy makers are concerned that the introduction of competition or prospective payments will result in hospital bankruptcy and both a reduction in service to under-served populations as well as a loss of jobs. Towns or state/canton/regional governments have a strong interest in maintaining hospital services even if that maintenance does not contribute to overall system efficiency.

2.3 *The regulatory dimensions of health care markets affecting competition*

In large part because of the complex nature of health-care services, health care markets and hospital services in particular are highly regulated in most, if not all, OECD countries. The state frequently plays a large role in the ownership and management of hospitals. In addition, because governments pay for a high percentage of health-care services, they often play a significant role in determining the nature of contracts between hospitals and payers.

Regulatory and governance oversight is particularly important for hospital services as related to

- Licensing controls;
- Role of payers;
- Ownership form; and
- Permitted forms of contracts.

11 Examples include northern Canada, many parts of the rural U.S., the Scandinavian countries, rural Japan, etc.

Licensing controls

Many OECD governments have instituted licensing controls and accreditation requirements for hospital services. Licensing controls for hospitals exist primarily:

- To ensure quality and safety;
- To ensure the provision of a desired level of services based on both physical capacity and a geographical distribution with an emphasis on:
 - Avoiding such excess capacity;
 - Limiting supplier induced demand; and
 - Containing health-care costs by limiting access to expensive equipment.

Planning controls over the construction of new facilities or additions to existing facilities are based on a concern that in absence of such controls, they would be overinvestment in hospitals and a geographic distribution that unduly favoured metropolitan areas. As a result, planning criteria considered the suitability of the proposed location, taking into account other facilities, and review whether a new facility would result in an oversupply of services. For example, in Australia's state of Victoria, the Department of Human Services and Health can refuse a license if this would result in more than 4.1 beds per thousand people in the relevant area. In Australia, these licenses can be traded between different owners. As result, in some areas, new private hospitals have been built after purchasing existing bed licenses. In 1998, the per-bed price of such licenses reached a maximum of around 20 000 AUD. In the United States, certificate of need (CON) laws have at times limited the entry of potential competitors. While they may have had some role in slowing the MAR, at times there is evidence that they would prevent cost-reducing competition. For example, Fournier and Mitchell (1992) find that maternity services provided in more competitive markets have lower costs. "This finding suggests that initiatives to eliminate obstetrical services from the CON regulation are likely to yield significant cost savings." (p.632)

The licenses required for beds have at times been questioned under competition law because of their impact and potential abuse as entry barriers. In particular, hospitals with existing licenses are likely to try to use the licensing system in order to prevent entry by potential competitors.

Structure of the insurance market and the role of payers

The existence of health-care insurance, whether privately purchased or government provided, is impacted by a large variety of rules. These rules can include specifications of what services are available and the financial and administrative conditions for the provision of services. For example, in France, hospitals have been required to provide services even when patients cannot prove that they are enrolled in an insurance plan. If hospitals need to recover money from patients, they are not permitted to withhold services until payment is assured. In the United States, hospitals are not permitted to turn away patients when turning them away could endanger their lives.¹²

While government-supported hospitals have often received support based on historical spending, rather than output, there is an increasing trend towards paying hospitals based on their output. Movements

¹² Nonetheless, there are claims that they do so.

towards market provision of hospital services have been extensively studied in the United States, where hospitals (generally not government-owned) and insurers negotiate prices between each other.¹³

Ownership and control of decision making

A high percentage of health care is provided in government-controlled or government-owned hospitals. Some observers have argued that hospital ownership and control has substantial impacts upon the willingness of hospitals to take advantage of market power by setting higher than competitive prices. Public managers are often considered to have objectives that differ from pure profit maximization. In most OECD countries, the majority of hospitals are publicly owned. But private hospitals have taken on an increasing role in recent years. In Australia, there were 294 private, acute care hospitals in 1999. (Productivity Commission; p.11) In the United States, private (non-government) hospitals account for the vast majority of hospital beds. For-profit hospitals account for a large proportion of hospital beds and non-profit hospitals also account for a large proportion of hospital beds. In the UK, the National Health Service is increasingly contracting with private hospitals. While it is generally not disputed that for-profit hospitals would take advantage of market power in order to increase prices there is more debate about the impact of market power for non-profit hospitals. The extent to which non-profit hospitals would take advantage of market power is a key issue for public policy and the application of competition law to hospitals.¹⁴

There is an established literature suggesting that not for-profit hospitals will not maximize profits but rather will seek objectives that reflect the preferences of the Board of Trustees, the administrators, the employees or the physician staff (Newhouse 1970, Pauly and Redisch 1973). Thus it is well accepted that non-profit hospitals may have different preferences from for-profit hospitals. The potential for different objectives however does little to establish that non-profit hospitals would not seek anti-competitively high prices. In particular if non-profit hospitals have costly charitable goals or seek high compensation for executives, they may have a strong incentive to take advantage of market power, when they have it, to raise prices.¹⁵

Form of contracts between payer and provider and price setting mechanisms

The forms of contract that are prevalent and legally available within a country have a substantial impact on the incentives for providers to:¹⁶

- Keep down their own costs;
- Maintain quality;

13 The largest insurance payer is nonetheless the government through its Medicare program which is designed to provide care for the elderly, the chronically ill and the disabled. Hospital payments through this program are not negotiated but provided on a take it or leave it basis in which if the hospital treats Medicare patients it must accept the Medicare reimbursement schedule which is mostly based on prospective payment.

14 The outcome of a number of hospital merger challenges by competition authorities has hinged upon the predicted behaviour of non-profit hospitals.

15 For-profit hospitals might like to have waiting lines, in order to ensure a steady stream of patients, whereas public hospitals seeking to maximize social welfare might prefer to eliminate waiting lines altogether. In practice, however, in a number of countries, private hospitals benefit from the long waiting lines at public, non-profit hospitals.

16 In this section, the term “contract” encompasses the terms and conditions attached to agreements and obligations to provide care, whether such agreement is reached by negotiation, government order or some other means.

- Avoid gold-plating of care;
- Provide care only to patients in need; and
- Assure a low margin between cost and price.

The types of contract available within a country are highly dependent upon laws and regulations. The nexus of conditions that affect hospital behaviour include which providers, if any, are preferred by the payer, what rights are available to consumers and the payment method for providers. Contracting forms may be limited even when there is a policy that favours direct competition between health care providers.

Payment methods for acute inpatient care include, but are not restricted to, combinations of:

- Global payments to hospitals based primarily on historical spending rather than on output;
- Payment by quantity of specified outputs;
- Payment by quality of specified outputs;
- Capitated payment (payment by population of patients);
- Per diem payment (payment by day of acute inpatient care);
- Percent of list price payment; and
- Average local price payment (payment based on the average price among local providers).

3. Possible tools for enhancing efficiency

Introducing competitive and market mechanisms in order to increase efficiency in the provision of hospital services must take into account the special and unique features of the hospital services market, notably physician behaviour and patient behaviour. A recent Canadian report by two senators states: “In a system as complex and multifaceted as healthcare, a top-down command and control strategy will almost certainly lead to compounding existing inefficiencies. Effective reform can only be achieved by putting in place a set of incentives that encourage individuals and institutions, acting in their own self-interest, to make the changes that are required. In essence the introduction of what are usually called market forces is the only effective way to make health care delivery system more efficient and its providers more productive.” (Kirby and Keon, 2004)

Reforming incentives does not necessarily require changes in ownership or oversight by the government. While competitive forces have the fewest restrictions in the U.S., there are many alternatives that do not duplicate this demand-driven system.

In such reforms, it is important to recognize that not all geographic areas will have the same possibilities for competition. Even when direct competition can be unleashed in urban areas, there may be geographic areas in which competitive forces are necessarily restricted, especially rural areas where there may not be sufficient demand to support multiple providers at minimum efficient scale. In such rural areas, the institution of a system of negotiated prices, for example, would be unlikely to provide much constraint on hospital behaviour.

3.1 *Pre-conditions for competition*

Health systems that have been based on command-and-control structures cannot simply institute a free right to contract and successfully introduce competition. Apart from the special case of benchmark competition, forces of rivalry are difficult to unleash unless certain conditions are present:

- Good information available about patient procedures and provider performance;
- Feasible alternative suppliers;
- Funds following patients; and
- Patients not limited to use of one historically-present facility and not given rights to access any facility on the same financial terms.

Strengthening third-party payers: the need for better information on provider performance

In many OECD countries, with government-provided healthcare, the government was both purchaser and provider and gave hospitals global budget to produce all their care. Increasingly, countries are moving away from global budgets towards a system that reimburses hospitals for services that are actually delivered. One review of Swedish health care reforms states that “of all the reforms, the requirement that hospitals get paid according to the services provided increased efficiency the most.” (Lofgren 2002 p.3)

Paying hospitals based on the service they provide clearly requires comparable information on services provided across hospitals. A number of countries have introduced hospital payments based on the Diagnostic Related Group (DRG) of the patient. Countries that have introduced such payment mechanisms include Australia, Austria, Belgium, Denmark, Germany, Japan (large university hospitals only), New Zealand, New Zealand, Sweden, Switzerland (certain cantons) and the United States. Countries in the process of introducing such systems include the Netherlands and France. Ultimately, measuring a service provided includes measuring the quality of the service.

Once comparable information is available on the provision of health care services, significant progress can be made in comparing the efficiency of delivery of services between different providers. Sweden has made extensive efforts to improve information about waiting times, as described in Appendix A. Comparisons between providers can include hospital to hospital comparisons, comparisons with outpatient centres and alternative providers and can include comparisons of efficiencies in outcomes when procedures are performed in different ways, such as when nurse midwives oversee births as opposed to physicians.

Feasible alternative suppliers

When entry costs are low, the creation of feasible alternative suppliers is not overly costly and when entry costs or exit costs are high, efficiency-enhancing effects of competition may be counter-balanced by the increasing costs from new facilities. A number of governments have responded to the fear of cost increases from new facilities by requiring licenses to be issued by the state for the construction of new facilities or the modification of existing facilities.

Funds follow patients

If hospitals receive fixed budgets, whether they provide more or fewer services, they will have little financial incentive to use their limited resources to provide services efficiently. In fact, in a model in which

work provides disutility, hospital staff may have financial incentives not to serve patients. However, once hospital finances vary according to the amount of work performed, and the marginal patient generates marginal revenues to a provider, the hospitals will have much stronger incentives to ensure that they do not waste resources.

Hospital selection based on competing offers, not historical practice

If there is no choice available over where a patient will receive health care services, then institutions will consider that they have a guaranteed volume and that this volume level may not change significantly in response either to increased or decreased efficiency. The key to enhancing incentives is for funds to follow patients towards more efficient service providers. In order for hospital service providers to be impacted by competitive forces, they can not have institutionally legislated monopolies. This is not to say that a hospital could not have a “legitimate” monopoly; it could if it wins the right to serve a set of patients exclusively through rivalry.

3.2 Improved management structure

Management oversight of hospitals can be changed in a number of different ways that reflect market forces or help to ensure that market forces can work. The primary changes that have occurred include:

- Purchaser-provider splits;
- Changing ownership forms; and
- Contestable management.

These options and some evidence on their effects are further described below.

Purchaser-provider splits

When a government both purchases and provides health-care services, substantial improvements in efficiency can sometimes arise from introducing a division between the purchasing function of the government and the providing function of the government. The idea is that introducing negotiation into the purchasing process, at times based on competition between different potential providers, can reduce the cost of provision of services and provide incentives to measure output carefully.

Purchaser-provider splits have been introduced in New Zealand, Sweden and the UK. Across Sweden, some councils have chosen to introduce a purchaser provider split and others have not. An efficiency based analysis of the Swedish hospital system from 1989 to 1995 by Gerdham et al. (1999) finds that “output-based reimbursement improves technical efficiency. The potential saving in costs due to a switch from budget-based allocation to output-based allocation is estimated to be almost 10%.”

The UK introduced a purchaser provider split in 1991. Between 1991-92 and 1996-97, “hospital efficiency increased by 1.7% per year on average” though it declined somewhat in subsequent years. (Le Grand 2002) But improvements were not as large as proponents had hoped. “This was partly because of the absence of any effective injury or exit strategy for providers, the restrictions on competition resulting from this and from the continuance of a powerful elements of central control.... and -- just possibly -- a reduction in some aspects of quality.(Propper et al. (2002))” (Le Grand, 2003)

Changing ownership forms and greater managerial independence as regards input costs

There is much debate in some OECD countries about whether public or private ownership is preferable for providers of hospital services. In the UK, the National Health Service (NHS) is increasing the independence of hospitals that provide services to the NHS. Under a Labour government, existing government hospitals are being permitted to become foundations, in order to increase their independence and to provide a greater opportunity for hospitals to compete with each other, taking into account the purchaser-provider split. Moreover a number of new hospitals are being constructed privately. In order to provide services to the NHS between 2000 and 2010, 100 new acute care hospitals are planned in the UK. As of February 2005, 15 of these hospitals were already open. The first public private-partnership hospital is located in Carlisle with 474 beds and was bond-financed with business guarantees from the government. Public-private partnerships are also being implemented in Australia, Brazil and Sweden.

According to the managing director of London International Healthcare Ltd., the benefits of public-private partnerships in health care include:

- New facilities are available earlier;
- Long-term maintenance is assured;
- Risk is transferred to the private sector;
- There are more incentives for the private sector to perform; and
- Forward spending commitments are known and able to be planned for.

In Sweden, private primary health care centres run by Praktikertjänst AB (Plc) are approximately 20% cheaper than those run by local government. (Svalander et al. (1997)). In 2002, 60% of primary health care centres in Stockholm County were operated by private companies under contract with the County Council. Sweden has one private hospital that was formerly a public hospital, as described in Box 2.

In the U.S., research has examined whether hospital ownership affects healthcare productivity. McClellan and Kessler (2001) examine the costs of treating elderly Medicare beneficiaries who have been hospitalized for a new heart attack between 1985 and 1996. They find that “Areas with the presence of for-profit hospitals have approximately 2.4% lower levels of hospital expenditures, but virtually the same patient health outcomes.”¹⁷

Box 2. Experience with a Private Hospital in Sweden: St. Gorans Hospital

One instructive example of changing the ownership and management structure of a public hospital has occurred at St. Gorans Hospital in Stockholm. St. Gorans Hospital was one of several government hospitals in downtown Stockholm in the early 1990s. These hospitals ran frequent deficits and suffered from excess capacity. Ultimately, in the summer of 1993, one of the hospitals closed and St. Gorans remained open. Under a conservative Stockholm County Council, St. Gorans Hospital was turned into a company with an ultimate objective of selling it to a private company. However before the hospital could be sold, a coalition led by the Social Democrats began running the Stockholm County Council. While the County Council sought to have the Council take over management of the hospital once again, the staff and unions objected. According to the local union chairman, staff felt the new hospital organization worked better than the previous one. Moreover the County Council had a large budget deficit and the staff felt safer working for a company rather than the Council, as a result of fears that the Council might close the

¹⁷ Sloan (1997) provides an extensive overview of U.S. research on the impact of for-profit and not-for-profit ownership on hospital behaviour.

hospital to reduce the deficit. In 1998, the Conservatives again ran the County Council and the hospital was sold to a private company in 1999.

Under the new management, work studies were completed to analyze the effectiveness of the hospital's workflows. A number of changes were made as result of these studies. Using the old methods, all doctors in a ward visited all beds jointly with a nurse, a physiotherapist and an occupational therapist. The new method was for the doctor to discuss the cases with a nurse and then for the doctor alone to see the patient. These changes meant that doctor rounds finished earlier and did not require the presence of other professionals, such as nurses, physiotherapists and occupational therapists, who could then be more productive.

Since becoming a company in 1994, the hospital has been profitable in all years except 1999, the year in which the council ran the hospital while it was being sold to a for-profit owner. (Lofgren, 2002)

Cream Skimming

Private hospitals are sometimes owned or part-owned by doctors. In Australia, a number of private hospitals are even co-located in the sense that they are immediately adjacent to public hospitals. Such co-location can be convenient for doctors who need to make rounds in both the public and private hospital where they have privileges. However, there is a concern that even if a public and private hospital are paid the same amount for the same general medical condition of a given patient, physicians will send less complex cases to the private hospital of which they are part owner and the more complex (more expensive) cases to the public hospital, thus increasing the average cost of the procedure in the public hospital while raising profits at the private hospital.¹⁸ This concern is much reduced when physicians have no special financial relationship with a private hospital.

"In the UK, the specialized physicians (consultants) "face a perverse incentive structure when they are dealing with a patient with the means to pay privately. If the consultants arrange private treatment for their patient, the patient will be treated more quickly (thus benefiting the patient and meeting the consultants professional concern) plus the consultant is paid, thus furthering his or her self-interest. On the other hand, if the consultant arranges for the patient to receive treatment under the NHS, the patient waits and the consultants get an increase in his or her workload for no extra reward." (Le Grand, 2003, pp. 14-15) Le Grand thus advocates moving towards a fee-for-service option for payment of consultants in order to ensure that consultants have a marginal incentive to treat patients in the public sector.

Contestable management

It can often be very difficult to close down a hospital that is not performing well, both because of local medical needs and the employment effects of closing a hospital. In contrast, changing the management of hospitals is a feasible and less dramatic action. Public or non-profit hospitals can be managed by companies that provide managers and that can be changed in case of unsatisfactory performance. Managerial outsourcing (also called contract management or contestable management) accounted for about 16% of non-federal community hospitals in the U.S. in 1998. Carey and Dor (2002) examine U.S. hospitals between 1991 and 1998 and find that "contract management firms are indeed able to introduce efficiencies over conventional, salaried managers... it would appear that third-party contracts are a way by which boards of predominantly non-profit institutions can impose greater market discipline on the institutions they govern." (pp. 16-17)

¹⁸ The existence of changed behaviour when physicians have an ownership stake in an asset is suggested by a number of examples. In the United States, ecographies were prescribed four times more frequently by doctors with equipment than those who send patients to a radiologist (see Commissariat Général du Plan, 1993 and sources therein.) (Oxley and MacFarlan, 1994)

3.3 *Sharpened incentives for providers*

A number of mechanisms exist for sharpening the incentives faced by providers. These include:

- Contracting
- Greater consumer choice
- Prospective pricing
- Paying for performance
- Physician purchasing

These mechanisms and some of their effects are described further below.

Contracting

Contracting methods, such as selective contracting or contracting out offer an important avenue for sharpening incentives to providers.

Selective hospital contracting was introduced in California in 1982, when private health-care insurance companies were able to negotiate over fees with hospitals and to leave hospitals out of their hospital networks if the insurance company chose to do so. In a study of selective contracting its impact on California hospital costs and revenues between 1983 and 1997, Zwanziger, Melnick and Bamezai (2000) found that “hospitals in more competitive areas had a substantially lower rate of increase in both costs and revenues over this extended period of time.”

Selective contracting does not have to involve an “all-or-nothing” approach in which the preferred hospital receives all patients and the less preferred hospital no patients. In a more moderate form, selective contracting could involve a less extreme adjustment to quantities. For example, the preferred hospital could receive 60% of patients and the less preferred hospital 40%.

Purchasers, and hospitals themselves, may wish to purchase certain services outside of a standard hospital setting. Particularly when entry and exit costs are low, there can be significant advantages to introducing a competitive contracting system in which alternative suppliers bid or negotiate to provide services. In Stockholm, laboratory services are subject to competition. “[C]ompetitive tenders have resulted in a 30% cut in costs, with no change in quality and quantity.”

Even inpatient surgeries can be provided outside a full-service hospital setting. In Stockholm, private companies have started providing back surgery. The number of back surgeries was expected to increase by 20 percent between 1999 in 2000 while the cost per surgery is expected to be 33% lower. (Lofgren 2002 p.25)

Even for medical equipment that is expensive, such as MRI scanners, institutions that purchase such equipment for performing services can have low exit costs. This is because such equipment can often be installed in standard office space, purchased on a second-hand market and sold on a second-hand market without very high transportation costs in case the institution ceases to provide that service.

Greater consumer choice over the provider

Evidence suggests that while consumer choice can at times raise costs, because consumers want more than a professional might deem necessary, consumer choice over the institution in which they are treated can substantially improve quality (e.g., by reducing waiting times.) To the extent that payments for services follow patient choices, competition between service providers may lead to quality increases (e.g., by reducing waiting times.)

In a number of countries there are rules that prevent a payer (whether government, private insurer or employer) from limiting the set of hospital service institutions that a consumer can choose. Rules may take the form of outlawing selective contracting (in which a payer contracts for non-emergency services at a limited set of facilities) or ensuring that patients have freedom of choice over which providers they will see. (Note that the payer can be the state, as in the UK's provider-payer split.) Recent work suggests that any-willing provider laws (which broadly guarantee that any qualified provider can receive reimbursement from a payer) and freedom of choice laws (that broadly guarantee a patient can select the provider of their choice) result in an increase of health expenditure on the order of at least 1-2 percent.^{19 20}

The UK government's plans to increase patient choice over hospitals do not provided unlimited choice to patients. Rather, patients in need of hospital services will be provided with a choice of between four and five providers determined by the body responsible for paying for and overseeing their health care.²¹

Waiting times vary considerably from one OECD country to another. When consumers or physicians are given a choice between multiple providers who have different waiting times and the information about average waiting times at each institution, institutions may compete with each other in order to lower their waiting times. At the same time in the political process of arguing that more funds are needed at a particular institution, institutions may seek to increase waiting times in order to suggest that they have an especially great need of funds.

The patients place significant value on reduced waiting times. Willingness to pay studies have been conducted that address waiting times. Popper (1990, 1995) seeks to value the time spent on NHS waiting lists and estimates that reducing the time on a waiting list by one month for non-urgent treatment is valued at £50 in 1991 prices while reducing the uncertainty related to admission dates has a value of £30 in 1991 prices. Johanneson et al. (1998) surveyed 1045 Swedish persons and found a willingness to pay for reducing waiting times by one month of £95 to £110 per month in 1991 prices. (Johanneson, Johansson

19 Vita (2001) compares per capita health care spending across U.S. states between 1980 and 1998 and estimates the impact of the introduction of weak and strong versions of any willing provider or freedom of choice laws. The introduction of strong laws is estimated to increase health care expenditure by between the \$52 out of average per capita spending of \$2917. Vita considers that the cost-increasing effect may be higher for physician than hospital spending.

20 Rules that limit the freedom of contracting of payers reduce their negotiating leverage and can result in reduced incentives for efficient operation by providers. For example, rules that prevent steering of patients towards specific hospital service providers that offer a low price will likely raise the costs of care because hospitals will be less likely to offer low prices if they do not receive a compensating increase in the quantity of patients. If payers pay a minimum (not the full) price for hospital services with patients paying for the difference between this minimum price and actual price, then the incentive for efficient operations is more easily maintained.

21 The body is called a Primary Care Trust. Source: Burgess et al. (2005).

and Soderqvist, 1998) Reducing waiting times therefore provides significant value to patients, not to mention permitting increased output for both paid and unpaid (household) occupations.²²

Sweden has pursued an approach that uses competition and choice to reduce waiting times, as described in Box 3.

Effective consumer choice requires information. Certain U.S. states publish 'scorecards' that provide quality related information for doctors and hospitals. The UK, 'league tables' that compare certain national health service facilities are now published. But such indicators can have mixed effects. On the one hand, public reports can provide an incentive for providers to deliver higher-quality care. On the other hand, since report cards do not control adequately for patient complexity, institutions and physicians may seek to provide services on less complex patients with a higher probability of good outcomes and turn away patients with highly complex conditions. Empirical evidence from the U.S. finds that both types of effect have occurred. Cutler et al (2004) examine the effect of the Cardiac Surgery Reporting System in New York State. They use data from 1991 through 1999 and find that the reports affected case volume and hospital quality. "Poor performing hospitals lost relatively healthy patients to competing facilities and experienced subsequent improvements in their performance as measured by risk adjusted mortality." That is, following a loss of patients, poor performing hospitals increased their quality of care. In contrast, Dranove et al. (2003) showed that quality report cards for coronary artery bypass graft surgery in New York State and Pennsylvania reduced quality, primarily by reducing the likelihood of surgery on high-risk patients. The authors suggested that physicians reduced their intake of complex patients in order to ensure that their "report card" would look better.

Box 3. Sweden's evolving policy on patient choice

Sweden has experienced a number of major policy changes related to waiting times since 1987. In Sweden, county councils are responsible for determining the rules and regulations governing health care delivery in their areas. In 1991, the Federation of County Councils agreed upon a maximum waiting time guarantee. The guarantee stated that patients who had been on a waiting list for any of 12 different procedures and had not been treated within three months, had a right to receive treatment in another hospital or private clinic at the home hospital's expense. On a national level the policy appeared successful in somewhat reducing waiting times during its first two years. However as time progressed waiting times once again began to increase and the national guarantee was abandoned in December 1996, substituted with a guarantee for a time to see a doctor. The evaluation of the guarantee policy is in some cases made more difficult because of a dramatic increase in the number of procedures performed. For example in 1990, before the guarantee was introduced, the number of cataract procedures performed in Sweden was 27 500. By 1996, the number of procedures performed annually had increased to 44 700. The number of patients waiting for the procedure was actually higher at the end of the period than the beginning of the period, despite the fact that the number of procedures performed had increased by 61.5%. The average wait for cataract procedures in 1990 was 8.5 months, which fell to 4.0 months by 1992 and then rose to 6.4 months in 1996, still a substantial reduction from the average wait time before the guarantee was introduced. "The maximum waiting guarantee contributed towards empowering patients and slowing the expansion of treatment indicators, but it was unsuccessful and levelling out the wide regional variations in surgical rates." (Hanning 2005)

One reason for the ultimate elimination of the guarantee was that few patients changed providers. "According to responses...in the two surveys, few patients elected to change providers....In two thirds of the departments/units with waiting times exceeding three months, no patient during the first three years elected to change providers." (Hanning, p 73)

One likely reason that patients did not change providers is that information about provider wait times was not easily available to patients. More recently, the Swedish Federation of County councils as well as certain or regional

²² A useful summary of material related to the impact of choice in health care is Burgess et al. (2005), which touches on many of the other issues related to competition in this paper.

organizations such as the Stockholm County Council, in addition to certain specific hospitals, have introduced web pages that state numerical information about waiting times for patients in different categories and for different procedures. The objective is to make this information is easily accessible as possible to patients and physicians. Making information available is considered important because there is so much variation in waiting time across hospitals on a national basis. For example in Stockholm a patient for primary plastic hip replacement surgery can be treated within a maximum of six weeks at a number of different clinics. But a patient in Gothenburg, for example, may be on a waiting list for at least 104 weeks. Similarly, for prostate surgery, a patient can wait as little as four weeks in Stockholm and more than 90 weeks in most parts of Sweden. (Hjertqvist 2001) This variation contributed to the resolve to start a waiting list project to provide more information to consumers and policy makers. (This project is described in Appendix A.)

Prospective pricing systems

Prospective payment systems are a form of benchmark competition. Under benchmark competition, a benchmark is set, and those firms that operate above the benchmark do well, while those that operate below the benchmark do less well. (Schleifer 1985) With prospective payment, payment is decided based on diagnoses (and, to some extent, procedures and complexity) In some cases, payment is largely weighted by the number of days of hospital stay and the medical intensity of different types of hospital beds. Typically, an average weight is calculated across all hospitals which then serves as the weight basis for payment to each one.²³ Prospective payment serves as an incentive to reduce length of stay (LOS). Hospitals that reduce LOS quickly will have a performance above the benchmark while those that do not reduce LOS will have a performance below the benchmark.

A more explicit form of benchmark pricing is also possible. Stockholm County in Sweden uses the most efficient hospital, St. Gorans, as a benchmark. Salander and Lindqvist (1998) suggest “St. Gorans is 10 to 20% more efficient than hospitals run by the Stockholm County Council.”²⁴ The County Council reimburses other hospitals in part based on costs at St. Gorans. This reimbursement method acts as a strong incentive for the less efficient hospitals to increase their operating efficiency in order to ensure that they receive sufficient revenue to cover their costs. Since the introduction of this system efficiency has improved at some of the other hospitals in Stockholm County. For example Södertälje Hospital, an emergency hospital, was estimated to be 19% less efficient than St. Gorans in 1994 and only 11% less efficient in 1998. This is not to say that all hospitals should be expected to achieve the same costs as the most efficient hospital. According to Lofgren (2002) “The Stockholm County Council no longer expects that all hospitals will be equally efficient.” (p.18)

A broader study of productivity changes in Sweden between 1990 and 1993 found that the five Swedish counties with per case payment had productivity increases of +14.1%, +16%, +12.1%, +17.4 percent, and +0.7%. The control group counties had a productivity increase of +2.4% on average. (Jonsson (1996) as reported in Hakansson (2000))

Paying for performance

Differences in quality of care are substantial across providers. One public policy objective is therefore to use comparative (or competitive) methods to reward those health care providers who have better quality measures, when appropriately adjusted for patient mix. While indicators of quality are often controversial, in the United States, broad reporting of quality of care indicators related to heart attack, heart failure and

²³ It is through the calculation of an average across hospitals that hospitals are effectively compared with each other and those with the superior performance identified and rewarded relative to those with a poor performance.

²⁴ From Lofgren (2002)

pneumonia have existed since 2003 as a result of incentives that increase hospital reimbursement by 0.4% less for those hospitals that did not provide a report. The result was that in 2004, 98% of all hospitals reported the specified quality measures.²⁵

Payment for performance involves rewarding hospitals with high clinical performance measures with somewhat higher payments for service provision. Such performance measures could be based on output success as well as procedural measures.

In a U.S. demonstration project, hospitals with quality indicators in the top 10% of quality for certain clinical areas will receive a 2% bonus payment from Medicare, while those that are in the second decile will receive a 1% bonus payment. Ultimately, hospitals that do not achieve performance improvements above a baseline will see their payments reduced. MedPAC, the body responsible for making recommendations to Congress on payment methodologies, has recommended in March 2005 that payment for performance become a part of the standard Medicare system.

Physician purchasing

Given that physicians are the main source of hospital referrals, a number of recent initiatives in OECD countries have focused on physician's roles as overseers of treatment. If physicians can be given incentives to seek out efficient hospitals, and if payment follows their choices, then hospitals will have an incentive to increase efficiency in order to attract referrals.

The U.K. has recently introduced a system of General Practitioner (GP)-guided purchasing (practice-based commissioning) that will provide GPs with a budget for purchasing hospital services on behalf of their patients.²⁶ Until 1999, the UK had another system for GP purchasing (called fundholding). Under the fundholding system, medical practices could opt to become fundholding practices. They would then be given an annual budget by their local health authority from which they became responsible for purchasing certain elective non-emergency procedures from local providers. Any leftover funds could be used for enhancing the practice but could not be turned into a direct income for physicians. Physicians have an incentive to order health care services for their patients who most need help, and at the same time, if an unusually large number of patients have demonstrably serious conditions, the physician will not be obliged to rest within the provided budget. By 1997 more than 50% of the population was registered with the fundholding general practice.

There is evidence that physician purchasing behaviour changes when they control their own budgets. Under fund holding, physicians have a greater incentive to shop around to find the best price and shortest wait for their patients. A recent study looks at the extent to which physicians concentrated their purchasing in a period in which they had fundholding compared to one in which they did not. Dusheiko et al. (2005) find that "GP fundholding practices which held budgets for elective admissions had less concentrated admission patterns than non-fund holders whose admissions were paid for by their primary care organization." The fundholding reduced elective admission rates by 3.3%.²⁷

25 In this instance, payment for performance can be considered as a quality-oriented benchmarking.

26 Funds that are not spend can be used to invest in the capital facilities of the practice, but do not redound immediately to the financial benefit of physicians.

27 Dusheiko et al. (forthcoming) compared the experience two years prior to the end of fund holding in 1999 to the experience in the two years after the end of fund holding. Their study controlled for the fact that practices that chose to become fund holders might have different characteristics from those that did not.

Hard budget constraints

In order to ensure that hospitals can derive financial or non-financial benefits from efficiency gains, it is essential to provide incentives to improve efficiency of service provision. But it is difficult to ensure benefits from efficiency gains if inefficient providers are immune from financial harm. In a number of countries, hospitals have received hospital budgets that are not based directly on the actual output of the hospital but rather on the historical budgets of the hospitals. This form of financing helps to avoid bankruptcy and financial distress but does little to encourage efficient provision of services. As hospital-provided services move away from such assured budgets, typically to a more output-based budget, it is possible that less efficient hospitals will have revenues that do not cover their costs. On the one hand, local or regional pressures to maintain accessibility are often strong so that there will be pressures to ensure that a hospital facing financial difficulties will receive subsidies to ensure continued operation. On the other hand, if such hospitals are provided with additional funds, they will face a less binding constraint to operate efficiently. Soft budget constraints will severely undermine the effectiveness of pro-competitive reforms.

3.4 Efficiency enhancing measures in the hospital sector

In addition to the mechanisms detailed above, competition can be promoted between different institutions providing similar care. Examples would include competition between regional centres of excellence, competition between local hospitals and outpatient or specialty centres and the reduction of barriers to flexible staffing, particularly those that arise from anti-competitive professional rules that effectively limit the roles of para-professionals. These mechanisms are briefly described below with a some evidence about their impacts.

Centres for excellence (regional centres with high volume for complex, expensive procedures)

Centres of excellence are high-level medical centres with significant expertise in certain procedures (such as open-heart surgery or organ transplants.) They may compete with advanced local hospitals. They benefit from economies of scale in their procedures, and can also offer increased quality of care, measured in survival rates. For example, a recent Canadian study finds that “Canadians have a better chance of surviving some types of highly specialized surgeries in hospitals where greater numbers of these procedures are performed. For the first time, CIHI studied the outcomes of more than 180,000 cases of nine elective procedures carried out between 1998–1999 and 2003–2004. The analyses found a link between higher hospital volumes and the risk of 30-day in-hospital mortality for three of the nine procedures, specifically angioplasty and two cancer-related surgeries (esophagectomy and pancreatic cancer surgery, known as the Whipple procedure).” (CIHI, 2005)

“Angioplasty patients treated in a lower-volume hospital were more likely to die than those who travelled farther for care at a higher-volume hospital. In the 30 days following admission, 1.6% of angioplasty patients died when treated at a nearby lower-volume hospital, compared to 0.7% of patients who were treated at a higher-volume hospital farther away.” (CIHI, 2005)

A recent review of the extensive literature on the relationship between volume and outcomes “showed that in more than two-thirds of the analyses, patients whose surgery was performed by a physician or in a hospital with higher volumes tended to have better outcomes. In the largest systematic review of research on the subject, researchers looked at more than 300 analyses, mostly from the United States, but also from Canada, Europe and Japan. They included procedures ranging from cardiac surgery to lung operations. In 68% of the analyses, the review found that the higher the volume of procedures, the better the patient outcomes. In nearly a third (31%) of analyses, either there was no statistical difference in outcomes between high- and low-volume hospitals, or the relationship was undetermined.” (CIHI, 2005)

Not only are outcomes often better in high volume institutions, costs are often lower. That is, economies of scale in the production of health services permit the services to be performed at lower cost in a large regional institution with high volume than when the same set of patients is treated at a number of different local hospitals. But not all procedures would benefit from being performed in regional centres. While a normal birth/delivery in Canada would cost on average \$1418 at a tertiary care hospital, the same procedure would cost about \$1000 less at a community hospital. (Kirby and Keon, 2004)

Regional centres can compete for certain procedures with a large number of local hospitals. While payers are often able to negotiate substantial discounts at such regional centres, they are often reluctant to force patients to go there, possibly out of respect for patient and physician choice.

Outpatient and specialty centres

For certain services, costs can be reduced through provision of services outside of a community hospital framework. Costs may be reduced for a variety of reasons, including lower overhead costs, increased flexibility of workers in small institutions and better scheduling of operating room facilities that permit surgeons to be more productive.²⁸

The presence of direct rivals for the performance of certain services can provide alternatives for purchasers of hospital services. To the extent that specialty hospitals provide alternatives to community hospitals, they permit payers to negotiate between competing providers. In some markets, “the community hospitals told us that the specialty hospitals had diluted some of the leverage the community hospitals might have otherwise had with payers.” (MedPAC 2005)

Some of the main alternatives to community hospitals include ambulatory surgery centres, specialty hospitals and diagnostic centres. At times, ambulatory surgery centres (ASCs) have sought accreditation as hospitals so that they could be reimbursed for overnight stays by patients who developed complications, even though such “hospitals” remain primarily outpatient facilities.

Specialty hospitals can be quite profitable compared with community hospitals. “The specialty hospitals in our study had an average all-payer margin of 13 percent in 2002, well above the 3 to 6 percent average for community hospitals in their markets.” (MedPAC 2005)

In some countries, specialty hospitals and ASCs are largely owned by doctors. According to one study of specialty hospitals with a physician ownership component, “On average, physicians own 60 percent: Physicians at heart hospitals own the smallest average share (35 percent), while those at surgical hospitals own the largest average share (73 percent). About one-third of orthopedic and surgical hospitals were owned almost entirely by their physicians..., while no heart hospital was.” (MedPAC 2005)

The presence of physician ownership leads critics of such institutions to argue that physicians will have an incentive to increase the number procedures they perform in order to earn higher profits. The strength of this incentive is unclear, however, because when physicians are paid by the procedure, they already have an incentive to perform more procedures whether that is in a public or a private hospital.

The presence of physician ownership also leads critics of such institutions to argue that the physicians will refer their most profitable cases to the private facilities in which they have an interest, while leaving uninsured patients, patients with low reimbursement and complex cases with higher costs to the public

²⁸ However, in some countries, such as France, the movement of patients to private facilities is not seen as beneficial, because of potential cream skinning and induced demand.

hospitals. Ellis (1998) suggests that prospectively paid providers facing a mix of patient severities will indeed cream skim low severity patients.

In contrast, some specialty hospitals state that physician ownership is necessary in order to convince banks to provide loans for the construction and equipping of specialty hospitals. Banks view a financial investment by physicians as an indicator of the physicians' commitment to refer patients to the facility. Without such evidence of commitment, banks cannot be sure that specialty hospitals will receive significant referrals. (MedPAC 2005)

"Cataract surgery, many orthopedic procedures and other procedures are performed by large institutions, whereas they could be undertaken in a more cost effective manner by specialized health-care clinics. Due to their lower overhead, and particularly to their more flexible work rules for the range of health care professionals they employ, specialized clinics can carry out many straightforward, routine procedures at substantially lower cost than most hospitals." (Kirby and Keon 2004)

Critics of specialty hospitals and ASCs sometimes argue that the presumed higher cost of community hospitals reflects the fact that they are forced to provide a number of unprofitable services. For example, they may be required to have emergency rooms even though they operate at a loss. Or they may be considered that their social obligation is to provide care to patients who are uninsured and poor. As a result, the hospitals need revenues above cost in other areas in order to subsidize the unprofitable activities of the community hospital. Since specialty hospitals and ASCs are not subject to such requirements, they are able to provide services without any need to cross-subsidize and thus can operate with lower costs.

To the extent that community hospitals are required to provide emergency services, there may be less costly ways to provide such services than in a community hospital setting. "In many regions of Canada, no alternatives to the emergency room are available. Overcrowding and long waits are the result. This problem could be alleviated, if not solved, by establishing small urgent care clinics (UCCs). In Ontario, a number of GCC's provide fast, one-stop emergency services for urgent or acute medical problems such as cuts, sprains, fractures, asthma, bronchitis, severe allergic reactions and arrhythmias, as well as laboratory, x-ray and pharmacy services and referrals to specialists and hospitals. Not only do they provide services faster, but they are also significantly less expensive than hospital-based emergency departments, mainly because of their lower overhead costs." (Kirby and Keon 2005)

One of the key variables for evaluating the benefits of ASCs and specialty hospitals is their cost of carrying out procedures compared to community hospital outpatient departments and community hospitals respectively. There is surprisingly little firm public data on this question. According to MedPAC interviews with market participants "Some specialty hospitals told us they are lower-cost providers than community hospitals and that payers have been eager to contract with them, reportedly paying some specialty hospitals lower rates." (MedPAC 2005)

Community hospitals have often responded through encouraging the maintenance of facility licensing laws that increase the difficulty of establishing a new facility. In the US, "[s]ome community hospitals barred their physicians from being owners at specialty hospitals; others were considering that step. Short of this, other hospitals have adopted policies that dampen specialty hospital expansion, such as including non-compete clauses in their physician contracts to protect them from physicians shifting their practices to specialty hospitals." "In reaction to the entry of specialty hospitals, some community hospitals sought exclusive contracts with private payers and Medicaid managed care plans, with varying success. In some markets, specialty hospitals have been locked out of contracts, undermining their ability to generate volume." (MedPAC 2005)

The overall impact of specialty hospitals is not yet clear. Some observers argue that specialty hospitals should be licensed by the government via a CON process, in order to ensure that cross subsidization can continue because the alternative is poor care for the uninsured. (Choudry et al., 2005) Others argue that cross-subsidization should be replaced by explicit subsidy. (Frech 1996) Havighurst emphasizes that the CON process did not succeed, in the US, in keeping down the costs of care. (Havighurst 2005) In the US, there has been a temporary ban on the construction of new physician-owned specialty hospitals.

Improved allocation of human resources

The majority of hospital spending covers the costs of wages, salaries and benefits for employees and staff. In order for hospitals to operate efficiently, they must allocate their staff resources in ways that are most efficient for the delivery of care. The importance of improving allocation of human resources is emphasized in a report by two Canadian senators, one of whom was a professor in and chairman of the Department of surgery at a faculty of medicine for 15 years. They emphasize two aspects of human resource use that limit deficiency, the first being rigid collective agreements and the second being scope-of-practice rules in hospitals.

Less rigid collective agreements

According to their report, rigid collective agreements may prevent staff from being assigned where they are most needed. "For example the number of nurses may be adequate overall, but if, for whatever reason, the emergency room is understaffed and the collective agreement restricts the hospital's ability to bring in nurses from elsewhere in the hospital, a de facto nursing shortage is created that diminishes the hospital's productivity." (Kirby and Keon, 2004, p. 17) Oxley and MacFarlan (1994) suggest that "individual institutions may need the scope to negotiate directly with their staff over pay and conditions rather than being bound by centralized agreements." (p.40)

Less rigid scope-of-practice rules

Scope-of-practice rules are professional or institutionally supported rules that prevent professionals who are technically qualified to perform certain kinds of work from doing so. Breaching these rules can result in loss of institutional accreditation or of professional qualifications. A recent OECD report has emphasized the benefits that could arise from increased flexibility in scope-of-practice rules which are often designed by a profession in order to provide effective monopolies over certain kinds of services.²⁹ Many rules have the effect of limiting the performance of certain tasks by para-professionals who would otherwise be competent to carry out such tasks. Since the para-professionals typically have lower hourly pay, such rules can result in substantially higher costs for the performance of the affected tasks.

"Rigid scope of practice rules in hospitals frequently prevent fully qualified health professionals, such as specially trained nurses, from performing services that are now delivered by more costly health care personnel. For example, a nurse practitioner cannot perform a flexible sigmoidoscopy in the place of a doctor." (Kirby and Keon, 2004 p. 17) "[R]igid scope of practice rules drive up health care costs. The most highly educated and skilled professionals spend inordinate amounts of time on matters that could just as easily be handled by other fully qualified providers with less training. This is costly to the system as a whole and makes for less satisfying work for the overqualified professionals." They recommend an "assessment of the productivity of the various health-care professions" that includes "a review of the barriers to productivity gains." They suggest that information on productivity will "considerably weaken a

²⁹ See OECD (2005) "Increasing beneficial competition in the health professions" for more information on undue restrictions of activity by para-professionals and other alternative professionals.

monopoly power currently held by groups of health-care providers and enable government to negotiate pay increases that are more in line with the productivity gains of the various groups” and “encourage competition among providers based on their relative productivity.”³⁰ (Kirby and Keon, p.24)

4. Competition law applied to hospitals and hospital services

Under a central, command-and-control structure of delivery of hospital services, competition laws typically have had little role. In contrast, when competitive forces are introduced between hospitals, as described above, many hospitals are likely to respond by attempting to reduce the pressure of competitive forces. In particular, hospitals that have previously been independent may seek to merge in order to cushion them from the impact of competitive forces. Burgess et al. (2005) suggest that, in the UK, increasing attention will have to be paid to oversight of such activities. In particular, they state that “gains from mergers will need to be weighed against the costs of reduced competition.” If competitive forces are to be encouraged, “the Department of Health will need a pro-competitive strategy.”

Increasingly, governments are focusing on the application of competition law to hospital actions. In a number of countries, including Australia, Germany, the Netherlands, South Africa and the U.S., competition authorities have investigated hospital mergers and in Australia, Germany and the U.S., proceedings to challenge hospital mergers have been active in 2005. Competition authorities have had dealings with hospitals in a number of non-merger contexts as well. Largely because the U.S. has historically had the most direct, competitive rivalry between hospitals, it also has the most extensive experience with the application of competition law application in this area. Some of this experience is reviewed below as it may prove helpful in considering how and whether to apply competition law in this area.

The main areas for the application of competition law include:

- Hospital mergers;
- Planning licenses;
- System negotiation and full-line forcing;
- Joint hospital-physician negotiations;
- Hospital exclusivity; and
- Most-favoured supplier contracts.

This is not a complete list of the hospital-related topic areas in which competition agencies have been active. For example, there have also been cases involving hospitals and pharmaceuticals.³¹

4.1 Hospital mergers

Hospital mergers have a number of different impacts when hospitals compete directly with each other and negotiate payment rates with payors. Mergers can reduce costs of operation of hospitals when there is

³⁰ There is little economic research that addresses scope of practice rules in a hospital setting. However, a U.S. study of dental auxiliaries finds that restricting the number of auxiliaries a dentist can hire and the functions it dental auxiliary may perform cost consumers an extra 700 million USD. (Shepard, 1978.)

³¹ Italy has had such cases.

actual clinical integration of facilities. However, in some countries mergers are not followed by integration of facilities as much as by subsequent integration of negotiations with payors.

Research has suggested that mergers between hospitals located in relatively rural areas are likely to be followed by price increases.

Evidence has suggested that hospital mergers can create market power that result in anti-competitive price increases in markets with few nearby hospitals. For example, in a case study, Vita and Sacher (2001) find that a merger of non-profit hospitals in Santa Cruz, California was followed by significant price increases that were not explained by factors besides market power. Gaynor and Vogt (2003) have simulated the effects of a merger in a relatively isolated area of California and found that price increases between 32% and 53% would have followed mergers of the three largest hospitals in the area.³²

Some judges and competition authorities have felt that a merger in a metropolitan area with many hospitals is not likely to result in any anti-competitive consequences because in metropolitan areas, there are many potential alternative providers. An increasing body of analysis suggests that this view is incorrect. Recent research has suggested that even in urban areas where a number of close rival hospitals are present, prices can at times increase substantially as a result of hospital mergers. This observation is supported both by qualitative and quantitative evidence.

One example of qualitative evidence arises from a 1997 merger of two hospitals in New York state. Two years after the merger of a large tertiary care hospital with a hospital network that included its closest competitor, the hospital systems' chief executive officer spoke of their better financial performance. Mr. Gallagher, "attributed the improved financial picture to the system's ability to negotiate better reimbursement rates with the 40 insurance companies with which it deals. It was this promise of negotiating clout that gave impetus to the merger of the two hospitals, fierce rivals since each was founded in the early 1950's." (NYT, Dec 17, 2000)³³

The quantitative evidence is increasingly based on structural analysis. For example, Town and Vistnes (2001) examine the impact of hospital mergers in California based on actual price data from two health plans with selectively contracted hospital networks. In examining mergers between a hospital in a network and its next-best substitute in the network, they estimate an impact of a merger between a hospital and its next-best substitute of 7.2%, with 59% of simulated mergers generating a price increase above 5%. For the other network, they find an average predicted price increase of 3.2% with 39% of simulated mergers causing a price increase in excess of 5%. Capps et al. (2003) examine the impact of potential hospital mergers in San Diego and particularly focus on a suburb where approximately 30% of its residents receive hospital care outside of the suburb. Many observers would have predicted that hospital mergers in such a situation would not be a problem because of prediction that substantial price increases would not be possible with such an outflow. However, Capps et al. (2003) find that if two of the three hospitals in the suburb merged, profit increases could be as high as 14.7% (and price increases as high as 11.1%). Moreover, if the three hospitals merged in this area with high outflow, profit increases could be as high as 21.5% and price increases as high as 13.2%. From these calculations, they conclude that substantial price increases are possible from hospital mergers in urban areas, even when there is a considerable outflow of patients from the area in question.

While mergers can result in price increases, they can also help to reduce hospital costs. Conner, Feldman and Dowd (1998) find that hospital mergers are unlikely to generate savings that exceed 3-4%. To

32 The area includes hospitals in San Luis Obispo County and nearby.

33 The merger between Long Island Jewish Hospital and the North Shore Hospital System was consummated in 1997.

the extent that mergers would result in an elimination of excess capacity that is otherwise unattainable, long-run savings could be considerably larger, on the order of 25%, based on a hospital cost analysis that compares optimal to actual occupancy rates in Ennis, Keeler and Schoenbaum (2000).³⁴

Given the evidence that hospital mergers can be harmful, it is not surprising that competition authorities have taken action against a number of hospital mergers. In 2005, at least three combinations involving hospitals have been challenged by competition authorities in Australia, Germany and the U.S. In addition, hospital mergers have been investigated by competition authorities in Netherlands and South Africa.³⁵ The most recent U.S. hospital merger litigation is interesting because it deals with a consummated hospital merger (see Box 4.) In this litigation, the administrative law judge agreed with many of the government's arguments and ordered a hospital divestiture, but the merging parties have appealed. Prior to this decision, the U.S. competition authorities lost 7 merger challenge cases in a row since 1994. The complexity of products, demand and purchasing of hospital services suggests that relying on competition authorities and courts to ensure that hospitals will not merge to increase their market power can be a risky approach.

Box 4. Hospital Merger Case: U.S. FTC in the matter of Evanston Northwestern Healthcare Corp.

The U.S. antitrust agencies were the first competition authorities to take action against hospital mergers. After some years of success in challenging mergers, beginning in the late 1980s and early 1990s, the U.S. agencies were unsuccessful in their challenges to seven consecutive hospital mergers. The seven mergers were all prospective mergers, i.e. they had not been consummated. For a variety of different reasons, District Court judges or appellate courts found that the claims of prospective harm were not convincing.

On February 10, 2004, the U.S. FTC filed a complaint challenging the already consummated merger between Evanston Northwestern Healthcare Corp. (ENH) and Highland Park Hospital. ENH consisted of two nearby hospitals in the North Shore region of the Chicago metropolitan area (Evanston and Glenbrook) and Highland Park Hospital was a nearby hospital, also in the north of Chicago. The administrative law judge who heard the case ordered divestiture of Highland Park Hospital. The case provides interesting arguments related to direct effects and harm arising from hospital mergers, hence its treatment here.

ENH and Highland Park Hospital merged on January 1, 2000. The hospitals are within 10 to 12 miles of each other and there are a number of other hospitals in the north of the Chicago metropolitan area. After their merger agreement was signed, the hospitals began to negotiate higher prices with health plans, according to the analysis of FTC experts. The hospitals moved away from per diem pricing to some extent, trying to substitute a discount-off-charges method which gives hospitals the ability to later raise prices without further negotiation, simply by increasing their charges, or list prices, for certain services. The hospitals threatened not to contract with the health plans if the health plans did not accept higher prices, according to the FTC.

A number of different health plans contracted with these hospitals prior to the merger. After ENH's insistence upon higher prices, at least one health plan dropped the hospitals from its network. According to this plan, customers complained about not having access to the ENH. While the plan pointed to a number of nearby hospitals as substitutes, customers insisted upon the ENH. In January of 2001, this plan acceded to the pricing demands of ENH in order to place these hospitals back in its network.

³⁴ However, it is clear that, at times, capacity reductions can occur absent mergers, for example through bankruptcy.

³⁵ In a merger of two hospital chains, the Australian Competition and Consumer Commission (ACCC) has required that Ramsay Health divest 19 hospitals, in total, as a result of its acquisition of Affinity. The Bundeskartellamt recently blocked the acquisition of the city hospital of Eisenhüttenstadt by Rhön-Klinikum and the U.S. FTC has recently litigated a merger between the ENH system and Highland Park in the Chicago area.

Health plans generally acceded to significantly higher prices, even plans that in other cases would drop a hospital from their network when that hospital sought prices that were too high. The reason the health plans acceded to the higher prices, according to the U.S. FTC, was that no reasonable substitutes were available. While most of the price information is confidential, the FTC witnesses claim that, in one case, prices increased by 60% in 2000 compared to 4-8% increases in prior years. In contrast, ENH has claimed the price increases were more in the range of 9-12% (see Chicago Tribune 2005a, 2005b). ENH argued that its price increases arose from learning about market prices as a result of access to the contract information from Highland Park Hospital and that prices should be adjusted for the quality which ENH claims increased.³⁶

The FTC argued that when there is direct evidence of anticompetitive effects, an elaborate market analysis is not required. The FTC expert claimed that the appropriate product market was general acute care inpatient services sold to health plans including primary secondary and tertiary services, while excluding quaternary and outpatient services. The merger guidelines delineate a geographic market by asking whether a hypothetical monopolist in the proposed to geographic market could impose a small significant not transitory increase in price and not lose so many sales and that the price increase would be unprofitable. As a result, the FTC expert identified the appropriate geographic market as the area adjacent or contiguous to the three ENH hospitals. ENH argued that the appropriate geographic market should be much broader because patients come from a broad area and go to a broad area. But the FTC experts argued that it is the reasonable substitutes of the health plans that matter not the reasonable substitutes of the patients, who may travel for idiosyncratic reasons.

The U.S. FTC claimed, and the administrative law judge agreed, that divestiture of Highland Park Hospital is the appropriate remedy. If the hospitals have not closely integrated services and provision, then such a remedy may not be too costly. Hospitals are particularly good candidates for post-merger divestiture given that their operations often remain highly independent even after merger.

Geographic Market Definition

Geographic market definition is an important element of the analysis of hospital mergers, as it is more generally for spatially differentiated goods and services. A commonly used standard for the U.S. courts in examining geographic market definition for many products was developed by Elzinga and Hogarty (1973). The Elzinga-Hogarty approach examines inflows and outflows of consumers or goods to establish market boundaries. After starting with a small market, boundaries are increased in till both inflows and outflows are below the cut-off level. The approach has the benefit that it is reasonably simple to apply, given sufficient data. Moreover, other approaches may be difficult to implement.

Werden (1992) argues that the Elzinga-Hogarty approach does not examine the primary question of relevance in mergers, namely how movements would change in response to a price increase by merging parties. Dranove and White (1998) observe that much travel for obtaining services such as hospital services occurs for idiosyncratic reasons. As a result, local sellers may face inelastic demand despite extensive travel elsewhere for services by local buyers. Capps et al. (2001) examine patient level data and find that “even in suburban areas with high outflows of consumers, some hospital mergers could lead to significant price increases.” Their work suggests that simple inflow and outflow methods may be prone to overestimate the relevant geographic market for the provision of hospital services.

In the recently litigated case described in Box 4, Dr. Elzinga stated his views that the Elzinga-Hogarty test is “inapplicable” to hospital markets. He states that many patients choose hospitals for reasons unrelated to price. Patient flow analysis will then incorrectly indicate “that the market area for hospital services is broader or more extensive geographically than it, in fact, it is.” The Elzinga-Hogarty test

³⁶ Winston and Strawn (2005) Post-trial Reply Brief of Respondent, U.S. FTC in the matter of Evanston Northwestern Healthcare, Corp, Docket No. 9315, July 1.

assumes that the consumer paying for a product is also the one consuming a product. However in the case of hospitals, the payor is typically an insurance company while the consumer of health-care services is a patient. The patients who are moving outside of a given geographic area are not necessarily doing so because of price. Rather, the most relevant negotiation is between payers and hospitals, for this determines the price. The FTC argues that the decisions of the payer determine the geographic market.³⁷ The recent U.S. FTC and U.S. DOJ Health Care Report (2004) states that “To date.... the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases.” (Chap. 5, p. 21)

Geographic market definition may differ for specific services. The ACCC has argued that:

“For basic private hospital services such as general surgery and common specialized services provided at most hospitals, the geographic market is limited to the local region surrounding a particular hospital. In these cases, convenience for patients -- in terms of proximity to family and friends -- and for doctors is an important constraint on the geographic limits of the market. Conversely, for ‘super specialized’ services -- such as complex cardiac procedures -- the geographic market appears to be statewide ‘as there are fewer suppliers and patients must travel for regional areas to receive treatment.’” (Productivity Commission (1999))

The recent U.S. FTC and U.S. DOJ report (2004) identifies a number of alternative sources of information to patient origin data that could help to establish the geographic market for hospital services. These include:

- Strategic planning documents from hospitals
- Payer testimony
- Willingness to travel studies

When hospital prices are determined through negotiation with payers, qualitative interviews with local payers are likely one of the best ways to gain information about geographic markets for hospital services and the alternatives that are available in case independent hospitals raise prices compared to the case when merged hospitals raise prices. In addition, strategic documents of hospitals often provide valuable information about competitive circumstances of merging hospitals and often are relevant evidence. The U.S. FTC and U.S. DOJ report (2004) concludes that: “The hypothetical monopolist test of the *Merger Guidelines* should be used to define geographic markets in hospital merger cases. The types of evidence used in *all* merger cases – such as strategic planning documents of the merging parties and customer testimony and documents – should also be used to delineate relevant geographic markets in hospital merger cases.” (Chap. 5, p. 21)

Non-profit status of hospitals

Litigation related to non-profit hospital mergers has often focused on the question of whether non-profits would engage in anticompetitive activity. In the Rockford hospital merger case from 1990, the District Court found: “the defendants’ ‘consumer-aligned’ boards and not-for-profit status will not

³⁷ U.S. FTC (2005) Complaint Counsel’s Post-Trial Brief, U.S. FTC in the matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, p. 59, May 27.

necessarily prevent the defendants from engaging in anti-competitive activity.”³⁸ This decision was affirmed by an appellate court ruling written by Judge Posner. However, in a hospital merger in Grand Rapids Michigan, the court found that while non-profit enterprises are not exempt from the antitrust laws, non-profit status could be “a relevant consideration if supported by other evidence that anticompetitive effects would not be produced.”³⁹ The court relied upon a study (Lynk (1995)) that found “market concentration among non-profit hospitals is not correlated with higher prices, but with lower prices.” The Lynk (1995) study has been extensively criticized (see Dranove and Ludwick (1998), Keeler et al. (1998) and Shin and Simpson (1998) for explanations of problems with the generality of Lynk’s conclusions.) More recent studies have tended to find that non-profit hospitals, like for-profit hospitals, often do have higher prices in areas with more market concentration. Keeler et al. (1998) find that, looking at hospitals in the same state as Lynk (1995), the “estimated effects of non-profit mergers rise from nil in 1986 to more than 7% higher in 1994. At all times, for profits show greater price response to competition than nonprofits, but by 1994 the difference in the effects of simulated mergers between for-profits and nonprofits” was less distinct than in earlier years. (p.80) This is consistent with an analysis by Vita and Sacher (2001) that provides a case study of price impacts of a merger of non-profit hospitals in Santa Cruz, California. They find that while “post merger quality improvements cannot be ruled out completely they cannot fully account for the observed increase [post-merger] in average price...These price increases....suggest that mergers involving not-for-profit hospitals are a legitimate focus of antitrust concern.”

More recent analyses, including Town and Vistnes (2001), Capps Dranove and Satterthwaite (2003) and Gaynor and Vogt (2002) find either that there is little “statistically significant differences between not-for-profit and for-profit hospitals’ pricing behaviour” (Town and Vistnes) or that, in contrast to for-profits (FPs), non-profit (NFP) “hospitals set lower prices, but have higher mark-ups than do for-profits, due to lower (behavioural) marginal costs...[A] merger simulation reveals no difference between NFPs and FPs in their willingness to exploit merger-created market power.” (p.48) Thus while there is some dispute over the impact of non-profit status on pricing, there appears to be a substantially greater degree of evidence for non-profit hospitals being willing to take advantage of market power, when they have it.

Arguments about the differences between non-profit and for-profit hospitals have also focused on quality differences, with some observers worried about the possibility that for-profit hospitals will offer substantially lower quality services in order to increase profits. McClellan and Staiger (1999) find that within specific hospital markets, “for-profit ownership appears if anything to be associated with better quality care.” They also find that overall there is a small average difference in mortality between for-profit and not-for-profit hospitals but this difference in averages “masks an enormous amount of variation in mortality within each of these hospital types.”

4.2 Planning licenses

Planning licenses can have the effect of serving as regulatory barriers to entry. Hence, great care must be devoted to their exercise. Case law in at least one OECD Member is moving in the direction of suggesting that CON rules do not preclude antitrust considerations.⁴⁰

U.S. Court of Appeals for the 11th Circuit has found that the submission of false or misleading information to a state board that decides on certificate of need applications may constitute a Sherman Act

38 *U.S. v. Rockford Memorial Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989), *aff’d*, 898 F. 2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990).

39 *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff’d per curiam*, No. 96-2440 (6th Cir. July 8, 1997).

40 Two cases are *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*.

violation.⁴¹ St. Joseph's Hospital alleged that HCA submitted false and misleading information to the State Health Planning Agency and the state had relied on that information in making its decision.

The U.S. Department of Justice recently filed a complaint and consent decree to stop two independent hospitals from agreeing to allocate services between them. According to the complaint, the hospitals used planning licenses (or CON) rules as a method of formalizing their agreement to allocate services.⁴²

4.3 *System issues and full-line forcing*

In a number of OECD Members, hospital systems have become increasingly important providers of hospital care. Such systems own or manage hospitals, frequently in a variety of different locations. When such systems negotiate with payers, they often do so as one entity and require payers to contract with either all or none of the hospitals. Payers would often prefer to selectively contract with the hospitals in a system, but this is often not possible due to the full-line forcing of hospitals combined with the fact that consumers want a broad choice of hospitals and many would leave a plan if it lacked all the hospitals in a network. As a result, payers will often agree to contract with all hospitals.

In response, some "payers have sought to 'tier' hospitals. Tiering results in different consumer co-payments (*i.e.*, high or low cost sharing) depending on the hospital at which care is provided. Hospital tiers may be established using a wide variety of criteria. Tiering generally does not apply to emergency admissions, and may depend upon where routine and specialty services are offered." For payers, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payer network. Tiering allows the payer to maintain a broad network, and include a "must-have" hospital, but simultaneously creates an incentive for consumers to use lower-cost providers." (U.S. FTC and U.S. DOJ, 2004)

"Some hospitals resist tiering, and if they have sufficient bargaining power, they can credibly threaten to withdraw from a payer network if they are placed in an unfavourable tier. Hospital systems can similarly threaten to pull all of their hospitals from a network if any system hospital is placed in an unfavourable tier. In some markets, hospital systems have taken pre-emptive steps to negotiate contract language with plans that prohibit tiering." (U.S. FTC and U.S. DOJ, 2004)

4.4 *Joint negotiations with physicians*

In a number of different members, hospitals are closely affiliated with physicians without necessarily being commonly owned. Such affiliations can result in the creation of a physician hospital organization (PHO). At times, a PHO may seek to engage in common bargaining on behalf of all of its members for certain contracts or it may seek to serve as an exclusive bargaining agent for its members in all contracts. Because there may be efficiency justifications for the formation of joint ventures, particularly justifications that involve shared financial risk, not all efficiency enhancements that involve joint activity are relevant to competition law enforcement. For example, sharing of standard of treatment information across members is likely not an activity that requires common negotiation of prices and so may not be an efficiency justification relevant to competition law enforcement. The case of Piedmont Health Alliance described in the box below provides one example of a competition agency enforcement action related to joint negotiation of contracts by physicians and hospitals.

41 In *St. Joseph's Hospital, Inc. v. Hospital Corp. of America*, 795 F.2d 948, 956 (11th Cir. 1986).

42 *U.S. v. Littlefield Regional Medical Center, Inc. and Princeton Community Hospital Association, Inc.* In the agreement, one hospital was allocated most cancer treatment services any other hospital was allocated cardiac surgery.

Box 5. Physician Hospital Organization Case: Piedmont Health Alliance

In December 2003, the U.S. FTC “issued an administrative complaint against Piedmont Health Alliance, Inc. (PHA), a physician-hospital organization in North Carolina, and ten individual physicians, alleging that they engaged in a price fixing arrangement involving physician services. In a related action, Frye Regional Medical Center, an acute care hospital in Hickory, North Carolina, and its parent company Tenet Healthcare Corporation, settled FTC charges concerning their role in PHA's allegedly unlawful activities. The settlement with Frye and Tenet represents the first case in which the FTC has named a hospital as a participant in an alleged physician price-fixing conspiracy.

“The price-fixing charge is based on an alleged arrangement whereby PHA's physician members agreed to use PHA as their bargaining agent, agreed to participate in all contracts PHA entered, and agreed to accept PHA-negotiated prices. The complaints also state that, starting in 2001, PHA began using what PHA calls a "modified messenger model" to enter into contracts with some payors. Legitimate messenger arrangements can reduce contracting costs between payors and physicians, but without involving or facilitating coordinated responses by the physicians. In this case, however, the FTC alleges that the approach employed by PHA was a price-fixing mechanism. Although PHA did ask each member physician individually what minimum price he or she would accept under payor contracts, according to the complaint the contract price was not individually negotiated. PHA allegedly helped its physicians set a minimum price by sending pre-existing, PHA-negotiated contract prices to its physician members, which many used to develop their individual prices. PHA then allegedly negotiated with payors on the overall average price levels to be paid to its physician members, and then set individual fee schedules based on those price levels. According to the complaint, the essence of this pricing conduct is that the physicians, through PHA, collectively determined the size of the overall pie, and the fee schedules were a means of dividing up the pie. The complaint alleges that PHA's collective negotiation on behalf of its physician members was not reasonably necessary to achieving any efficiency-enhancing integration.

“Frye and its parent company, Tenet Healthcare, were charged for their alleged role in facilitating and participating in the physician price fixing. The complaints allege that Frye was instrumental in PHA's formation, expansion, and operation. Frye's Board of Directors allegedly authorized Frye's CEO to use Frye funds to develop a PHO that would include Frye and physicians who practiced at Frye, and Frye's Chief Operating Officer (COO) initially directed PHA's operations. The complaints state that Frye subsequently coordinated the inclusion of two other hospitals - Caldwell Memorial Hospital and Grace Hospital - and their respective medical staffs in the PHO, and has invested substantial funds in the project. Frye's Chief Financial Officer and COO served as PHA's principal contract negotiators from 1994 to 1996. Frye's representative on the PHA Board also participated in the Board's actions regarding payor contracts and physician fees.

“This case shows that hospitals face significant antitrust risks if they facilitate or participate in price fixing by physicians, absent a legitimate efficiency justification.” (Creighton, 2004)

4.5 Hospital exclusivity

At times, community hospitals have been accused of entering into illegal exclusive contracts with insurance companies with the objective of achieving or maintaining dominance. At other times, hospitals have been accused of denying new hospital privileges to physicians in order to limit competition with hospitals existing physicians. Such claims have typically been pursued through private litigation.

Courts have generally given broad discretion to hospitals to determine which physicians should have a right to practice at those hospitals. There is a fear that if hospitals do not have such a broad discretion, they will not be able to refuse privileges to physicians who may be providing low-quality care. However, such discretion is not immutable. A recent appellate court ruling, reinstated dismissed claims by an anaesthesiologist that a hospital maintained an exclusive dealing arrangement that prevented her from competing in the town of Arecibo, Puerto Rico.⁴³

43 *Morales-Villalobos v. Garcia-Llorens*, No. 02-1499 (1st Cir. Jan. 14, 2003).

In one recent U.S. case, a district court ruling from 2002 holds that an ambulatory surgical centre can pursue antitrust claims under sections 1 and 2 of the Sherman act.⁴⁴ In this case, yet to be litigated on its merits, an ambulatory surgical centre claims that a local community hospital conspired with physicians practising at the hospital to monopolize the outpatient surgery market in the community and that it entered into illegal exclusive contracts with major third-party insurers in order to limit the flow of patients to the ambulatory surgical centre. In the same month that the physician-owned ambulatory care centre opened, the community hospital passed a Bylaw that allowed it to deny privileges to any physician who referred patients to facilities besides Rome Memorial Hospital. The judge found that there was a basis for a reasonable inference that Rome Ambulatory Surgical Center's presence "decreased the market price of ambulatory surgery" and that the exclusive contracts prevented consumers from benefiting from that competition.

4.6 *Most-favoured supplier*

Most favoured supplier (or Most Favoured Nation (MFN)) agreements mean that a seller (hospital) has a contract that requires the seller to give the purchaser discounts at least as good as those given to other purchasers. Large volume purchasers, for example, often demand MFN clauses in their contracts, to ensure that they receive good prices. One impact of such clauses, however, is to change the incentives for discounting to firms besides the ones that have a MFN clause. If the firm with a MFN clause has 30% of the business with a hospital, then giving another supplier a price below that of the contract with the MFN clause will mean that the hospital has to lower the price on an additional 30% of its business.

In a recent case (South Georgia Health Partners, or SGHP) the U.S. FTC sued to stop the SGHP from negotiating for a set of un-integrated hospitals. "The SGHP operating agreement...restricted member hospitals' ability to contract outside the PHO. The hospitals agreed not to deal independently for most payor contracts unless authorized to do so by 75% of the SGHP Board. SGHP hospitals also agreed that even if a member hospital was authorized by the Board to contract independently with a payor, that hospital could not offer a greater than 10% discount off its list prices unless it offered the deeper discount to every payor with which SGHP has a contract...this [MFN clause]... appeared to create a substantial disincentive against discounting." (Creighton, 2004)

5. Conclusions -- Increasing competition: challenges and limits

5.1 *Is competition the most appropriate tool for enhancing the achievement of health care goals?*

Competition works most effectively in the absence of market power. Relying on a competitive mechanism to convince hospitals that have significant market power to lower prices and increase efficiency is likely not a reasonable expectation. In short, competitive market-oriented solutions will only work when reasonably close substitutes are available. This suggests that if policymakers seek to place emphasis on competitive solutions, policies to reduce entry barriers and to prevent anticompetitive mergers may be of high importance.

At times, the introduction of competition may actually lead to the creation of excess capacity or to other changes that result in increased system costs, such as increased provision of unnecessary care. Therefore great care must be taken in evaluating policy alternatives within the context of local health-care systems and societal values.

In countries without a national health system, there may be a concern that competition will lead to less provision of care for the uninsured. Often this care is provided by cross subsidy. Frank and Salkever (1991)

44 *Rome Ambulatory Surgical Center, LLC v. Rome Memorial Hospital, Inc.*, 5:01-CV-23 (N.D.N.Y.)

found that where more hospitals competed in a local market, charity care increased. In contrast, Gruber (1994) finds that between 1984 and 1988, charity care in California fell more in competitive markets than in non-competitive markets. Frech (1996) urges that hidden cross subsidies used to pay for charity care should be substituted with explicit taxes and subsidies.

For systems that are not operating with high levels of efficiency, the question arises of how to improve efficiency of health care delivery. Because of the complexity of hospital services and the multiple actors involved in providing care, centrally managed systems may have great difficulty in improving their levels of efficiency. Competition in which successful providers prosper and less successful providers face difficulty is one of the best mechanisms for improving incentives to operate providers of hospital services efficiently. Competition can lead to the more rapid diffusion of cost reducing technological advances, best practice methods and the elimination of waste.

5.2 *What is the best mix of market and non-market tools to enhance health system performance*

All OECD health care systems involve both market and non-market tools. However the degree to which market tools are used varies substantially. This paper has explored a number of different mechanisms for introducing competition into the provision of hospital services and has found experience to suggest that many of these mechanisms have at times either helped to reduce costs or increased quality of service provision. Underlying many transitions towards competitive mechanisms is better quality data about exactly what care patients receive and how long they must wait to receive those treatments. It is increasingly possible for researchers and government to determine the likely impacts of different competitive mechanisms.

Technical efficiency benefits appear particularly significant for:

- Private operation
- Contract payment methods, including
 - Separation of purchasing and provision
 - Prospective payment
 - Payment for results
 - Physician purchasing
- Greater consumer choice
- Reduced control over allocation of tasks to professions
- Regional centres for complex care

Regulatory restrictions can place particular limits on the ability of market-oriented solutions to operate. Licensing controls, contracting limits and professional licensure rolls have all served as methods for limiting effective competition. Rules in these areas are not innocuous. Policy makers focused on introducing competition need to consider both the mechanisms that they desire and the regulations (whether government or non-government) that already exist.

As competitive forces become more significant, a natural reaction of service providers, including hospitals, is to form negotiating alliances that are thinly disguised cartels. While competition law may not be desirable in all areas of health care provision, especially when governments are highly involved in directing that provision, it may be essential in order to ensure that market-based solutions can have a chance to work. When hospitals merge while the introduction of a competitive system is in course but not yet finally decided, actors in the competition law arena should carefully consider the possibility of taking action if it appears likely that such a merger would diminish effective competition once a new regime is in place. Once market-based systems are formally introduced, the role of competition enforcement can become particularly important and the precedents that are set by merger challenges can have a broad impact on the effectiveness of market-based mechanisms. In such situations, competition authorities in health ministries are likely to find that they have many interests in common.

APPENDIX A: THE SWEDISH WAITING LIST PROJECT

The waiting list project started in 1996 when a few county councils in southern Sweden sought to compile data on waiting times and instructed clinics and hospitals within their counties to provide information to the Swedish Federation of County Councils. By the fall of 2001 fewer than half of clinics and hospitals were reporting. A reason for this was under-reporting was an absence of staff and of appropriate computer systems for compilation of data. To encourage collection and reporting of data, the government planned to spend an additional 1.25 billion crowns annually from 2002 to 2004. These extra funds were to be made available to county councils that delivered the data necessary for the construction of a comprehensive national database of both estimated and actual waiting times. The intention is for clinics and hospitals to use the extra funds at least in part to develop computer systems that will permit the ongoing collection of data.

A waiting list database in Sweden concerns wait times for outpatient visits to 25 different types of clinics and specialties covering six diagnostic procedures and 27 elective care treatments. For each clinic and hospital in the system and for each procedure, information is available about:

- The prospective waiting time in weeks for a new patient, assuming the patient is considered non-urgent and non-priority. (This statistic is reported by the clinic itself.)
- The date when the prospective waiting time was reported. (The figures for perspective waiting times are supposed to be less than one month old.)
- The number of patients on the waiting lists. This number includes all patients whether they have the book date or not and all priority groups. (This figure is reported three times a year.)
- The percentage of patients treated in each reporting period that have an actual waiting time less than three months.
- Total production during the last reporting period. (This can be interpreted as the number of new patient diagnoses or procedures.)

The idea behind these data is to ensure that patients have as much information as possible when choosing where to receive care. Thus both historical and prospective information is provided.

Additional figures are accessible to managers and politicians. They can receive information on:

- The number of patients who have waited longer than 12 months;
- The median waiting time; and
- The waiting time for which 90% of patients registering on a certain day would have received their care.

Table 1. Selected OECD Health Care Statistics

	Acute care beds per 1 000 ⁽¹⁾	Acute care occupancy rate	Average length of stay, acute care ⁽²⁾	Discharges per 1000 persons ⁽³⁾	Total exp inpatient care USD PPP	Public expenditure per capita USD PPP	% inpatient care spending public	inpatient care expenditure as % GDP	Total exp on inpatient care, million NCU
Australia	3.6	73.9	6.2	156.6	-	-	-	-	-
Austria	6.0	76.2	5.8	302.0	871	707	81.2%	2.9%	6,422
Belgium	4.0	-	7.7	159.9	-	-	-	-	-
Canada	3.2	86.6	7.4	88.3	842	731	86.8%	2.8%	33,208
Czech Republic	6.5	73.9	8.3	227.6	440	416	94.5%	2.6%	65,188
Denmark	-	-	3.6	197.4	1400	1316	94.0%	4.6%	63,601
Finland	2.3	-	4.3	249.8	837	777	92.8%	2.9%	4,214
France	3.8	74.8	5.6	251.1	1196	1108	92.6%	4.2%	65,045
Germany	-	80.1	9.2	201.6	1073	884	82.4%	4.0%	84,276
Greece	-	-	-	-	-	-	-	-	-
Hungary	5.9	77.2	6.7	257.5	323	288	89.2%	2.3%	376,861
Iceland	-	-	5.2	181.3	1760	1760	100.0%	5.9%	48,011
Ireland	3.0	84.7	6.5	124.1	-	-	-	-	-
Italy	3.9	76.9	-	140.5	937	893	95.3%	3.5%	45,489
Japan	8.5	79.5	20.7	102.0	855	759	88.8%	-	15,650,243
Korea	5.9	71.6	10.6	110.7	241	156	64.7%	1.2%	9,005,478
Luxembourg	5.7	68.8	7.4	175.2	1285	1055	82.1%	2.5%	562
Mexico	1.0	73.7	3.9	42.0	221	152	68.8%	2.3%	158,056
Netherlands	3.2	-	-	97.1	1178	928	78.8%	3.9%	17,649
New Zealand	-	-	-	203.9	-	-	-	-	-
Norway	3.1	88.5	5.4	170.9	1724	1621	94.0%	4.7%	72,817
Poland	5.1	77	7.9	-	-	-	-	-	-
Portugal	3.1	85.2	-	78.2	-	-	-	-	-
Slovak Republic	5.9	65.4	7.9	187.9	236	236	100.0%	1.8%	21,630
Spain	3.1	-	-	108.9	499	430	86.2%	2.1%	15,562
Sweden	-	-	4.8	160.1	809	797	98.5%	2.9%	67,608
Switzerland	3.9	85.2	9	154.9	1812	1114	61.5%	5.5%	23,935
Turkey	2.3	61.9	5.2	81.0	-	-	-	-	-
United Kingdom	3.7	85.1	6.7	236.6	-	-	-	-	-
United States	2.8	66.2	5.7	117.1	1526	899	58.9%	4.1%	443,718
Average	4.1	76.8	7.2	163.0	955.5	810.8	85.3%	3.3%	-

Source: OECD HEALTH DATA 2005, June 05

* 2002 data

Notes:

1. The definition of "acute care" beds may vary from one country to the other. In Japan, many "acute care" beds are devoted to long-term care. Cross-country variations should therefore be interpreted with caution.

2. Austria, Czech Republic, France, Hungary, and the United States include same-day separations whereas other countries exclude them. Starting in 1994, the Canadian figures represent ALOS in short-stay hospitals; many of the short-stay hospitals also have long-term care beds. Data for Mexico are restricted to public hospitals only.

3. Austria, Czech Republic, France, Hungary, New Zealand and the United States include same-day separations whereas other countries exclude them. Finland includes transfers from one hospital unit to another while these are excluded in other countries. Data for Mexico are restricted to public hospitals only.

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NOTE DE RÉFÉRENCE

AMÉLIORER L'EFFICACITÉ DES SERVICES HOSPITALIERS PAR LE BIAIS DE LA CONCURRENCE ET DE MÉCANISMES CONNEXES

1. Introduction

Les services hospitaliers constituent une part importante du volume total des dépenses de santé et des dépenses publiques dans les pays de l'OCDE : en 2002, ils ont représenté 41 % de ces dépenses dans les membres de l'Organisation. Par ailleurs, dans ces pays, c'est le secteur public qui assume 85 % des dépenses en soins hospitaliers.¹ Au cours des dix dernières années, cette catégorie de dépenses a enregistré une augmentation nettement supérieure à la hausse de l'IPC. Compte tenu de l'évolution démographique, liée au vieillissement de la population, cette tendance devrait se maintenir. Du fait du pourcentage élevé des recettes de l'Etat et du budget national généralement associé à la fourniture de services hospitaliers, l'efficacité de ces services revêt une grande importance politique dans la plupart des pays de l'OCDE, et ce d'autant plus qu'il est manifeste que cette efficacité n'est pas toujours ce qu'elle devrait être. L'une des mesures adoptées de plus en plus fréquemment pour remédier à cette situation consiste à renforcer le rôle de la concurrence. Le présent document a pour objet de recenser et de décrire les différents mécanismes de concurrence actuellement adoptés pour améliorer l'efficacité des soins en milieu hospitalier, ainsi que d'en donner une première évaluation.

Dans de nombreux pays, y compris ceux dotés d'un système de santé national, la mise en place de mécanismes basés sur le marché est effective ou à l'étude. Plusieurs ont adopté des systèmes de sous-traitance qui font jouer la concurrence et récompensent les bonnes performances. Au Royaume-Uni, par exemple, un nouveau système d'acquisition de services hospitaliers par des médecins a été présenté en octobre 2004. L'Allemagne a introduit un dispositif de paiement prospectif. Aux Etats-Unis, il est de plus en plus fréquent d'accorder des bonus à des institutions hospitalières en fonction de la qualité des services. Si les démarches axées sur la concurrence se généralisent, celle-ci reste souvent limitée – en ce qui concerne les services hospitaliers – par les réglementations officielles et les normes en matière de remboursement. Ces limites ont un impact considérable sur les services fournis en milieu hospitalier.

La concurrence entre les fournisseurs de services hospitaliers peut avoir des répercussions diverses : diminution des séjours excessifs en hôpital, réduction du coût lié à ces soins et meilleure qualité de soins.² L'expérience montre généralement que :

- Les fournisseurs et les utilisateurs de services hospitaliers réagissent positivement aux incitatifs financiers visant à plus d'efficacité.

1. Source: Données Eco-santé de l'OCDE, 2005. Pour les statistiques correspondantes, se reporter au tableau 1.

2. Parmi les travaux antérieurs de l'OCDE consacrés à l'étude des avantages pouvant découler d'une concurrence accrue en matière de services hospitaliers, on citera ceux de Oxley et MacFarlan (1994), ainsi que ceux de Docteur et Oxley (2003).

- La concurrence entre les hôpitaux ou les autres fournisseurs de services hospitaliers peut, dans de nombreux cas, améliorer l'efficacité des prestations, en permettant une réduction des coûts, une meilleure qualité des services, voire une combinaison de ces deux avantages.
- Lorsque la concurrence ne joue que sur le plan de la qualité et que les prestations sont variables, les coûts peuvent parfois s'en trouver majorés sans qu'aucun avantage vienne compenser cette augmentation.
- Même lorsque les services hospitaliers sont assurés en grande partie par les pouvoirs publics, il peut s'avérer intéressant de faire intervenir la concurrence, dans le secteur public lui-même ou entre ce dernier et les cliniques privées. La véritable difficulté consiste à identifier les moyens par lesquels la concurrence influe sur les recettes des hôpitaux publics.
- Une totale liberté de choix pour les patients qui n'ont à supporter qu'un faible coût en matière de soins de santé ne favorise pas la concurrence sur les tarifs, car les patients concernés ne subissent pas les conséquences de leur choix ; un meilleur incitatif à la réduction des coûts et des tarifs consisterait à limiter leur choix à quelques prestataires de services hospitaliers ou à offrir cette possibilité à certains acteurs confrontés à des contraintes budgétaires (par exemple : les médecins).
- Pour que la concurrence soit efficace dans le domaine des prix, il importe que l'offre de services soit supérieure à la demande, de sorte que le consommateur puisse, de façon crédible, menacer de s'adresser à un autre prestataire.
- Dès lors que des mesures d'incitation à la concurrence sont mises en place, le respect du droit de la concurrence peut s'avérer utile, y compris dans les cas où les services hospitaliers sont soumis au contrôle des pouvoirs publics.

Les services hospitaliers proprement dits constituent un ensemble complexe de produits et de services englobant différents types d'activités axées sur le patient. Outre les actes chirurgicaux, la maternité et les soins avec hospitalisation, les hôpitaux dispensent des soins d'urgence, un éventail de services de diagnostic, des produits pharmaceutiques et d'autres services de soutien. Pour certains d'entre eux, comme les services d'urgence, il peut se produire qu'un hôpital ait peu de concurrents, voire qu'il n'en ait aucun. Pour d'autres – par exemple : les actes chirurgicaux programmés avec hospitalisation – il peut y avoir concurrence entre plusieurs établissements proposant des soins comparables. Certains services de haut niveau (parfois appelés « services tertiaires »), comme les opérations à cœur ouvert, les transplantations, les soins aux grands brûlés et la médecine néonatale, sont parfois proposés par un petit nombre d'hôpitaux seulement. Enfin, s'agissant de certains services comme les services de diagnostic, les consultations de spécialistes et les soins ambulatoires, les hôpitaux peuvent parfois se trouver en concurrence avec des centres de diagnostic, des cabinets médicaux et des centres de chirurgie ambulatoire. Aucun de ces prestataires extérieurs au milieu hospitalier n'étant outillé pour offrir la même gamme de services qu'un hôpital général de soins approfondis, ils ne sauraient, par conséquent, se substituer entièrement à l'hôpital, mais lorsqu'ils peuvent remplacer certains services hospitaliers, il est parfois possible de gagner en efficacité en assurant la prestation en dehors de l'hôpital.³

Les services de santé, y compris en hôpital, associent un certain nombre de caractéristiques inhabituelles susceptibles d'entraîner des dépenses excessives si l'approche adoptée est celle d'un marché totalement libre. Au nombre de ces caractéristiques figurent (1) l'effet « assurance », lié au fait que le prix

3 La multiplicité des services hospitaliers peut rendre particulièrement difficile l'estimation des coûts de certaines prestations particulières.

dont le consommateur doit s'acquitter est souvent très inférieur au coût marginal des services qu'il reçoit (ce qui l'incite à exiger certains services dont le coût est supérieur aux avantages escomptés) ; (2) l'effet « information », induit par le fait que le consommateur a du mal à évaluer la qualité des soins, que ce soit avant ou après la prestation ; (3) un objectif de redistribution en matière de bien-être, visant à une vaste couverture médicale applicable aux pauvres et aux défavorisés. En dépit de ces caractéristiques du secteur de la santé, il apparaît que le jeu de la concurrence permet, dans certains cas, une efficacité accrue.

Le présent document se propose de définir un certain nombre de mécanismes propres à améliorer l'efficacité des services hospitaliers. Chacun de ces mécanismes a été mis à l'épreuve dans au moins un pays de l'OCDE. On a pu constater que même des incitations financières relativement limitées peuvent entraîner une réduction sensible des coûts ou une amélioration de la qualité. La mise en place de dispositifs adéquats dans l'ensemble des pays de l'OCDE pourrait se traduire par des économies importantes et des gains de qualité non négligeables. Par exemple, si les dépenses liées aux soins hospitaliers diminuaient de 1 % dans tous les pays de l'OCDE, ce sont plus de huit milliards de dollars qui seraient économisés chaque année.

Le présent document recense les mesures suivantes en vue du renforcement de la concurrence ou des forces du marché :

- veiller à la collecte et à la diffusion de données plus complètes sur les performances des prestataires ;
- soutenir les nouvelles entrées lorsque les coûts d'entrée et de sortie sont peu élevés ;
- encourager l'exploitation indépendante et privée de certaines installations ;
- améliorer l'affectation des ressources humaines, notamment grâce à une évaluation des restrictions anti-concurrentielles appliquées par les professionnels ;
- introduire des dispositifs contractuels qui permettent de récompenser les performances et les résultats ;
- offrir un choix plus vaste au consommateur, en particulier lorsque les listes d'attente sont longues ;
- mettre l'accent sur les centres régionaux pour les procédures complexes ;
- envisager la création de licences pour les centres de soins ambulatoires et les hôpitaux spécialisés ;
- rendre possible la contestation de la gestion d'un hôpital ;
- faire appliquer le droit de la concurrence.

Dans l'ensemble, le présent document montre qu'il est très possible de mettre à profit les mécanismes d'incitation axés sur le marché et la concurrence pour accroître l'efficacité des prestations de services hospitaliers. Nombreux sont les cas où de tels mécanismes ont entraîné des économies substantielles et une nette amélioration de la qualité. Les dispositifs privilégiant la concurrence et le marché présentent des avantages considérables ; les cas examinés ci-après montrent en effet que, du moins dans certains cas :

- Les appels à la concurrence pour les services de laboratoire peuvent se traduire par des économies de 30 %, voire davantage.
- La concurrence par les prix entre plusieurs hôpitaux sous contrat peut permettre des économies de 7 % ou plus.
- L'analyse comparative des coûts et des performances des hôpitaux les plus efficaces peut permettre une réduction de 6 % des dépenses dans les établissements moins performants.
- Le système de l'enveloppe budgétaire pour les médecins peut contribuer à réduire de 3,3 % le taux d'admissions.
- Les paiements à l'acte peuvent permettre une économie de 10 % ou davantage par rapport à un financement des hôpitaux fondé principalement sur le montant des dépenses précédentes.
- Dans une zone géographique donnée, on peut associer l'existence d'hôpitaux à but lucratif à une baisse de 2,4 % des coûts hospitaliers.

Toutefois, les généralisations quant aux avantages de la concurrence pour les prestations de services hospitaliers ne sont pas toujours judicieuses. Les répercussions que peut avoir cette concurrence varient suivant la forme qu'elle revêt, le système de financement des soins de santé, le système de paiement des hôpitaux, la nature des services en cause, les types de prestataires concernés, la possibilité de laisser s'implanter de nouveaux fournisseurs, la réglementation en vigueur et les avantages sociaux qui régissent l'offre et la demande en matière de soins de santé. Un mécanisme donnant de bons résultats dans un système donné ne sera pas forcément facile à transposer dans un autre.

De tous les pays de l'OCDE, c'est aux Etats-Unis que la concurrence est la plus vive, depuis une vingtaine d'années, en ce qui concerne les services hospitaliers. Le coût des soins de santé par habitant dans ce pays figure parmi les plus élevés de la zone OCDE ; toutefois, la concurrence sur les prix entre les hôpitaux s'est traduite par un ralentissement de la hausse des tarifs pour les services hospitaliers, du moins au cours des années 1990.⁴

Il est peu probable que d'autres pays ayant choisi une démarche axée sur le marché adopteront le même système de concurrence directe que les Etats-Unis. Ce système n'en reste pas moins valable. Toutefois, des mécanismes faisant intervenir une concurrence moins directe pourraient s'avérer bénéfiques. C'est peut-être en matière d'application du droit de la concurrence que l'on pourrait trouver les ressemblances les plus marquées entre les Etats-Unis et d'autres pays de l'OCDE. Un grand nombre de gouvernements pourraient envisager des fusions d'hôpitaux ainsi que des contrats de services avec les hôpitaux, et l'expérience des Etats-Unis pourrait se révéler riche d'enseignements, notamment pour ce qui concerne l'application du droit de la concurrence dans ce domaine.

2. Définir les problèmes

Avant d'analyser les mécanismes susmentionnés, il importe de réfléchir aux aspects suivants :

4 L'évolution qui s'en est suivie concernant les conditions des prestations, en raison notamment de fusions d'hôpitaux, ainsi que le durcissement des réglementations officielles relatives aux contraintes que les assureurs peuvent imposer aux prestataires et aux patients, ont peut-être contribué à l'augmentation des coûts globaux et des primes d'assurance, et ce malgré la possibilité de négocier les tarifs des services hospitaliers.

- objectifs d'une concurrence dans le secteur des services hospitaliers ;
- caractéristiques principales des marchés de services hospitaliers ;
- contraintes imposées par la réglementation.

2.1 *Les objectifs d'une concurrence dans le secteur hospitalier*

La concurrence dans le domaine des services hospitaliers englobe différents mécanismes d'incitation, qu'il s'agisse de marchés entièrement libres – selon le modèle américain, dans lequel de nombreux assureurs négocient avec un grand nombre d'hôpitaux le prix des soins et d'autres aspects des prestations – ou de systèmes plus souples visant à exploiter au mieux la puissance du marché dans d'autres contextes institutionnels. Il peut s'agir d'une mise en concurrence par étalonnage des performances, du système des contrats sélectifs, d'achats par des médecins et, plus généralement, de mécanismes propres à instaurer des rivalités ou à contraindre les hôpitaux à se comporter comme s'ils avaient de la concurrence. Ces différents mécanismes, durs ou souples, peuvent avoir de nombreuses incidences positives.

L'intérêt de la concurrence dans le domaine hospitalier tient principalement au fait qu'elle pourrait accroître l'efficacité des prestations, tant pour les aspects techniques que pour l'affectation des ressources, ce qui permettrait d'améliorer la qualité des services fournis et, en fin de compte, la maîtrise des coûts à l'échelle du système. Ce dernier point peut contribuer à faire en sorte que soit atteint l'objectif social d'un large accès aux soins de santé et que le gain en qualité ne représente pas une dépense excessive pour les gouvernements.

Il est indispensable, pour évaluer les répercussions de la concurrence, de comparer ses avantages aux coûts potentiels. Ces derniers peuvent revêtir différentes formes, depuis les capitaux investis dans des capacités excédentaires jusqu'aux coûts administratifs. Une concurrence réelle et directe entre prestataires rivaux exige une surcapacité, de sorte que les consommateurs de services hospitaliers puissent effectivement menacer de quitter un établissement pour un autre. Cette surcapacité peut cependant s'avérer coûteuse, puisqu'elle nécessite un investissement et une maintenance permanente. Elle représente donc un élément de coût lié à la concurrence.

L'introduction de la concurrence peut alourdir les dépenses administratives associées au remboursement des services. Aux Etats-Unis, par exemple, on estime que les coûts administratifs globaux – notamment ceux des hôpitaux et des cabinets médicaux – représentent 31 % des dépenses de santé, soit 1059 dollars par habitant ; au Canada, en revanche, où il existe un seul assureur public, le poids des coûts administratifs est bien moindre : 16,7 % des dépenses de santé, soit 307 dollars par habitant (Woolhandler, Campbell et Himmelstein, en 2003). Ces chiffres moins élevés sont le reflet, dans une certaine mesure, d'une absence quasi-totale de concurrence.⁵ L'examen du rapport coût-avantages (introduction de la concurrence/dépenses administratives) ne permet pas toujours de dégager des résultats clairs, car on reste largement tributaire des systèmes d'information déjà en place.

Amélioration de l'efficacité des prestations

L'un des avantages les plus fréquemment cités concernant l'introduction de processus fondés sur le marché tient au fait que ceux-ci permettent d'améliorer les mesures d'incitation en vue d'une production

5 Il convient cependant de souligner que ces écarts de coûts s'expliquent en partie par la collecte d'informations sur le comportement des prestataires de services, probablement plus fréquente aux Etats-Unis qu'au Canada. Ces informations peuvent à leur tour être utilisées pour faire pression sur les hôpitaux afin qu'ils réduisent les coûts et améliorent leurs performances.

plus efficiente. Pour que cet avantage puisse se concrétiser, il faut que les modalités en place avant l'introduction du nouveau système aient présenté des lacunes en la matière. Quantité d'éléments montrent que, dans de nombreux pays, les hôpitaux pèchent sérieusement par manque d'efficience. Zuckerman, Hadley et Iezzoni (2002), par exemple, estiment que ce type d'insuffisance est à l'origine de 13,6 % des coûts hospitaliers globaux aux Etats-Unis. Selon Cellini, Pignataro et Rizzo (1996), 3,4 % seulement des hôpitaux italiens pris en compte dans leurs travaux se situent dans la limite en matière de coût ; il s'ensuit que 96,6% des hôpitaux italiens pourraient améliorer leur efficience sur le long terme.⁶

L'efficacité technique des prestations dans le domaine de la santé s'accroît lorsque la quantité de services fournis pour un volume de dépenses donné augmente ou lorsque la qualité des services s'améliore sans dépenses supplémentaires. L'instauration d'une rivalité entre différents fournisseurs constitue l'un des meilleurs procédés pour inciter à fonctionner efficacement. L'efficacité technique peut provenir à la fois d'une intensification du recours à des ressources sous-employées et d'économies d'échelle. Du fait de l'apparition de nouvelles technologies ayant permis de réduire la durée d'hospitalisation nécessaire après une intervention chirurgicale, les hôpitaux en sont arrivés de plus en plus fréquemment à tourner en deçà de leur courbe d'exploitation optimale. Keeler et Ying (1996), ainsi que Gaynor et Anderson (1995), soulignent que le taux d'occupation optimal d'un hôpital doit prendre en compte les fluctuations statistiques quotidiennes de la demande, de même que l'obligation faite aux établissements hospitaliers de fournir des soins : un taux d'occupation de 100 %, qui conduirait à refuser fréquemment de nouveaux patients, serait donc, en réalité, un signe de non-efficience.⁷ Toutefois, les taux d'occupation sont désormais inférieurs à 70 % dans certains pays de l'OCDE, ce qui est probablement insuffisant pour assurer une efficience satisfaisante (voir tableau 1). En outre, les variations importantes entre les durées moyennes d'hospitalisation en soins actifs/aigus fournissent un indicateur supplémentaire des économies possibles.

Améliorer l'efficience des prestations pourrait contribuer à la mise en œuvre des objectifs des gouvernements concernant la maîtrise des coûts pour l'ensemble du système. Il s'agit d'un aspect particulièrement important, si l'on garde à l'esprit que les pouvoirs publics assument 85 % des dépenses consacrées aux soins hospitaliers.

Améliorer la qualité des prestations et la capacité de réaction aux attentes des patients

La concurrence peut contribuer grandement à l'amélioration de la qualité des services fournis aux patients. Toutes les formes de qualité n'ont pas, cependant, la même valeur.⁸ Lorsque la libre concurrence a pour corollaire une réduction sensible des délais d'attente pour les interventions chirurgicales, le patient bénéficie directement de cet avantage. Par contre, si elle se traduit par des dépenses d'investissement

6 L'interprétation des résultats de l'analyse des différentes enveloppes pourrait se trouver quelque peu compliquée par l'impossibilité de distinguer entre les auteurs de bonnes et de faibles performances, une fois prise en compte l'importance statistique de ces données.

7 Le problème se pose avec plus ou moins d'acuité selon les périodes. On soulignera que l'objectif social visant à maintenir des capacités excédentaires ne sera pas adopté par un hôpital à but lucratif qui, s'il est rémunéré sur la base du nombre de jours d'hospitalisation, préférera vraisemblablement que la totalité de ses lits soient occupés.

8 En dernière analyse, il serait utile de mesurer les améliorations qualitatives en termes de gains pour la santé des patients, plutôt que de les lier à la fourniture de types de soins déterminés; or, la mesure d'un état de santé est encore plus malaisée que l'évaluation de la qualité d'un service. Un grand pas a cependant été accompli dans ce sens grâce à la prise en compte des années de vie ajustées à la qualité de cette dernière : sont prises en considération notamment les restrictions à la mobilité intégrale, ainsi que la santé potentielle en vue d'évaluer différentes options d'investissement à l'aide des fonds limités affectés au système de santé (Voir Williams, 1995).

excessives, consacrées par exemple à l'aménagement de salles d'attente luxueuses ou à l'acquisition de matériel de diagnostic superflus – comme des scanners IRM ou des appareils à rayons X qui seront peu utilisés – l'impact d'une concurrence axée sur des aspects autres que les prix pourrait n'améliorer que de façon très limitée la situation des populations en matière de santé et être considérée au contraire comme une « course à l'armement médical (CAM) » (voir l'encadré 1).

Encadré 1. La concurrence entre hôpitaux conduit-elle à une course aux armements médicaux?

De nombreux décideurs ont émis le point de vue que la concurrence entre établissements hospitaliers constituait en soi un gaspillage et que son introduction sur le marché des services hospitaliers se traduirait par une augmentation des dépenses de santé. Les enseignements de l'expérience leur donnent à la fois tort et raison, et dépendent pour une large part des caractéristiques du système de santé dans son ensemble. Un consensus semble toutefois se dégager pour affirmer que, si la concurrence entre hôpitaux risque de favoriser une véritable course aux armements médicaux (CAM), celle-ci ne représenterait probablement – à supposer même qu'elle se produise – qu'un très faible pourcentage des coûts.

Robinson et Luft (1985) ont laissé entendre que, dans les cas de concurrence plus vive, les hôpitaux investiraient dans des services parfaitement superflus par rapport aux exigences du marché. « Bien que les patients des hôpitaux arrivent parfois directement de services d'urgence ou de cliniques de soins ambulatoires, la majorité d'entre eux sont admis sur décision de médecins de quartier affiliés à l'institution concernée.... L'hôpital est tributaire de ces médecins affiliés pour avoir des patients : à l'inverse, les médecins dépendent de l'hôpital pour les services qu'ils ne peuvent fournir commodément, ou avec efficacité, dans leur cabinet. » (Robinson et Luft). L'hypothèse d'une course aux armements se fonde sur l'idée qu'en l'absence de toute rivalité sur les prix, les hôpitaux se feront concurrence pour les médecins, qui déterminent les courbes d'admissions. Or, l'un des moyens d'attirer les médecins consiste à proposer des services de haute technologie. Par exemple : si une zone géographique donnée ayant une demande suffisante pour justifier l'utilisation d'un scanner IRM dispose de deux hôpitaux, et qu'un seul de ces établissements obtient ce matériel, l'autre pourra alors s'efforcer de se doter à son tour du même équipement afin de rester aussi attrayant pour les médecins. C'est ainsi qu'une zone qui avait réellement besoin d'un scanner IRM se retrouvera équipée de deux appareils dont l'utilisation ne sera que partielle. Autre élément à l'appui de cette hypothèse : les hôpitaux seront tentés de renforcer la qualité de leurs prestations dans le but d'attirer des patients qui, grâce à leur assurance, n'ont pas à supporter la totalité des coûts liés à cette amélioration.

Robinson et Luft ont étudié la situation des hôpitaux des Etats-Unis en 1972, avant que la concurrence sur les prix ait un rôle important à jouer pour les services hospitaliers dans ce pays. Ils en ont conclu que, par comparaison avec les hôpitaux en situation de monopole, le coût moyen d'une journée d'hospitalisation était de 5,6 % supérieur pour un hôpital ayant un seul établissement similaire dans son voisinage ; l'écart passait à 9,1 % pour un hôpital dont le nombre de voisins était compris entre deux et quatre, à 16,3 % s'il se situait entre cinq et dix, et à 20,5 % s'il était égal ou supérieur à onze. (p. 347) Il convient de souligner que, pour ces estimations, il n'a pas été procédé à des tests spécifiques concernant la densité technologique et que ces écarts pourraient donc découler de facteurs sans rapport avec l'hypothèse CAM.

Aucune de ces études ne vient étayer l'hypothèse CAM en confirmant l'existence d'un sur-investissement dans des équipements de pointe. Dranove, Shanley et Simon (1992) ont procédé à une analyse minutieuse des catégories de services de haute technologie proposés en 1983, c'est-à-dire à une époque où la concurrence agressive sur les prix n'était pas encore devenue monnaie courante entre établissements hospitaliers. Les services qu'ils ont étudiés sont les suivants : chirurgie à cœur ouvert, tomodensitographie complète, radiothérapie, scintigraphie, ainsi que plusieurs types de services groupés selon des critères cliniques ou technologiques, et axés sur la cardiologie, les accouchements, le diagnostic, les urgences, la néonatalogie, la pédiatrie et l'enseignement. Leurs conclusions attestent bien un effet CAM, mais celui-ci a un impact économique limité. Par ailleurs, les chercheurs ne s'attendent généralement pas à ce que les fusions d'hôpitaux aboutissent à une réduction des dépenses en biens d'équipement si la course aux armements médicaux prenait fin.

Dranove et al. considèrent, au vu de schémas comparant le nombre d'hôpitaux au nombre de prestataires de services par habitant, que le phénomène de la CAM est relativement important. En cardiologie, le premier prestataire spécialisé apparaît lorsque la population locale atteint approximativement 62 000 personnes, le deuxième à 277 000, et les suivants 680 000 et 830 000. « Si le phénomène de course aux armements médicaux était le principal facteur

déterminant en matière de prestations de services spécialisés, et si nous escomptions que les chiffres traduisent une tendance générale à la hausse – à mesure que les hôpitaux seraient plus nombreux sur le marché, la concurrence les inciterait à offrir des services dépassant les exigences de la population. En fait, les chiffres révèlent plutôt une tendance à la baisse. On peut en déduire qu'à mesure que les marchés se développent et que les hôpitaux se font plus nombreux, les effets les plus importants résident probablement dans les économies d'échelle et d'envergure, l'effet CAM n'étant que marginal. » (p.257)

2.2 *Quelques caractéristiques essentielles des services hospitaliers*

Le marché des services hospitaliers présente plusieurs caractéristiques particulières, qu'il importe de prendre en compte pour déterminer l'opportunité d'introduire ou de modifier certains mécanismes propres à développer la concurrence, notamment :

- complexité de la production ;
- asymétrie de l'information ;
- poids du marché local ;
- concentration des investissements ;
- importante capacité d'emplois ;
- systèmes de paiement peu favorables à la recherche de gains d'efficience.

Complexité de la production et rapidité des évolutions technologiques

Les produits fabriqués en vue de la prestation de services hospitaliers sont extrêmement complexes. Ils sont parfois adaptés aux patients car, même en cas de diagnostics similaires, les besoins peuvent varier, ce qui rend difficile toute standardisation.

La rapidité des progrès technologiques est un aspect prépondérant dans le domaine des services hospitaliers. Ainsi, la sclérose des artères coronaires, qui nécessitait autrefois une opération à cœur ouvert, peut désormais fréquemment être traitée par cathétérisation cardiaque. La modernisation des méthodes chirurgicales, des procédés médicaux, des protocoles de traitement et des systèmes de diagnostic peuvent faire évoluer considérablement, et en peu de temps, les marchés relatifs à certains services hospitaliers. Les avancées technologiques pourraient, entre autres, réduire la durée de la convalescence après un acte chirurgical et, par conséquent, le nombre de lits nécessaires pour une population donnée. Toutefois, la plupart des hôpitaux étant construits pour le long terme, ces évolutions peuvent se solder par de plus faibles taux d'utilisation des installations, ce qui ne facilite pas les retours sur investissement.

Asymétrie de l'information entre organismes payeurs, patients et prestataires

Dans la plupart des pays de l'OCDE, la grande majorité des patients ont contracté une assurance couvrant le recours à des prestations hospitalières. Si les patients doivent parfois contribuer au financement des soins prodigués, ils n'en supportent généralement qu'une fraction très modeste, voire nulle. Patients et organismes payeurs ont souvent du mal à évaluer la nécessité des soins. Par conséquent, si chaque acte donne lieu à remboursement, les hôpitaux seront incités à fournir davantage de prestations. De même, les patients peuvent se sentir encouragés à surconsommer des services dont seule une très faible partie du coût est à leur charge, et solliciter des soins dont le bénéfice marginal réel qu'ils en retirent est inférieur au coût supporté par l'organisme payeur. En d'autres termes, il y a asymétrie de l'information sur plusieurs points :

- l'importance des soins nécessaires ;
- le coût réel de ces soins ;
- leur intérêt en termes de santé.

Poids du marché local lié aux économies d'échelle et aux coûts de transport

Les économies d'échelle sont considérables pour un grand nombre de services hospitaliers, mais pas pour la totalité d'entre eux. C'est là une des raisons pour lesquelles la plupart des hôpitaux installés dans des zones rurales offrent une gamme de services beaucoup plus étroite que les grands hôpitaux urbains secondaires ou tertiaires. Le nombre de personnes desservies par un hôpital ne permet pas, dans de nombreux domaines, de fournir un service économique. Certains services, toutefois, n'affichent pas des rendements d'échelle très élevés. Par exemple, les services de laboratoire peuvent s'avérer efficaces à partir d'un seuil relativement bas et être peu sensibles aux effets d'échelle.

La distance entre l'hôpital et le domicile ou le lieu de travail du patient a des conséquences non négligeables sur la volonté de ce dernier de faire appel à un établissement donné : c'est ce qu'avaient constaté McGuirk et Porell (en 1984), ainsi que Dranove, White et Wu (en 1991). Selon eux, la distance est un facteur de choix important sur le marché local ; par ailleurs, les patients qui ne peuvent bénéficier des soins de santé dont ils ont besoin dans l'hôpital situé à proximité de chez eux se tournent généralement vers l'établissement le plus proche répondant à leurs attentes. Dans une enquête canadienne réalisée en décembre 2004, on peut lire ce qui suit : « un Canadien adulte sur trois estime « extrêmement important » d'avoir accès à des soins chirurgicaux dans un hôpital à proximité de sa résidence » (Institut canadien d'information sur la santé – ICIS, 2005), ce qui s'explique par le fait que patients et médecins imputent un coût à la distance parcourue et à la durée du déplacement. Il en découle que des hôpitaux offrant des services comparables peuvent se trouver différenciés sur des critères géographiques ; ils ne sont donc pas interchangeables, ce qui permet de penser que certains établissements peuvent avoir une certaine emprise sur le marché.⁹

Le débat est vif entre juristes et économistes quant à la définition appropriée du marché géographique de services hospitaliers. D'une part, il ne fait guère de doute que la plupart des hôpitaux sont très interchangeables dans les zones urbaines densément peuplées. Certains chercheurs soutiendront que le marché des services hospitaliers couvre, dans les zones urbaines de grande dimension comme Los Angeles, l'ensemble de la métropole. Mais cette affirmation est incompatible avec la hausse de prix constatée dans un hôpital de Santa Monica après que son principal concurrent, endommagé par un séisme en 1994, eut fermé puis fonctionné à capacité réduite pendant plus d'une année, alors même que plusieurs autres établissements disposaient de capacités non utilisées dans un rayon de huit kilomètres.¹⁰ Il ressort de cet exemple de fermeture temporaire que la définition du marché géographique de services hospitaliers peut être très étroite, y compris pour une large métropole.

9 L'existence d'une emprise sur le marché ne signifie pas nécessairement que les prix pratiqués dépasseront le niveau « concurrentiel ». Les analystes de la politique continuent de débattre sur le point de savoir si les hôpitaux sans but lucratif profitent de leur puissance sur le marché.

10 Ennis (1995) a constaté que les prix d'hospitalisation au Santa Monica Hospital ont progressé de 15 à 25 % pendant l'année où l'un des deux hôpitaux situés à proximité l'un de l'autre à Santa Monica a été fermé ou a fonctionné avec très peu de lits. (Santa Monica se trouve dans la zone métropolitaine de Los Angeles et ne comporte que deux hôpitaux sur la centaine que compte cette zone).

A l'appui de l'idée selon laquelle un marché géographique peut être plus restreint qu'une zone métropolitaine, on constate de plus en plus souvent – comme on le verra ci-après – que les fusions d'hôpitaux dans les grandes métropoles peuvent s'accompagner de hausses de prix.

Dans ce contexte, on soulignera l'existence, dans de nombreux pays de l'OCDE, de vastes zones où la population est à la fois peu dense et très dispersée, ce qui limite considérablement les possibilités de concurrence sur le marché des services hospitaliers.¹¹

Concentration des investissements à long terme

Un hôpital étant le résultat d'investissements massifs à long terme, dont une grande partie de coûts irrécupérables, la stratégie de l'entrée « éclair » sur le marché ne semble guère applicable face aux augmentations de prix anticompétitives pratiquées par certains hôpitaux. S'il est vrai que de nouveaux établissements sont construits dans les régions à forte croissance démographique ou insuffisamment pourvues, il est rare que des hôpitaux destinés aux soins aigus offrant une gamme complète de services viennent s'implanter dans des zones de marchés stables, principalement parce que les progrès accomplis dans les techniques chirurgicales ont permis de réduire la durée des hospitalisations, ce qui se traduit par des surcapacités importantes dans de nombreux établissements. Si les nouvelles entrées sur le marché ne sont guère fréquentes, l'existence de surcapacités a conduit à la fermeture de nombreux hôpitaux dans plusieurs pays de l'OCDE. Aux Etats-Unis, par exemple, où le taux d'occupation des lits était de 66,2 % en 2002, plus de 500 hôpitaux ont fermé leurs portes entre 1980 et 2000. Au Canada, le nombre d'hôpitaux en activité est tombé de 1 194 en 1992-1993 à 744 en 2002-2003. Par contraste, au Royaume-Uni, où le taux d'occupation a atteint 85,1 %, plusieurs hôpitaux ont été construits récemment ou le seront prochainement. La situation aux Etats-Unis, caractérisée par un excédent de capacités, tranche avec celle que connaît le Royaume-Uni, où l'on a constaté que les lits manquaient dans certaines régions.

L'hôpital est un grand pourvoyeur d'emplois et représente un service public important au niveau local

Le maintien d'un accès aussi large que possible aux soins fournis par les hôpitaux est une priorité essentielle pour les gouvernements des pays de l'OCDE. Certains décideurs redoutent que l'introduction de la concurrence ou d'un système de paiement prospectif mène les hôpitaux au dépôt de bilan, et entraîne à la fois une diminution des services offerts aux populations moins bien loties et des pertes d'emplois. A tous les niveaux – municipal, cantonal, régional, national – les autorités ont tout intérêt à maintenir les services hospitaliers existants, même si cela doit se faire au détriment de l'efficacité globale du système.

2.3 Aspects réglementaires des marchés de soins de santé ayant des répercussions sur la concurrence

En raison, surtout, de la complexité des services de soins de santé, les marchés y afférents et plus particulièrement les services hospitaliers sont soumis, dans la plupart – voire dans la totalité – des pays de l'OCDE, à une réglementation rigoureuse. L'Etat joue souvent un rôle important dans la structure juridique et dans la gestion des hôpitaux. En outre, un pourcentage élevé des dépenses de santé étant à la charge des pouvoirs publics, il est fréquent que ces derniers interviennent énergiquement dans les décisions sur la nature des contrats entre hôpitaux et organismes payeurs.

La réglementation et le contrôle de l'Etat sur les services hospitaliers sont particulièrement stricts en ce qui concerne :

11 A titre d'exemples, on peut citer le nord du Canada, nombre de régions rurales des Etats-Unis, les pays scandinaves, les zones rurales du Japon, etc.

- les contrôles de licences ;
- le rôle des organismes payeurs ;
- les régimes de propriété ;
- les types de contrats autorisés.

Contrôles de licences

De nombreux pays de l'OCDE ont instauré des contrôles de licences et des normes d'accréditation pour les services hospitaliers. Les contrôles relatifs aux licences ont essentiellement pour but :

- d'assurer qualité et sécurité ;
- de garantir un niveau adéquat de services, en fonction des capacités matérielles existantes et de la répartition géographique, en veillant tout particulièrement à :
 - éviter les surcapacités ;
 - limiter la demande induite par l'offre ;
 - maîtriser les coûts en limitant l'accès aux équipements onéreux.

Les mesures d'encadrement de la planification concernant la construction de nouvelles installations ou les ajouts aux installations existantes ont été suscitées par la crainte qu'en l'absence de tels contrôles, les hôpitaux donnent lieu à des investissements excessifs et qu'une répartition géographique inappropriée favorise les zones métropolitaines. Les critères de planification prennent donc en considération l'emplacement proposé, en tenant compte des autres établissements, et déterminent si une installation supplémentaire serait ou non superflue. C'est ainsi que dans l'Etat australien de Victoria, par exemple, le ministère de la Santé et des Affaires sociales peut refuser une licence afin que ne soit pas dépassé le ratio de 4,1 lits pour 1 000 habitants dans la zone concernée. En Australie, ces licences peuvent s'échanger entre plusieurs détenteurs, ce qui a permis, dans plusieurs régions, la construction d'hôpitaux privés en rachetant des licences existantes. En 1998, le prix de ce type de licence a atteint le montant record de 20 000 dollars australiens par lit. Aux Etats-Unis, les lois imposant l'obtention d'une attestation de besoin (« certificate of need ») ont parfois restreint l'arrivée sur le marché de concurrents potentiels. S'il est vrai que de telles dispositions ont pu contribuer à ralentir la course aux armements médicaux, certains éléments montrent également qu'elles empêchent une concurrence propre à réduire les coûts. Par exemple, Fournier et Mitchell (1992) ont constaté que les services de maternité fournis dans le contexte de marchés plus compétitifs présentaient un coût moins élevé. « Cette constatation permet de penser que les initiatives visant à exempter l'obstétrique de la réglementation sur le « certificate of need » devrait permettre des économies significatives » (p.632).

Les licences nécessaires pour la création de lits supplémentaires ont parfois été remises en cause dans le cadre de la loi sur la concurrence, du fait de leurs répercussions en tant qu'obstacle à l'entrée de nouveaux concurrents sur le marché et en raison des risques d'abus. Il est en effet probable que les hôpitaux disposant de telles licences, notamment, sont tentés de tirer parti du système pour barrer l'entrée sur le marché de concurrents potentiels.

Structure du marché de l'assurance et rôle des organismes payeurs

L'assurance-maladie, qu'elle relève d'un contrat privé ou qu'elle soit financée par l'Etat, fait l'objet d'un large éventail de règlements : spécifications relatives aux services disponibles, conditions administratives et financières des prestations. En France, par exemple, les hôpitaux sont tenus de fournir des soins même lorsque le patient n'est pas en mesure de prouver son affiliation à une caisse d'assurance. Si un patient est débiteur envers un hôpital, ce dernier ne peut subordonner sa prestation au paiement des sommes dues. Aux Etats-Unis, les hôpitaux ne sont pas autorisés à refuser des patients si cela risque de mettre en danger la vie des personnes concernées.¹²

Bien que les hôpitaux bénéficiant de fonds publics perçoivent fréquemment une aide calculée à partir de leurs dépenses passées plutôt que sur les résultats obtenus, on observe de plus en plus souvent une inversion de cette tendance. Les Etats-Unis ont consacré de nombreuses études à l'évolution vers des prestations hospitalières régies par le marché : dans ce pays, les hôpitaux (le plus souvent privés) et les organismes d'assurance négocient entre eux le prix de ces services.¹³

Propriété et contrôle des processus décisionnels

Une forte proportion des soins de santé sont fournis dans des hôpitaux contrôlés par les pouvoirs publics ou appartenant à l'Etat. De l'avis de certains observateurs, la propriété et le contrôle des hôpitaux influent considérablement sur la volonté des établissements de mettre à profit leur emprise sur le marché pour fixer des tarifs supérieurs à ce qu'ils devraient être pour rester concurrentiels. Les responsables du secteur public sont souvent perçus comme ayant des objectifs autres que l'optimisation des bénéfices. Dans la plupart des pays de l'OCDE, la majorité des hôpitaux appartiennent à l'Etat. Toutefois, les hôpitaux privés occupent une place croissante depuis quelques années. En Australie, on recensait 294 établissements privés pour les soins de courte durée en 1999 (Productivity Commission; p.11). Aux Etats-Unis, ce sont les hôpitaux privés (pour lesquels les pouvoirs publics n'interviennent pas) qui concentrent la grande majorité des lits. Les hôpitaux à but lucratif regroupent une forte proportion des lits, tout comme les établissements à but non lucratif. Au Royaume-Uni, le National Health Service passe de plus en plus de contrats avec des hôpitaux privés. S'il est communément admis que les hôpitaux privés à but lucratif profitent de leur position de force sur le marché pour augmenter leurs tarifs, le débat est loin d'être réglé quant à l'impact du marché sur les établissements à but non lucratif. Il est essentiel, aussi bien pour que les pouvoirs publics puissent définir leur politique que pour appliquer aux hôpitaux le droit de la concurrence, de savoir dans quelle mesure cette dernière catégorie d'établissements tenterait de tirer avantage de son emprise sur le marché.¹⁴

Différents ouvrages reconnus indiquent que les hôpitaux à but non lucratif ne cherchent pas à dégager le maximum de bénéfices, mais se fixent plutôt des objectifs conformes aux préférences de leur Conseil d'administration, des administrateurs, des employés ou du personnel médical (Newhouse 1970, Pauly et Redisch 1973). Il est donc largement accepté que ces hôpitaux puissent avoir des priorités autres que celles des établissements à but lucratif. Toutefois, cette constatation ne permet guère d'affirmer que les hôpitaux à but non lucratif ne souhaitent pas pratiquer des tarifs élevés au point d'en devenir anti-

12 Certains affirment cependant que cela se produit.

13 Le premier organisme d'assurance reste néanmoins l'Etat, par le biais de son programme Medicare, dont l'objectif est de fournir des soins aux personnes âgées, aux malades chroniques et aux handicapés. Les paiements faits aux hôpitaux dans le cadre de ce programme ne sont pas négociés, mais « à prendre ou à laisser » : si l'hôpital traite des patients Medicare, il doit accepter le plan de remboursement du système, qui s'appuie essentiellement sur des paiements prospectifs.

14 La remise en cause, par les autorités de la concurrence, d'un certain nombre de fusions d'hôpitaux, a pesé lourdement sur le comportement annoncé des hôpitaux privés à but lucratif.

concurrentiels. En particulier, si les hôpitaux sans but lucratif se fixent des objectifs charitables mais coûteux, ou s'ils accordent des rémunérations élevées à leurs dirigeants, ils peuvent être fortement incités à tirer parti d'une éventuelle position de force sur le marché afin d'augmenter leurs prix.¹⁵

Types de contrats entre organismes payeurs et prestataires, et mécanismes de fixation des prix

Les types de contrats à la fois autorisés par la loi et les plus répandus dans un pays donné influent fortement sur les mesures visant à inciter les prestataires à :¹⁶

- limiter leurs coûts ;
- maintenir un certain niveau de qualité ;
- éviter le luxe excessif ;
- fournir des soins exclusivement aux patients qui en ont besoin ;
- veiller à maintenir une marge modeste entre coûts et prix.

Les types de contrats envisageables dans un pays donné dépendent pour beaucoup des lois et réglementations en vigueur. Parmi les facteurs qui ont une incidence sur le comportement des hôpitaux figurent l'éventuelle préférence de l'organisme payeur pour certains prestataires, les droits du consommateur et la méthode de paiement des fournisseurs de services. Les formes contractuelles peuvent être limitées même si la politique adoptée favorise la concurrence directe entre prestataires de services de santé.

On peut citer les méthodes de paiement suivantes pour les soins de courte durée avec hospitalisation (liste non exhaustive) :

- paiement forfaitaire à l'hôpital, calculé principalement sur la base des dépenses antérieures plutôt que des résultats ;
- paiement calculé en fonction de certains résultats déterminés au préalable ;
- paiement en fonction de la qualité de certains résultats ;
- paiement calculé à partir du nombre de patients ;
- paiement à la journée (en soins de courte durée avec hospitalisation) ;
- pourcentage du prix tarifaire ;
- prix moyen local (paiement calculé à partir du tarif moyen des prestataires locaux).

15 Les hôpitaux à but lucratif souhaitent parfois établir des listes d'attente, de manière à assurer un flot continu de patients, alors que les établissements publics, désireux d'améliorer au maximum le bien-être social s'efforcent de les éliminer purement et simplement. Dans la pratique, cependant, les listes d'attente des hôpitaux publics profitent aux hôpitaux privés dans de nombreux pays.

16 Dans la présente section, le terme « contrat » englobe les termes et conditions associés aux accords et à l'obligation de fournir des soins, que l'accord ait été conclu par la négociation, par décret gouvernemental ou par d'autres moyens.

3. Outils possibles pour un renforcement de l'efficience

L'introduction de la concurrence et de mécanismes commerciaux pour accroître l'efficience des services hospitaliers doit prendre en compte les caractéristiques particulières, voire uniques, du marché de ces services, et plus spécialement le comportement des médecins et des patients. Dans le rapport établi récemment par deux sénateurs canadiens, on peut lire : « Dans un système aussi complexe que celui de la santé, on ne peut continuer à fonctionner à partir d'une organisation hiérarchique traditionnelle et centralisée sans risquer de perpétuer et d'accentuer les inefficiences déjà présentes. La seule façon d'assurer une réforme efficace est de mettre en place une série de mesures qui inciteraient les individus et les institutions à faire, dans leur propre intérêt, les changements qui s'imposent. En d'autres termes, l'introduction de ce qu'on appelle communément les « forces du marché » est le seul moyen d'améliorer la productivité et de rendre la prestation des soins de santé plus efficace. » (Kirby et Keon, 2004)

La réforme des mesures d'incitation ne nécessite pas forcément de changements dans le rôle de l'Etat en tant que propriétaire ou dans sa fonction de contrôle des hôpitaux. Bien que ce soit aux Etats-Unis que les restrictions à la concurrence soient les plus limitées, il existe de nombreuses autres formules, qui ne font pas nécessairement double-emploi avec ce système axé sur la demande.

Pour mener à bien de telles réformes, il importe de reconnaître que les possibilités de concurrence ne seront pas les mêmes dans toutes les régions géographiques. S'il est vrai que la concurrence directe peut s'avérer effrénée dans les zones urbaines, elle sera inévitablement restreinte dans certains secteurs géographiques, et notamment dans les zones rurales où la demande pourrait ne pas suffire au maintien de nombreux prestataires avec un minimum d'efficience. Dans ces régions, il est peu probable que la mise en place d'un système de prix négociés, par exemple, pèserait beaucoup sur le comportement des hôpitaux.

3.1 Conditions préalables à la concurrence

Les systèmes de santé qui reposent sur des structures de planification et de contrôle ne peuvent instaurer simplement le droit de passer des contrats en toute liberté et introduire avec succès la concurrence. Excepté dans le cas particulier de la concurrence par étalonnage des performances, il est difficile de laisser le champ libre aux rivalités si les conditions suivantes ne sont pas réunies :

- informations suffisantes sur les procédures concernant les patients et les performances des prestataires ;
- existence d'autres prestataires crédibles ;
- financement suivant les patients ;
- absence d'obligation, pour le patient, d'utiliser une installation au motif qu'elle existe depuis longtemps; aucune automaticité de l'accès à certains équipements selon les mêmes modalités financières.

Renforcement des tiers payants: nécessité d'une meilleure information sur les performances des prestataires

Dans de nombreux pays de l'OCDE où les soins de santé sont financés sur les fonds publics, le gouvernement est à la fois consommateur et prestataire, et alloue aux hôpitaux une enveloppe globale pour la totalité des soins qu'ils prodiguent. Les pays s'écartent de plus en plus de cette formule pour s'orienter vers un système qui prévoit le remboursement aux hôpitaux du coût des services réellement fournis. Une étude consacrée à la réforme du système de santé suédois souligne que « de toutes les réformes, la plus

fructueuse en termes d'efficacité est celle qui a instauré le remboursement aux hôpitaux des services fournis » (Lofgren 2002 p.3).

La rémunération des hôpitaux sur la base de leurs prestations exige, de toute évidence, des informations comparables sur les services fournis dans tous les établissements. Plusieurs pays ont introduit un mode de financement fondé sur le système des Groupes homogènes de malades (GHM). Au nombre des pays qui ont adopté ce type de dispositif figurent l'Australie, l'Autriche, la Belgique, le Danemark, l'Allemagne, le Japon (pour les grands hôpitaux universitaires exclusivement), la Nouvelle-Zélande, la Suède, la Suisse (dans certains cantons) et les Etats-Unis. D'autres pays – dont les Pays-Bas et la France – procèdent actuellement à la mise en place de ce système. En fin de compte, l'évaluation de la prestation fournie comprend l'évaluation du niveau de qualité.

Dès lors que l'on dispose d'informations comparables sur les différentes prestations de services de santé, la comparaison de l'efficacité des différents prestataires peut se faire de manière beaucoup plus concluante. Comme indiqué dans l'Appendice A, la Suède a consenti des efforts considérables pour améliorer les informations sur les délais d'attente. Les comparaisons entre prestataires peuvent revêtir plusieurs formes -- hôpitaux/hôpitaux, hôpitaux/centres de soins ambulatoires ou autres – et peuvent porter, par exemple, sur les degrés d'efficacité atteints avec des procédures différentes, par exemple : suivi d'un accouchement par une sage-femme plutôt que par un médecin.

Autres prestataires crédibles

Lorsque les coûts d'entrée sont faibles, l'arrivée sur le marché de nouveaux prestataires crédibles n'est pas trop onéreuse ; si, à l'inverse, les coûts d'entrée ou de sortie sont élevés, les effets positifs de la concurrence sur l'efficacité des prestataires peuvent se trouver atténués par l'augmentation du coût des nouvelles installations. Un certain nombre de gouvernements ont répondu à cette crainte en exigeant que l'Etat octroie des licences pour la construction de nouveaux établissements hospitaliers ou pour la modification des installations existantes.

Financement suivant les patients

Lorsque les hôpitaux reçoivent des dotations globales, indépendamment de la qualité de services qu'ils fournissent, ils sont peu motivés – d'un point de vue financier – pour optimiser leurs ressources, limitées, et opérer de façon efficace. De fait, dans un modèle selon lequel le travail produit de la désutilité, le personnel de l'hôpital peut être incité, pour des raisons financières, à ne pas fournir certains services aux patients. Toutefois, dès lors que les finances de l'établissement varient en fonction du nombre de prestations, et qu'un patient supplémentaire est source de revenus additionnels pour le prestataire, l'hôpital est beaucoup plus motivé pour veiller à ne pas gaspiller ses ressources.

Choix de l'hôpital sur la base des offres en concurrence, et non en fonction des habitudes en vigueur

Si le patient n'a pas la possibilité de choisir l'établissement qui lui prodiguera les soins nécessaires, les hôpitaux estimeront qu'ils ont un volume d'activité garanti, peu susceptible d'évolution en fonction d'une progression ou d'un déclin de leur efficacité. Pour accroître leur motivation, la solution consiste à faire en sorte que les fonds suivent les patients qui s'adressent à des prestataires efficaces. La concurrence n'aura un impact sur les prestataires de services hospitaliers qu'à la condition que ces derniers ne jouissent pas d'un monopole institutionnalisé. Cela ne revient pas pour autant à proscrire une éventuelle situation de monopole « légitime », qui peut s'instaurer si un hôpital obtient le droit de soigner un certain nombre de patients exclusivement pas le biais de la concurrence.

3.2 *Amélioration des structures de gestion*

Il est possible de modifier les modalités de contrôle de la gestion des hôpitaux de différentes façons, afin de tenir compte des forces du marché et de contribuer à leur bon fonctionnement. Les principaux changements enregistrés à cet égard concernent notamment :

- séparation consommateur-prestataire ;
- évolution des régimes de propriété ;
- possibilité de contester la gestion.

On trouvera ci-après une description de ces différentes options, ainsi que des éléments d'information sur les résultats constatés.

Séparation consommateur-prestataire

Lorsque les pouvoirs publics sont à la fois acheteurs et prestataires de services dans le domaine de la santé, la séparation de ces deux fonctions permet parfois de gagner considérablement en efficacité. Le principe qui sous-tend cette démarche est le suivant : l'introduction d'une dose de négociation dans le processus d'acquisition, qui repose parfois sur la concurrence entre différents prestataires potentiels, peut réduire le coût des prestations de services et inciter à une évaluation attentive des performances.

La séparation consommateur-prestataire est en vigueur en Nouvelle-Zélande, en Suède et au Royaume-Uni. S'agissant de la Suède, certaines municipalités ont choisi de l'appliquer, d'autres pas. Une étude réalisée en 1999 par Gerdham et al. sur l'efficacité du système hospitalier suédois entre 1989 et 1995 constatait que « le remboursement des prestations en fonction des performances améliore l'efficacité technique. On peut estimer que le passage d'affectations budgétaires à des financements fondés sur la performance devrait permettre des économies de près de 10 pour cent. »

Le Royaume-Uni a instauré cette séparation en 1991. Entre 1991-1992 et 1996-1997, « l'efficacité des hôpitaux s'est accrue de 1,7 % par an en moyenne », mais a enregistré un léger déclin dans les années qui ont suivi. (Le Grand, 2002) Toutefois, les améliorations n'ont pas été à la hauteur des attentes. « Cela s'explique en partie par l'absence de stratégie de pénalité ou de sortie à l'intention des prestataires, ainsi que par les restrictions à la concurrence découlant de cette lacune, du maintien d'un contrôle centralisé puissant et – peut-être – d'une réduction de la qualité à certains égards. (Propper et al. (2002) » (Le Grand, 2003)

Evolution des régimes de propriété, et autonomie de gestion accrue en ce qui concerne le coût des intrants

Un débat animé est en cours, dans certains pays de l'OCDE, afin de déterminer s'il est préférable que les prestataires de services hospitaliers appartiennent à l'Etat ou au secteur privé. Au Royaume-Uni, le National Health Service (NHS) accorde davantage d'indépendance aux hôpitaux qui fournissent des services dans le cadre de ce système. Sous un gouvernement travailliste, les hôpitaux publics sont actuellement autorisés à se muer en fondations, ce qui leur confère une indépendance accrue et facilite la concurrence en respectant la séparation entre consommateur et prestataire. Par ailleurs, de nombreux hôpitaux sont en cours de construction, grâce à des fonds privés. Cent établissements de soins de courte durée devraient voir le jour entre 2000 et 2010 au Royaume-Uni pour fournir des prestations au NHS ; quinze d'entre eux avaient déjà ouvert leurs portes en février 2005. Le premier hôpital fonctionnant selon un système de partenariat public-privé se trouve à Carlisle : équipé de 474 lits, il a été financé par des

émissions obligataires et a reçu des garanties de marché des pouvoirs publics. L'Australie, le Brésil et la Suède ont également mis en place des partenariats entre secteur public et secteur privé.

Selon le PDG de London International Healthcare Ltd., les avantages des partenariats public-privé sont notamment les suivants :

- disponibilité plus rapide de nouvelles installations ;
- garantie d'une maintenance sur le long terme ;
- transfert du risque au secteur privé ;
- incitations à la performance plus nombreuses pour le secteur privé ;
- les prévisions de dépenses sont connues, ce qui en permet la planification.

En Suède, les centres privés de soins de santé primaires gérés par Praktikertjänst AB (Plc) pratiquent des tarifs inférieurs d'environ 20 % à ceux des centres gérés par les autorités locales. En 2002, 60 % des centres de soins primaires du district de Stockholm étaient gérés par des sociétés privées sous contrat avec le Conseil de district. Il existe en Suède un hôpital devenu privé après avoir appartenu au secteur public (encadré 2).

Aux Etats-Unis, des chercheurs ont tenté d'établir si la propriété des hôpitaux a une incidence sur la productivité en matière de soins de santé. McClellan et Kessler (2001) ont examiné le coût des traitements reçus par des bénéficiaires âgés du système Medicare hospitalisés pour une récurrence d'attaque cardiaque entre 1985 et 1996. Ils ont constaté que « les zones où sont implantés des hôpitaux privés à but lucratif affichent des dépenses hospitalières inférieures d'environ 2,4 %, mais des résultats sensiblement identiques. »¹⁷

Encadré 2. Exemple d'un établissement privé en Suède: l'hôpital St. Gorans

L'hôpital St. Gorans de Stockholm fournit un exemple intéressant de changement de régime de propriété et de gestion dans un établissement public. St. Gorans faisait partie, au début des années 1990, des hôpitaux publics de la capitale suédoise, qui se caractérisaient par des déficits fréquents et des capacités excédentaires. Au cours de l'été 1993, l'un de ces établissements dut finalement fermer ses portes, mais St. Gorans continua de fonctionner. Sous l'égide du Conseil du département de Stockholm, alors conservateur, l'hôpital St. Gorans est devenu une entreprise, l'objectif étant de le vendre ensuite à une société privée. Toutefois, avant que la vente ait pu avoir lieu, une coalition dirigée par les Sociaux Démocrates prit les rênes du Conseil de région. Celui-ci tenta de reprendre la gestion de l'hôpital, mais se heurta au refus du personnel et des syndicats. Selon le président du syndicat local, le personnel considérait que la nouvelle gestion était plus efficace que la précédente. Le Conseil était en outre confronté à un déficit budgétaire imposant ; redoutant la fermeture de l'hôpital pour des raisons financières, le personnel jugeait plus rassurant de travailler pour une compagnie privée. En 1998, les Conservateurs reprirent la direction du Conseil ; l'hôpital fut vendu à une société privée en 1999.

La nouvelle direction fit procéder à des études sur l'efficacité des activités. Un certain nombre de changements furent ensuite apportés au vu des résultats. Dans l'ancien système, tous les médecins d'un service se rendaient au chevet de tous les patients en compagnie d'un(e) infirmier(-ère), d'un kinésithérapeute et d'un ergothérapeute. Selon la nouvelle méthode, le médecin examine le cas des différents patients avec une infirmière, puis se rend seul auprès des malades. La tournée du médecin se termine donc plus tôt et ne nécessite plus la présence d'autres professionnels (infirmiers, kinésithérapeutes, ergothérapeutes), qui peuvent dès lors être plus productifs.

¹⁷ Sloan (1997) dresse un tableau très détaillé des travaux menés aux Etats-Unis sur l'incidence que peut avoir, concernant le comportement d'un hôpital, le fait qu'il appartienne au secteur public ou privé.

Depuis sa conversion en entreprise en 1994, l'hôpital a dégagé des bénéfices tous les ans, sauf en 1999, année où l'établissement fut cédé à un propriétaire privé et où le Conseil en assura la direction pendant la durée de la transaction. (Lofgren, 2002).

Ecrémage

Les hôpitaux privés sont parfois, en totalité ou en partie, la propriété de médecins. En Australie, un certain nombre de ces établissements sont même co-implantés, dans le sens où ils sont immédiatement adjacents à des hôpitaux publics. Cette formule s'est révélée commode pour les médecins qui doivent effectuer des tournées à la fois dans les hôpitaux publics et privés, où ils jouissent de certains privilèges. Certains craignent cependant que, même si deux établissements – l'un étant public, l'autre privé – perçoivent une rétribution identique pour un patient souffrant d'une pathologie donnée, les médecins adressent les cas les plus simples à l'hôpital privé, dont ils sont partiellement propriétaires, et réservent les plus complexes (donc plus onéreux) à l'hôpital public, faisant ainsi augmenter le coût moyen de la procédure dans ce dernier tout en augmentant les bénéfices de l'établissement privé.¹⁸ Cette préoccupation n'a plus guère lieu d'être lorsque les médecins n'ont aucun lien financier particulier avec un hôpital privé.

« Au Royaume-Uni, les médecins spécialistes (consultants) sont confrontés à des mécanismes d'incitation pervers lorsqu'ils ont affaire à des patients en mesure d'assumer le coût d'une consultation privée. Si le spécialiste traite son patient en privé, ce dernier sera soigné plus rapidement (ce qui est dans son intérêt et répond aux préoccupations professionnelles du médecin) et le consultant est mieux rémunéré, ce qui va dans le sens de ses intérêts financiers. En revanche, si le spécialiste fait en sorte que son patient soit traité dans le cadre du NHS, celui-ci doit attendre et le médecin doit faire face à un surcroît de travail sans contrepartie supplémentaire. » (Le Grand, 2003, pp. 14-15) Le Grand préconise donc une formule de rémunération à la prestation pour les spécialistes, afin de donner à cette catégorie de médecins une incitation supplémentaire à traiter leurs patients dans le secteur public.

Possibilité de remise en cause de la gestion d'un hôpital

Il peut souvent s'avérer très difficile de fermer un hôpital dont les performances ne sont pas satisfaisantes, tant en raison des besoins médicaux de la zone concernée que des incidences d'une telle mesure sur l'emploi. Le changement de gestion, en revanche, est plus facilement réalisable et moins spectaculaire. Les hôpitaux publics sans but lucratif peuvent être gérés par des sociétés qui fournissent des gestionnaires et qui, en cas de mauvais résultats, peuvent être remplacées. Le recours à des gestionnaires extérieurs (également appelé « gestion contractuelle » ou « gestion ouverte à la contestation ») concernait, en 1998, quelque 16 % des hôpitaux communautaires non fédéraux aux Etats-Unis. Carey et Dor (2002) ont étudié les hôpitaux de ce pays entre 1991 et 1998, et sont parvenus à la conclusion que « les sociétés de gestion contractuelle peuvent effectivement apporter un gain d'efficacité par rapport à des gestionnaires salariés conventionnels ... Il apparaît que les contrats passés avec des tiers permettent aux conseils d'administration d'établissements majoritairement dépourvus de visées lucratives d'imposer une discipline de marché plus rigoureuse sur les institutions qu'ils administrent. » (pp. 16-17)

3.3 Incitations plus fortes pour les prestataires

Différents mécanismes permettent de renforcer les incitations pour les prestataires, parmi lesquels :

¹⁸ De nombreux exemples permettent de supposer que les médecins modifient leur comportement lorsqu'ils sont partiellement propriétaires d'installations médicales. Aux Etats-Unis, on a constaté que les médecins équipés des appareils nécessaires prescrivaient quatre fois plus d'échographies que ceux dont les patients devaient se rendre chez un radiologue. (voir Commissariat Général du Plan, 1993, et sources citées) (Oxley et MacFarlan, 1994)

- les contrats
- le choix plus large offert au consommateur
- la tarification prospective
- la rémunération liée à la performance
- les achats réalisés par des médecins

Ces mécanismes, et certains de leurs effets, sont décrits ci-après.

Contrats

Les méthodes contractuelles, comme les contrats sélectifs ou la sous-traitance, offrent de nombreuses possibilités de mesures incitatives à l'intention des prestataires de soins hospitaliers.

La pratique des contrats sélectifs avec des hôpitaux a été introduite en Californie en 1982 : les sociétés privées d'assurance-maladie ont alors pu négocier les tarifs avec les hôpitaux et refuser d'admettre certains établissements dans leurs réseaux si elles le souhaitaient. Dans une étude consacrée aux contrats sélectifs et à leur impact sur les coûts et les recettes des hôpitaux californiens entre 1983 et 1997, Zwanziger, Melnick et Bamezai (2000) estimaient que « dans les hôpitaux des zones où la concurrence était plus forte, la progression des coûts et des recettes avait été nettement moins marquée au cours de cette période. »

La méthode des contrats sélectifs ne nécessite pas une approche du type « tout ou rien », selon laquelle l'hôpital retenu reçoit la totalité des patients tandis que le moins coté n'en a aucun. De façon plus équilibrée, cette formule peut prévoir une répartition moins radicale : par exemple, l'établissement sélectionné traite 60 % des patients, contre 40 % pour le moins bien noté.

Les acheteurs, et les hôpitaux eux-mêmes, souhaitent parfois acquérir certains services en dehors du cadre de l'hôpital. Lorsque les coûts d'entrée et de sortie sont peu élevés, notamment, il peut s'avérer très intéressant de mettre en place un système de contrats faisant intervenir la concurrence, permettant à différents prestataires de faire des offres ou de négocier pour la fourniture de services. A Stockholm, les services de laboratoire sont soumis à la concurrence. « Le recours aux appels d'offres s'est traduit par une baisse des coûts de 30 %, sans que la quantité ou la qualité des services en soient modifiées. »

Des interventions chirurgicales avec hospitalisation peuvent également avoir lieu ailleurs que dans le cadre d'un hôpital offrant une gamme de services complets. A Stockholm, des sociétés privées ont commencé à proposer des interventions de chirurgie du dos : il était prévu que le nombre d'actes augmente de 20 % entre 1999 et 2000, pour un coût unitaire en baisse de 30 %. (Lofgren 2002 p.25)

Les établissements qui achètent du matériel médical peuvent -- y compris dans le cas d'équipements onéreux comme les scanners IRM -- bénéficier de coûts de sortie peu élevés. Cela s'explique par le fait que ce type de matériel peut généralement être installé dans des locaux standard, être achetés d'occasion et revendus sans frais de transport importants si l'hôpital concerné cesse de fournir le service qui en nécessite l'utilisation.

Choix plus large de prestataires pour le consommateur

L'expérience montre que, s'il est vrai que le choix dont dispose le consommateur peut parfois faire augmenter les coûts, notamment du fait que le patient exige davantage que ce qu'un professionnel pourrait

juger nécessaire, la possibilité de choisir l'établissement qui assurera les soins peut améliorer sensiblement la qualité des prestations (par exemple, en réduisant les délais d'attente). Pour autant que la rétribution des services suive le patient, la concurrence entre plusieurs prestataires peut entraîner un gain de qualité.

Dans de nombreux pays, la réglementation empêche l'organisme payeur (qu'il s'agisse de l'Etat, d'un assureur privé ou de l'employeur) de limiter le nombre d'établissements hospitaliers parmi lesquels le patient peut faire son choix : il peut s'agir d'interdire les contrats sélectifs (l'organisme payeur passe des contrats avec un groupe limité d'établissements pour des services non urgents), ou de veiller à ce que le patient ait bien toute liberté de choisir son prestataire. (L'organisme payeur peut être l'Etat, comme au Royaume-Uni, où s'applique la séparation prestataire-payeur.) Il ressort de certaines études récentes que les lois empêchant la mise à l'écart de certains fournisseurs de services (ce qui garantit plus ou moins que tout prestataire qualifié puisse recevoir un remboursement de la part de l'organisme payeur) et imposant une totale liberté de choix (ce qui garantit au patient la possibilité d'opter pour le prestataire qu'il préfère) entraînent une augmentation des dépenses de santé de l'ordre de 1 ou 2 pour cent.^{19 20}

Bien que le gouvernement britannique ait décidé d'élargir le choix du patient en matière d'hôpitaux, la gamme des possibilités n'est pas illimitée. Les patients ayant besoin de services hospitaliers pourront se déterminer entre quatre ou cinq prestataires retenus par leur organisme payeur, également chargé de contrôler le déroulement des soins.²¹

Les temps d'attente varient considérablement d'un pays à l'autre au sein de l'OCDE. Lorsque le consommateur ou le praticien se voient proposer le choix entre plusieurs prestataires imposant des délais différents, et sont informés du temps d'attente moyen de chaque prestataire, les établissements peuvent se faire concurrence pour tenter d'améliorer la situation. Par contre, sous l'angle de la politique à adopter en vue d'obtenir des fonds supplémentaires dans un hôpital donné, les établissements peuvent être tentés d'allonger leurs délais afin de montrer à quel point ils ont besoin d'argent.

Les patients sont particulièrement intéressés par la possibilité de raccourcir l'attente. Des études ont été réalisées sur le consentement à payer, sous l'angle du délai d'attente. Popper (1990, 1995) s'est efforcé de chiffrer la valeur du temps passé sur les listes d'attente du NHS: il en a conclu qu'une réduction d'un mois de ce délai pour un traitement non urgent était évaluée à £ 50 (prix de 1991), alors qu'un allègement de l'incertitude concernant la date d'admission valait £ 30 (prix de 1991 également). Johanneson et al. (1998) ont interrogé 1045 personnes en Suède, pour constater qu'elles étaient prêtes à déboursier entre £ 95 et £ 110 (prix 1991) pour chaque mois déduit de leur temps d'attente (Johanneson, Johansson et Soderqvist, 1998). Il s'agit donc d'un aspect très important pour les patients, sans parler de l'intérêt qu'il

19 Vita (2001) a comparé les dépenses de santé par habitant aux Etats-Unis entre 1980 et 1998 et a évalué les incidences des versions douce et dure des lois sur l'acceptation de tous les prestataires qui le souhaitent et sur la liberté de choix. Il estime que l'adoption de lois strictes devrait accroître de 52 dollars les dépenses de santé, dont le montant moyen s'élève à 2917 dollars par habitant. Selon Vita, la hausse des coûts pourrait être plus importante pour les médecins que pour les hôpitaux.

20 Les réglementations qui limitent la liberté des organismes payeurs en matière de contrats réduisent également le poids que ceux-ci peuvent avoir dans des négociations, ainsi que les incitations à l'efficacité des prestataires. Par exemple, les dispositions empêchant d'orienter les patients vers des prestataires de services hospitaliers offrant des tarifs peu élevés augmenteraient vraisemblablement le coût des soins, car les hôpitaux seront moins à même de proposer des prix bas s'ils ne bénéficient pas, en compensation, d'une augmentation du nombre de leurs patients. Par contre, si les organismes payeurs accordent un montant minimum (et non le prix total) pour les services hospitaliers, le patient devant s'acquitter de la différence entre ce tarif minimum et le coût réel, il devient plus facile d'inciter les prestataires à fonctionner avec efficacité.

21 Organisme appelé « Primary Care Trust ». Source: Burgess et al. (2005).

présente pour la conduite de leurs activités, qu'elles soient rémunérées ou non (femmes ou hommes au foyer).²²

La Suède a adopté une approche qui, en vue de raccourcir les délais, tire parti de la concurrence et du choix (voir Encadré 3).

Pour faire un choix éclairé, le consommateur a besoin d'informations. Certains Etats américains publient des « fiches de résultats » attribuant des notes de qualité aux médecins et aux hôpitaux. Au Royaume-Uni, des tableaux de résultats sont désormais diffusés, avec des comparaisons entre différents établissements du NHS. Il faut bien souligner, cependant, que de tels indicateurs peuvent avoir des effets mitigés. La communication au public de ces rapports peut certes inciter les prestataires à privilégier la qualité. Par contre, du fait que ces documents ne tiennent pas suffisamment compte de la complexité des cas des patients, les hôpitaux et les médecins peuvent décider d'axer leurs prestations sur les cas plus simples, améliorant ainsi leurs chances d'avoir de bons résultats, et de refuser les patients dont l'état requiert des soins plus délicats. L'expérience des Etats-Unis montre que ces deux types de conséquences ont été enregistrées. Cutler et al. (2004) se sont penchés sur l'impact du système de compte rendu instauré dans l'Etat de New York pour les actes de chirurgie cardiaque (Cardiac Surgery Reporting System), à partir de données portant sur les années 1991 à 1999. Ils ont constaté que ces rapports avaient une incidence sur le volume de cas traités et sur la qualité des établissements. « Les hôpitaux dont les résultats étaient médiocres ont perdu des patients en relativement bonne santé au profit de concurrents, puis ont amélioré leurs performances, à en juger d'après le taux de mortalité ajusté en fonction du risque. » En d'autres termes, certains hôpitaux peu performants ont amélioré la qualité de leurs services après avoir perdu des patients. A l'inverse, Dranove et al. (2003) ont montré que la publication de rapports de qualité pour les pontages coronariens dans l'Etat de New York et en Pennsylvanie s'était traduite par une baisse de la qualité, principalement parce que la probabilité d'interventions chirurgicales sur des patients à haut risque avait fortement diminué dans certains hôpitaux. Les auteurs laissent entendre que les médecins concernés accueillaient moins de cas complexes afin d'obtenir de meilleurs rapports.

Encadré 3. Evolution de la politique de la Suède concernant le choix offert aux patients

Depuis 1987, la politique de la Suède relative aux délais d'attente dans le domaine des services hospitaliers a connu plusieurs changements importants. Dans ce pays, les Conseils de régions sont chargés de définir les principes et les réglementations qui doivent régir les prestations de soins de santé dans leur district. En 1991, la Fédération des Conseils de régions a arrêté un temps d'attente maximum, garantissant aux patients qui avaient figuré sur la liste d'attente pour l'un ou l'autre de douze actes médicaux prédéfinis et qui n'avaient toujours pas été traités au bout de trois mois, le droit de s'adresser à un autre hôpital ou à une clinique privée aux frais de l'établissement de départ. Cette formule a d'abord semblé porter ses fruits au plan national, l'attente ayant été quelque peu raccourcie pendant les deux premières années de sa mise en œuvre. Au fil du temps, cependant, les délais ont recommencé à prendre de l'ampleur ; la garantie nationale a été supprimée en 1996 et remplacée par une autre, concernant, la possibilité de consulter un médecin dans un certain délai. Dans certains cas, l'évaluation de la politique de garantie est plus difficile en raison de la hausse spectaculaire du nombre de prestations accomplies. C'est ainsi qu'en 1990, par exemple – avant l'introduction de la garantie susmentionnée – 27 500 opérations de la cataracte furent effectuées en Suède. En 1996, le chiffre annuel était passé à 44 700. Le nombre de patients en attente était en réalité plus élevé à la fin de la période qu'au début, et ce malgré une augmentation de 61,5 % du nombre d'interventions pratiquées. La durée d'attente moyenne pour ce type d'opération, qui atteignait 8,5 mois en 1990, avait été ramenée à 4 mois en 1992 et est repassée à 6,4 mois en 1996, ce qui représentait encore une nette amélioration par rapport au délai moyen nécessaire avant la garantie. « Le délai maximum garanti a contribué à donner plus de poids aux patients et à ralentir le développement des indicateurs sur les performances, mais il n'a pas réussi à aplanir les écarts régionaux ».

²² On se reportera aux travaux de Burgess et al. (2005) pour un résumé intéressant des travaux relatifs aux répercussions découlant d'un choix plus large dans le domaine des soins de santé : s'y trouvent abordées bon nombre des autres questions liées à la concurrence et traitées dans le présent document.

considérables concernant le nombre d'actes chirurgicaux effectués. » (Hanning 2005)

L'une des raisons de la suppression de cette garantie réside dans le fait que peu de patients ont changé de prestataire. « D'après les réponses obtenues au cours des deux enquêtes, peu de patients ont fait le choix de s'adresser à un autre prestataire... Dans les deux tiers des unités où le temps d'attente dépassait trois mois, aucun patient n'a franchi le pas au cours des trois premières années. » (Hanning, p 73)

On peut probablement expliquer ce comportement par le fait que les patients n'avaient pas facilement accès aux délais d'attente des différents prestataires. Plus récemment, la Fédération suédoise des Conseils de région, ainsi que certaines organisations régionales comme le Conseil de la région de Stockholm, en plus de certains hôpitaux, ont publié sur Internet des informations chiffrées sur les délais d'attente dans différentes catégories d'établissements et pour différentes pathologies. L'objectif est de rendre ces données aussi accessibles que possible aux patients et aux médecins. Il s'agit d'un aspect jugé important en raison des nombreuses différences constatées entre les divers hôpitaux du pays. A Stockholm, par exemple, le remplacement d'une hanche en plastique peut se faire avec un délai maximum de six semaines dans un certain nombre de cliniques privées. En revanche, un patient de Göteborg, par exemple, pourrait rester sur une liste d'attente pendant au moins 104 semaines. De même, en ce qui concerne la chirurgie de la prostate, un patient pourra être pris en charge en quatre semaines à Stockholm, alors qu'il attendra plus de 90 semaines dans la plupart des régions de Suède. (Hjertqvist 2001) Ces écarts ont contribué à la décision de lancer un projet concernant les listes d'attente, dans le but de mieux informer les consommateurs et les responsables de l'élaboration des politiques. (On trouvera une description de ce projet à l'appendice A.)

Systèmes de tarification prospective

Le paiement prospectif est une forme de concurrence par étalonnage des performances : on fixe une référence, et les entreprises dont les résultats se situent au-dessus du niveau sont jugées performantes, les autres moins (Schleifer 1985). Selon le système du paiement prospectif, la rémunération est déterminée sur la base des diagnostics (et, dans une certaine mesure, des actes médicaux et de la complexité des pathologies). Dans certains cas, le montant est fortement pondéré par le nombre de journées d'hospitalisation et par l'intensité médicale des différents types de lits. Un coefficient moyen de pondération est généralement calculé pour l'ensemble des hôpitaux, puis utilisé comme référence pour la rémunération de chaque établissement.²³ Cette formule encourage les hôpitaux à limiter la durée des séjours : selon qu'ils le feront rapidement ou non, les établissements auront un niveau de performance supérieur ou inférieur à la référence fixée.

Le principe du tarif de référence peut également s'appliquer de manière plus radicale. En Suède, la région de Stockholm utilise comme référence l'hôpital le plus performant, St. Gorans. Selon Salander et Lindqvist (1998), « St. Gorans a un taux d'efficacité de 10 à 20 % supérieur à celui des hôpitaux gérés par le Conseil de la région de Stockholm ».²⁴ Pour rembourser les autres hôpitaux, le Conseil de région s'appuie en partie sur les coûts de St. Gorans : une méthode qui incite fortement les établissements moins performants à améliorer leur efficacité opérationnelle afin de s'assurer des recettes suffisantes pour couvrir leurs dépenses. Depuis la mise en place de ce système, plusieurs des autres hôpitaux de la région de Stockholm ont gagné en efficacité. L'hôpital Södertälje, par exemple, spécialisé dans les urgences, avait en 1994 un taux d'efficacité inférieur de 19 % à celui de St. Gorans ; l'écart n'était plus de 11 % en 1998. Cela ne signifie pas que tous les hôpitaux doivent aligner leurs coûts sur ceux du plus performant. Logfren (2002) estime que « le Conseil de la région de Stockholm ne s'attend plus à ce que tous les hôpitaux parviennent au même degré d'efficacité. » (p.18)

²³ C'est le calcul d'une moyenne pour l'ensemble des hôpitaux qui permet de comparer les établissements entre eux, de repérer ceux dont les performances sont bonnes et de les récompenser par rapport aux autres.

²⁴ Lofgren (2002)

Une étude plus globale de l'évolution de la productivité en Suède entre 1990 et 1993 a fait apparaître que les cinq régions pratiquant la rémunération à l'acte avaient enregistré des gains de productivité de +14,1 %, +16 %, +12,1 %, +17,4 % et +0,7 %. Dans les régions ayant opté pour le principe des groupes de contrôle, cette hausse a été de 2,4 % en moyenne. (Jonsson (1996), cité par Hakansson (2000))

Rémunération en fonction de la performance

On constate d'importants écarts dans la qualité des soins en fonction des prestataires. L'un des objectifs des pouvoirs publics consiste donc à recourir à des comparaisons (ou à la concurrence) pour récompenser les prestataires mieux classés au plan de la qualité, en tenant dûment compte de la diversité des cas. Bien que les systèmes d'évaluation de la qualité soient fréquemment controversés, les Etats-Unis ont mis en place en 2003 des indicateurs généraux pour des pathologies telles que la crise cardiaque, l'arrêt cardiaque et la pneumonie : des mesures d'incitation avaient abouti à des remboursements inférieurs de 0,4 % pour les hôpitaux qui ne soumettaient pas de rapport sur la qualité de leurs prestations. Le résultat s'est fait sentir dès 2004, où 98 % de l'ensemble des hôpitaux ont présenté les évaluations requises.²⁵

La rémunération selon les performances récompense, par une rétribution un peu plus importante des services, les hôpitaux qui affichent des performances cliniques élevées. Les évaluations de résultats peuvent s'appuyer tant sur le nombre de cas traités avec succès que sur les méthodologies appliquées.

Dans le cadre d'un projet de démonstration mis en oeuvre aux Etats-Unis, les hôpitaux que les indicateurs de qualité placent dans les 10 % supérieurs de certaines zones cliniques recevront de Medicare un bonus de 2 %, alors que les établissements du décile suivante percevront 1 % de bonification. Enfin, les hôpitaux dont l'amélioration des performances ne dépasse pas un certain niveau de référence verront leur rémunération diminuer. L'organisme chargé de faire des recommandations au Congrès concernant les méthodes de remboursement, le MedPAC, a préconisé en mars 2005 que la rémunération liée aux performances fasse partie intégrante du système Medicare traditionnel.

Achats par les médecins

85. Les médecins étant la principale raison de l'orientation des malades vers tel ou tel hôpital, plusieurs pays de l'OCDE ont récemment pris des initiatives axées sur le rôle des praticiens dans la supervision des traitements. Si les médecins sont suffisamment motivés pour rechercher les hôpitaux efficaces, et si la rémunération est conforme à leur choix, les hôpitaux seront incités à se montrer plus efficaces afin d'attirer davantage de patients.

Le Royaume-Uni a introduit récemment un système d'acquisition guidé par les généralistes (et fondé sur l'expérience), dans lequel ces médecins se voient attribuer un budget afin d'acheter des services hospitaliers pour le compte de leurs patients.²⁶ Jusqu'en 1999, le Royaume-Uni disposait d'un autre mécanisme, qui fonctionnait au moyen d'enveloppes budgétaires. Un cabinet médical pouvait alors décider de devenir détenteur d'une enveloppe budgétaire. L'administration locale d'assurance-maladie lui octroyait alors un budget annuel, au moyen duquel il devait financer certains actes médicaux non urgents auprès de prestataires locaux. L'excédent éventuel pouvait être utilisé pour améliorer les installations du praticien, mais ne pouvait pas constituer un revenu direct pour ce dernier. Les médecins sont désormais encouragés à commander des services de santé pour ceux de leurs patients qui ont le plus besoin d'aide ; par ailleurs, dans l'hypothèse où un nombre exceptionnellement élevé de patients se trouveraient dans un état sérieux,

25 Dans ce cas précis, la rémunération liée aux performances peut être considérée comme une forme d'étalonnage axé sur la qualité.

26 Les fonds non utilisés peuvent être investis dans l'équipement du cabinet médical, mais ne peuvent constituer un revenu direct pour les médecins.

le médecin ne serait pas tenu de rester dans les limites du budget fourni. En 1997, plus de 50 % de la population était inscrite auprès d'un cabinet médical détenteur d'une enveloppe.

Les faits attestent que le comportement des médecins qui achètent des services pour leurs patients change à partir du moment où ils contrôlent leur propre budget. Avec les enveloppes budgétaires, ils ont davantage de raisons de rechercher le meilleur prix et le temps d'attente le plus court. Une étude récente s'est intéressée à la densité des achats de services effectués par certains médecins, selon qu'ils disposaient d'une enveloppe budgétaire ou pas. Dusheiko et al. (2005) ont constaté que « les praticiens détenteurs d'enveloppes pour des hospitalisations non urgentes soumettaient moins de demandes d'admission que ceux dont les admissions étaient financées par l'organisme de soins de santé primaires. » Le système des enveloppes a réduit de 3,3 % les admissions non urgentes.²⁷

Rigueur des contraintes budgétaires

Pour qu'un gain d'efficacité représente à coup sûr un avantage, financier ou autre, pour les hôpitaux concernés, il est essentiel d'inciter ces derniers à se montrer plus performants dans les prestations de services. Si les prestataires inefficaces sont à l'abri de toute répercussion financière, il est difficile de faire en sorte qu'une amélioration de l'efficacité s'accompagne systématiquement de retombées positives. Dans un certain nombre de pays, les hôpitaux reçoivent des dotations qui ne sont pas calculées directement en fonction de leurs performances réelles, mais plutôt sur la base de leurs budgets antérieurs. Ce type de financement contribue certes à éviter les faillites et autres ennuis financiers, mais n'incite guère à l'efficacité des prestations. Lorsque les services fournis par les hôpitaux ne sont plus financés par des budgets garantis, mais – ce qui est généralement le cas – par un budget dont le montant est davantage lié aux résultats de l'établissement, il devient possible que les revenus des hôpitaux peu efficaces ne suffisent plus à couvrir leurs coûts. Si les pressions locales ou régionales sont souvent fortes en vue de maintenir l'accès aux soins, et donc pour faire en sorte que des hôpitaux confrontés à des difficultés financières reçoivent des subventions propres à assurer leur fonctionnement, il est par contre probable que ces établissements, après avoir reçu des fonds supplémentaires, se sentiront moins tenus de faire preuve d'efficacité. Des contraintes budgétaires trop douces risquent de compromettre gravement l'efficacité des réformes en faveur de la concurrence.

3.4 Mesures propres à améliorer l'efficacité dans le secteur hospitalier

Outre les mécanismes décrits précédemment, d'autres moyens permettent de promouvoir la concurrence entre différents établissements offrant des soins similaires. On peut citer à cet égard la concurrence entre centres régionaux d'excellence, ou entre hôpitaux locaux et centres de soins ambulatoires ou spécialisés, ainsi que l'allègement des obstacles à l'assouplissement des politiques de personnel, notamment ceux liés aux réglementations professionnelles anti-concurrentielles qui limitent sensiblement le rôle des professions para-médicales. Ces mécanismes sont exposés brièvement dans les paragraphes suivants, qui donnent également quelques exemples de leurs effets.

Centres d'excellence (centres régionaux assurant un grand nombre de prestations complexes et coûteuses)

Les centres d'excellence sont des centres médicaux de haut niveau, dotés d'une expérience solide dans certains domaines (comme la chirurgie cardiaque ou les transplantations d'organes) et capables de rivaliser avec les hôpitaux locaux les plus avancés. Ils bénéficient d'économies d'échelle, et peuvent

²⁷ Dusheiko et al. (à paraître) ont comparé la situation pendant les deux années qui ont précédé la fin des enveloppes budgétaires, en 1999, et les deux années qui ont suivi. Leur étude tient compte du fait que les cabinets médicaux optant pour le système des enveloppes budgétaires peuvent présenter des caractéristiques autres que ceux qui font un choix différent.

également assurer une meilleure qualité de soins, mesurable d'après le taux de survie. A titre d'exemple, une étude canadienne récente révèle que « les Canadiens ont de meilleures chances de survie après certains types de chirurgie très spécialisées s'ils optent pour des hôpitaux où elles sont pratiquées en grand nombre. Pour la première fois, l'ICIS a étudié les résultats de plus de 180 000 patients ayant subi, entre 1998-1999 et 2003-2004, une des neuf chirurgies non urgentes retenues pour l'étude. Les analyses ont permis de mettre en évidence une corrélation entre les hôpitaux à volume élevé et le risque de mortalité à l'hôpital dans les trente jours pour trois des neuf interventions. Il s'agit de l'angioplastie et de deux chirurgies liées au cancer (l'oesophagectomie et l'intervention pratiquée en cas de cancer du pancréas appelée « opération de Whipple »). (ICIS, 2005)

« Pour les patients devant subir une angioplastie, le risque de décès était plus élevé s'ils optaient pour un hôpital à faible volume plutôt que pour un hôpital à volume élevé plus éloigné de leur lieu de résidence. Dans les trente jours suivant l'admission, 1,6 % des patients ayant subi une angioplastie dans un établissement à faible volume près de leur lieu de résidence sont décédés, contre 0,7 % des patients traités dans un établissement à volume élevé situé plus loin de leur résidence. » (ICIS, 2005)

Il ressort d'un examen récent des nombreux documents consacrés à la corrélation volume-résultats que, « dans plus des deux tiers des analyses, les patients qui ont subi une chirurgie dans un établissement à volume élevé ou qui ont été confiés à un médecin qui l'avait pratiquée à de nombreuses reprises avaient tendance à obtenir de meilleurs résultats. Les chercheurs responsables de cette recherche méthodique, au demeurant la plus vaste réalisée sur le sujet, ont passé en revue plus de 300 analyses : la plupart étaient américaines, d'autres avaient été réalisées au Canada, en Europe ou au Japon. Ils ont examiné toute une gamme d'interventions, de la chirurgie cardiaque à l'opération des poumons, et ils ont constaté que, dans 68 % des analyses, plus le volume des interventions était élevé, meilleurs étaient les résultats pour les patients. Dans près d'un tiers des cas (31 %), il n'y avait pas de différence statistiquement significative entre les hôpitaux à volume élevé et faible, ou la relation restait indéterminée. (ICIS, 2005)

Non seulement les résultats sont souvent meilleurs dans les hôpitaux à fort volume d'activité, mais les coûts y sont généralement moins élevés. De fait, les économies d'échelle dans la production de services de santé permettent des prestations à moindre coût dans un établissement régional de grande dimension ayant un volume d'activité important, par rapport au cas de figure où le même nombre de patients sont dispersés dans plusieurs hôpitaux locaux. Toutefois, les avantages d'un grand centre de soins régional ne seraient pas les mêmes pour tous les actes médicaux. Si un accouchement normal revient en moyenne à 1 418 dollars dans un hôpital de soins tertiaires au Canada, ce coût est inférieur d'environ 1 000 dollars dans un établissement local (Kirby and Keon, 2004).

En ce qui concerne certains actes médicaux, les centres régionaux peuvent concurrencer de nombreux hôpitaux locaux. Cependant, s'il est vrai que les organismes payeurs ont souvent la possibilité de négocier des réductions non négligeables dans ces centres, ils se montrent souvent réticents à contraindre les patients à s'y rendre, peut-être par respect pour leur liberté de choix et pour celle de leur médecin.

Centres de soins ambulatoires et centres spécialisés

Pour certains services, les coûts peuvent être réduits si la prestation s'effectue hors du cadre d'un hôpital communautaire, pour différentes raisons : frais de fonctionnement moins élevés, souplesse accrue du personnel dans les établissements de petite dimension, et meilleure planification de l'utilisation des salles d'opération, permettant aux chirurgiens d'être plus productifs.²⁸

28 Néanmoins, dans certains pays, comme la France, le passage de patients vers des établissements privés n'est pas considéré comme un avantage, en raison de l'écroulement et de la demande accrue qui pourraient en découler.

La présence de concurrents directs pour certaines prestations peut offrir des possibilités de choix supplémentaires aux acheteurs de services hospitaliers. Pour autant que les hôpitaux spécialisés représentent une réelle solution de remplacement par rapport aux hôpitaux communautaires, ils permettent aux organismes payeurs de négocier avec les différents prestataires. Dans certains cas, « les hôpitaux communautaires ont affirmé que les établissements spécialisés avaient en partie dilué l'influence dont ils auraient pu jouir auprès des payeurs ». (MedPAC 2005)

Parmi les solutions autres que les hôpitaux communautaires, figurent principalement les centres de chirurgie ambulatoire, les hôpitaux spécialisés et les centres de diagnostic. Les centres de chirurgie ambulatoire demandent parfois leur accréditation en tant qu'hôpitaux, afin de pouvoir être remboursés lorsqu'un patient souffrant de complications doit passer la nuit sur place ; ces établissements restent cependant, avant tout, des « hôpitaux de jour ».

Les hôpitaux spécialisés peuvent dégager des bénéfices considérables par rapport aux hôpitaux communautaires. « Les hôpitaux spécialisés pris en compte dans notre étude affichaient une marge moyenne de 13 pour cent en 2002 (pour l'ensemble des organismes payeurs), bien supérieure à la moyenne de 3 à 6 pour cent des hôpitaux communautaires. » (MedPAC 2005)

Dans certains pays, hôpitaux spécialisés et centres de chirurgie ambulatoire sont, pour une large part, la propriété de médecins. Selon une étude portant sur les hôpitaux spécialisés dont une partie appartient aux médecins, « les médecins détiennent en moyenne 60 % des parts : c'est dans les établissements cardiologiques que ce chiffre est le plus faible (35 %), et dans les centres chirurgicaux qu'il est le plus élevé (73 %). Un tiers environ des centres orthopédiques et chirurgicaux appartiennent quasi-totalement à leurs médecins, ..., ce qui n'est le cas d'aucun hôpital cardiologique. » (MedPAC 2005)

Au vu de ces exemples, les détracteurs de ces institutions affirment que les médecins propriétaires ont ainsi de bonnes raisons d'accroître le nombre de prestations qu'ils fournissent afin d'engranger des bénéfices plus importants. La véracité de cet argument reste cependant à démontrer : en effet, un médecin rémunéré à l'acte dispose déjà d'un bon motif pour traiter davantage de patients, qu'il travaille dans un hôpital public ou privé.

Autre argument avancé par les détracteurs de ces établissements: les médecins ont tendance à orienter les cas les plus intéressants financièrement vers les hôpitaux privés dans lesquels ils détiennent un intérêt ; en revanche, ils laissent aux hôpitaux publics les patients sans assurance ou peu remboursés, ainsi que les cas complexes et plus coûteux. Ellis (1998) estime que les prestataires recevant une rémunération prospective et confrontés à des pathologies de gravité variable seront tentés de procéder à un écrémage en faveur des cas moins lourds.

A l'inverse, certains hôpitaux spécialisés jugent nécessaire que les médecins soient partiellement propriétaires pour convaincre les banques d'accorder des prêts en vue de la construction ou de la dotation en équipements de ce type d'établissements. Les banques voient dans l'investissement financier des médecins le signe de leur volonté d'adresser leurs patients aux établissements concernés. Or, sans cette preuve d'engagement, elles ne peuvent avoir la certitude que les hôpitaux spécialisés recevront suffisamment de patients. (MedPAC 2005)

« Les opérations de la cataracte, de nombreuses prestations dans le domaine orthopédique et d'autres actes médicaux sont assurés par de grands hôpitaux, alors que des cliniques spécialisées pourraient s'en charger pour un meilleur rapport coût-efficacité : compte tenu de leurs frais généraux moins élevés, et en particulier de l'organisation plus souple du travail des professionnels de la santé qu'elles emploient, ces cliniques peuvent assurer de nombreuses prestations simples et courantes, pour un coût sensiblement inférieur à ce qu'il est dans la plupart des hôpitaux. » (Kirby and Keon 2004)

Les détracteurs des hôpitaux spécialisés et les centres de chirurgie ambulatoire avancent parfois l'argument que les coûts prétendument plus élevés des hôpitaux communautaires s'expliquent par l'obligation qui leur est faite de fournir un certain nombre de prestations non rentables. Par exemple, un hôpital général peut être tenu d'avoir des chambres réservées aux urgences, même si elles fonctionnent à perte. Ce type d'établissement peut également considérer qu'il relève de sa mission sociale de fournir des soins aux patients démunis et sans assurance. Ces hôpitaux doivent donc pouvoir compter sur des recettes supérieures à leurs dépenses dans d'autres domaines, de manière à financer les activités non rentables. Les hôpitaux spécialisés et les centres de chirurgie ambulatoire n'étant pas soumis à ce genre de contrainte, ils peuvent fournir des services sans recourir aux subventions croisées, et donc fonctionner à moindres coûts.

« Les hôpitaux généraux étant contraints d'assurer des services d'urgence, peut-être serait-il envisageable, pour réduire les coûts, de déplacer ces prestations en dehors de ces établissements. « Dans de nombreuses régions du Canada, il n'existe pas d'autre solution que le service d'urgence, ce qui se traduit par une surpopulation et de longs délais d'attente. Il serait possible d'atténuer ce problème, sinon de le résoudre, en créant de petites cliniques spécialisées dans les urgences. Dans l'Ontario, plusieurs de ces cliniques assurent des soins ponctuels et rapides pour des cas urgents : coupures, entorses, fractures, asthme, bronchites, allergies graves et arythmies sévères ; elles disposent également de laboratoires, d'appareils de radiographie et de médicaments, et adressent les patients vers des spécialistes ou des hôpitaux. Non seulement elles assurent ces prestations plus rapidement, mais leurs coûts sont également beaucoup moins élevés que ceux des services d'urgence des hôpitaux, principalement en raison de frais généraux plus faibles. » (Kirby et Keon 2005)

L'une des variables clés à prendre en compte pour évaluer les avantages des centres de chirurgie ambulatoire et des hôpitaux spécialisés concerne le coût des actes médicaux dans ces établissements par rapport aux hôpitaux généraux et aux services de soins ambulatoires de ces hôpitaux. Il est surprenant de constater que l'on dispose de peu de données publiques fiables sur cette question. D'après certains entretiens que le MedPAC a pu avoir avec des acteurs du marché : « Certains hôpitaux spécialisés ont déclaré que leurs prestations revenaient moins cher que celles des hôpitaux généraux et que les organismes payeurs souhaitaient passer contrat avec eux, le niveau de rémunération de certains établissements spécialisés étant apparemment moins élevé. » (MedPAC 2005)

Les hôpitaux communautaires réagissent fréquemment en encourageant le maintien des lois sur l'octroi des licences, qui compliquent la mise en place d'installations nouvelles. Aux Etats-Unis, « certains hôpitaux généraux ont empêché leurs médecins de détenir des intérêts dans des hôpitaux spécialisés ; d'autres envisagent le recours à une telle mesure. Sans aller jusque là, d'autres ont adopté des politiques destinées à freiner le développement des établissements spécialisés, incluant par exemple des clauses de non-concurrence dans les contrats de leurs médecins afin de les empêcher de transférer leurs cabinets vers ces hôpitaux. » En réaction à l'arrivée d'hôpitaux privés sur le marché, certains hôpitaux généraux ont tenté d'obtenir – sans toujours y parvenir -- des contrats exclusifs avec des organismes payeurs privés et des contrats d'assurance maladie gérés par Medicaid. Des hôpitaux spécialisés ont parfois été exclus des contrats, se trouvant alors dans l'incapacité d'augmenter le volume de leurs activités. » (MedPAC 2005)

L'impact global des hôpitaux spécialisés reste difficile à déterminer. Selon certains observateurs, c'est le gouvernement qui devrait attribuer leurs licences, par le biais d'une attestation de nécessité : cela permettrait de conserver les subventions croisées, indispensables au maintien de services de santé corrects pour les patients dépourvus d'assurance (Choudry et al., 2005). D'autres jugeraient préférable de remplacer les subventions croisées par des subventions explicites (Frech, 1996). Havighurst fait observer que l'obligation d'une attestation de nécessité n'a pas empêché l'augmentation du coût des soins aux Etats-Unis (Havighurst, 2005). La construction de nouveaux hôpitaux spécialisés appartenant à des médecins a été temporairement interdite dans ce pays.

Meilleure répartition des ressources humaines

La majeure partie des dépenses des hôpitaux concernent les honoraires, les salaires et les indemnités du personnel médical et des employés. Pour fonctionner de manière efficiente, un établissement doit affecter judicieusement ses ressources en personnel de façon à lui permettre de fournir ses prestations avec un maximum d'efficacité. Un rapport établi par deux sénateurs canadiens – dont l'un a enseigné pendant quinze ans dans le service de chirurgie d'une faculté de médecine, qu'il présidait par ailleurs – souligne l'importance d'une affectation plus judicieuse des ressources humaines. Ils mettent l'accent sur deux aspects limitant l'efficacité : la rigidité des accords collectifs et les dispositions qui régissent le champ d'activité dans les hôpitaux.

Nécessité d'accords collectifs moins rigides

D'après le rapport de ces deux sénateurs, la rigidité de ces accords risque d'empêcher l'affectation du personnel dans les services où sa présence est le plus nécessaire. « Par exemple, le nombre global d'infirmières peut être suffisant, mais si, pour une raison ou une autre, le service des urgences manque de personnel et que l'accord collectif restreint la possibilité de déplacer des infirmières d'un service à un autre, une pénurie se crée *de facto*, diminuant la productivité de l'établissement. » (Kirby et Keon, 2004, p. 17) Selon Oxley et MacFarlan (1994) « les établissements peuvent par exemple avoir besoin de pouvoir négocier directement avec leur personnel les conditions de travail et de rémunération au lieu d'être liés par des conventions à l'échelon central ». (p.40)

Nécessité de règles moins strictes en matière de champ d'activité

Ces règles, qui bénéficient du soutien des établissements et des associations professionnelles, empêchent des professionnels d'accomplir des prestations pour lesquelles ils sont techniquement qualifiés. Le non-respect de ces dispositions peut conduire à la perte d'accréditation ou de qualifications professionnelles. Un récent rapport de l'OCDE a mis en lumière les avantages qui pourraient découler d'un assouplissement de ces règles, souvent conçues par une profession dans le but d'instaurer des monopoles de fait pour certaines catégories de services.²⁹ Bon nombre de règles ont pour effet de limiter la prestation de certains actes par des professions para-médicales qui possèdent pourtant les compétences nécessaires. Ces professions étant généralement moins bien rémunérées, ce type de réglementation peut accroître considérablement les coûts des services concernés.

« La trop grande rigidité des règles relatives au champ d'activité dans les hôpitaux empêche souvent des professionnels de santé pleinement qualifiés, comme des infirmières ayant reçu une formation spécialisée, d'assurer des prestations qui sont actuellement fournies par du personnel plus coûteux. C'est ainsi, par exemple, qu'une infirmière ne peut procéder à une rectosigmoïdoscopie à la place d'un médecin. » (Kirby et Keon, 2004 p. 17) « La rigidité des règles relatives au champ d'activité fait augmenter le coût de soins de santé. Les professionnels les mieux formés et les plus compétents consacrent un temps fou à des questions dont pourraient tout aussi bien s'occuper d'autres prestataires, pleinement qualifiés mais moins diplômés. Cette situation grève le système dans son ensemble, et contraint des professionnels surqualifiés à assumer des tâches peu gratifiantes. Les auteurs du rapport recommandent « une évaluation de la productivité des différentes professions de santé ... passant également en revue les obstacles à l'amélioration de la productivité. » Ils considèrent que les informations concernant la productivité « affaibliront sensiblement le monopole qu'exercent aujourd'hui des groupes de prestataires de services de santé et permettront aux pouvoirs publics de négocier des hausses de salaires plus conformes

29 Pour plus d'informations concernant les restrictions excessives imposées aux professions paramédicales et aux professions parallèles, se reporter au document OCDE (2005) intitulé « Pour une concurrence profitable dans les professions de santé ».

aux gains de productivité des différents groupes », ce qui encouragerait « la concurrence entre les fournisseurs de services en fonction de leurs performances respectives ».30 (Kirby et Keon, p.24)

4. Application du droit de la concurrence aux hôpitaux et aux services hospitaliers

Dans le domaine des services hospitaliers, une structure centralisée de planification et de contrôle laisse généralement peu de place au droit de la concurrence. En revanche, lorsque la concurrence intervient entre plusieurs hôpitaux, comme indiqué plus haut, de nombreux établissements sont susceptibles de réagir en limitant le poids des forces concurrentielles. En particulier, les hôpitaux qui étaient précédemment indépendants peuvent envisager une fusion afin de se protéger des effets de la concurrence. Burgess et al. (2005) sont d'avis que le Royaume-Uni devra veiller davantage au contrôle de ces activités. Ils soulignent notamment que « les retombées des fusions devront être comparées aux coûts d'une concurrence plus limitée ». « Le ministère de la Santé devra mettre en œuvre, pour encourager la concurrence, une stratégie qui la favorise. »

Les pouvoirs publics s'attachent de plus en plus à faire appliquer le droit de la concurrence aux activités des hôpitaux. Dans de nombreux pays, dont l'Australie, l'Allemagne, les Pays-Bas, l'Afrique du Sud et les Etats-Unis, les autorités responsables de la concurrence ont enquêté sur des fusions d'hôpitaux et – pour ce qui concerne l'Australie, l'Allemagne et les Etats-Unis -- ont déclenché en 2005 des procédures visant à contester certaines de ces fusions. Elles ont également eu maille à partir avec des hôpitaux sur un certain nombre de questions autres que celle des fusions. La rivalité entre établissements hospitaliers ayant toujours été très directe aux Etats-Unis, c'est ce pays qui a l'expérience la plus vaste de l'application du droit de la concurrence dans ce secteur. Plusieurs aspects de cette expérience, examinés ci-après, pourraient s'avérer utiles pour déterminer l'utilité et, le cas échéant, les modalités de la mise en œuvre de ces principes dans le domaine hospitalier.

Principaux domaines d'application du droit de la concurrence :

- fusions d'hôpitaux ;
- planification des licences ;
- réseaux et obligation d'accepter l'ensemble d'un réseau ;
- négociations communes hôpitaux-médecins ;
- contrats d'exclusivité de certains hôpitaux ;
- clause du fournisseur le plus favorisé

Il ne s'agit pas d'une liste exhaustive des sujets sur lesquels les organismes chargés de la concurrence interviennent en ce qui concerne les services hospitaliers. Certaines procédures ont également porté sur des hôpitaux et des produits pharmaceutiques.³¹

30 Peu d'économistes se sont intéressés à cette règle du champ d'activité dans le contexte hospitalier. Toutefois, une étude réalisée aux Etats-Unis sur les auxiliaires dentaires estime à 700 millions de dollars le montant des coûts supplémentaires imposés au consommateur en raison de la restriction du nombre d'auxiliaires qu'un dentiste peut engager et des tâches que ceux-ci peuvent accomplir. (Shepard, 1978.)

31 C'est le cas de l'Italie.

4.1 Fusions d'hôpitaux

Les fusions d'hôpitaux ont des répercussions différentes lorsque les établissements sont en concurrence directe et négocient les tarifs avec les organismes payeurs. Elles peuvent se traduire par une réduction des coûts de fonctionnement lorsqu'elles s'accompagnent d'une intégration clinique réelle des installations. Dans certains pays, toutefois, l'intégration concerne moins les installations que les négociations avec les payeurs.

Des études semblent indiquer que les fusions entre hôpitaux implantés dans des zones plutôt rurales sont susceptibles d'entraîner des hausses de tarifs.

Il ressort de l'expérience que les fusions d'hôpitaux placent les établissements ainsi formés en position de force sur le marché, ce qui entraîne des augmentations de coûts sur les marchés où il existe peu d'hôpitaux à proximité. Dans une étude de cas, par exemple, Vita et Sacher (2001) observent que la fusion d'hôpitaux sans but lucratif à Santa Cruz, en Californie, a été suivie d'augmentations importantes des prix qu'il n'a pas été possible d'expliquer par des facteurs autres que ceux liés à une emprise nouvelle sur le marché. Gaynor et Vogt (2003) ont simulé les effets d'une fusion dans une région de Californie assez isolée : la fusion des trois plus grands hôpitaux de la région aurait provoqué des hausses de prix comprises entre 32 % et 53 %.³²

A en croire certains juges et responsables de la concurrence, une fusion intervenant dans une zone métropolitaine bien dotée en hôpitaux ne devrait pas avoir d'incidences négatives sur la concurrence puisque les prestataires potentiels ne manquent pas. Or, un nombre croissant d'analyses montre que cette supposition est fautive. Des travaux récents ont fait apparaître que, même dans les zones urbaines où plusieurs établissements rivaux se côtoient, les prix peuvent parfois connaître une envolée suite à une fusion. Cette constatation est étayée par des données qualitatives et quantitatives.

L'une de ces données qualitatives concerne une fusion réalisée en 1997 entre deux hôpitaux de l'Etat de New York. Deux ans après la fusion entre un grand hôpital de soins tertiaires avec un groupe hospitalier dont faisait partie son principal rival, le principal responsable de l'ensemble faisait état de ses meilleurs résultats financiers. M. Gallagher « attribuait l'amélioration de la situation financière à la capacité de l'établissement de négocier de meilleurs taux de remboursement avec les 40 sociétés d'assurance avec lesquelles il traite. C'est la perspective de pouvoir influencer sur les négociations qui a accéléré la fusion des deux hôpitaux, concurrents acharnés depuis leur fondation, au début des années 1950. » (New York Times, 17 décembre 2000)³³

Les données quantitatives reposent de plus en plus sur l'analyse structurelle. Par exemple, Town et Vistnes (2001) ont étudié l'impact des fusions d'hôpitaux en Californie en s'appuyant sur les tarifs réels de deux régimes d'assurance maladie qui fonctionnaient avec des réseaux d'hôpitaux sur la base de contrats sélectifs. L'examen de fusions entre un hôpital appartenant à un réseau et son équivalent le plus proche dans ce même réseau leur permet d'en estimer l'impact à 7,2 %, et de constater que 59 % des fusions simulées entraînent une augmentation des tarifs supérieure à 5 %. S'agissant de l'autre réseau, ils prévoient une hausse moyenne de 3,2 %, voire supérieure à 5 % pour 39 % des fusions simulées. Capps et al. (2003) se sont intéressés aux conséquences que pourraient avoir des fusions d'hôpitaux à San Diego, axant plus spécialement leurs travaux sur une banlieue dont environ 30 % des habitants vont se faire soigner dans des hôpitaux extérieurs. De nombreux observateurs auraient affirmé que des fusions d'hôpitaux dans un tel contexte ne poseraient pas de problème, considérant que des augmentations de tarifs

32 La région comprend les hôpitaux du district de San Luis Obispo et des environs.

33 La fusion entre le Long Island Jewish Hospital et le North Shore Hospital System est devenue effective en 1997.

importantes n'étaient guère possibles avec autant de départs. Capps et al. (2003) sont cependant parvenus à la conclusion que, si deux des trois hôpitaux de la banlieue en question fusionnaient, l'augmentation des bénéfices pourrait atteindre 14,7 % (et celle des prix 11,1 %). Par ailleurs, si la fusion portait sur les trois hôpitaux dans une région dont les patients sont nombreux à aller se faire soigner ailleurs, on pourrait enregistrer une hausse des bénéfices pouvant aller jusqu'à 21,5 % et une augmentation des prix de 13,2 %. Ils déduisent de ces calculs que les fusions d'hôpitaux dans les zones urbaines peuvent entraîner des hausses de tarifs, y compris lorsque de nombreux patients s'adressent à des hôpitaux extérieurs au secteur géographique concerné.

S'il est vrai que les fusions peuvent faire augmenter les tarifs, elles peuvent également contribuer à une réduction des coûts dans les hôpitaux. Conner, Feldman et Dowd (1998) ont souligné que les fusions d'hôpitaux ne pouvaient guère engendrer des économies dépassant trois ou quatre pour cent. Si ces fusions permettent l'élimination des surcapacités (qui serait impossible par d'autres moyens), les économies à long terme peuvent être nettement plus importantes – de l'ordre de 25 % : c'est ce qui ressort d'une analyse des coûts hospitaliers comparant les taux d'occupation réel et optimal (Ennis, Keeler et Schoenbaum, 2000).³⁴

Les faits ayant montré que les fusions d'hôpitaux pouvaient avoir des conséquences négatives, il n'est guère surprenant que les autorités de la concurrence aient pris des mesures à l'encontre d'un certain nombre d'entre elles. En 2005, trois projets au moins impliquant des hôpitaux ont été contestés par les responsables de la concurrence en Australie, en Allemagne et aux Etats-Unis. Par ailleurs, plusieurs fusions d'établissements hospitaliers ont donné lieu à des enquêtes de la part de ces services aux Pays-Bas et en Afrique du Sud.³⁵ Le cas le plus récent de contestation d'une fusion d'hôpitaux devant les tribunaux des Etats-Unis est particulièrement intéressant, car la fusion a déjà eu lieu (voir encadré 4). L'issue de cette affaire n'est pas encore connue, mais on peut souligner que les organismes américains chargés de la concurrence ont tout de même perdu sept procès d'affilée. Compte tenu de la complexité des produits, de la demande et des procédures d'acquisition de services hospitaliers, il peut s'avérer hasardeux de compter sur les autorités de la concurrence et sur les tribunaux pour empêcher des hôpitaux de fusionner.

Encadré 4. Etude d'un cas de fusion d'hôpitaux: intervention de la Federal Trade Commission (FTC) des Etats-Unis dans l'affaire Evanston Northwestern Healthcare Corp.

Les organismes antitrust des Etats-Unis ont été les premières instances de réglementation de la concurrence à prendre des mesures contre les fusions d'hôpitaux. Après un certain nombre de succès, enregistrés entre la fin des années 1980 et le début des années 1990, ils ont vu échouer successivement sept actions en justice destinées à empêcher de telles fusions. Ces sept procès concernaient tous des projets ; en d'autres termes, les fusions n'avaient pas encore pris effet. Pour différentes raisons, les juges des tribunaux de district ou les cours d'appel ont estimé que les allégations concernant un éventuel préjudice n'étaient pas convaincantes.

Le 10 février 2004, la FTC a déposé plainte, contestant la fusion – déjà effective – entre la société Evanston Northwestern Healthcare Corp. (ENH) et Highland Park Hospital. ENH se composait de deux hôpitaux implantés dans la région North Shore de la zone métropolitaine de Chicago (Evanston et Glenbrook), et Highland Park Hospital était également situé dans le nord de Chicago. Bien que l'issue de cette affaire ne soit pas encore connue, nous avons choisi de l'évoquer ici en raison des arguments intéressants qu'elle fournit quant aux conséquences et au préjudice

³⁴ Toutefois, il apparaît clairement que les réductions de capacités peuvent parfois avoir lieu en l'absence de fusions, par exemple dans le cadre d'une faillite.

³⁵ Lors de la fusion de deux chaînes d'hôpitaux, l'Australian Competition and Consumer Commission (ACCC) a souhaité que la société Ramsay Health, qui venait d'acquérir Affinity, cède ses actifs dans 19 hôpitaux au total. En Allemagne, le Bundeskartellamt a récemment bloqué l'acquisition de l'hôpital de la ville d'Eisenhüttenstadt par Rhön-Klinikum, et la Federal Trade Commission des Etats-Unis a récemment engagé un procès contre une fusion entre le système ENH et Highland Park, dans la région de Chicago.

directement liés aux fusions d'hôpitaux.

ENH et Highland Park Hospital ont fusionné le 1^{er} janvier 2000. Les établissements concernés sont éloignés de 15 à 20 kilomètres ; on compte en outre de nombreux autres hôpitaux dans le nord de la métropole de Chicago. Après la signature de l'accord de fusion, les hôpitaux ont commencé – d'après les analyses des experts de la FTC -- à négocier des tarifs plus élevés avec les sociétés d'assurance maladie. Ils ont, dans une certaine mesure, abandonné la tarification journalière, à laquelle ils ont tenté de substituer une méthode de remboursement fondée sur une actualisation des charges, laquelle permet aux hôpitaux d'augmenter leurs tarifs par la suite sans négociation supplémentaire, en augmentant leurs charges, ou leurs prix, pour certains services. Selon la FTC, les hôpitaux ont menacé de ne plus passer de contrats avec les sociétés d'assurance si ces dernières n'acceptaient pas un relèvement des tarifs.

Différents régimes d'assurance maladie avaient passé contrat avec ces hôpitaux avant la fusion. Devant les exigences d'ENH concernant les hausses de tarifs, un organisme au moins a écarté ces établissements de son réseau. Selon cette société d'assurance, les clients se sont plaints de ne pas avoir accès à l'ENH. Informés sur plusieurs autres hôpitaux implantés à proximité et susceptibles de remplacer les premiers, les clients ont maintenu leur demande. En janvier 2001, la société d'assurance a accédé aux exigences d'ENH afin de réintégrer ces hôpitaux dans son réseau.

Les régimes d'assurance maladie ont dans l'ensemble accepté des augmentations de tarifs sensibles, y compris ceux qui, dans d'autres circonstances, auraient écarté de leurs réseaux un hôpital dont ils auraient jugé les demandes excessives. La FTC a expliqué ce choix par l'absence de solutions de remplacement raisonnables. Bien que les données concernant les tarifs soient le plus souvent confidentielles, la Commission a affirmé que, dans l'un des cas, les tarifs avaient augmenté de 60 % en 2000, contre 4 à 8 % les années précédentes. L'ENH, en revanche, a prétendu que les hausses, qui étaient plutôt de l'ordre de 9 à 12 % (voir Chicago Tribune 2005a, 2005b), avaient été décidées sur la base des prix du marché après consultation de données contractuelles communiquées par Highland Park Hospital, et que les prix avaient dû être ajustés afin de tenir compte de la qualité des services qui, selon ENH, a été améliorée.³⁶

La FTC a fait valoir que, lorsque les conséquences sont manifestement préjudiciables à la concurrence, il n'est pas nécessaire de procéder à une analyse approfondie du marché. De l'avis de l'expert de la Commission, le marché approprié porte sur la vente aux organismes d'assurance-maladie de soins de courte durée nécessitant une hospitalisation ; sont inclus les services primaires, secondaires et tertiaires, et non les services quaternaires et les soins ambulatoires. Les grandes lignes de la fusion définissent les contours d'un marché géographique, en cherchant à déterminer si l'éventuel détenteur d'un monopole sur ce marché pourrait imposer une augmentation des prix, limitée mais significative et non transitoire, sans perdre un nombre de ventes tel que cette augmentation perdrait tout intérêt. Pour l'expert de la FTC, par conséquent, le marché géographique approprié correspond à la région adjacente aux trois hôpitaux de l'ENH. Cette dernière considère que le marché devrait être beaucoup plus large, car les patients se déplacent dans des zones géographiques très vastes. Toutefois, les experts de la FTC estiment que ce sont les formules de substitution raisonnables en matière de régimes d'assurance qui comptent, et non pas les solutions de remplacement adoptées par les patients : ces derniers, en effet, se déplacent parfois pour des raisons idiosyncratiques.

Selon la FTC, la bonne solution consiste à se désengager du Highland Park Hospital. Si l'intégration des services et des prestations n'est pas très poussée, cette mesure ne devrait pas s'avérer trop coûteuse. Les hôpitaux se prêtent particulièrement bien à un désengagement post-fusion, car ils conservent des systèmes de fonctionnement très indépendants.

36 Winston et Strawn (2005) Post-trial Reply Brief of Respondent, U.S. FTC in the matter of Evanston Northwestern Healthcare, Corp, Docket No. 9315, 1^{er} juillet.

Définition géographique du marché

La définition géographique du marché est un aspect important dans l'analyse des fusions d'hôpitaux : les biens et services concernés sont en effet, de façon générale, différenciés dans l'espace. Elzinga et Hogarty (1973) ont élaboré une norme communément appliquée par les tribunaux des Etats-Unis dès lors que doivent être définies les limites géographiques du marché concernant un grand nombre de produits. La méthode Elzinga-Hogarty consiste à analyser les entrées et les sorties de consommateurs et de biens pour déterminer les limites du marché. A partir d'un marché de faibles dimensions, les frontières sont repoussées jusqu'à ce que les entrées et les sorties passent en deçà de la limite. Cette méthode présente l'avantage d'être relativement simple à appliquer, pour autant que l'on dispose de données suffisantes. De plus, les autres approches pourraient s'avérer plus complexes à mettre en oeuvre.

Werden (1992) estimait que la formule établie par Elzinga et Hogarty ne tenait pas compte de la question primordiale dans le cadre d'une fusion, à savoir : l'évolution des flux en cas d'augmentation des tarifs décidée par les parties à la fusion. Dranove et White (1998) ont observé que les patients obéissent souvent à des raisons de convenance personnelle lorsqu'ils se déplacent pour des services tels que les soins hospitaliers. Il en résulte que les fournisseurs locaux peuvent se trouver confrontés à une demande inélastique en dépit du fait que les consommateurs se déplacent abondamment pour se procurer certains services. Après examen des données relatives aux patients, Capps et al. (2001) ont constaté que « même dans les banlieues dont de nombreux habitants vont ailleurs pour se procurer des services de santé, certaines fusions pourraient se solder par des augmentations de tarifs importantes ». Il ressort de leurs travaux que les méthodes consistant simplement à analyser les entrées et les sorties pourraient conduire à surestimer le marché géographique approprié pour les services hospitaliers.

Concernant le procès mentionné dans l'encadré 4, M. Elzinga a jugé que la méthode Elzinga-Hogarty n'était pas applicable aux marchés hospitaliers. Selon lui, de nombreux patients choisissent leur hôpital pour des raisons sans rapport avec le prix. Or, l'analyse des flux fait apparaître le marché des services hospitaliers plus vaste, et plus étendu géographiquement, qu'il ne l'est en réalité. Le système mis au point par Elzinga et Hogarty s'appuie sur l'hypothèse que le consommateur qui paie un produit est également celui qui l'utilise. Toutefois, dans le cas des hôpitaux, l'organisme payeur est généralement une compagnie d'assurances, le consommateur de services de santé étant le patient. Les patients qui sortent d'une zone géographique donnée ne le font pas nécessairement en raison des tarifs. C'est plutôt entre organismes payeurs et hôpitaux que se déroulent les négociations déterminantes, c'est-à-dire celles qui permettent de fixer les prix. La FTC pense que ce sont les décisions de l'organisme payeur qui dessinent le marché géographique.³⁷ Dans le rapport publié récemment par le FTC et le ministère américain de la Justice sur les soins de santé (2004), on peut lire : « A ce jour ... l'expérience des sociétés d'assurances et la recherche font apparaître que la méthode Elzinga-Hogarty ne permet pas de définir de façon fiable les limites géographiques des marchés dans les cas de fusions d'hôpitaux. » (Chap. 5, p. 21)

La définition géographique du marché peut varier selon les services. Pour l'ACCC :

« En ce qui concerne les prestations de base fournies dans des hôpitaux privés – chirurgie générale et services spécialisés courants assurés dans la plupart des hôpitaux – le marché géographique se limite aux zones proches de l'hôpital concerné. Dans ces cas, le confort du patient (en termes de proximité de la famille et des amis) et du médecin influe considérablement sur les limites géographiques du marché. A l'inverse, dès lors qu'il s'agit de services hautement spécialisés – comme dans les cas de pathologies cardiaques complexes – le marché

37 U.S. FTC (2005) Complaint Counsel's Post-Trial Brief, U.S. FTC in the matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, p. 59, 27 mai.

géographique s'étend à l'Etat tout entier, car les prestataires sont moins nombreux et les patients doivent se déplacer à l'échelle des régions pour recevoir un traitement. » (Productivity Commission (1999))

Le rapport publié en 2004 par la FTC et par le ministère de la Justice des Etats-Unis recense plusieurs sources d'informations, autres que l'origine du patient, pour établir le marché géographique des services hospitaliers. Il s'agit notamment des éléments suivants :

- Documents de planification stratégique des hôpitaux
- Témoignage des organismes payeurs
- Etudes sur la mobilité des patients.

Lorsque les tarifs des hôpitaux sont fixés par la négociation avec les organismes payeurs, les entretiens qualitatifs avec les sociétés d'assurance locales offrent probablement l'un des moyens les plus efficaces d'obtenir des informations sur les marchés géographiques de services hospitaliers, de même que sur les solutions de remplacement possibles dans l'hypothèse d'augmentations des tarifs des hôpitaux indépendants par rapport aux cas d'augmentations découlant de fusions. En outre, les documents stratégiques des hôpitaux livrent souvent des indications précieuses quant aux aspects concurrentiels des fusions, et nombre d'entre eux constituent des témoignages pertinents. Le rapport de la FTC et du ministère de la Justice des Etats-Unis (2004) indique en conclusion : « Le test du monopole hypothétique des *Merger Guidelines* doit être appliqué pour définir les limites géographiques du marché dans les cas de fusions d'hôpitaux. Les différents éléments de preuve utilisés dans tous les cas de fusion – plans stratégiques des parties à la fusion, témoignage des clients, documents – devraient également contribuer à délimiter les marchés géographiques appropriés pour les fusions d'hôpitaux. » (Chap. 5, p. 21)

Hôpitaux ayant le statut de société à but non lucratif

Il est fréquent que les actions en justice relatives à des fusions d'hôpitaux sans but lucratif soient axées sur la question de savoir si ces établissements envisagent une activité contraire à la concurrence. Dans l'affaire de l'hôpital Rockford, en 1990, le tribunal du district a conclu ce qui suit : « Les commissions de défenseurs, qui s'alignent sur les intérêts des consommateurs, et le statut d'établissement à but non lucratif n'empêcheront pas nécessairement les « accusés » de se lancer dans des activités anti-concurrentielles. »³⁸ Cette affirmation émanait d'une décision de la cour d'appel écrite par le Juge Posner. Toutefois, lors d'une fusion d'hôpitaux dans le Michigan (Grand Rapids), le tribunal a estimé que, si les sociétés à but non lucratif ne sont pas dispensées de respecter les lois antitrust, leur statut pourrait néanmoins constituer « un élément de réflexion pertinent, à condition d'être étayé par d'autres preuves que la libre concurrence ne serait pas mise à mal. »³⁹ Le tribunal s'est appuyé sur une étude de Lynk (1995), selon laquelle « la concentration du marché entre les mains d'hôpitaux sans but lucratif n'avait pas de lien avec l'augmentation des prix, mais plutôt avec leur diminution. » Cette étude a suscité de très nombreuses critiques (voir Dranove et Ludwick (1998), Keeler et al. (1998), et Shin et Simpson (1998), qui exposent les problèmes soulevés par les généralisations de Lynk). Des travaux plus récents montrent plutôt que les hôpitaux sans but lucratif pratiquent souvent, à l'instar des autres établissements, des tarifs plus élevés dans les régions où l'on constate une plus forte concentration du marché. Keeler et al. (1998), qui ont étudié la situation dans des hôpitaux de la même région que ceux dont parle Lynk (1995), estiment que « les

38 *Gouvernement des Etats-Unis contre Rockford Memorial Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F. 2d 1278 (7^e Cir.), *cert. denied*, 498 U.S. 920 (1990).

39 *FTC contre Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd per curiam*, No. 96-2440 (6^e Cir. 8 juillet 1997).

conséquences des fusions d'hôpitaux sans but lucratif, nulle en 1986, ont augmenté de 7 % en 1994. Quelle que soit l'année considérée, les établissements à but lucratif augmentent davantage leurs tarifs que les autres dans un contexte de concurrence, mais la différence est moins marquée en 1994 qu'au cours des années précédentes. (p.80) Ces observations corroborent l'analyse de Vita et Sacher (2001), qui ont étudié l'impact d'une fusion entre des hôpitaux à but non lucratif à Santa Cruz, en Californie. D'après leurs observations, « si l'on ne peut exclure tout à fait les améliorations de la qualité après une fusion, celles-ci ne peuvent expliquer entièrement la hausse constatée dans les prix moyens ... Compte tenu de ces augmentations de prix ... les fusions impliquant des hôpitaux à but non lucratif figurent en bonne place – de manière très légitime – parmi les objectifs des initiatives antitrust. »

Des analyses plus récentes, et notamment celles de Town et Vistnes (2001), Capps, Dranove et Satterthwaite (2003), ainsi que Gaynor et Vogt (2002), relèvent qu'« en matière de comportement tarifaire, il n'existe que peu de différences statistiquement significatives entre hôpitaux à but lucratif et sans but lucratif » (Town and Vistnes) ou encore que, par comparaison aux établissements à but lucratif, les hôpitaux sans but lucratif « affichent des prix plus bas, mais pratiquent des majorations plus fortes que les établissements à but lucratif, en raison de coût marginaux (comportementaux) plus faibles ... [Une] simulation de fusion ne montre aucune différence entre les deux types d'hôpitaux quant à leur volonté d'exploiter une position de force sur le marché découlant de la fusion » (p.48). On voit donc que, s'il n'y a pas d'accord sur l'impact du statut « sans but lucratif » sur les prix, il apparaît qu'il existe davantage de preuves que les hôpitaux sans but lucratif sont enclins à tirer parti de leur pouvoir sur le marché lorsqu'ils en disposent.

Les discussions relatives aux deux types d'hôpitaux ont également porté sur les différences de qualité, certains observateurs craignant que les établissements à but lucratif offrent des services de qualité sensiblement moindre afin d'écarter leurs bénéfices. Or, McClellan et Staiger (1999) ont constaté que, sur des marchés hospitaliers spécifiques, « s'il existe une différence, c'est que le concept d'hôpital privé à but lucratif semble associé à des soins de meilleure qualité ». Ils relèvent également qu'il existe une légère différence dans la moyenne de mortalités entre les deux types d'établissement, mais que cette différence entre moyennes générales « masque des variations énormes en matière de mortalité au sein de l'un et l'autre type d'hôpitaux ».

4.2 Planification des licences

La planification des licences peut avoir pour effet d'introduire des obstacles réglementaires à l'entrée sur le marché, et cet exercice doit dès lors être pratiqué avec la plus extrême prudence. La jurisprudence dans au moins un pays de l'OCDE tend à suggérer que les attestations de nécessité ne doivent pas exclure la prise en considération des aspects antitrust.⁴⁰

La Cour d'appel du 11^e circuit des Etats-Unis a retenu que la soumission d'informations fausses ou trompeuses à une Commission d'Etat statuant sur les demandes d'attestation de nécessité pouvait constituer une violation de la loi Sherman.⁴¹ Le St. Joseph's Hospital avait fait valoir que Hospital Corp. of America avait fourni des indications incorrectes et fallacieuses à l'Agence de l'Etat chargée de la planification sanitaire, et que l'Etat s'était fondé sur de telles informations pour prendre sa décision.

Le ministère de la Justice américain a rendu récemment un arrêt sur une plainte avec règlement à l'amiable, dont le but était d'empêcher deux hôpitaux indépendants de se répartir certains services. Selon la

40 Deux cas: National Geromedical Hospital et Gerontology Center contre Blue Cross def Kansas City.

41 Cas de St. Joseph's Hospital, Inc contre Hospital Corp. of America, 795 F.2d 948, 956 (11e Cir. 1986).

plainte, ces établissements avaient utilisé des règles afférentes à la planification des licences (ou à l'attestation de nécessité) afin d'officialiser leur accord de s'allouer certains services. 42

4.3 Réseaux et obligation d'accepter l'ensemble d'un réseau

Dans plusieurs pays de l'OCDE, les réseaux d'hôpitaux sont devenus des prestataires de services de santé de plus en plus importants. Ces réseaux possèdent ou gèrent des hôpitaux fréquemment implantés dans des endroits différents. Lorsque ces réseaux négocient avec des organismes payeurs, ils le font pour tout leur groupe et exigent que les contrats avec les organismes payeurs couvrent, soit l'ensemble, soit aucun, des hôpitaux du réseau. Les payeurs préféreraient souvent conclure des contrats sélectifs avec certains hôpitaux d'un réseau ; il est cependant fréquent que cela ne soit pas possible : en effet, d'une part, le réseau insiste pour que tous ses hôpitaux soient inclus dans le contrat et, d'autre part, les consommateurs souhaitent disposer d'un choix très large d'hôpitaux, au point que beaucoup d'entre eux quitteraient le plan d'assurance-santé si ce dernier ne traitait avec aucun des hôpitaux du réseau. Par conséquent, les organismes payeurs acceptent souvent de passer un contrat avec l'ensemble des hôpitaux en cause.

Par réaction, « certains organismes payeurs se sont efforcés d'établir des degrés de remboursement distincts en fonction de l'hôpital où les services sont rendus, ce qui signifie que la quote-part supportée par le consommateur sera différente (plus lourde ou moins importante) selon l'hôpital prodiguant les soins. Ces niveaux peuvent être définis sur la base d'un grand nombre de critères différents. Cette différenciation, qui ne s'appliquera généralement pas aux urgences, sera fonction de l'endroit où seront rendus les soins de routine ou les services spécialisés. Pour les payeurs, cette différenciation constitue une réponse potentielle aux pressions des réseaux d'hôpitaux visant à inclure tous leurs établissements dans les contrats avec l'organisme payeur ; ce système permet également aux plans d'assurance maladie d'offrir à leur clients un large choix d'hôpitaux, y compris l'hôpital « incontournable », tout en incitant les consommateurs à recourir aux prestataires de services les moins chers. » (FTC et ministère de la Justice des Etats-Unis, 2004)

« Certains hôpitaux s'opposent à cette gradation des remboursements et, pour autant que leur puissance de négociation soit suffisante, il peuvent menacer en toute crédibilité de se retirer de la liste des établissements sous contrat avec tel ou tel organisme payeur s'ils sont mal placés en matière de taux de remboursement. En outre, les réseaux d'hôpitaux peuvent menacer de retirer tous leurs hôpitaux si un de ces derniers se trouve en position défavorable à cet égard. Sur certains marchés, les réseaux d'hôpitaux ont inséré préventivement, dans leurs contrats avec des organismes payeurs, des clauses qui interdisent de telles différenciations de remboursements. » (FTC et ministère de la Justice des Etats-Unis, 2004)

4.4 Négociations communes avec les médecins

Dans plusieurs des pays membres, les hôpitaux sont étroitement associés aux médecins, sans pour autant être la propriété commune de ces derniers. Il peut en résulter une Organisation Médecins-Hôpital (OMH) qui peut parfois entreprendre, à propos de certains contrats, des négociations collectives pour le compte de l'ensemble de ses membres ou qui peut s'efforcer de devenir le négociateur exclusif représentant ses membres pour tous les contrats. Certaines associations peuvent se justifier pour des raisons d'efficience -- notamment s'il s'agit de répartir les risques financiers ; toutes les associations visant à l'améliorer l'efficacité ne relèvent donc pas du droit de la concurrence. Par exemple, l'échange d'informations sur des protocoles de traitement ne nécessitera probablement pas des négociations collectives liées aux rémunérations et ne constituera donc pas une justification à visée d'efficience qui

42 Gouvernement des Etats-Unis contre Littlefield Regional Medical Center, Inc. et Princeton Community Hospital Association, Inc. L'accord prévoyait qu'un hôpital se verrait allouer la plupart des services d'oncologie alors que l'autre obtiendrait la chirurgie cardiaque .

tombe sous les lois relatives à la concurrence. Le cas de la Piedmont Health Alliance, décrit dans l'encadré ci-après, constitue cependant un exemple d'action d'une agence de surveillance de la concurrence qui concerne la négociation en commun de contrats par des médecins et des hôpitaux.

Encadré 5. Organisation médecins-hôpital : Piedmont Health Alliance

En décembre 2003, la FTC « a déposé une plainte administrative contre la Piedmont Health Alliance, Inc. (PHA), organisation médecins-hôpital (OMH) implantée en Caroline du Nord, et contre 10 médecins, au motif qu'ils avaient conclu un accord tarifaire concernant la fourniture de soins médicaux. Dans une action connexe, le Frye Regional Medical Center, un hôpital pour soins aigus de Hickory, également en Caroline du Nord, et sa maison-mère, la Tenet Healthcare Corporation, ont réglé les montants demandés par la FTC comme amendes pour leur rôle dans les activités de la PHC réputées illégales. Ce cas impliquant Frye et Tenet est le premier dans lequel la FTC a cité un hôpital en tant que complice d'une conspiration visant à une entente tarifaire entre médecins.

“L'accusation d'entente tarifaire repose sur un arrangement selon lequel les membres médecins de la PHA auraient convenu d'utiliser cette dernière comme négociatrice, auraient accepté d'être parties à tous contrats conclus par la PHA et auraient marqué leur accord pour accepter tous tarifs négociés par PHA. La plainte indique également qu'en 2001, la PHA a commencé à utiliser ce qu'elle appelait un « modèle du "messenger" modifié » afin de conclure des contrats avec certains organismes payeurs. Les arrangements de type « messenger » licites peuvent permettre de réduire les coûts des contrats entre médecins et organismes payeurs, mais sans entraîner ou faciliter des réactions coordonnées de la part des médecins. Or, dans le cas particulier, la FTC prétend que l'approche adoptée par la PHA constituait un mécanisme de fixation des prix. Certes, la PHA a bien demandé à chacun de ses membres médecins la rétribution minimale qu'il ou elle accepterait dans le cadre des contrats avec l'organisme payeur, mais ce montant contractuel n'a pas fait l'objet de négociations individuelles. La PHA est accusée d'avoir aidé ses médecins à fixer un prix minimal en leur communiquant les prix contractuels préexistants négociés antérieurement par elle, ce que de nombreux médecins ont utilisé pour déterminer leurs propres tarifs. La PHA est encore accusée d'avoir négocié avec les payeurs les prix moyens globaux à régler à ses médecins, puis d'avoir fixé les honoraires individuels sur la base de ces niveaux. La plainte souligne que l'approche aurait consisté, pour les médecins, à déterminer collectivement la taille du gâteau, par l'intermédiaire de la PHA, puis à fixer leurs honoraires de façon à se répartir ce gâteau. La plainte déposée prétend que la négociation collective menée par la PHA au nom de ses membres médecins n'était raisonnablement pas nécessaire sous l'angle d'une recherche d'intégration propre à accroître l'efficacité.

“L'accusation contre Frye et sa société-mère, Tenet Healthcare, portait sur le rôle qu'ils auraient joué en facilitant et en participant à la fixation d'honoraires de médecins. Selon les plaintes, Frye serait intervenu dans la constitution de la PHA, ainsi que dans son expansion et son fonctionnement. Le Conseil d'administration de Frye aurait autorisé le Directeur général de la société à utiliser la trésorerie de Frye afin de mettre en place une OMH comprenant Frye et des médecins qui y travaillaient. C'est le Directeur exécutif de Frye qui a dirigé les premières activités de la PHA. Les plaintes soulignent encore que Frye a coordonné ensuite l'élargissement de ces arrangements OMH à deux autres hôpitaux - Caldwell Memorial Hospital et Grace Hospital – et à leurs médecins respectifs, et que Frye a investi des sommes importantes dans ce projet. Ce sont le Directeur financier et le Directeur exécutif de Frye qui ont été les principaux négociateurs des contrats entre 1994 et 1996. Le représentant de Frye au Conseil d'administration de la PHA a participé également aux mesures prises par ce Conseil en matière de contrats avec les organismes payeurs et les honoraires des médecins.

“Ce cas démontre que les hôpitaux seront confrontés à des risques antitrust importants s'ils facilitent ou participent à la fixation d'honoraires de médecins en l'absence de toute justification légitime liée à l'efficacité.” (Creighton, 2004)

4.5 Contrats d'exclusivité de certains hôpitaux

Certains hôpitaux généraux ont parfois été accusés de passer illégalement des contrats d'exclusivité avec des compagnies d'assurance, dans le but d'acquiescer ou de maintenir une position dominante. D'autres se sont vu reprocher de refuser à de nouveaux médecins l'accès aux privilèges attachés à un établissement

afin de limiter la concurrence avec les praticiens déjà en place. De tels cas sont généralement portés en justice à titre privé.

Les tribunaux accordent le plus souvent toute latitude aux hôpitaux pour accorder ou non à tel ou tel médecin le droit d'exercer dans leurs murs. D'aucuns redoutent que, si les hôpitaux ne jouissaient pas de ce pouvoir discrétionnaire, ils ne puissent plus refuser l'obtention de privilèges à un médecin dont les prestations seraient de qualité médiocre. Cette liberté n'est cependant pas immuable. Une décision prise récemment en appel a donné suite à la plainte d'un médecin anesthésiste, auparavant débouté, selon laquelle un hôpital d'Arecibo, Porto Rico, avait conclu un arrangement d'exclusivité qui l'avait empêché de présenter sa candidature à un concours de recrutement.⁴³

Dans le cadre d'une affaire récente, aux Etats-Unis, un tribunal local a décidé en 2002 qu'un centre de chirurgie ambulatoire pouvait engager des poursuites pour constitution de monopole au titre des sections 1 et 2 de la loi Sherman.⁴⁴ Dans cette affaire, qui doit encore être jugée sur le fond, un centre de chirurgie ambulatoire reproche à un hôpital local d'avoir passé un accord avec certains de ses médecins afin de monopoliser le marché des interventions chirurgicales de jour, et d'avoir conclu des contrats d'exclusivité illégaux avec d'importantes sociétés d'assurance responsabilité civile pour limiter le nombre de patients susceptibles de s'adresser au centre de soins ambulatoires. Au cours du mois durant lequel le centre de soins ambulatoires a ouvert ses portes, l'hôpital général a adopté un arrêté l'autorisant à refuser l'accès aux privilèges à tout médecin adressant des patients à des établissements autres que le Rome Memorial Hospital. Le juge a estimé que l'on pouvait raisonnablement en déduire que l'existence du Rome Ambulatory Surgical Center « faisait chuter le prix des actes de chirurgie ambulatoire sur le marché » et que les contrats d'exclusivité privaient les consommateurs des avantages de la concurrence.

4.6 *Clause du fournisseur le plus favorisé*

Aux termes de cette clause (« fournisseur le plus favorisé » ou « nation la plus favorisée »-NPF), un vendeur (hôpital) est contraint d'accorder à l'acheteur un rabais au moins aussi intéressant que ceux accordés à d'autres acquéreurs. Les acquéreurs de volumes importants, par exemple, demandent souvent l'inclusion de cette disposition dans leurs contrats, afin de bénéficier d'un bon prix. Toutefois, elle influe, entre autres, sur les rabais consentis aux entreprises ne bénéficiant pas de la clause. En effet, si la société qui a obtenu cette clause détient 30 % des contrats avec un hôpital donné, celui-ci devra – pour offrir à un autre fournisseur un prix inférieur à celui fixé par le contrat assorti de la clause NPF, baisser ses tarifs sur 30 % supplémentaires de ses transactions.

La FTC a récemment engagé une procédure visant à empêcher la société South Georgia Health Partners (SGHP) de négocier au nom d'un groupe d'hôpitaux non intégrés dans un réseau. « Les modalités de fonctionnement de la SGHP ... limitaient la possibilité des hôpitaux de passer des contrats en dehors de l'OMH. Les hôpitaux acceptaient de ne pas négocier individuellement la plupart de leurs contrats avec les organismes payeurs, à moins d'y être autorisés par 75 % du Conseil d'administration de la SGHP. Les hôpitaux du réseau SGHP étaient également convenus que, dans l'hypothèse même où un hôpital membre serait autorisé par le Conseil à traiter individuellement avec une compagnie d'assurance maladie, cet hôpital ne pouvait offrir un rabais de plus de 10 % sur ses tarifs, sauf à proposer la ristourne la plus forte à tous les payeurs avec lesquels SGHP avait passé contrat. ... Il est apparu que cette clause NPF était de nature à dissuader fortement toute pratique de rabais. » (Creighton, 2004)

43 *Morales-Villalobos v. Garcia-Llorens*, No. 02-1499 (1^{er} diffusion le 14 janvier 2003).

44 *Rome Ambulatory Surgical Center, LLC v. Rome Memorial Hospital, Inc.*, 5:01-CV-23 (N.D.N.Y.)

5. Conclusions – Développement de la concurrence : défis et limites

5.1 *La concurrence est-elle l'instrument le plus approprié à utiliser pour mieux atteindre les objectifs fixés en matière de soins de santé ?*

C'est lorsqu'aucun des acteurs n'est en position de force sur le marché que la concurrence fonctionne le mieux. Il ne serait guère raisonnable, en effet, de compter sur ce mécanisme pour convaincre les hôpitaux ayant assis leur emprise sur le marché de baisser leurs prix et d'accroître leur efficacité. En d'autres termes, les formules axées sur le marché ne donneront des résultats que s'il existe des produits de remplacement présentant des caractéristiques raisonnablement similaires. Par conséquent, si les législateurs veulent mettre l'accent sur des solutions privilégiant la concurrence, il importe de prévoir des politiques limitant les obstacles aux entrées sur le marché et interdisant les fusions anti-concurrentielles.

L'introduction de la concurrence peut parfois conduire à la mise en place de capacités excessives ou à d'autres modifications susceptibles d'augmenter les coûts pour l'ensemble du système ; c'est le cas, par exemple, d'une offre accrue de prestations inutiles. Par conséquent, une grande prudence s'impose dans l'évaluation des moyens d'action possibles, dans le contexte des régimes d'assurance locaux et des valeurs sociétales de la région concernée.

Dans les pays dépourvus de système de santé national, il peut y avoir un risque que la concurrence entraîne un recul des prestations fournies aux personnes non assurées. Ces services sont le plus souvent fournis par le biais de subventions croisées. Frank et Salkever (1991) ont constaté que les prestations de santé bénévoles se faisaient plus nombreuses sur les marchés où il y avait davantage d'hôpitaux en concurrence. A l'inverse, Gruber (1994) a observé qu'entre 1984 et 1988, en Californie, le bénévolat en matière de services de santé enregistrait un déclin plus marqué sur les marchés concurrentiels que sur les autres. Selon Frech (1996), il faut remplacer, pour financer les prestations bénévoles, les subventions croisées qui ne disent pas leur nom par des taxes et des subventions explicites.

S'agissant des systèmes peu efficaces, la question se pose de savoir comment rendre plus efficaces les prestations de soins de santé. Compte tenu de la complexité des services hospitaliers et du grand nombre d'intervenants, les systèmes dont la gestion est centralisée pourraient avoir beaucoup de mal à améliorer leur taux d'efficacité. L'une des meilleures formules pour inciter les prestataires de services hospitaliers à travailler efficacement consiste à mettre en place un mécanisme de concurrence qui facilite le développement des prestataires performants tout en rendant le parcours plus difficile pour les autres. La concurrence peut permettre une diffusion plus rapide des progrès technologiques propres à réduire les coûts, le développement des meilleures pratiques et la suppression des gaspillages.

5.2 *Quelle est la meilleure association d'outils marchands et non marchands pour renforcer les performances des systèmes de santé ?*

Tous les systèmes de santé des pays de l'OCDE associent des outils marchands et non marchands. Toutefois, le degré d'utilisation des instruments marchands varie sensiblement. Le présent document a examiné plusieurs types de mécanismes permettant d'introduire la concurrence dans les prestations hospitalières ; l'expérience semble montrer que bon nombre de ces mécanismes ont parfois contribué à réduire les coûts ou à améliorer la qualité des services. La meilleure qualité des données disponibles sur la nature exacte des soins dispensés aux patients et sur les délais d'attente est un élément sous-jacent à de nombreuses transitions vers des mécanismes concurrentiels. Chercheurs et pouvoirs publics ont, de plus en plus, la possibilité de déterminer les effets probables des différents systèmes de concurrence.

Les avantages de l'efficacité technique paraissent particulièrement importants pour :

- une exploitation par le secteur privé
- les modes de paiement contractuels, et notamment :
 - la séparation des achats et des prestations
 - la tarification prospective
 - la rémunération liée aux résultats
 - les achats effectués par des médecins
- un choix plus large offert au consommateur
- un assouplissement des contrôles quant à l'affectation de tâches déterminées à différentes professions
- des centres régionaux spécialisés dans les pathologies complexes.

Les restrictions réglementaires peuvent imposer des limites particulières au fonctionnement des formules axées sur le marché. Les contrôles relatifs à l'octroi des licences, les limites en matière de contrats et les registres de licences professionnelles sont autant de méthodes utilisées pour freiner la libre concurrence. Les règles définies dans ces domaines ne sont pas sans conséquences. Les décideurs qui s'emploient à instaurer la concurrence doivent prendre en considération à la fois le type de mécanisme qu'ils souhaitent mettre en place et les réglementations déjà en vigueur (qu'elles émanent ou non des pouvoirs publics).

A mesure que les forces concurrentielles se développent, les prestataires de services, dont les hôpitaux, tendent tout naturellement à former des alliances de négociation, qui sont en fait des cartels à peine déguisés. Si l'application du droit de la concurrence n'est pas forcément souhaitable dans tous les secteurs des soins de santé – et plus spécialement lorsque les gouvernements sont très impliqués dans la supervision des prestations – elle peut néanmoins s'avérer essentielle pour que les options axées sur le marché aient une chance de donner de bons résultats. En cas de fusion d'hôpitaux alors que l'instauration d'un système concurrentiel se profile mais n'est pas encore tout à fait décidée, les acteurs compétents en matière de droit de la concurrence doivent étudier attentivement la possibilité d'intervenir s'il s'avérait probable qu'une telle fusion serait préjudiciable à une concurrence effective après la mise en place d'un nouveau régime. Dès lors que des systèmes fondés sur les règles du marché entrent officiellement en vigueur, le rôle des personnes chargées de faire respecter le principe de concurrence peut prendre une importance particulière ; par ailleurs, les précédents créés par les contestations de fusions peuvent influencer largement sur l'efficacité des mécanismes marchands. C'est alors que les autorités de la concurrence des ministères de la Santé constateront, très probablement, qu'elles ont de multiples intérêts en commun.

APPENDICE A: PROJET DE LISTE D'ATTENTE EN SUÈDE

Le projet de liste d'attente a été lancé en 1996, date à laquelle plusieurs conseils régionaux du sud de la Suède, désireux de réunir des données sur les délais d'attente, ont chargé les cliniques et les hôpitaux des régions concernées de communiquer des informations à cet égard à la Fédération des Conseils régionaux de Suède. A l'automne 2001, moins de la moitié des établissements sollicités s'étaient manifestés. L'une des raisons de ce faible taux de réponse est à chercher dans le manque de personnel et d'ordinateurs appropriés pour inventorier les données. Afin d'encourager la collecte et la communication des informations nécessaires, le gouvernement a alors envisagé de consacrer au projet 1,25 milliard de couronnes supplémentaires par an de 2002 à 2004. Ces fonds devaient être mis à la disposition des conseils de régions qui soumettraient les données indispensables à l'élaboration d'une base de données nationale complète, qui recenserait à la fois les estimations et les chiffres réels en matière de délais d'attente, l'objectif étant de permettre aux cliniques et aux hôpitaux d'utiliser les fonds additionnels – du moins partiellement – pour mettre au point des systèmes informatiques permettant la poursuite de cette collecte de données.

La base de données sur les temps d'attente en Suède porte sur les délais préalables aux consultations externes dans 25 types de cliniques ou de services spécialisés, pour six procédures de diagnostic et 27 catégories de traitements non urgents. Pour chaque clinique et hôpital, et pour chaque procédure, des informations sont fournies concernant :

- Le délai d'attente prévu (en nombre de semaines) pour un nouveau patient, l'hypothèse étant qu'il s'agit d'un cas non urgent et non prioritaire. (Statistique donnée par la clinique elle-même.)
- La date à laquelle la durée prévue de l'attente a été communiquée. (On suppose que le délai est inférieur à un mois.)
- Le nombre de patients inscrits sur les listes d'attente. Ce nombre englobe la totalité des patients, qu'ils aient ou non une date de rendez-vous, ainsi que tous les groupes prioritaires. (Ce chiffre est présenté trois fois par an.)
- Le pourcentage de patients traités au cours de chaque période considérée, et pour lesquels le temps d'attente réel a été inférieur à trois mois.
- La production totale au cours de la dernière période analysée (ce qui peut être interprété comme le nombre de diagnostics ou d'actes médicaux concernant de nouveaux patients).

L'objectif sous-jacent consiste à faire en sorte que les patients puissent disposer d'informations aussi complètes que possible avant de déterminer le lieu où ils seront traités. Les données communiquées sont donc à la fois historiques et prospectives.

Les cadres et les responsables politiques ont accès à des chiffres complémentaires. Ils peuvent être informés sur :

- le nombre de patients dont le temps d'attente a dépassé douze mois ;
- le délai d'attente moyen ;
- le délai au terme duquel 90 % des patients inscrits à une date donnée auront été traités.

Tableau 1. Sélection de statistiques relatives aux soins de santé dans les pays de l'OCDE

	Soins aigus- Nb de lits/ 1 000 ⁽¹⁾	Soins aigus taux d'occ.	Durée moyenne d'hosp. en soins ⁽²⁾	Nb. De sorties/ 1000 ⁽³⁾	Dép. Tot. soins en hôpital. Par hab. USD PPP	Dép. publiques soins en hôp. Par hab. USD PPP	% soins en hôpital/dépenses publ.	Soins en hôpital. Dépenses en % PIB	Total dép. soins en hôp. Millions NCU
Australie	3.6 *	73.9 *	6.2 *	156.6 *	-	-	-	-	-
Autriche	6.0	76.2	5.8	302.0 *	871 *	707 *	81.2% *	2.9% *	6,422 *
Belgique	4.0 *	-	7.7 *	159.9 *	-	-	-	-	-
Canada	3.2 *	86.6 *	7.4 *	88.3 *	842	731	86.8%	2.8%	33,208
République tchèque	6.5	73.9	8.3	227.6	440	416	94.5%	2.6%	65,188
Danemark	- *	-	3.6	197.4	1400	1316	94.0%	4.6%	63,601
Finlande	2.3	-	4.3	249.8	837	777	92.8%	2.9%	4,214
France	3.8	74.8	5.6	251.1 *	1196	1108	92.6%	4.2%	65,045
Allemagne	- *	80.1 *	9.2 *	201.6 *	1073	884	82.4%	4.0%	84,276
Grèce	-	-	-	-	-	-	-	-	-
Hongrie	5.9	77.2	6.7	257.5	323 *	288 *	89.2% *	2.3% *	376,861 *
Islande	-	-	5.2 *	181.3 *	1760	1760	100.0%	5.9%	48,011
Irlande	3.0	84.7	6.5	124.1	-	-	-	-	-
Italie	3.9 *	76.9 *	- *	140.5	937	893	95.3%	3.5%	45,489
Japon	8.5	79.5	20.7	102.0 *	855 *	759 *	88.8% *	-	15,650,243 *
Corée	5.9	71.6	10.6	110.7 *	241	156	64.7%	1.2%	9,005,478
Luxembourg	5.7	68.8	7.4	175.2	1285 *	1055 *	82.1% *	2.5% *	562 *
Mexique	1.0	73.7	3.9	42.0	221	152	68.8%	2.3%	158,056
Pays-Bas	3.2 *	-	-	97.1	1178	928	78.8%	3.9%	17,649
Nouvelle-Zélande	-	-	-	203.9	-	-	-	-	-
Norvège	3.1	88.5	5.4	170.9	1724	1621	94.0%	4.7%	72,817
Pologne	5.1	77 *	7.9 *	-	-	-	-	-	-
Portugal	3.1	85.2	-	78.2	-	-	-	-	-
République slovaque	5.9	65.4	7.9	187.9	236	236	100.0%	1.8%	21,630
Espagne	3.1	-	-	108.9 *	499	430	86.2%	2.1%	15,562
Suède	-	-	4.8 *	160.1 *	809 *	797 *	98.5% *	2.9% *	67,608 *
Suisse	3.9	85.2	9	154.9	1812	1114	61.5%	5.5%	23,935
Turquie	2.3	61.9	5.2 *	81.0	-	-	-	-	-
Royaume-Uni	3.7	85.1	6.7	236.6	-	-	-	-	-
Etats-Unis	2.8	66.2	5.7	117.1 *	1526	899	58.9%	4.1%	443,718
Moyenne	4.1	76.8	7.2	163.0	955.5	810.8	85.3%	3.3%	-

Source : Données Eco-santé de l'OCDE, juin 2005.

Données de 2002

Notes :

1. La définition de « soins aigus » peut varier d'un pays à l'autre. Au Japon, un grand nombre de lits de « soins aigus » sont réservés aux soins de longue durée. Ces nuances doivent donc être interprétées avec prudence.
2. L'Autriche, la République tchèque, la France, la Hongrie et les Etats-Unis incluent dans leurs chiffres les hospitalisations de jour, alors que les autres pays n'en tiennent pas compte. Les données canadiennes représentent, à partir de 1994, la durée moyenne de séjour (DMS) dans les établissements de soins de courte durée ; une forte proportion des hôpitaux fournissant des soins de courte durée ont également des lits pour les hospitalisations de longue durée. Les chiffres du Mexique ne concernent que les hôpitaux publics.
3. L'Autriche, la République tchèque, la France, la Hongrie, la Nouvelle-Zélande et les Etats-Unis incluent dans leurs chiffres les hospitalisations de jour, alors que les autres pays n'en tiennent pas compte. La Finlande englobe dans ses données les transferts d'un service à un autre, alors que les pays ne les prennent pas en compte. Les chiffres du Mexique ne concernent que les hôpitaux publics.

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CANADA

The OECD WP2 Roundtable on Competition and Efficiency in the Provision of Hospital Services comes at an opportune time in relation to the development of the Canadian health care sector. There has traditionally been limited use of market like incentives and competition in the supply of hospital services in Canada. However, increasing health care costs, lessons from other countries, ongoing fiscal constraints and other developments have created increasing interest in their potential to promote the efficient, high quality and innovative supply of hospital services.

This note outlines developments in Canada relating to the use of incentives and competition in the hospital sector. Section 1 provides relevant features of the Canadian health care system. Section 2 discusses the debate in Canada over competitive hospital services. Section 3 outlines the limited developments that have taken place to date toward the use of incentives and competition within the sector. Section 4 provides some concluding remarks.

1. Canadian Hospitals Overview

Canada spent about \$130 billion on health care in 2004, or just under 10% of its GDP.

Although their portion of health care costs has declined significantly over the past several years, hospitals remain the single largest cost category. They accounted for 30% of total expenditures on health care in 2004, or about \$39 billion. By comparison, physicians and drugs accounted for 13% and 17%, respectively.¹ As of 2002-2003, there were 744 active hospitals listed in Canada, with a total of 115,000 beds. They admitted over three million patients and had more than 14 million emergency visits.

Constitutionally, the provision of health care, including hospital services, is an area of provincial/territorial (provincial) government responsibility in Canada. All provinces provide publicly funded health insurance for their residents. While there is some variation in the scope of provincial health care coverage, all include, at a minimum, medically necessary hospital and physician services.

Although jurisdiction over health care in Canada resides with the provinces, the Federal government plays an important role in the sector through federal health insurance legislation, the *Canada Health Act*.² The Act establishes criteria and conditions that provinces and territories must meet in order to receive full federal cash contributions under the Canada Health Transfer in support to insured services and extended health care services. These criteria include the following:

1 Other cost categories include nursing homes and other institutions (10%), other professional services (11%), public health and administration (6%), capital (4%), and other costs (e.g., research, medical transportation, occupational health) (9%). Canadian Institute for Health Information, *Health Care in Canada*, 2005, p. 27. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_43_E

2 *Canada Health Act*, R.S. 1985, c. C.6.

Public Administration

Provincial and territorial health insurance plans are to be administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions.

Comprehensiveness

The health care insurance plans of the provinces and territories must cover all medically-necessary hospital and physician services and, when the province/territory permits, services rendered by other health care practitioners.

Universality

All insured residents of a province or territory must be entitled to the insured health services on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Portability

Residents moving from one province or territory to another must remain covered for insured health care services by the "home" province during a waiting period, not exceeding three months, imposed by the new province of residence. Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

Accessibility

The health insurance plans of the provinces and territories must provide reasonable access to insured health care services on uniform terms and conditions.

These criteria or principles for public health insurance were reaffirmed in September 2004 in the 10-Year Plan for Strengthening Health Care in Canada developed between the federal government and the provincial and territorial governments.³

Most Canadian hospitals are not-for-profit entities owned by community-based corporations or religious organisations. A number are owned by provincial governments, municipal governments or universities.⁴ Private for-profit hospitals are rare in Canada and were generally excluded from receiving public subsidies when the provinces began funding hospitals. For the most part, the for-profit hospital sector consists of long-term facilities or specialised facilities such as addiction centres.

The overwhelming majority of hospitals in Canada provide services within the publicly funded health care system with those outside of the system being concentrated in services that are not covered by provincial health insurance. Parallel supply of publicly insured hospital services is not prohibited. However, it has been strongly discouraged by the existence of publicly financed health insurance schemes in all provinces. In addition, a number of provinces, including British Columbia, Alberta, Manitoba,

³ See <http://pm.gc.ca/eng/news.asp?id=260>

⁴ Provincial government ownership is concentrated in psychiatric hospitals.

Ontario, Quebec, and Prince Edward Island, prohibit private insurance coverage for publicly insured services.⁵

In most jurisdictions, responsibility for the development, oversight and allocation of funds to hospitals has been delegated to Regional Health Authorities (RHAs). RHAs were established in the late 1980's and 1990's in response to concerns that a highly fragmented health care system, with numerous local health boards, made it difficult to assign authority and responsibility, and implement coherent policies. Another reason for their creation was to decentralize the delivery of health services to improve integration of health care services based on community needs. RHAs are responsible for the planning and delivery of health care services within a specific geographic area. Depending on the area, these services may include health promotion and prevention activities, hospitals, community care, and long-term facilities. The boards of RHAs are composed of local citizens allowing communities to provide input into how local health care services are provided.

RHAs receive funds from provincial governments for carrying out their responsibilities. In 3 provinces this is done based on a population needs-based formula. In the remaining provinces, funding is according to historic global budgets. The RHAs allocate funds to, and enter into arrangements for the delivery of hospital and other health care services.

Canadian jurisdictions that have not established RHAs include Ontario, Prince Edward Island, the Yukon and Nunavut. In these jurisdictions, the management, funding and operation of hospitals remains under the control of the provincial or territorial government and local hospital boards.

Public funding accounts for 90 percent of all hospital funding in Canada with the remainder coming principally from ancillary operations (e.g., parking lots), donations, investment income and other sources.⁶ A variety of methods are used for allocating funds to the hospitals themselves. Some provinces use a primary method to allocate the majority of funds and a secondary method for specific purposes. The variations are noted in the table below.

Table 1. Methods of Funding Hospitals by Province⁷

Province	Primary Funding Approach	Secondary Funding Approach
British Columbia	Line-by-line and Population-Based	Policy-Based
Alberta	Population-Based	Policy-Based
Saskatchewan	Population-Based	None

5 The other four provinces, Saskatchewan, New Brunswick, Nova Scotia and Newfoundland, do not explicitly prohibit private insurance for publicly insured services but may have other regulations that discourage its development. The various provincial regulations affecting private payment for health care are reviewed in, Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada", *Canadian Medical Association Journal*, Volume 164 (6), 2001, pp. 825-830.

6 The division of funding for hospitals and other medically necessary services cannot be directly measured due to the manner in which federal funds are transferred to the provinces. Recent estimates put the shares of provincial versus federal government funding in the range of 75% versus 25%. See Report of the Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, Commissioner Roy Romanow, National Library of Canada, November 2002, pp. 65 - 66.

7 The Standing Senate Committee on Social Affairs, Science and Technology, Chair: The Honourable Michael J.L. Kirby, Deputy Chair: The Honourable Marjory LeBreton (2002) *The Health of Canadians - The Federal Role*, October, 2002, Volume 6: *Recommendations for Reform*, p. 28.

Manitoba	Ministerial Discretion	None
Ontario	Global Budget	Policy-based, Facility-Based. Population-Based and Service-Based
Québec	Line-by-Line and Population-Based	Population-Based and Service-Based
New Brunswick	Ministerial Discretion	None
Prince Edward Island	Ministerial Discretion	None
Newfoundland	Ministerial Discretion	None

All provincial governments use a project-based method for funding capital investments (hospital construction, major building renovations, and high-cost equipment purchases).

As indicated by the table, no provincial governments currently use service-based funding for hospitals. The approach has been used, in one case, to allocate supplementary publicly funding to hospitals in Ontario. However, as discussed further below, a number of conditions need to be met for the effective adoption of this funding approach on a broader scale.

2. Proposals for Pro-Competitive Hospital Reform in Canada

Market like incentives, such as service-based funding, and competition have traditionally played a limited role in the evolution of the Canadian hospital system. Rather, the development and restructuring of the system has been achieved administratively. For example, various Royal Commissions and similar inquiries conducted by the provinces in the 1980s and early 1990s found ample room for rationalisation and cost containment within the provincial hospital systems. Significant restructuring took place under budget constraints brought on by a recession in the early 1990s. Per-capita hospital bed capacity fell by about one-third while day surgery and other hospital-based ambulatory services increased dramatically.⁸

More recently, the potential for using pro-competitive reforms to further enhance the efficiency and quality of hospital services delivery has received increasing attention.⁹ Potential pro-competitive hospital reforms are most extensively considered in a Senate Committee Report, *The Health of Canadians - The Federal Role*, (the “Kirby Report”) completed in 2002.¹⁰ The Report recommends an evolutionary approach toward the introduction of internal markets for hospital services within the existing public health insurance framework.¹¹

8 For further discussion of this matter see Morris L. Barer, Steven G. Morgan and Robert G. Evans (2003) “Strangulation or Rationalization? Costs and access in Canadian Hospitals”, in, *Longwoods Review* 2003;1(4):10 - 19.

9 See, for example, supra note 6, esp’ly chs. 2-3, Premier’s Advisory Council on Health for Alberta, *A Framework for Reform: Report of the Premier’s Advisory Council on Health*, Chair: Right Honourable Don Mazankowski, P.C., O.C. December, 2001 and Atlantic Institute for Market Studies, *Definitely Not the Romanow Report*, December 2002, Section 9.

10 Supra note 6, chs. 2 - 3.

11 Retention of the single payer public insurance model for medically necessary hospital and doctor services is supported in the Report based on its findings that the model has broad public acceptance and provides various efficiencies including: administrative, economic and informational economies of scale; reduced costs associated with the marketing of, billing and collection of premiums for, and risk evaluation in support of competing health insurance schemes; and the avoidance of costs associated with adverse selection concerns. The reasons underlying the Committee’s support for the single payer system are outlined in The Standing Senate Committee on Social Affairs, Science and Technology, supra note 6, *Volume 5: Principles and Recommendations for Reform*, section 2.1.

As a first step toward broader pro-competitive hospital reforms the Report recommends that the provinces adopt service-based funding under which fixed prices would be set for different procedures based on the actual costs of doing them.¹² Payments to hospitals would be based on the number and types of services performed. Following the effective adoption of service-based funding, RHAs would be given the necessary authority to establish internal markets by competitively contracting for hospital services. Access to these markets might be made available to private-for-profit health service providers as well as not-for-profit entities.¹³

While interest in pro-competitive hospital reform appears to be increasing, important related questions and obstacles remain. They include the following:

- While there may be potential for incentives and competition to promote lower cost supply of hospital related services, the potential size and nature of these benefits remains to be determined.
- Implementation of service-based funding and internal markets would require substantial expenditures, for example, to put the necessary costing, measurement, regulatory and management systems in place. The size of these costs is also uncertain in relation to the potential benefits.
- Careful consideration is required of the feasibility of competition with respect to different hospital services and for different regions of the country. While it may be feasible in relation to relatively standardised services in densely populated areas, for other more complicated or rare services, teaching hospitals and less densely populated areas, the potential for competition may be limited.¹⁴
- The potential role of for-profit facilities in providing services that are currently provided by public hospitals and the potential implications of these facilities for the public hospital system remain to be determined.¹⁵
- The effective establishment of internal markets may require further devolution of control to RHAs and hospitals. In this regard, the Kirby Report indicates that a pre-condition for internal markets would be devolution of control over doctor services to the RHAs and hospitals to enable them to effectively contract for the supply of medical services.¹⁶

12 The transition to service-based funding is also supported by the Ontario Hospital Association. In this regard, see Ontario Hospital Association, *Advancing Accountability Through Hospital Funding Reform: A Policy Framework to Promote Greater Access, Efficiency and quality of Care*, April, 2004.

13 Similar elements are contained in the other reports referred to in note 8 above. However, the reports differ in terms of the scope of services to be covered and support for other health care reforms.

14 In a presentation to the Committee, Michael Decter, at the time the Chair of the Board of Directors for the Canadian Institute for Health Information, suggested that 70% of Canada's population resides in urban areas that may be sufficient to support internal markets. See *supra* note 6, p.73.

15 A number of concerns regarding the participation of for-profit entities in the supply of hospital services were expressed in *supra* note 5, pp. 6 - 8.

16 Currently, remuneration of physicians is a provincial government responsibility. Under the Kirby Report proposal, this function would be devolved to RHAs with hospitals being given greater control over hospital based physicians enabling them to contract to supply medical services. To enable seamless delivery of services through hospitals, the Kirby Report further recommended that they be given authority over spending on prescription drugs. See, *supra* note 6, ch. 3.

- RHAs currently do not exist in Ontario, the Yukon and Nunavut. Therefore, alternative means for organising internal markets in these jurisdictions would be required.
- In implementing service-based funding and internal markets, care would have to be exercised to ensure that it does not create incentives and opportunities for hospitals to over-service patients.
- While the introduction of service-based funding and competition would be for the purpose of promoting more efficient delivery of services, it may also create greater health care budget uncertainty that will have to be managed.

3. Competition Related Developments in the Canadian Hospital Sector

The developing interest in service-based funding and competition in the Canadian hospital sector has not yet resulted in substantial reforms. Nevertheless, some significant related developments have taken place over the past several years.

Within the existing single payer public health care framework in Canada, there has been some increase in the use of independent health care facilities (IHF) for the supply of surgery facilities outside of hospitals.¹⁷ IHFs have long played an important role in the provision of insured diagnostic services in Canada.¹⁸ In addition, they have played a significant role in providing facilities for insured ophthalmological and plastic surgery procedures as an adjunct to their provision of uninsured elective procedures. More recently, a number of RHAs have contracted with IHFs for the supply of other surgical procedures such as knee, hip, hernia and other day surgeries that would otherwise have to be performed within regional hospitals.¹⁹

As noted in section 1, the parallel supply of insured hospital services of the public system has traditionally been limited due to provincial restrictions against private health insurance; the existence of the tax-funded public health care system and restrictions against physicians operating jointly within and outside of the public system.²⁰ However, the limits of provincial restrictions of private health care have recently been called into question by the Supreme Court of Canada decision in the *Chaoulli* case.²¹ In the decision, the majority of the Court (four out of seven judges) struck down Quebec legislation prohibiting private health insurance for medically necessary health care services. They found that the legislation violated S.1 of the Quebec Charter of Human Rights and Freedoms, which provides that every human being has a right to life; to personal security; inviolability and freedom, due to lengthy wait times in the publicly funded health care system. However, with respect to Section 7 of the Canadian Charter which

17 For insured procedures, the IHF is given a facility fee only. Physician fees are paid directly by the province.

18 In Ontario alone there are some 1,000 IHFs providing insured diagnostic services.

19 See, for example, the *Calgary Health Region 2004 - 2005 Annual Report*, ch. 8, http://www.calgaryhealthregion.ca/bulletins/2004_2005_Annual_Report.pdf, *IH Tackles Waitlist with Help from Private Clinic*, B.C. Interior Health Authority press release, November 25, 2004, and *Increasing Private Delivery of Publicly Funded Services?*, Canadian Medical Association Journal, January 18, 2005, p. 167.

20 It may be noted that despite these limitations, a number of facilities exist in Canada providing essential surgical and emergency services entirely outside of the public health care system.

21 *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, <http://www.lexum.umontreal.ca/csc-scc/en/rec/html/2005scc035.wpd.html> In this case, the Supreme Court found Québec's legislative restriction against private health insurance to be in violation of the province's Charter of Rights.

provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice of the Court was evenly divided three-three as to whether the prohibitions violated it or not, with one judge not deciding the question.

The ruling has also fuelled much debate in the media and public throughout Canada. Although the Courts ruling does not strike down legislation in the eight other provinces and territories which are similar to that of Quebec, the decision has nonetheless had the effect of opening the door to discussions in other provinces and territories on the role for private health insurance for medically necessary hospital and physician services.

As the legislation at issue in this case is provincial in nature, the Supreme Court of Canada's decision does not have any immediate impact on the federal health insurance legislation - the *Canada Health Act*. This Act was not challenged in this decision, and the validity of the *Canada Health Act* was not questioned by the Supreme Court judges. Since the Court decided on the basis of the *Quebec Charter* and not on the basis of the *Canadian Charter*, the Court's ruling directly affects only Quebec legislation and the Quebec health care system. As the ruling of the Court came into effect immediately, Quebec applied to the Court for a temporary stay of the decision to provide the province with time to consider how to implement the Court's decision while ensuring a strong publicly funded health care system. The Court granted Quebec's request and has suspended the decision until June 2006. This means that Quebec's prohibitions on private insurance will remain valid until then.

4. Concluding Remarks

In summary, the potential use of incentives and competition to promote efficient delivery of hospital services is an area of increasing interest in Canada. The development of the Canadian hospital system over the past several years including, most notably their reorganisation along regional lines, has increased the potential to use competitive mechanisms. However, many obstacles to, and questions concerning the potential impact of such mechanisms remain to be resolved.

Given the limited amount of competition within the Canadian hospital system it has not been the subject of extensive study. Rather, the debate regarding the potential benefits and costs of competition has relied on evidence from other jurisdictions.²² It remains to be determined whether this evidence is applicable in the unique Canadian context.

22 See, for example, volume 3 of the Kirby Report.

DENMARK

1. Danish submission to Roundtable on Competition and efficiency in the provision of hospital services

The driving force regarding competition in the provision of hospital services in Denmark stems mainly from a free choice of hospital system, supported by the introduction of activity-based budget procedures. This is reflected in this submission which focuses primarily on these areas.

2. Background

Free medical treatment and equal conditions for all citizens is the fundamental principle of the Danish health system. Both the funding and the provision of health services are an integrated part of the public sector. The costs of the health system are thus borne by all citizens through taxes.

The 14 counties in Denmark are responsible for the public health sector. This responsibility regards the administration and funding of the public health insurance, and the operation of the public hospitals. In particular, a county is responsible for the medical treatment of the citizens living in the county. The counties are competing with each other in the sense that patients have a free choice of hospital option, which will be described below.

However, a substantial structural reform of the health sector is about to be implemented in 2007. The consequences of this reform will be explained below.

3. Consumer choice

In Denmark, payments follow the patient, who can choose freely among all public hospitals. In addition, if treatment cannot be guaranteed within two months, payments will follow the patient to private suppliers which may be located abroad. However, any excess transportation costs must be covered by the patient.

In Denmark, the trade off between efficiency and quality regarding hospital services has not been an issue. This is probably because of the free choice system in effect, which prevent the hospitals from cutting quality.

The free choice arrangement is based on two different systems, respectively *general free choice* and *extended free choice*.

The *general free choice system* was implemented in 1993. This system gives the patient the option to switch from the hospital in their home county to which the patient was originally referred, to a preferred hospital. Patients may switch to any of the public hospitals in Denmark but have to accept the waiting time of the particular hospital that is chosen.¹

¹ The waiting times of different hospitals are publicly available on the Internet

It is the hospital in the patient's home county that is responsible for the patient's treatment, and this includes the funding. Thus, if a patient chooses treatment in another county, a money transfer between the counties will take place. DRG-rates² are used to determine the size of such transfers.

There are no figures for the number of patients who use the free choice option within their home county. But in 2004, 12 percent of the hospital patients chose treatment in a hospital outside their home county. Since 1997, this number has increased continuously from 8 percent.³ Hence, the mobility of patients, though increasing, is still limited.

The general free choice system serves to create competition between the public hospitals. This has implied a larger degree of uncertainty with respect to the counties budgets. Especially the small counties have experienced a net loss of patients.

The experience with the general free choice system is that it induces competition on quality. There has been a tendency toward a harmonisation, on a higher level, of the quality level of services provided by different public hospitals, as the mobility of patients limits the scope for differences in quality levels. However, a detailed benchmarking system of different hospitals' quality levels is needed if the potential of the free choice system is to be fully exploited. This will be discussed below.

In addition to the general free choice system described above, the *extended free choice system* was implemented in 2002. This system gives the patient the option to switch to a private hospital, which may be located in Denmark or abroad, if the home county hospital cannot guarantee treatment within a period of two months. From 2007, the extended free choice will be available if treatment cannot be guaranteed within one month.

The extended free choice, however, is conditioned on the existence of an agreement between the society of the Danish counties and the private service provider.^{4,5} In addition, the waiting time of the private provider must not exceed the public hospital's waiting time.

The extended free choice system is (coupled with the general free choice) effective in keeping waiting times down. Furthermore, the extended free choice system increases the number of potential service providers of treatments for which there are long waiting times, and thus enhances competition between private providers as well as between public and private providers. However, in some cases it is difficult to create a competitive market for a service, because private providers are not ensured a constant flow of patients, as this flow is dependent on the length of the public hospitals' waiting lists which vary over time.

The extended free choice system adds some pressure on the counties' budgets. When patients are treated by private suppliers, the counties pay the bill and save the variable cost of the treatment. But in addition, they still need to cover their own fixed costs of hospital capacity.

The number of patients who have used the extended free choice system has increased continuously since the introduction of the system. However, the use of the system is still rather limited.

2 DRG (Diagnostic Related Groups) is an accounting system that categorises medical treatments into more than 500 groups.

3 Source: "Sundhedssektoren i tal September 2005", *The Ministry of the Interior and Health*, page 37.

4 Complaints regarding such agreements can be submitted to the Minister of Health.

5 Agreements have so far been made with 160 private service providers, 20 of which are located in Sweden and Germany.

In 2004 an evaluation of the extended free choice system was carried out. One of the problems with the system has been the rates at which private suppliers are compensated by the counties. These have been based on DRG-rates. It seems however, that the DRG-rates used have been too broadly defined, as they are average rates for relatively broad groups. This has to some extent induced different kinds of cream-skimming.

Private providers chose only to setup agreements on the most profitable types of treatments within DRG-groups. In other cases, private suppliers refuse to accept complicated patients. Furthermore, it has been difficult to establish agreements about treatments that have long and uncertain durations. These problems limit the effect of the extended free choice system, as not all kinds of treatments are available for the patient outside the public system.

The Danish National Board of Health is currently improving the cost database that the DRG-rates are based upon. This should enable the estimation of rates that are more specific to the particular type of treatment and procedure in question. However, as suggested in the evaluation rapport of the extended free choice system, there should still be room for negotiation of the rate in the specific case to smoothen the system.

4. Paying for performance

At the moment, hospitals are not directly rewarded for the quality level of their services. However, a high quality level will attract patients through the free choice system. Hence, hospitals will benefit indirectly from a higher quality level in the service provision.

On the other hand, paying for performance with respect to the quantitative output has been in effect the last couple of years. In order to improve the efficiency of hospitals through incentives, an output-based budget procedure based on DRG-rates was introduced in 2002. This has implied that 20 percent of the funding of the hospitals is now based on activities. This percentage will be increased to 50 in 2007. The new budget procedure gives the hospitals a financial incentive to increase their activity.

Furthermore, with the aim of rewarding the most efficient hospitals, a so called 'additional activity fund' was established in 2002. This fund rewards the hospitals that have produced the largest productivity increases. The annual amount of money paid out from the fund corresponds to approximately 2.5 percent of the total spending on public hospitals. This amount is planned to increase to 5 percent within the next couple of years.

The experience with the output-based budget procedure and the 'additional activity fund' was evaluated recently.⁶ The conclusion of the evaluation report is that these new instruments have successfully increased the productivity of the public hospitals. The annual number of operated patients has increased by 15 percent from 2001 to 2004. This increase however, is also partly due to the introduction of the extended free choice system. In the same period, the average waiting times have been reduced by 26 percent.

The further combination of the free choice system and the output-based budget procedure has increased the general productivity of hospitals. The free choice system enables hospitals with a high productivity to increase their demand by 'stealing' patients from other hospitals. This is because the waiting time is an important parameter when a patient chooses his preferred hospital. Counties with productive hospitals have thus increased their activity and attracted patients from other counties.

⁶ Source: "Evaluering af takststyring på sygehusområdet", May 2005, *The Ministry of the Interior and Health*.

The introduction of the output-based budget procedure has not increased costs. Also, no significant change in the pattern of the kinds of treatments carried out on different hospitals has been observed. Furthermore, no relationship between the introduction of output-based budget procedures and the quality of services has been experienced so far.

However, in order to better exploit the potential of the output-based budget procedure, it has been noticed that the DRG-rates need to be improved. It is e.g. important that the DRG-system supports coherent courses of treatment, as well as the continuous technological development with respect to treatments.

5. Benchmarking

Systematic benchmarking of hospitals with financial consequences is not employed in Denmark yet. The type of benchmarking that is observed is related to efficiency standards rather than quality standards.

Nevertheless, in order for the free choice of hospital system to function efficiently, a comprehensive benchmarking system based on the quality of services is required. The patients need to be able to compare the offers from different hospitals. Therefore, an independent institute, with the sole purpose of developing a national benchmarking system for the quality of medical services, has just been established in Denmark.

The benchmarking system will cover all medical service providers financed by the authorities, and the results will be publicly available. In the longer run, some of the funds from the 'additional activity fund' will be distributed according to quality standards revealed by the benchmarking system. The benchmarking system is expected to be implemented at the end of 2006.

6. Outsourcing

Outsourcing of essential medical services is not very common in Denmark. However, a few examples have been observed. These include the outsourcing of particular heart disease treatments, special hip operations, treatments for cataract and MR-scanning.

Outsourcing is mainly observed in relation to non-essential services, such as cleaning, catering etc, where the transaction costs are low due to well-defined administrative rules.

However, an increase in the use of the free choice systems might induce more outsourcing, since it puts pressure on the counties budgets due to more competition. Such pressures might induce a more efficient resource allocation, which could include the outsourcing of tasks better suited for private provision. On the other hand, an increased use of the extended free choice system can serve as a substitute to outsourcing, if certain types of operations end up being supplied primarily by private providers.

7. Future developments

A larger reform of the health system's administrative structure is going to take place in 2007. The 14 counties responsible for the health system today will be reduced to 5 competing health regions. These regions will be required to use activity-based budget procedures to a large extent in the funding of the hospitals.

The reform will also affect the way public hospitals are financed. Today, the hospitals are financed primarily through taxes collected by the counties who run the hospitals. After 2007, the regions responsible for the hospitals will be financed through a subsidy from the state. The size of the subsidy will depend on the composition of the population in the regions. Thus, the soft budget constraint which exists in the

counties today will be removed. In addition, it will secure equal economical conditions for the different regions and hence a fair competition.

In addition to the subsidy from the state, the local authorities will contribute to the funding of the future health regions. The size of the local authorities' contribution will depend on the activities provided by the hospitals for patients from each municipality. This is to create incentives for the local authorities to carry out prevention activities relevant for health care; as such activities would reduce the local authority's contribution to its health region. Thus, the aim is to construct a health system that integrates prevention activities with the treatment of the patients.

FRANCE

Le système hospitalier français met en présence plusieurs acteurs au sein d'une **organisation qui n'est ni totalement libérale, ni totalement centralisée** : le financement des dépenses¹ repose essentiellement sur des prélèvements obligatoires (cotisations basées sur les salaires, CSG), avec mise en œuvre de la solidarité nationale (redistribution des bien-portants au profit des malades, des jeunes au profit des vieux, des riches au profit des pauvres). Tout résident est obligatoirement affilié à une caisse d'assurance maladie, qui lui rembourse une partie des dépenses de santé engagées ; les assureurs complémentaires, qui sont majoritairement des mutuelles à but non lucratif, interviennent uniquement pour assurer un complément de remboursement, selon des modalités variant d'un contrat à un autre.

Quelques chiffres :

En 2003, le nombre de lits d'hôpitaux pour soins aigus s'élève à 3,8 lits par milliers d'habitants en France, un nombre assez proche de la moyenne des pays de l'OCDE². Le nombre de lits d'hôpitaux disponibles par habitant a diminué au cours des vingt dernières années (réduction de la durée moyenne des séjours à l'hôpital, recours accru aux soins de jour sans hébergement à l'hôpital).

Les dépenses effectives de l'assurance maladie se sont élevées en 2004 à 130,4 Md€, les établissements d'hospitalisation ayant reçu environ 59 M€.³

1. Cette organisation, ajoutée à d'autres facteurs, rend difficile la régulation des dépenses de santé par la demande.

En effet, le consommateur, entièrement libre de ses choix, n'est pas incité à acheter des prestations hospitalières au meilleur rapport qualité/prix :

- De toutes façons, il ne dispose pas des connaissances médicales nécessaires pour choisir le traitement le plus adapté à sa maladie. Seuls les médecins détiennent cette connaissance (asymétrie d'information dans le diagnostic, le traitement et l'efficacité des soins) ;
- Par ailleurs, le prix n'est pas pour lui un critère de choix : d'une part, le consommateur ne connaît pas le coût réel de son hospitalisation, le système du tiers payant conduisant l'assurance maladie et l'assureur santé complémentaire éventuel à payer directement l'hôpital, le consommateur finançant uniquement les sommes restant à sa charge ; d'autre part, sur un plan individuel, chaque consommateur estime que sa santé n'a pas de prix et sa demande de soins a tendance, de ce fait, à être illimitée ;

1 76,3% des dépenses de santé sont financés en France par des fonds publics (source = « Eco-Santé OCDE 2005 : comment la France se positionne »)

2 Source : « Eco-Santé OCDE 2005 : comment la France se positionne »

3 Cour des comptes septembre 2005 : 50 583 M€ pour les établissements sous dotation globale et 8 200 M€ pour les cliniques privées

- Enfin, des études ont montré l'induction de la demande par l'offre : il y a un rapport positif entre le nombre de journées d'hôpital et le nombre de lits disponibles pour 1 000 habitants⁴.

En forçant le trait, le consommateur n'achète rien : il s'en remet à son médecin (décision d'achat), puis à ses assureurs (paiement des soins). Dans cette organisation, les hôpitaux ne sont pas mis en concurrence. Seuls quelques assureurs complémentaires proposent des remboursements améliorés aux assurés acceptant de se faire soigner dans des établissements présélectionnés selon des critères du meilleur rapport qualité / prix. La responsabilisation financière du consommateur est donc embryonnaire et dépend de l'importance des sommes restant à sa charge.

2. Les pouvoirs publics ont donc essayé de réguler les dépenses hospitalières en pilotant l'offre de soins.

En France, le secteur hospitalier comprend un secteur à but non lucratif (établissements publics ou privés participant au service public hospitalier) et des cliniques privées à but lucratif.

Si l'on se réfère à l'étude de la Fédération hospitalière de France en 2001, les établissements du secteur non lucratif réalisent près des 2/3 de l'activité d'hospitalisation traditionnelle, soit 81% en médecine, 66% en obstétrique, 50% en chirurgie.

Le pilotage de la politique hospitalière est assurée, au niveau central, par le ministère de la santé et, au niveau régional, depuis 1996, par les agences régionales d'hospitalisation (ARH) qui regroupent au sein d'une même structure les services locaux de l'État (ex-tutelle des hôpitaux publics) et de l'assurance maladie (ex-tutelle des cliniques privées).

L'organisation de l'offre de soins consiste à planifier sa répartition sur le territoire en fonction des besoins de la population et à l'orienter en vue de son adaptation aux besoins. Il s'agit d'appréhender l'organisation des soins dans sa globalité et non plus par secteur (hôpital public, clinique privée, soins de ville). Le pilotage concerne l'implantation

- Des activités de médecine, chirurgie et obstétrique (MCO), de psychiatrie, soins de suite ou de réadaptation (SSR) et de soins de longue durée ;
- De certains équipements matériels lourds (ex. appareils d'imagerie par résonance magnétique, mammographies,) ;
- Des activités de soins de coût élevé.

Les ARH ont le pouvoir de délivrer des autorisations pour ces installations. Elles concluent par ailleurs des contrats avec les établissements hospitaliers (« contrats d'objectifs et de moyens » « projet d'établissement »), contrats qui fondent le financement alloué aux structures hospitalières.

La recomposition de l'offre de soins passe notamment par la promotion de la coopération entre les établissements hospitaliers quel que soit leur statut, public ou privé, (ex. la création de groupements pour gérer des équipements d'intérêt commun). La procédure d'accréditation des établissements hospitaliers doit permettre de s'assurer qu'ils développent une politique d'amélioration continue de la qualité et de la sécurité des soins délivrés aux patients.

Cette organisation montre que le secteur hospitalier est un secteur

4 Source OCDE 1983 repris dans le livre de Michel Mougeot « Systèmes de santé et concurrence »

- Soumis à de fortes barrières à l'entrée,
- Où la pression concurrentielle entre établissements hospitaliers est faible. Outre que les capacités hospitalières sont inégalement réparties sur le territoire⁵, ce qui signifie pour le consommateur une inégalité de l'accès aux soins, la logique du pilotage n'a pas pour conséquence d'accroître la concurrence inter établissements : essayer de structurer l'offre en fonction des besoins revient parfois à éviter une dispersion excessive des moyens, à fermer des services ou centres en surnombre et/ou ne répondant plus aux exigences de sécurité exigées par la loi, à spécialiser les structures hospitalières dans leurs pôles d'excellence respectifs.

Par ailleurs, la régulation de structures hospitalières menée par le ministère de la santé et les ARH heurte parfois des sensibilités locales, la population ou les élus locaux n'appréciant pas la fermeture de tel service ou établissement.

Dans ces conditions, le secteur ne peut se réguler par le simple jeu du marché, puisqu'il n'y a pas de réelle confrontation entre une offre et une demande et que les offreurs – quand ils sont plusieurs - ne sont pas en concurrence véritable.

3. Pour réguler les dépenses hospitalières, les autorités françaises ont donc tenté d'agir sur le financement alloué aux hôpitaux.

- Jusqu'en 1983, les sommes allouées aux hôpitaux relevaient d'un paiement à l'acte en fonction du nombre de journées d'hospitalisation. Le prix de journée était calculé a priori par la tutelle en fonction d'un prix de revient prévisionnel et remboursé a posteriori par l'assurance maladie. L'absence de contraintes budgétaires durant une certaine période a conduit au développement de la médecine de pointe mais aussi à une envolée des dépenses hospitalières. Les limites du système ont été identifiées - surproduction et « sur qualité⁶ » de soins - puisque :
 - Les tutelles n'avaient pas les moyens d'identifier les manipulations comptables conduisant à la définition du prix de journée a priori,
 - Les hôpitaux avaient intérêt à adopter des stratégies de maximisation du taux d'occupation.
- En 1983, le système a donc été abandonné pour les hôpitaux publics, qui ont dû ajuster leurs dépenses sur un budget global calculé *ex ante* par la tutelle, à partir du budget de l'année précédente. L'inflation des dépenses hospitalière a certes été freinée mais, face à la fixation d'une contrainte financière a priori, les établissements hospitaliers ont réagi, en réduisant la durée du séjour et le nombre de journées d'hospitalisation (réductions en volume), voire en réduisant la qualité des services offerts. Dans la réalité, cette réforme a conduit au résultat paradoxal que le prix de la journée d'hospitalisation a augmenté⁷ (les budgets ont augmenté pendant que le nombre de journées d'hospitalisation diminuait). Enfin, le mode de calcul retenu pour la fixation du budget global a entretenu et amplifié les

5 Cour des comptes septembre 2002 « La sécurité sociale » : les excédents les plus élevés (plus de 40%) sont situés en PACA, Languedoc-Roussillon et en Corse ;

6 Utilisation de techniques de pointe coûteuses là où une technique classique suffirait, multiplication des analyses préalables,

7 Mougeot : « Système de santé et concurrence »

inégalités existantes dans les dotations financières des établissements, sans prendre en compte l'évolution de l'activité réelle des hôpitaux.

- c) L'introduction de la tarification à l'activité (T2A) à partir de 2004⁸ modifie profondément le financement des établissements hospitaliers. Les hôpitaux recevront un forfait calculé par l'État (forfait à la pathologie ou « groupe homogène de malades ») qui correspondra à la prestation rendue. Ces forfaits sont calculés grâce aux données relatives à l'activité des hôpitaux recueillies par le programme de médicalisation des systèmes d'information (PMSI). La fixation de ces forfaits est assortie de quelques souplesses, notamment :
- Il existera deux échelles de forfait : l'une pour les établissements relevant du « secteur public », l'autre s'appliquant aux cliniques privées lucratives ;
 - Les forfaits pourront être majorés ou minorés de plusieurs suppléments en fonction de la durée du séjour ;
 - Les urgences feront l'objet d'une enveloppe forfaitaire à part, etc.....

Ce système introduit une concurrence « fictive » par les prix : les établissements ne sont pas en concurrence réelle mais le financement sur la base d'un prix fixe conduit chaque hôpital à comparer ses coûts réels au prix qu'il reçoit. L'hôpital est ainsi mis face aux conséquences de ses choix thérapeutiques (compétence de ses médecins - sur-qualité) et/ou économiques (qualité de la gestion et de la politique d'achat, bon arbitrage entre des prestations réalisées en interne et celles externalisables, comme par exemple la réalisation des analyses de biologie, la gestion du linge et/ou la restauration, niveau d'équipement ;).

4. Ce nouveau mode d'allocation des ressources sera-t-il efficace ?

Il est bien trop tôt pour pouvoir tirer des enseignements de cette dernière réforme qui est entrée en application pour les cliniques privées lucratives en 2005, et dont la mise en œuvre sera plus progressive pour les hôpitaux relevant jusque là du budget global.

Il ne peut cependant être exclu que certains établissements hospitaliers trouvent des stratégies de contournement leur permettant de conserver une partie de leur rente de situation (chaque réforme a constaté a posteriori la mise en place de telles stratégies) : manipulation des codages, diminution de la qualité des soins dispensés,

Les conséquences fâcheuses de la tarification à l'activité constatées aux États Unis – sélection des malades et spécialisation des hôpitaux dans l'activité pour laquelle ils sont performants – ne semblent pas totalement transposables en France : les établissements relevant du service public hospitalier ne peuvent théoriquement pas sélectionner leurs malades ; les ARH doivent s'assurer que la population peut accéder à l'ensemble des soins nécessaires au maintien de sa santé.

Certaines études universitaires⁹ insistent sur la nécessité de prendre en compte l'hétérogénéité existant entre les établissements hospitaliers, c'est-à-dire de faire une application raisonnable de la T2A, qui ne saurait conduire de façon aveugle à un alignement général des prix sur le forfait calculé par la tutelle.

⁸ Loi de finances de la sécurité sociale du 18 décembre 2003

⁹ « Systèmes de tarification et évolution de la variabilité des coûts en France et aux États Unis » : Carine Milcent, Brigitte Dormont, Éric Delattre, Mark McClellan

Le succès de cette réforme dépendra en partie de la capacité des autorités de tutelle à appréhender cette notion d'efficacité, grâce à des outils permettant de

- Mesurer la qualité des soins,
- Comprendre l'hétérogénéité des coûts constatés pour un même acte : différence liée aux patients (légèrement ou gravement malades), aux techniques de soins mises en œuvre, au niveau de sécurité et de compétence offert, à l'organisation et à la gestion de l'établissement ?

Les hôpitaux auront naturellement un grand rôle à jouer. Dans la mesure où le nouveau mode de financement n'a pas prévu de « récompense » financière particulière pour les bons gestionnaires, les établissements seront d'autant plus incités à réduire leurs coûts que les forfaits auront été fixés à un niveau pertinent, c'est-à-dire à un niveau permettant de fournir des soins à moindre coût, sans sacrifier la qualité ou sélectionner les maladies « rentables ».

GERMANY

1. Introduction

The organisation of the German health care system is based on the principle of subsidiarity of state action. The state – in Germany the federal government as the central power and the *Länder* – should only take on those tasks which cannot be appropriately accomplished by other institutions. The implementation of the principle of subsidiarity in the German social security system therefore requires, to a large extent, the self-management of health insurance funds, hospitals and registered doctors. The state's sole task is to provide the necessary legal framework. On the basis of this regulatory framework co-operation between those responsible for self-management in the health care system takes place independently.

2.. The Structure of the German Hospital Sector

2.1. *Regional structure of the hospital sector*

In the German hospital sector the responsibility for capacities and the provision of health care services lies mainly with the 16 *Länder*. They have to ensure the provision of area-wide in-patient medical care for the population. In their respective hospital laws, the *Länder* have included the administrative districts and independent cities in the task of providing hospital care. Where no other suitable hospital operator can be found the local municipalities are obliged to build and run hospitals to ensure health care services for the population in their areas. However, so far such an emergency has never occurred.

2.2 *The principle of hospital operator diversity: state hospitals, non-profit and private hospitals*

German hospital law postulates the principle of operator diversity. Accordingly, the existence of non-profit and private hospitals has to be guaranteed. The principle prohibits that state hospitals or municipal hospitals be given priority over private and non-profit hospitals.

Health care services are provided as follows: 37 per cent by public hospitals (municipalities), 41 per cent by non-profit hospitals (operated by churches, foundations and other non-profit organisations) and 22 per cent by private hospitals; in addition, there are 34 *Länder*-supported university hospitals. In contrast to many other states the German hospital sector is therefore not dominated by state hospitals. It is to be expected that the number of public hospitals will fall while the number of private hospitals will increase, because more and more municipal hospitals are being purchased by private hospital chains. In addition, some hospitals are owned by a municipal authority but are run by a private operator on the basis of a management contract.

In principle, the patients, both those with private health insurance and those with statutory health insurance, can choose freely among the registered hospitals. The costs are borne by the health insurance funds; travel expenses for long journeys to distant hospitals which are not medically indicated are not covered, however.

Another important factor is that all hospitals, including the public hospitals, are independent in their structure and organisation. The recruitment of doctors or administrative staff is not subject to state

regulation. The outsourcing of certain areas, such as kitchen and laundry services, is allowed, as well as the external operation of dormitories, provided overall responsibility remains with the hospital.

3. Requirements Planning in the German Hospital Sector

Due to the regional structure of hospital care the federal *Länder* each prepares a hospital plan according to which the respective regional requirement planning is conducted. On the basis of these hospital plans, hospitals are categorised under three different health care levels.

- Basic and regular care: local health care of the population, comprising health care services in the fields of surgery, internal medicine and gynaecology.
- Central health care: various specialisations in addition to basic care.
- Maximum health care: the complete spectrum of in-patient health care services (university hospitals and several large municipal hospitals).

In general, the hospital plans are drafted on an annual basis. The basic conditions such as population numbers; population structure; morbidity; new and improved methods in diagnostics and therapy; new forms of health care service organisation or health care laws, are constantly changing.

In order to operate, a hospital does not have to be listed in the respective hospital plan of a *Land*. However, to be able to provide in-patient treatment covered by statutory health insurance funds, hospitals must either be listed in a Land hospital plan or have a provision contract with the health insurance fund associations. Being included in a hospital plan is also important with regard to investment assistance grants. Only those hospitals that are included in a hospital plan receive grants from the respective federal *Land* for the purchasing or replacement of equipment and other long-term investments. The regular payment for hospital services in the form of hospital allowances does not cover such investment costs (so-called “dual financing”). In accordance with the principle of diversity in the ownership of hospitals, apart from public hospitals about 80 per cent of the private hospitals in Germany are also included in the hospital plan of a *Land*. Each year the *Länder* raise just under 3 billion Euro for investments in the hospital sector.

Due to the fact that the granting of investment assistance and the accreditation for health care services covered by the statutory health insurance funds are conditional upon a hospital being listed in a hospital plan, the drafting of the plans also has a regulatory effect with regard to market entry. The objective of the requirements planning of the *Länder* is to prevent the oversupply and misallocation of hospital services and to ensure the necessary level of supply.

Nevertheless, the requirements planning of the *Länder* was not able to prevent overcapacities in the past. A limitation of the number of health care providers as a result of requirements planning has proved difficult, in particular for political reasons. According to the German Federal Statistical Office¹ in 2004 there were 2.157 hospitals in Germany (preventive care and rehabilitation centres excluded) with approximately 528.000 planned beds. The average bed occupancy was 77.6 per cent² (2003), the average hospital stay 8.7 days. Compared to previous years there has been a steady cost increase in health care services while the measurable quantity of services has dropped just as steadily. This applies to the number of hospitals, planned beds, patients, the average duration of hospital stays and the average bed occupancy. The overall effect of these developments is that considerable overcapacities have emerged, in particular in the conurbations. These overcapacities ultimately lead to a competition for patients. The exact size of these

1 Status 29 April 2005, the data for 2004 are still preliminary.

2 In the opinion of the *Länder* the ideal bed occupancy rate would be 85%.

overcapacities is unclear. Some claim that around 80.000 beds are redundant. Indeed, with 64 beds per every 10.000 inhabitants Germany ranks first in Europe.

It are therefore health insurance funds in Germany, in particular, that criticise the requirements planning as being too statistic and inflexible. They claim that many of the hospitals listed in the hospital plans are no longer necessary to meet requirements.

4. Remuneration of Hospital Services

The previous hospital financing system focused on the costs incurred by the hospitals, not on the services they actually provided. With the Health Reform undertaken in 2000 the system was therefore changed from financing costs to financing services. The conversion to the system of Diagnosis Related Groups, DRG, which had been optional since 1.1.2003, became binding as of 1 January 2004. As of this date almost all hospital services have been covered by DRGs.

One of the objectives of such a service-oriented grouping system is to avoid wrong incentives emanating from a remuneration system based on patient days, which leads to patients staying longer, and to replace it by a performance-oriented remuneration system which provides sustainable incentives for economic efficiency. Another essential aspect in this context is the fact that the introduction of DRG in Germany has improved transparency regarding the type and volume of services provided by hospitals. This increased transparency provides information on the hospitals' areas of focus and specialisation and makes it possible to compare individual clinics (benchmarking). These improved possibilities of comparison have also strengthened the health insurance funds' strategic position in budget negotiations with the hospitals.

Although the DRG system only became binding in Germany in 2004 and quantitative data on initial experience with its implementation are still limited, the providers of hospital services are already reacting to financial incentives for a more efficient provision of hospital services. The following reactions can be observed:

- Reduced length of stay within acute in-patient units
- Improvement of the economic framework conditions for service provision: Increasing number of mergers and co-operations between hospitals, more systematic admission and discharge of patients, optimisation of internal processes (e.g. by using clinical treatment paths)
- Indications of increased orientation towards the patient's needs: avoidance of unnecessary waiting time for diagnosis and surgery through optimised process organisation, enhanced service structures in the different regions through increased co-operations, emergence of competence centres, improved quality of medical services through increasing specialisation.

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

5. Ensuring the Quality of Hospitals

In Germany, great emphasis is placed on quality assurance. Hospitals which do not adhere to agreed measures of quality assurance may therefore e.g. have to face cuts in remuneration.

The following quality assurance measures are applicable to hospitals:

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

The conflict between efficiency and quality is of particular significance since the German hospital market is characterised by large overcapacities which result in fierce competition between the hospitals. Hospitals can only be competitive in the long term if care is taken to ensure the quality of their services. In order to deal with this conflict between efficiency and quality there must be an improvement in transparency in health-care services. This cannot only be achieved by implementing the DRG system per se. In Germany, the publication of quality reports also contributes to meeting this objective. On the basis of these quality reports accredited physicians and the insured persons can be provided with comparative information on the hospitals' quality characteristics, and health insurance funds can recommend certain hospitals. Furthermore, information on the effects of the DRG system, also on the quality of care, is to be gained through accompanying research on the new remuneration system to be carried out by the parties involved in the self-management system. Adequate transparency on the provision of in-patient care ultimately also enables the German *Länder*, which are in charge of hospital planning, to check compliance with their provisions on in-patient care.

6. Competition Law Enforcement

6.1. *Applicability of competition law in the hospital sector*

Competition law, and in particular merger control, is applicable to the hospital sector without limitations, notwithstanding the fact that the hospital market is a highly regulated market. However, it should be noted that due to the turnover threshold of EUR 500 Mio. per year only mergers with overall economic significance are notifiable to the Bundeskartellamt. Internal consolidations of a hospital operator are not subject to merger control and mergers between public and non-profit hospital owners usually do not reach the turnover threshold indicated above.

Social law and hospital planning on the one hand and merger control on the other regulate completely different areas. Social law regulates the service relations between health insurance funds and service providers in the health care sector. The objective of hospital planning is to provide requirements-oriented acute hospital care for the population. Merger control, on the other hand, aims at maintaining competitive framework conditions in this economically highly significant and socially sensitive area where planning requirements and market-economy control mechanisms exist alongside one another. Enforcing competition as a controlling mechanism does not jeopardise the provision of health care services to the population but ensures a long-term offer of choices for patients in the interest of high-quality care. In addition, the

decisive factor is the relationship between patients and hospitals. The patients are direct consumers of hospital services. They decide independently whether to go into a hospital, and if so, which hospital to choose.

Moreover, despite high regulatory density, hospitals still have sufficient scope for competitive action. Particularly because patients can choose freely between hospitals, the latter compete against each other without restrictions in terms of quality and investment. This competition applies to the main medical services and nursing services, as well as other factors, such as the attractiveness of rooms, e.g. in terms of size, sanitary facilities and bed occupancy, or the quality and range of the food offered.

6.2. *Individual cases of merger control*

Due to the existing overcapacities in the hospital sector new hospitals are rarely opened. Consequently, there is strong competition for the acquisition of established hospitals. This competition mainly takes place between private hospital operators, in particular large hospital groups. Public or non-profit operators only pursue an acquisition policy at a local level, if at all, due to their lack of capital. At least no case is known where a public or non-profit operator took over a hospital which before was under private ownership.

This year the Bundeskartellamt for the first time prohibited two mergers in the hospital sector; in both cases a large private hospital group had planned to acquire public hospitals which would have led to a strengthening of its dominant position. Another case was only allowed subject to conditions. Both prohibition decisions have been appealed against. The parties to the merger doubt the applicability of the Act against Restraints of Competition. The undertakings have claimed that competition law is not applicable to their case because the competitive situation in the German hospital sector is regulated by the state in the form of numerous social provisions and the hospital planning of the *Länder*. The Bundeskartellamt, however, assumes unlimited applicability of competition law.

In the cases named above the product and geographical market definition is controversial. The product market affected is the market for acute hospitals. The market comprises of all general hospitals and specialised clinics in Germany. A more narrow market definition, e.g. involving specialised hospital departments, is considered inappropriate as two thirds of all hospital beds are accounted for anyway in the specialised areas of internal medicine, surgery and gynaecology which can be found in almost any general hospital. In addition it was established that the distinction between specialised departments is blurred in medical practice and that the hospitals' areas of activity overlap one another. Therefore general hospitals are competitors of specialised clinics in terms of product. Out-patient treatment as well as rehabilitation and other nursing centres are not covered by this product market. From the patient's perspective, the services provided by these institutions cannot be substituted by hospital services. While hospital treatment is concerned with combating diseases, rehabilitation treatment aims at preventing, removing or improving the consequences of diseases, such as ability dysfunctions or impairments.

To define the geographical market the Bundeskartellamt conducted a comprehensive survey of patient flows. The investigations showed that a vast majority of patients only choose hospitals located within a relatively short distance to their home.

Based on the number of hospital cases the Bundeskartellamt established the market position of the hospitals involved in the affected product and geographical markets. The planned mergers would have resulted in an increase of market shares of approx. 25% to approx. 65% or 75%; the market share lead over the next largest competitor would have been well above 50%. Also with regard to other competitive structural factors, such as financial resources, product range and access to the sales market, the parties to

the merger were in a much more advantageous position than other competing hospitals which was another reason to expect a strengthening of dominant positions in the hospital market.

ITALY

1. Structure and organisation of the SSN

The Italian national health service (so-called *Servizio Sanitario Nazionale*, SSN) was established in **1978**¹ with the objective to guarantee uniform health assistance to all citizens, independently from their social, economic and employment conditions, and was intended to be financed entirely from general taxation. The SSN was going to be implemented by regional and local bodies, responsible for the delivery of health services (Local Health Units, *Unità Sanitarie Locali*, USL).

With the **1992 reform**², the principles of “private” management were introduced in the system and the Local Health Units were transformed in Local Health Care Enterprises (*Aziende Sanitarie Locali*, ASL), under the direction of managers appointed by the Region on a contractual basis with performance related remuneration. At the same time major hospitals (all part of Public Administration) were transformed into Hospital Enterprises (without any change in ownership).

With the **1999 reform**³ the services to be provided by the SSN are decided with reference to the health care needs in the territory as determined by the Regions. Given the general goal of increasing efficiency and reducing costs in the provision of health care services, the reform set limits to the entitlements to health care: in particular, the SSN guarantees only services which are “necessary, effective, appropriate and efficient”.

The constitutional **reform of 2001**⁴ completed the transformation of the SSN into a regional system, with the progressive reduction of the transfers from central government, substituted by a pre-established share of tax revenues originating in the Region. A twelve year period was established in order to achieve a “uniform and essential” level of health care (*Livelli Essenziali di Assistenza*, LEA) throughout the country: a national health fund was established in order to supplement regional funding when needed. By 2003 own-source revenues of the Regions averaged 53%, with some less wealthy Regions receiving proportionately more financial resources from central Government. Conversely, wealthier Regions are bound to fully finance their health care expenditure.

The SSN is articulated on three levels: the State, the Regions and the local units, and the most relevant role in the management of the system is attributed to the Regions, that act through the ASL. In this framework, the State, through the Ministry of Health, is responsible for:

- The adoption of the national health plan (*Piano Sanitario Nazionale*, PSN), that specifies the essential and uniform level of assistance and the general and strategic objectives to be achieved. The Plan is adopted every three years by the conference of State and Regions and provides an

1 See law n. 833/1978.

2 See the Legislative Decree n. 502/1992 and Legislative Decree n. 517/1993.

3 See the Legislative Decree n. 229/1999 and its integrations and modifications.

4 See the Legislative Decree n. 56/2000 and the law n. 3/2001.

updating of the essential level of assistance, considering the evolution of health conditions in the population and the technological and scientific progress;

- The financing of the SSN and its distribution between the regions;

The law attributes to the Regions the power to implement and apply legislative and administrative measures in the field of health care, given the level of essential health assistance fixed in the National Health Plan. In particular, the Regions are responsible for:

- The adoption of the regional health plan in conformity with the national health plan;
- Ensuring the optimal distribution of the health care structures (hospitals, ambulatory, speciality centres) on the territory, in order to guarantee the provision of the essential level of assistance;
- The standards for reimbursement of ASL and hospitals;
- The control over the performances of the providers of health care services.

Finally, the Regions can implement the essential levels of assistance with additional services, to be financed with internal resources, in order to comply with the health assistance needs of the local population.

The ASLs on their part must ensure the level of assistance established by the national health plan: the local units are autonomous in their organisation, management and accounting, but have the obligation that all costs be fully covered. The ASLs perform a double role in the system. On the one hand, they are public purchasers, in the sense that they pay health service providers, whether these are internal suppliers (directly managed hospitals, ambulatory care facilities and others) or external suppliers (hospital trusts, public teaching hospitals, non profit and for profit hospitals, non profit and for profit ambulatories, pharmacies), for services delivered to SSN patients. Furthermore, national legislation requires the ASLs to negotiate bilateral agreements with private and public providers in order to acquire health care services: the effective freedom of choice of the ASL in the purchasing decisions depends on the regulation established within each Region. On the other hand, ASLs have direct responsibility in the management and supervision of public health care facilities, as well as in the provision of hospital services.

The SSN includes both private and public structures: the access by private operators to the SSN is regulated by law and is conditioned to the obtaining of:

- The local authorisation for the building of the structure and for the provision of health care services (based only on objective parameters);
- The accreditation by Regional Authorities ;
- After being accredited, the negotiation of service agreements with the Region, which is necessary for private hospitals in order to be reimbursed.

2. Financing the national health service

When created in 1978, the SSN was intended to be financed entirely from general taxation. From 2001 the financing of the SSN is established in proportion of regional tax revenues (value added tax, income tax and fuel tax), and a central fund was established for the purpose of guaranteeing a horizontal equalisation between Regions. Each Region is now responsible for the financing of the ASL and the

Hospital Enterprises located on its territory. The mechanism in place until 2001, where the ASL and the Hospital Enterprises were being financed on the basis of the historic expenditure on health care, considering the size and the special features of the regional territory, is being phased out in twelve year time. In practice, the financing of ASL and Hospital Enterprises depends on the regional transfer and on direct revenues (patients payments and co-payments, real estate properties, donations, authorised loans). As a consequence, inter-regional differences in the provision of health care services are becoming larger. The equalization fund represents only a partial rebalancing mechanism because it only relates to the provision of essential services.

Accredited hospitals that are not enterprises are financed in relation to the amount of service provided on the basis of DRG-based tariffs (Diagnosis Related Group, cost per case or global budget). The DRG tariffs are fixed by each Region using the criteria established at the national level on the basis of a hypothetical average treatment. Activities with lengthy down-times (as emergency services and intensive care) or with costs largely unrelated to volume (for example, organ transplants) are financed with a block grant. For less serious types of care DRG tariffs are reduced and outpatient care is encouraged. Private hospitals and ambulatories accredited into the SSN are financed on the basis of bilateral agreements negotiated with the relevant ASL: such agreements specify the volume of services to be delivered, the tariffs (DRG-based tariffs) and the conditions to be satisfied in delivering services (such as length of stay, waiting lists, prevalence of outpatient care versus inpatient care). Hospitals with cost per case contracts must remain within agreed annual volume or revenue ceilings, otherwise a tariff reduction mechanism is activated, in order to discourage an excessive quantity of publicly reimbursed services provided by the private sector.

3. Structural Conditions

Exit/restructuring

As described above, each Italian Region develops individual policy options concerning the financing of (public and private) hospitals. As a result, local situations differ significantly. For instance in Emilia-Romagna there has been a thorough assessment of population needs in terms of nature and quality of health services. As a consequence several local hospitals have been re-organized in order to provide those services that were in need in the specific geographic area. In other Regions, since the new financing scheme has been introduced with a very long (12 years) transition period, extra costs are simply financed with additional funding.

Non-profit/government

In Italy, as mentioned above, health services are provided both by public (government) and private (for-profit) hospitals. Some private hospitals are admitted to reimbursements by ASLs on the basis of the specific services provided. Health services are paid irrespective of the nature (public or private) of the hospital, but some Regions impose ceilings on the total amount of private services reimbursed by ASLs. The same does not apply to services provided by public hospitals which, in this way, are able to maintain the same level of revenue over time. In principle, the favouritism of public hospitals depends also on the requirement that they set capacity according to peak, not average demand.

4. Contracting and Competition Mechanism

Entry for new providers/outpatient centres

Entry by private or public hospitals is regulated by Regional Authorities and is based on the likely need of new structures. Usually, every three years Regions prepare a health plan which identifies demand needs and therefore the developments of new hospitals. In theory, private hospitals may be authorized to

enter the market as long as they possess certain technical requirements, but in some Regions such authorizations are provided only if new hospitals are actually foreseen in the Health plan. After receiving the authorization, a hospital needs to be accredited to the ASL in order to be eligible for reimbursement. This is automatic for public hospitals, but not for private ones. This represents the main barriers for private enterprises which may be kept outside the reimbursement schemes, irrespective of the quality and efficiency they may possess.

Outsourcing

Several Regions are adopting measures to reduce inefficiencies and outsource those services that cannot be considered the core of hospital services. The experience so far includes the outsourcing of information technology systems, cleaning services, food services (through catering companies), car leasing, maintenance services for biomedical instruments, management of drugs warehouses, building maintenance. Such experiences are widespread all over the country, with some Regions (Tuscany, Liguria, Latium, Marche) leading the way.

Consumer choice

Patients can choose the provider of hospital services they prefer. Of course if they choose private providers which are not accredited to the Local Health Authority they will have to pay themselves for the services provided (unless they have private insurance). If they choose an accredited hospital (whether public or private), no payment is due and the hospital will be directly reimbursed by the ASL. The presence of private hospitals (financed also by the public) helps to reduce waiting times, but it should be taken into account the fact that reimbursements to private hospitals are limited. Every year a specific budget is allocated to reimburse private hospitals for an agreed quantity of services and if at the end of the year the quantity of services is higher than agreed, then a tariff reduction mechanism is triggered off (i.e. the hospital receives a lower reimbursement per service provided).

Geographical mobility is also allowed among Regions. More efficient Regions do have indeed significant inflows of patients from other Regions. A compensation system is in place in order to pay for services supplied to out of region patients. Such mobility is also encouraged to overcome the problem of peaks in demand for hospital services. It may happen that an unexpected quantity of specific hospital services is required which may not be met by local providers. Should this occur, hospitals in different areas (Regions) will provide the necessary services which may not be postponed (like urgent surgeries or transplants)

Centres of excellence

The promotion of centres of excellence is a matter of regional health policies. In Emilia Romagna, for instance, a “hub-and-spoke” system has been adopted. The “hub” represents a centre of excellence, specialized in top-end surgery and transplants, whereas dozens of local hospital represent the rest of the system, which deals with ordinary interventions and assesses whether patients need to be referred to the “hub”. This has allowed Emilia Romagna to allocate financial resources according to the needs of local demand, to transfer technology and know-how to few highly specialized hospitals where qualified research is also carried out in collaborations with international institutions.

5. Competition Law

The Italian Competition Authority has not applied competition law to hospital services in relation to possible abuse or collusion cases. However, in several occasions, it has issued advocacy reports to Parliament and Government on the possible negative impact on competition of the double role played by ASLs. In fact, ASLs are both providers of hospital services and managers of reimbursement funds. That

means that private accredited hospitals will have to deal with ASLs to define the terms and conditions of their reimbursements, when the same ASLs also manage public hospitals which compete for the same reimbursements for health services.

In June 2005, the Italian Competition Authority launched an inquiry into public and private hospital services. The Authority is aware that the public health service is a social right, guaranteed in the country's Constitution and therefore recognizes its special character when compared with other public services.

The inquiry will address several issues. First, the various regulatory models, as implemented at the Regional level, will be analysed in order to evaluate which competitive principles have been introduced or could usefully be introduced to ensure the best performance of hospitals' health services. Second, the inquiry will investigate the effects of the 1999 reform. To this end, the Authority will assess the role of the ASLs, with particular reference to the accreditation system. Third, the Authority proposes to examine the issue of relevant markets definition for hospital services, looking at both supply and demand side characteristics, as well as geographic differentiation.

JAPAN

1. Non-Profit/Government

In Japan, health care services may only be provided by medical institutions established in compliance with procedures stated in law. These medical institutions are classified into medical offices, offering mainly outpatient services, and hospitals, offering mainly hospitalisation services. A medical office generally has smaller structural facilities than a hospital.

Private enterprises are permitted to establish medical institutions, as are individuals such as physicians/surgeons and dentists. A juridical person can also establish a medical institution. In addition to governmental medical institutions, private medical institutions also provide necessary health care services for local residents and play an important role in maintaining systems for the provision of medical care.

Although in Japan health care service providers are free to set prices for their services, government medical insurance is generally used to pay for medical services, and in these cases, service is provided at the same price in all medical institutions.

2. Entry for new providers / outpatient centres

Basically, in Japan any physician/surgeon or dentist is permitted to become a new provider of medical services, provided that he or she is not a profit-making corporation. Entry to health care services is barred to profit-making corporations because the pursuit of profit is likely to cause problems in maintaining proper medical services in regional areas, due to hospital closure when expected profits cannot be achieved, resulting in failure to provide proper medical care services to consumers in the area.

The nature of the health care service the consumer wishes to receive is left to the discretion of the consumer.

3. Benchmark competition / Physician purchasing

As an example of the structure of standardisation of hospital services, the Prospective Payment System by Diagnosis Procedure Combination (DPC) was introduced in 82 special functioning hospitals in 2003 for hospital services at acute periods, and as a trial run, has been implemented in 62 private hospitals since 2004.

In the DPC system, approximately 3,000 categories of diagnosis procedure are defined based on a combination of “disease” and “medical procedure during hospitalisation”. For 1,700 categories, medical fees are comprehensively evaluated per day, for basic hospital charges, medication, injections etc.

The amount to be paid for medical bills consists of a ‘hospital fee’ evaluated on a bulk basis according to the diagnosis procedure combination, and the ‘doctor fee’ evaluated by each service provided. The sum of these two elements is the total amount to be paid.

Portion evaluated on a bulk basis according to diagnosis procedure combination

The number of points per day based on diagnosis procedure combination is calculated in three categories according to the number of days of hospital treatment. Fees are [added by 15%] MEANING on the averaged number of points up to 25 percent for days of hospital stay, and when the average days are exceeded, fees are determined at 85% of the number of points of the previous day.

Portion evaluated on services basis

Medical bills for consultations, operations, anaesthesia, radiation therapy, and treatments which points are for more than 1,000 are calculated on services-provided basis.

Effects such as a decline in the average days of hospital stay (from 21.22 days in 2002 to 19.11 days in 2004) have been observed in a survey conducted in 2004 when an impact statement on introduction of DPC was performed. It is also worth noting that no decline in the quality of health care service due to the introduction of comprehensive evaluation system was observed.

Improving the efficiency of hospital services at acute periods by enhancing the DPC system is a challenge that will need to be addressed in future.

4. Paying for performance

As an example of the reform of payments for performing services, there is the new approach for reviewing the medical service fee payment system currently being studied based on the Basic Policy adopted in the Cabinet Decision of 2003 (Basic Policy under the Provisions of Paragraph 2, Article 2 of Supplementary Provisions of the Law for Partial Amendments to the Health Insurance Law [March 2003 Cabinet Decision]).

For example, the proper and reasonable evaluation of medical technology, which the “Basic policy” mentions as one of a concrete source of the new approach, shall be conducted by taking into consideration the expertise of medical staff and team treatment, and also carrying out the necessary investigation/analysis of difficulty, time, and quality of techniques on the basis of fee-for-service evaluation system.

For operations, certain points are assigned depending on the type of operation, and the evaluation is conducted more precisely according to the degree of difficulty. In addition, a system for evaluating operation standards at each institution was introduced in 2002, and the evaluation is based on the number of the cases or the years of experience of surgeons being studied.

5. Outsourcing

Among services provided medical care services themselves must be provided only by the medical institutions established in accordance with the procedure regulated in law and the institutions are not allowed to outsource such practice. However, some other services which might have a critical impact on customers, such as sterilisation/disinfection of clothing or linen for customers, and meal services, are permitted to be provided outside of a hospital setting, provided that the quality of service is maintained at an acceptable level by controlling the qualification of service providers based on regulations. Other services can be outsourced.

KOREA

1. Introduction

In Korea, the national health insurance system was introduced in July 1989 to provide health insurance and medical assistance to all the people. As public demand for medical services increases and the size of hospitals grows, functions of hospitals are getting more diverse and complicated. As a result, interest in hospital management is increasing while efforts are being made to enhance management efficiency in order to respond to market opening pressure.

Medical sector regulatory authorities are pursuing to abolish or improve unreasonable regulations and strengthen economic regulations to increase the quality of hospital service and strengthen competitiveness. Competition authorities are also continuously requiring improvement or amendment of the regulations causing entry barriers or competition restriction.

In an environment where pressure of competition is growing due to market opening and government deregulation, medical institutions are expected to cut costs and to innovate business management for survival. At the same time, it is likely that they will engage in anti-competitive or unfair business practices to avoid competition. Therefore, the roles of the competition authority, which are already enforcing competition laws in the hospital service sector, will become more important.

This report will examine current status of regulations in the hospital service sector and introduce law enforcement cases of the Korean competition authority.

2. Market Regulations in the provision of hospital services

Structural conditions

Disparities between efficiency and equal provision of hospital services

To guarantee equal accessibility to medical services, public health care institutions are operated. In particular, public health centers and sub-centers are operated for local health care, and primary health care posts are established for health care in farming and fishing villages.

Table 1. Regional Health Care Centers and Budgets support

	Establishment standards	Number	Budget support
Public health center	1 for each city, country and district	246	General account and special tax for rural areas
Public health sub-center	1 for each town and township	1,273	
Primary health care post	For remote areas	1,902	

(Source: The Ministry of Health and Welfare, as of the end of 2004)

For the efficient management of local health care centers, health care plans are drawn up and their implementation is evaluated each year. Evaluation results are notified to related health centers and made public through the media in order to motivate competition. For example, the Korean government recognised as an exemplary institution and provided one billion won (approximately \$ one million) to the Daegu Medical Center, which has been in the black for six years with a profit of 23 million won (approximately \$ 23,000) in 2004 alone.

To provide reliable health services for rural areas, the government is also giving support to private medical institutions. Small and medium-sized hospitals located in remote areas receive a ten percent reduction in income tax or corporate tax. And the private health institutions providing some of public health services are supported with part of their operational expenses.

Non-profit/public medical institutions

Medical institutions in Korea are classified into public institutions, which are established and operated by the State or local governments, and private institutions, which are established and managed by medical juristic persons or individuals. Hospital service provision in Korea is heavily dependent on the private sector (92.7%).

Table 2. Number of Medical Institutions by Type of Establishment

	Total		Public Institutions		Private Institutions	
	Number	%	Number	%	Number	%
Institutions	48,698	100	3,546	7.3	45,152	92.7
Beds	344,341	100	46,876	13.6	297,465	86.4

(Source: The Korean Hospital Association, as of the end of 2004)

As one can see in the next table, public health institutions, unlike private institutions, receive budget support and tax benefits from the government. Though the public institutions suffer deficits more or less, they are subsidised by the government for the goal of providing hospital services to the underprivileged and, thus, continue their businesses rather than go out of the market. To strike a balance between public benefits and efficiency, however, the government has in place a system to assess efficiency and motivate public health institutions.

Table 3. Comparisons of Medical Institutions by Type of Establishment

		Public Institutions	Private Institutions	Comparison
Operator		The State or local governments	Medical juristic persons	-
Financial support	Ordinary revenues	Medical fees	Medical fees	Regulated by the government
	Budget support	Government financial support	No government financial support	Discriminatory support
		100% tax support	Little tax support	Discriminatory support

(Source: The Korean Hospital Association, as of the end of 2004)

For instance, the National Medical Center was designated as a model institution for management accountability in 2000 and, since then, has applied special accounting (corporate accounting) procedures based on autonomy and accountability. The Center is an example of introducing performance management system. Under the special accounting rule, expenditures of an institution are financed by its revenues. This

guarantees financial and administrative autonomy and holds medical institutions accountable for management performance, offering incentives for efficient management.

3. Competition and competition Mechanism

Entry for new provider

Under the Medical Service Act, any person who desires to establish a medical clinic, dental clinic or herb clinic should file a report with the head of country governor or district leader. And those who want to establish a general hospital or other hospital should obtain a permit of the Mayor or the governor of a province. A medical person cannot establish more than one medical institution.

The Ministry of Health and Welfare (MOHW) recently announced that it would reduce entry barriers, such as allowing medical persons to provide services at more than one medical institution as non-attached staff without establishing a medical institution. In addition, foreign medical persons will be able to belong to a domestic hospital and render medical services to citizens living in Korea.

Hospital Accreditation Program

The Korean Hospital Association operates the Hospital Accreditation Program, which has been implemented as part of efforts to improve quality of hospitals since 1967. Under the Program, medical institutions conduct self-assessment and peer assessment regarding about 1,600 items including safety of the premises and functions of a hospital; organisation of doctors' work; quality of hospital service; facilities and equipment; and overall business management. The programme encourages hospitals to meet the standards of assessment.

Hospitals failing to meet the standards are notified of areas to be improved, along with a review report, while those satisfying the standards receive an accreditation certificate and the assessment will be replaced with document review for one to two years. Assessment results are reflected in designating training hospitals and setting the number limit of medical specialists. Hospitals that fail to meet the standards cannot increase the number limit of medical specialists above the level of previous year and be designated as a training hospital.

Paying for performance

The Ministry of Health and Welfare has carried out an evaluation of services of medical institutions since 1994. The system is designed to encourage improvement of service quality by evaluating the service quality of medical institutions and providing different supports depending on the evaluation results. Article 47-2 of the Medical Service Act prescribes matters regarding evaluation, publication of results and financial and administrative supports to excellent institutions. Evaluation standards are as follows:

- Patient's rights and level of patients' satisfaction with convenience
- Work process and performance of medical persons
- Quality of facilities, equipment and personnel
- Other matters regarding operation of medical institutions

Based on the evaluation conducted in the second half of 2004, the MOHW granted financial supports ranging from 100 million to 300 million (approximately \$ 100,000 to \$ 300,000) to excellent hospital service providers. The Ministry plans to carry out the evaluation in October 2005. In response to criticism

that the evaluation system is overlapping with the Hospital Accreditation Program, the MOHW is considering measures to integrate the two systems.

Outsourcing

When establishing high-tech medical systems like PACS (picture archiving communication system), OCR(Order Communication System) and EMR(Electronic Medical Record), many large general hospitals in Korea outsource system operation to system integration companies. The Seoul National University Hospital and the Korea University Medical Center turned to outsourcing after building a medical information system.

The Korea University Medical Center and its outsourcing company, Samsung SDS, said that the biggest benefit from digitalisation of prescription procedures is reduction in time needed to examine and treat patients. Online and computer issuance of prescriptions led to time reduction, and hospitals can provide hospital services to 300 more patients a day. Patients do not have to wait for a long time while hospitals earn additional revenues of 6 billion won (approximately \$ 6 million) a year. Furthermore, it has become easier to manage stock such as medicines. The medical systems are connected to insurance system, guaranteeing clear and correct insurance coverage and preventing over-prescription. This can be translated into enhanced transparency in charging medical fees.

Open hospital system

In 2003, the Open Hospital System was launched, where primary care providers can share facilities, medical equipment and human resources of secondary or tertiary medical institutions (open hospitals) in the neighborhood to provide hospital services for their patients. As of 2005, 41 medical institutions operate the system.

The system enables hospital service providers to curtail initial investment costs and open a clinic more easily, while allowing open hospitals to jointly use health care resources and improve their business management. The economic effect of this system is estimated at a 12.8% cost reduction for a specific part of surgical departments.

Consumer choice

Korea adopted a “chosen medical examination and treatment” system. Article 37-2 of the Medical Service Act stipulates that every patient or his protector may choose a specific doctor to ask him for his medical examination and treatment and that any medical institution may, where the chosen medical examination and treatment are provided in a manner that certain requirements are met, collect additional expenses. As of 2003, 9.5% of hospitals in Korea carry out chosen medical examination and treatment.

The system is evaluated as effective in promoting market functions since it ensures patients’ right to choose their own doctor and different pricing based on the selection of hospital services. Efforts are being made to create an environment where consumers’ right to choose is fully exercised. As part of such efforts, information on doctors providing chosen medical examination and treatment is available to the patients.

4. Competition Law Enforcement in the provision of hospital service

Violation of Prohibited Activities of Enterprisers Organization (Article 26 of MRFTA)

In 2000, the MOHW introduced a system barring doctors from selling drugs directly and prohibiting pharmacists from selling drugs without a prescription. This meant doctors’ role became limited to prescribing drugs, unlike in the past when they had both prescribed and dispensed drugs. Against the

decision, members of the Korea Medical Association (KMA) agreed to stop treating patients and sent letters to the Korean Hospital Association (KHA) asking for its help. The KHA urged its member hospitals to participate in the agreement.

The KFTC prosecuted the KMA and KHA based on the judgment that the two Associations unreasonably restricted business activities of their members with the power to deprive membership and impose financial sanctions against the members who did not comply with the agreement.

Violation of Fair Labeling and Advertisement Act

In 2004, the KFTC issued a corrective order and an order to publish the fact of violation against a hospital, which made a misrepresenting advertisement saying “24/7 ER Treatment by Medical Specialists”. It turned out that medical specialists were not available on Sundays.

Violation of Regulation of Adhesion Contracts Act

In 2001, the KFTC issued a corrective order against 13 hospitals providing funeral services for violating the Regulation of Adhesion Contracts Act. The KFTC decided that the adhesion contracts of the 13 hospitals violated prohibition of exemption clause, included a provision on undue termination of contract and went against the principle of good faith.

The provisions of the adhesion contracts are as follows:

- The customer shall bear responsibility for all accidents occurring in the premise, irrespective of circumstances
- Upon termination of contract, the customer must return the premise to the provider within three hours and pay the rent despite termination
- In case of dispute, only the interpretation by the provider will be valid

Unfair Business Practices (Article 23 of MRFTA)

There was a case in which large medical institutions with buying power in medicine distribution abused their power. In March 2003, the KFTC issued a corrective order against 21 large medical institutions for taking advantage of their bargaining position in transactions with medicine wholesalers. The unfair practices were as follows:

- Extending the payment date unilaterally without paying delay interest
- Setting trading terms and conditions under which they can pay for the purchase arbitrarily, and their transacting partners cannot object to that and request delay interest
- Setting trading terms and conditions under which they can adjust already agreed prices because the prices are high and their transacting partners should comply with this adjustment

5. Conclusion

As it can be seen, the KFTC has taken actions against unfair business practices, undue labeling and advertisement and unfair adhesion contracts in the hospital service sector since 1980. There have not been many cases related to traditional competition issues, such as mergers and cartels.

However, in an environment changing towards market opening and deregulation, competition is getting intensified and interest in intellectual property rights is newly growing. At the same time, it is expected that anti-competitive practices will increase to avoid or undermine market competition and abuse of IPR will become a serious problem. Recognising this, the KFTC will carry out continuous monitoring and active competition advocacy work to promote fair competition in the hospital service market.

MEXICO

1. Introduction

This note addresses competition issues arising in the provision of hospital services in Mexico. The first section provides an overview of the main features of the health care system while the second identifies key issues associated with the efficiency of the system. The third section summarises some recommendations to enhance efficiency of hospitals and other institutional providers; productivity of health-care professionals; and quality and cost-effectiveness of care. The fourth section presents the experience of the Federal Competition Commission (FCC) in the enforcement of competition law in this sector. Finally, section five presents some concluding remarks.

2. Main features of the health care system¹

The Mexican health care system comprises two public subsystems that are vertically integrated, social security institutes and hospitals headed by the Ministry of Health, and a large private sector.

The social security sector encompasses two main providers: the Mexican Social Security Institute (IMSS) that offers protection to employees working in the formal private sector; and the ISSSTE that provides services to government workers. Additionally, other social security institutions serve employees of the navy (SEMAR), the National Defence Ministry (SEDENA) and the state-owned oil monopoly company (PEMEX). These institutions provide a range of benefits including pensions, health care, disability and life insurance, and sometimes recreation and child care. Each has developed their own vertically integrated infrastructures and is financed by earmarked payroll taxes and legally mandated government contributions.

Other publicly provided health care services are delivered by the Ministry of Health (MOH) and State Health Service providers (SHS), which target the uninsured population. The MOH is also in charge of poverty alleviation programmes related to health. Most of these services are entirely financed by general tax revenues, with a small proportion financed by income-related user fees.

The private sector provides an important share of health care. Although there is a small non-profit/NGO sector, the great majority of private care is for-profit. Medical care delivered by the private sector is heterogeneous in quality and level of services. This market is mostly unregulated and patients pay mainly out-of-pocket. Private insurance covers only 3% of the population.

People demanding services from the health system may be divided into three groups. The first one comprises people working in the formal sector of the economy covered by social security institutions. The second is integrated by urban middle and upper-income level people, who may contribute to social security but also seek care in the private sector, either through out-of-pocket payments or through pre-paid medical insurance. The third group consists of the unemployed or self-employed, both urban and rural, who are left without the benefit of social security. The latter are potential beneficiaries of the *Popular Health Insurance* program described below.

¹ For more detailed analysis, refer to OECD (2005); Barraza-Llorens M, Bertozzi S, Gonzalez-Pier E and Gutierrez J (2002) and Gonzalez Pier, E. and Peña Baca, H. (2004).

The System for Social Protection in Health

In 2004, a major reform established the System for Social Protection in Health (SSPH), aimed at providing financial protection to families without access to social security coverage. It comprises of two components: i) public funding for community health services and ii) a tripartite contribution scheme to cover personal services through the Popular Health Insurance (PHI). This voluntary universal insurance scheme is intended to provide subsidised basic health care and catastrophic coverage to all the uninsured by 2010. It covers an essential package of primary and secondary interventions in ambulatory settings and general hospitals, as well as a package of high-cost tertiary level care that is financed through the Fund for Protection against Catastrophic Expenditures. The essential package of interventions is a quality-assurance tool, which is designed to guarantee that all necessary services are offered. These services are decentralised to the state level as they are associated with low risk and high probability health events. On the other hand, the package of catastrophic interventions requires a fund that aggregates risk at the national level. The PHI also covers prescription drugs. The premise of the reform is that extending risk pooling through public health insurance, combined with an improvement in the quality and coverage of health care services, will generate the necessary financial protection to achieve a reduction in catastrophic health spending among families, as well as the financial incentives to make health finance more efficient, competitive and equitable.

The total cost of the SSPH is estimated at 1% of Gross Domestic Product (GDP). Although affiliation is voluntary, states have the budgetary incentive to affiliate the entire population. The affiliation process is gradual over the seven-year period, and a maximum of 14.3% of the uninsured population can be included each year beginning with the poorest families. By August 2004, the PHI had affiliated over one million families, approximately 10% the population not covered by social security. About 70% of current beneficiaries are single-mother households.

Hospital services

The Mexican hospital sector is heterogeneous in quality, geographical distribution, and the type of facilities available to doctors and patients. On the one hand, there are private and public specialised hospitals that offer high-quality services similar to those provided in the US and Canada. On the other, there are hospitals, mostly general hospitals that provide poor-quality care.

Both the social security system and MOH and SHS facilities provide care at primary, secondary and tertiary levels. General hospitals supply secondary care, including accidents and emergencies, maternity services, and treatments of a few basic specialties. Specialised hospitals comprise tertiary-level facilities equipped to supply the full range of services and all specialties. MOH facilities include the prestigious National Health Institutes and the federal reference hospitals, which are autonomous highly specialised health care and medical science institutions that carry out education and research activities. Social security tertiary level hospitals are also highly specialised and undertake education and research activities. Most tertiary-level hospitals are located in Mexico City and in a few other large cities.

Hospital supply in Mexico is the lowest in OECD countries, with only 1 acute-care bed per 1,000 population compared with an OECD average of about 4.1 in 2003. Despite this gap, bed supply per capita has been stable in Mexico since 1990. The average length of stay for acute care in hospitals has slightly decreased over the past decade in Mexico, from 4.4 days in 1993 to 4.1 in 2003, a downward trend also observed in other OECD countries. Social security institutions have slightly higher availability of doctors, nurses and hospital beds than the government sector.

Finally, the Mexican private sector accounts for 34% of total hospital beds in the country which are concentrated in larger cities in richer states with nearly half of private hospital facilities found in Mexico

City. Only 15% of private hospitals have more than 15 beds and only 3% have more than 50. The establishment of hospitals, clinics and pharmacies in the private sector is left to private entrepreneurial initiative as no constraints are placed on providers concerning their location, activities and prescriptions, and at present, no regulation concerning their quality of services. Many physicians combine private practice with public work at an IMSS or MOH facility.

3. Financing

In 2002 the share of GDP spent in financing public health was 6.1%. Social security is financed by contributions from the government, the employer and the employees. Funding for the three major social security institutions is based on a tripartite logic of financial responsibilities and rights: a federal social quota; a co-responsible contribution that guarantees solidarity within each population group and redistribution within states; and contributions by affiliated individuals.

Funds from the government are allocated through a component in the national budget. The public financing sources in Mexico include the federal Ministry of Health, the state Ministries of Health and Social Security Institutions. States receive federal funding from the national budget through the Fund for Health Services (FASSA) and also contribute by allocating state funds.

The IMSS co-responsibility and solidarity quotas are paid by the private employer, while that for ISSSTE are paid by the government in its role as employer. In both cases, employee contribution is deducted from the payroll.

Under this financing scheme, the natural competition among public institutions for resources has tended to concentrate resources where political and economic power is strongest, which has exacerbated inequality. It is possible that the fragmentation of public sector institutions has interfered with the sector's collective ability to advocate for increased resources.

Although the funding model of the SSPH follows this tripartite logic it implies a radical change in incentives for state governments and providers: the federal government makes a per-capita contribution to states (social quota) for each family affiliated to the PHI. This contrasts with federally-allocated state budgets in health, which were historically determined by inertia, the size of the health sector payroll, and discretionary allocations of the overall state budget to health. The federal social quota for the SPSS was set at 15% of the mandatory minimum wage. Co-responsibility and solidarity are established between the federal and the state governments to redress differences among states. The federal solidarity contribution is on average 1.5 times the social quota, but is increased for poorer states at the expense of wealthier states. The state solidarity quota is the same in all states: half of the federal social quota funded through state revenues. The family contribution to the PHI is based on a sliding-scale subsidy on the principle that no family should have to contribute more than a fair share of their disposable income. Families in the lowest two income quintiles do not contribute in monetary terms, but will be required to adhere to participation rules associated with good health practices. For other income quintiles, the family contribution is a fixed, equal to a proportion of disposable income, thus guaranteeing that it is highly progressive in terms of total family income.

Payment of providers

The methods for payment to providers vary between the public and the private sector. Public-sector doctors and nurses are paid on a salary basis by the institution they work for, while hospitals are allocated funds on the basis of historical budgets. In the private sector, providers are paid on a fee-for-service basis.

Pay in the public sector is based on seniority. Wage levels are relatively low, and doctors' incomes appear low when compared to average income. There are differences in wage levels between the social

security sector and institutions catering to the uninsured, the former being higher than the latter. Low wages reduce incentives for professionals to remain in the healthcare sector and may also lead to absenteeism and involvement of health professionals in other jobs (in either the public or the private sector, or even outside of the health sector). Nurses' hourly wages appear to be particularly low, representing approximately one-third less than the average wage.

The effect of this salary-based remuneration system is a lack of incentives for increased flow-through of patients. Patients who are unable to obtain satisfactory and timely treatment in the public sector search for private medical care. This creates an incentive for public-hospital doctors to under-serve patients in the public sector and encourages a shift to the private sector.

Public sector hospitals are set annual global budgets. These are predominantly determined on the basis of historical cost and availability of resources, without taking into account hospital efficiency, responsiveness to patients or other indicators of performance. This has been a key reason for inequality in federal allocations at the state level and is also likely to be account for similar financing problems faced by hospitals within states. The largest part of each hospital budget is absorbed by personnel costs. This represents, for example, around 80% of the budget in IMSS hospitals. Hospitals have little autonomy or control over labour spending, because wage rates, personnel hires and working conditions are agreed centrally in contracts with unions, most often negotiated at the national level. In the case of IMSS, a small fraction of the remaining 20% of the budget is allocated based on the level of activity. In addition, most SHS staff are covered by a single federal labour agreement. This has hindered attempts by states to explore alternative contractual arrangements, because there is little scope for paying higher wages to attract individuals to provide SHS services, particularly in outlying rural areas.

Overall, hospital administrators have little managerial discretion over how to run their facilities, and on how to allocate resources. When the hospital runs into deficit, the shortfall is covered by the corresponding central institution, be it the federal or state government, IMSS or ISSSTE central offices.

In the private sector, fee-for-service is the predominant payment arrangement. Fees charged by doctors are not regulated, and doctors are usually paid in cash. If doctors participate in private insurers' networks, not yet a widespread practice, fee levels charged to insured patients are negotiated with the relevant insurance company. Private hospitals also operate on a fee-for-service basis. Fees are set freely but insurers negotiate lower fees with private hospitals for the treatment of insured patients. The volume of hospital activity channelled through insurers varies by private hospitals, and can be as high as half of overall hospital activity. Private hospitals can also receive revenues from physicians who rent or purchase some space from private hospitals for their private practice.

Labour contracts

As described above, existing labour contracts appear to limit the flexibility of management, while unions tend to exert a significant degree of control over internal decisions and work organisation. There is a need to renegotiate existing restrictive labour practices in order to permit a better allocation of human resources where they are most needed, both within and between individual institutions.

In addition, the capacity to provide adequate health care services to social insurance enrolees is becoming constrained by the pension systems of both IMSS and ISSSTE. In the absence of a reform, payments to retired employees may significantly limit their capacity to provide health care in the future.

Governance

The Ministry of Health has an overarching responsibility for establishing the governance framework of the health system. Nevertheless, the fragmentation of the health system has made it difficult for it to

exercise this role fully. A particular problem concerns the social insurance system where its oversight is weaker than for the services it can itself supply. For example, IMSS reports to the Ministry of Labour with the Ministry of Health playing only a consultative and coordinating role with respect to the health care component.

State health ministries have been progressively strengthened to help in this matter. However, progress has been slow in many of the less-developed parts of the country, where there has been relatively little investment in management capacity. Smaller states may also have found it costly to maintain health policy-making teams.

Beginning in 2000, IMSS began to decentralise some of its decisions to lower administrative levels. Four regional Medical Zones were established, below them 37 delegations that oversee a number of primary clinics, general hospitals, and specialised hospitals.

Despite decentralisation, there is no assurance either that greater independence will give local units the capacity to take on these roles effectively. Restraints imposed by collective labour agreements still hamper management's attempts to introduce productivity-improving measures at the local level.

Regulation

Voluntary hospital certification began in 1999 under the Certification Programme for Medical Care Establishments. It entails an assessment of the quality of operation processes, not the evaluation of output, and includes both public and private sector hospitals. However, regulation of the private sector has been weak, operating mainly through self-regulation by professionals and providers.

As regards to professional qualifications for doctors and nurses, an accreditation system has started to take form. All medical schools have applied for accreditation following a ruling which limits hiring in the federal and state health services facilities as well as in the social security system, to graduates from accredited institutions. Accreditation of specialists has been left to the specialist councils linked to the National Academy of Medicine and the National Academy of Surgery.

Another regulatory entity is the National Commission for Medical Arbitration (CONAMED), established in 1996 to resolve conflicts between providers and patients through conciliation and arbitration procedures. It is the main body providing patients' protection in Mexico.

Finally, the Ministry of Health is responsible for the regulation and protection against public health risks through the Federal Commission for the Protection against Public Health Risks (COFEPRIS). COFEPRIS is responsible for preventing health hazards in the consumption of products and services.

4. Key features of the health system

Unequal access to health care

The share of population with weak access to health care services is largest in rural areas, while health care access in low income urban areas is not always adapted to patient needs. Problems of access to care are also more acute for the uninsured population, mostly living in rural areas where services are provided by institutions outside the social security system, and social security institutions face stringent financing. Higher-level services are also ill-distributed across the country, as they concentrate in the main cities.

Unequal coverage of health insurance and financing

Unequal access to health insurance is a distinguishing feature of the Mexican health care system. Among OECD countries, Mexico has the lowest degree of formal public insurance coverage. Around 51% of the population is covered by social security and no more than 2-3% is covered by private health insurance. In contrast, 95% of the population in other OECD countries is covered by some form of insurance for health-care costs. Only 45% of total health care spending is public, with the remainder directly financed by households and serviced by private sector, by means of out-of-pocket payments, which account for 52% of total health expenditure.

Public insurance coverage is strongly linked to income given that it is linked to a formal employment scheme. As a result, insurance coverage in Mexico is regressive both between households and across states. Over 60% of the richest quintile is insured compared with 10-12% of the poorest quintile. This fact, along with the high levels of out-of-pocket spending accounts for a high level of catastrophic and poverty-creating health-care expenditures in lower income quartiles.

Use of health care services

Despite the low resource levels for the provision of public health-care services, international comparisons show, paradoxically, that the use of the system is low by OECD standards and that the intensity of use of these resources also tends to be below-average. Demand may be low because of the relatively young age structure of the population and associated patterns of disease, attitudes regarding when one should consult a doctor and the degree of cost sharing or partial reimbursement. Alternatively, low intensity of use could also signal an inefficient use of resources and high levels of spending on private health care may, then, result from a spill-over of un-satisfied demand for public-sector health services. In addition, Mexico stands out as one of the OECD countries where the rich use services more intensively than the poor.

Quality

Budgetary constraints combined with low efficiency in public supply have limited both the quantity and the quality of care to the poor, leading to significant implicit rationing throughout the system and complaints over the quality of care.

Medical care is extraordinarily heterogeneous in quality and in the number of services provided among public and private providers. In fact, due to long waiting time and low quality service in public and social security institutions, a large share of both insured and uninsured families from all income levels often use private providers paying out-of-pocket at the point of use.

In summary, increasing access to coverage and quality care among disfavoured groups is a critical challenge to the authorities. Progress in this area will require increasing the level of resources allotted to the health sector and reducing the inequalities in the distribution of financing both across and within states.

Market fragmentation

The market is highly fragmented. On the one hand, there are many social insurance providers that serve employees in the salaried labour market. On the other, there is the public hospital system that provides services to those not covered by the social security system.

Since the 1990s, the government has tried to reduce this fragmentation by moving progressively towards a system organised horizontally on the basis of health-system functions. An important concern is the governance of the system. The current governance structure may not facilitate movements in the

direction desired. First, there is no one institution able to set the overall parameters of the health-care system. This partly reflects the “bundling” of health insurance with other components of social insurance coverage, which has brought the social security system as a whole under the jurisdiction of the Ministry of Labour. This potentially limits the capacity to develop coherent over-arching policies for the entire health-care sector, although system coordination has been enhanced through the General Health Council, which brings together the main actors of the system.

Another concern is associated with the decentralisation of responsibilities for health-care provision to the states, intended to tailor supply better to the needs of the local population. However, such flexibility can create future co-ordination problems if state systems move in different directions. There is a need to build strong administrative capacity to control the system and to enhance transparency.

A related concern refers to the insurance of health-care risks, which could occur through social security, private insurance or other insurance models, such as those proposed within the SPSS. In this framework there would be a progressive increase in the size of the population covered by either the social security or the PHI, while the private sector would remain present but probably not take on a larger role in the system.

5. Review of recommended mechanisms to enhance efficiency of hospital market services

The OECD review of Mexico’s health system (OECD 2005) presents several recommendations for the current system. Among these are targeting enhanced efficiency of hospitals and other institutional providers; increasing productivity of health-care professionals; and ensuring quality and cost-effectiveness of care. These recommendations are listed below and complemented by findings of two other papers.²

A key issue to consider during the early years of the SPSS is how to improve the efficiency of public health care, because a significant share of overall resources used to finance additional care will only be available when the programme is fully established. One of the core recommendations aims at introducing a clearer payers-provider split with contractual arrangements that would reduce the present segmentation of the system, for example by allowing patients to choose the provider. The review thus summons to allow MOHs to purchase care from all available providers, not only those within the National Health System, as currently occurs under the SPSS, including the private sector for selected services. It encourages a greater use of agreements on the minimum content of contracts, resembling those existing between insurance institutes and the MOH, in both the social insurance system and at the level of states.

In a similar vein, Barraza Llórens, Bertozzi and González Pier (2002) present a strategy that includes a single centrally funded scheme where resources follow the patient, even across institutional barriers. Under this scheme, payment mechanisms between purchasers and providers would provide incentives to improve quality of care and efficiency. They consider that, with appropriate inter-institutional coordination, it is possible to gradually move away from a vertically integrated insurer-provider model and separate insurance and provision functions, through the purchaser-provider split.

Better performance also requires more output-based or prospective payment mechanisms, which are more efficient than the traditional methods of allocating resources between institutions based on capped budgets. These mechanisms should be introduced at both the federal and state level. Such a decentralised health system, where providers are granted administrative independence, requires that state MOHs implement adequate and transparent monitoring and oversight mechanisms.

2 Barraza-Llorens M, Bertozzi S, González-Pier E and Gutiérrez J (2002)

A final recommendation regarding efficiency is to organise the purchasing of all health-care services on the bases of catchment areas, covering more than one state. These zones have been defined in the master plan for infrastructure and are used to site third-level hospitals. The suggestion is to use regional purchasing agencies to provide care at the secondary and primary levels. This proposal would break down institutional barriers between providers, and lead to savings in management resources and to a more intensive use of existing supply.

The review makes three recommendations to enhance productivity of health care professionals. First, staff remuneration should be linked to efficiency and quality goals. This requires to ensure that greater throughput respects overall resource constraints and to balance salaries increases with enhanced health-care supply. Second, since the current salary-based remuneration system provides incentives for public hospital doctors to practice regularly in the private sector, it is necessary to eliminate the conflict of this practice with service availability in public institutions, once the remuneration system is modified.

Third, it is also required to review existing labour contracts that limit the flexibility of management and to limit the significant control that unions exert over internal decisions and work organisation. It is particularly important to renegotiate restrictive labour practices that impede better allocation of human resources within and between institutions.

Another set of recommendations address the quality and cost-effectiveness of care. These include expanding certification of care institutions, health care personnel and medical schools and using these mechanisms to encourage quality improvements in under performing care units. The SPSS already takes into account these incentives by noting that only accredited and or certified institutions can supply services to PHI enrollees, but there is an opportunity to extend these policies to other areas. In this respect, González Pier and Peña Baca (2004) observe that there is a case for strengthening signalling mechanisms that may reduce imperfect market information. Currently, certification of health institutions is not a compulsory requirement for their operation. It evaluates the quality of operation processes, but not the quality of outputs. Furthermore, it does not include specific qualifications for each unit and process. Therefore, certification does not differentiate hospitals by quality levels. Multiple certification categories would create incentives for hospitals to differentiate themselves on the basis of service quality. In addition, to become effective signals for users, certification mechanisms must be complemented with information transmittal mechanisms.

Although not directly related to efficiency goals, the feasibility of the recommendations portrayed above depends on the adequate funding of the health system. The OECD recommendation in this respect is that a fiscal reform that permits higher tax revenues be introduced and that public-sector pension reforms are implemented to ensure that social insurers have adequate resources to finance health care services. Barraza Llórens, Bertozzi and González Pier (2002) also draw attention to this issue as part of their proposal to create universal health insurance comprising a core package of services across all social groups, funded through general taxation and detached from current payroll-based social security schemes. According to them, a major financial reform that increases the tax base is required to make such a scheme sustainable in the long run.

6. Competition law applied to hospitals and hospital services

Enforcement of the Federal Law of Economic Competition (FLEC) in the hospital sector in Mexico comprises the review of private hospital mergers and bid rigging cases in the procurement of medical supplies for public hospitals. Below we describe five outstanding cases, as well as the participation of the FCC in the privatisation process of the state-owned insurance company that provided compulsory insurance policies to government.

Hospital mergers

Since 1998 the FCC has reviewed 2 mergers in hospital services, none of which was blocked or conditioned.

In the acquisition of Hospital de México by Grupo Empresarial Ángeles in 1998, to define the relevant market the FCC took into account the type of hospitals owned by the acquirer (three) and the one purchased, which comprised general private hospitals (offering several specialties) equipped with medium and high technology and more than 50 beds. This definition assumes that public hospitals are not substitutes for private general hospitals since patients demanding private hospital services may be clearly differentiated in terms of their income level and the availability of public health programmes.

The geographic dimension was defined as Mexico City's metropolitan area, which is the location of the hospitals involved in the transaction. Although patients demanding specialty services may be willing to travel relatively long distances, the demand for hospital services provided by the majority of users in this relevant market was considered to come from neighbouring areas. Concentration indices were calculated based on market participation in terms of the number of beds available in the relevant market. The indices fell within the limits established by the FCC.

Lumpy investments in equipment and skilled staff were identified as the main economic barriers to entry. However, the existence of an important number of competitors and low regulatory barriers were considered sufficient to conclude that the transaction would not generate adverse effects on competition.

Later, in 2003 Grupo Ángeles Servicios de Salud, formerly Grupo Empresarial Ángeles, purchased subsidiaries of Inovamed. These subsidiaries render health services including management and operation of clinics, medical offices, hospitals and laboratories. The transaction involved the acquisition of one hospital in Mexico City, four pharmacies and nine laboratories. Nevertheless the analysis focused on the market for hospital services, which was the only market where the acquirer competed with Inovamed.

The relevant market was defined as private hospital services, excluding public hospitals, as in the preceding case. However, the analysis focused on a segment, following the classification used by insurance companies that takes into account certain features such as technology levels, specialties covered, infrastructure, which are also related to clients' purchasing power. The relevant segment corresponded to the category of Clínica Londres, the acquired hospital, which is medium-low type. The geographical market definition was the metropolitan area of Mexico City, for the same reason described in the previous case.

Given the existence of an important number of competitors, none of the regulatory and economic requirements to establish a hospital were deemed to represent insurmountable barriers to entry. Regarding prices, which are freely set in this market, the FCC found that the negotiating power of insurance companies and of banks that contract hospital services for their employees would effectively preclude any attempts by hospitals to impose prices. Further, concentration indices in this segment fell within the parameters considered acceptable by the FCC, reflecting the prevalence of competitors. The merger was thus deemed not to affect competition and free market access.

Collusion in public auctions

A constitutional mandate subjects government procurement to public auctions. The regulatory law establishes that government entities may acquire, lease, contract services and public works by means of public auctions, inviting at least three agents, or under certain circumstances they can obtain these services by direct adjudication. Two main types of auctions apply for health care institutions: those granted to a single provider and those granted to various providers (or simultaneous provision). The applicant offering

the lowest price obtains the supply contract in an auction targeting a single provider. In case of tie, supply is equally divided among those presenting equivalent tenders. In the second type of auction, supply is allotted to more than one bidder, according to previously specified proportions.

Public auctions introduce competition in the purchase of pharmaceuticals and medical supplies by public hospitals, which face stringent budget restrictions, supply shortage and inefficient operation. The FCC's enforcement of the competition law in this area may improve public hospital performance.

Following a complaint filed by Grupo Sutinmex challenging Internacional Farmacéutica, Serral, Le Mare Internacional de México and Matcur with the alleged collusion in public auctions of surgical sutures, the FCC analysed two public auctions called by the General Hospital of Mexico and the ISSSTE. In both cases, a bid pattern among the participants could be identified. One of the most important pieces of evidence considered in the investigation was the scarce variation among the bids, which differed in all cases only by a few pesos. In addition, evidence of coordination was derived from proceedings initiated by the alleged violators regarding the auctions. During the investigation, the defendants recognised that their conduct could be interpreted as a violation to the FLEC, agreed to pay each a fine and to refrain from infringing the FLEC in the future.

In the complaint filed by Reliable de México against Kodak Mexicana, SA de CV (Kodak), GPP Mexicana, SA de CV (GPP) and Juama, SA de CV (Juama) for alleged collusion in public auctions called by public health care institutions for the purchase of x-ray material, the FCC analysed the participation of the alleged responsible parties in 35 public auctions from 1997 to 2000. Indications of the existence of collusion were found in 21 of these auctions.

The proceeding against Kodak Mexicana, S.A. de C.V. was terminated in advance, in view of the commitments this firm proposed, according to Article 41 of the Regulations to the FLEC. The Plenum considered that these undertakings were appropriate and economically feasible since they would allow the FCC to assess whether public auctions interfered with freely functioning markets where the company participated, and would provide it information on the prices it charged for chemical developers. In addition, the FCC imposed a fine on Kodak.

As to Juama and GPP, the FCC found that these firms and Kodak offered identical tenders in eleven auctions thus obtaining equal shares of the supply contracts, most of them called by the IMSS. Further, the FCC observed that the defendants bid the same prices for several product codes whenever two or the three of them participated in the same auction. Thus, the FCC found Juama and GPP responsible for violating the FLEC, ordered suspension of the practice, and imposed a fine on each of them. In reconsideration appeals filed by Juama and GPP the Plenum confirmed its resolution.

Following the complaint filed by Back Quality & Co., SA de CV charging GPP and Juama with the alleged collusion in national auctions for the acquisition of chemicals used to develop x-ray plates, the FCC investigated auctions called by the ISSSTE and the IMSS from 1997 to 2001. It found that the firms involved in the case were the only participants in all of the auctions that took place in this period, except for three, and that in 17 of these processes, Juama and GPP presented similar economic proposals. The defendants argued that the health institutions commonly provide reference prices and, on this basis, explained the similarity in their tenders. The FCC found that since 2001 the IMSS publishes in its internet site the prices actually paid after each auction. These are the minimum prices offered by bidders, not as maximum prices that the institution is willing to pay. Nevertheless, the Commission considered that the publication of this price information did not justify identical tenders by bidders and could not be considered a requirement of IMSS in order to be granted the auction. The FCC thus ordered GPP and Juama to suppress the illegal practice and imposed a fine to each one.

Privatisation of AHISA

The FLEC provides a role for the FCC to issue an opinion on economic agents interested in participating in privatisation proceedings. Based on this faculty, the FCC analysed the privatisation proceeding of the state-owned insurance company Aseguradora Hidalgo, SA (AHISA). This firm was exclusively empowered to provide collective life, health, and damages insurance policies to government employees through payroll deductions, and therefore faced the lowest costs in the industry. It also offered collective insurance products to government agencies, local governments and state-owned companies such as Pemex.

The proceeding involved the relevant markets for (a) life and health insurance, with mayor effects in collective insurance segment; and (b) management of pension funds. The Commission's analysis determined that the auction would exclusively allocate collective insurance contracts from federal employees to the auction winner for an indefinite period, thus endowing it with market power and the capacity to fix prices or restrict supply. Hence, in 2000 the FCC resolved to block the transaction by objecting to the participation of all auction applicants.

In 2001, the Federal Government proposed new auction rules that restricted the validity of AHISA's insurance policies to 2004. As in the previous proceeding, the FCC reviewed the rules for the auction, as well as prospective participants. In 2002, the FCC concluded that the modified auction rules addressed its previous concerns and issued a favourable opinion to auction participants MetLife, Inc/ MetLife International Holding, Seguros Inbursa, SA/Fianzas Guardiania Inbursa, SA Inbursa, Mapfre América Vida, SA, and Ausa Holding Company.

7. Final Remarks

The Mexican health system is characterised by unequal access to health care, unequal insurance coverage and financing, low use of services, heterogeneous quality of services, and market fragmentation. There are important opportunities to enhance productivity, service quality and overall performance of the system by using more aggressively incentive-based mechanisms and promoting competition. There are recent developments intended to expand coverage of health services through insurance and attempts to introduce incentives to enhance performance, through decentralisation and a progressive movement towards a horizontal organisation of the system. There are a number of recommendations by OECD and policy-makers directed at improving efficiency by introducing competition mechanisms such as the purchaser/provider split, prospective payment mechanisms and linking remuneration to efficiency and quality goals.

Although the enforcement experience of the FCC in this sector has not been profuse, it clearly illustrates the rationale for preventive and corrective actions of this authority both in the public and private sectors.

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NETHERLANDS

1. Introduction

The Netherlands has a unique and complicated health insurance and finance system. This is composed of a mix of public and private insurance. Government plays an active role in legislation around health care and in the financing of health services. During the last decennia however, several market incentives were introduced to increase competition. Based on 'A Question of Demand' -the leading document about reforming the Dutch health care system- we changed the structure of the health care system from a supply driven market into a more demand driven market with regulated competition.

The proposed changes are seen as inevitable. Future developments (ageing and advanced medical technologies) put a strain on health care, both on capacity and financial burden. It's forecasted that, without (policy) changes, in 2025 little over 22% of the Dutch workforce will be employed in health care (2005: 13%). Furthermore it is forecasted that the percentage of the GDP on health care will increase from 8.7% in 2001 to about 15% in 2040.

This is not a uniquely Dutch circumstance, but does require a sustainable health care system. The reform has three parallel tracks:

- (1) Competition between health care providers. The first track aims to reform the control of health care. The old health care system was characterised by supply side control and budgetary financing. Several measures are (being) implemented to strengthen the demand side.
- (2) Competition between insurers. The second track is a reform of the insurance system.
- (3) Meeting consumer demands and consumer responsibility. Consumer/patients must be allowed to make more and better choices concerning health care, but must also be held responsible for the consequences of their choices.

The proposals include a shift in decision-making power from government to the market; deregulation of planning and tariff legislation; competition between insurance agencies and between health care providers; greater consumer influence; and the introduction of financial incentives for all the parties involved. At the same time - to prevent a "Wild West" situation - the government will stay responsible for several public guarantees. The central government keeps authority over quality control, defines coverage of the mandatory insurance, enforces a duty to accept all insured, and - very importantly - develops proper market regulation specifically tailored to the health care sector.

In 2006 the difference between public and private insurance will disappear because of the new 'Zorgverzekeringswet'. This is a major breakthrough, because a private system will be introduced where everyone is obligated to be insured.

As mentioned, an important starting point of the Dutch health care system is solidarity which protects consumers from adverse selection. This is established as follows:

1. A standard package of health care services is defined at the national level. A health insurer is required by law to minimally offer this package.
2. A health insurer is required by law to accept every citizen as a customer, irrespective of his/her age, health status, social circumstances etc. The health insurer may not differentiate the price of the premium for a different type of customer.
3. Health insurers are partly funded (50%) based on the characteristics of their population. This a complex risk adjustment model (ex ante), guaranteeing the health insurers a budget for their customers, preserving the incentive for efficient and effective health care purchases.
4. Health insurers are legally obliged to purchase/organise adequate health care for their customers. For example in case of scarcity and waiting lists; they are responsible for organising adequate care, not the health provider.
5. Besides the organisation of health care by the health insurer and their service level, they compete on the height of their premiums. The direct premiums are approximately 50% of the revenues.

Summarised:

The Dutch trend towards regulated competition is a slowly evolving process in which possible risks for adverse events are carefully weighed. Government also states that developments will not evolve into a fully free market; there will always be specific sectors which remain under strong central control. When there is enough confidence that market incentives will produce the intended results, we will move ahead one step at a time.

This is both one of our strengths, as well as one of our weaknesses. Because the route to a more liberalised market is constantly debated upon and measures are implemented during a long period of time, every now and then we risk turning backwards. Above that, the positive effects of regulated competition - which is partly a quality and responsiveness issue, can hardly be measured. The Dutch model works in theory, but time will tell if everything works as planned. One element which still needs to be developed further, is improving market transparency in order to let insurers/patients actually make informed choices and put enough pressure on insurers and providers to improve their performance.

2. Structural conditions

2.1 Health care providers

The Netherlands have about 100 hospitals (including 8 academic) and about 50 ZBC's (Dutch abbreviation for small, specialised clinics for day care). All hospitals and ZBC's are privately owned, except for academic hospitals. All hospitals and ZBC's are by law (called WZV) prohibited to make a profit. The entrance of new providers is controlled at national level by the government. Both hospitals and ZBC's need to receive permission before they are allowed to operate. ZBC's can only offer outpatient care (also called day care or non clinical care). The government has traditionally relied upon private initiative to ensure the presence of enough hospital care.

Building a new hospital or major renovation of a hospital is also only permitted if there is written approval from government. Smaller renovations and ZBC's are not subjected to approval.

There are working standards to ensure availability and quality of care. However, these are not laid down in legal rules. Almost all general and academic hospitals have an acute care ward. There have been incidents where hospitals wanted to close part of their facility (especially acute care/emergency facilities

after a merger), conflicting with those standards. In those cases specific solutions have been provided for. In recent years the government has regulated that a number of smaller acute care wards can get extra money if they are kept open. It is not possible to prescribe hospitals to keep certain wards or facilities open. The only way to do this is indirectly by financial incentives or by specific regulations by government to ensure a minimum level of quality.

The number of ZBC's has risen dramatically over the last few years. Only since the late nineties has this kind of organisation been formally acknowledged. In 10 years dozens of ZBC's have emerged. However in financial terms still only a very small percentage of general hospital care is provided by ZBC's. These ZBC's usually have a few specialists working for them; sometimes they are owned by specialists.

There are also some private clinics, which do not fall under the scope of the WZV and therefore do not need a permit and are allowed to make profit. However these clinics are only permitted to provide easy care. And they are only allowed to bill the costs of the specialist, they cannot bill hospital costs.

All hospitals deliver the same kind of care. There are but a few exceptions, certain kinds of special care are limited to a few hospitals. There is a special law (called WBMV) by which certain kinds of care can be assigned to a specific number of hospitals. Only these appointed hospitals are permitted to deliver this care (e.g. in vitro fertilisation). In the system of budgets (see later) there are special parameters, with their own monetary value.

There is a new law that will come into force in 2006 (called WTZi, law on the admission of health care institutions). With this law, when public interest is at stake, government can order adjustments. The government can set conditions for health care providers. It can be made compulsory to deliver a certain kind of special care or to keep an acute care ward open. There will be less government involvement with building instructions.

With this new law it will also be easier to enter the health care market. The kind of care a ZBC's can deliver will expand. They will also be allowed to provide inpatient care that can be planned and is relatively easy ('inpatient B-segment care', see later).

2.2 *Investment costs*

Written approval for building presently leads to reimbursement of these costs. This reimbursement is based on depreciation based on actual, historic cost and an average interest for loans. These reimbursements make up a part of the tariff that patients or insurers pay to the hospital.

Other investment costs also are a part of the tariff, but these are not calculated on an actual cost level. Instead a norm is calculated regardless of actual costs.

In recent years there has been a gradual shift from reimbursing actual costs to calculating average costs. This trend will continue and it is foreseen that in a few years there will be no more reimbursement for actual cost, only for average/normative costs.

The WTZi aims to control health care institutions by conditions for good entrepreneurship instead of building procedures. The government wants health care institutions to make their own comparative assessment on whether they can recover investment costs by delivering health care services. This aspiration is described in a letter to parliament in March 2005. The paper "Transparent and integral tariffs in health care" explains how investment costs can be integrated in performance based payment in a well-considered way. Subsequently risk-bearing of health care institutions for fluctuations in sales can gradually increase. Building procedures can be ended when risk-bearing is substantial.

2.3 *Profit*

Nowadays health care institutions are not allowed to compensate financiers by paying dividends. As a consequence the financing of investments is limited to loan capital. The new law WTZi allows rules to be changed so as to allow for profit health care providers in future (target date 2012).

The paper “Transparent and integral tariffs in health care” mentions the following conditions for allowing for-profit institutions. First of all performance based payment, including investment costs, has to be implemented. Secondly the health care institutions have to be fully risk-bearing for fluctuations in sales. Thirdly there should be no leaks of collective financial means to commercial parties.

2.4 *Financial problems*

When a hospital faces financial problems, there is a possibility of getting support. The hospital can ask for a financial contribution if bankruptcy is imminent. There are strict conditions to which such an application has to adhere (for instance: there has to be a serious danger to the continuation of care, insurers have to agree there are no other means of financial support) and strict conditions during the years the hospital gets the extra financial support. ZBC's cannot apply for financial support from the government.

Because of the gradual introduction of more competition in health care, there is a tendency to interfere less with providers facing financial turmoil. Smaller health care providers, like home care institutions, have gone bankrupt in recent years. However there have -not yet- been any hospitals that have gone belly up.

Since there is a change towards regulated competition, this necessitates a change the way of dealing with financial problems. This will be in line with the future way of more output oriented finance systems. This will lead to lessening the role of the government, but also a more pro-active monitoring of the financial situation of hospitals.

3. *Contracting*

3.1 *DBC's*

In 2005 a new hospital payment system was introduced. The DBC system is part of the health care framework that is currently introduced in the Netherlands. Main starting points for the system are transparency, performance based payment and competition. The framework is the basis for competition in health care, providing a safety net to withhold citizens to drop out of the system.

The essence of the Dutch system is the competition among providers at the level of individual medical conditions. For this the DBC (Diagnosis Treatment Combination) system for product definition has been developed.¹ A DBC contains the whole outpatient and inpatient cure and care process, resulting from the initial care request by the patient.

1 DBC's are developed in the Netherlands. In de mid nineties there was a broad consensus that we needed a product definition in hospital care to make competition possible. After studying DRG's, this concept was rejected by the parties involved. Thee DBC-system than was constructed. Important differences between DRG's and DBC's are: (1) DBC's are also applicable in the outpatient clinic (one payment scheme for all hospital care); (2) doctor's fees are included (no fee-for-service-payment); (3) diagnosis and therapy are equally important to determine the hospital product; (4) DRG's are a patient classification system and DBC's an episode management classification or product definition; (5) a DRG is determined after the patient leaves the hospital done by medical coders , a DBC is a process description, the input is based on the patient's medical file and coded by the physician.

The DBC data set offers the hospital management insight in the medical process. This improvement in the management information will improve the controllability, not only in terms of finance. The data will offer direct insight in the cost of the therapy chosen. This will increase the awareness of staff and management with respect to costs and medical content. The possibility of comparing data of different medical specialists will provide insight in the variation between specialists and will probably support the decrease of this phenomenon.

In terms of quality the DBC methodology offers the opportunity to link indicators and determine protocols. DBCs are a medical process description and as such excellent for using protocols and the design of guidelines to be linked to the process. Furthermore DBCs can also be used for the development of quality monitoring programs.

At local level the DBC methodology provides an instrument for capacity planning. Each DBC provides an estimate for the average required capacity. This applies for specialists, but is very well possible for nursing and care staff as well. In case long term, when clinical profiles are known, the related shift in capacity can be determined. Not the least the use of DBC data can support the decision making process of capacity management.

Currently an experiment is put in place that describes a health product even disregarding institutional borders (diabetes). DBC cost prices vary among the different suppliers, based on their individual cost and production pattern.

The introduction in the beginning of this year has been successful, but difficult. People have a lot of questions about this new kind of billing system. There are some unforeseen side-effects, but most of them should be resolved in 2006.

3.2 Revenues and budgeting

The funding of hospitals is a hybrid system.² First of all there is a difference between payment to the hospital (revenue) and the amount of money a hospital is entitled to (budget). Second of all there is a difference in pricing between different forms of care since 2005 (free tariffs in part B, fixed tariffs in part A). And third there is a difference between hospitals and ZBC's and private clinics.

	Revenue	Budget	Difference between actual cost and budget
Hospital – fixed part (A)	DBC-tariffs plus surcharge (fixed)	Based on several different parameters	To/from reserve Not distributable
Hospital – free part (B)	DBC-tariffs (negotiated)	Equals DBC-revenue	To/from reserve Not distributable
ZBC	DBC-tariffs (negotiated and partly price-cap)	Equals DBC-revenue	Not distributable
Private clinic	Specialist tariffs	Equals revenue	Distributable

² The National tariffs authority (CTG/ZAio), a public advisory body, is responsible for rules and regulations regarding the budget-system and sets tariffs. The government can withhold approval of the rules.

Segment B

Currently the hospital health care market is free for 10% of the total hospital production. For this 10% insurers and providers are free to negotiate on price, volume and quality. The government has regulated which kind of care, which DBC's, make up this 10%. This contains relatively non-complex care, which can be easily planned, and has no shortage of supply.

However there is still a price-cap on a part of the DBC: the income of the specialist is maximized by an hourly rate (€ 140 per hour). In this segment the revenue of a hospital is all there is. There is no historic budget or any other mechanism of reimbursement.

Health insurers are responsible to purchase hospital health care products. The focus in the negotiations on the DBC contracts between hospitals and their major insurers has shifted to the "content" of the delivery of care. Differences in care are discussed on the level of added value of specific diagnostic tests or therapeutic procedures. Another major change is the introduction of a quality dimension in the contract, like the percentage of complications accepted for treating a certain diagnosis. The outcome of care is also part of the new equation; one insurer offers a bonus to general practitioners providing diabetes care when the HbA1C is below a certain level.

Although this is the ideal approach which is not yet followed in all negotiations, the good news is that a paradigm shift can be observed from a very global discussion about some very simple production parameters setting the hospital budget to a disease orientation, balancing costs, quality and outcome.

Segment A

The remaining 90% of hospital care is still budgeted, having a fixed and a variable component. For this 90% providers and insurers negotiate on volume and quality. Prices are fixed, determined by the government. This is called segment A. The fixed component of the budget is based on location and availability related supply-factors such as infrastructure, buildings, number of beds and number of specialists. The supply-factors are determined by the government. The variable component is derived from production-agreements with health insurers and includes four factors: nursing days, number of admissions, number of first outpatient visits and volume of day care. The unit price for each of these factors is determined by an independent institution using historical financial data. Except for historic investments these parameters are the same for all hospitals, including academic hospitals. However these academic hospitals do receive an extra budget which is historically based ('academic component').

About 60% of the medical specialists work in hospitals as free professionals organised in partnerships. They receive a fixed amount of money (lump sum) based on historical turnover data. Production is agreed upon in contracts with the health insurer. The remaining group of specialists, among which specialists of 8 academic hospitals, consists of salaried employees whose earnings are determined by collective labour agreements for the sector.

Health insurance companies receive a budget to serve their population of customers. Currently health insurance companies are compensated for ninety-five percent of the shortfall in hospital-expenditures.

DBC's were also introduced in this segment in 2005. But they are only used as method of distributing costs among health insurers. The billing of DBC's is used as the cash flow system to guarantee the hospitals income. Usually the budget the hospital is entitled to will be higher than the revenues from DBC's. The difference between these two leads to a surcharge on the price of the DBC, calculated by the government. This surcharge differs per hospital.

ZBC

ZBC's can operate in both segment A and B, but can only provide outpatient care. ZBC's do not have a budget in segment A, and the prices are not fixed, but have a price-cap. So for ZBC's all that matters are DBC prices. Otherwise there is no difference in rules and regulations between hospitals and ZBC's in segment B.

3.3 *Negotiations: DBC's as a steppingstone for quality*

Segment B

For the free 10% the health insurer may negotiate with restricted (preferred) suppliers and can direct their customers to these providers. The DBC has introduced a new language for the negotiations between insurers and care providers. The introduction of the DBC contracts has resulted in very interesting results. Part of the government strategy was to open competition on care which could also be provided by ZBC's. As there was a major difference in prices between the ZBC's and the hospitals, it forced the hospitals to review their delivery process for these DBC's. This resulted in optimizing their internal process and thus lowering their internal costs. Competition managed to provide more value for a better price. The new system drives the hospitals to act and start changing long existing ways of care delivery. Our experience at this moment is that medical results and performance indicators play a central role in the negotiations next to price and volume, quality is an important aspect of the power of discernment of the health insurer. This is "*competition at the level of diseases or treatments*" with "*transparent pricing*".

A new wave of modernisation has been initiated. Some clinicians show their entrepreneurship and start new ZBC's to offer care for some specific conditions. They deliver higher production levels, provide better process and clinical quality to patients and raise work satisfaction to clinicians.

If the consumer chooses to obtain health care in a non-contracted hospital, an additional payment may be required. This additional payment leads to heated public debate. On the one hand it is said that insurers must have opportunities to refuse having a contract with a hospital, and that they are representatives of their policyholders. On the other hand it is said that people should not be restricted in their choice of health care provider, so they should be able to go to a non-contracted hospital, but additional payment may prevent that.

Segment A

For the 90% the consumer is free to consume health care services were he/she chooses. Insurers have to negotiate with hospitals about quantity and quality. Prices are fixed, and are not open to negotiation. These negotiations concern the parameters that make up the budget, i.e. number of hospital days, etc., not yet about DBC's for this part.

The monetary value of these parameters was calculated in the 1980's when this system of so-called functional budgeting was introduced. There have been adjustments in these amounts, but in recent years maintenance has been limited. This has mainly consisted of indexing, adjustment of some obsolete figures and adding some new parameters in case of new developments. The focus in the last years has been on the introduction of the DBC's.

Although this system has worked very well for more than a decade, it now seems to be obsolete. Incentives in this system are no longer desired, it is focussed on activities and operations, e.g. in this system a hospital receives a higher budget if a patient stays longer.

ZBC's

With ZBC's this is different. Since they do not have a separate budget, the negotiations are all about DBC's. A part has free prices; the other part has prices with caps.

3.4 *Future of DBC's*

It is the objective of government to increase the 10%-free prices segment the next years. But, the new dynamics on the health care market are already promising.

Depending on the experiences with this free segment, the speed and quantity of DBC's that will be 'transferred' from segment A to B will be determined.

There is a discussion on what will ultimately stay in segment A. This has not yet been decided upon, but it is the intention to change payment system in this segment. It is generally agreed upon that the current budget-system, based on a relatively limited number of parameters should be changed towards a case payment system based on DBC's. The pricing of these new DBC-parameters is currently under investigation. The government has asked the national tariffs authority to investigate the use of benchmark and yardstick competition to set prices. Another method which will be investigated is the use of price-cap regulation.

3.5 *Benchmark*

At this moment hospitals do benchmark. They use information to improve their performance. Publicity is the way to make achievement in a hospital known to other hospitals (www.snellerbeter.nl). The results from benchmarking are not used for pricing and efficiency gain purposes.

3.6 *Consumer choice*

Health insurers play an important role in informing the health consumers on where to obtain the best treatments for specific health requests. Furthermore DBC information is made accessible by using internet web applications in cooperation with the National Board of Patient Groups (NPCF). The next step is to make the performance indicators and medical results publicly available at the level of individual providers and individual health products (DBCs).

To be sure that the necessary information for consumers will be available in short time, the Ministry of Health started www.kiesBeter.nl. On this website consumers can find information to make choices between insurers, health providers, medicines and treatments. In 2006 the service to consumers will be enlarged with a telephone line and cooperation with existing organizations where face-to-face service can be given to consumers.

3.7 *Innovation*

The rising competitive pressure of both health insurers and consumers gives the providers the right incentive to innovate. We can see this for instance in eye surgery, where surgeons are now stimulated to develop further their treatment to cheaper, safer and quicker solutions as a result of DBC price negotiations with health insurance companies. The latter compare the different DBC offers they receive, including treatment patterns and costs, and use this information in the negotiations with other hospitals. Other good examples are the developments shown in hip and knee surgery. Also innovations that lead to more effective but more expensive DBCs are part of reality.

In order to stimulate innovation in the DBC system a Scientific Medical Advisory Board is put in place. This board is responsible for the definition of new innovative DBC's including the treatment pattern, and to remove other DBC's which have become obsolete regarding new medical standards. To do so the Scientific Board can use the treatment and cost data of all providers. This information will become readily available from a national database. All providers are required by law to deliver their production data to this national data warehouse.

Furthermore, patient interest groups need to have the right information about DBC's, treatment standards and costs, in order to be able to make the right decision for a provider and to force the insurance company to contract the right DBC's from the right providers.

The Scientific Board has to ask the government to approve a new or changed DBC. Only when they have been approved will it be possible to charge these to an insurance company, and even then only if the insurer wants to contract this.

4. Competition law

Introducing regulated competition in Dutch hospitals' services makes competition law applicable on negotiating parties. Both the Dutch Competition authority (NMa) and the National Health authority (NZa) will keep guard over market behaviour in health care.

The NMa is in charge of execution and enforces general national competition law, which is based on the European competition law of the Treaty. The NMa concentrates on cartels, abuse of market power and mergers in health care.

Next to the NMa, a special authority will be formed in 2006 that will get special tasks and qualifications in the health market. The national tariffs authority will merge with another public body, the supervisor on the health insurance companies, to form this new public body: the National Health authority (NZa). The NZa will be in charge of execution and enforcement of the specific law regulating health achievements and –prices (Wet Marktordening Gezondheidszorg). This new authority will play an important role in advising the government on the best pricing strategy to be applied and will also act in a supervisory capacity for the liberalised parts of the health care market.

The NZa is a regulator and focuses on market engineering. It is responsible for enforcement of sector specific performance and price regulation and aims to prevent abuse of dominant positions. The NZa is comparable to regulators in the telecom sector.

4.1 Abuse of dominant position

There is no experience with cartels or (preventing) abuse of dominant position. Several government reports, however, suggest that the current circumstances result in a relatively high risk of hospitals abusing market power in order to realise excessive pricing and predatory pricing. First, those circumstances are due to historical factors: Some hospitals find themselves in a dominant position, which makes excessive pricing behaviour possible. Second, the current split in the health care financing structure results in opportunities for financing predatory pricing in segment B by means of cost misallocation (cross-subsidy) from segment A. In future, competition authorities investigating such unlawful behaviour will have to define geographic markets using methods as described below.

Other possible anticompetitive behaviours, recognized by the NZa, are:

- Price discrimination;

- Tying;
- Abuse of buying power by health insurers;
- Horizontal agreements, e.g. referral arrangements;
- Non competes of health insurers.

4.2 Mergers

The Netherlands Competition authority (NMa) has dealt with 3 merger cases concerning hospitals:

- 3524/Leyenburg Ziekenhuis - Rode Kruis-Juliana Kinderziekenhuis. (28-1-2004): a merger in an urban region (The Hague)
- 3897/ Ziekenhuis Hilversum - Ziekenhuis Gooi-Noord. (1st phase decision 15-07-2004, 2nd phase decision 08-06-2005): hospital merger in a suburban region.
- 5047/Erasmus MC – Havenziekenhuis. (08-06-2005): a merger in an urban region (Rotterdam)
- Recently (September 2005) a fourth hospital merger has been notified.

All cases involve(d) mergers between suppliers of the full scale of (basic) hospital services. So far all of these mergers have eventually been cleared by NMa. (One of them after a second phase of investigation).

Product market definition

In all cases a distinction has been made based between clinical and non clinical healthcare. Clinical healthcare requires the patient to stay overnight. For each of these two product markets a further possible distinction has been considered between a market for separate medical specialities vs. a market for general hospital services.

NMa has conducted (not case specific) research to establish whether a market for general hospital care or different markets, divided according to specialities, should be assumed. For this purpose, NMa commissioned a consultant to carry out research on the definition of product markets in the hospital sector. This research had both a quantitative and a qualitative component. The assumption was that from a SSNIP perspective, given the limited influence of demand side substitution when it comes to healthcare products, in order for the relevant product market to be broader than a single medical speciality, arguments of supply side substitution are required. Although the research provided useful insights, the results were inconclusive on this point and did not answer the question whether separate relevant markets for every medical specialty should be considered in merger cases. In the second phase decision in case 3897/Ziekenhuis Hilversum - Ziekenhuis Gooi-Noord as well as the decision in 5047/Erasmus MC – Havenziekenhuis separate product markets per speciality were, for practical reasons, not considered any longer.

Geographical market definition

For the definition of the geographical market in first phase investigations the NMa has relied on the Elzinga Hogarty test. (Patiënt-flow data are available in the Netherlands and it is relatively easy and quick to execute this test). We have not applied the strict 90%-90% boundaries for LIFO and LOFI scores but

used the numbers of past patient travel behaviour as an indication of the geographical region, next to other more qualitative evidence.

In the second phase investigation in Ziekenhuis Hilversum / Ziekenhuis Gooi-Noord a more dynamic approach to geographical market definition was taken. In order to assess whether hospitals in the immediate environment of the parties could exercise an adequate disciplining effect on the behaviour of the parties, a research was conducted on the extent to which patients would not be willing to visit the parties' hospitals, but would rather travel to a different hospital, due to a certain change in the price/quality ratio of the services offered. Because of a lack of responsiveness from patients to hospital price increases, instead a decrease in quality was modelled using three approaches. Firstly, the travelling time was used to provide an estimate of the price which patients pay for their healthcare services.³ Then the response of demand to a fall in three quality factors was examined using a conjoint analysis. The results indicated that patients assign low value to travelling time compared to quality indicators, such as hospital reputation, which suggests that quality competition leads to an increase in patients' willingness to travel. Finally, research has been carried out to establish how patients' choice of hospital would be affected by an increase in the insurance premium which they have to pay for the healthcare product provided by the hospitals. The vast majority (three-quarters) of the patients said to be prepared to travel further than the nearest hospital in case of higher prices (10 percent) of that hospital.

5. Conclusion

The Netherlands are in the middle of reforming the provision of hospital services. The current system no longer meets future developments and leads to an increasing pressure on capacity and a growing financial burden. The challenge to government is to design and implement a system that is sustainable and delivers the desired outcome, i.e. is both affordable and results in availability of high quality services for those in need. In order to achieve this, market incentives are gradually introduced for health insurers, providers and consumers. The changing incentive structure asks for continuous attention from policy makers, the Dutch Competition authority and the National Health authority. During the transition period of this (necessary) reform programme, complex questions will no doubt have to be answered, but belief in the benefits regulated competition offers, inspires confidence for the future of Dutch health care.

3 The method used entails calculating what value patients attach to their travelling time in choosing a hospital, compared to other factors (such as the quality of the hospital) on the basis of a dataset with actual patient flows. The explanatory variables in the model contain both variables which are patient specific (such as travelling time to a hospital), and variables which are hospital specific (certain quality variables of hospitals). A model can be derived from this calculation which can then be used to determine what the effect on patient choices is of a change in one of the optional variables. This model simulates the consequence of a hypothetical increase in travelling time on patients' choices. Travelling time is used as an approximation of the price which patients pay for healthcare services. A time elasticity of demand is also derived. See Capps, C.S., D. Dranove, S. Greenstein, and M. Satterthwaite. "Antitrust Policy and Hospital Mergers: Recommendations for a New Approach", *The Antitrust Bulletin*, 2002, p. 677 et seq.

NEW ZEALAND

1. Introduction

1.1 *New Zealand Health Strategy*

The last decade has been one of change for the organisation of health and disability support in New Zealand. Policy and legislative reforms introduced at the turn of the century have dramatically changed the way that Crown funding is provided for the provision of health services and have impacted on how public hospitals work together to achieve the goals of the New Zealand Health Strategy. These recent reforms have moved public health from a purchaser/provider model to a more community oriented, population based health care system.

As well as being the subject of policy and legislative reforms, the health sector has been a priority area for New Zealand's competition authority, the Commerce Commission. The Commission has devoted considerable time and resource to this sector and has conducted a number of important investigations, in both the market behaviour and the market structure areas.

1.2 *Hospital services in New Zealand*

Hospital services are provided by both public and private health care providers. There are currently approximately 445 hospitals in New Zealand, of which approximately 85 are publicly funded. Essential health care services are provided free through the public health system but most hospital doctors (specialists) can only be seen after referral from a general practitioner.¹ Public hospitals undertake most surgical procedures including emergency services.

Elective (scheduled, non-urgent) surgery is also performed by public hospitals but funding limitations have meant that waiting times for treatment can be lengthy for some specialities². Patients may choose to source elective treatment from a private hospital. Private hospitals which do provide surgical services focus almost exclusively on elective surgery, leaving emergency services to be provided by public hospitals.

1.3 *District Health Boards*

At the end of 2000 the New Zealand Public Health and Disability Act received royal assent. This Act creates District Health Boards as both providers and funders of health and disability services to the public. Public hospitals are owned and run by District Health Boards.

In launching the New Zealand Health Strategy the Minister of Health articulated a perception that competition between public hospitals was leading to increased costs. There were concerns that public hospitals were unable or unwilling to co-operate with each other to achieve economies of scale, exchange information, share investment in high cost equipment and the like. The New Zealand Health Strategy seeks

1 The referral system is discussed in greater detail below

2 The sector is working to address these problems through the introduction of a system based on clarity, timeliness and fairness to ensure that patients are prioritised against objective criteria and are dealt with fairly, depending on their level of need.

to balance a need for robust competition with recognition that some collaboration may be necessary to achieve economies of scale and other benefits. The Minister of Health expressed³ this as follows: “The strategy calls for the health sector to work co-operatively towards common goals rather than competing for the largest share of the health dollar.”

The focus on collaboration and co-operation is embodied in a number of provisions of the New Zealand Public Health and Disability Act. These are provided in an appendix to this paper.

It should be stressed that, notwithstanding the focus on collaboration and co-operation in providing public hospital services, District Health Boards remain bound by the Commerce Act. In addition, this is a sector in which the Commerce Commission has been very active. The application of the Commerce Act to hospitals is discussed further below.

1.4 Private hospitals

Most private hospital services are provided to patients on a user- pays basis (either through insurance or on a self funding basis).⁴ A typical private surgery will provide about three quarters of its services on a user pays basis, with the remaining quarter being funded through the ACC⁵ (about 22%) and District Health Boards.

The New Zealand Private Hospitals Association is a voluntary association of independent hospitals. Most of its members are exclusively concerned with long-term care of the elderly. Private hospitals which do provide surgical services focus almost exclusively on elective surgery. Patients wishing to avoid the waiting lists associated with elective services in public hospitals, or seeking a smaller hospital with more personalised care, may choose to undergo elective surgery at a private hospital.

2. Application of Competition Law to Hospitals

2.1 Commerce Act

Both public and private hospitals are bound by the provisions of the Commerce Act. Public hospitals however, enjoy limited protection from some of the prohibitions of the Act by way of the ‘interconnected bodies corporate’ provision in the Act⁶. This limited protection allows District Health Boards to co-operate with each other in achieving the goals of the New Zealand Public Health and Disability Act but does not allow them to engage in anti-competitive conduct outside of this mutual collaboration. The protection applies to bilateral conduct only where both of the parties to potentially infringing conduct are District Health Boards (or other defined health sector Crown entities). It does not apply to unilateral conduct by a District Health Board. District Health Boards remain bound by the generic competition law in all situations except where they co-operate with each other to achieve the goals of the New Zealand Public Health and Disability Act.

3 New Zealand Health Strategy <http://www.moh.govt.nz/moh>

4 There are approximately 30 insurance providers registered and operating in New Zealand.

5 The Accident Compensation Fund (ACC) administers New Zealand’s accident compensation scheme, which provides personal injury cover for all New Zealand citizens, residents and temporary visitors.

6 Section 44(1A). A copy of the relevant provisions is included in the appendix.

2.2 *The choice of hospitals*

In practice there is a relatively complex set of relationships leading to a particular patient being operated on by a particular surgeon in a particular hospital. Patients do not consult a specialist directly but are rather referred to a specialist by their primary health care provider (usually a GP). The GP will usually recommend both whether specialist consultation is warranted and which specialist should be consulted. Most GPs will have surgeons who they generally refer patients to. Once a surgeon is chosen patients will generally have little input into the choice of hospital since surgeons have relationships with particular hospitals. The choice of surgeon will determine the choice of hospital.

3. *Commerce Commission Activity in the Health Sector*

3.1 *Introduction*

The Commerce Commission has, in recent years, devoted considerable time and resources to the health sector, which was identified some time ago as a priority area for the Commission. At the OECD meeting of October 2004 the delegate from New Zealand discussed a number of important cases which have recently been taken by the Commission against members of the medical profession. These did not directly concern hospital services and are not discussed further here. They are, however, important in that they indicate the seriousness which the Commission attaches to the proper functioning of the health sector.

Furthermore, while recent activity has not been focussed on conduct by hospitals, the Commission has conducted a number of investigations into potentially anti-competitive conduct by providers who provide services to public hospitals. The recent refusal of a clearance for a merger of pathology laboratories is a case in point. The Commission declined the application for clearance on the grounds that it was not satisfied that the proposed merger would not have the effect or likely effect of substantially lessening competition in the market. Since these pathology laboratories provide services to District Health Boards, any substantial lessening of competition in the market could prejudice the provision of hospital services by District Health Boards.

At the meeting of October 2004 the New Zealand delegate commented that there was still some resistance from the medical profession to the notion that the Commerce Act should apply to their activities.

3.2 *Commerce Commission consideration of hospital services*

Hospital services have been directly considered by the Commission in a number of merger clearance applications. The Ascot Hospital and Clinics Limited/Mercy Hospital Auckland Limited⁷ application was considered subsequent to the reforms of 2000 and provides useful guidance on a number of areas raised in the OECD background paper. When this matter was decided there were no directly parallel previous decisions by the Commission. One earlier decision, regarding a merger of Eastbay Health Limited and Western Bay Health Limited concerned two geographically separate public hospitals, before the reforms of 2001, and was of little assistance.

3.3 *Defining the market*

The OECD background paper acknowledges that hospital services are complex products which may encompass many different types of patient-oriented activities and that, for some services a hospital may have few competitors while for others it may compete for patients with other service providers. This

7 14 December 2001. Decision No. 449

complexity was recognised by the Commission in its consideration of the market definition and, in particular, in its deliberations on the product dimension of the market.

In the Ascot Hospital decision the Commission, in defining the product under consideration, emphasised that private and public hospitals in New Zealand package the surgical services provided to patients differently. Public hospitals generally provide the surgeon and other specialist skills such as anaesthetists in addition to the facilities and support staff such as nursing staff. Private hospitals, on the other hand, will generally provide only the facilities and support staff, while the surgeon contracts directly with the patient. Thus, the product with respect to publicly funded operations is the provision of the surgery and the facilities while the product with respect to privately funded operations is only the provision of the facilities.

The Commission distinguished between a market for publicly funded work and a market for privately funded work. It found that private hospitals are directly competing with public hospitals for elective surgery whereas only a small amount of privately funded work is undertaken in public hospitals. The Commission found that: “Therefore, for publicly funded operations, public and private institutions are in the same market, whereas, for privately funded operations that is not the case.”

The Commission found that it was meaningful to differentiate between elective surgery and acute, emergency surgery, and also that it was meaningful to distinguish between secondary and tertiary surgery.

These factors led the Commission to conclude that: “... it is now appropriate to define separate markets for publicly and privately funded elective surgical work. Both private and public hospitals operate in the publicly funded market, whereas only private hospitals operate in the privately funded market.”⁸

Notwithstanding these different markets the Commission did acknowledge that public hospitals are a constraint on the privately funded elective surgery market because the potential for public hospitals to increase the amount of elective surgery undertaken remains and patients still retain the choice whether to pursue public or private care. The Commission found that the service dimension, especially timeliness favours the private provision while price favours the public. If the price in the private system becomes too high the patient may switch to the public system.

The OECD background paper states that “geographic market definition is often an important and complicated aspect of such cases”. In this matter the Commission considered the region from which the two hospitals drew their patients, and the willingness of patients to travel for treatment. The Commission found, in this case, that the vast majority of patients serviced by these hospitals came from the Auckland region. It also found that patients would be unwilling to travel for treatment. The geographic region was therefore defined as being the Auckland region.

3.4 Competition analysis

One of the issues before the Commission was how to measure market share in cases such as this. The applicant argued that market shares should be measured by bed numbers but the Commission determined that a more appropriate measure is the number of operating theatres. This conclusion was based, among other factors, on the consideration that the nature of surgery has changed such that many surgical procedures which would, in the past, have required hospital stays can now be performed on a day-patient basis, thus reducing the number of beds required. In concluding that operating theatres are the most

⁸ in coming to this conclusion the Commission departed from its earlier stand in the Decisino 331. This shift is attributed to changes in health policy which now discourages the carrying out of private work in public hospitals.

appropriate measure of market share the Commission recognised that this is not a perfect measure. It acknowledged that surgical procedures vary considerably and that the output of one theatre may be very different to the output of another. However, it found that, to the extent that surgical facilities can be used across a variety of branches of medicine, the number of theatres is a useful proxy to market share.

At first glance it may appear that the demand for health care is relatively inelastic. It may be argued that people value their health highly and will therefore prioritise health care ahead of other expenditure. In the Ascot Hospital matter, however, the Commission found that, where the surgery under consideration was elective, as in the current case, demand was relatively elastic. By definition this surgery is non-urgent and there is always the option of delay, despite the inconvenience or discomfort that this may cause. Patients who are willing to delay have the option of pursuing the public health care route, and there may be other medical options, such as the use of pharmaceuticals instead of surgery. The demand for private elective surgery may, therefore be elastic, which is what the Commission concluded in this case.

4. Funding, Quality Assurance and Efficiencies in Public Hospitals

4.1 Introduction

The call for papers recognises that there may be a tension between a need to ensure broad accessibility to health care services and an attendant need to subsidise public hospitals on the one hand, and the need to ensure that public hospitals operate in an efficient, competitive manner on the other. Legislation and policy settings seek to balance these potentially conflicting concerns through a combination of funding reforms and accountability requirements. This section of the paper considers how public hospitals are funded and how performance is monitored.

4.1 Funding of District Health Boards

With the reforms introduced in 2000 came new funding provisions for District Health Boards (and, therefore, for public hospitals). A population-based funding formula was introduced⁹. The aim of the population based funding formula is to fairly distribute available funding between District Health Boards according to the relative needs of their populations and the costs of providing health and disability services to meet those needs. The rationale behind the population based funding formula is that each District Health Board should be given the same opportunity, in terms of resources, to respond to the needs of its population. According to the population based funding formula, each District Health Board's share of health and disability funding is determined by:

- (1) Its share of the projected New Zealand population, weighted according to the national average cost of health and disability support services used by different demographic groups;
- (2) An additional policy-based weighting for unmet need that recognises the different challenges District Health Boards face in reducing disparities between the population groups; and
- (3) A rural adjustment and an adjustment for overseas visitors, each of which redistributes set amounts of funding between District Health Boards to recognise unavoidable differences in the cost of providing certain health and disability support services.

⁹ A copy of the PBFF document is available on the Ministry of Health's website at: <http://www.moh.govt.nz/moh.nsf>

District Health Boards are, therefore, not funded per output but rather on the basis of the needs of the population group that it services. This supports District Health Boards in working with their communities to achieve the most appropriate mix of health services for their populations.

4.2 *Accountability for performance*

District Health Boards are accountable to the Minister of Health (who is ultimately responsible to Parliament) for achieving Government expectations. District Health Boards enter into annual funding agreements with the Crown (known as Crown Funding Agreements) which specify the services that the District Health Board will be expected to deliver within the levels of funding. These have explicit performance targets based on the goals and objectives of the New Zealand Health Strategy. It is intended that annual funding agreements contain clear, measurable performance indicators. Performance is benchmarked and publicised and achievement recognised and rewarded.

In addition to the annual funding agreement, District Health Boards operate under a number of accountability instruments, including:

- A statement of intent which includes a report on the extent to which the District Health Boards has met its objectives under the New Zealand Public Health and Disability Act, a report on the hospital and related services it owns and a statement of how the District Health Board has given effect to and intends giving effect to its functions under the Act;
- An Annual Report;
- A District Annual Plan (to be agreed with the Minister);
- A District Strategic Plan; and
- Quarterly reports on its performance

4.4 *Conclusion*

The reforms in New Zealand's health care sector are relatively recent and District Health Boards may be experiencing some initial difficulties as the regime beds in. The Commerce Commission will continue to monitor and work with the sector closely to ensure that public hospitals fulfil their obligations in accordance with the Commerce Act. The Ministry of Health will continue to monitor the sector closely to ensure that District Health Boards perform their legislative functions and fulfil the developing requirements of the New Zealand Health Strategy.

APPENDIX

Key points to note (July 2003)

- NZ is a small country in which the majority of the population live in cities while the minority are widely dispersed in rural areas;
- Over the last decade there has been a general increase in the number of health professionals, including the number of doctors and nurses, but there are still shortages in some areas;
- Expenditure on health in real terms has risen consistently over the last decade;
- Health expenditure as a proportion of GDP is similar to that in most other OECD countries; and
- Life expectancy has risen over the last half century but there remain disparities in life expectancy based on ethnic and socioeconomic differences.

Provisions in the New Zealand Public Health and Disability Act relating to co-operation and collaboration by District Health Boards

- Section 3(5) provides that, in giving effect to the purposes set out in subsection (1), the Crown and District Health Boards must endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services.
- Section 23(1)(b) provides that, for the purpose of pursuing its objectives, each District Health Board has various functions, one of which is to actively investigate, facilitate, sponsor and develop cooperative agreements and arrangements with persons in the health and disability sector in order to promote the inclusion of individuals and encourage independence.
- Section 24 provides that a District Health Board may enter into a co-operative arrangement with persons (whether or not in the health sector) in order to assist the District Health Board in meeting its objectives, enhancing the health or disability outcomes for people or enhancing efficiencies in the health sector.

NORWAY

1. Introduction

This paper deals with competition and efficiency issues in relation to the provision of hospital services in Norway. In this paper we do not cover all the questions in the guide for country submissions. Here we focus on what we regard as the most interesting features of the Norwegian system for provision of hospital services.

The health enterprise model is the cornerstone of the Norwegian system for providing hospital services and other specialist health services. This model potentially paves the way for competition between the suppliers of health services, competing for orders from the health undertakings. An elaboration of this model is given in section two, 'Structural conditions'. The financing model is another cornerstone. The health enterprises are financed partly through a fixed yearly payment, and partly through output-based reimbursement. We also describe the main characteristics of the financing model in section two.

In section three we describe contracting and competition mechanisms, focusing particularly on benchmark competition, outsourcing and the effects of consumers' choice. In section four we describe some relevant cases under Norwegian competition law.

2. Structural Conditions

2.1 *Public and private provision of hospital services in Norway – an overview*

Norway has a national health care system. Hospital services are mainly financed by the government, and the right to receive hospital services is regulated by law.

Hospital services are supplied not only by government-owned institutions, but also by non-profit private institutions and commercial private providers of hospital services. However, the government-owned institutions supply most of these services. The government-owned hospitals had 93 % of the hospital admissions in 2004; non-profit private hospitals had 4 % and commercial private providers 3 %.

The extent of commercial private hospital services has grown significantly the last 15 years. The number of enterprises has increased from 2 in 1990 to 26 in 2004. These private providers have specialised in scheduled treatment, especially outpatient surgeries (78 % of their activities).

From 2000 to 2004 private commercial providers have multiplied their number of scheduled hospital admissions by more than 20. Their contribution constitutes more than half the total increase in the supply of the services they have specialised in.

2.2 *Ownership to public hospitals*

Until 2001 public hospitals were controlled by the counties. In January 2002 the State took over the ownership of these and all other public institutions within the specialist health service.

The hospitals are organised as enterprises. The enterprises are separate legal entities, which do not form a part of the central public administration. The State has no authority or responsibility for the day-to-day operation of the enterprises. However, as owner the State lays down the articles of association and other framework conditions and objectives, and selects the board members. The Ministry of Health Services may also, in the general meeting, lay down instructions for the boards of the regional enterprises. All decisions of considerable importance must be presented at the general meeting. It is clear from the preparatory works to the Health Enterprises Act that the State as owner is entitled to make decisions of strategic, financial or other vital nature. It was also an explicit premise that the reform should lead to a centralised management of the health enterprises.

Norway is divided into five health regions. In each region a regional health enterprise (regionalt helseforetak, RHF) is established. Each of these RHF's owns 4-8 subsidiary health enterprises. Each of the health an enterprise (helseforetak, HF) owns and operates one or more hospitals or other health institutions. The production of public health services takes place in these institutions.

2.3 *Responsibilities for the health enterprises*

The State is responsible for providing specialist health services to the public, according to the Patients' Rights Act. This act states that the patient is entitled to receive necessary health care from the specialist health service. The specialist health service shall also set a time limit within which the patient shall receive necessary health care. If the patient does not receive such care within the time limit, the patient has a right to receive necessary health care immediately – if necessary from a private service provider or from a service provider outside Norway.

The RHF's are directed to fulfil this responsibility of providing hospital services for the population in their own region. The RHF's have two possible ways of doing this. Their own subsidiaries (the health enterprises) can produce the services, or the RHF's can buy the services from other suppliers – private or public.

Each RHF and each HF is responsible for its own economic result. The enterprises are obliged to be in economic balance over time, within the framework conditions set by the State. The Norwegian Accounting Act applies for the public health enterprises as well as for private enterprises. There is, however, an exception made for the estimation of the capital value in the opening balance at the time of foundation. Health enterprises also differ from other enterprises because they can not be taken under bankruptcy proceedings.

The state has instructed the RHF's to coordinate the activities of the subsidiaries when required. Based on the ownership the RHF's can request the health enterprises to cooperate.

2.4 *The role of private providers*

Two types of private enterprises provide hospital services: Non-profit institutions and commercial institutions.

Non-profit institutions have a similar role to public health enterprises (HF's). They are financed in a similar way, and their agreements with the RHF's resemble the agreements between a RHF and its HF's. Non-profit institutions may provide a broad range of specialist health services, including emergency help. After the Health reform in 2002 some of these non-profit institutions became public health enterprises. Today there are 7 non-profit institutions with an agreement with a RHF.

Commercial private providers of hospital services have another role. The government regard these as a supplement to the public providers. They constitute a competitive benchmark and contribute to

innovation. During the last years they have also played an important role in reducing waiting time and shortening the queue of patients waiting for outpatient surgeries or diagnostics by radiology or laboratory testing. In 2004 there were 26 commercial providers of hospital services, and in addition 35 private providers of laboratory and x-ray services. There is potential for more competition in the market for such services. We will comment on this in section 3.

Private specialists outside hospitals also provide specialist health services. For some specialities they provide a substantial part of the total services.

2.5 *Financing of the health enterprises*

The financing model for health enterprises in Norway is a mixed model, combining a fixed budget appropriation and an output-based reimbursement. The main features of this model were implemented in 1997.

2.6 *Fixed budget appropriation*

Each regional health enterprise receives a fixed budget appropriation for each year. The Parliament decides the total sum, and the allocation of this to the RHF's, for one year at the time. The allocation is based on principles decided by the Parliament in 2003, including the regions' population size, age distribution and travel distance to hospitals. There is also a special grant to the northern region.

The allocation model is not fully implemented, and historical budgets (from the period before the reform) still have significant influence on allocation. Some of the RHF's receive substantially less than the model prescribes.

There is no mechanism that compensates a health enterprise which faces financial difficulties. It is possible for an enterprise to have a negative operating result, and cover this by loan financing. The size of the loan must, however, be accepted by the Ministry of Health and Care Services.

2.7 *Output-based revenue mechanisms*

The model contains two output-based revenue mechanisms. These are not differentiated from the regional health enterprises.

Input-based financing (*Innsatsstyrt finansiering*, ISF) is a DRG-based reimbursement system, which applies to most of the hospitalised treatment. The RHF's receive 60 % of the calculated DRG-price (equivalent to the average operating cost for each DRG). This percentage has varied from year to year. In 1997, when the system was implemented, the percentage was 30 %. In 2003 it was 60 %, then reduced to 40 % in 2004 and again increased to 60 % in 2005.

For outpatient treatment, radiology and laboratory services there is another output-based reimbursement system – RTV-payment – based on fixed payments for each type of consultation. The RTV-rates are different for private providers and public health enterprises. The patients themselves also pay a small amount for each consultation (there are some exceptions to this). As for ISF, the percentage cost absorption has varied. Since 2004 the sum of payments from the patient and from RTV has been approximately 40 % of the calculated average operating costs.

2.8 *Financing of private hospital service providers*

Private providers of hospital services must have an agreement with one of the regional health enterprises to obtain state reimbursement. If the provider has no agreement with a RHF the patient will be responsible for paying for the treatment.

In 2005 26 commercial private providers of hospital services and 30 private providers of radiology or laboratory services have agreements with regional health enterprises.

3. *Contracting and Competition Mechanisms*

3.1 *Entry for new providers*

Private hospitals or private health care service providers must be authorised by the Ministry of Health and Care Services. The Ministry focuses on whether the services in question are beneficial from both a social and economic point of view. It is also emphasised whether there is an actual need for the services, and if the intended use of health care personnel is considered to be reasonable. Lastly, it is also taken into consideration whether the services are sound from a professional viewpoint.

A patient with a right to necessary scheduled treatment has a statutory right to choose the hospital or other institution in which the treatment shall be carried out. It is a condition that the institution is owned by a regional health enterprise, or has an agreement with a regional health enterprise that entitles the patient to make such a choice.

Private laboratory and radiology service providers do not need any authorisation to be allowed to supply their services. However, an agreement with a regional health enterprise is a condition to be entitled to public reimbursement. Thus, the RHF's have a key role regarding the entry of new providers.

3.2 *Benchmark competition*

ISF-payments and RTV-payments are prospective payment systems, and imply benchmark competition for hospital services. The hospitals have incentives to be more efficient, and they have incentives to shut down inefficient units.

Since ISF was introduced, two kinds of restructuring have been observed. First, an increasing part of the treatment is performed as day treatment (the patient is leaving the hospital the same day as he arrives). There are various explanations for this; economic reasons are most likely among them. Second, the length of stay (LOS) is significantly reduced since the prospective payment systems were introduced. For most DRGs the decrease in LOS has been between 10 % and 20 % from 2000 to 2004. This is partly due to the increase in day treatment for conditions that earlier demanded several days of hospitalisation. However, the length of stay is also significantly reduced for treatment where the patients stay for more than 24 hours. More efficient procedures may be one of the explanations for this.

There are reasons to believe that the potential of benchmark competition is far from exhausted. The ISF offers a payment of 60 % of calculated average operating cost, and this percentage has varied between 30 % and 60 % since the system was introduced in 1997. The change in conditions has made it difficult for the enterprises to make rational decisions about investments or closing down of units.

It is also possible that the requirement for private enterprises to have an agreement with the RHF's represents an entry barrier, and thus reduces the number of competitors.

3.3 *Outsourcing*

The RHF is responsible for providing hospital services to the population in their region. They can produce the services in their own HFs, or they can buy the services from other providers. This structure paves the way for competition among suppliers of specialist health services.

The extent of such outsourcing of hospital services is still modest, but the option has been increasingly used by the RHF. They have used tenders to bring about competition among private providers of surgery, other kinds of scheduled treatment, radiology, laboratory services and ambulance services. The RHF is free to bargain prices and other conditions with the private providers.

One unsolved problem is the dual role of the RHF. Since the RHF is responsible for the provision of the relevant health services, and also a dominant producer of the same services, it may have incentives to choose its own HFs to supply the service, even when private enterprises are more efficient. The NCA has called attention to this problem on several occasions.

Concerning radiology and laboratories, the Government has introduced a provisional solution to this problem. For 2005 and 2006 the RHF is obliged to outsource at least the same volume of these services as in 2004.

The scope and scale of outsourcing of hospital services is still modest, and we do not know of any studies of the possible efficiency gains of this competition. It should be possible to increase both scope and scale of outsourcing, maybe also by letting private and public hospitals compete on equal terms.

3.4 *Consumer choice and waiting times*

Regarding emergency health services, the Norwegian patients have no choice. For scheduled treatment there is, within specified framework conditions, a freedom of choice.

The system is based on a gatekeeper model. All citizens are entitled to a personal general practitioner (GP). The GP sees the patient for initial diagnosis, and then decides whether the patient should be referred to the specialist health service. The specialist health service will then decide whether the diagnosis gives the patient a right to treatment.

Since 2001, patients are free to choose a hospital for scheduled treatment (and specialist consultations/diagnostic services). Free hospital choice means that a patient who is referred to further investigations and/or treatment has the right to choose the hospital. The patient can, however, not choose the level of treatment. The right to choose follows from the Patients' Rights Act.

The patient's travelling costs, and costs for food/accommodation, are reimbursed by the RHF. The patient only pays up to NOK 440,-.

The information service "*Free Hospital Choice Norway*" facilitates patients' rights to choose where to receive treatment. The service offers up to date information concerning patients' rights and waiting times for the different hospitals, as well as other relevant information. This enables patients to make better-informed decisions as to which hospital/institution to choose for different types of treatment. The patients may ask their GP to help them to choose, book treatment themselves by using a web site constructed specially for this purpose, or call a toll-free telephone number.

The information covers all public and private hospitals that have an agreement with the RHF to perform selected treatments. One purpose of this service is to contribute to a better utilisation of the

capacity of treatment within the Norwegian healthcare services, and to increase competition among state-run hospitals.

The freedom of choice obviously may reduce the waiting time for each patient that uses this right. A recent study shows that patients using their right to choose, on average have a waiting time which is 70 days shorter than comparable groups of patients. A study by Sintef shows that the waiting time in the period 2002-2005 was reduced in all the 5 health regions, and that the difference between the regions has become significantly smaller during this period. The study also shows that the patient groups which have the lowest degree of haste have the largest reduction in waiting time. These are the groups where the RHF to the largest extent have bought health services from the private providers. Private institutions treat most of the patients who choose treatment away from their nearest hospital.

The average LOS for mobile patients is one day shorter than for patients that are treated at their nearest hospital. The older the patient is, and the more complex diagnosis, the less likely it is that he will choose another hospital.

3.5 *Exit/restructuring*

Exit of non-efficient units is essential to realise efficiency improvements. The board of a HF can decide to shut down hospitals. However, the RHF or the Ministry of Health and Care Services can reverse such decisions in the general meeting. In such situations, it is up to the HF to find other ways to improve efficiency to be able to meet the budget constraints.

If the HFs or RHF choose to close down less efficient hospitals, the protection of vulnerable consumers is ensured partly through the standards defined in the Patients' Rights Act, partly through the right to choose hospital. In this respect there are important differences between scheduled treatment and emergency care. When closing down hospitals, the health enterprise can choose to supply scheduled treatment from other institutions in the enterprise, or reduce its total supply. In any case, the patients are guaranteed to get the services they have legal right to. The combination of free choice of hospital, and waiting list guarantee, ensures this. Concerning emergency care it is the RHF's responsibility to ensure this in all parts of its region, according to the standards defined in the Patients' Rights Act.

4. Competition Law Application

The last years reforms have opened up for more competition between hospitals. Still, the Norwegian Competition Authority (NCA) has only limited experience with applying competition law in this area. We will in the following describe some relevant cases.

4.1 *Case 1: Private Hospital Association*

The first case the Competition Authorities handled under the new Competition Act of 2004 was a complaint from the Private Hospital Association. The Association argued that the government's regional health organisations were in breach of section 10 of the Act due to collusive pricing.

As shown in section 2, the RHF is responsible for providing hospital services to the population in their region. The RHF is organised as separate legal entities, but the Ministry of Health is ultimately responsible for both financing and management of the service. Private companies offer to some extent specialist health services. The private service providers generally have agreements with the RHF regarding payment for rendered services.

As the RHF use of private institutions to help reduce medical waiting lists has increased, it is today normal that private healthcare providers have agreements with more than one RHF. The RHF has

therefore demanded that the lowest price offered by the private institution for rendering a specific service to one RHF should be applicable to all RHFs. The Private Hospital Association asked for an evaluation of this practice.

In this case the NCA had two basic questions to answer. First, whether the RHFs are enterprises under the Competition Act i.e. carries on an “economic activity”. Secondly, whether the RHFs were to be considered as different economic entities, since section 10 of the Act only applies to agreements between two or more independent enterprises.

The NCA did not give a specific answer to the first question. They gave a general description of the concept “economic activity” in accordance with EC case law, and concluded that it was not possible to give a general answer as to when the a RHF is engaged in economic activity. RHFs will in some circumstances be considered as enterprises and not in others. This will, according to case law, depend especially on whether the activities concerned have an economic nature and what role the principle of solidarity plays. It is therefore essential that a case by case assessment is made.

Regarding the second question the NCA concluded that the five RHFs are considered to be one economic entity. It was important for the conclusion that the RHFs were 100 % state owned, hereunder that the state was in charge of financing and strategic decisions. Furthermore it was emphasised that the Ministry of Health Services is formally and actually in control of the RHFs and their activities, (by law).

4.2 *Case 2: Competition between private and public hospitals*

The second case that was handled by the NCA is in some ways similar to the first one. A private hospital asked the NCA to examine the competition situation between public and private hospitals in general. As mentioned above, the first question to be answered in these cases is whether public specialist healthcare providers are considered to be enterprises. It is not possible to give a general answer to this question because one must do a case by case assessment. The Competition Authorities therefore gave a description of the principles laid down by the ECJ in their practice, but a more explicit conclusion was not reached.

4.3 *Case 3: Laboratory services*

In a case concerning laboratory services, the NCA is making a concrete assessment of whether a public health provider is engaging in “economic activity”, and whether section 11 of the Competition Act is applicable. The case concerns a private laboratory which has made a complaint against one of the RHFs laboratories. The latter gave rebates to customers (doctors) that requisitioned more than 5.000 laboratory samples a year.

First, the NCA has to address the question whether the RHF offering laboratory services is engaging in “economic activity”. Second, the NCA must consider whether the rebate system in question amounts to an abuse of a dominant position. The NCA will most likely reach a decision this fall.

5. *Final Comments*

The provision of hospital services in Norway is still characterised by restricted competition. However, the extensive reforms the recent years have introduced market elements like output-based reimbursement and free choice of hospitals. The establishment of five regional health enterprises with a responsibility to provide specialist health services lay the ground for competition.

The Norwegian Competition Authority has dealt with competition issues in the specialist health services market in some cases. An important question in these cases has been whether the public hospital service in question is engaging in “economic activity”. Another ongoing case will be settled in 2005.

Competition in the specialist health services market has high priority for the NCA. In October 2005 we start up an R&D-project, analyzing competition issues in this market. The aim of the project is to present proposals to promote increased competition between the public health enterprises, and increased competition between public and private hospitals. The project will be finished by summer 2006.

SWEDEN

- Health care in Sweden is almost exclusively financed by taxes, and most hospitals providing short-stay, somatic care are owned and managed by the county councils.
- In recent years, the operation of three public hospitals has been transferred to private companies operating on a for-profit basis.
- Amendments in June 2005 to the Health and Medical Services Act mean that if a county council transfers the operation of a hospital to another party, the hospital may not be run for the purpose of creating profit for the contractor, and the services shall be exclusively financed with public funds and care fees.
- Generally, private care providers depend heavily on public financing, which constitutes an important barrier to entry.
- In the 1990s, several county councils introduced some form of purchaser-provider organisation, often using prospective payment systems based on DRG (diagnosis-related groups). The purchaser-provider split has then been modified or terminated.

1. Structural conditions

Under the Health and Medical Services Act, the 20 county councils in Sweden (and one local authority) are responsible for providing health services and for the overall planning of these services.¹ The county councils decide on the allocation of resources to the health services and are entitled to levy taxes to finance their activities. Health care is almost exclusively financed by taxes, mostly county taxes. Patient fees amount to 3 per cent of the total costs excluding dental care, and private, voluntary health insurance is non-significant.

Most hospitals providing short-stay, somatic care, are owned and managed by the county councils. The county council hospitals, currently more than 70, are, with some exceptions, performing emergency surgery. For highly specialised care the county councils cooperate in six medical regions with eight regional or university hospitals.

Health care services have also been available for a long time at a few, small, non-profit hospitals. They are not automatically included in the county councils' network, but usually they have an agreement with the county council to provide hospital services.

In recent years, the operation of three public hospitals has been transferred to Capio and Praktikertjänst; companies operating on a profit basis and with 2 per cent each of the health care services market, including primary and dental care.² In Stockholm, for example, St. Göran's Hospital is run by

1 The domestic care of elderly and disabled people is the responsibility of the local authorities (municipalities) rather than the county councils.

2 Capio operates in several other countries, e.g. the UK, France and Spain.

Capio in agreement with the county council. St. Göran's Hospital has lower costs and prices than the hospitals operated by the county council but also a more advantageous agreement in some respects, with compensation for DRG-creep, rent increase, interpretation services etc.³ A new agreement will come into force next year with another compensation system.

A number of clinics for specialities such as eye surgery, orthopaedics, and heart operations have been built up as independent, privately owned units. Through agreements with the county councils, they can accept publicly financed patients, but also patients with private health insurance.

Since the early 1990s, the number of emergency hospitals has diminished, certain specialities and advanced specialised care have been concentrated to fewer hospitals, and there have been hospital closures and mergers, aiming at higher quality and scale advantages in larger organisations. In some regions, the restructuring process has been slow, due to worries about availability of services and labour market problems. Attempts to close hospitals have often met with political and public opposition. Local political parties have been established opposing hospital closures as their main issue. There are no explicit standards to ensure geographical availability of hospital services.

Amendments in June 2005 to the Health and Medical Services Act mean that the county councils must run at least one hospital themselves within their own geographical area. Furthermore, they will not be allowed to entrust the operation of regional hospitals to any other party. If the county council transfers the operation of other hospitals to another party, the terms of the agreement must stipulate that the hospital may not be run for the purpose of creating profit for the contractor and that the services shall be exclusively financed with public funds and care fees. The amendments will come into force on 1 January 2006. Agreements on operation of health care entered into before this date may be extended, on certain conditions, if this is done before the end of 2011. Primary care services; hospitals established by private providers; and specialist clinics in outpatient care, outside the hospital organisation, will not be affected by the legislative amendments.

The county councils are responsible for ensuring that their residents have access to good medical care on equal terms. In the bill proposing the legislative amendments, the Government considers that there is a risk that the county councils may not be able to fulfil this obligation if they entrust the operation of all hospitals to another party.⁴ A large proportion of regional medical care services can be characterised as highly specialised. If the operation of a regional hospital were to be transferred to another party, the Government believes that there would be a risk of having less influence on an activity of national interest. The Government also takes the view that hospital services run for the purpose of making a profit may risk being in conflict with medical and social goals and that financing exclusively with public funds and care fees is important to minimise the risk of financial resources taking precedence over medical needs.

The Government has proposed a new type of company with a restriction on dividends, similar to the Community Interest Company in the UK, in order to make it easier for non-profit organisations to run hospitals.

Capio has now signed a new agreement with the county council. As a consequence, St. Göran's Hospital will stop accepting patients paying privately. Capio Artro Clinic, which has been part of the hospital, will continue treating patients with different types of financing, at another place and on the basis of a special agreement.

3 Landstingsrevisorerne (County Council Audit Board) (2002)

4 Proposition (Government Bill) 2004/05:145

Studies of hospitals operated by private for-profit companies in agreement with the county councils indicate mainly positive effects of this element in a hospital structure dominated by the county councils.⁵ It would appear that the private hospitals have contributed to an increased efficiency, and “fast tracks” for patients paying privately have not been observed. The development of agreements and compensation systems has been stimulated.⁶

2. Contracting and competition mechanisms

There are no rules or regulations that limit entry by new hospitals or centres capable of providing certain hospital services. However, the financing of the services has a crucial importance. Generally, providers can not rely on patient fees or private health insurance only, and the county councils can deny entering into agreement with private hospitals or clinics. This dependence on public financing constitutes, of course, an important barrier to entry.

Several county councils have introduced some form of purchaser-provider organisation. The purchasing units negotiate contracts with providers operated by the county council, often using prospective payment systems based on DRG. Prospective payment can also be used to compensate private hospitals and clinics. Unfortunately, the county councils do not usually follow up provider achievements systematically, and, therefore, efficiency gains do not necessarily affect resource allocation in a systematic way.⁷

A substantial increase of productivity in health care was observed in the early 1990s, which, to some extent, probably can be explained by the purchaser-provider split and other market reforms at that time. In recent years, however, the productivity seems to have decreased. It should be noted that the productivity may be systematically underestimated, for example by not taking into account the shift from inpatient to outpatient care. The purchaser-provider split has been modified or terminated by some county councils, and co-operation among the actors rather than competition is now promoted.

Payment for performance may be based on quality indicators. Under the new agreement between Capio and the county council, for example, 2 per cent of the total payment for St. Göran's Hospitals' provision is related to quality indicators.

Hospitals are able to outsource the provision of services provided at lower costs outside the hospital setting. In fact, this is rather common with ancillary services, such as cleaning, and delivery and serving of food. In Stockholm, the county council has purchased cataract operations, laboratory services, radiology etc. Not only providers with the lowest price have been contracted, but it would appear that competition has reduced the price for certain services.⁸

Patients have the right to choose among county council hospitals anywhere in Sweden. Referral is required in some cases, particularly if the patient chooses a provider outside of his or her own county. If the hospital is situated in another county, the patient has to pay for the travel cost, and high cost treatments must be approved in advance. These rules are recommended by the Federation of County Councils and applied by all county councils since 2003.

5 Jönsson, B. et al. (2004)

6 Landstingsrevisorerna (County Council Audit Board) (2002)

7 Jönsson, B. et al. (2004)

8 Ekelund, M. (2004)

In order to reduce waiting times for certain forms of treatment for which there were long queues, a care guarantee for patients was introduced in 1992. However, waiting times are still a major problem, and therefore the Ministry of Health and Social Affairs and the Federation of County Councils have agreed on a new, more far-reaching guarantee. Under the new guarantee, patients are entitled to be treated within three months of the day on which the decision to treat is taken. Should this be impossible in the county where the patient lives, he or she has the right to be treated in another county. The new guarantee will be introduced in November 2005.

3. Competition law

The Swedish Competition Authority has not addressed any case of importance in the area of the provision of hospital services under the Swedish competition law.

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SWITZERLAND

1. Background: Health insurance in Switzerland

In contrast to many other OECD countries, health insurance in Switzerland is provided by private health insurance funds that compete for clients. The Swiss health insurance market is divided into two tiers:

- *Compulsory basic health insurance* : The market for compulsory basic health insurance is strongly regulated. It is compulsory for every resident in Switzerland to buy a basic health insurance policy. Federal law defines what services and products are covered. Insurance companies are obliged to accept any person requesting insurance and they are not allowed to make profit on basic health insurance policies. There is an obligation to contract with basically all private practitioners and *all* hospitals that are on the so called “hospital list”. Collective bargaining between insurance funds and hospitals takes place at Cantonal level in order to agree on tariffs for hospital services. The compensation system varies by Canton. Some Cantons have implemented performance-based compensation, such as compensation based on Diagnosis Related Groups (DRGs).
- *Complementary Private Health Insurance* : Complementary private health insurance policies extend coverage of basic health insurance, e.g. by including better room quality in hospitals (such as twin rooms or single rooms), by extending choice of providers or by including health services that are out of scope of basic health insurance such as alternative medicine or extended international coverage. Complementary private health insurance is comparably loosely regulated. Health insurance companies are allowed to make profit, to accept or reject applicants and to exclude or include specific health care providers.

2. Public and private hospitals in Switzerland

The regional supply with health services is a task conferred to Cantons by the Swiss constitution. Therefore, approaches can vary between different Cantons to a certain degree.

Important in each Canton is the planning system of the so called “hospital lists”. On the hospital lists, Cantons list all the hospitals that are allowed to provide services for in-patient treatment under compulsory basic health insurance. Public hospitals as well as private hospitals can be on the list. Private hospitals that are not included in the list will have to focus on treatment of patients that have acquired a complementary private health insurance policy.

- *Public hospitals*: Public hospitals are hospitals that are generally owned by Cantons or communes. By Federal law, their investment costs are to be fully covered by the Cantons. At the same time, a maximum of 50% of their running costs are to be covered by health insurance, while the rest is again covered by the Cantons or communes. Public hospitals treat patients covered by compulsory basic health insurance as well as patients that are covered by private complementary health insurance.

- *Private hospitals:* The ownership of private hospitals is independent from the state. Important players are some private for-profit hospital groups, but there exist also smaller, not-for-profit private hospitals. When treating patients, they do not receive subsidies for their running costs, in contrast to public hospitals. The full costs have to be recovered from health insurance and patients. Therefore, it is usually not financially attractive for them to treat patients under compulsory basic health insurance.

The market share of private hospitals is, depending on regions and services, between 10% and 30%.

On the one hand, private hospitals have the advantage that they do not have to contribute to basic primary health care. On the other hand, private hospitals currently have a financial disadvantage compared to public ones. They must usually cover all their costs from insurance companies or directly from patients, while public hospitals always receive subsidies from the Cantons covering their investment costs and about 50% of their running costs. In order to win patients and contracts covered by private complementary health insurance, private hospitals must deliver a benefit, such as employing specialists or offering more “luxury” in their rooms, which is demanded by patients and therefore included in certain complementary private health insurance policies.

3. Advantages and competitive issues in the Swiss hospital sector

An advantage of the current system is that the presence of a number of public and private providers combined with relatively free choice of providers by patients lead to a demand-oriented supply of hospital services. Waiting lists are usually very short in Switzerland. The system also leads to a certain amount of quality competition. However, costs are difficult to control in the current system.

There are basically two issues that currently hinder competition in hospital services. The first one is the fact that all the insurers in a given Canton have to accept the costs from all the hospitals working for the basic insurance system due to the obligation to contract. Tariffs are negotiated between health insurance funds and hospitals, but unified by Canton (result of collective bargaining). If hospitals on the one side and insurance funds on the other side cannot agree on tariff structure, the Canton, which is usually an important player itself by owning hospitals, can decide over tariffs. Hence, price competition is limited.

The second issue is the way of financing hospitals in Switzerland. The dual financing system (costs are partly financed by Cantons, partly financed by insurance) leads to a complex mixture of incentives. At the same time, the subsidies lead to a distortion in competition between private and public hospitals and secondly to a distortion between in-patient and out-patient services as only in-patient treatments are eligible for subsidies.

4. Reforms

4.1 Reforms at the cantonal level

At the level of Cantons, several reform projects have been undertaken. An example is the change towards performance-based compensation of hospitals, sometimes based on DRGs. Specifically remarkable is the switch of the Canton of Zurich to a DRG-based compensation system in 2002. In 2004, a new law came into force in the Canton of Zurich that introduced a benchmarking system for all hospitals receiving public subsidies. Since then, resource allocation to subsidised hospitals depends on performance in the benchmarking system that relies on the DRGs and an analysis of case-mix in hospitals. According to

the health department of the Canton of Zurich, reforms have already contributed to a slower than average increase in hospital costs.¹

4.2 Reforms at the federal level

At the federal level, a current project led by the Federal Office for Public Health intends to reform the financing system of hospital services. In a first reform step, it is planned to introduce a so called “dual-fix” system. In this system, 50 % of the payments to each hospital on the Cantonal hospital list will be covered by the Cantons or communes. The other 50% will be covered by health insurance funds, regardless whether the service is provided by public or private hospitals. At the same time, Cantonal hospital lists are planned to comprise public as well as all private hospitals in order to better control the quantity of hospital beds offered. Compensation of hospitals will be fully based on performance. Although it has not been decided yet which system for performance compensation will be used, DRGs are an option, as they are already in use in some Cantons.

Important achievements of this first reform step would be a more transparent financing and the removal of current distortions between public and private hospitals. An important step would also be the change towards performance-based compensation, which could remove some of the incentives to extend supply. At the same time, the extended hospital lists would allow to better control costs in the hospital sector.

The Federal Office of Public Health had ordered a scientific study on further reform steps from Prof. Robert Leu of the University of Berne. The health economist suggested a change to a so called “monist” financing of hospital services. According to Mr. Leu, the financing of hospital payments should be fully assigned to one single payer, i.e. insurance companies. Another suggested element, which is widely discussed, is the removal of the obligation to contract in the in-patient sector. It has to be noted that the reform steps described in this paragraph reflect the view of the external study.

Another reform idea would be to build on the benchmarking experiences of the Canton of Zurich. If Cantonal hospital lists are kept, the benchmarking could be used to define how many resources are allocated to which provider and which providers should eventually be selected for what kind of services. An expert group at federal level is currently developing such a standardized benchmarking system. Furthermore, in the area of specialized health services a public debate has emerged on which services should be provided in which Canton. A standardized benchmarking system could deliver arguments for decision-making at the cantonal level and for resolving disputes at federal level in the case of imposed tariffs by Cantons.

5. Competition law application

En Suisse, contrairement au domaine de l'assurance-maladie de base qui est très réglementé, le domaine de l'assurance-maladie complémentaire n'est pas régi par des dispositions légales particulières qui empêcheraient l'application de la loi fédérale sur les cartels (LCart).

De ce fait, les autorités suisses de la concurrence se sont prononcées en deux occasions sur l'activité d'établissements hospitaliers (publics et privés) dans le secteur des prestations privées et semi privées (=

¹ Refer to the further information section for documentation of DRG use in Swiss hospitals

prestations de soins et hôtellerie couvertes par l'assurance complémentaire: par exemple possibilité de séjourner dans une chambre avec un ou deux lits au maximum).

Un premier cas portait sur un contrat signé entre cliniques privées et assureurs ainsi qu'un contrat entre hôpitaux publics et assureurs. Les deux contrats définissaient la forme des remboursements et leur niveau (en principe il s'agissait de prix forfaitaires par cas ou de taxes fixes). Ces contrats ont été considérés comme problématiques d'un point de vue cartellaire car ils conduisaient à la création d'un accord sur les prix entre l'ensemble des cliniques privées et entre les hôpitaux publics. La concurrence sur les prix (c.-à-d. le type de remboursement et le niveau des tarifs) avait été réduite. Le marché géographique a été défini comme étant cantonal et, plus précisément, celui du Canton d'Argovie. En effet, selon les informations récoltées au cours de l'enquête, bien que les produits d'assurance complémentaire prévoient la possibilité de se faire soigner partout en Suisse, le pourcentage de patients qui choisissaient / choisissent de se déplacer au delà des frontières cantonales pour un séjour dans un hôpital s'est révélé être marginal.

La décision a été en partie cassée par la première instance de recours (Commission de recours pour les questions de concurrence) et renvoyée aux autorités de la concurrence. Principalement, elle contestait le fait de n'avoir pas suffisamment prouvé la non existence de motifs d'efficacité économique qui aurait justifié un accord impliquant la plupart des établissements (privés et publics) et les assureurs.

A cet égard, dans le cadre de l'application des nouvelles dispositions légales sur la concurrence, un certain nombre d'assureurs a annoncé des contrats passés avec des hôpitaux dans le domaine de l'assurance complémentaire. Les autorités de la concurrence doivent se prononcer sur leur licéité vis-à-vis de la LCart. Les autorités de la concurrence ont déjà pu conclure à la licéité d'un certain nombre de contrats qui portent sur l'introduction de systèmes d'APDRG (All Patients DRG) dans le domaine hospitalier. La Commission de la concurrence juge ce système comme étant un instrument capable de mettre en concurrence les établissements hospitaliers qui y adhèrent. Pour les autres contrats qui reprennent le contenu de l'accord passé dans le Canton d'Argovie, les autorités de la concurrence ont l'intention de lancer des nouvelles procédures afin d'éclaircir définitivement la conformité de tels accords avec la LCart.

Le deuxième cas concernait l'Association des cliniques privées de Genève (ACPG). Cette association, en accord avec ses membres, avait conclu une convention sur l'hospitalisation en division privée et semi privée avec les assureurs-maladie dans le Canton de Genève. Cette convention prévoyait un tarif uniforme pour différentes prestations. A titre d'exemple, on peut mentionner les frais de salle de réveil, de salle d'opération, de salle d'accouchement, les taxes de soins et de surveillance paramédicale, ainsi qu'un tarif uniforme pour des gestes médicaux ou du matériel (appareil à oxygène, contrôle des signes vitaux etc.). Ce tarif était élaboré au sein de l'ACPG. Cette convention a été considérée comme un accord sur les prix qui, pour le moins, réduisait la concurrence entre cliniques privées. Au cours de l'enquête, l'ACPG s'est engagée à ne pas renouveler la convention en enlevant ainsi tout objet à la procédure. Celle-ci a été classée sans suite. En analogie avec le cas mentionné ci-dessus, le marché géographique était encore une fois défini comme étant cantonal.

6. Further information

- Research program on Swiss DRG, Institut d'Economie et de Management de la Santé, University of Lausanne: <http://www.hec.unil.ch/iems/rechercheexpertise/projets/SwissDRG>
- Further information on APDRG and its use in the Cantons of Zurich and Vaud: <http://www.apdrgsuisse.ch/public/fr/publications.htm>

UNITED KINGDOM¹

1. Introduction

This paper focuses on Department of Health policies applicable to English National Health Service (NHS) organisations that contribute to competition and efficiency in the healthcare sector. This is set in the context of the English NHS and its funding arrangements.

2. General system of healthcare in England

The NHS Plan (2000) sets out the core principles of the NHS and the funding arrangements for this. The NHS provides a universal service for all based on clinical need, not ability to pay. This is funded out of public expenditure, primarily taxation. This is a fair and efficient means for raising funds for healthcare services and these funds are devoted solely to NHS patients. The NHS provides access to a comprehensive range of services throughout primary and community healthcare, intermediate and hospital based care, providing clinically appropriate cost-effective services.

3. Reform Programme

The English NHS is currently undergoing a programme of reform, the aim of which is to develop the systems and incentives to help the NHS provide high quality care, led by the needs and wishes of today's patients, in the most effective way. The reforms represent a series of interlinked policies with efficiency and contestability being themes that run through.

In the late 1990s, a series of consultations and reviews were carried out to look at how the NHS could continue to provide high quality care to all, free at the point of delivery, within the context of changing patient needs and increased demands on resources.

The outcomes of this work included the NHS Plan (2000) and Wanless Report (2001), which outlined that a significant increase in investment was needed, along with a series of changes, which included people taking a far greater role in managing their own health.

This work made several observations. Firstly, that we all expect a great deal more from public services these days; society and its needs have changed a great deal since the NHS was founded in 1948 and public expectations have risen. Secondly, that as medicine advances and the problems that it can tackle become more complicated, the cost involved in delivering what we believe is the 'best care' will rise. And thirdly, that as a result of better healthcare and disease prevention, demands on the service occur increasingly amongst older people – something the NHS was not originally designed to meet. The changes happening in the NHS are designed to address these issues. Competition and efficiency are themes that run through these changes.

1 . The submission presents the views of the UK Department of Health

4. Reform Programme – Competition and efficiency

With the introduction of the reform policies, competition in the NHS is based on quality and the extent to which services are perceived to be based around the needs of the patient.

A number of policies that contribute to this high quality and patient focus as well as improvements in efficiency are discussed in more detail below in relation to some of the key questions. Payment by Results, Practice Based Commissioning, Choice and the use of the independent sector are the key policy areas that work together to improve efficiency in hospital provision.

The introduction of payment by results, a national tariff, based on NHS average costs for services, removes the possibility of competition on price. It is also the most significant development that focuses providers on the need to improve their efficiency. The volume and mix of services that meet population need and reflect appropriate packages and pathways of care for patients need to be provided to ensure that organisations are the provider of choice for patients.

National targets on waiting times for outpatient appointments and elective operations in hospitals have also removed the possibility of competition in terms of access.

Standards of service will improve if patients are given more choice because providers will be forced to change the way they work to make sure they are convenient to patients and so that they deliver the highest quality of care possible. However, it is essential that we maintain local access to certain services, such as Accident and Emergency (A&E) and do not ask them to compete with other providers. Even in the future, there will still be a large proportion of care provided by the NHS and careful regulation of all providers will be needed to ensure that healthcare in the UK remains universal, equitable and safe. Within this context, however, the Government is bringing in more competition to offer patients more choice, and to drive up standards. The independent sector will play a key part in this, as will other statutory and voluntary providers.

Competition in the NHS should not be perceived as being between organisations but between services within each provider.

5. Discussion of key competition and efficiency policies

5.1 Payment by Results (Benchmark Competition)

Under Payment by Results, service providers are paid for each patient they treat, according to a set national tariff. The tariff is built on clinically meaningful groups of treatments and activities with the prices for the service based on NHS average cost. Provider income will depend on the number of patients treated. This is a major reform for the NHS and draws on international experience of similar schemes being run in Europe, Australia and USA.

Patient demand will mean that popular services will thrive and those that are substandard will be forced to improve, or if they don't respond to the needs of patients, possibly close. This will only happen if there are enough alternative choices available locally for patients and indispensable services like A&E or specialist burns services will continue to be provided.

There is a strong incentive for provider organisations to treat patients more efficiently i.e. for less than the tariff price as they can reinvest any efficiency gains they make back into local services. Currently, providers that operate more efficiently gain no reward for doing so and any surplus achieved is returned to the central coffers. PbR gives more scope to offer variety and innovation, as well as providing direct incentives to continually improve. The system will reward efficiency and promote fairness in payment for

work done and will help encourage a growing plurality of provision in the delivery of NHS services. Where staff do more work and are more efficient their organisation will benefit. Trusts should be able to reinvest surpluses they earn if they provide care at costs below the tariff rate, while meeting quality standards.

The system began in a small way in 2003-04, was extended in 2004-05, and, for the majority of trusts, includes only elective care in 2005/06. In 2006/07 non-electives, outpatients and A&E will be included for all trusts. It is expected that within the next three to four years the majority of hospital and community healthcare will be fully reimbursed through national tariff.

There is currently little evidence on the impact that Payment by Results has had on efficiency in the provision of hospital services due to the new status of this policy. There is however, anecdotal evidence to suggest that provider organisations are aware of the difference between their cost base and the tariff price. Evidence suggests they are working to reduce costs in order to reap the benefits of providing services at less than tariff price and re-invest into hospital services. Commissioning organisations are beginning to engage in demand management strategies to manage admission and discharge procedures, which may in time lead to a reduction in the length of stay of patients, which is an obvious indicator of efficiency.

5.2 *Practice Based Commissioning (Physician Purchasing)*

Practice Based Commissioning, which gives GPs more power to shape services for their patients, is likely to mean that patients can benefit from a greater variety of services that are closer to home or more convenient for them. Local doctors can commission health services in line with what they see as the clinical needs of their community. From April 2005, practices have been able to receive an indicative budget from primary care trusts that they can use to improve the delivery of services.

5.3 *Choice (Consumer Choice)*

Guaranteeing patients' choice in key areas is a central part of how the NHS is changing. It is about meeting higher patient expectations and patient desires to be more involved in taking decisions about where and when they are treated. This will involve encouraging individual parts of the service to respond better to what patients really need or want.

The first steps towards giving patients more choice have focused on elective care. Patients who have been waiting for an extended period for treatment are being given the choice of a faster alternative. By 2008 there will be free choice to go anywhere in the country. National standards will guarantee safe and effective services for patients making that choice.

From December 2005, patients will be offered the choice of four or more hospitals and a booked appointment when they need referral for elective care. Some 10 million patients a year are expected to benefit. During 2006, patients will have an extended choice of the four or more locally commissioned providers, together with all NHS Foundation Trusts, all Independent Treatment Centres and other pre-qualified independent sector providers who meet NHS standards. This will greatly increase the number of choices available to patients. By 2008 patients will be able to choose any healthcare provider that meets NHS standards and can provide care within the price the NHS is prepared to pay. Research has shown that patients will choose a hospital for elective treatment based on a number of different factors: ease of access, reputation of hospital, quality of care and waiting times. Choice is another incentive for provider organisations to improve efficiency to meet these factors and attract patients. There is strong evidence to suggest that choice has had a positive impact on driving down waiting times.

Payment by Results supports the choice agenda by enabling money to transfer to the service the patient chooses.

5.4 *Private Providers/Entry for new providers*

The independent sector, which includes private sector healthcare companies, as well as voluntary and community organisations, has always had a role to play in NHS service provision.

Alternative providers have helped the NHS to reduce waiting times. NHS and independent sector treatment centres, which offer short stay surgery and diagnostic procedures, have ended long waits in some specialties.

The role of different providers, such as National Health Service Foundation Trusts (NHSFTs), set up in 2004 as one of the reforms, as well as independent providers, and the range of different services will continue to be a feature of the NHS. NHSFTs give patients, the public and frontline staff more of a say in how local hospital services are designed and run. This is because NHSFTs are set up as independent Public Benefit Corporations. This status means that key stakeholders are able to influence local hospital services and way of operating. In addition, NHSFTs are free from central Government control, which gives them more flexibility to be innovative and deliver services to meet specific local needs. This will mean more choice for patients. It will also mean an injection of new ideas, and consistently better care across the board as all providers strive to attract patients.

Making alternative options available for patients will provide an added incentive for both newer and more traditional providers to raise the standards of patient care by making the best use of resources available. The goal is to support the NHS core aim of providing high quality care, free at the point of need, by introducing some elements of a competitive market into healthcare.

5.5 *Incentive Payments (Paying for Performance)*

Following the publication of the 2003/04 performance ratings of trusts, those organisations achieving the highest status of three stars were eligible for a non-recurrent capital bonus of up to £1million depending on their size. This year, 2004/05, this financial incentive was not available but three star organisations were rewarded by alternative means in line with our commitment to devolve power as much as possible to high performers. Earned autonomy is the ethos of the new performance improvement system, as standards improve and modernisation takes hold across the NHS there will be progressively less central control and progressively more devolution. The best performing NHS organisations will be rewarded with greater autonomy and national recognition. This is in line with a commitment in the NHS Plan to devolve responsibility and decision making away from the centre where the NHS has demonstrated it can use this freedom to perform to a high standard.

6. Conclusion

The reforms outlined above must be considered in the context of healthcare in England; a universal service based on clinical need not ability to pay, funded through public expenditure. The reforms focus on driving up efficiency and introducing some elements of competition to improve the quality of care for patients.

7. "What role is there for competition authorities when competitive mechanisms are present?" (Comments from the OFT)

Where competitive market mechanisms are present with respect to healthcare provision, the OFT takes the view that the role of competition authorities is, as in other sectors, to make markets work well for consumers.

In the case of healthcare, the consumers are the users of the medical services. As in other sectors, competition authorities, where competitive mechanisms are present, should aim to prevent anti-competitive collusion and monopolistic abuse as well as mergers of healthcare providers which tend to result in a substantial lessening of competition in the relevant healthcare market.

In undertaking this enforcement task, competition authorities should of course bear in mind the nuances of healthcare provision systems, which may include (among others) issues relating to market definition (especially on the geographic side), the interaction between state-funded and privately financed services, the social objectives that influence healthcare provision and the vertical relationships which exist between those financing private healthcare provision (e.g. insurance companies) and those actually providing the healthcare services (e.g. hospitals).

UNITED STATES

The competition enforcement agencies of the United States – the Antitrust Division of the Department of Justice and the Federal Trade Commission (“the Agencies”) – have been active in applying competition laws to the health care marketplace, including the hospital industry, for more than two decades.

The invitation for written submissions to this roundtable identified a number of issues of interest including: structural conditions in the hospital industry, contracting and competitive mechanisms, and the application of competition law. In this submission, we have focused on these three areas, which are particularly germane to the experience of the United States hospital industry. We describe the market environment in which hospitals in the United States operate, including the competitive and other pressures that hospitals face; the restructuring of the hospital industry that has occurred in recent years, through consolidations, the growth of hospital networks and other developments; and the effect of private payor and government purchasing of hospital services on the hospital marketplace. Finally, we consider the application of competition laws to hospital competition, focusing primarily on merger cases, and discuss a number of issues important to merger law analysis, including market definition, entry, efficiencies, and the non-profit status of hospitals.¹

1. Introduction to Structural Conditions in the Hospital Industry

In cities and towns throughout the United States, hospitals are a key part of the health care delivery system. Currently, payments to hospitals for inpatient care account for approximately 31 percent of total health care expenditures in the United States. Expenditures on hospital services have grown over the past two decades, but the rate of spending growth has varied. The federal government’s introduction of a prospective payment system in the early 1980’s (see discussion Section II) slowed the rate of hospital expenditure growth. The rise of private-sector managed care plans slowed the rate of expenditure growth further; from 1993 through 1998, hospital expenditures increased at an average annual rate of 3.7 percent, and, in some areas of the country, the *per diem* price of a hospital stay actually decreased. In the past five years, however, rising hospital prices have driven spending on hospitals higher, even though hospital utilisation is declining.² As discussed below, analysts attribute rising hospital prices to a variety of factors, including hospitals’ increasing ability to negotiate higher prices from private payers.³

1. Much of the material in this paper is drawn from *Improving Health Care: A Dose of Competition-A Report by the Federal Trade Commission and the Department of Justice* (2004) available at http://www.usdoj.gov/atr/public/health_care/204694.htm

2. See Bradley C. Strunk & Paul B. Ginsburg, *Tracking Health Care Costs: Trends Turn Downward in 2003*, 2004 Health Affairs (Web Exclusive) W354, 356-57 (spending on hospital inpatient care per privately insured person rose 6.5 percent; spending on hospital outpatient care per privately insured person rose 11 percent), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.354v1>.

3. See Katharine Levit et al., *Health Spending Rebound Continues in 2002*, 23 Health Affairs 147, (Jan./Feb. 2004) at 154-55. See also Strunk & Ginsburg, *supra* note 1, at W357 (“This trend is consistent with qualitative research, which has showed that many hospitals solidified their negotiating leverage over plans during 2002 and 2003 and continued to use their formidable power to demand large payment rate increases.”)

By way of background, hospitals in the United States vary by the types of services they offer, ranging from specialty hospitals that treat only a single type of patient (paediatric and women's hospitals) or condition (cardiac, orthopaedic, psychiatric and rehabilitation hospitals) to "general acute care hospitals", which treat a variety of acute medical conditions, excluding treatments such as long term rehabilitation, psychiatric care, or substance abuse care. Hospitals also vary in the sophistication of the services they offer, ranging from the most basic hospital services, to the most sophisticated, cutting edge procedures.

Hospitals in the United States are also differentiated by their ownership structure into one of three categories: (1) non-profit (71 percent of hospital beds); (2) for-profit (13 percent of hospital beds); and (3) governmentally owned (or "public") (16 percent of hospital beds). Although these classifications might appear mutually exclusive and immutable - they are not. Many non-profit hospitals own for-profit institutions or have for-profit subsidiaries. Similarly, for-profit systems often manage non-profit and publicly owned hospitals. Hospitals also may change their institutional status. Even without changing their status, hospitals that previously have not competed in the marketplace can choose to do so. For example, some states have granted local government's broad authority to determine how public hospitals under their control will be operated. Relying on that authority, public hospitals are increasingly entering into competition with private hospitals.⁴

2. Contracting and Competition Mechanisms

2.1 Public Payors

Federal and state governments are responsible for almost 60 percent of payments to hospitals for inpatient care.⁵ A substantial share of hospital spending is provided by the Federal Centres for Medicare & Medicaid Services (CMS), chiefly for care of the elderly. Each state also has a Medicaid program, which pays for care provided to the poor and disabled. Within broad guidelines established by Federal law, each state sets its own payment rates for Medicaid services and administers its own programme.

Prior to 1983, CMS and most other insurers paid hospitals on a cost-based reimbursement system. Under the cost-based reimbursement system, hospitals informed payors of the cost of the care that was provided, and payors reimbursed hospitals for those amounts. Although there were some constraints on what a hospital could claim as its costs, the overall result was to increase the volume of procedures performed and discourage efficiency. Additionally, comprehensive health insurance (both private and public) imposed minimal out-of-pocket costs on patients. Thus, insured patients had little incentive to select lower cost procedures or more efficient providers.

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4. Authorising healthcare statutes in several states, including Michigan, Kentucky and Ohio, have granted local governments the broad power to operate hospitals. M.C.L.A. sections 331.1301(g) *et seq.*; (KRS section 216.335(6)); and Ohio (R.C. section 339.06)(boards of municipal hospital corporations in Ohio "shall have the entire management and control of the hospital, and shall establish such rules for its government and the admissions of persons as are expedient"). The purpose behind many of these broad grants of authority has been to remove the legal constraints upon the operation of public hospitals that inhibit their ability to compete with private hospitals. *See, e.g., Surgical Care Ctr. of Hammond v. Hospital Serv. Dist. No. 1 of Tangipahoa Parish*, 171 F.3d 231, 235 (5th Cir. 1999) (en banc) (Louisiana statutes granted additional powers to hospital service districts so they could compete with other entities on a level playing field); *Jackson, Tenn. Hosp. Co. v. West Tenn. Healthcare, Inc.*, 414 F.3d 608, 610 (6th Cir. 2005) (Tennessee statutes intended to remedy a competitive disadvantage of some public hospitals by removing certain legal constraints upon their operations and giving them the same operating and organizational powers enjoyed by private hospital authorities).
 5. *See* Levit, *supra* note 2, at 154. Because private insurance tends to cover a younger and typically healthier population, it accounts for a smaller share of overall health care spending.

The cost-based payment system led to substantial increases in health care spending over time. An important initial effort to curb these increases in spending was launched in 1983, when CMS implemented a prospective payment system for inpatient care.

2.1.1 *Prospective Payment Systems (Benchmark Competition)*

Under the prospective payment system CMS uses for inpatient care (IPPS), the payment that a hospital receives for treating a patient is based on the diagnosis-related group (DRG) that justified the episode of hospitalization. Each DRG has a payment weight assigned to it, based on the average cost of treating patients in that DRG. The average reimbursement for each DRG is derived from an analysis of the costs of treating both the very ill patients who require more intensive care for a particular DRG, and the “healthier” ill, who do not cost as much to treat. All DRGs are adjusted to reflect the wage index of the geographic location of the hospital; in addition, DRG payments are increased for teaching hospitals and for any hospital’s treatment of exceptionally ill, “outlier” patients. By receiving a predetermined amount regardless of the actual cost of care of a particular patient, hospitals have an incentive not to use more resources than are necessary to treat any given patient. The IPPS was intended to moderate rising federal expenditures, create a more “competitive, market-like environment, and curb inefficiencies in hospital operations engendered by reimbursement of incurred cost.”⁶

As with inpatient care, CMS also formerly paid hospitals for outpatient care on a cost-based system. Under the prospective payment system that CMS adopted in 2000 for outpatient care (OPPS), however, hospitals receive a predetermined median cost amount for each outpatient service or procedure, based on which one of the approximately 750 ambulatory payment classifications justified the episode of care. The inpatient IPPS system was designed to control rising inpatient hospital costs and shift more care to the outpatient setting. The OPPS was designed to control rising outpatient costs, and both systems help to constrain costs more effectively than the cost-based systems they replaced.⁷

2.1.2 *The Impact of Government Purchasing*

CMS has tremendous bargaining power in the market for medical services, and providers are extremely responsive to the signals sent by CMS. Prior to the adoption of the IPPS, average hospital length-of-stay had been stable for seven years. Once IPPS went into effect, the length-of-stay began an immediate decline.

There are limitations, however, to CMS’s ability to create incentives that encourage price and non-price competition among providers. CMS does not have the freedom to respond to changes in the marketplace as do many private purchasers. For example, CMS has only limited authority to contract selectively with providers or to use competitive bidding to meet its needs. With a few exceptions, CMS cannot require providers to compete for CMS’s business or encourage suppliers to reduce their costs and enhance their quality by rewarding them with substantially increased volume or substantially higher payments if they do.

One Medicare programme that has generated competitive incentives for providers is a managed care option, the Medicare Advantage (MA) programme. MA programmes provide Medicare beneficiaries with a range of managed care options, including health maintenance organisations and preferred provider

6. Gregory C. Pope, *Hospital Nonprice Competition and Medicare Reimbursement Policy*, 8 J. HEALTH ECON. 147 (1989DAF/COMP/WP2/WD(2005)71).

7. See Centers for Medicare & Medicaid Services, *Program Information on Medicare, Medicaid, SCHIP, and Other Programs*, § 1, at 18 (June 2002), at <http://www.cms.hhs.gov/charts/series/sec1.pdf>.

organisations. Medicare beneficiaries who have joined MA plans have often received greater benefits (e.g., prescription drug coverage) in exchange for accepting limits on their choice of providers. Nevertheless, these plans are new and have limited acceptance among Medicare participants. In 2002, MA plans (then-called the Medicare + Choice (M+C) plan) provided health care to 5 million Medicare beneficiaries, down from 6.35 million enrollees in December 1999.

Generally, however, CMS's payment systems do not reward higher quality care, or punish lower quality care. Indeed the Medicare payment system is said to be largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. To be sure, these problems are not unique to Medicare but confront private payors as well. Indeed, the Institute of Medicine noted that "current [compensation] methods provide little financial reward for improvements in the quality of health care delivery, and may even inadvertently pose barriers to innovation."⁸

2.2 *Private Third Party Payors*

The second largest source of payment for hospital services is payments from private health insurance plans. Private health insurance is primarily obtained through benefits offered by employers, but is also available through other types of groups and through individual purchases from insurance companies. These payors are collectively referred to as third-party payors. Included in this category are employers who self insure their employees medical costs, but hire an insurance company to administer the health insurance benefits, including negotiating prices with hospitals for services covered by the employer's plan.

Third-party payors typically contract directly with hospitals to provide services to the patients covered under the payors' plan(s), and the prices are negotiated directly between the payor and the hospital.⁹ The most common payment schemes are *per diem* rates, per case rates, or discounts off charges rates. Under a *per diem* rate, the third party payor pays the hospital a fixed price for each day of hospital care without regard to the actual diagnosis of the patient or the resources the hospital uses in the treatment. Under a per case rate, the third party payor pays the hospital a fixed price for the hospital stay for a particular type of case, regardless of the number of days the patient stays or the resources the hospital uses in the treatment. Under a discount off charges rate, also called a percentage-of-charges rate, the third party payor pays a percentage of the hospital's "charges" for the hospital stay, where the "charges" are the prices the hospital charges for each resource used in treating the patient.

In some instances, private payors have copied Medicare's reimbursement strategies or used Medicare DRGs as a reference price for reimbursement negotiations with hospitals. Thus, some payors negotiate either a specified discount or a specified payment relative to the amount CMS would pay for a specified treatment episode. Outpatient payment provisions, where the hospital does not provide an overnight stay for the patient, are typically structured on a percentage-of-billed charges or a fee-schedule basis.

8 . Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* 193 (2001).

9. Contracting between hospitals and private payors has sometimes been contentious. Some hospital industry observers claim that hospital systems routinely "terminate then negotiate" for large increases in reimbursement, and use the media to scare the public. They also state that hospital systems insist that all hospitals in the system be included in a payor network ("all or nothing contracts"), irrespective of whether the payor actually wants to include the entire hospital system. Hospital representatives claim that they are protecting their institutions' interests and that their services had been artificially and unsustainably underpriced in the past. These dynamics have played out in several markets in the past few years. Although commentators have noted that particular hospitals and hospital systems seem to have the upper hand in some markets, whether hospitals or health plans have bargaining advantages varies substantially within and among different markets.

Generally speaking, payors seek to contract with hospitals that contribute to the marketability of their insurance products.¹⁰ Factors that affect marketability include: the price of coverage; the number of hospitals at which care can be provided; the perceived quality, desirability, and accessibility of those institutions; and the alternative insurance products that are available in the market. Payors seek to balance the price of the hospital services they must purchase to offer insurance coverage against the desirability of the resulting network to the purchasers of their insurance products. If patients view several hospitals as adequate substitutes for one another, it will be easier for the payor to threaten credibly to exclude one or more of these hospitals. Conversely, if enrollees will drop an insurance plan if their preferred hospital is no longer in its network, the hospital will find it easier to insist on higher reimbursement.

2.2.1. *Consumer Price Sensitivity and Information*

The lack of consumer information about the costs of hospital services and lack of incentives for the consumer to choose the most cost effective hospital makes it more difficult for payors to exclude high-priced, but otherwise desirable hospitals from the payors health plans. Insured consumers often have only a vague idea of the price of the medical services they receive, because insurance largely insulates them from the financial implications of their medical treatment.¹¹ Consumers who pay the same co-payment, regardless of the price of the treatment they receive, have no reason to inquire into the price of the treatment, or to factor that price into their decisions. Consumers who have co-payments that vary depending on where they receive care will focus on the differing amounts of the co-payment, but not on the total price of the services they receive. Even if consumers become motivated to know the total price of the care they receive, they will find it extremely difficult to obtain that information.¹² Proposals to increase consumer price sensitivity must confront this reality, and develop strategies to increase the transparency of hospital pricing.¹³

2.2.2. *Hospital Tiering – A Competitive Response to Market Conditions*

Consumer pressure for broader or open networks has made it more difficult for payors to exclude an entire hospital system from their plans outright; this affects the bargaining dynamics. In a few markets, payors have responded by seeking to “tier” hospitals. Tiering is a payor reimbursement method whereby

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10. See generally Gregory Vistnes, *Hospital, Mergers and Two Stage Competition*, 67 ANTITRUST L. J. 671, 674 (2000). A marketable network is one that is not too expensive and includes hospitals that enrollees and plan physicians want. Complex rules can make a plan less marketable.
 11. Herbert Simon, *A Behavioral Model of Rational Choice*, in MODELS OF MAN (1957).
 12. See Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 J. HEALTH Pol., Pol’y & L. 967, 986 (2001) (“[O]ne need only imagine a patient beset by chest or stomach pain in Anytown, USA, as he or she attempt to ‘shop around’ for a cost-effective resolution to those problems. Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest. The prices of health services are jealously guarded proprietary information.”).
 13. Medical savings accounts represent a recent attempt to require consumers to bear some of the increased expenses associated with receiving care at a more expensive hospital. A medical savings account provides the consumer with a fixed sum of money to pay for the consumer’s portion of their healthcare costs. If, in any given year, the consumer does not use all of the money, the consumer retains the money for future use. Medical savings accounts attempt to raise consumer sensitivity to the costs associated with their health care decisions. For this strategy to work effectively, however, consumers need access to good information about the price and quality of the services they must choose between. Without good information about the actual prices charged by different hospitals, a consumer facing a 25 percent co-payment at one hospital and a 15 percent co-payment at another cannot accurately assess the financial consequences of choosing one hospital over the other.

consumers incur different co-payments (*i.e.*, high or low cost sharing) depending on the hospital at which the consumer chooses to have care provided. Tiering generally does not apply to emergency admissions and may depend upon where routine and specialty services are offered.

For payors, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payor network. Tiering allows the payor to maintain a broad network, and include a “must-have” hospital in its plans, but simultaneously creates an incentive for consumers to use lower-cost providers. Some hospitals resist tiering, and with sufficient bargaining power, they can credibly threaten to withdraw from a payor network if they are placed in an unfavourable tier. In some markets, hospital systems have taken pre-emptive steps to negotiate contract language with payors that prohibit tiering. Because tiering is a relatively new development, there are, as yet, no systematic studies available on the prevalence or consequences of this strategy.

2.23. “Any Willing Provider” Laws

An important parameter in hospital/payor contracting practices in many states has been the presence in those states of so-called “any willing provider” or “freedom of choice” laws. Any willing provider (AWP) laws require managed care companies to include in their networks any provider that is willing to participate in the plan in accordance with the plan’s terms.¹⁴ Freedom of choice (FOC) laws are similar to AWP laws, but are directed at consumers instead of providers. FOC laws prohibit payors from denying coverage to an insured for using any licensed provider that the patient chooses. Many states have adopted some form of AWP and/or FOC laws.¹⁵

The staff of the FTC has repeatedly expressed concerns about AWP and FOC laws, noting that they could have anticompetitive effects and harm consumers.¹⁶ These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that otherwise likely would result from restricted provider networks. They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand. These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.

As Commission staff explained in one of its advocacy letters on this issue,

14. Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of ‘Any Willing Provider’ Regulations*, 20 J.HEALTH Econ.955, 956 (2001).

15. See, *e.g.*, *id.* (“By one count, 34 states had enacted some form of FOC or AWP law by 1996”).

16. See FTC staff comments on proposed legislation that incorporated any willing provider or “freedom of choice” provisions in the following states: Rhode Island (Letter from Office of Policy Planning et al., to Patrick C. Lynch, Attorney General (Apr. 8, 2004)), at <http://www.ftc.gov/os/2004/04/ribills.pdg>; Massachusetts (Letter from Bureau of Competition, to John C. Bartley, Representative (May 30, 1989)); New Hampshire (Letter from Office of Consumer & Competition Advocacy, to Paul J. Alfano (Mar. 17, 1992)); California (Letter from Office of Consumer & Competition Advocacy, to Patrick Johnston, Senator (June 26, 1992)), at <http://www/ftc/gov/opa/predawn/F93/calpharm.htm>; Montana (Letter from Office of Consumer and Competition Advocacy, to Joseph P. Mazurek, Attorney General (Feb. 4, 1993)); New Jersey (Letter from Office of Consumer and Competition Advocacy, to E. Scott Garrett, Assemblyman (Mar. 29, 1993)); Pennsylvania (Letter from Office of Consumer and Competition Advocacy, to Roger Madigan, Senator (Apr. 19, 1993)); South Carolina (Letter from Office of Consumer and Competition Advocacy, to Thomas C. Alexander, Representative (May 10, 1993)); and Nevada (Letter from Bureau of Competition, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986)).

Empirical evaluations of any willing provider and “freedom of choice” provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/freedom of choice laws spent approximately 2% more on healthcare than did states without such policies. This finding likely reflects the fact that these laws reduce the ability of insurers to offer less expensive plans with limited provider panels.¹⁷

3. Restructuring of the Hospital Industry

3.1 Background on the Consolidation Trend

Over the past 25 years, hospitals have been consolidating into multi-hospital systems.¹⁸ While in 1979, only about 31 percent of hospitals were part of a multi-hospital system, by 2001 almost 54 percent of hospitals operated as part of a system, with an additional 12.7 percent in looser health networks. Initially, consolidations involved national systems acquiring hospitals throughout the United States, but recent acquisitions have been more localised.¹⁹ Consolidation can occur over a broad spectrum of possibilities. At one end of the spectrum, consolidating hospitals may have a shared license and common ownership; reports unified financial records, and eliminate duplicative facilities. At the other end, a common governing body may own the consolidating hospitals, but the hospitals maintain separate hospital facilities, retain individual business licenses, and keep separate financial records.

Some observers of the hospital industry assert that hospital consolidations have provided opportunities for hospitals to compete more efficiently, improve the quality of care, and limit duplication of services or administrative expenses. Others, including many payors, believe that important motivations for the creation of multi-hospital systems have been hospitals’ desire to gain market power, secure higher reimbursement from payors, and impose other onerous requirements on payors, e.g., “all-or-nothing” contracting. The development of hospital networks, through common ownership of, or other affiliations among, hospitals may play a significant role in the evolution of hospital markets. If the hospital networks formed do not include significant integration among the member hospitals, for example, if they are simply “virtual networks,” with no integration or real common ownership, and formed merely to set prices collectively, they run the risk of being challenged as illegal combinations under the antitrust laws. Most

17 . See, e.g., FTC Staff letter to Rhode Island, *supra* note 15 at 6. See also Michael A. Morrissey & Robert L. Ohsteldt, Do State ‘Any Willing Provider’ and ‘Freedom of Choice’ Laws Affect HMO Market Share?, 40 INQUIRY 362 (2003/2004).

18. Deborah Haas-Wilson, Managed Care and Monopoly Power: The Antitrust Challenge 28 (2003). See also Deborah Haas-Wilson & Martin Gaynor, *Increasing Consolidation in Healthcare Markets: What Are the Antitrust Policy Implications?*, 33 Health Services Res. 1403 (1998) (“Healthcare providers and insurers have been aligning in a plethora of coalitions as mergers, networks, joint ventures, and contracts have developed and dissolved with great rapidity. The implications of this reorganization for healthcare competition, and thus for costs, quality, and innovation, are profound. The key questions are to what extent these changes enhance efficiency and quality, and to what extent they facilitate collusion and market power.”); Martin Gaynor & Deborah Haas-Wilson, Change, Consolidation and Competition in Health Care Market 19 (Nat’l Bureau of Econ. Research, Working Paper No. 6701, 1998) (“The most extensive research evidence on competitive conduct by firms in health care markets is on hospitals; Dranove and White (1994) offer an extensive survey. These studies use differing product and geographic market definitions and research methods, yet the consistency of the results is striking. Increased concentration is associated with increased prices in markets for hospital services.”), available at <http://papers.nber.org/papers/w6701.pdf>.

19. David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 J. Health Econ. 983, 984 (2003); Alison Evans Cuellar & Paul J. Gertler, *Trends in Hospital Consolidation: The Formation of Local Systems*, 22 Health Affairs 77, 80 (Nov./Dec. 2003).

studies of the relationship between competition and hospital prices generally find that increased hospital concentration is associated with increased prices.²⁰

3.2 *Certificate of Need (CON) Programs – Entry Limitations*

A factor influencing the restructuring of the hospital industry has been the presence or absence of certification of need (CON) laws or regulations in particular states. CON programmes, which initially were adopted at a time that cost-plus reimbursement was the norm, were intended to control costs by restricting provider capital expenditures. State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities that there is an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.²¹

3.2.1 *Competitive Concerns Raised by CON Programs*

CON regimes prevent new health care entrants from competing without a state-issued certificate of need, which is often difficult to obtain. Their effect is to shield incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is depressed below competitive levels. Moreover, CON programs can retard entry of firms that could provide higher quality services than the incumbents. By protecting incumbents, CON programs likewise can delay the introduction and acceptance of less costly, innovative treatment methods. Similarly, CON programmes curtailing of services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payers. Empirical studies confirm that CON programmes generally fail to control costs and can actually lead to increased prices.²²

3.2.2 *CON and Cost Control*

Commentators note that the reason that CON restrictions have been ineffective in controlling costs is that they do not put a stop to supposedly unnecessary expenditures but merely redirect any such expenditure into other areas. Thus, a CON rule that restricts capital investment in new beds does nothing

20. David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & Econ. 179, 201 (1993) (finding that market concentration in California led to rate increases); Glenn A. Melnick et al., *The Effect of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217 (1992) (finding market concentration appears to increase hospitals' bargaining power with insurers and self-insurers); Ranjan Krishnan, *Market Restructuring and Pricing in the Hospital Industry*, 20 J. Health Econ. 213, 215 (2001) (mergers that increase hospital market share in specific hospital services, as measured 33 DRGs, show a corresponding increase in prices of those services).

21. See John Miles, 2 *Health Care & Antitrust Laws: Principles and Practice* § 16:1, at 16-2, 16-5 to 16-6 (2003); James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 Utah L. Rev. 3; Randall Boybjerg, *The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 Utah L. Rev. 83; Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 Va. L. Rev. 1143 (1973).

22. See Daniel Sherman, Federal Trade Comm'n, *The Effect of State Certificate-of-Need Laws On Hospital Costs: An Economic Policy Analysis* (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, *Competition Among Hospitals* 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); Keith B. Anderson & David I. Kass, Federal Trade Comm'n, *Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis* (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale).

to prevent hospitals from adding other kinds of high-tech equipment and using them to compete for consumers.

Furthermore, CON programmes can provide hospitals with a forum in which to engage in anticompetitive conduct. For example, the Justice Department recently charged two competing West Virginia hospitals with using the CON programme of their state as a mechanism for developing an illegal service allocation agreement, in which one hospital agreed not to offer cardiac surgery in return for the other hospital not offering cancer services.²³

For all these reasons, the Agencies believe that CON programmes are generally not successful in containing health care costs and can pose anticompetitive risks. Therefore, the Agencies have urged states with CON programmes to reconsider whether the continuation of such programs best serves their citizens' health care needs.

3.3 *Development of Specialty Hospitals and Ambulatory Surgery Centres*

3.3.1. *Specialty Hospitals*

Specialty hospitals are not new to the hospital industry; paediatric, rehabilitation, and psychiatric hospitals have existed for decades. More recently, specialty cardiac and orthopaedic surgery hospitals have opened. These newer, single-specialty hospitals (SSHs) differ from their predecessors in that many of the physicians who refer patients to them have an ownership interest in the facility. SSHs may compete with both inpatient and outpatient general hospital surgery departments as well as with ambulatory surgery centres.

There still are relatively few SSHs. In 2003, the General Accounting Office (GAO) identified 100 existing SSHs with an additional 26 under development. SSHs are located in 28 states, but two-thirds are located in only seven states.²⁴ The GAO concluded that "the location of specialty hospitals is strongly correlated to whether [the CON programmes of] states allow hospitals to add beds or build new facilities without first obtaining state approval for such health care capacity increases."²⁵ Observers have identified a number of market developments that have encouraged the emergence of SSHs, including: less tightly managed care, the willingness of providers to invest in an SSH, physicians' desire to "provide better, more timely patient care," physicians looking for ways to supplement declining professional fees, and the growth of health care provider entrepreneurs.

Among the asserted benefits of SSHs are achieving better outcomes and important disease management and clinical standards, as a result of focusing on a single area of medical specialty and performing increased volumes of procedures. Critics of SSHs, however, note that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care. Such critics believe this gives SSHs an unfair competitive advantage over 24-hour hospitals with emergency departments. A 2003 GAO study analysed whether SSHs provided care to Medicare and

23. Press Release, U.S. Department of Justice, "Justice Department Requires Two West Virginia Hospitals To End Illegal Market-Allocation Agreements" March 21, 2005, available at http://www.usdoj.gov/atr/publis/press_releases/2005/208209.htm.

24. U.S. General Accounting Office, GAO-04-167, *Specialty Hospitals: Geographic Locations, Services Provided and Financial Performance 3-4* (2003) (Report to Congressional Requesters) [hereinafter GAO, *Specialty Hospitals*], at <http://www.gao.gov/new.items/d04167.pdg>. The seven states are Arizona, California, Texas, Oklahoma, South Dakota, Louisiana, and Kansas. Of those seven states, only three (Texas, Oklahoma and Arizona) require all hospitals to have an emergency room. *Id.*

25. *Id.* at 15.

Medicaid patients. The study found that there were modest differences between the percentage of Medicare and Medicaid patients who received treatment at general hospitals and SSHs.²⁶

Other critics of SSHs are concerned that SSHs would siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross-subsidise other socially valuable, but less profitable, care. Still others suggest that physicians with an ownership interest in an SSH have an incentive to over-refer patients to that facility to maximise their income. In 2004 a moratorium was imposed on Medicare payments to SSHs, and Congress mandated that the cost structure of specialty hospitals and their effect on community hospitals be studied. Under the moratorium, physicians were not allowed to refer Medicare patients to a specialty hospital in which they had an ownership interest, and Medicare may not pay specialty hospitals for any services rendered as a result of a prohibited referral.

In early 2005, the MedPAC and CMS published the reports that Congress had instructed them to prepare, regarding physician-owned specialty hospitals.²⁷ Following these reports, CMS continued the Medicare reimbursement moratorium on new specialty hospitals until 2006, so that it would have an opportunity to determine whether Medicare reimbursement rates for certain procedures may have unwarrantedly encouraged the development of physician-owned specialty hospitals.²⁸

In addition, the MedPAC Report found that although the industry is in its early stage, physician-owned specialty hospitals thus far do not appear to have lowered the costs for treating Medicare patients. It also concluded that, although specialty hospitals generally treat patients having less severe illnesses than patients treated in community hospitals, they have had limited impact on community hospitals.²⁹ The CMS Report found that specialty hospitals provide a high level of quality of care; the total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that tax-exempt community hospitals devoted to uncompensated care; and “the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals is not supported.”³⁰

General hospitals have reportedly reacted to the emergence of SSHs in a number of ways. Some general hospitals have established their own specialised single-specialty wings or partnered with physicians on their medical staff to open SSHs. Other general hospitals have reacted with actions targeted at the SSH’s physicians, such as removing those physicians from on-call rotation; making it more difficult for them to schedule surgeries; and limiting their access to operating rooms and ability to take on “extra assignments” to augment their professional fees. General hospitals also have used CON laws to encumber specialty hospital entry.

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26. *Id.* at 18. There were larger differences in the frequency of emergency departments (ED) at SSHs and general hospitals. In particular, 92 percent of general hospitals had an ED, but by contrast 72 percent of cardiac hospitals, 50 percent of women’s hospitals, 39 percent of surgical hospitals, and 33 percent of orthopedic hospitals had an ED. *Id.*
 27. Report to The Congress, Physician-Owned Specialty Hospitals (March 2005) (“MedPAC Report”), available at www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf; CMS, Study of Physician-Owned Specialty Hospitals Required In Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“CMS Study”), available at <http://www.cms.hhs.gov/media/press/files/052005/RTC-StudyofPhysOwnedSpecHosp.pdf>.
 28. Fact Sheet, CMS Outlines Next Steps As Moratorium On New Specialty Hospitals Expires (June 9, 2005), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1478>.
 29. MedPAC Report at vii.
 30. CMS Study at 62-63.

3.3.2. Ambulatory Surgery Centres

Ambulatory surgery centres (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of ASCs are single-specialty. Single-specialty ASCs generally specialise in gastroenterology, orthopaedics, or ophthalmology. Most ASCs are small (two to four operating rooms). ASCs' ownership structures vary: some are completely physician owned; some are owned by joint ventures between physicians and companies; some are owned by physician/hospital joint ventures; and some are owned by hospitals and hospital networks. Innovations in technology have made it possible to offer a broad range of services in ASCs.

ASCs require less capital than SSHs, and are generally less difficult to develop because they do not require the facilities or support services needed to offer care twenty-four hours a day, seven days a week. ASCs generally do not have emergency departments, and CON regulations, if they apply at all, often are not as rigorous for ASCs. ASCs were originally intended to compete with hospital inpatient units, but they now compete more against hospital outpatient surgery units. The number of ASCs has doubled in the past decade, and they currently total more than 3,000. ASC development was encouraged by many of the same factors that spurred the growth of specialty hospitals.

Many of the concerns expressed about SSHs have also been expressed about ASCs. In general, critics assert that ASCs are eroding the outpatient market share of hospitals; they do not care for Medicaid beneficiaries; they "cherry-pick" the patient base, focusing on the more profitable procedures and the better-insured patients; and they only enter areas where business is profitable. It also appears that many of the actions taken to curb the entry of specialty hospitals are also being employed against ASCs. For example, hospitals have engaged in legislative efforts to encumber ASCs with unnecessary regulations and mandatory services. Consistent with the First Amendment, antitrust law does not typically prevent hospitals from lobbying state governments, either unilaterally or collectively, in connection with CON proceedings. In addition, the antitrust laws would not, in most instances, prevent individual hospitals from unilaterally responding to SSH or ASC competition by, for example, terminating physician admitting privileges. If there is specific evidence of anticompetitive conduct by an individual hospital or of hospitals acting together against SSHs or ASCs, then the Agencies will aggressively pursue those activities.

4. Hospital Merger Analysis

4.1 Overview

While the Agencies have wide jurisdiction over anticompetitive conduct in the hospital industry,³¹ Most of the cases brought by the Agencies have involved mergers. For this reason, this section will focus on hospital mergers. Because preservation of hospital competition is vital to health care cost containment, both Agencies maintain vigorous enforcement programs to scrutinise hospital mergers for their potential effects on competition. The Agencies have a long history of such scrutiny, which has on occasion led to the challenge of particular hospital mergers. Most hospital mergers and acquisitions, however, do not present competitive concerns.

The Agencies analyse hospital mergers using the same analytical framework they use for other mergers, following the 1992 *Horizontal Merger Guidelines* ("*Merger Guidelines*"). The *Merger Guidelines* specify that "mergers should not be permitted to create or enhance market power or to facilitate

31. With some minor exceptions, the Federal Trade Commission does not have jurisdiction over the conduct of non-profit hospitals outside of merger review. The Antitrust Division is not so limited in its jurisdiction.

its exercise.”³² In applying the *Merger Guidelines* to hospital mergers particular issues have arisen with respect to the definition of the product and geographical market. In addition, some questions have been raised about whether the non-profit ownership structure of many hospitals should alter the *Merger Guidelines* analysis.

4.2 *Product Market Definition*

The *Merger Guidelines* provide the framework for defining the relevant product market for hospital services. The product market has typically been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or observation.³³ This broad grouping makes sense because, from the perspectives of payors and patients, inpatient services are complementary and bundled. Even if inpatient hospital prices are increased, patients and payors cannot separate and outsource nursing care, diagnostic tests, and room and board from the other treatments provided as part of a hospital stay.

Over the past twenty years, many hospital merger cases have considered and rejected outpatient services as part of the relevant product market for hospitals.³⁴ Commentators agree that providers of outpatient services, such as physicians’ offices, urgent care centres, and ambulatory surgery centres, should generally not be included in the product market definition for hospital services.

In the future, it is likely that the Agencies will have to determine whether certain specialty hospitals should be included in an inpatient product market for particular proposed hospital mergers. Historically, the narrow scope of services provided by various specialty hospitals (children’s, psychiatric, Veterans Administration, military, and rehabilitation) justified their exclusion from the product market in analysing mergers of general acute care hospitals.³⁵ In recent years, specialty hospitals focusing on cardiac or orthopaedic care have emerged in numerous locations. General acute care hospitals view these specialty hospitals as competitors in the provision of such services.

Some also have suggested approaches for defining an inpatient hospital product market more narrowly. Instead of treating acute inpatient treatment as an aggregated group, some suggest the possibility of grouping diagnosis related groups (DRGs) together, based upon the types of diseases and medical conditions treated. Or if more specialised medical procedures raise greater competitive concerns than do primary care services, the product market may include only a specific service or limited number of services. Similarly, it is possible that some mergers may involve hospitals with distinct attributes, such as strong expertise in one or more specific specialties, so that health plans would need to include one of them

32. U.S. Dep’t of Justice & Federal Trade Comm’n, Horizontal Merger Guidelines § 0.1 (1992 rev. 1997, efficiencies section only) [hereinafter *Merger Guidelines*], available at <http://www.ftc.gov/bc/docs/horizmer.htm>.

33. In *American Medical International, Inc. and Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. *American Med. Int’l*, 104 F.T.C. 1, 107 (1984); *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986).

34. See, e.g., *FTC v. University Health, Inc.*, 938 F. 2d 1206, 1210-11 (11th Cir. 1991); *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990) (Posner, J.); *Hospital Corp. of Am. v. FTC*, 807 F.2d at 1388.

35. Psychiatric and rehabilitation hospitals provide a limited scope of care and do not offer general acute care services. Children’s and Veterans Administration hospitals provide inpatient care similar to general acute care hospitals, but are dedicated to a specific group. Although a children’s hospital might compete with a general hospital for a subset of the general hospital’s patients, non-veterans cannot substitute the VA for a general hospital.

to make their networks acceptable to consumers. In such cases, a separate product market analysis, focusing on such “must have” or anchor hospitals, may be justified.³⁶

4.3 *Geographical Market Definition*

The Agencies define hospital geographical markets using the framework set forth in the *Merger Guidelines*. Although there is widespread agreement on the basic theory, there is much controversy on the specifics of how to define relevant geographical markets for hospitals. Some advocate using the *Elzinga-Hogarty* test and critical loss analysis while others offer alternative analytical techniques and evidentiary sources.³⁷ In addition, direct evidence of anticompetitive effects may make it unnecessary to define a relevant geographical market. For example, consummated merger cases may present opportunities to assess competitive effects without using detailed market definitions.³⁸

Since 1995, the Agencies have lost several hospital merger cases because the courts accepted the merging parties’ reliance on patient flow data to define the geographic market much more broadly than the

36. See *Healthcare and Competition Law and Policy Hearings*, [hereinafter “*Healthcare Hearings*”] March 28, 2003 at 76:12-76:25, 77:10-78:11 (discussing the Antitrust Division’s proposed product market in 1997 hospital challenge). But see *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997) (rejecting DOJ’s argument that the relevant product market was “the bundle of acute care inpatient services provided by anchor hospitals to managed care plans”).

37. The *Elzinga-Hogarty* test is named for the two economists who first proposed this particular analysis. See Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973) Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 Antitrust Bull. 1 (1978). The *Elzinga-Hogarty* test has been used extensively in hospital merger cases despite the fact that, as many commentators note, it is not readily applicable to heterogenous goods or differentiated products--and hospitals generally provide heterogenous or differentiated goods and services.

The term “critical loss analysis” was first used in an article: Barry Harris & Joseph Simons, *Focusing Market Definition: How Much Substitution Is Necessary?* 12 Res. IN L. & Econ. 207 (1989). Critical loss analysis has the potential to provide a useful way to implement the *Merger Guidelines*’ hypothetical monopolist test, but problems with its application have led some commentators to question its value to antitrust analysis. Conventional critical loss analysis posits a particular price increase and asks what proportion of the hypothetical monopolists’ sales would have to be lost to yield a net decrease in the hypothetical monopolist’s profits. If the estimated actual loss exceeds the critical loss, it is inferred that the price increase would be unprofitable, and the candidate market is too small to be a market.

There are a number of pitfalls that analysts face in applying critical loss analysis. Most notably, typical applications posit only a small (five percent) price increase. Yet, the *Merger Guidelines*’ methodology for delineation of relevant markets recognizes that a profit-maximizing price increase could be larger than five percent. In other words, even though a monopolist might find a five percent price increase unprofitable, a larger price increase might be profitable. Other possible calculation errors, stemming to incorrect estimates of hospitals’ marginal costs and profit margins, may skew the critical loss analysis. Likewise, critical loss analysis can go awry in the second step of the process-- estimation of the actual loss--through the inappropriate use of consumer surveys or patient flow data to estimate the actual losses in sales that would result from a price increase.

38. See e.g., Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63 (2001) (using a control group methodology to assess competitive effects). Here, the competitive effect of the transaction is identified by comparing the change in price at the merging hospitals to the change in price (measured over the same time period) at a set of “control” hospitals. The control hospitals are hospitals in other geographic areas that are otherwise similar to the merging hospitals. Note, however, that a price increase by itself may not be sufficient to prove anticompetitive effects.

plaintiff Agency alleged.³⁹ Patient flow data is data maintained by each hospital showing the zip (postal) code of origin of each patient admitted to the hospital for inpatient care. Analysis of patient origin data for all of the hospitals in a geographical area can reveal the area from which the hospitals draw various percentages of their patients, as well as calculate the percentage of patients living in the geographical area who are admitted to hospitals outside the area. Many believe that judicial acceptance of implausibly large geographical markets relying too heavily on patient flow data, has led to judicial approval of mergers that would not be permitted in other industries, and thus to the lessening of competition in hospital services markets.

Most commentators agree that it is not appropriate to use patient flow data uncritically as the sole basis for defining the geographical market. They agree that no one piece of information is sufficient to define a hospital's geographical market. In essence, these commentators hold that the courts should apply the *Merger Guidelines*' hypothetical monopolist test in hospital merger cases, just as they do in merger cases involving other industries and products. The question is *how* to implement the hypothetical monopolist test, and what analytical frameworks and evidence should be used to do so.

One important analytical framework for defining hospital geographical markets that has been offered is built on the observation that hospital competition is a two-stage process. In the first stage, hospitals compete to be included in the networks of health plans. At this point, health plans are the buyers, and prices may be constrained if a health plan can credibly threaten to, or actually, exclude the merging hospitals from its provider network and divert patients to alternative hospitals. In defining the geographical market for this first stage of competition the focus is on hospital locations, not patient locations. Once a hospital is in the plan's network or in some cases even if it is not, the hospitals then compete at the second stage - for individual patients. Other proposed alternative approaches to geographic market definition in this sector include a formal demand analysis model that would require data on patient and hospital characteristics in addition to the patient origin and destination data traditionally used.

There are numerous additional sources of evidence that could be used to help to establish the geographical market for hospital services. These sources include types of evidence typically assessed in non-hospital merger cases: strategic planning documents and testimony from the merging parties and their competitors, and documents and testimony from major purchasers of services from the merging parties - here, third-party payors.

4.4 *The Impact of Non-profit Status*

The significance of a hospital's institutional form (non-profit versus for-profit) to competition analysis has been a long-disputed issue in hospital merger cases, and the subject of a number of empirical studies. In antitrust merger analysis the relevant question is not whether non-profit hospitals behave in a manner indistinguishable from for-profit institutions, but whether they would use merger-created market power in ways harmful to consumers. Some courts and analysts have taken the position that even if non-

39. See *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999). In this case, the Eighth Circuit relied on both an Elzinga-Hogarty test and a critical loss analysis to conclude that a broad geographic market was appropriate. Similarly, in *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 1045 (8th Cir. 1997) the District Court relied on patient migration patterns, regional hospitals' outreach clinics, and the lack of evidence that patients' loyalty to their physicians would prevent them from defeating a price increase to find a broad geographic market. See also *J. Jacobs* 3/28 at 72-74 (noting DOJ lost the *Mercy Health Services* case on the geographic market definition for all these reasons, but suggesting that the government could address successfully some of these issues today); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000) (finding insufficient evidence of a relevant geographic market); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (holding the Commission had failed to identify a relevant geographic market).

profit hospitals achieve market power through merger, their long-term public interest missions will prevent them from raising prices above competitive levels. The best current empirical evidence, however, indicates that nonprofits will exercise market power when given the opportunity to do so.⁴⁰

4.5 *Efficiencies Claims for Consolidations*

Merging hospitals often claim that their merger will produce significant efficiencies. Claimed efficiencies often include avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs.

Scholars have conducted numerous studies on the effect of hospital mergers on hospital costs.⁴¹ The results are mixed: Some studies have found that merged hospitals enjoy lower costs (or lower rates of cost increase) than non-merging hospitals; others have found no differences in cost experience between merging hospitals and otherwise similar non-merging facilities. Even if a hospital merger is likely to create efficiencies, however, to pass antitrust muster those efficiencies must be sufficient to reverse a hospital merger's potential to lead to price increases.

In several merger cases, hospitals have signed "community commitments" or agreements with state attorneys general, promising not to raise prices for a specified period of time or promising to pass on to consumers a specified amount of money from claimed efficiencies.⁴² Some state attorneys general have signed these agreements in an attempt to translate claimed merger-induced cost savings into actual price reductions to consumers. Community commitments are temporary and do not solve the underlying competitive problem when a hospital merger has increased the likelihood that market power will be exercised.⁴³ Community commitments represent a regulatory approach to what is, at bottom, a structural market problem -- and that problem will remain after the commitment has expired. Therefore, the Agencies

40. Robert Connor et al., *The Effects of Market Concentration From Horizontal Mergers on Hospital Costs and Prices*, 5 Int'l J. Econ. Bus. 159 (1998). Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63, 76-77 Tbls. III & IV, 80-82 (2001). An earlier study by different authors found that hospital mergers resulted, on average, in a 5 percent cost savings. Connor et al., *supra*, at 159. Emmett B. Keeler et al., *The Changing Effects of Competition on Nonprofits and For-Profit Hospital Pricing Behavior*, 18 J. Health Econ. 69 (1999). *But See* 23 Health Affairs 147, 154 (Jan./Feb. 2004).
41. Jeffrey A. Alexander et al., *The Short-Term Effects of Merger on Hospital Operations*, 30 Health Services res. 827 (1996); Robert A. Connor et al., *Which Types of hospital Mergers Save Consumers Money?* 16 Health Affairs 62 (Nov./Dec. 1997); Robert A. Connor et al., *The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices*, 5 Int'l J. Econ. Bus. 159 (1998); David Dranove & Mark Shanley, *Cost Reductions Versus Reputation Enhancements as Motives for Mergers: The Logic of Multihospital Systems*, 16 Strategic Mgmt. J. 55 (1995); David Dranove et al., *Are Multihospital Systems More Efficient?* 15 Health Affairs 100 (Spring 1996); Heather Radach Spang et al., *Hospital Mergers and Savings for Consumers: Exploring New Evidence*, 20 Health Affairs 150 (July/Aug. 2001).
42. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149; *Butterworth Health Corp.*, 946 F. Supp. at 1302. Other states also have entered into decrees with merging hospitals that provided for some type of community commitment. *See, e.g., Wisconsin v. Kenosha Hosp. & Med. Ctr.*, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree); *Pennsylvania v. Capital Health Sys.*, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree) (court ordered merged hospitals to pass at least 80 percent of the net cost savings to consumers); *Pennsylvania v. Providence Health Sys.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree).
43. *See Healthcare Hearings, supra* note 35 at 78:16-80:10 (discussing what happened after one community commitment expired).

do not endorse community commitments as an effective resolution to likely anticompetitive effects from a hospital (or any other) merger.

4.6 *A Summary of the Agencies' Hospital Merger Challenges*

The Agencies prevailed in some early challenges to hospital mergers,⁴⁴ and also obtained a number of consent decrees, allowing multiple hospital mergers to proceed, subject to requirements that certain hospitals be divested.⁴⁵ However, more recently courts have rejected the Agencies' (and state attorneys' general) attempts to prevent mergers between hospitals that the Agencies claimed would reduce competition.⁴⁶

Focusing solely on litigated cases, however, obscures the larger picture of the Agencies' overall enforcement agenda. The Agencies are sometimes able to obtain relief without trials, as when the hospitals agree to a settlement or abandon the transaction.⁴⁷ For example, the Antitrust Division's investigation of the merger of two hospitals in Cape Girardeau, Missouri, led, in part, to the hospitals deciding not to merge.⁴⁸ The Cape Girardeau matter also reflects the continuing efforts of the Agencies to prevent anticompetitive hospital mergers, an effort currently reflected in the FTC's challenge to the Evanston hospital merger.

In 2004, the Federal Trade Commission issued a complaint against Evanston Northwestern Healthcare Corporation (ENH), an organisation that owns three hospitals in the Chicago, Illinois suburbs.⁴⁹ The Complaint alleges that, in January 2000, ENH, which was then a two-hospital system, merged with a third hospital, Highland Park Hospital. According to the complaint, following the merger, ENH negotiated uniform prices for the three hospitals, and raised prices. The Complaint further alleges that ENH raised prices far above the price increases at comparable area hospitals.

The three hospitals that formed ENH after the merger form a geographical triangle in the northern suburbs of Chicago, a relatively affluent area. There are no other hospitals within the triangle formed by the three ENH hospitals, but there are hospitals outside of the triangle, including hospitals relatively close to each of the three ENH hospitals. The geographical triangle defined by the locations of the three ENH hospitals did not satisfy the kinds of tests that courts had previously used to define geographical markets in hospital merger cases.

44. See, e.g., *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986); *American Med. Int'l, Inc.*, 104 F.T.C. 1 (1984), *as modified by*, 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986).

45. *Columbia/HCA Healthcare Corp./Healthtrust, Inc. - The Hosp. Co.*, 120 F.T.C. 743 (1995) (consent order); *Healthtrust, Inc. - The Hosp. Co./Holy Cross Health Servs. of Utah*, 118 F.T.C. 959 (1994) (consent order); *Columbia Healthcare Corp./HCA-Hosp. Corp. of Am.*, 118 F.T.C. 8 (1994) (consent order).

46. *Tenet Healthcare Corp.*, 186 F.3d 1045; *Freeman Hosp.*, 69 F.3d 260; *Sutter Health Sys.*, 130 F.Supp.2d 1109; *Long Island Jewish Med. Ctr.*, 983 F. Supp. 121; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, *aff'd*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997); *Mercy Health Servs.*, 902 F.Supp. 968.

47. *Healthcare Hearings*, *supra* note 35 at 69:19-70:07 (discussing one matter in which the Division obtained relief through a settlement and one matter in which the Division obtained relief because the transaction was abandoned)

48. *Id.* at 70:01-70:07

49. The Complaint can be found at <http://www.ftc.gov/os/caselist/0110234/04021emhcomplaint.pdf>. All the public pleadings in the case can be found at <http://www.ftc.gov/os/adipro/d9315/index.htm>. The complaint also included allegations concerning physician price fixing not germane to this discussion.

This Complaint is a marked departure from the previous Agency actions regarding hospital mergers. In the other cases, the Agencies attempted to prevent the consummation of mergers that they alleged would lead to a diminution of competition. In this case, suit was filed over four years after the merger, and the Complaint seeks to undo a merger that had long been consummated.

The Complaint against ENH was tried before an Administrative Law Judge (ALJ) in the winter and spring of 2005. The current scheduling order calls for the ALJ to issue his decision by mid October, 2005, although if the ALJ needs more time, he may grant himself an extension.

6. Conclusion

The appropriate competition policy with respect to hospitals, and particularly hospital mergers, has not been settled by the courts. While the *Evanston* case may bring some answers it is unlikely to be the final answer. At the same time the hospital industry in the United States continues to evolve, as does public policy toward paying the hospital costs of an aging population. The move to prospective payments systems is unlikely to be the final change in government payment programmes to hospitals. Government programmes and institutional relationships are likely to continue to change as new programmes are developed and tested. The goal is the availability of efficiently provided high quality hospital care. The industry and its customers continue to look for ways to achieve this goal.

EUROPEAN COMMISSION

Contribution of the Services of the European Commission DG Competition to the Roundtable on competition and Efficiency in the Provision of Hospital Services October 2005.

1. Provision of health services under the EC Treaty

Article 152 of the Treaty setting up the European Community requires that “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”, and that “Community action ... shall fully respect the responsibility of the Member States for the organisation and the delivery of health services and medical care”. Therefore, in the area of health the main responsibility remains at national level. This is also consistent with the fact that the markets in which health professionals operate are probably of local nature.

Article 86(2) of the EC Treaty foresees the non-application of EC rules if the application of such rules obstructs the performance of the services of general economic interest (hereinafter SGEI).

In practice Member States have a wide margin of discretion to classify services as being SGEI, and health services appear typically to fall under this category.

However, whenever this is possible DG Competition does take on an active role in promoting competition at the Community level. In relation to the healthcare market other Directorates General whose activities might affect that market are notably DG Internal Market, DG Health and Consumer Protection and DG Employment and Social Affairs. DG Competition can therefore primarily play a role in advocating competition issues in healthcare in our contacts with those services. The most recent example concerns the co-operation between services which led to the Commission White Paper on SGEI¹

In general, the application of competition to the health sector is considered relatively new; for this reason, advocacy of competition in this sector is extremely important.

2. Role of the European Commission under State aid rules

There are no specific guidelines concerning State aids in the field of health services. Nonetheless, the Treaty rules, in particular Article 87(1) EC, apply to health services, including hospitals and they allow taking into account the specificity of the hospital sector.

Article 87(1) EC states that any State intervention that distorts competition by favouring certain undertakings² is incompatible with the common market in so far as it affects trade between Member States.

1 White Paper on services of general interest, COM(2004) 374 final, Brussels, 12.5.2004

2 There is, as yet, no case law of the Community Courts dealing with this precise issue in the hospital sector. However, there is extensive case law discussing the concept of an undertaking in other sectors: e.g. pursuant to the judgement of the European Court of Justice, in case C 41/90, “Höfner v. Macrotron”, [1991], ECR I-1919, “*the concept of an undertaking encompasses every entity engaged in an economic activity, regardless of the legal status of the entity and the way in which it is financed*”.

On the other hand, the health sector is usually characterised by a high level of national regulation, and the provision of hospital and health services more generally is typically regarded as a public service across the EU.

Article 86(2) EC allows a derogation from the State aid rules where they would hinder the performance of a service of general interest in so far as certain conditions are respected. Accordingly, State funding of hospitals is allowed, if it is necessary to finance the costs of the health services of general economic interest which have been defined by the State, entrusted to the hospital and if the compensation is limited to those costs. On the contrary, it is not allowed that hospitals use public resources to cross-subsidize purely commercial activities.

In July 2005, the Commission adopted the SGEI “package” in order to provide greater legal certainty for financing services of general economic interest by specifying the conditions under which the compensation to companies for the provision of public services is compatible with State aid rules. The SGEI package is composed of a

“Community framework for State aid in the form of public service compensation” and of a Commission decision “on the application of Article 86(2) of the Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest”.

The three conditions underscoring the compatibility of compensation for SGEI in the “package” derive from Article 86(2) EC and namely are: clear public service definition; transparency and objectivity of the compensation; absence of over-compensation of the discharge of the public service.

In respect of hospitals, the aforementioned Commission decision acknowledges that the following specific characteristics have to be taken into consideration:

“Hospitals and undertakings in charge of social housing, entrusted with tasks involving services of general economic interest have specific characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in those sectors is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research, and undertakings in charge of social housing providing housing for disadvantaged citizens or socially less advantaged groups, which due to solvability constraints are unable to obtain housing at market conditions, should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States”.

For the above reasons, the Commission decision thus foresees the exemption from the notification obligation under Article 88(3) EC of all aids to hospitals which meet the requirements of Article 86(2) EC.

3. Competition cases

At national level there is often a complex interplay of State intervention (public healthcare) and markets. As a consequence there are many State measures aimed at steering and controlling demand and supply, which are formally not covered by the competition rules.

State aid cases

Up to now the Commission has rarely applied the Treaty rules on State aids to hospitals. In the last five years, there has been only one Commission decision approving aids to hospitals³. However, the Commission has recently received an increasing number of complaints calling for the establishment of a level playing field between different service providers. Following the adoption in July 2005 of the decision on SGEI, the Commission will handle these complaints verifying that the Article 86(2) EC conditions are satisfied.

Antitrust cases

The Commission has so far not dealt with any case dealing with hospitals in the antitrust field. There are currently two complaints open for alleged violation of Article 86 EC and/or Article 10 in combination with Articles 82. The complaints allege that Italy would induce the Local Sanitary Units (ASL) to abuse their alleged dominant position in the markets for the purchase and provision of public healthcare services, by granting them the power to decide which private healthcare providers are admitted, and according to which rules, to be reimbursed by the national healthcare system.

It is not clear whether the Local Sanitary Units can be considered an ‘undertaking’ in the sense of competition law. The Commission is analysing the matter under the reasoning used in the *Poucet and Pistre* and in the *Fenin* judgments⁴.

In the meantime, the Italian Competition Authority has also opened an enquiry on the hospital services sectors⁵, which will look in particular at the problems identified in the complaints.

3 N 543/01, Capital allowance for Hospitals, Ireland, Decision of 27.02.02.

4 Joined Cases C-159/91 and C-160/91 *Poucet and Pistre* [1993] ECR I-637, and Case T-319/99, *Fenin v. Commission*. In *Poucet and Pistre* the Court concluded that the organisations managing the health funds in question in that case were not carrying on an economic activity and were not, therefore, undertakings for the purposes of Articles 81 EC and 82 EC. The Court relied on the fact that they were fulfilling an exclusively social function, that their activity was based on the principle of national solidarity and, lastly, that they were non-profit-making, the benefits paid out being statutory benefits that bore no relation to the level of contributions. In *Fenin* the Court ruled that if the activity for which an entity purchases goods is not an economic activity, it is also not acting as an undertaking for the purposes of Community competition law.

5 IC 30, n° 14389 of 16 June 2005

ARGENTINA

In the Argentinean health system we can distinguish three types of economic factors: i) the lenders of medical services (offerers); ii) the patients (final consumers) and, iii) the different institutions that finance the expense of the patients in such services. The consumption decision is therefore a result of the confluence of these three aforementioned agents.

The main agents backers are: i) The State that finances most of the expenses of the public hospitals (from general rents), and covers the demand of services of the population's health that is not covered by another type of health insurance. (in the eventuality of accidents or treatments that are not covered by other backers the State provides these treatments to the whole population) ii) The public insurance (compulsive) of health that conform the National System of Health sure, regime regulated by the Law N° 23.660 and regulation and complementary norms, and that they understand mainly the group of union social securities, of directive, national and provincial personnel whose resources come from the obligatory contributions of the beneficiaries wages; iii) The private health insurance (prepaid medicine), which is optional and by means of a monthly quota finances the expense of their members' health.

According to the Nation's Health Ministry report, the heterogeneous offer of coverings sandal 24 provincial public systems, near 300 nationals' social securities, 24 provincial social securities, several dozens prepaid medicine companies, private health insurance and great quantity of mutual besides the National Institute of Social Services for Retired and Pensioners (PAMI). The lack of coordination and articulation of this universe impedes the conformation of a health system attempting against the efficient use of resources and the achievement of acceptable levels of justness in its covering.

Therefore, based on the above-mentioned, it is observed that the provision of health is covered by three sub sectors, each one operates with its own operation rules: the public, the social security and the private sector.

In Argentina, according to the Assistance Establishments Guide upgraded in the year 2000, there are 16.085 established hospitals, of which 43.3 percent depends on the public financing, 1.4 percent on the Social securities and 55.2 percent on the private sector. Inside the Hospitals that depend on the public financing, only 0.2% depends on the National Government, 67% percent on the provincial governments and 29% on the Municipal Governments.

The lack of integration characterizes the relationship among the different sub sectors and it is also presented to the interior of the same ones. Also, It must be taken into consideration the division of the public sector that is according to it's jurisdiction (National-provincial-municipal) levels in which there isn't a necessary coordinated grade between them. The strong heterogeneity of the resources dedicated to the public health by the different provincial jurisdictions should be pointed out: while the City of Buenos Aires dedicates 1/4 of its budget to the attention of the health, other provinces dedicates less than 8%.

The transfer of 20 public hospitals and institutes that were in charge of the Nation at beginning of the 90's was the last step of a decentralizing politic in the public provision of health services. In this opportunity the financial objectives prevailed above the requirements of the sector as regards improvements in the efficiency and the justness. This process of decentralization had as compensation a

multiplicity of local answers. The coordination absence from the central level allowed a great heterogeneity of behaviours.

As the above-mentioned consequence, most of the capacity installed in public health services is under the provincial orbit, belonging a 67% of the total of the assistance establishments and a 76% of the beds that are under the public orbit to the provincial orbit. Also, the participation of the municipal level is of particular importance in certain jurisdictions like the province of Buenos Aires, Córdoba and Santa Fe.

The National Government's list is less important in terms of direct benefit of health services than in questions related to the realization of programs, financing, regulation and setting in practice of public politics. Being the Argentina a Federal country is necessary to look at these aspects inside the three possible environments of political action: the National one, the Provincial one and the Municipal one. In the case of the direct benefit of services, the national government's expense is centred mainly in the national hospitals that assist pathologies of high complexity.

In general it can be affirmed that exists a diversity of organization modalities with different grades of hospital autonomy, disparate levels of integration of its nets of attention, heterogeneous political human resources, diverse medical obligatory programs and other outstanding variables.

The fragmentation of the system in sub sectors, jurisdictions and levels, generates inefficacy in the use of the existent resources, duplicating offers and services unnecessarily and, in consequence, the expense.

Also, it is observed that such inefficacy in the environment of the articulation of the net of services can redound in a deterioration of the quality of attention generating unsatisfied sanitary results.

1. The social security

The social security sub sector is composed by a great number of heterogeneous institutions as for population's type that they contain, the covering that they toast, the available financial resources by affiliated and the varied operation modalities.

On one hand there is the National Social Securities (OSN), which grants covering to approximately the 40% of the population. However, the population's proportion that is covered by the National Social Securities varies considerably among the provinces.

The OSN system is integrated by 276 entities of different juridical nature, regulated in its activity by the Superintendence of Health insurance. They are beneficiaries of the system about 14 million people, 10.5 are rooted in the Social Securities Union and of Personal of Direction and the remaining ones in the INSSJyP.

The entities have been conformed around the productive activity, generating by this way strong differences in the size of the same ones, giving place to small ones that from the point of view of the theory of the insurance they would be helpless of conforming an appropriate pool of risks.

The financing pattern adopted corresponds to an allotment system, but limited to the interior of each national social work. The National Social Security is financed in the most part by personal employees' contributions and by employers' employer taxes. The contributions to the Solidary Fund of Redistribution establish a mark of solidarity among all the entities of the system, channelled through an automatic subsidy and the payment of benefits of high cost. However, even strong differences persist among the different social works in the available resources per layer.

They are also part of the social security system the Provincial Social Security (OSP). The asymmetries that characterize the combined actors that integrate the system are also observable in the case of the OSP. The populations' covering is very diverse and it is in direct relationship with the public employment participation regarding the total population. The offered coverings are variable and in some cases they are not adjusted to a reference package as the one established by the Obligatory Medical Program. The OSP lacks of a group regulation: each one counts with its own legislation that assigns them functions and particular characteristics. However, it is a common denominator of these structures the financial precariousness.

The Provincial Social Security (OSP) contains all the state employees of each province and the pensioners of provincial boxes. One of the distinctive features between the OSP and other social works is that the state employees are affiliated obligatory; that is to say, they cannot change from a provincial social security to any other one.

2. The private sector

The private sector can be analysed in its insurer function or as a health service provider. In some cases, the social securities are also direct suppliers of some health services by means of their own facilities but in general it is verified that they hire most of the services to private suppliers and it is observed that it is more common the direct benefit of the health services in the case of the private institutions (prepaid medicine).

The prepaid medicine finds their main source of clients in the strata of high and average incomes of the population. The covering of the prepaid medicine companies includes approximately the 9% of the population, with a great variability among the provinces. Due to the obligatory affiliation to the respective social securities of each activity branch, for the workers that are not of address, there is a significative part of the population covers by private insurance that maintains the contribution to its social securities. Of the above-mentioned it is deduced that part of the 9% of the affiliated population to a prepaid medicine company finances the social security system partly.

In function of certain parameters; (quantity of affiliated, readiness of internment centres and own diagnosis, geographical localization, international covering, price level, lenders' quality, presence of corporate contracts, preponderance of open or close health plans, the prepaid medicine companies can be classified in: i) Medicine prepaid of more than 70.000 members that have internment centres and own diagnosis, a national and partially international radius of action, high prices to means, better lenders and high participation of corporate contracts and of open health plans; this segment understands approximately six signatures; ii) prepaids of among 20.000 and 70.000 members that are characterized for having it's own diagnosis centres, a smaller geographical reach, intermediate prices, lenders of high and medium level and smaller prevalence of corporate contracts; iii) prepaid of less than 20.000 members that, in general terms, they lack of internment centres or own diagnosis, they have a local radius of action, prices of means to first floor, lenders' half level, agreements for mainly singular and health plans mainly of close type. This segment counts with more than 100 companies.

3. Population without covering

There is an important percentage of the population that is not covered neither with the services provided by the social security system neither by the prepaid health system. According to data of 2001, the 48% percent of the population is under these conditions. These individuals find as their only alternative the services that provides the public sector. This figure could have been increase in the last years product of the economic crisis that affected the country.

However, the public establishments not only offer services to those people without covering, they are also used either by individuals that are covered by the sector of the social security or by the private sector.

With the purpose of trying to recover a proportion of the actual expense done by the hospitals in patients that possess covering, the figure of the Public Hospital of Self-management was implemented. For this the Superintendence of Health insurance was authorized to carried out the retentions corresponding to the total of resources that correspond to the social securities for the Fund of Redistribution for the amount of the realized benefits to their beneficiaries in the Public Hospitals of Self-management.

The last end of the Hospitals of Self-management is to obtain supplementary financing by charging the social securities and companies of prepaid medicine from the services rendered to the members that are assisted in the public hospital. However, given the decentralized character of the public offering of health services, the implementation of this different regime varies thoroughly from province to province besides also varying the total of resources recovered by the hospitals.

4. Sources of finance of the system

As it was already said, the main expense in the rendering of health services corresponds to the provincial governments, existing, according to data of the Ministry of Economy, strong disparities among what is assigned to each province.

The attention of health in each province is financed through the resources that the provinces obtain from the federal co-partnership and through the taxes that are collect by the same ones. Explicit redistributational mechanisms don't exist for helping those provinces whose health systems supports a bigger load, just as it happens in the National Social Security System.

The only resources of specific assignment that provinces receives from the National Government are the transfers for specific ends carried out by means of some of the National's government programs. These transfers pass outside of the system of federal co-partnership and they possess their own distribution rule among each one of the jurisdictions.

If the National Government is considered, the same one obtains its resources to finance its expense in health from co-partnership taxes and from non co-partnership taxes, besides the international financing. The central government transfers resources or assets to the provincial governments so that they can execute different health programs (already analyzed in the previous chapter) at the same time that he executes for him different health programs besides transferring resources to the public hospitals that were not transferred to inferior levels of government. The National Government also carries out purchase of medications that will be dedicated to these hospitals or to be given in the provinces by means of the health programs.

The provincial governments obtain their resources from the federal co-partnership, from their own taxes and from external financing. At the same time carries out expenses related with health programs, its the responsible for the operation of the public establishments that depends on the same ones, also carries out purchase of medications for these hospitals. Besides this direct cost carried out by the provincial governments, inside their dependences they are the Provincial Social Insurance, which give health covering to their employees and in some cases to the pensioners of the Provincial Funds. The municipal governments finance their expense in health attention by means of own resources and by means of the resources coming from the federal co-partnership. The OSP receives resources mainly from the contributions and taxes carried out by the province government and from the municipalities of this province. In turn, the social securities hire benefits with private suppliers and they buy medications for their members. It is necessary to notice that since the main source of entrance of the provincial social

securities is the contributions and taxes that carried out by the same provincial state, this situation can give space to opportunist handlings by the provincial government in the moment the employee's taxes and contributions are effective.

5. Competition among the different subsystems

Regarding the provision of health insurance, as much from the demand as from the offer of this insurance, the substitution possibilities for coverings of similar width and quality are restricted by the legal régime to the one that prepaid medicine companies and social securities are subject. The beneficiaries tied to the regime of compulsive contributions can only opt among the diverse social securities and most of them are of labour union type (I Decree N° 504/98) and among those entities tied to the System created by the Law N° 23.661 (I Decree N° 446/2000). Those contributions cannot be derived to the prepaid medicine companies, except for those cases of social securities that have management agreements or have the administration of the wallet of the affiliated people with prepaid companies; or for those cases in which the entity sticks to the National System of Health insurance. The beneficiaries that don't work in dependence relationship can only opt among taking an insurance through a social securities (labour union or of directive personnel) paying a monthly quota as affiliated adherent or to hire a private health insurance.

It corresponds to highlight that the new regulatory system supervised by the Superintendence of Health Services , organism created in 1996 - it is reasonable as for it gives answer to those problems that are typically are in regimes of freedom election , such as the adverse selection or the concentration of individuals of high risk in the best entities. This way, for example, the transfer possibility was limited to its exercise by family group as maximum once a year, at the time that was settled down that when an individual changes the entity and uses certain services in the first months after the transfer had occurred, the origin social security should compensate the receiver monetarily for such expenses. In turn, it was determined that the beneficiaries are "owners" of their contributions and taxes (except in the portion that is channelled by the Fund of Redistribution), reducing this way the crossed subsidies and the horizontal inequity, opening the possibility to agree among the parts superior plans to the PMO to differentiated "prices."

On the other hand, the institutions of prepaid medicine (with or without ends of lucre) cannot be constituted legally as social securities to offer their services under the same institutional conditions, that is to say covering their costs with a compulsive contribution and, then, assisting a captive demand, unless they carry out their adhesion to the National System of health Insurance.

In other words, still saving for the high existent heterogeneity among the provided health plans for the different insurers actors, which limits in great measure the substitution for the side of the demand among institutions that offer insurance of different quality and covering, fact that is not only verified in the competition between prepaid medicine companies and social insurance but among the members of each group to each other, it is also observed that, by virtue of the conditions that characterize the different subsystems, a strong asymmetry exists as long as the companies of prepaid medicine face the competition of the regime of adherence (not compulsive) of the social works (labor union, of directive and other personnel), but these last ones don't face the competition of the first ones (insurance of compulsive health).

Together with the prepaid medicine companies it should also be considered those lenders (mainly some hospitals of prestige in Capital Federal) that have entered to the segment of optional health insurance through a group of products that are denominated "health plans." As a result of this process offers of medical plans arose on the part of certain private hospitals that in fact work as prepaid medicine companies. This segment crosses the stage of bigger growth in its cycle since life it is one of the proposals of smaller time in the market and whose development has been facilitated by the crisis since the two

leaders of the segment - French Hospital and Italian - registered the biggest increment in the number of capitals when they focused in the lowest socioeconomic levels.

Finally, the public hospital is only a near substitute from the theoretical point of view. In the practice an inferior infrastructure quality and the restrictions in the accessibility to the services bear associated costs for the consumer that the segment of population in the prepaid medicine would not be willing to pay. These agents cover the population's necessities without covering or with chronic problems.

6. Federal Plan of Health

In the mark of the document "Bases of the Federal Plan of Health 2004-2007" of the Ministry of Health of the Nation there are evaluated a series of modifications with the idea of improving the efficiency and effectiveness of the Argentinean health system in their group.

Although at the moment an institutional design that allows to increase the efficiency in the use of the resources on the part of the service providers of health don't exist (publics), one of the proposed changes consists on the setting-up of a system of "categorical qualifications" that embrace the public and private establishments and that this categorical qualifications take place in a periodic and published way, likewise homogeneous, in order to guarantee the users the aptitude in the operation and organization for the resolution of its health problems. This will guarantee a level of quality for the user, grant the establishment a stamp of quality that allows it to be compared with other establishments, have bigger information on the available resources for each institution and to have up-to-date information of the conditions of the system and to improve by this way the effectiveness of the planning to the level of the authorities of the different jurisdictions.

Another of the points of the proposal refers to the financing pattern. The objective of the same one is that the resources are assigned in function of the acting of each institution. The making of the budgets of each institution, identifying the hospital product and their costs, will allow the evaluation of the services that are offered in terms of efficiency and technical effectiveness. The determination of the hospital product will be the element vinculante with the National budget.

7. Decree 317/2005

The Decree 317/2005 establishes the creation of the System of Regional Recruiting of the Social Securities. The regulatory scheme arises starting from the verification that, in certain domestic regions of the country where there is not a great population concentration, an important number of social securities faces difficulties to maintain the covering of its beneficiaries, since the existent atomization removes them recruiting capacity.

That is why a group of norms were elaborated and also mechanisms that encourage the grouping of beneficiaries of the social securities residents in certain domestic regions of smaller populations density, in order to reach a number of people that, as critical mass, facilitate a bigger concentration in the recruiting and a consequent rationalization in the use of the available resources to pay the benefits of health.

This way, the primary objective of the system is to avoid the intermediation between the social securities and the group of lenders, so as the recruiting is carried out in direct form among the groups of social securities incorporated to the System and the group of lenders that are qualified to offer the benefits in the geographical environment.

It is useful to point out that one of the requirements settled down by the Decree that the lenders should obey in order to adhere the System refers to the implementation of the necessary measures into a better quality and homogeneity in the health services that are offered to the beneficiaries.

This way, the aforementioned Decree constitutes an advance, with the objective of a better use of the available resources without neglecting relative questions of the justness in the provision of health services even in terms of readiness of the services like of the quality of the same ones.

8. Performances of the CNDC in the Health Markets

A brief summary is presented below of some of the investigations that the CNDC had worked related with the health market.

8.1 *Analysis of accusations*

Raúl Ricardo Barisio c /Regional Odontologic Circle of Venado Tuerto. In this case the denounced behaviour imposed against the Odontologic circle of Venado Tuerto in Santa Fe referred to the exclusion in the market of those odontological professionals' benefits that competed with the entity in the rendering odontologic services for the attention of affiliated of the administrators of funds for the health. Such way of acting was possible because of an abuse exercised by the entity because of their domain position in the geographical market of General López's Department, Santa Fe province. Indeed, the Odontológico circle of Venado Tuerto agglutinated 93% of the professional offer of odontologists in the city of Venado Tuerto and most, and more important, contracts with the social securities and companies of prepaid medicine of the area.

As probatory element of an exclusive behavior, the CNDC considered the inclusion in the articles of association of the odontologic Circle of Venado Tuerto of admission restrictions for the odontologists that requested the entrance to the association, demanding them in exchange for the permission that they had not worked in certain type of institutions. It was also proven that the Regulation of the odontologic working Center belonging to the orbit of the denounced entity, among other prohibitions settled down, for the integral odontologists of the same one, to not take benefits from private social securities with salary and to not assist other social securities that does not have a direct relationship with this center.

The procedure was therefore to order the odontologic Circle of Venado Tuerto the ceasing of the exclusive behavior, a monetary sanction was imposed and finally it was order the elimination of any restrictive clause of competition, as much in their association articles as in any other type of regulation of the entity that fixed entrance rules for the professional odontologists in their listings of lenders for attention to affiliated to the administrators of health funds.

Pharmacies of Sunchales c / Personal Mutual Association Sancor (AMPS). The investigated behavior in this case was the exclusion of six pharmacies in the city of Sunchales, province of Santa Fe, on the sale of medications and special medicines for the members of that mutual, when AMPS directed its great mass of affiliated only to the Minardi-Fenoglio Pharmacy, managed by AMPS. The relevant market of the product was defined as a market of sale services of pharmaceutical products and special medicine with discount called "complement" and it was bounded geographically to the town of Sunchales.

The beneficiaries of AMPS reached direct or indirectly to more than 60% of the Sunchale's population. This entity was vertically integrated to the societies of the Sancor group and participated in societies dedicated to the pharmaceutical and sanatorium activity. Therefore, the CNDC considered that AMPS had a position in the market of medications in the city of Sunchales that allowed it to determine the economic viability of a competitor or participant in the market.

As test of the behavior it was considered the signed agreement between the mutual and the Pharmacy Minardi Fenoglio, in which it was granted to this last one the exclusivity of providing the service of provision of medications to the members of AMPS whom for a monthly contribution to this entity received the discount that granted the social security to which they belonged, an additional ones that AMPS

recognized them. It was also valued the communications by part of AMPS to their associated of the obligation of buying their medications in the Minardi cia Fenoglio Pharmacy, incorporating to those associated with covering of the social securities PAMI, OSSEG and OSDOP.

Finally, the CNDC ordered the ceasing of the exclusive behavior and imposed a monetary sanction because the investigated behavior had the potentiality of excluding the competitors of the market of medications with the rising monopolization of the same one.

Health Coordinator S.R.L. (CODESA) c / Clinical and Sanatoriums Association of Tucumán (ACyST). The analyzed behaviour was the agreement between the clinical and sanatoriums associations of Tucumán and the 17 sanatoriums that decided to not assist with their services the affiliated people with the social securities that has an agreement with the Health coordinator firm, .competitor of AcyST in the obtaining of the mentioned contracts of medical assistance benefits. The practice was developed starting from a Record of Assembly of the ACyST, subscript for 17 of the assistance centres that participated in it, followed by a series of national publications and local journalistic means by means of which it was given to knowledge the adopted decision.

This CNDC considered that for the position that they occupied the ACyST and the 17 sanatoriums and what they had solved in relation with CODESA, it could be configure an agreement to exclude CODESA of the market of intermediation of sanatoriums benefits and this means a restriction to the competition of the involved market and also this behaviour could carry a damage to the general economic interest, diminishing the number of available options for the social securities to hire its sanatoriums benefits and to increase the power of responsible market of the presumed ones in the intermediation of this benefits, in detriment of the members of the social securities.

It was also considered that this decision charged particular relevance being considered that the ACyST agglutinated among its associates and adherent more than the 3/2 parts of the sanatorial offer of the area and it granted assistance benefits to 80% of the existent social securities, circumstances that confer him a domain position in the market.

Therefore it was order the ceasing of the behavior and a sanction was settled down for having incurred in an abusive exercise of its domain position in the market, with enough entity to affect the general economic interest.

8.2 Operations of Economic Concentration

"SWISS MEDICAL S.A AND HSBC ARGENTINEAN HEALTH S.A s / NOTIFICATION ARTICLE 8° LAW 25.156 (Conc.439)."

The concentration operation consisted on the sale on part of HSBC Chacabuco Investments (Argentina INC), HSBC Argentina Holdings INC and HSBC Latin America B.V., to SWISS MEDICAL, of 100% (a hundred percent) of the capital stock of HSBC HEALTH (Argentina) S.A, represented by 3.010.000 (three millions ten thousand) stock shares that grant SWISS MEDICAL S.A the control of that society. The notified operation represented a horizontal combination among the Swiss Medical Group and the HSBC Health and it could be interpreted, also, like a strategy of the first one to extend its operations to the corporate market, in which the second signature had an important participation.

According to the limits for the Analysis of Operations of Economic Concentration, it was defined as a relevant market the provision of non compulsive health insurance in a national level, in which the most important prepaid medicine companies converge. and the private hospitals that offered health plans, approach that was so much of the substitution possibilities from the offer like from the demand, keeping in

mind the effective institutional restrictions and the purchasing power from the members to the merged companies.

In the year 2003 the eleven big and medium prepaid that headed the ranking of companies for volume of affiliated, gathered near 2,2 million associates, which represented near 77% of the total one and approximately 81% of the total billing of the sector that contained approximately 280 companies of prepaid medicine. Swiss Medical Group was positioned in the third place in terms of quantity of affiliated, with a participation of 12,7%, while HSBC Health participated with 7,5%.

Swiss Medical Group is an important lender of health services and has the Clinic and Swiss Maternity Argentina, Sanatorium Drains, I Center Doctor San Luis, Medical Center Junín and Swiss Medical Center like internment centers and own diagnosis that not only assist the beneficiaries of its own health insurance, but also assists members of other prepaid and social securities, it Has 3 clinics of Dentistry also in Capital Federal and Neuquén.

HSBC Health on the other hand possesses two own medical centres: Microcentro and North Neighbourhood.

The concentration level measured through the indicative Herfindahl-Hirschmann (HHI) previous to the operation reaches to 1.112 points. Once the operation is sophisticated this index 17% would be increased, reaching the 1.303 points, which reflected that the concentration level in the analyzed market would be conserved in reasonable considered levels and that is why the CNDC authorized the operation.

BRAZIL

Brazilian Experience with Applying Competition Law in the Field of the Provision of Health Care Services

Abstract

This Report assesses the achievement and application of competition law and policy in the Brazilian Health Care Market. The assessment focus on the structure and functioning of the Health Care services in Brazil and the role of the Brazilian Competition Policy System in eliminating economic abuses and enhancing benign social welfare effects in connection to the correction of the failures of the Health Care market.^{1 2}

1. Introduction

Health Care is an indispensable service to the maintenance of the social welfare. In the past decades, competition has profoundly altered the institutional and structural arrangements through which health care is financed and delivered.

In Brazil, privately funded providers operate in parallel to public delivery system, enhancing access to care due to the difficulty that public cover face to provide a comprehensive and universal coverage.

Understanding the role of the Brazilian Competition Policy System in health care system requires understanding the functioning of such system. This Report; thus, assesses how the framework Brazilian Health Care market is assembled, the key-role of the regulatory Agency (ANS) in controlling private sector activities and prices, as well as the market failures the Brazilian Competition Policy System (BCPS) currently face, and the relation between the sector regulator and the competition regime.

To assess the role of the BCPS in repealing the market restraints, in order to build and maintain a competitive health care environment and to enhance consumer welfare, this Report outlines the economic actors in the Brazilian health care market and the institutional framework that has led them to concentrate. Considering this setting, the following section describes the role of the Brazilian Competition Policy System in restraining market failures and ensuring the development and promotion of competition in this market.

The analysis set out the logical framework provided by the BCPS for evaluating the economic effects of the conducts at the health care market describing conducts considered unlawful by the Brazilian Legislation. Concluding remarks are presented in the final section.

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- 1 This Report is based on info collected prior to October 2005 and therefore does not take into account current and future reform proposals.
 - 2 This Report is one of a series of case studies regarding competition and efficiency in the provision of hospital services in selected OECD countries. The study uses data collected from survey studies carried out by the Secretariat of Economic Law in the Ministry of Justice and a comprehensive review of database and policy literature of the National Agency of Supplemental Health.

2. Organization of Health Care System

The principles of the provision of health care services in Brazil are established at the Brazilian Constitution of 1988. Article 196 provides that

“the health care provision is a collective right and assignment of the State which shall be guaranteed by public and economic policies that aims the decrease of the illnesses’ risks and other injuries, as well as the universal and egalitarian access to the actions and services to its promotion, protection and recovery.”

The provision and the financing of the health care services by private and public systems reflect a policy decision that government control is inappropriate to accomplish strategic objectives established at the Brazilian Constitution.

Clearly, as happens in several OECD countries where public coverage is neither universal nor comprehensive, Brazilian private health insurance has enhanced access to care. Despite universal public health insurance, private health insurance continued to be a main pillar of the Brazilian Health System, providing coverage to a large part of the population.

Given this framework, Brazilian Health Care System is characterized as a compound system in which both public [National Health System (Sistema Único de Saúde)] and private system [Private Health System (Sistema Suplementar de Saúde)] promote the provision and the financing of the health care services.

The main problem that arises from the given scenario is the difference between what private and public health care sector pay to providers. The first paying providers more than they could earn in the public system encourages high service volumes and productivity, the quality and quantity of public financed services suffering as a consequence.

This is one of the multiple factors that have lead to a substantial growth of the private health care market, regardless of any specific regulatory action.

In line with these provisions, in spite of a favorable scenario for market deregulation, Law 9656 establishing national coverage was enacted in June 1998 aiming to regulate the private health care sector. Law 9961, enacted two years later created the National Agency of Supplemental Health [*Agência Nacional de Saúde Suplementar (ANS)*].

This independent regulatory Agency was created by the federal government to ensure that economic and public policy objectives are met by the privately owned utilities.

The National Agency of Supplemental Health (ANS) is a technical, non-political regulatory Agency competent to establish the regulatory policy in relation to the private health care player activities’. ANS’s objectives must raise the balance among the consumers, stakeholders and Government aiming an independent market regulation, as well as to promote both public health principles and price reduction of the health plans.

Generally speaking, regulatory measures do work as corrective instruments to the imperfections of the Brazilian health market; even though such actions have indirectly fostered a larger concentration in the market.

Brazilian Health Care market currently faces a profound economic crisis, justified by specialists by the disproportionate increase in premiums in relation to the amounts paid and the average inflation rate, considering a restricted demand due to the presence of low wages.

In this framework, the trend of rising costs and adopting the regulatory norms pressure the premium's increase. This price increase, therefore, makes the small health plans less competitive, as they must reduce the number of users, lowering their profits.

Currently, this pressure on costs leads health plans towards economic constraints, specially the small ones, which may even cause either bankruptcy, or a reduction of the coverage of health plans that leads to enhancing oligopoly's power of large companies.

Looking at the market standard of competition, there is a relative concentration of a few health plans struggling for the majority of consumers.

The Brazilian Ministry of Health estimates that there are at least 38 millions of citizens³ to which at least one of the private economic actors provide services to, which correspond roughly to one quarter of the number of Brazilian citizens⁴.

The health care system in Brazil is formed by a variety of players, each of them having their own interests and competition strategies. Generally speaking, economic actors at the private care system can be grouped into eight broad types.

The following are the pre-paid medical organizations acting at the Brazilian Health Care Markets

i) Health Insurance Companies: Corporations that may operate several kinds of insurances related to health and life. They are similar to “reimbursement” plans, although they must count on physicians and hospital nets for providing the medical services. In the case of “free choice” of medical doctors, the health insurance company shall reimburse the consultations' expenses incurred by the consumer. Exams and the hospitalizations respect specific limitations and franchises. This category has little representation in absolute values (14 companies, corresponding to 0.64% of the companies in operation at the market, according to ANS, 2004), but holds substantial percentage of the global number of associates and high financial movement.

ii) Medical Group (prepaid group practice): Companies that manage health plans and deliver medical services. It is common that the leading companies have their own hospitals. This category represents around 33% of the companies in operation at the market.

iii) Medical Cooperatives: Groups of physicians organized throughout the national territory working as partners as well as providers. Some of them have their own hospitals. The Brazilian Union of Doctors (Unimed), for instance, is formed by 90 thousand autonomous doctors, represents 370 cooperatives, and develops health insurance activities.

3 Brazil, Ministry of Health, National Agency of Supplemental Health. *Understand the sector*, available at <<http://www.ans.gov.br>>

4 According to the Brazilian Institute of Geography and Statistics (IBGE – Instituto Brasileiro de Geografia e Estatística), Brazilian population are estimated roughly in 184 millions. Available in ><http://www.ibge.gov.br><

5 The dental medical cooperatives and the dental insurance companies are organizations responsible for the assistance on the dental care sector, and are apart from the listed groups, as dental care services are usually not included in general health plans in Brazil.

iv) *Administrator*: Entities that operate plans or health care services of third parties, thus not assuming the risks of the business or having their own net. An organization that operates plans or health care services, but also manages other types of private health insurance, may be classified as an administrator for example. This group represents 0.54% of the companies of the market.

v) *Companies' Health Plans*: Large private companies usually have their own private plans, which are regularly non-profit organizations. The employers manage the health programs through their human resources department or through their employee associations and have also preventive programs and outpatient clinics for treating small risks.

vi) *Philanthropy*: Non- profit pre-paid medical organizations are classified as such. The Ministry of Justice declares the public utility motivation of those entities and the National Council of Social Assistance gives them a declaration recognizing its "philanthropy" activities.

As referred, according to the ANS database the health care market counted with 38,747,393 beneficiaries in July 2004. The Medical Groups and the Medical Cooperatives are the most numerous organizations providing health care system, as the following figures show:

Table 1: Distribution of pre-paid medical organizations and Beneficiaries, Brazil – June, 2004				
Classification	Total	%	Beneficiaries	%
Companies' Health Plans	326	14.89	5,543,140	14.3
Medical Cooperatives	370	16.89	9,074,900	23.42
Philanthropy	123	5.62	1,397,358	3.61
Medicine Group	737	33.65	12, 619,379	32.56
Health Insurance Companies	14	0.64	5,682,958	14.66
Dental insurance company	450	20.56	3,128,271	8.07
Dental cooperatives	170	7.76	1,301,441	3.36
Total	2,190	100	38,747,393	100

Source: File of pre-paid medical organizations – ANS/MS – August/2004

File of Beneficiaries– ANS/MS – June/2004

Note: Presented at the Working Paper entitled "Qualification of the Private Health System – New Perspectives at the Regulation Proceeding". Brazil, Ministry of Health, ANS6.

3. Market Structure

An exam of the standard of competition in the Brazilian health market leads to the assumption that the regulatory and financial market difficulties have lead to the current difficult scenario of the Brazilian health care market, where the largest concentration of consumers use the largest pre-paid medical organizations as health plans:

Table 2: Medical Organizations and Beneficiaries' distribution for range, Brazil – June/2004.				
Beneficiaries' Range	Medical Organizations	%	Beneficiaries	%

1 to 2,000	658	29.81	496,423	1.29
2,001 to 10,000	591	26.78	2,956,857	7.67
10,001 to 20,000	215	9.74	3,098,954	8.04
50,001 to 100,000	83	3.76	6,019,642	15.62
100,001 to 500,000	52	2.36	10,898,163	28.28
Above 500,000	9	0.41	9,378,110	24.33
Without any active beneficiaries	589	25.17	-	-
Total	2,340	100	38,035,108	100

Source: Medical Organizations' Database– ANS/MS – August/2004

Beneficiaries' Database – ANS/MS – June/2004 Note: Presented at the Working Paper entitled “Qualification of the Private Health System – New Perspectives at the Regulation Proceeding”. Brazil, Ministry of Health, ANS 7.

Table 2 demonstrates that approximately 1.29% of the total of beneficiaries join small medical organizations (with 2,000 beneficiaries top), while 52.61% of them join medium size organizations (with more than 100,000 beneficiaries).

Although there are many differences among the types of health plans concerning their financial structure, health plans and health insurances are somehow close substitutes for each other.⁸

The above-presented data demonstrates considerable concentration of beneficiaries in medium to large size entities, which reflects the dominance of the Brazilian Health Care market by players with considerable market power.

The analysis; thus, indicates that the pre-paid medical care organization work somehow as an oligopsony, with high buying power at the health care market. Provided other things remain equal, it is possible to assume that buyer coordination to reduce prices by restricting collective purchases is likely to have a detrimental welfare effect and serves to reduce social welfare and the deadweight welfare loss.

3.1 *Health Care Network Joint Ventures*

Historically, physicians acted predominantly alone or with a small-group of practitioners, competing with other such practitioners in their particular service and geographic market. Nevertheless, the high concentration of market power in a few medical organizations has driven the medical doctors to develop means of collectively collaboration in response to the strong concentration on the demand side of the market.

Given the imperfect market place characterized by an oligopsony, it has been identified that the physicians, recognizing their weakness and dependence to the buyers, have agreed on a strategy of price-

7 ANS, idem

8 See Robinson, *apud* Ocké-Reis, CO, *Challenges of the Private Healthplans Regulation in Brazil*, available at <www.ans.gov.br>.

fixing agreements in the context of joint arrangements. Those agreements may be applied both for health plans and/or to hospitals.

The analysis of this scenario becomes particularly relevant in connection to the matter of the exercise of *countervailing power*, according to which the exercise of market power on one side of the market leads to the development of market power on the other side and this acts as a countervailing force against the original market power.

The Brazilian Competition Policy System has already identified that those physicians joint arrangements - who are responsible for the provision of services at the health care market - are organized to increase physicians bargaining leverage in relation to medical organizations and are commonly organized by private self-regulatory associations, state board and medical cooperatives.

In this regard, there is currently some debate concerning the recognition of an antitrust exemption for labor unions based on the Brazilian Constitution. Notwithstanding, regardless the conclusion about labor unions' exemption, such exemption would only be applicable if physicians were deemed to be employees. However, as physicians are not employees - instead, they are independent professionals who are largely self employed - the Brazilian competition agencies have been so far understanding that physician associations' are not exempted from the antitrust legislation.

Collective bargaining is likely to substantially increase the price of health care services, as medical service providers collectively are likely to demand higher fees and refuse to negotiate individually. In joint professional agreements such as these of the medical doctors, the partnership is regarded as one single firm competing with other sellers in the market.

Traditionally, more organized medical doctor specialists in the Brazilian health care market are the anesthesiologists, general surgeons and emergency physicians.

Based on the described scenario, the most common collusive practice incurred by physicians that is faced by the competition agencies in relation to the Brazilian health care market are the horizontal agreements to set uniform prices, concerted refusals to deal and agreements that control output and limit physicians' decision making. As mentioned, such joint practice by physicians is imposed both for health plans and to hospitals.

Maximum and minimum price fixing may have different consequences, but are both faced by the Brazilian agencies due to their anticompetitive potential.

The agreements to fix prices are commonly followed by concerted refusals to deal or boycotts that enable the physicians' group to impose the services' arbitrary and unreasonable prices to health plans and/or hospitals. Those groups of physicians have enough market power to impose their conduct and may be considered a cartel for restricting output.

Among other things, those agreements usually limit individual independent decision and/or independent decisions regarding price and ability to contract individually or throughout a different health care network joint venture. Thus, those agreements may reduce the participants' ability or incentive to compete independently. In many cases, the association even imposes sanctions for those individuals that do not act according to the rules.

It has been noted that self-regulatory associations or entities that represent physicians' interests are responsible for establishing barriers to block potential entrants to compete profitably in a determined market.

By fixing (in many cases unnecessary) rules to allegedly guarantee the proper practice of the activity, these associations in fact seek to protect the association market power from existing or potential competitors. As an example, any participant of the physician network is restricted from individually contracting with third parties and is also prevented from affiliating to another network. This guarantees the maintenance of the equal division of joint supra normal profits for all physicians in the long run, which yields them a share of the surplus generated according to their relative eagerness to settle.

It is important to mention that medical practice in Brazil requires a mandatory previous register at the local Board of Medicine (*Conselho Regional de Medicina*) and also to the specific specialization board. Even though those registrations at the boards may be deemed as a technical requirements, no doubt they have the effect of barriers to entry to new practitioners.

The power to represent the whole physicians group, the capacity to influence physicians acts and the restriction for physicians to autonomously offer their services indicate that the associations have considerable market power.

According to the statutes of the association, any conducts that are not in accordance with the rules may be taken to the association's Ethics Commission, which have the power to deliberate the exclusion of the physician from the group. It has been acknowledged that self-regulated associations and local Boards of Medical Doctors impose physicians' penalties from not accomplishing the associations' rules regarding price fixing. Once the conduct has been analyzed and the physicians' behavior characterized as opposed to the Physicians Ethics Code by the Ethics Commission, he/she may be pledged guilty. In those situations, records show cases in which physicians' registries have been in fact canceled.

This topic has been dealt in quite a few civil suits filed by physicians and their associations.

The creation of a new physicians' association to face the incumbent market power is not plausible. The power exerted by the dominant focused on the enhancement of joint profits by the entire network reflects the absence of a market structure that encourages the constitution of new physicians associations at the same specialty.

Some physicians argue that the collective bargaining and the settlement of uniform prices are the only means to exercise countervailing power against the large health care organizations and/or hospitals.

Indeed, they have been lobbying heavily for an antitrust exemption by means of the issuance of a Law that allows independent physicians to settle a *physicians' fee schedule* in force within the national territory and to equalize the bargaining power between physicians and health care plans. They argue that the market power of the large health care organizations would be undoubtedly diminished by means of the establishment of such schedule.

4. The Key Role of the Brazilian Competition Policy System: The Agencies' Perspective on Issuing Antitrust Enforcement on Health Care

4.1. Overview

The main goal of the Brazilian Competition Policy System (BCPS) is to promote competition and consumer welfare, seeking to foster a competitive market and eliminate economic abuses.

The BCPS is formed by three agencies: the Administrative Council for Economic Defense (CADE), an autonomous Agency with adjudicative authority in BCPS cases; (2) SDE, the Secretariat of Economic Law in the Ministry of Justice, which has the main investigative role; and (3) SEAE, the Secretariat for

Economic Monitoring in the Ministry of Finance, which also has investigative authority but is primarily responsible for providing economic analysis in BCPS proceedings.

There is a boundary between what is subject to specific regulation and what is subject to antitrust law enforcement. On the one hand, the regulatory actions of the National Agency of Supplemental Health work as instruments to promote competition to correct failures of health plan market concerning the promotion of public health principles and the price reduction of the health plans. On the other hand, Agencies of BCPS are committed to eliminate unlawful restraints in the marketplace by punishing or imposing restrictions to practices that harm competition and economic efficiency.

In line with the provisions set out at the Brazilian Constitution, Article 1 of Law 8884 states that the statute's objective is to "set out antitrust measures in keeping with such constitutional principles as free enterprise and free competition, the social role of property, consumer protection, and restraint of abuses of economic power."⁹

Competitor's coordination may harm competition and consumers by increasing the ability or incentive to raise price or reduce output, quality, service, or innovation below what is likely to prevail in the absence of a relevant agreement.

The substantive provisions of Brazil's competition law concerning anticompetitive conducts are established in Articles 20 and 21, as follows.

Box 1. Conduct

Article 20 contains general language providing that "any act in any way intended or otherwise able to produce the effects listed below, even if any such effects are not achieved, shall be deemed a violation of the economic order." The specified effects are (1) to limit, restrain or in any way injure open competition or free enterprise; (2) to control a relevant market of a certain product or service; (3) to increase profits on a discretionary basis; and (4) to abuse one's market control. The article specifies that the "market control" violation described in item (2) does not include control achieved by means of "competitive efficiency." A concluding sentence provides that market control is "presumed" when a company or group of companies possesses a 20% share, and vests CADE with authority to change the 20% presumption with respect to specific sectors of the economy.

Article 21 contains a lengthy but non-exclusive list of acts that are considered unlawful if they produce the effects enumerated in Article 20. The listed practices include several kinds of horizontal and vertical agreements and unilateral abuses of market power.¹⁰ With respect to horizontal agreements, the list covers collusion among competitors, including agreements to fix prices or terms of sale, divide markets, rig bids, and limit research and

⁹ The Brazilian Constitution establishes an explicit foundation for competition policy. Article 173, paragraph 4 provides that "[t]he law shall repress the abuse of economic power that aims at the dominance of markets, the elimination of competition, and the arbitrary increase of profits." More generally, Article 170 contemplates that the "economic order" of Brazil shall be "founded on the appreciation of the value of human work and on free enterprise," and shall operate with "due regard" for certain principles, including "free competition," "the social role of property," "consumer protection," and "private property."

¹⁰ The proposed legislation amending Law 8884 leaves the conduct violations specified in Articles 20 and 21 essentially unchanged, except that the reference to abandonment or destruction of crops or harvests in Article 21 XVII is replaced by an express reference to demands for or grants of exclusivity (including territorial exclusivity) in the distribution of products or services.

¹¹ The final paragraph in Article 21 provides that "for the purpose of characterizing an imposition of abusive prices or unreasonable increase of prices, the following items shall be considered, with due regard for other relevant economic or market circumstances: (I) the price of a product or service, or any increase therein, *vis a vis* any changes in the cost of their respective input or with quality improvements; (II) the price of a product previously manufactured, as compared to its market replacement without substantial changes; (III) the price for a similar product or service, or any improvement thereof, in like competitive markets; and (IV) the existence of agreements or arrangements in any way, which cause an increase in the prices of a product or service, or in their respective costs."

development. The listed vertical agreements include resale price restraints and other restrictions affecting sales to third parties (including limits on sales volumes and profit margins), as well as price discrimination and tying. As to unilateral conduct, the list specifies various actions to exclude or disadvantage new entrants or existing rivals, including refusals to deal and limitations on access to inputs or distribution channels.

Other unilateral practices cited in Article 21 are actions to impose unreasonable contractual terms or conditions, “bar the use of industrial or intellectual property,” “unreasonably sell products below cost,” discontinue production or other business activities without good cause, “affect third-party prices by deceitful means,” hoard or destroy raw materials and intermediate or finished goods (including agricultural products), “require or grant exclusivity in mass media advertisements,” impair the operation of manufacturing or distribution equipment, impose “abusive prices,” or “unreasonably increase the price of a product or service.”¹¹

Source: “Peer Review of Brazil’s Competition Law and Policy – Note By The Secretariat” by the Inter-American Development Bank and Organization For Economic Co-Operation And Development.

Currently the BCPS applies the competition law based on a *rule of reason* approach; Agencies seeking effective or potential anticompetitive effects on each and every practice acknowledged.

Enforcement guidelines for Articles 20 and 21 were issued in 1999 as attachments to CADE Resolution 20. This resolution establishes procedures applicable to the presentation of a proposed case to the Council by the assigned Reporting Commissioner, and requires that the commissioner “verify whether the proceeding [is] duly supported”. The Attachments to the resolution establish a standard analytic scheme for restrictive practices, presented at the following Box.

Box 2. Investigating the Conducts

According to Attachment I, a finding of illegality for either horizontal or vertical restrictions entails establishing “the existence of market power in the relevant market of origin, as well as an effect on a substantial share of the market that is the target of such practices,” Attachment II elaborates on these themes by outlining the “basic criteria for the analysis of restrictive trade practices,” and describing the specific steps to be followed. They include:

1. identifying the precise practice at issue and assuring that there is an adequate evidentiary basis to conclude that the practice was implemented;¹²
2. determining the existence of a dominant position, which involves (a) defining the relevant market in both product and geographic dimensions, by considering actual or potential product or service substitution by buyers; (b) determining market shares and measures of concentration, using either or both of the additive market share (CRx) or the Herfindahl-Hirschman (HHI) indices; and (c) analysing barriers to entry; and
3. weighing the economic efficiencies likely to result from the practice against the actual or prospective competitive harm.

4.2. Enforcement Practices

Competition has substantially affected health care markets over the past decades. New forms of organization and regulation have been developed in response to lowering costs and enhancing quality of care. Nonetheless, competition remains less effective than desirable in most health care markets.

In a series of cartel cases beginning in 1994, CADE upheld price-fixing charges against self-regulatory associations or entities that represent physicians’ interests.

¹² The guidelines provide that substantiating evidence “need not be restricted to documentary evidence, but may include circumstantial evidence such as the absence of economic rationale for adoption of a practice that is not necessarily illegal.” Attachment II, § B1.2.

Most cases have been commonly followed by concerted refusals to deal and involved some form of exclusionary conduct to foreclose or impede horizontal competitors. CADE's first decision about price-fixing focused on the illegality of the uniformization of services' and physicians' fees. Furthermore, the decision pointed out that the suggestive price schedules also had anticompetitive, not only compulsory ones. That case, involving Brazilian Medical Association (AMB)¹³, is described in the following box.

¹³ File Suit n°. 61/92, of 14/02/1996. Reporting Comissioner Neide Theresinha Malard.

Box 3. Brazilian Medical Association

In 1996, CADE held that the AMB unlawfully has obtained or influenced collusion among competitors (Article 21, II Law 8884/94). AMB elaborated and disclosed a physicians' minimum fee schedule in force within national territory.

AMB argued that the Antitrust Law was not applicable to civil associations with no financial purposes such as itself, as well as that the mentioned schedule was merely suggestive and represented a mechanism to stand for the physicians and consumers' rights.

In examining AMB's reasoning, CADE assumed that the relevant product market was the physicians' services and the geographic market was the national territory. In CADE's view, for representing the physicians in the national territory, AMB had market power ample enough to influence the physicians' collusion. Furthermore, CADE stated that no civil associations were exempted from the Antitrust Law.

CADE has also consented that it is not vital the fee schedules being mandatory. Regardless of such schedule's compulsoriness, it has been considered illegal once AMB has used its notoriety to influence such schedule's adoption. Although there have been noted differences of power between the players, CADE concluded that there was no persuasive legal, economic or sound policy basis for permitting physician associations to impose fee schedules.

CADE concluded that the conduct by AMB was illegal and constituted a restraint on competition under Article 20 II. The proposed order prohibited AMB from engaging in certain conduct, including agreeing to negotiate on behalf of the organization with payers, determined AMB to cease publishg or recommend physicians' fee schedule or any other document through which the fees are set. In addition, the order required AMB to communicate every associates that the physicians' schedule must neither be used nor up-to-dated as well as CADE's decision must be widely disclosed.

As to the numbers above-presented, pre-paid medical organizations retain considerable market power in Brazilian health care market. In response, physicians have joined forces and turned to collective negotiations in an effort to gain some bargaining power and negotiate for higher fees.

Likewise other OECD countries, the constitution of physicians' association to enhance their countervailing power has become recurring in Brazil. Associations have been constituted in several States, such as Espírito Santo, Bahia, Pernambuco and Ceará.

These efforts, however, have been challenged by antitrust laws, which forbid collaborative efforts that restrain trade.

Since the Brazilian Medical Association's case, several suits regarding the constitution of cooperatives and physicians' associations and the imposition of fee schedules, boycotts and concerted refusals to deal have been appraised by CADE and many others are been analyzed by the Brazilian Competition Policy System.¹⁴

The influence of the Boards of Medical Doctors in physicians conduct has increased in the past few years. They have become more active at physicians' fee negotiation with pre-paid medical organizations, specially the Federal Board of Medicine and the Board of Medicine of São Paulo.

¹⁴ Currently, there are 49 proceeding under investigation at the Secretariat of Economic Law in the Ministry of Justice regarding the practice of parallel conducts by pre-paid medical organizations.

The use of price schedules on joint physicians network arrangements has received special attention by the Agencies, with several cases being decided by CADE against practitioners such as anesthesiologists in Goiás and Pará, general physicians in Piauí, and urologists in Ceará.

Due to its particularities, there is no doubt that the health sector is the one that requires a conscientious and specific analysis prior to the interference of the competition Agencies.

In drawing upon this analysis, the Agencies' approach is framed around questions concerning evidences of market power at the buyer, supplier the downstream levels; followed by considerations on market behavior, underlying economic conditions and effects of the potential anti-competitive practices.

The Agencies' analysis begins with an examination of buyer power and the circumstances under which it will be executed to be potentially anti-competitive, given that buyer power may offer efficiency benefits as well as being potentially anti-competitive.

In assessing whether a particular network arrangement could raise prices or exclude competition, the Agencies seek to examine whether the physicians collectively have the ability and incentive to engage in such conduct. The Agencies consider not only physicians' association market power, but also their ability to transact with the competing pre-paid medical organizations, as well as the presence of non-linear pricing.

The Agencies examine the extent to which participants have the ability and incentive to compete independently as well. The Agencies evaluate other market circumstances, *e.g.*, barriers to entry that may foster or prevent anticompetitive harms.

Among others, the Agencies shall also seek to identify social welfare resulting from the exercise of market power on both sides of the market, even though efficiency has not been a discharge in cartel cases in Brazil.

The exercise of seller and buyer power at the health care market have been highly examined and the Agencies have been spending considerable effort to examine the implications arising from the exercise of countervailing power – whether by an association or a group of pre-paid medical organizations.

Given these developments, the Agencies intervention must be appraised in a context of a comparable analysis seeking to identify the conditions where detrimental effects are likely to dominate benign social welfare effects and develop appropriate responses to the presence of buyer power. In the context of health care market, the Agencies seek to guarantee that physicians' associations constituted to obtain negotiation power will not give rise to spillover effects.

According to the Brazilian administrative case law, if physicians, for example, were given freedom to bargain collectively with competing medical organizations, they would be able to command the collusive profit maximizing price and supply the corresponding quantity. According to CADE's decision, this solution would reduce social welfare and ought to be challenged by the Agencies.

Besides, horizontal agreements to settle uniform prices tend to provide the same economic rewards to all practitioners regardless of their skill, experience, training or willing to employ innovative procedures. Such restraint also discourages entry into the market by new physicians.

Indeed, actual improvements appraised from countervailing power are exceptionally rare. The competition Agencies use appropriate enforcement to ensure that monopoly power does not decrease social welfare.

The BCPS has successfully challenged anticompetitive restrictions imposed by private self-regulatory associations or state boards, where the state board regulation extended beyond protected "state action doctrine" and other agreements among competitors, including price or commercial practice.

Despite few decisions either exerted by CADE or reviewed by the courts on second instance appeals of the opposite direction, CADE has consistently opposed these anticompetitive behavior involving medical service fee schedules arguing that they are likely to harm consumer by increasing costs and reducing social welfare without improving quality of care.

Further, BCPS has also challenged horizontal agreements other than price-fixing, including horizontal exclusivity clauses imposed by Unimed. Unimeds, found in most Brazilian towns and cities, have traditionally barred their member physicians from contracting with other health plans. CADE's long-standing enforcement policy is to attack such clauses where a Unimed's local market share of physicians is high. CADE decisions against Unimeds have involved associations in cities like São Paulo, Araguari, Uberlândia and Macapá.

The Agencies recognize that new types of risk sharing arrangements may develop and emphasize that it is not Agencies' intent to treat such physician networks' either more strictly or more leniently than joint ventures in other industries, or to favor any particular pro competitive organization or structure of health care over other forms that consumer may desire. Rather, the Agencies' goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

5. Concluding Remarks

This report assessed the Brazilian Health Care Market aiming to reveal insights about the challenges faced by the Brazilian Competition Policy System with applying the Competition Law in the health care market. The Report described the Agencies' role in challenging the most recurring practices in the health care market and the concerns that frame the Agencies' approach in drawing upon those analysis.

Clearly, in the past few years, the Agencies' role in implementing antitrust law and policy on health care market has improved. Besides, notwithstanding the growing interaction between BCPS and the National Agency of Supplemental Health has already revealed some positive results in promoting competition to enhance welfare gains, there are still several challenges to be faced.

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CHINESE TAIPEI

This submission outlines the establishment and development of Chinese Taipei's National Health Insurance scheme (the NHI) and its impact on the medical care services sector.

1. National Health Insurance Programme

In March 1995, Chinese Taipei implemented the NHI which provides medical coverage for all nationals as well as foreign nationals with residency in Chinese Taipei. Before the introduction of the NHI, there were 10 different public insurance schemes in place, with each covering a particular subset of the population. Among these schemes were: Labour Insurance (1950), Government Employee Insurance (1958), Farmers' Insurance (1985) and Low-Income Household Insurance (1990), among others. Even so, all 10 programmes together covered only 59% of the 21.4 million population at that time, leaving 41%, or 8.62 million people, uninsured. The majority of these were children under the age 14 and seniors older than 65, whose need for health care was likely greatest.

The NHI integrated these public insurance schemes into one mandatory universal medical care service. The National Health Insurance Act requires that every qualified national participate in this social insurance program, and anyone who fails to do so can be subject to administrative penalty until he or she complies.

By the end of the first year of being implemented, the NHI covered 92% of the total population. In 2002, Chinese Taipei's Supreme Court further ruled that no one could be denied medical care because of a lack of ability to pay the premium. For those temporarily unable to pay the premium, for example because of unemployment, the Bureau of National Health Insurance (the BNHI), under the ministerial-level Department of Health (the DOH), established a fund to provide those individuals with an interest-free loan with which they can pay the premium. By the end of 2004, NHI coverage expanded considerably - to approximately 99% of the population.

The government has adopted various measures to ensure there is an adequate supply of medical care services for people in remote areas and, equally, for minority and economically disadvantaged segments of the population, including indigenous people. Such measures include the setting up of a Medical Care Development Fund (MCDF) to supplement the salary of private providers willing to serve in remote areas, the restructuring of emergency networks to ensure access to medical care services for all, the sending out of medical teams to visit remote areas on a regular basis and measures to encourage medical care providers to form an Integrated Delivery System (IDS) for the purposes of coordinating services among contracted providers and local medical care authorities and reducing redundancy and waste.

The BNHI was established as the sole insurer in the administering of the services of the NHI. The National Health Insurance Act, in fact, required the BNHI be economically self-sustainable. For this very reason, the universal services scheme must deploy strong cross-subsidization between upper and lower income groups and urban and rural residents so as to diversify the risk of the new insurance program.

By and large, costs are primarily covered by a payroll tax premium with additional subsidies from the government's general revenue. The NHI is financed by the income-based type of premium of social

insurance systems. Individual families, employers and government all pay a share of the premium. In 2004, 39% of the total premium income was paid by the insured, 33% by employers and 28% by the government.

This NHI program has significantly facilitated people's financial access to medical care, and in fact, since its inception, no one in Chinese Taipei has declared bankruptcy for the reason of medical care expenses. The NHI's comprehensive benefits package includes the following services: prevention services, outpatient services (in both clinical and hospital settings), inpatient services, dental services, prescription drugs, traditional Chinese medicine and home-visiting-nurses.

Although it is difficult to precisely measure the average waiting time for an individual to see a physician or to be admitted to a hospital, in general, patients have access to all types of services without any significant waiting period. People tend to visit physicians frequently. On average, each person visits a physician 14.7 times annually, and each visit tends to be short, about 3-5 minutes.

2. Structure of the Medical Care Services Market

In 2004, medical care spending per person was US\$755. Total 2004 NHI expenditure was US\$13.5 billion, nearly 6% of the GDP of Chinese Taipei.

According to Lu & Hsieh (2003), the features of Chinese Taipei's medical care services system include:

- Chinese Taipei's medical care services system is a closed one. Physicians employed by hospitals (on salary or salary plus bonus) are not allowed to practice privately in their own clinics. Conversely, private practitioners with their own clinics do not have hospital privileges to complement their private treatment.
- Patients have total freedom to choose their physicians, clinics and hospitals, and this without any significant restrictions. A referral system does exist, but it is not compulsory, and nor does it function well under the closed medical care services system. Patients do not have any incentive to use the referral system because they have ready access to every hospital.
- Hospitals in Chinese Taipei are like multi-product providers in that they offer outpatient services, inpatient services, emergency services and various lab tests. One point worth noting is that under the closed system, hospitals run large outpatient departments like channels to decide whether patients require inpatient services or not. The outpatient departments of hospitals, therefore, constitute horizontal competition to small local clinics.
- The NHI is a government-run, single-payer national health insurance scheme. The sole insurer BNHI is, in essence, a monopsony in the medical care services market. On the other hand, under the mandatory social insurance scheme, the BNHI is also a monopoly in the medical care insurance market.

As the BNHI is the sole insurer of the national health care services program, any medical care institution willing to provide services under the NHI program can contract with the NHI in accordance with the National Health Insurance Act. Currently all hospitals and approximately 90% of all clinics in Chinese Taipei contract with the NHI.

In terms of ownership, hospitals in Chinese Taipei can be categorized into public hospitals owned and managed by the central or local governments, non-profit hospitals owned and managed by legal persons in medical care and private hospitals owned and managed by individual physicians, not by corporations or

partnerships. According to the accreditation standards set up by the DOH, hospitals can further be classified into medical centres, regional hospitals and local community hospitals. Two-thirds of all physicians are employed by hospitals, while the remaining third are private practitioners with their own clinics.

Almost all outpatient services are paid by the NHI on a fee-for-service basis, with thousands of items in the form of physician services and lab tests plus thousands of individual drugs. 85% of inpatient services are also paid on a fee-for-service basis, and the other 15% are paid on the basis of the Diagnostic Related Group (DRG) payment system. The hospital payment rate varies by the type, or “level”, of hospital (i.e., medical centre, regional or local community hospital.) The fees are decided on the basis of different methods, with some services and procedures paid on a point system and others on a per-case basis. To prevent any abuse of the system, the NHI program uses cost-sharing strategies to reduce the potential demand for unnecessary services, especially when the charge for a particular service does not cover cost. However, the amount that any patient has to pay for inpatient co-insurance for any calendar year is capped at 10% of per capita national income. Veterans, low income families, people living in remote mountain areas or on offshore islands, and patients with major illnesses/injuries are exempt from all co-payment obligations.

During the first 3 years of the NHI, the program ran a surplus which was banked as cash reserve. Since 1998, however, the NHI’s expenditures have outstripped its revenues. Over the 1995-2001 period, the NHI’s revenues increased at an average annual rate of 4.21%, while its expenditures increased at an annual rate of 6.26%. The previous reserve was used to cover the deficit for the 1998-2002 period. By mid-2002, the BNHI started to borrow from banks to pay the claims.

Two factors, namely the overuse and misuse of the medical care resources, were most often identified as being responsible for the deficit. First, patients were not paying the full amount of the premium—only a part of it, and all the rest was covered by employers and governments. Nor was the amount of the premium paid related to the volume and types of services received. Patients clearly lacked the incentive to decrease their excessive and, oftentimes, unnecessary demand for medical care services and, as a consequence, this caused waste and an overuse of the NHI. And secondly, because of the inflationary nature of the fee-for-service payment method, physicians tended to be motivated to increase the volume of services as well as lab tests and drugs they provided to earn more profits.

Steps were taken to overcome the issues causing the increasing deficit. The NHI scheme changed the payment system for certain services from the previous Retrospective Payment System (RPS) to the Prospective Payment System (PPS). The Diagnostic Related Group (DRG) payment system was introduced for 50 procedures, which include procedures for hip fracture, appendicitis and pneumonia.

The original design of the NHI called for global budgeting, but the BNHI did not implement this policy until 5 years later. Now the NHI does set fee levels under a global budget system. The government establishes a total global budget based on its expected revenue in a given year, and then it sub-divides the total into individual global budgets for different groups. With this reform, the fee-schedule multiplied by the volume of services cannot exceed the global budget. When the budget is exceeded, the fee-schedule will be reduced. The global budget system applied to dental services in 1998, then Chinese medicine, such as herbal medicine and acupuncture, in 2000, clinics in 2001, and finally it applied to hospitals in 2002. Each year, these global budgets determine the fee level set for each service. The amount of the fees is initially based on historical charges and is then adjusted annually through a negotiation process under the global budget set by the government.

In addition to responding to the deficit issue, it was considered necessary to respond to concerns over quality; to this end, in recent years the BNHI has piloted a quality-based payment program, still in its early

stage, whereby the NHI pays for the treatment of certain diseases, like breast cancer, asthma, diabetes, tuberculosis and cervical cancer screening, but this is based on clinical outcomes, or in other words, it takes the so-called “fee-for-outcomes” approach. For example, physicians who do patient counselling or who can demonstrate improved outcomes are rewarded a higher salary the following years.

3. Impact of the NHI on the Medical Care Services Market

To be sure, the implementation of the NHI has had a significant impact on the medical care services market in Chinese Taipei. Pricing competition has nearly been eliminated, and the pricing practices of medical care services providers are now dictated by the payment system of the NHI.

Firstly, the NHI determines the proportion of the budget which is for outpatient and that which is for inpatient provisions. Hospitals seem to be committed to running large outpatient departments, with some even accommodating more than 5,000 outpatient visits per day. One possible reason for this is that the reimbursement the NHI pays for inpatient services is not profitable, which means that hospitals tend to use the payments they receive for outpatient services to subsidize the costs for inpatient services. In 2003, the NHI spent nearly 66% of its budget on outpatient services, and more than half of this was provided by hospitals.

According to the Standard of Reimbursement for NHI Medical Expenses set by the BNHI, the reimbursement the NHI pays for the application of the same medical procedure is different and is dependent on the level of the relevant medical care institution. In the BNHI’s view, the so-called higher level medical care institutions should be providing more sophisticated services, and hence, should be better reimbursed. This reimbursement policy in fact leads to unfair competition among the different levels of medical care institutions, thus motivating medical centres to expand their scales and regional or local community hospitals to “upgrade” their level so as to receive better reimbursement; beyond this, it even forces some small local hospitals which are not paid well to withdraw from the market. In 1995-2003, the number of medical centres increased 76% and that of regional hospitals increased to 66%; against this, the number of local community hospitals decreased 23%.

The number of clinics, however, continues to grow. The reason may be that the factors patients consider when choosing a medical care institution to visit include time cost, financial cost and the gravity of the disease. Since the financial cost is relatively minor under the NHI program, if the disease is not fatal and time cost is high, patients tend to visit a clinic which is in their neighbourhood. On the other hand, if the disease is more complicated and the time cost is not too high, patients tend to visit a more comprehensive medical centre with better resources no matter where it is located. The NHI’s payment system thus creates conditions conducive for the higher level medical care institutions and low level clinics to thrive.

Thirdly, the NHI’s payment system seems to be leading to a redistribution of human resources, i.e., physicians, among specialties. The NHI’s reimbursement of different specialized physicians may not reasonably reflect the potential labour input of the said physicians. The payment system, in other words, frequently gives medical students the motivation to choose a specialty that requires a lower input of labour and that can yield high reimbursement. As a case in point, a medical student may decide not to choose his/her specialty, say surgery, that requires more input and instead may decide to shift to a field that requires less, such as rehabilitation or dermatology. As Yang and Hung (1998) put it, the number of physicians in family medicine, ophthalmology and dermatology has been growing rapidly by virtue of the fact they can receive a higher salary and face fewer potential lawsuits; all the while, the number of physicians in surgery has plunged. Aside from this, the fact that the payment for outpatient services makes up more than one-half of the NHI’s total expenditure further reduces the amount of reimbursement for

inpatient services which require greater labour input. This can unquestionably bring about a shift in the allocation of human resources, and in this case- physicians.

Last but not least, medical care institutions respond to low fees for some services by profiting from the sale of products and services not covered by the NHI or by emphasising the sale of NHI-covered products on which the NHI allows large profits. Prominent among these are prescription drugs.

4. Issues regarding Drugs Expenditures

Drug expenditures as a share of total health expenditures are approximately 30% in the NHI scheme. In Chinese Taipei, physicians both prescribe and dispense drugs. Given that there is no NHI reimbursement if patients chose to directly purchase drugs from pharmacies, patients generally tend to rely upon their physician for drug dispensing.

For each of his/her outpatient visits, a physician is reimbursed for the following: consultation, lab tests and diagnostic procedures, the service of dispensing drugs and the drugs dispensed. On average, from 1977-1999, drugs were dispensed in approximately 97% of all outpatient visits. During the same period, drug expenditures increased at an average rate of 12.5% per year, compared to 9% per year for total health expenditures and 5.5% for outpatient expenditures.

The real problem comes when physicians are able to prescribe and make profits from dispensing drugs as this may give rise to conflicts of interest. The reason is simple: medications prescribed to maximize income may differ from those prescribed to maximize patients' welfare. Unfortunately, under these incentives, treatment may be compromised.

Policy-makers have been greatly concerned that under these profit incentives, physicians may prescribe and dispense an excessive amount of drugs, above and beyond what is medically necessary. To combat increasing drug expenditures and the potential distortion of treatments, Chinese Taipei implemented a new policy to separate the prescription from the dispensing of drugs beginning March 1, 1997, and it was phased in over four years.

Under this separation policy, physicians are no longer allowed to dispense drugs, meaning that they lose revenue from both drug reimbursement and the \$10NT (\$0.32 US) per visit service fee for dispensing. To compensate for this lost revenue, the consultation fee for each visit was increased to \$25NT (\$0.80US). The separation policy transfers the reimbursement for dispensing services and for the drugs themselves to pharmacies; as an incentive for pharmacies to take up this new role, the dispensing service fee was increased from \$10NT to \$20NT (\$0.32US to \$0.64US).

Important to note is that while physicians are no longer allowed to dispense drugs, those who hire on-site pharmacists may still dispense drugs through them, thereby earning the \$20NT drug dispensing fee and reimbursement for the drugs dispensed. Although hospitals are, in principle, regulated by the new policy, they are, for all intents and purposes, unaffected because they have always had on-site pharmacists. Thus far, the separation policy has not been able to effectively re-structure the nexus of the tightly twisted hospitals/pharmacies market and achieve its goal.

Further, to reduce prescription expenses, measures like encouraging generic drug use and enacting a prescription pricing ceiling have been adopted. In addition to that, another target has been to minimize the gap, or the so called "price differential", between what the BNHI pays the medical care institutions and what those institutions really pay the pharmaceutical companies.

One problem that arises with regard to this gap cannot be overlooked. Even when the BNHI has set a reimbursement price for a certain kind of drug, larger hospitals are often able to negotiate with the relevant

pharmaceutical company for a better deal. Take the following scenario as an example. Instead of 100, a pharmaceutical company provides the hospital with 200 pills at the same cost; the point is that, in reality, the hospital is only paying one-half the price for those pills, yet it claims the set price from the BNHI. According to Cheng and Hsieh (2005), in the 1997-2002 period, total drug expenditures of medical centres and regional hospitals increased at an annual rate of 14%, while those of local community hospitals increased at a rate of only 1.5%, and those of clinics decreased sharply.

With this in mind and to get a better grasp on the prices being paid, the BNHI now conducts an annual price survey, requesting that pharmaceutical companies report their selling prices and that the medical care institutions detail the volume they bought and the price they paid. The results of the survey can lead to significant cuts in reimbursement payments. Among the complaints that abound are that the prices of brand name products are too low and that the prices of generics, which are already exempt from R&D and testing fees, are still too high. Price cuts cannot really solve all of the issues concerning the price differential since hospitals can always find cheaper substitutes which enable them to maintain the price differential. Another important point is that cuts in reimbursement payments can actually be a hindrance to innovation in the pharmaceutical sector.

5. Enforcement of Competition Law

For medical care institutions, there are three sources of revenue: 1) re-imbursement from the BNHI; 2) appointment fees and co-payments paid directly by patients; and 3) the provision of medical care services or drugs not covered under the NHI program. Although the medical care services market is monopolized by the state, around 90% of the revenues received by the medical care institutions are from the NHI scheme, there is still some role for the FTC to play in implementing competition law in the relevant market.

As stipulated in the Medical Care Act, an appointment fee is administrative in nature and can therefore be decided by the medical care institutions themselves. In some instances, the FTC has had to take action against clinics in the same medical region or against practitioners of Chinese medicine in the same trade association who tried to raise the appointment fees through the trade association's decisions.

For example, in November 2004, a complaint was filed with the FTC alleging that a Chinese medicine clinic in Taichung city had posted an announcement, saying that the appointment fee would be raised from NT\$ 50 to NT\$ 100 from January 1st 2005 in accordance with the resolution of the Taichung City Physicians' Association of Chinese Medicine (the TCPACM).

Upon investigation, the FTC found that: due to the decrease in payment from the NHI, the TCPACM in its Director and Supervisor Joint Conference decided to request that all its members raise their appointment fee to compensate their loss. The "Appointment Fee Adjustment Announcement" was attached to the decision delivered to all members of the association that was to be announced to patients. Such action restrained the members of the association from freely conducting business activities and had the effect of restraining competition.

The FTC believed that the TCPACM had clearly been conducting an act of concerted action and was thus in violation of the Fair Trade Act. In its decision about this misconduct, the FTC issued a cease-and-desist order to have the illegal practice stopped, and it imposed an administrative fine of NT\$ 500,000 on the TCPACM.

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BIAC

1. Introduction

1.1 *The dimensions of competition*

The hospital sector is an important area, as hospital costs still account for the greatest share of total healthcare costs. Nevertheless, it is crucial to consider health facilities not only from the viewpoint of health expenditure, but also from the perspective of the systems global efficiency and of the resulting health protection for citizens, considering that social costs resulting from an inadequate quality of care must be taken into account. Within any future research in this area, competitive mechanisms, particularly with respect to competition in health care markets, must be analysed in a broad manner, which extends to competition on prices, on services provided, on speed of response, and on quality of care.

The problem of cost must not prevail over quality concerns, and it is of the highest importance to examine the appropriate connection between these two determinants.

A kind of competition limited to prices only can be hazardous for the quality of services and consequentially, for patients. In the framework of a rigorous analysis of cost and remuneration criteria, competition among providers - on the supply side - and consumer choice - on the demand side - can contribute to maintaining a satisfactory quality level, reducing waste caused by inefficiencies. By consequent, competitive incentives within the hospital sector must be evaluated with reference to quality standards and productivity performances, both which result from efficient management.

In addition, the role of the consumer choice has to be examined, not only because healthcare is a fundamental right, but also because the right to freely choose one's doctor and hospital is the driving force for quality, through the offer of real alternatives set up by a plurality of providers.

The role of the State is to set the rules for fair competition, facilitating:

- Equity in access conditions for citizens and in accreditation conditions for providers,
- Quality through rigorous and equal controls for all providers,
- Financing, which is determined by correct and homogenous remuneration criteria for all the contributing providers – private and public hospitals – in order to attain efficient funding,
- Information for citizens about services supply and transparency for the financing agency of healthcare providers about service quality and costs.

If these conditions are fully respected, competition among a plurality of providers can increase the amount of available resources and stimulate productivity, and general performance in a viable system. Within this framework, the promotion and measurement of quality need to be tracked in accordance with the productivity and responsiveness of the health care system. In fact, quality must be defined positively as a method of management and a decisive factor within the health system's performance, beyond the

traditional ‘command and control’ method. It would be also essential to measure outcomes, but this kind of evaluation it is not always reliable as it requires a multi-faceted analysis approach.

2. The effects of competition

2.1 *Productivity gains*

Sustained enhanced productivity allows the same results to be obtained with lower costs, and consequently, it is the appropriate answer to cost pressure. For BIAC, the permanent search for productivity gains is a positive factor for stimulating economic growth. Thus, productivity must become a standard for the management of health systems, because it can have a positive impact on expanding resources and in finding answers to new needs.

This search for enhanced productivity supposes permanent progress in the hospital sector, relevant reward systems and positive incentives, and in health care systems which have an emphasis on quality.

2.2 *Sustainability and funding*

The long-term sustainability of health care depends also upon effective funding, which will become increasingly the condition for well-functioning health systems. By improving quality, productivity and responsiveness, OECD countries will create an environment favorable to the success of new and adaptable schemes of funding. While all of these countries face rising costs in the hospital sector, it is important to stress the necessity of maintaining a balance between the need to preserve the competitiveness of the health care industry and to adequately respond to health needs by an equitable access to services provided.

2.3 *Positive impacts on economic growth*

The hospital sector, which responds to the collective health demand, also serves at the same time as an important sector of the economy, as long as health care services are well managed, productive and quality driven. No OECD country can afford to see its healthcare system only as a burden.

It is important to study competition methods and effects also on the supply side. Particularly in the hospital sector, the relationship between cost, quality and benefits must be examined in depth by the OECD.

3. Health Systems Reforms and Competition

The main thread through different reform initiatives implemented by many European countries over the two last decades has been to introduce entrepreneurial behavior into healthcare systems, in order to gain the advantages of market efficiency, without neglecting the principles of universality, equity and solidarity (in other words, the social justice that is obtained through the policy direction, control and responsibility exercised by the State.)

To reach this objective, a policy focused on innovation was pursued: new models of management in the health sector were implemented; incentives for competition and entrepreneurial behavior were injected into public structures, and private structures were incorporated into the general health system under public control.

The OECD document on “*Health care systems: lessons from the reform experience*” underlines that “efforts to introduce competition” outside the United States have not achieved the expected results. Consequently, the attempts at active competition in healthcare markets in Europe have been reduced.

OECD research has emphasised that competitive mechanisms were implemented in order to put pressures on providers to constrain expenditure, particularly in the hospital sector. In our opinion, when cost constraint is the major or the only concern, the healthcare sector is considered an unproductive investment, as opposed to an important employer, a consumer of goods, and a leader in the field or research and development. Moreover, healthcare represents a service intended to preserve the fundamental resource of modern society: human capital. Thus, it is important to also take its economic effects on global social expenditure into account.

A possible involution of the policy trends is very dangerous, OECD research warns that “long periods of budget (or wage) restraint may make it more difficult to create conditions conducive to change, particularly where improvements depend on investments in human and physical capital.” In this regard, the BIAC Task Force on Healthcare Policy, representing the industrial and entrepreneurial world, is seriously concerned about a possible reversal and, in its statement, would like to highlight the importance of identifying opportunities for:

- Productivity increases in the healthcare sector, including improvement in management;
- Competition in and between both the public and private segments of the healthcare sectors;
- Enhanced organisational innovation;
- More efficient health care coverage through a better balance between private and public insurance;
- Increasing patients’ involvement and responsibility for their health; and
- Regulatory reform in the health care sector.

These principles can be implemented in a mixed system, composed of a plurality of competing institutions, public and private, for profit and not for profit, among which citizens can choose. This is very hard to achieve in a monopoly regime. If quasi-market reforms have not achieved all the expected results that is due principally to the reason, pointed out in the OECD research: the experiment with competition was “discontinued after a relatively short period, more time has been needed for positive results to appear. The positive impact of such policies has most often been weakened by continued central control”. Moreover, the former failure of quasi-monopolistic systems must not be neglected.

4. The Need for an Improved Regulatory Environment

In a mixed system, the relationship between public and private sector must be based on free entry and a qualifying role for all providers, without any other distinction than the quality of services offered to citizens.

The implementation of effective competition between the public and private sectors in Europe is still a matter of national perspectives. Analysing the different national situations with respect to the concrete equality in competitive schemes between public and private hospitals, a European survey shows the specificities of the situation.

The results highlight an inadequate implementation of a fair competition. A greater convergence in the treatment of public and private institutions emerges with regard to:

- The evaluation of the quality of services provided;

- The control of the compulsory prerequisites (architectural and security obligations, equipment, organization, quality standards, personnel) ;
- The introduction of new health-related technologies without a previous authorisation

According to this enquiry, the actual situation concerning competition is characterised, within the countries examined, by a limited and sometimes unfair use of competitive mechanisms.

5. Conclusion

It is necessary for OECD countries to gain a better understanding of the impact of health on economic growth and sustainable development, in order to provide guidance on the economic implications of health, namely improving the cost efficiency of health care systems.

In this context, it is important to focus on enhancing the effectiveness and efficiency of healthcare systems. In so doing, a solid base of evidence would be created, which could be used to overcome the misguided perspective in which health expenditure is conceived only as a cost and not as an investment. Such a perspective has conditioned national governments to balance public budgets through distorted competition between the public and private sectors. As a result, the rationalisation of health expenditure has often resulted in the rationing of health services.

The creation of competition in this sector will, for example, avoid waiting lists. This problem has plagued many countries because of the shortage of services that arise due to economic reasons. If the private hospital sector takes part in the supply of services – as they relate to social insurance or the national healthcare service – access opportunities for citizens will increase, broadly resulting in better health protection – a fundamental human right.

Positioning health as a driver of economic growth and sustainable development implies that it is necessary to promote the optimal use of resources in the healthcare sector. In light of the public expenditure on health, the contribution of private resources allow the State to save capital investment and to impose a tax on earnings. Moreover, the private hospital sector can help to contain health expenses through efficient management. Capital and human resources provided by the private sector play a key role in the provision of healthcare services, and are a complementary measure to national publicly funded care.

A rational and effective allocation of resources – based on a better use of structural, technological and professional equipment (both public and private) – will ensure that the health systems of industrialised countries contribute to a real improvement in their macroeconomic situations. Private capital could help health care facilities build long-term medical infrastructure.

Effective management and entrepreneurship, in both public and private institutions, provides the concrete possibility of guaranteeing equity of access to, and financial sustainability of the system.

The success of the move towards a sustainable development approach will depend on managerial innovation, as well as by regulatory reforms, and on the correct implementation of pro-competitive incentives within a welfare market. In a healthcare system where the State sets rules for promoting fair and collaborative competition, the private sector can ensure a function of general interest. Private hospitals if they accept the same obligations as public ones are entitled to the same rights in an integrated system.

The State should play a special role in ensuring that no actor in the hospital sector bypasses the rules relating to competition rules in order to benefit from various forms of monopoly.

Continuing attention should be paid to the conditions and the efficiency of competition. This will have a significant impact on public health.

Despite the differences of national healthcare systems, a significant model is emerging; it gives due consideration to the complexity of healthcare, and reaches a balance between access, quality of treatments and financial viability.

The common principles for a better model of healthcare service are:

- Citizens' right to freedom of choice
- Plurality of providers, public or private, that offers citizens concrete alternatives
- Competition based on quality, because in periods of budget constraints, institutions offering the best at compatible costs must be supported with stimulating incentives;
- Independent control institutions (Authorities) in order to guarantee quality standards and a fair and effective competition.

BIAC states that a model of healthcare service, responding to the obligations of a general interest service (universality, equity, solidarity, security) and financially viable can be based on a public-private mix, fairly managed and able to guarantee:

- Free choice of citizens
- Equality of all providers
- Fair competition
- Abolition of monopolistic (or quasi-monopolistic) regimes
- Better use of public and private sector
- Effective use of the resources
- Adequate and rapid answer to the demand
- Quality improvement

ANNEXES

ANNEX 1: OTHER PERSPECTIVES

In research by the University of Pavia concerning “Competition in Italy, in the European Union, in the World”, the importance of subsidiarity in healthcare is highlighted. This fundamental principle within the European Union inspires an institutional convergence in the direction of giving the State a less pervasive role. In a health system in which the state is able to reinterpret its role, without necessarily identifying it with the direct management of services, competition criteria can be successful in achieving satisfactory results, as research based on OECD Data (2000) concludes. In a mixed system, the relationship between the public and private sectors must be based on free entry and the qualifying role for all the providers, without any other distinction than the quality of services offered to citizens.

In a report - “Hospitals & Health” (OSPEDALI & SALUTE), published in 2004 by the Italian research Institute, ERMENEIA, a chapter concerns the implementation of effective competition between the public and private sectors in Europe. The purpose is to analyze the different national situations with respect to the concrete equality in competitive schemes between public and private hospitals, through a survey based on interviews with a panel of opinion leaders representing the national associations of the private hospital sector in a few European countries.

The results highlight an inadequate implementation of fair competition. A greater convergence in the treatment of public and private institutions emerges with regard to:

- the evaluation of the quality of services provided;
- the control of the compulsory prerequisites (architectural and security obligations, equipment, organisation, quality standards, personnel);
- the introduction of new health-related technologies without previous authorisation.

Within this framework, Italy is on average in one of the lower positions, but it is important to consider that there are different regional health systems with different laws and approaches.

Table 1. Comparative evaluation of competition by a panel of representatives of private hospitals.

	France	Belgium	Austria	Italy
Does full freedom of establishment for hospitals exist?	Evaluation: 0 A public authorisation is needed and it is necessary to comply with national and regional planning.	Evaluation: 1 In theory it exists, but the planning has an impact on the freedom of the establishment of hospitals which need to obtain the authorisation	Evaluation: 2 It really exists, but is limited, because the authorisation depends on many conditions: hospital aims, pathologies treated, doctors' qualifications, number of patients admitted	Evaluation: 0 Public authorisation is needed.
Does full equalization exist between the financing of public and private hospitals providing services for the national system?	Evaluation: 0 At present, criteria and tariffs are different: public hospitals are paid on the basis of a global budget and not on the activity provided, while the private ones are remunerated by DRG.	Evaluation: 1 It exists within the laws, but deficiencies of public hospitals are made up by the State.	Evaluation: 0 An Austrian DRG-System was implemented first in the public sector. From 2002 the same method is in force also in the private hospital sector, but the worth of a point is lower than for the public hospitals.	Evaluation: 1 In principle, DRG are the same for public and private hospitals, but deficiencies of public hospitals are made up by the State.
Does full freedom exist in opening whatever specialty in the accredited hospitals?	Evaluation: 2 Within an authorised specialty, it is allowed to open new activities: for instance, within surgery, it is possible to practice orthopedics, or ophthalmology exc. without asking for new authorizations.	Evaluation: 0 It doesn't exist for all specialties	Evaluation: 0 It doesn't exist	Evaluation: 0 Public authorisation is needed.
Does an equal system exist between public and private in order to introduce new equipment for diagnostics without a specific authorization?	Evaluation: 1 You don't need authorisation only for the conventional diagnostic, but you must request one for new technologies (scanners, nuclear medicine)	Evaluation: 0 Authorisation is necessary for new diagnostics equipment (new technologies)	Evaluation: 0	Evaluation: 2/3 The implementation of a new technology depends on an autonomous decision, but only for in – patients. For the use of new equipment for out-patients, authorisation is requested.

	France	Belgium	Austria	Italy
Does a fully equal system exist for allocating resources (on the basis of DRG or other systems) between the public and private sectors?	Evaluation: 1 Since January 2005, the DRG system was implemented, but it will be applied to the public sector in eight years .	Evaluation: 1 The remuneration is based on activity (number of admissions, length of stay etc.). DRG are only used as an evaluation method. Principles are the same, but public hospitals' deficiencies are made up by the State.	Evaluation: 1 The documentation is the same, but the tariffs are not equivalent.	Evaluation: 0 Within the private sector, budgetary or activity volumes are limited by law.
Does an equal system exist between the public and private sectors concerning the payment of the services (with regard to waiting times and methods)?	Evaluation: 1 Payment conditions are not equivalent, but at present are satisfying	Evaluation: 1 It exists in the laws, but not in reality.	Evaluation: 1 The system is the same, but tariffs are different.	Evaluation: 0/1 Times and conditions are different at the regional level, but generally are long (6 months, 1 year)
Does an equal system exist between the public and private sectors concerning the control of the characteristic required by law (architectural and security conditions, equipment, personnel) ?	Evaluation: 3 Laws for the control of the conditions of the characteristics required are effectively comparable and a formally independent body exists which is responsible.	Evaluation: 3 The standards required are effectively equal.	Evaluation: 3 Equality is complete and real.	Evaluation: 1 It exists in the laws, but controls are bureaucratic and not always so rigorous within public hospitals as in private ones.
Does an equal system exist between the public and private sectors concerning the evaluation of the services provided?	Evaluation:3	Evaluation: 3 The evaluation of services is really equal in the public and private sectors.	Evaluation: 3 The equality is complete and real.	Evaluation: 1 It exists in a few regions, but voluntary initiatives implemented by private hospitals for quality certification and improvements are not taken in consideration

0 = It doesn't exist; 1 = It exist only in the laws, but not in the administrative practice; 2 = It exists in fact, but partially; 3 = It exists in facts, completely and effectively.

According to this enquiry, the actual situation concerning competition is characterised by limited and sometimes unfair use of competitive mechanisms, within the countries examined.

ANNEX 2

Within the EU, citizens' right to freely choose their doctor and hospital – through the offer of a real alternative set up by a plurality of providers – is a “society choice”. In principle, access to services must depend only on a real need for treatment, on the speed of obtaining it and on the quality guaranteed. In fact, the majority of European citizens are favorable to a system in which individual free choice and a plurality of providers, in conjunction with competitive collaboration and available resources, strives for a constant improvement in therapy standards and assistance.

Without attempting to arrive at a final conclusion, but in order to direct research towards suitable parameters, it is interesting to reflect on the indicators proposed within the above mentioned research by the University of Pavia, “Competition in Italy, in the European Union, in the World”. According to this approach, each local or national health system's position can be evaluated with reference to the balance between long term investment and short term solidarity. These trends can be measured by integrated use of some indicators.

The first indicator is represented by the degree to which competition between public and private operators is triggered. This indicator depends on the payment system per service – equalized between all hospitals – as well as the degree of free choice left up to users. A significant parameter to quantify the first indicator is the public versus private hospital bed ratio.

A second indicator is the ratio between research expenditure and investment versus overall running expenditure.

A third indicator is the degree of a healthcare facility's autonomy, which implies for example that no action has been taken in favor of those hospitals with a deficit position.

These parameters, taken as a whole, give an indication as to the system's ability to profitably use available resources.

It emerges from the research that industrialised countries are moving towards greater efficiency and encouraging long-term investments within their healthcare systems. For this process to be supported by the market, the hospital sector must acquire even greater competitive abilities.

Finally, talking about competition is not enough. It is necessary to implement the conditions for impartial management of the public-private mix which is the basis of most western healthcare systems. Only in this way can competitive mechanisms be able to improve the overall performance of healthcare services. The same mechanisms can ensure the real protection of welfare principles, allowing a progression from a theoretical declaration of rights to an adequate answer to citizens' concrete needs, through the best possible use of the available resources, and within a perspective of a sustainable growth.

SUMMARY OF THE DISCUSSION

Introduction

The Chairman, Alberto Heimler, began by stating that this is the second roundtable the Working Party has held in the healthcare sector. Previously, there was a roundtable on the healthcare professions. This roundtable concerns hospital services. Hospital services represent almost half of OECD member country healthcare spending. In many countries there is a system of universal healthcare covering the whole population. Furthermore in many countries, hospitals are either all or for the most part run by the government. Even if they are private, however, patients usually do not pay; instead, insurance companies or general government-run programmes pay for hospital services. Since hospital revenues often originate from government transfers, hospitals do not have a very strong incentive to minimise costs or to enhance quality. One increasingly common approach among our member countries for increasing efficiency in hospital services is to enhance the degree of competition among the different providers of hospital services. However, there is a problem of capacity in a privately-run hospital system because private entrepreneurs would adjust capacity to average demand not to peak demand. With hotels, where the capacity of rooms in a city is adjusted to average demand, when there is a peak demand, prices are raised as a form of rationing. This would be unacceptable in hospital services. This is why many observers state that regulation is important in hospital services, even regulation of capacity. At the same time there are a number of circumstances in which competition is associated with increased efficiencies and increased consumer welfare. Mechanisms that can reduce the uncertainty in the quality of care include the collection and distribution of information on providers' performance. What is important is that this information is made public and not solely collected to be distributed to hospitals in order for them to benchmark. In fact, the spread of information is important because it promotes consumer choice and in this way quality can effectively become a characteristic that patients or doctors are able to consider. Cost discipline can also be improved by giving financial responsibilities to hospitals and by introducing contracts that reward performance and output. Capacity can be guaranteed by favouring, for example, specialisations in regional centres for complex procedures by appropriate pricing mechanisms. Quality of care (and costs) will not always be lower when there are more providers, as regional centres can help to cut costs and improve quality. Antitrust enforcement – as seen from the submissions received – plays a residual role in hospital services. However, there has been active enforcement in public procurement in many countries in avoiding collusion in the setting of professional fees and especially for countries that have a private system in merger control. This roundtable is timely because in many jurisdictions there is a movement towards regulatory reform in the sector in order to increase quality, efficiency and cost discipline. The discussion will be organised around five major themes: competition and public provision of hospital services; competition and private provision of hospital services; quality of care and consumer choice in a competitive environment; how regulation can impede strategic behaviour on the part of hospitals; and finally antitrust enforcement in hospital services.

Competition and public provision of services

With respect to competition and public provision of hospital services, two countries have indicated that although the payment of hospital services and also the supply of hospital services are mainly public, they are implementing a thorough competition-oriented reform; these countries are the UK and the Netherlands. What is interesting in their report and in their experience is that rivalry among different hospital service providers is being discussed in a framework where the final consumer does not pay

because there is a nation-wide healthcare insurance system. In the UK the reform has introduced a system of payment by results and a national tariff based on the National Health Service's average cost. According to the UK submission, payment by results is effective only if associated with greater choice by patients, so that providers will be forced to convince patients that they deliver the highest quality of care possible. As a consequence,

“Popular services will thrive and those that are substandard will be forced to improve or, if they don't respond to the needs of patients, possibly close”.

So under payment by results there is strong incentive to treat patients more efficiently, but this is effective only if public hospitals are run under an incentive scheme for managers so that hospitals that do deliver receive benefits and those that do not deliver suffer as a consequence, potentially even closing down. How can this be achieved when the ultimate objective is public service, not profit? In particular if policy makers want a bed ready for the last patient to fill it up, one might argue that hospitals cannot be run under a profit constraint because then they would want to have a line at the door so that their beds are always full and the capacity is utilised 100%. There is a contrast between the private incentive and social welfare. How does the UK view this contrast being solved?

A delegate from the UK stated that within the system, the government works with finite resources which obviously remain within the public services. These resources are always re-invested in the provision of healthcare so that those hospitals that are performing well are rewarded with greater autonomy and freedom to do what they will with the resources. Those hospitals that are doing well and providing those services for less than the tariff price can re-invest to improve their services for the population. Some local hospitals will be forced to improve if they do not meet that tariff price and they do not become the hospital of choice. As a public service, the policymakers need to ensure that there is adequate provision for all local populations, so the incentive will exist to operate with improved efficiency and for hospitals to improve, while ensuring that populations are able to access their local services. Practice-based commissioning is also being introduced to counter balance what was said about the hospitals being incentivized to be 100% full at all times. Physician-based purchasing will mean that the incentives of payment by results are reduced by the incentives of practice-based commissioning.

Practice-based commissioning gives General Practitioner (GP) physicians more choice over where they buy their services so the incentive is for hospitals to provide the best services for their local population. GPs will have the opportunity to choose different hospitals for their patients, so it means that hospitals will have to make sure that within tariff prices they are still providing quality services for their local populations.

The Chairman stated that one key element of the Dutch reform is that it starts by introducing competition among insurance companies. This competition will help to guarantee public hospital provision leads to an increase of competition among hospitals so that each insurance company would contract with a number of hospitals and this would, in turn, lead to hospitals competing for contracts with insurance companies. The Chairman asked whether each Dutch citizen has the right to choose any insurance company or whether each one is obliged to choose one for example, by location or by profession and how the insurance company generated competition will work.

A delegate from The Netherlands responded that it is possible to choose any company a consumer wants and every insurance company is obligated to give insurance, even if you are ill. If a customer has an illness or chronic illness, the insurance company is obligated to provide access to healthcare facilities. The price differs, however. This means that competition is activated so that customers can choose the company they believe has the best price-quality ratio. There are some restrictions- also, because it is impossible for

an insurance company to differ its premium towards the people they insure; that is, it is not allowed to ask an ill person a higher premium than a healthy person.

There is a mandatory minimum of healthcare to be provided and the law states what kind of healthcare the companies have to give. So, for example, hospital care, physical therapy, and other services are included within the government mandated package. The way that healthcare providers deliver that care is their own decision, but there is a general standard on the types of care that must be delivered.

The insurance companies compete on quality and price in the framework of this standard amount of healthcare. Insurance companies have contracts with hospitals and then they can see to it that the price quality ratio is higher or lower and it is on this ratio that people choose their insurance companies. It is also possible for insurance companies to abstain from making a contract with a certain hospital, for example because it does not provide the quality they seek.

A hospital can set 10% of prices of its own accord and 90% is fixed by the government. The way patients choose is based on the price premium they have to pay for the insurance that they want; the contracts which an insurance company has with hospitals; and how much they will have to pay if they go to a hospital with which the insurance company does not have a contract. Furthermore, many people choose an extra insurance because there is the standard package but an insurance company will offer extra services at an additional cost. Usually, consumers who select an extra contract would choose to take that from the same company. It is possible to sign up for an extra contract from another company but this is rare. So the contracts for extra services enter into consideration when choosing an insurance company.

The Chairman stated that in Canada most hospitals are not-for-profit and they are owned by community-based corporations or religious organisations. A number are also owned by municipal governments, provincial governments, or universities. Private for-profit hospitals are rare in Canada and were generally excluded from receiving public subsidies when the provinces began funding hospitals. For the most part, the for-profit hospital sector provides different types of services from public hospitals, being specialised, for example, in long-term facilities or addiction centres. So there is little competition, between public and private hospitals in Canada. What also comes out quite clearly from the report is that the Canadian system seems to be working very well and provides good quality generally at a relatively low cost. Since there is some discussion of competition-oriented reform in Canada, what are the weaknesses that people see in the system so that they would promote competitive-oriented reform?

A delegate from Canada stated that the healthcare system is highly valued by the Canadians and does deliver high quality care. A movement to promote competitive-oriented reform would not reflect weaknesses in the system but the possibility to make it better. Certainly there have been some issues with waiting times for certain procedures. But Canada, like other countries, is facing increasing healthcare costs. It is a tax-financed system, which places pressures on the public financing system. Like other countries, Canada is looking for ways to innovate and restructure the hospital sector as well as other parts of the healthcare system to make it more efficient. This is really a case of looking at how Canada can make its hospital system work more efficiently possibly by introducing some kinds of market-like incentives into the hospital sector and, maybe later, some form of competition among hospitals within the public healthcare system.

The Chairman asked about the nature of employee costs and organisations in Canada.

A delegate from Canada responded that staff salaries are the largest component of hospital costs in Canada accounting for about 2/3 of their costs. Broken down by categories, the single largest expenditure area for hospitals, about 30%, has been inpatient nursing services. Other major cost categories include support, diagnostic and therapeutic, administrative, ambulatory care, operating and emergency services.

Physician services are generally not included among hospital costs but rather are paid for by provincial health authorities. While in-hospital nursing services may be paid for by the hospitals themselves, salary levels may be set according to collective bargaining arrangements negotiated at provincial or regional level.

The Chairman noted that in Sweden, which has a similar system to the Canadian one in the sense that there is significant decentralisation of responsibility, county councils are responsible for ensuring good medical care on equal terms for all citizens. In fact in Sweden the government believes that it is important that the county councils maintain the control of hospital facilities and they suggest that otherwise, cost might increase and the average quality might decline. At the same time, however, hospitals have been encouraged to outsource some of their minor activities— for example, cleaning, catering and laboratory services – while the major part is still run by government. The government control of hospital services seems to be highly valued in Sweden. On the other hand, competition was extremely beneficial on these minor types of activities. In the Swedish healthcare system an important provision is made for reducing waiting times. Competition between counties was introduced in the sense that, after 3 months without a treatment, the patient has the right to be treated in a different county paid by the home county. The Chairman sought information on the role of the antitrust authority in the debate on the role of competition in hospitals services.

A delegate from Sweden responded that healthcare in Sweden is mainly financed by county taxes and most hospitals are run by the county councils. However three formerly public hospitals are run by for-profit companies of which St Gorans hospital is one. These hospitals have not been sold but the operation has been transferred to the companies for a limited period of time. In 2006 such agreements will not be possible when amendments to the Health and Medical Services Act will come into force. If a county council transfers the operation of a hospital to another party, the hospital may not be run for the purpose of creating profit and the services shall be financed with public funds and care fees only. If hospitals are run for-profit there may be a conflict with medical and social goals, according to the government. Public financing is a way to eliminate the risk of giving preference to patients who pay themselves. This new regulation is based on reports and recommendations from a governmental commission of enquiry and a memo from the Ministry of Health and Social Affairs. The report and the memo were referred to the competition authority and other public agencies and organisations for comments. The competition authority opposed the amendments and argued that this new law could weaken competition when county councils were purchasing hospital services and even eliminate competition in some areas. The competition authority also argued that the law could lead to increased costs and lower quality and that the effects of the regulation should have been analysed more carefully. The government has, however, proposed a new type of company with a restriction on dividends to make it easier for non-profit organisations to run hospitals. According to the competition authority this would not give sufficient earnings to the owners of for-profit companies in line with the risks they take.

Competition and private provision of services

The Chairman turned to competition and private provision of hospital services. In the US, where a nationalised system of healthcare does not exist, the majority of hospitals are private, even if not-for-profit, while quite a significant share, especially with respect to other countries, are for-profit. Even though the system is private, the federal and state governments are responsible for a significant share of payments to hospitals, almost 60%, through Medicare and Medicaid services. One question is whether government-owned hospitals are in the same market as private hospitals or whether they serve different parts of the population or different sorts of needs.

A delegate from the United States responded by saying that public hospitals in the U.S. differ substantially; some may be part of public universities, others may find themselves located in small cities or

counties that have a smaller population and are thus the major sole provider of hospital services in a wide geographic area and a third broad category of public hospital are located in major metropolitan areas and may serve sectors or segments of those cities that are otherwise less well served by the non-profit or for-profit hospitals due to geographical location. A common characteristic of all public hospitals is that their main funding comes from the same general sources as the private hospitals, that is, the public hospitals are reimbursed on a per-patient basis by either the other public funds, Medicare or Medicaid, or by private insurers. But to get to the core of the question, where those reimbursements do not cover the total cost of operating in that hospital, it is public funds that make up the difference. For that reason in some communities the continued operation of public hospitals has been controversial as they are subsidised directly by tax dollars. There have been some instances of public hospitals closing down or being threatened with closure. One of the changes seen over the last decade or so with regard to public hospitals is that they have moved more and more towards a market model so that public hospitals in various states have been authorised to participate in the market the way private firms do and in doing so they try to achieve greater efficiency, higher quality care and better reputations so that they can attract not only the patients who come to them as a hospital of last resort, but they become a hospital of choice for patients who do have choice. In that way the hope is that public hospitals will improve and the benefits of market forces will accrue to those portions of population who have less choice otherwise.

The Chairman pointed out that many states have certification of need programmes that authorise hospitals to operate if there is a proven need for them. It seems that these certifications of need exist to avoid excessive supply. The Chairman expressed interest in better understanding how such programmes work and whether they lead to higher prices.

A delegate from the United States suggested that some states still have certificate of need programmes and the reasons for their existence have changed over the years. They initially developed because the way the federal government reimbursed hospital costs provided an incentive for the overbuilding of hospitals. Today the types of evidence that are used to justify new capital expenditure, such as building a new hospital, tend to be focused on a formula comparing the population in a given area to the total capacity in that area. The enquiries themselves tend to be heavily disputed and include focus on the viability of incumbent firms, their margins and whether they would be harmed or not harmed by a new entrant comes into the market. The direct question of whether there is unmet demand that would be satisfied by new entry is generally beyond the scope of the certificate of need hearings.

In some states it is a major regulatory impediment to new entry and provides a forum for strategic behaviour by incumbents to impede new entry. Incumbent operators at times initiate these proceedings. The process can provide fertile ground for anticompetitive behaviour by the incumbent firms. Sometimes the behaviour is protected because it involves petitioning the government. In one recent example, the U.S. Department of Justice sued two hospitals because the incumbent firm used the certificate of need proceeding as a way to engage the new entrant and allocate the market between the two firms.

The Chairman welcomed comments and recognised BIAC.

A delegate from BIAC stated that BIAC has had a long standing interest in promoting competition among hospitals, not only because BIAC represents the private sector, but because employers believe the moderately priced care of good quality is essential to the competitiveness of economies. BIAC would like to see a description that classifies countries by different systems of competition. BIAC would also like to underline the fact that competition can change the incentives at many different levels of the hospital structure and that, in consequence, observing the ultimate impact of competition may require 10 to 15 years. So before judging reforms, they must be given the chance to work. BIAC believes that non-urgent surgeries can be exported, such as cataract operations. While technological costs are heavy in this sector, returns to for-profit investing are, for a variety of reasons, rarely large. BIAC is in favour of competition

among competing institutions over quality levels. The definition of capacity, in the context of hospitals, is extremely complex and not easily defined.

The Chairman noted that there is a problem in leaving hospital services only to market forces which would need some regulatory intervention in order to ensure sufficient capacity.

A delegate from Ireland stated that in a public system, and most OECD members have public systems, the existence of excess capacity may be difficult to generate, given that there is a propensity to consume more healthcare and that most consumers do not pay for the service. But without excess capacity, competition is unlikely to be strong. Financing authorities are unlikely to state they will facilitate excess capacity to make it possible for competition to exist.

A delegate from the United States commented that the process of competition has itself led to available capacity as insurance companies compete to lower their costs and have required, whenever it is safe for consumers, to have procedures performed on an outpatient basis. There has been a historic trend, since moving towards a more competitive system, for more and more procedures to be performed on this basis. This has left additional capacity in inpatient beds; the capacity is not destroyed, it is maintained. As the population has aged, inpatient demand has increased, and the capacity has been there to meet that need in most areas without the addition of new hospitals.

The Chairman added that Sean Ennis, the author of the background paper, had stated that in France the pricing mechanism can help to ensure capacity. For example, patients may pay extra for a single room, but there may be a second bed in the room. If there is excess demand, the opportunity to stay alone disappears. That is, the patient will pay for a single room if there is capacity, but if the capacity is diminished then this opportunity is retracted.

Quality of care and consumer choice in a competitive environment

The Chairman proceeded to the third part of the discussion, concerning quality of care and consumer choice in a competitive environment. In hospital services, quantity is important but of course quality is also critically important because the ultimate goal of hospital services is to heal patients; so what matters is health output, not quantity output. However, measurement of health is even more discretionary than measuring the quality of services being supplied. Competition can of course play a very important role in increasing the quality, for example, because free entry can substantially reduce waiting times. On the other hand competition may result in excessive capital investment and thus increased costs without much benefit. One solution is benchmarking so that patients, doctors and GPs are made aware of the offers of different hospitals and of the difference of quality of the different hospitals. In Denmark for example an independent institute with the sole purpose of developing a national benchmarking system for the quality of medical services has been established and is going to be implemented at the end of 2006. In Switzerland public and private hospitals co-exist. But it's not clear to me whether they provide the same type of services or whether there is a clear distinction of markets in which the two operate. For example it is not clear whether private hospitals are obliged to offer emergency services or not. Further, the report refers to a benchmarking system in the canton of Zurich. Are the results of the benchmarking exercise made public or are they only used to control the government outlays?

A delegate from Switzerland stated that private hospitals are for profit and owned by companies, one of which is a large company owned by a British investment fund. Public hospitals are owned by municipalities or cantons. Private hospitals focus on the treatment of patients that often own complementary private health insurance. Generally, they focus on so-called private patients. Public hospitals treat not only patients that have mandatory health insurance but also patients with private insurance. With regards to emergency services, the actions of private hospitals depend on the cantons, but

usually the private hospitals offer, or are required to offer, a certain amount of emergency services, but less so than public hospitals. Sometimes when there is an accident the private hospitals have to treat the patient, but if an operation is needed that is not urgent, then the patient may be moved to a public hospital if the patient lacks a private complementary health insurance policy.

With regards to the benchmarking system in the canton of Zurich, it is mainly for controlling subsidies to the hospitals. The government decides, considering the benchmarking results, which hospitals receive what resources from the canton. The system is basically installed to control spending. It is not widely used yet, having been installed in 2004.

The Chairman noted that in Korea there is a hospital accreditation programme operated by the Korean Hospital Association which has been implemented since 1967 in order to improve the quality of the hospitals. In the programme there is a self- assessment and peer assessment. Around 1600 items of data are analysed, including safety data, safety of the premises, functions of the hospital, organisation of doctors' work, quality of facilities, equipment and overall management. The programme encourages hospitals to meet the standards of assessment and the Chairman asked whether the programme is being implemented seriously and also whether it is made known to the public? Seriously because it is self assessment, as mentioned in Denmark, there is also an authority to do this assessment so it is somehow removed from the interest of the parties.

The delegate from Korea stated that the implementation in Korea is very serious. The result of the assessment of each hospital is notified only to the hospital not to the public. Hospitals failing to meet the standards are notified of the areas to be improved following the review report while those satisfying the standards receive an accreditation certificate. However, analysis of the reports of overall results of the assessment programme is made public each year.

The Chairman stated that in the U.S., the prices of hospital services are not set by the state or by the federal government but freely determined in the market. Quality assessment has a purpose because if the results are made known to the public, patients may choose their hospital given this information. Indeed some states in the U.S. intervene by imposing freedom of choice clauses that allow consumers to choose among different companies. At the same time there are sometimes other rules called "any willing provider provisions" requiring managed care companies to include in their network any provider who is willing to participate in the plan in accordance with the plan terms. However the two are not at all equal in terms of the effect they provide and on costs in particular. The Chairman asked for further explanation.

A delegate from the United States noted that there is very little information on quality of hospitals available to consumers and very little information on quality of hospitals comprehensible to consumers. In many geographic areas there is no quality information comparing different hospitals available to consumers, so consumers are unable to choose hospitals on the basis of reported, comparable measures of quality. Generally consumers and their physician advisors use other characteristics. Often, the primary determination of where the consumer will go for hospital services is the hospital that their doctor recommends or where their doctor chooses to practice. The agencies have found that freedom of choice laws and any willing provider laws are not really attempts to enhance consumer welfare but attempts to thwart the ability of insurance companies to selectively contract to use competition to drive down the prices of hospital services. The effect of the laws is a little different, because under the freedom of choice laws, the insurance companies cannot preclude payments if the consumer chooses a particularly high price hospital. Under any willing provider laws, the insurance company cannot exclude a particular hospital in order to divert more capacity to another hospital to negotiate a lower price. Under the freedom of choice laws, insurance companies have an incentive to make contracts with all hospitals because they want to get discount off the retail price that the hospitals charge consumers who have no insurance, so the freedom of choice laws give the insurance companies an incentive to get some discount from everybody. Under the

any willing provider laws the insurance companies can no longer go to, for instance, one of two hospitals in the area and say they will contract exclusively with a particular hospital if that hospital gives substantially lower prices in return for its volume. Insurers can no longer make this type of deal because the 2nd hospital has the right under the law to also contract with the insurance company. Both of these laws are mechanisms to preclude the insurance companies from effectively using selective contracting to keep the cost of hospital services lower.

The U.S. Federal Trade Commission has regularly appealed to states who are considering these types of laws not to implement them because of the way they interfere with the ability of insurance companies to freely negotiate for competitive prices from hospitals. In some states, the government has rejected these laws and in others they have not.

The Chairman observed that the German report suggests that there is a conflict between efficiency and quality since the German hospital market is characterised by large over capacity. The Chairman asked for an explanation of how this excess capacity developed.

A delegate from Germany stated that the capacities exist mainly for historical and political reasons. Germany has a state planning system by 16 German Länder which set up hospital plans and as a hospital you have to be listed in such a plan if you want your treatment cost to be covered by statutory health insurance funds. The problem with state planning is that it is ill-placed to predict future developments. There has been pressure from municipalities and political parties to set up more hospitals even if the number of inhabitants would not justify that. There is even more fierce resistance against closing hospitals and reducing bed capacity. Historically hospital financing was based on the annual historical spending. That is the reason why excess capacity was built. Excess capacity is good for competition, so market mechanisms were introduced in 2004, such as prospective payment systems that are now based on diagnosis related groups. These will likely lead to more efficiency and will reduce excess capacity.

The Chairman observed that the publication of a quality report contributes to meeting the objective of making sure that hospitals provide good care. On the basis of this report accredited physicians and insured persons can be better informed about the quality characteristics of hospital services, and health insurance funds can recommend certain hospitals. Quality reports are made public; they are not only used by the government to check cost efficiency of hospitals but they are also widespread. The German report states that there is substantial competition between hospitals. Given that prices are fixed by the government, the chairman wondered how this competition operates.

A delegate from Germany responded that price is not actually an issue for consumers or patients because they do not have to pay for the services, but the insurance pays for services. For consumers, competition focuses on quality of services, technical equipment and attractiveness of rooms and food, and so forth. Especially in maternity services, competition is on quality of room, for example. 37% of hospitals are public, 41% are non-profit and 22% are private hospitals. Private hospitals are increasingly prevalent because they are taking over public hospitals. Many of the public hospitals are now making losses, and that is the reason why they are sold to large private groups. Privatisation of hospitals is quite active.

The Chairman noted that Japan has introduced a system of payment based on performance and wondered how this operates and whether the quality assessment of different hospitals is made known to the public.

A delegate from Japan stated that a number of issues need to be addressed to make the health care system more competitive and efficient. One of the most important issues is the revision of the fee table (or price list) that is set by the government and is applied to all medical institutions. In fact, the fee table will be revised next year. The government has not decided the details yet but the table will include payment in

accordance with the level of difficulty of hospital services. In this scheme, if a hospital performs a difficult operation, it will be rewarded more. Also, for certain difficult operations, insurance will pay more money if the hospital performs more than a certain number of surgeries because such a hospital can be considered high quality. These payments are not exactly the same as payments for outcome but they work in a similar way by rewarding better hospitals.

Regarding the results of assessments, there is no public information about hospitals that receive more money. But ten years ago Japan introduced a third party evaluation system for hospitals. Currently one fifth of all the medical institutions have been evaluated and the results are public.

Japan emphasises the value of free access: patients can go wherever they prefer. In this sense, the Japanese system is competitive. But one of the most important challenges in ensuring consumer choice is the asymmetry in knowledge between doctors and patients. There is no magic bullet to solve this problem but evaluation helps consumers to choose better hospitals.

The Chairman opened the floor for questions.

An expert from Belgium stated that he is a medical doctor and wanted to urge more focus on evidence-based healthcare. He stated that many interventions mention quality of care but he did not hear a definition of quality of care. The evidence-based definition of quality includes the dimension of appropriateness. In healthcare, supply-induced demand exists. The delegate has participated in a major study in Belgium but numerous other studies demonstrate that much care is not appropriate and even can be termed “overuse” or “waste”. This occurs in large countries – for example, the work of David Weinberg is known from U.S. – but even in small countries enormous variations can occur from one region to another that are not easily explained. There are even disease “mongrels” sometimes mentioned, such as baldness, suggesting that if you do not have any patients you just create them. From the perspective of evidence-based medicine, not every new technology is an innovation. The delegate does know that a lot of technologies are introduced into the market and they do just the same thing but they cost more, with only a minor benefit. So if there is a desire to define or increase the value, the discussion should start with a definition of quality of care. Quality indicators can be made public but these are proxies and not always real clinical quality of care. They can increase risk selection of patients: just have the good patients come in for major cardiac surgery and you will have very good results; that means that some people are left out. A question needs to be asked: can patients indeed make their own decision in every situation? Can they indeed behave as real consumers? How can they become informed? Is all the information that is spread in healthcare really objective or independent? A major source of information for patients may come from the pharmaceutical industry, but not all the evidence that is available is objective or independent.

The Chairman commented that when quality assessment results are not made known to the doctors that make the decisions for (or recommendations to) patients, the possibilities of making comparisons of different alternatives is weakened.

A delegate from the United States commented that there has been a great deal of study in the U.S. over how to measure the clinical quality of physicians in hospitals. A major complicating factor is patient selection. If some hospitals have a less healthy population, their outcomes may predictably be worse than another hospital. Nonetheless there are attempts to implement the findings in the market place. The delegate’s personal opinion was that the private sector health plans have been more successful in harnessing quality competition. There are two areas to mention, in particular: one is variation of practice. In the U.S. there have been many studies done by academics to identify certain best practices for treating diseases that provide the best way to get the best outcome at lowest cost. These best practices, however, are not implemented uniformly throughout the country. What has occurred is that health plans have been able to marshal market forces to get better quality outcomes in terms of the way in which disease is treated.

This occurs not so much with cutting edge treatments as with, for example, people with kidney disease. At the opposite extreme, where there has been seen some market-based reform is the concept of centres of excellence. A delegate for the United States spoke about why the competition agencies have viewed any willing provider laws as reducing the ability of health plans to selectively contract not only in price but also on quality. And one of the developments that is very current in the U.S. is this idea of centres of excellence where, for certain high-end treatments, hospitals are identified that have well-recognised practitioners, high volume and an ability to deliver the treatment well. An insurer may direct patients to go there, give patients financial incentives to go there, and cost can be driven down by driving volume through these hospitals.

A delegate from BIAC spoke up and argued against the creation of a bureaucracy based on evidence-based medicine. BIAC believes that quality is measurable and that private firms are not ready to purchase any medicine or treatment at any price. There is substantial knowledge about costs or surgical intervention and what good treatment is. But BIAC would not want public insurers to establish a new bureaucracy, based on statistics, that would impose new treatments or rationing. While talking about competition, many countries have responded by viewing it as a threat to public health, when in fact public health would be strengthened by competition. Collective norms should not be imposed on the private sector.

Regulatory solutions for impeding strategic behaviour on the part of hospitals

The Chairman stated that one major problem in hospital services where private and public co-exists is the problem of cream skinning. Private hospitals often owned by physicians are able to take the high-profit activities away from the public hospitals while leaving the less profitable activities to public hospitals, which can result in a spiral of lower and lower quality service in public hospitals. Among the submissions are a number of regulatory solutions that avoid this type of problem. For example hospital supply in Mexico is the lowest in OECD countries with only 1 bed for 1000 population compared with an OECD average of 4.1 beds in 2003. The Mexican private sector accounts for 34% of supply and is concentrated in large cities in rich states where nearly half of private hospitals are in Mexico City. Private hospitals however are small, only 3% have more than 50 beds. Furthermore public hospitals provide relatively low quality services. Doctors that are employed by public hospitals practice regularly in the private sector as well. The solution used in Italy was to allow doctors to perform private practice in the public hospital itself. But one suggestion, and this is an important suggestion, to eliminate the conflict of interest between a doctor in the public sector that sees a patient and could channel the patient to the private clinic that he owns, one solution would be to modify the remuneration of public doctors.

A delegate from Mexico suggested that to answer the question you have to see the hospital market service in a more integral way. In the 2005 OECD review of Mexico's health care system, recommendations were made in three basic areas: Firstly to enhance the efficiency of hospitals, secondly to increase productivity of healthcare professionals and thirdly to ensure quality and cost effectiveness of healthcare.

Regarding the efficiency of hospitals, four proposals were made. The first was to introduce a clearer payer-provider split with contractor arrangements that reduce the present segmentation of the system. For example, allowing patients to choose the provider is very important, as is allowing the Ministry of Health to purchase care from all available providers not only those within the National Health system. The second was to create a centrally funded scheme where resources from the patients with appropriate inter-institutional coordination would gradually move away from a vertically integrated insurer-provider towards separate insurance and provision functions. The third was to create more output-based or prospective payment mechanisms which are more efficient than traditional methods of allocating resources between institutions based on pre-established budget caps. The mechanisms should be introduced at the federal and

state level. The fourth proposal was to organise the purchasing of all healthcare services on the basis of catchment areas covering more than one state to take advantage of economies of scale.

To enhance the productivity of healthcare professionals, three proposals were made, including one of the elements suggested by the Chair. Firstly staff remuneration should be linked to efficiency and quality goals. Secondly, remuneration systems should be modified to allow practitioners to offer private services in public hospitals, which is precisely what you are suggesting. At this moment the salary-based remuneration system provides incentives for public hospital doctors to practice regularly in the private sector. In order to allow for this possibility obviously you need to increase the capacity or to have an excess capacity in the public hospitals which is a problem in Mexico, but the problem must be solved in an integrated way. The third proposal is to review existing labour contracts. This is a major problem in Mexico, because they limit the flexibility of management so that unions have control over internal decisions.

In terms of quality and cost effectiveness of care, an expanded certification of care is proposed for institutions, healthcare personnel and medical schools, which could help to encourage quality improvement in underperforming care units. Multiple certification categories would create incentives for hospitals to differentiate on the basis of service quality. Certification mechanisms must be complemented with the transmission of information in order to have a much better signalling mechanism in this market.

The Chairman noted that in Chinese Taipei, it is prohibited for physicians employed by hospitals on a salary or salary plus bonus to practice privately in their own clinics. It is very difficult to enforce such rules because making sure that they do not own private facilities themselves is feasible, but making sure that a relative does not own it is difficult. Conversely private practitioners with their own clinics do not have hospital privileges to complement their private treatment. The report recognises a distortion originating from the payment system, over the choice of a specialisation for medical students. Would the elimination of the prohibition to private practice eliminate the distortion? Or has there been consideration of permitting private practice within the public hospitals?

A delegate from Chinese Taipei responded that since 1996 Chinese Taipei has implemented a very comprehensive mandatory almost universal medical care insurance system. As a result, Chinese Taipei has a national insurance system whose function is as an intermediate between the medical service providers and patients. As you can imagine, as a result of this implementation system, the price competition in the medical sector is virtually non-existent because all these providers are medical hospitals that compete for payments under the national insurance system. In Chinese Taipei, all patients have free access to all hospitals and all clinics, so the referral system is not very popular. Many are well-known hospitals owned by the government. All major medical centres operate in a very integrated way; they provide a full range of services from very sophisticated brain surgery to large scale outpatient service. Among all the payments under the insurance system, significant payments are related to outpatient service. As a result, they have little desire to provide complementary service to physicians who run their own private clinics. As many of these medical centres are government operated, traditionally the physicians are not allowed to run their own private part-time practice. So there is a segregation of large scale national medical centres and competition with privately owned clinics. One solution would be to promote competition between physicians running their own clinics and large scale medical centres, for example through a regulation that imposes the obligation on part of the national hospital to provide complementary services to private physicians if the private physicians make a request. But another possible solution would be to eliminate the restrictions that prevent physicians who work full-time for national medical centres from conducting private practice. While these possible solutions may be desirable, there may be more structural problems because of the closed competition system, where it may not be ideal to force a competitive environment. The medical service market in Taiwan indeed causes a kind of brain-drain for some specialisations within the medical services; for example 10 years ago for all medical students the most popular specialisation

would have been surgery, anaesthesia for example. But now popular specialisations have shifted to areas like pathology, EN&T and cosmetics. One reason of course is because of this payment system. Students or doctors fear that if they choose surgery as their specialisation they will suffer and their income will decrease.

The Chairman moved to a different topic within the regulatory solution. Many countries are moving away from global budgets towards a system that reimburses hospitals for services that they actually deliver, particularly countries that finance hospital services through general taxation. For example, in Denmark free medical treatment is provided generally. However the Danish report already mentioned the fact that the government instituted an independent regulator for assessing quality and the report often speaks of competition as the driving force of recent reform. For example in order to increase the efficiency of hospitals in output-based budgets diagnosis related groups' funding was introduced in 2002. This has implied that 20% of hospital funding is now based on activities and this percentage, according to the report, will increase to 50% in 2007. The new budget procedure gives the hospitals a financial incentive to increase their activity and be more efficient. However given that hospitals are part of public administrations, how can the system of incentives work? What is the effect of incentives if hospitals do not suffer any problems in terms of funding because of their public nature?

A delegate from Denmark responded that in order to induce hospitals to operate efficiently and to increase their activity, one would think that high-powered incentive contracts to the management would be necessary. In Denmark that kind of contract is not used yet. To a large extent; the activity budget procedures implies that when a hospital increases its activity, funding goes up and thus more resources would be available for this hospital. The hospital management has a general incentive to increase activity and operate the hospital efficiently as the management is responsible for whether the hospital performs well. There is a threat that the hospital may be closed down. Since the 1980s, several small and inefficient hospitals have been closed down. Moreover, hospitals that do not perform well may lose employees due to lower funding. So there are genuine incentives to increase activity and to perform well. At the moment they are not really high-powered incentives that directly link the salary of hospital management to the performance of the hospital. However the use of such contracts is increasing.

The Chairman observed that in Norway, diagnosis related group rates have recently been introduced in order to increase efficiency. However, competition and effectiveness of this change requires that successful hospitals flourish and unsuccessful ones may close down. But is this coherent with the public nature of Norwegian hospitals?

A delegate from Norway responded that regional health enterprises that own the hospitals are obliged to be in economic balance. However, each year if the economic result is negative, the enterprises may cover the difference with loans. These loans however must be accepted by the Ministry. So in the long run they must be in balance and some years they have to pay back the loans. The reform is from 2002 and now all the regional enterprises have negative results and quite large loans so it remains to see how this will be handled in the years to come and whether they really do pay back these loans. Health enterprises and hospitals do find the budget constraints more binding than before the reform.

The Chairman observed that from 2004, France is introducing diagnostic related group based reimbursement which is profoundly changing the nature of hospital financing. The rates will be calculated based on details about the activities, as in other countries, however, France will have a different payment level for public and private establishments. In addition, payments for emergency care will be made separately. At times, it may be difficult to assess independently whether an episode of care constitutes emergency care or not.

A delegate from France responded that public and private hospitals that participate in public service are paid according to the same scale. Such private hospitals might be run by associations or by not-for-profits. In contrast, for-profit private hospitals would be paid on a different scale. Historically, the public service hospitals received payments that included the payment for physicians. In contrast, the private for-profit hospitals received payments that excluded the physician payment. This difference continues and thus there are two different scales, for the moment. One of the objectives of the reform is to improve comparability across different provider types. The intention is ultimately to have a uniform scale. Public hospitals are gradually going to enter into output-based finance, but for the moment most of their funds still come from global budgets. A recent study by CAM suggests that private for-profit hospitals have taken some share of the market from public service hospitals, particularly through ambulatory surgery.

The Chairman opened the floor for questions and comments.

An Expert from Belgium commented that fee-for-service without major restraints indeed increases activity, and can provoke overuse or misuse, but on the other hand often results in high patient satisfaction. Diagnostic related group payment is certainly progress compared with fee for service, but it is not very helpful for judging quality and appropriateness of care, for example with ambulatory care surgery. In Belgium, there is a high level of ambulatory arthroscopy and yet there is little evidence that people are better off as a result. Randomised control trials suggest that there is not much difference in terms of functional impairments between arthroscopy, no operation at all and maybe sham surgery. Whatever reform is started, there should be a monitoring system. Transition takes time, reforms take time, but evaluation of impact requires the monitoring of side effects and of medical and clinical endpoints.

A delegate from BIAC stated that insurers make a significant effort to improve the quality of medical practice. For example, in France, the government health insurance system sends its doctors to practitioners' office to review prescriptions and procedures with a view to assessing whether they have been overly intensive or under-intensive in their prescriptions and procedures.

Antitrust enforcement

The Chairman proceeded to the final section of the roundtable discussion, focused on antitrust enforcement. The public nature of hospital services in many countries has often prevented an active involvement of antitrust authorities in the hospital sector. In Italy, for example, public hospitals are part of public administration and not subject to antitrust scrutiny, except for private hospitals and purchasing or procurement activities. Indeed, public procurement issues or questions related to tariff negotiation do fall under antitrust law. For example in Brazil CADE intervened a number of times against price scheduling of the Brazilian medical association nationally, at the state level or locally. What is striking is the Brazilian report suggests that such violations increased after CADE intervened and became more frequent maybe because CADE had more information on those events.

A delegate from Brazil stated that two major practices in this area that have led to action, one being price fixing for physician services and the other being a form of horizontal exclusivity imposed mainly by cooperatives of physicians. In both cases, the practices are violations and, according to our understanding, similar in result to a situation in which physicians were given freedom to bargain collectively with competing medical organisations. The physicians say that they have to organise themselves against the healthcare insurance companies or healthcare plans otherwise they will be abused. So they organise themselves to practise a kind of countervailing power. Besides, horizontal agreements to set uniform prices and to provide the same economical rewards to all practitioners, regardless of their skills, reduce the benefits of training or willingness to employ innovative procedures. Such restraints also discourage entry to the market by new physicians. So CADE has understood that this countervailing power would have a negative impact on consumer social welfare. At the same time, an increasing number of violations have

been identified. This is because of more investigations but also because CADE is still building its reputation in this area. Fines have not been collected from these violations. The reason is that Courts have overruled our decisions. Why? Judges evaluate the relation between the physicians and the healthcare company, but do not always consider social welfare. So they feel CADE is not focusing on the right issues and they prevent the collection of fines. The co-operative law does not say that co-operatives have antitrust immunity but the judge sometimes believes they have such immunity. CADE is seeking to discuss these issues with judges so that fines could be collected and the behaviour deterred.

The Chairman stated that the Argentinean authority reports an antitrust case in the hospital sector in which there was an agreement between the clinical and sanatorium association of a town. Because the sanatorium did not provide assistance to people affiliated to the social security agency, they provided services only to patients associated with one social security service. It is not clear why this has occurred, since accepting patients is good for them.

A delegate from Argentina commented that the services are paid for by the union social security agencies. By not giving services to the affiliates of union social security agencies that have contracts with other clinics and that are not in this association, they force these union social security agencies to contract only with the clinics that are in the association. That is the reason why this conduct was excluding clinics and other associations from the market.

The Chairman turned to New Zealand where the report contains a detailed description of a merger between 2 Auckland hospitals. For market definition, the report argues that public and private hospitals are in the same market for some activities, but at the same time private hospitals are different because – especially for elective surgery – while public hospitals provide the service on a full cost basis, private hospitals only provide the facility and the patient for elective surgery has to negotiate with a private doctor regarding the cost of the surgery. However it seems to me that the fact that the two products are different or separate does not mean that they are not in the same market and in fact the New Zealand authority concluded that the products were actually competing despite the fact they were supplied in a different way. What is even more interesting to me in the discussion of the New Zealand case is that the elasticity of demand for elective surgery is reportedly high, implying that the degree of substitution is much wider than should be expected. The Chairman wondered whether this had any effects on market definition, because when there is a high elasticity of demand, then the market is normally broad.

A delegate from New Zealand confirmed that in fact the Commission did distinguish between the market for publicly funded work and a market for privately funded work, finding that private hospitals are directly competing with public hospitals for elective surgery whereas only a small amount of privately funded work is undertaken in public hospitals. The government had recently announced a limitation on the extent to which public hospitals in the future would be allowed to provide facilities for private surgeons. Because of this recent policy change the commission took a conservative approach to market definition because market definition is really a pragmatic exercise. It is there to lay bare any competition issues that might arise as a result of a merger proposal. The commission acknowledged that there was at least some argument for a wider market but believed that if those arguments were strong they would come out in the competition analysis anyway. When undertaking the competition analysis, the Commission did ultimately conclude that there was some constraint from the public hospitals, because demand was relatively more elastic than had been expected. Because of that the Commission proceeded to perform an entry analysis based on a narrower market and found indeed that entry had recently taken place and that entry barriers were low on that basis taking into account also some constraints from the public systems. The Commission was consequently able to clear the merger. Had these constraints not existed, the Commission would have been forced to seek additional time to consider the merger proposal. The issue about breadth of market is particularly difficult when considering elective surgery. More recently, the Commission has considered

other markets where hospitals compete, private and public, and in each of those cases it has been clearer that a narrow market definition is relevant.

The Chairman observed that in Italy, the hospital sector had quite a number of public procurement cases for hospital supplies and for drugs, but there has not been any antitrust enforcement of hospital services as such because of the public nature of hospital services in Italy. Recently however the Italian authority launched a fact finding investigation on the role played by private-public interface in hospital services. The Chairman asked about the motivation for the investigation.

A delegate from Italy responded that there are two main areas of interest or complaint from the private sector. Private hospitals may ask the local health authorities for accreditation which means that they are allowed to be reimbursed publicly with public funds for services that they provide to customers. Access to this accreditation process is a key factor in order to be included in the public health sector. In some regions responsible for providing health services the accreditation review has not taken place in 20 years. The incumbent private hospitals have no competitive pressure whatsoever if the accreditation review does not take place for a number of years. So, regional review for accreditation of various hospitals is a topic of enquiry.

The second area of the enquiry concerns the role of local health authorities. They play a double role in the system: they pay for all the publicly fund services whether they are provided by public hospitals or private accredited hospitals, but at the same time they run and manage and supervise public hospitals. So there has been a demand from private hospitals for us to look at how the system actually works because there is a tendency for the local authorities to favour the public hospitals in terms of the quantity of services that are reimbursed. The way it works is that every year the public health authorities decide how much money is going to go to the private hospitals which are accredited and this is based on how much money is left from their budget. So there is a DRG-based tariff but this is going to be fully implemented in 12 years which means by the year 2010. Some public hospitals are paid based on their historical cost which means that there is some money left for the private accredited hospitals. And private accredited hospitals have no way to guess every year how much money there's going to be for services they provide within the public health system. So this is another area being examined in order to find out whether there might be competitive tools that could improve the situation.

The Chairman pointed out that the European Commission is the only delegation that had addressed state aid in its contribution. The European Commission enforces the state aid rules within the EU and, in particular, article 86 of the EC treaty allows the derogation from the state aid rules where they would hinder performance of a service of general interest insofar as certain conditions are respected. Accordingly, state funding of hospitals is allowed in the EU if it is necessary to finance the cost of health services of general economic interest and if compensation is limited to this cost. On the contrary it is not possible to use public funds to subsidise commercial activities. So there are a number of questions. First of all, what is a commercial activity within the domain of hospital services? How can you define cross-subsidies in hospital services where indeed there are a number of fixed cost that need to be allocated and, as is well known, there is no mechanical way to allocate these costs in a meaningful way? The most efficient way of allocating costs is by Ramsey rules that make them inversely proportional to the elasticity of demand, but this is quite difficult to implement for healthcare.

A delegate from the European Commission noted that, given the high cost of investment in this area, it is fundamental that there is control on potential cross-subsidisation. In many of the member states of the Union, a state intervention takes place at 2 levels. On the one hand member states substantially finance investments made by hospitals participating in the healthcare system related to the social security. But this intervention, a state intervention, does not leave it to that, it goes beyond that and in many instances, and not only in respect of public hospitals, member states also grant operating subsidies eventually covering

losses generated by hospitals. In this situation there is in fact a very high risk that money initially granted for social security purposes or for public services will cross-finance activities in markets open to competition where both public and private hospitals operate. On the other hand there is the problem that this equipment has in fact a dual use: you can use this equipment for patients coming under the social security system and then on the other hand you can use it also for patients coming from segments of the market open to competition. Then it is fundamental that it is sufficiently monitored in the system of allocation of common costs used by hospitals. As to how to allocate costs between markets subject to competition and regulated markets, there is substantial debate. In fact the European Commission has started to intervene in this domain and believes that member states must in fact make an effort to clarify the definition of the tasks that are entrusted with hospitals as regard the social security system and also in terms of transparency about the means that are made available to these hospitals to cover the costs of these activities. Depending on the situation of the hospital and on the equipment, the Commission could discuss with the member state authorities appropriate ways to discuss the common costs of this equipment that is in fact subject to this dual use.

The Chairman wondered whether an example could be provided of a commercial service within a hospital that should be protected by state aid rules.

A delegate from the European Commission stated that the answer depends on the member state's position because, under community law, it is up to the member states to define the scope of public services to be provided in certain areas of economic activity. In public health, it is up to member states to define what healthcare activities fall under the social security system. According to Community law and jurisprudence this part of the activity is outside the application of state aid and competition rules. Of course there are other activities that go beyond these activities. These are "services of general economic interest". It is up to the member state to define the scope of these services. The Commission can start applying article 86-2 and basically the role of the commission would be to ensure that there is no over compensation of the costs that are linked to the provision of this activity. Answering your question therefore depends on the member state's choice because they can choose the scope of these services of economic general interest in the healthcare system.

General discussion

The Chairman opened the floor for general discussion.

A delegate from New Zealand stated that, for a number of years, the health sector has been a priority for the NZ Commerce Commission. As some of our colleagues have found, this area contains a large number of actions that are of concern, particularly on the enforcement side. The Commission has been successful in some proceedings against the ophthalmologists and the society that represents them. In a second case against ophthalmologists, a decision is expected from the High Court to agree to a settlement that has been reached in which they have acknowledged liability once again for further infringement of the Commerce Act. At least another six investigations are under way into medical professions in New Zealand. At the same time, competition is emerging in some areas. Often this competition is upstream and downstream from the publicly owned hospitals. It is important for this competition to continue. One issue that has recently come to the Commission's attention is a tendency for public hospitals to want to negotiate with only one party in the private sector. They are entering into long term contracts, often up to 10 years. It is a very short-term focus trying to get short-term gains and not looking to see where the competition will come from in the future. Private parties constantly tell the Commission to take into account the countervailing power of the public sector. Yet the way they enter into contracts and even the way they go about bidding yields little evidence that they are using a countervailing power in the way you would expect or hope in competition terms. At the same time, the private sector is increasingly arguing that the health system in general should be exempt from the Commerce Act. The government has made some moves in

this direction but has resisted thus far. The delegate stated that it is important that a body such as this Working Party reinforce the importance of competition and competition law in the health sector.

A delegate from the United States noted that there is one characteristic of hospital markets in the U.S. that is worth emphasising. Hospitals are competing like other market participants in other industries. As a result, there is often behaviour that gives rise to antitrust concerns. For decades, there has been antitrust enforcement involving hospitals, but also conduct by hospitals. The comments from the New Zealand delegate about the role of physicians in this competition are important because a very salient feature of hospital competition is the influence of physicians on patients over hospital choice. And one area in which both the U.S. Department of Justice and the U.S. Federal Trade Commission have been very active is in protecting against hospitals orchestrating physicians so that the physicians not only fix prices among themselves but so that the physicians are no longer a force facilitating competition among hospitals. Dominant hospitals will take the physicians into their medical staff and organise them in a way that purchasers cannot use competition to discipline those hospitals. Another action that has recently been seen in the U.S. is hospitals using access to the hospital as a means of disciplining physicians who do not favour that hospital or who try to steer patients to hospitals that compete with the hospital imposing the restrictions. Not only has the government investigated cases in this area but there are also a lot of private suits by physicians themselves suing hospitals or threatening to sue hospitals over this type of monopolistic conduct.

The Chairman concluded that, following up on the New Zealand delegate's comments, there is quite a scope for competition in hospital services throughout our jurisdictions but many members are in a process of transition and the process is not easy. Competition in hospital services requires quite an active regulatory framework promoting competition. Many countries are moving towards reimbursement by diagnosis related group. If there is no effect on hospital finances from a new system of remuneration, then quality and efficiencies will not be forthcoming.

The Italian example made it clear that when the regulator is at the same time the owner of the public hospitals and controller of public hospitals, it becomes very difficult for that regulator to be independent. So independence is important. Denmark discussed the assessment of quality. Independence also here is quite important, particularly for spreading information on quality reports. Quality itself is difficult to measure. There is a long way before competition in hospital services is fully active in most countries. Where beneficial, regulation should be adjusted to allow it and to promote it. Rivalry, even within a public system, can provide substantial benefits to citizens.

COMPTE RENDU DE LA DISCUSSION

Introduction

Pour commencer, le Président, Alberto Heimler, précise qu'il s'agit de la deuxième table ronde organisée par le Groupe de travail dans le secteur des soins de santé. La première portait sur les professions de santé. Celle-ci concerne les services hospitaliers. Les services hospitaliers représentent près de la moitié des dépenses de santé des pays membres de l'OCDE. Dans de nombreux pays, il existe un système universel de soins de santé couvrant l'ensemble de la population. En outre, dans de nombreux pays, les hôpitaux sont gérés intégralement ou essentiellement par la puissance publique. Même, s'il s'agit d'hôpitaux privés, les patients ne payent généralement pas ; ce sont les compagnies d'assurances ou des programmes gérés par l'Etat qui règlent les services hospitaliers. Dans la mesure où les revenus des hôpitaux proviennent souvent de transferts publics, ceux-ci ne sont guère incités à minimiser leurs coûts ou à améliorer leur qualité. De plus en plus, les pays membres cherchent à accroître l'efficacité des services hospitaliers par une plus grande concurrence entre les différents prestataires de ces services. Mais un problème de capacité se pose dans les systèmes hospitaliers privés car les entrepreneurs privés ajustent habituellement la capacité à la demande moyenne et non pas à la demande de pointe. Dans le secteur hôtelier où la capacité en termes de nombre de lits est également ajustée à la demande moyenne, les prix augmentent lorsqu'on est en situation de demande de pointe, ce qui constitue une forme de rationnement. S'agissant de services hospitaliers, cela serait inacceptable. C'est pourquoi de nombreux observateurs déclarent qu'il est important d'instaurer une régulation des services hospitaliers, même une régulation de la capacité. Parallèlement, dans un certain nombre de cas, la concurrence est associée à une efficacité accrue et à un bien-être accru des consommateurs. Les mécanismes susceptibles de réduire l'incertitude de la qualité des soins sont notamment la collecte et la diffusion d'informations sur les performances des prestataires. L'important c'est que cette information soit rendue publique et non pas seulement collectée en vue d'être diffusée aux hôpitaux pour leur permettre de faire des évaluations comparatives (benchmarking). En fait, la diffusion de l'information est importante car elle promeut le choix des consommateurs et permet ainsi à la qualité de devenir une caractéristique que patients ou médecins sont capables de prendre en considération. La rigueur budgétaire peut également être améliorée en donnant aux hôpitaux des responsabilités financières et en introduisant un système de contrats qui récompensent la performance et le résultat. La capacité peut être garantie, par exemple, en favorisant les spécialisations dans les centres régionaux pour les procédures complexes par des mécanismes appropriés de fixation des prix. La qualité des soins (et les coûts) ne sera(ont) pas toujours moindre(s) lorsque les prestataires seront plus nombreux car les centres régionaux peuvent contribuer à une réduction des coûts et à une amélioration de la qualité. Comme en témoignent les rapports reçus, l'application des lois antitrust joue un rôle résiduel dans les services hospitaliers. Toutefois, dans de nombreux pays ces lois ont été activement appliquées dans les marchés publics afin d'éviter tout phénomène de collusion dans la fixation des honoraires professionnels, en particulier pour les pays ayant un système privé de contrôle des fusions. Cette table ronde tombe à point nommé car de nombreux pays s'engagent sur la voie d'une réforme réglementaire du secteur afin d'améliorer la qualité, l'efficacité et la rigueur budgétaire. La discussion sera organisée autour de cinq grands thèmes : la concurrence et l'offre publique de services hospitaliers ; la concurrence et l'offre privée de services hospitaliers ; la qualité des soins et le choix des consommateurs dans un environnement concurrentiel ; la manière dont la réglementation peut entraver un comportement stratégique des hôpitaux, enfin l'application des lois antitrust dans les services hospitaliers.

Concurrence et offre publique de services

Pour ce qui est de la concurrence et de l'offre publique de services hospitaliers, deux pays ont indiqué mettre en œuvre une réforme en profondeur orientée vers la concurrence, bien que l'offre de services hospitaliers et le paiement de ces services soient principalement publics. Ces pays sont le Royaume-Uni (RU) et les Pays-Bas. Ce qui est intéressant dans leur rapport et dans leur expérience c'est que la rivalité entre les différents prestataires de services hospitaliers est discutée dans un cadre où le consommateur final ne paye ces services pas du fait de l'existence d'un système national de soins de santé. Au Royaume-Uni, la réforme a mis en place un système de paiements au résultat et un tarif national établi sur la base du coût moyen du service national de santé (National Health Service). Selon le rapport du RU, le paiement au résultat n'est efficace que s'il est associé à un choix plus large des patients, de sorte que les prestataires soient contraints de convaincre les patients qu'ils offrent la meilleure qualité de soins possible. En conséquence

les services très prisés se développeront et les services inférieurs aux normes seront contraints d'améliorer leur niveau de qualité ou, s'ils ne répondent pas aux besoins des patients, éventuellement de fermer.

Dans le paiement au résultat les prestataires sont fortement incités à offrir aux patients un meilleur rapport coût-efficacité mais cela ne marche effectivement que si les hôpitaux publics sont gérés selon un système incitatif pour les gestionnaires de telle sorte que les hôpitaux efficaces en tirent des avantages et ceux qui ne le sont pas en subissent les conséquences, lesquelles peuvent aller jusqu'à la fermeture. Comment cela peut-il se faire lorsque l'objectif ultime n'est pas le profit mais le service public. En particulier, si les responsables de l'élaboration des politiques veulent avoir toujours un lit prêt pour tout patient qui se présente, on pourrait arguer que les hôpitaux ne peuvent fonctionner selon une contrainte de profit car alors il leur faudrait avoir une file d'attente à leurs portes de sorte que leurs lits soient toujours pleins et leur capacité utilisée à 100%. Il existe une contradiction entre l'incitation privée et le bien-être social. Comment le Royaume-Uni envisage-t-il de sortir de cette contradiction?

Un délégué du Royaume-Uni a déclaré qu'à l'intérieur du système le gouvernement travaille avec des ressources finies qui restent à l'évidence dans les services publics. Ces ressources sont toujours réinvesties dans l'offre de soins de santé, de sorte que les hôpitaux qui enregistrent de bonnes performances bénéficient d'une plus large autonomie et sont libres d'utiliser leurs ressources comme bon leur semble. Les hôpitaux bien gérés qui dispensent des services pour un prix inférieur au barème peuvent réinvestir dans l'amélioration des services qu'ils offrent à la population. Certains hôpitaux locaux seront contraints d'améliorer leur gestion s'ils ne se conforment pas au prix de barème et s'ils ne deviennent pas un hôpital de choix. S'agissant d'un service public, les décideurs doivent faire en sorte que l'offre soit adéquate pour toutes les populations locales ; ils sont donc incités à faire preuve d'une plus grande efficacité opérationnelle et à améliorer la gestion des hôpitaux tout en veillant à ce que les populations soient à même d'accéder à leurs services locaux. Un système d'achats orientés par les praticiens (« practice-based commissioning ») est également mis en place pour contrebalancer ce que l'on a dit concernant l'incitation pour les hôpitaux d'avoir à chaque instant tous leurs lits occupés. Les incitations d'un tel système limiteront les incitations d'un paiement au résultat

Le practice-based commissioning permet aux médecins généralistes (GP) d'acheter leurs prestations auprès d'un éventail plus large d'hôpitaux de sorte que les hôpitaux sont incités à offrir les meilleures prestations pour leur population locale. Les GP auront le choix entre différents hôpitaux pour leurs patients, ce qui signifie que les hôpitaux devront faire en sorte de continuer à fournir à l'intérieur des prix de barème des prestations de qualité pour leurs populations locales.

Le Président a déclaré que l'un des éléments clés de la réforme néerlandaise est de commencer par introduire la concurrence entre compagnies d'assurances. Cette concurrence contribuera à garantir que l'offre hospitalière publique aboutira à une concurrence accrue entre les hôpitaux de sorte que chaque compagnie d'assurances passera contrat avec un certain nombre d'hôpitaux, ce qui mettra les hôpitaux en situation de concurrence pour la signature de contrats avec les compagnies d'assurances. Le Président a demandé si chaque citoyen néerlandais avait le droit de choisir une compagnie d'assurances quelle qu'elle soit ou si chacun était tenu d'en choisir une, par exemple, en fonction de son implantation géographique ou de sa profession et comment fonctionnera la concurrence créée par la compagnie d'assurances.

Un délégué des Pays-Bas a répondu que le consommateur peut choisir la compagnie qu'il souhaite et que chaque compagnie d'assurances est tenue de vous assurer, même si vous êtes malade. Si un client souffre d'une pathologie ou d'une maladie chronique, la compagnie est tenue de lui assurer l'accès aux installations de soins de santé. Le prix diffère toutefois. Cela signifie que la concurrence est activée de telle sorte que les clients peuvent choisir la compagnie dont ils pensent qu'elle offre le meilleur rapport qualité/prix. Mais il y a également quelques restrictions car il n'est pas possible pour les compagnies d'assurances de pratiquer des niveaux de primes différents selon les personnes qu'elles assurent ; autrement dit, elles ne peuvent pas demander aux personnes malades une prime supérieure à celle qu'elles demandent à des personnes bien portantes.

Il y a un minimum obligatoire de soins de santé à fournir et la loi établit les types de soins de santé que les compagnies doivent couvrir. Par exemple, les soins hospitaliers, les services de physiothérapie et autres sont englobés dans le paquet de soins imposé par les pouvoirs publics. Il appartient aux prestataires de soins de santé de décider de la manière dont ils dispensent ces soins mais il existe une norme générale sur les types de soins devant être dispensés.

Les compagnies d'assurances se font concurrence au niveau de la qualité et du prix dans le cadre de ce montant standard de soins de santé. Les compagnies d'assurances ont des contrats avec les hôpitaux et elles peuvent veiller à ce que le rapport qualité/prix soit supérieur ou inférieur et c'est sur la base de ce ratio que les personnes choisissent leur compagnie d'assurances. Il est également possible pour les compagnies d'assurances de s'abstenir de passer contrat avec un hôpital donné, par exemple parce qu'il n'offre pas la qualité qu'elles recherchent.

Un hôpital peut fixer à son gré 10% de ses prix ; les 90% restants sont fixés par les pouvoirs publics. Les patients choisissent sur la base des primes qu'ils doivent acquitter pour obtenir la couverture qu'ils souhaitent, des contrats qu'une compagnie d'assurances a passé avec des hôpitaux et du montant qu'ils devront déboursier s'ils vont dans un hôpital avec lequel la compagnie d'assurances n'a pas passé contrat. Par ailleurs, nombreux sont ceux qui choisissent une assurance complémentaire car en dehors du paquet standard une compagnie d'assurances proposera des services complémentaires moyennant un supplément de coût. Habituellement, les consommateurs qui choisissent de souscrire une assurance complémentaire le feront auprès de la même compagnie. Il est possible de souscrire un contrat supplémentaire auprès d'une autre compagnie mais c'est rare. Les contrats pour services supplémentaires sont un élément à prendre en considération dans le choix d'une compagnie d'assurances.

Le Président a déclaré qu'au Canada la plupart des hôpitaux sont des établissements à but non lucratif appartenant à des sociétés collectives ou à des organisations religieuses. Un certain nombre d'hôpitaux appartiennent également à des administrations municipales ou provinciales ou à des universités. Au Canada, les hôpitaux privés à but lucratif sont rares et, en règle générale, ils ont été exclus des aides publiques lorsque les provinces ont commencé à financer les hôpitaux. Pour l'essentiel, le secteur hospitalier à but lucratif offre des types de services différents de ceux qu'offrent les hôpitaux publics ; il est spécialisé, par exemple, dans les établissements de SLD ou les centres d'accueil des toxicomanes. En conséquence, il n'y a guère de concurrence entre hôpitaux publics et hôpitaux privés au Canada. Par

ailleurs, il ressort clairement du rapport que le système canadien semble très bien fonctionner et qu'en règle générale il fournit des services de bonne qualité pour un coût relativement modique. Dans la mesure où une réforme orientée vers la concurrence fait quelque peu débat au Canada, voyons quelles sont les faiblesses du système qui incitent à promouvoir une réforme orientée vers la concurrence?

Un délégué du Canada a déclaré que le système de soins de santé est très apprécié des Canadiens et qu'il dispense des soins de grande qualité. Une évolution visant à promouvoir une réforme orientée vers la concurrence ne reflèterait pas les faiblesses du système mais la possibilité de l'améliorer. Assurément, les délais d'attente pour certaines procédures ont posé quelques problèmes. Mais, à l'instar d'autres pays, le Canada est confronté à un accroissement des coûts des soins de santé. Le système est financé par l'impôt, ce qui est source de pressions pour le système public de financement. A l'instar d'autres pays, le Canada cherche des façons d'innover et de restructurer le secteur hospitalier mais aussi d'autres parties du système de santé de manière à le rendre plus efficace. Il s'agit réellement de voir comment le Canada peut rendre son système hospitalier plus efficace, vraisemblablement en introduisant dans le secteur hospitalier certaines formes d'incitations marchandes et, peut-être ultérieurement, une certaine forme de concurrence entre les hôpitaux à l'intérieur du système public de soins de santé.

Le Président s'est enquis de la nature des coûts salariaux et des organisations de salariés existant au Canada.

Un délégué du Canada lui a répondu que les salaires du personnel constituent la principale composante des coûts des hôpitaux (environ les deux tiers). Une ventilation par catégories montre que les services infirmiers aux patients hospitalisés constituent pour les hôpitaux le poste de dépense le plus important (environ 30%). Les autres grands postes de dépenses sont les services de soutien, de diagnostic et les services thérapeutiques, les services administratifs, les soins ambulatoires et les services d'urgence. Les prestations des médecins ne sont généralement pas incluses dans les coûts des hôpitaux mais prises en charge par les autorités sanitaires des provinces. Si les services infirmiers rendus en milieu hospitalier peuvent être pris en charge par les hôpitaux eux-mêmes, les niveaux des salaires peuvent être fixés selon des conventions collectives négociées au niveau provincial ou régional.

Le Président a fait observer qu'en Suède, où le système de santé est analogue au système canadien en ce sens que la responsabilité est largement décentralisée, il incombe aux conseils de comté de veiller à ce que des soins médicaux de qualité soient dispensés selon des termes d'égalité de tous les citoyens. En fait, le gouvernement suédois pense qu'il est important que les conseils de comté gardent le contrôle des équipements hospitaliers et suggère que s'il en allait autrement les coûts pourraient augmenter et la qualité moyenne des services diminuer. Mais, dans le même temps, les hôpitaux sont encouragés à sous-traiter quelques unes de leurs activités mineures comme le nettoyage, la restauration et les services de laboratoire, bien que la majeure partie de ces activités continuent d'être gérées par les pouvoirs publics. Le contrôle exercé par les pouvoirs publics sur les services hospitaliers semble hautement apprécié en Suède. En revanche, l'ouverture à la concurrence de ces activités secondaires a été extrêmement bénéfique. Dans le système suédois de santé l'offre de soins est importante afin de minimiser les délais d'attente. L'ouverture à la concurrence a été instaurée entre les comtés en ce sens qu'un patient n'ayant reçu aucun traitement à l'issue d'une période de 3 mois est en droit de se faire traiter dans un autre comté aux frais de son comté d'origine. Le Président a cherché à obtenir des informations sur le rôle de l'autorité antitrust dans le débat sur le rôle de la concurrence dans les services hospitaliers.

Un délégué suédois a répondu qu'en Suède les soins de santé sont principalement financés par les taxes levées au niveau des comtés et que la plupart des hôpitaux sont exploités par les conseils de comté. Toutefois, trois anciens hôpitaux publics au rang desquels figure l'hôpital de St Gorans, sont exploités par des sociétés à but lucratif. Ces hôpitaux n'ont pas été vendus mais leur exploitation a été cédée à ces sociétés pour une durée limitée. En 2006, lorsque entreront en vigueur les aménagements apportés à la Loi

sur la santé et les services médicaux, de tels accords ne seront plus possibles. Si un conseil de comté cède à un tiers l'exploitation d'un hôpital, ce dernier ne peut être exploité dans une optique de profit et les services seront financés uniquement par les deniers publics et les honoraires versés au titre des soins. Si les hôpitaux sont exploités dans une optique de profit il peut y avoir un risque de conflit avec les objectifs médicaux et sociaux, selon le gouvernement. Le financement public est une façon d'éliminer le risque de voir les patients payant de leur poche bénéficier d'un traitement de faveur. Cette nouvelle réglementation repose sur les rapports et les recommandations d'une commission d'enquête gouvernementale et d'une note du ministère de la Santé et des Affaires sociales. Le rapport et la note ont été adressés pour commentaires à l'autorité de la concurrence ainsi qu'à d'autres agences et organismes publics. L'autorité de la concurrence s'est opposée aux aménagements et a argué que cette nouvelle loi pourrait affaiblir la concurrence entre les conseils de comté lorsque ceux-ci achètent des services hospitaliers voire même l'éliminer dans certaines régions. L'autorité de la concurrence a également argué que la nouvelle loi pourrait conduire à une augmentation des coûts et à une baisse de la qualité et que les effets de la réglementation devraient être analysés plus attentivement. Les pouvoirs publics ont toutefois proposé un nouveau type d'entreprise assorti d'une restriction frappant la distribution de dividendes afin de faciliter l'exploitation des hôpitaux par des organisations à but non lucratif. Selon l'autorité de la concurrence, ce type d'entreprise n'assurerait pas aux propriétaires d'entreprises commerciales des revenus suffisants par rapport aux risques qu'ils prennent.

Concurrence et offre privée de services

Le Président a traité ensuite de la concurrence et de l'offre privée de services hospitaliers. Aux Etats-Unis, où il n'existe pas de système national de soins de santé, la majorité des hôpitaux sont privés, même si ce ne sont pas des établissements à but lucratif, tandis que dans d'autres pays une proportion importante d'hôpitaux sont des établissements à but lucratif. Même si le système est privé, l'administration fédérale et les autorités des Etats prennent en charge une part importante des paiements aux hôpitaux (près de 60%) par le biais des programmes Medicare et Medicaid. On peut se demander si les hôpitaux publics desservent les mêmes marchés que les hôpitaux privés ou s'ils sont au service de différentes parties de la population ou de différents types de besoins.

Un délégué américain a répondu qu'aux Etats-Unis le système des hôpitaux publics est sensiblement différent ; certains peuvent être intégrés à des universités publiques, d'autres peuvent être situés dans de petites agglomérations ou dans des comtés moins peuplés où ils sont l'unique prestataire important de services hospitaliers dans une vaste étendue géographique ; enfin, une troisième grande catégorie d'hôpitaux publics sont situés dans les grandes zones métropolitaines et desservir des secteurs de ces villes qui sont moins bien desservis par les hôpitaux à but lucratif et à but non lucratif du fait de leur situation géographique. Tous les hôpitaux publics ont une caractéristique commune : leurs principales sources de financement sont les mêmes que celles des hôpitaux privés ; autrement dit, les hôpitaux publics sont remboursés sur la base du nombre de patients traités soit par les autres fonds publics (programme Medicare ou Medicaid) soit par des assureurs privés. Mais, pour aller au fond de la question, lorsque ces remboursements ne couvrent pas le coût total de fonctionnement de cet hôpital, ce sont les fonds publics qui comblent la différence. C'est la raison pour laquelle dans certaines collectivités, la poursuite de l'exploitation des hôpitaux publics est un sujet de controverse car ceux-ci sont directement subventionnés par l'impôt. Il y a eu quelques cas de fermeture (ou de menaces de fermeture) d'hôpitaux publics. L'un des changements observés au cours de la dernière décennie concernant les hôpitaux publics, c'est le fait qu'ils ont évolué de plus en plus vers un modèle de marché de sorte que dans différents états les hôpitaux publics ont été autorisés à faire appel au marché à l'instar des entreprises privées et, ce faisant, ils s'efforcent de parvenir à une plus grande efficacité, une meilleure qualité des soins et une plus grande renommée de manière à pouvoir non seulement attirer les patients qui s'adressent à eux en tant qu'hôpital de dernier recours mais devenir un hôpital de choix pour les patients qui ont le choix. On espère que, ce faisant, les

hôpitaux publics amélioreront leurs prestations et que les bénéfices du libre jeu du marché reviendront aux parties de la population qui autrement auraient moins de choix.

Le Président a souligné que de nombreux états ont des programmes de certification des besoins autorisant les hôpitaux à fonctionner en cas de nécessité avérée. Il semble que la raison d'être de l'existence de ces certifications des besoins soit d'éviter une offre excessive. Le Président s'est dit intéressé de mieux comprendre comment fonctionnent ces programmes et de savoir s'ils conduisent ou non à des prix plus élevés.

Un délégué des Etats-Unis a suggéré que certains Etats ont toujours des programmes de certification des besoins mais que les raisons de l'existence de ces programmes ont changé au fil des ans. Initialement, ces programmes ont été imaginés parce que le mode de remboursement des coûts des hôpitaux par le gouvernement fédéral constituait une incitation à une construction excessive d'hôpitaux. Aujourd'hui, les types d'éléments probants utilisés pour justifier de nouveaux investissements, tels que la construction d'un nouvel hôpital, tendent à se focaliser sur une formule comparant la population d'une région donnée à la capacité totale de cette région. Les demandes d'informations elles-mêmes tendent à être fortement contestées et incluent une focalisation sur la viabilité des entreprises titulaires, leur marge et le fait que l'arrivée sur le marché d'un nouvel entrant serait ou non préjudiciable pour elles. La question directe de savoir s'il existe ou non une demande non satisfaite qui pourrait l'être par l'arrivée d'un nouvel intrant sort généralement du champ des auditions relatives à la certification des besoins.

Dans certains Etats, il s'agit d'un obstacle réglementaire majeur à l'arrivée d'un nouvel entrant qui est l'occasion d'un comportement stratégique des titulaires pour s'opposer à l'arrivée d'un nouvel entrant. Ces délibérations se font parfois à l'initiative des opérateurs en titre. Le processus peut nourrir les comportements anticoncurrentiels des entreprises titulaires. Parfois, le comportement est protégé parce qu'il implique des pouvoirs publics requérants. Dans un exemple récent, le département américain de la Justice (DOJ) a engagé des actions à l'encontre de deux hôpitaux parce que l'entreprise en titre utilisait la procédure de la certification des besoins comme un moyen pour engager le nouvel entrant et se partager le marché entre les deux entreprises.

Le Président a salué les commentaires et reconnu l'action du BIAC.

Un délégué du BIAC a déclaré que le Comité cherche depuis bien longtemps à encourager la concurrence entre les hôpitaux non seulement parce que le BIAC représente le secteur privé mais parce que les employeurs estiment que des soins de bonne qualité d'un prix modéré sont essentiels pour la compétitivité des économies. Le BIAC aimerait voir une description classant les pays par système de concurrence. Le BIAC aimerait également souligner le fait que la concurrence peut modifier les incitations à un grand nombre de niveaux de la structure hospitalière et qu'en conséquence il faudrait dix à quinze ans pour observer l'impact ultime de la concurrence. Aussi, avant de juger des réformes, il faut leur donner une chance de fonctionner. Le BIAC pense que les interventions non urgentes, comme l'opération de la cataracte, peuvent être exportées. En effet, si les coûts technologiques sont lourds dans ce secteur, les retours sur investissement à but lucratif sont, pour toute une série de raisons, rarement importants. Le BIAC est favorable à une concurrence entre établissements sur les niveaux de qualité. La définition de la capacité, dans le contexte hospitalier, est extrêmement complexe et malaisée.

Le Président a fait observer que le fait de s'en remettre aux seules lois du marché pour les services hospitaliers pose problème et qu'une certaine régulation serait nécessaire pour assurer une capacité suffisante.

Un délégué irlandais a déclaré que dans un service public (et la plupart des Etats membres de l'OCDE ont un service public), il peut être difficile de créer de la capacité excédentaire étant donné la propension à

consommer davantage de soins de santé et le fait que la plupart des consommateurs ne payent pas pour le service reçu. Or, sans capacité excédentaire, il est peu probable que la concurrence soit forte. Il est également peu probable que les autorités responsables du financement déclarent qu'elles faciliteront une capacité excédentaire pour permettre à la concurrence d'exister.

Un délégué américain a fait le commentaire suivant : en soi, le processus d'ouverture à la concurrence a créé de la capacité disponible car les compagnies d'assurances qui se font concurrence sur les coûts ont exigé qu'à chaque fois que cela peut se faire sans risques pour les patients, un nombre croissant de procédures soient effectuées en ambulatoire. Depuis que l'on s'oriente vers un système plus concurrentiel, un nombre croissant de procédures doit être effectué sur cette base. Cela permet de dégager une capacité supplémentaire de lits pour patients hospitalisés ; il n'y a pas destruction mais maintien de la capacité. Avec le vieillissement de la population, la demande d'hospitalisation s'est accrue et la capacité disponible a permis de répondre à ce besoin dans la plupart des régions sans ouverture de nouveaux hôpitaux.

Le Président a ajouté que Sean Ennis, l'auteur du document de référence, a déclaré qu'en France le mécanisme de fixation des prix peut aider à garantir la capacité d'accueil. Les patients peuvent, par exemple, payer un supplément pour chambre individuelle alors que la chambre comporte un deuxième lit. En cas de demande excédentaire, la possibilité de rester seul dans la chambre est supprimée. Autrement dit, le patient payera pour une chambre individuelle si la capacité d'accueil est suffisante mais si la capacité diminue cette possibilité sera supprimée.

Qualité des soins et choix des consommateurs dans un environnement concurrentiel

Le Président est passé à la troisième partie de la discussion, concernant la qualité des soins et le choix des consommateurs dans un environnement concurrentiel. Dans les services hospitaliers, la quantité est importante mais, bien entendu, la qualité est également d'une importance critique car la finalité ultime des services hospitaliers est de guérir les patients ; ce qui importe c'est donc la production de santé pas la production de quantité. Toutefois, l'évaluation de la santé est encore plus discrétionnaire que l'évaluation de la qualité des services fournis. Bien entendu, la concurrence peut contribuer très largement à l'amélioration de la qualité, par exemple parce que la liberté d'entrer sur le marché peut réduire sensiblement les délais d'attente. En revanche, la concurrence peut conduire à des investissements excessifs et donc grever les coûts sans générer beaucoup d'avantages. Une solution consiste à pratiquer l'analyse comparative ou benchmarking de manière à informer les patients et les médecins généralistes sur l'offre et sur la différence de qualité des différents hôpitaux. Au Danemark, par exemple, un institut indépendant a été créé, dans le seul but d'élaborer un système national de benchmarking de la qualité des services médicaux, et va commencer à être opérationnel fin 2006. En Suisse, hôpitaux publics et hôpitaux privés cohabitent. Mais je ne vois pas très bien s'ils fournissent le même type de services ou si les marchés sur lesquels ils opèrent sont clairement distincts. En outre, le rapport fait référence à un système de benchmarking dans le canton de Zurich. Les résultats du benchmarking sont-ils rendus publics ou uniquement utilisés pour contrôler les dépenses publiques?

Un délégué de la Suisse a déclaré que les hôpitaux privés sont des entreprises à capitaux privés et à but lucratif ; l'un d'eux est une grosse société appartenant à un fonds d'investissement britannique. Les hôpitaux publics sont la propriété des municipalités ou des cantons. Les hôpitaux privés traitent essentiellement des patients qui ont, le plus souvent, une assurance maladie complémentaire privée. En règle générale, ils traitent essentiellement ce que l'on appelle des patients privés. Les hôpitaux publics traitent non seulement des patients ayant une assurance maladie obligatoire mais également des patients ayant souscrit une assurance privée. Pour ce qui est des services d'urgence, les actions des hôpitaux privés dépendent des cantons mais habituellement les hôpitaux privés proposent, ou sont tenus de proposer, un certain nombre de services d'urgence, mais moins que les hôpitaux publics. Parfois, en cas d'accident, les

hôpitaux privés doivent traiter le patient mais si une opération non urgente est nécessaire, le patient peut être transféré dans un hôpital public s'il n'a pas d'assurance complémentaire privée.

Concernant le système de benchmarking mis en place dans le canton de Zurich, il vise principalement à contrôler les aides aux hôpitaux. Au vu des résultats du benchmarking, le gouvernement décide qui reçoit quoi du canton. Le système a été essentiellement mis en place pour contrôler les dépenses. Mais cette mise en place ne datant que de 2004, il n'est pas encore très largement utilisé.

Le Président a noté qu'il existe en Corée un programme d'agrément des hôpitaux géré par l'Association des hôpitaux coréens et mis en place depuis 1967 pour améliorer la qualité des hôpitaux. Ce programme prévoit une autoévaluation et une évaluation par les pairs. Quelque 1 600 éléments de données, incluant des données sur la sécurité, la sécurité des locaux, les fonctions de l'hôpital, l'organisation du travail des médecins, la qualité des installations, le matériel et la gestion globale ont été analysés. Le programme encourage les hôpitaux à se conformer aux normes d'évaluation et le Président a demandé si le programme était mis en œuvre sérieusement et s'il était porté à la connaissance du public. Sérieusement mais, étant donné qu'il s'agit d'une autoévaluation, il y a aussi, comme on l'a indiqué pour le Danemark, une autorité chargée d'effectuer cette évaluation qui est ainsi quelque peu indépendante des intérêts des parties.

Le délégué coréen a décrété qu'en Corée le programme est mis en œuvre très sérieusement. Le résultat de l'évaluation de chaque hôpital est notifié uniquement à l'hôpital, pas au public. Les hôpitaux qui ne se conforment pas aux normes se voient notifier les domaines dans lesquels des améliorations sont nécessaires suite au rapport d'examen tandis que ceux qui se conforment aux normes reçoivent un certificat d'agrément. Une analyse des rapports des résultats globaux du programme d'évaluation est toutefois publiée chaque année.

Le Président a déclaré qu'aux Etats-Unis, les prix des services hospitaliers ne sont pas fixés par les Etats ou par le gouvernement fédéral mais librement déterminés sur le marché. L'évaluation de la qualité a un but car si les résultats sont portés à la connaissance du public, les patients peuvent choisir leur hôpital en tenant compte de ces informations. De fait, certains Etats des Etats-Unis imposent des clauses de liberté de choix qui autorisent les consommateurs à choisir entre différentes compagnies. Dans le même temps, il existe parfois d'autres règles appelées clauses du prestataire consentant qui imposent aux sociétés de soins gérés d'intégrer à leur réseau tout prestataire qui consent à participer au plan conformément aux modalités du plan. Toutefois, ces clauses et règles ne sont nullement égales en termes d'impact et en particulier d'impact sur les coûts. Le Président a demandé plus d'explications.

Un délégué des Etats-Unis a fait observer que les consommateurs disposent de très peu d'informations sur la qualité des hôpitaux et que ces informations sont rarement compréhensibles pour eux. Dans de nombreuses régions géographiques, les consommateurs ne disposent d'aucune information comparative sur la qualité des différents hôpitaux de sorte qu'ils sont dans l'incapacité de choisir un hôpital sur la base de mesures rapportées et comparables de la qualité. Généralement, les consommateurs et les médecins qui les conseillent utilisent d'autres caractéristiques. Bien souvent, les consommateurs se déterminent principalement en fonction de l'hôpital que leur recommande leur médecin ou dans lequel leur médecin a choisi de pratiquer. Les agences ont trouvé que les lois relatives à la liberté de choix et les lois relatives au prestataire consentant ne constituent pas réellement des tentatives pour améliorer le bien-être des consommateurs mais pour s'opposer à la capacité pour les compagnies d'assurances de passer des contrats sélectifs pour faire baisser le coût des services hospitaliers en faisant jouer la concurrence. L'impact des lois est un peu différent car, en vertu des lois sur la liberté de choix les compagnies d'assurances ne peuvent éviter de payer si le consommateur choisit un hôpital dont le prix est particulièrement élevé. En vertu des lois sur le prestataire consentant, la compagnie d'assurances ne peut exclure un hôpital donné dans le but de détourner une plus grande capacité d'accueil vers un autre hôpital et de négocier un prix

moins élevé. En vertu des lois sur la liberté de choix, les compagnies d'assurances sont incitées à passer contrat avec tous les hôpitaux parce qu'elles veulent obtenir une remise sur le prix de détail que les hôpitaux facturent aux consommateurs n'ayant aucune assurance. Les lois sur la liberté de choix incitent donc les compagnies d'assurances à obtenir une certaine remise de chacun. En vertu des lois sur le prestataire consentant, les compagnies d'assurances ne peuvent plus, par exemple, se rendre dans l'un des deux hôpitaux de la région et dire qu'elles ne passeront contrat avec un hôpital en particulier que si cet hôpital leur accorde des remises de prix sensiblement plus importantes en échange du volume apporté. Les assureurs ne peuvent plus faire ce type de deal car, aux termes de la loi, le deuxième hôpital a le droit, lui aussi, de passer contrat avec la compagnie d'assurances. Ces deux lois sont des mécanismes destinés à empêcher les compagnies d'assurances d'utiliser efficacement le système des contrats sélectifs pour maintenir le coût des services hospitaliers à un niveau moins élevé.

La Commission fédérale américaine du Commerce (FTC) a régulièrement demandé aux Etats qui envisagent d'adopter ces types de lois de ne pas les mettre en oeuvre en raison de la manière dont elles interfèrent avec la capacité des compagnies d'assurances à négocier librement pour obtenir des hôpitaux des prix compétitifs. Dans certains Etats, le gouvernement a rejeté ces lois ; dans d'autres, il ne l'a pas fait.

Le Président a fait observer que le rapport allemand suggère l'existence d'un conflit entre l'efficacité et la qualité dans la mesure où le marché hospitalier allemand se caractérise par une surcapacité importante. Le Président a demandé qu'on lui explique comment on en est arrivé à cette situation de surcapacité.

Un délégué allemand a déclaré que les raisons de l'existence de ces capacités sont principalement historiques et politiques. L'Allemagne a un système de planification étatique avec 16 Länder qui établissent les plans hospitaliers ; en tant qu'hôpital vous devez être inscrit dans ce plan si vous voulez que le coût de vos traitements soit couvert par les caisses d'assurance maladie obligatoire. Le problème de la planification étatique c'est qu'elle est mal placée pour prédire les évolutions futures. Les municipalités et les partis politiques ont fait pression pour obtenir l'ouverture de nouveaux hôpitaux même si le nombre d'habitants ne le justifiait pas et la résistance à la fermeture d'hôpitaux et à la diminution du nombre de lits d'hôpitaux est plus acharnée encore. Historiquement, le financement des hôpitaux se fondait sur les dépenses annuelles historiques. C'est ainsi que s'est développée un excédent de capacités. Une telle situation étant bonne pour la concurrence, des mécanismes de marché ont été introduits en 2004, tels que les systèmes de paiement prospectif qui se fondent désormais sur les diagnostics regroupés pour la gestion (DRG). Ces systèmes conduiront probablement à une plus grande efficacité et réduiront les excédents de capacité.

Le Président a fait observer que la publication d'un rapport sur la qualité contribue à la réalisation de l'objectif consistant à s'assurer que les hôpitaux prodiguent des soins de qualité. Sur la base de ce rapport, les médecins agréés et les assureurs peuvent être mieux informés des caractéristiques de qualité des services hospitaliers et les caisses d'assurance maladie peuvent recommander certains hôpitaux. Les rapports sur la qualité sont publics ; ils ne sont pas utilisés uniquement par les pouvoirs publics pour contrôler le rapport coût-efficacité des hôpitaux mais également largement diffusés. Le rapport allemand établit l'existence d'une vive concurrence entre les hôpitaux. Etant donné que les prix sont fixés par les pouvoirs publics, le Président se demandait comment s'opère cette concurrence.

Un délégué allemand a répondu que le prix ne constitue pas véritablement un problème pour les consommateurs ou patients car ceux-ci n'ont pas à payer les services qui sont réglés par l'assurance. Pour les consommateurs, la concurrence concerne essentiellement la qualité des services, les équipements techniques, l'agrément des chambres, la qualité de la nourriture, etc. Dans les services de maternité, notamment, la concurrence porte, par exemple, sur l'agrément et le confort des chambres. 37% des hôpitaux sont des hôpitaux publics, 41% des établissements à but non lucratif et 22% des hôpitaux privés.

Les hôpitaux privés s'imposent de plus en plus car ils reprennent les nombreux hôpitaux publics actuellement déficitaires qui sont vendus à de grands groupes privés. La privatisation des hôpitaux se poursuit activement.

Le Président a observé que le Japon a adopté un système de paiement fondé sur la performance et se demandait comment fonctionne ce système et si l'évaluation de la qualité des différents hôpitaux est portée à la connaissance du public.

Un délégué japonais a déclaré qu'un certain nombre de problèmes doivent être réglés pour que le système de santé soit plus concurrentiel et plus performant. L'un des principaux problèmes est la révision du barème des honoraires (ou des prix) qui est fixé par les pouvoirs publics et appliqué à tous les établissements médicaux. En fait, le barème sera révisé l'an prochain. Le gouvernement n'a pas encore fixé les détails mais le barème comportera un système de paiement en fonction du niveau de difficulté des services hospitaliers. Dans ce schéma, si un hôpital réalise une opération délicate, il sera payé davantage. De même, pour certaines opérations délicates, l'assurance versera un montant supérieur si l'hôpital effectue plus d'un certain nombre d'interventions chirurgicales car un hôpital de ce type peut être considéré comme étant de bonne qualité. Ces paiements ne sont pas strictement équivalents à des paiements au résultat mais ils fonctionnent de la même façon en récompensant les meilleurs hôpitaux.

Concernant les résultats des évaluations, il n'y a pas d'informations publiques sur les hôpitaux qui reçoivent plus d'argent mais, il y a dix ans, le Japon a mis en place un système d'évaluation des hôpitaux par des tiers. Actuellement, un cinquième de tous les établissements médicaux ont été évalués et les résultats des évaluations sont publics.

42. Le Japon souligne l'intérêt de la liberté d'accès : les patients peuvent aller là où ils préfèrent aller. En ce sens, le système japonais est concurrentiel. Mais l'une des principales difficultés que pose le choix donné aux consommateurs est l'asymétrie entre la connaissance des médecins et celle des patients. Aucune baguette magique ne permet de résoudre ce problème mais l'évaluation aide les consommateurs à choisir les meilleurs hôpitaux.

Le Président a ouvert la séance de questions.

Un expert belge se déclarant docteur en médecine voulait insister pour que l'on mette davantage l'accent sur les soins de santé. Il a déclaré que de nombreuses interventions mentionnent la qualité des soins mais qu'aucune n'en donne la moindre définition. Une définition de la qualité reposant sur des éléments probants inclut la dimension de caractère approprié. Dans les soins de santé, il existe une demande induite par l'offre. Le délégué a participé à une étude majeure réalisée en Belgique mais un grand nombre d'autres études démontrent qu'il n'est pas nécessairement approprié de dispenser beaucoup de soins et que l'on peut même parler à ce propos d'utilisation excessive voire de gaspillage. C'est le cas dans les grands pays (voir, par exemple, les travaux de David Weinberg aux Etats-Unis) mais même dans les petits pays ; d'énormes disparités ne pouvant aisément s'expliquer peuvent se produire d'une région à l'autre. On mentionne même parfois des « pseudo » maladies comme la calvitie, ce qui donne à penser que si vous n'avez pas de patients, il vous suffit d'en créer. Du point de vue de la médecine fondée sur l'expérience clinique, toute technologie nouvelle n'est pas une innovation. Le délégué sait fort bien qu'un grand nombre de technologies mises sur le marché donnent exactement les mêmes résultats mais pour un coût plus élevé et un avantage minime. Alors, si l'on désire définir la valeur ou créer de la valeur, il faut commencer par donner une définition de la qualité des soins. Des indicateurs de qualité peuvent être rendus publics mais il s'agit de mesures indirectes et pas toujours de la qualité clinique réelle des soins. Ces indicateurs peuvent accroître la sélection des risques : il vous suffit d'avoir de bons patients admis en cardiologie pour une intervention majeure et vous aurez de très bons résultats ; cela signifie que certaines

personnes sont laissées pour compte. Il convient de se demander si les patients peuvent effectivement prendre eux-mêmes la décision dans chaque situation, s'ils peuvent effectivement se comporter comme de véritables consommateurs. L'industrie pharmaceutique peut être une source majeure d'information pour les patients mais tous les éléments probants dont nous disposons ne sont pas objectifs ou indépendants.

Le Président a indiqué que lorsque les résultats des évaluations de la qualité ne sont pas portés à la connaissance des médecins qui prennent les décisions pour les patients (ou qui leur font des recommandations), la possibilité de comparer différentes alternatives s'en trouve amoindrie.

Un délégué américain a indiqué qu'un grand nombre d'études ont été faites aux Etats-Unis sur la manière de mesurer la qualité clinique des médecins dans les hôpitaux. La sélection des patients est un facteur majeur de complication. Si des hôpitaux ont une population moins aisée, on peut prédire que leurs résultats seront plus mauvais que ceux d'un autre hôpital. Néanmoins, on peut signaler des tentatives de mise en oeuvre des constats sur le marché. De l'avis personnel du délégué, les plans du secteur privé pour la santé sont mieux parvenus à maîtriser la concurrence au niveau de la qualité. Deux domaines sont à mentionner en particulier : l'un est la disparité des pratiques. Aux Etats-Unis, de nombreuses études ont été faites par des universitaires pour identifier certaines pratiques exemplaires pour le traitement des maladies qui donnent le meilleur résultat pour le moindre coût. Mais ces pratiques exemplaires ne sont pas appliquées de manière uniforme dans l'ensemble du pays. Ce qui s'est passé c'est que les plans de santé sont parvenus à guider les forces du marché pour obtenir de meilleurs résultats en termes de traitement de la maladie. Cela se produit non pas tant pour les traitements d'avant-garde que, par exemple, pour le traitement des maladies du rein. A l'autre extrême où ont été opérées certaines réformes fondées sur le marché on trouve le concept des centres d'excellence. Un délégué américain a expliqué pourquoi les agences de la concurrence ont vu dans les lois relatives au prestataire consentant le moyen de réduire la capacité des plans pour la santé à inciter à la pratique des contrats sélectifs reposant non seulement sur le prix mais aussi sur la qualité. Et l'un des phénomènes actuellement très répandus aux Etats-unis est le concept des centres d'excellence qui identifie, pour certains traitements de pointe, les hôpitaux ayant des praticiens de renommée, un important volume d'activité et la capacité de bien administrer le traitement. Un assureur peut orienter les patients vers ces centres, les y inciter financièrement et les coûts peuvent être tirés à la baisse par le volume d'activités de ces hôpitaux.

Un délégué du BIAC a pris la parole pour s'opposer à l'instauration d'une bureaucratie reposant sur une médecine fondée sur l'expérience clinique. Le BIAC pense que la qualité est mesurable et que les entreprises privées ne sont pas prêtes à acheter des actes ou des traitements médicaux à n'importe quel prix. On en sait suffisamment sur les coûts d'une intervention chirurgicale et sur ce qui constitue un bon traitement. Mais le BIAC ne voudrait pas que les assureurs publics instaurent une nouvelle bureaucratie fondée sur les statistiques qui imposerait de nouveaux traitements ou une forme de rationnement. Tout en parlant de concurrence, de nombreux pays ont déclaré y voir une menace pour la santé publique alors qu'en fait la concurrence renforcerait la santé publique. Il convient de ne pas imposer de normes collectives au secteur privé.

Solutions réglementaires pour empêcher un comportement stratégique des hôpitaux

Le Président a déclaré que l'un des principaux problèmes qui se pose dans les services hospitaliers où le secteur privé cohabite avec le secteur public est celui de l'écroulement. Les hôpitaux privés, qui appartiennent bien souvent à des médecins, sont à même de prendre aux hôpitaux publics les activités très rentables et de leur laisser les activités les moins rentables, ce qui peut engendrer une spirale de baisse de la qualité dans les hôpitaux publics. Parmi les solutions proposées figurent un certain nombre de solutions réglementaires qui évitent ce type de problème. Prenons le cas du Mexique où l'offre hospitalière est la plus faible des pays de l'OCDE avec seulement un lit pour 1000 habitants en 2003 contre une moyenne de 4.3 lits dans la zone OCDE. Au Mexique, le secteur privé représente 34% de l'offre et se concentre dans

les grandes villes des états riches : la ville de Mexico concentre plus de la moitié des hôpitaux privés. Mais les hôpitaux privés ont une faible capacité d'accueil : 3% seulement ont plus de 50 lits. De plus, la qualité des prestations des hôpitaux publics est relativement médiocre. Les médecins qui travaillent dans les hôpitaux publics travaillent aussi régulièrement dans le privé. La solution adoptée en Italie a été d'autoriser les médecins à avoir également une activité privée à l'intérieur de l'hôpital public. Mais une suggestion, qui semble pertinente pour éliminer le problème du conflit d'intérêts pour un médecin du public qui voit un patient en consultation et pourrait l'orienter vers la clinique privée dont il est propriétaire, serait de modifier la rémunération des médecins du public.

Pour répondre à la question, un délégué mexicain a suggéré d'adopter une vision plus intégrale du marché des services hospitaliers. L'examen, en 2005, du système de santé mexicain faisait trois grandes recommandations : 1) améliorer l'efficacité des hôpitaux, 2) accroître la productivité des professionnels des soins de santé et 3) garantir la qualité et le bon rapport coût-efficacité des soins de santé.

Concernant l'efficacité des hôpitaux, quatre propositions étaient formulées. La première était de séparer plus clairement la fonction de payeur et celle de prestataire en passant des accords avec les contractants pour réduire la segmentation actuelle du système. Il est très important, par exemple, d'autoriser les patients à choisir le prestataire, mais aussi d'autoriser le ministère de la Santé à acheter des soins auprès de tous les prestataires disponibles et pas uniquement auprès des prestataires du système national de santé. La seconde était de créer un régime à financement centralisé dans lequel les ressources des patients, sous réserve d'une coordination interinstitutionnelle appropriée, évolueraient progressivement d'une fonction assureur-prestataire à intégration verticale vers des fonctions assurance et prestation distinctes. La troisième était la création de mécanismes de paiement prospectifs ou davantage fondés sur le résultat qui sont plus efficaces que les méthodes traditionnelles d'affectation des ressources entre les établissements sur la base de plafonds budgétaires préétablis. Les mécanismes devraient être introduits au niveau fédéral et au niveau des Etats. La quatrième proposition était d'organiser l'achat de tous les services de soins de santé sur la base de circonscriptions hospitalières couvrant plusieurs Etats de manière à bénéficier d'économies d'échelle.

Pour accroître la productivité des professionnels de santé, trois propositions incluant l'un des éléments suggérés par le Président de séance, ont été formulées. La première était de lier la rémunération du personnel à des objectifs d'efficacité et de qualité. La deuxième était de modifier les systèmes de rémunération pour permettre aux praticiens de proposer des prestations privées dans les hôpitaux publics, ce qui est précisément ce que vous suggérez. Actuellement, le système de la rémunération au salaire incite les médecins des hôpitaux publics à avoir une activité régulière dans le privé. Pour que cela soit possible il faut, à l'évidence, accroître la capacité ou avoir une capacité excédentaire dans les hôpitaux publics, ce qui est un problème au Mexique mais la solution doit être une solution intégrée. La troisième proposition était de revoir les contrats de travail existants qui sont au Mexique un problème majeur car ils limitent la flexibilité de la gestion de sorte que les syndicats ont un droit de regard sur les décisions internes.

En termes de qualité et de rapport coût-efficacité des soins, une certification élargie des soins est proposée pour les établissements, le personnel de soins et les écoles de médecine ; cela pourrait contribuer à encourager l'amélioration de la qualité dans les unités de soins dont les performances sont insuffisantes. Des catégories multiples de certification inciteraient les hôpitaux à se différencier sur la base de la qualité des services. Les mécanismes de certification doivent être complétés par la transmission d'informations de manière à avoir sur ce marché un mécanisme de signalement bien meilleur.

Le Président a fait observer qu'à Taïwan, il est interdit aux médecins salariés (salaire ou salaire plus prime) des hôpitaux d'exercer à titre privé dans leur propre clinique. Il est très difficile de faire appliquer cette réglementation car s'il est possible de s'assurer qu'un médecin ne possède pas sa propre clinique, en revanche il est difficile de s'assurer qu'un de ses proches n'en possède pas. A l'inverse, les praticiens

privés ayant leur propre clinique ne bénéficient pas des privilèges de l'hôpital en complément de leur traitement privé. Le rapport reconnaît un phénomène de distorsion, lié au système de paiement, du choix d'une spécialisation pour les étudiants en médecine. La suppression de l'interdiction de la pratique privée éliminerait-elle le phénomène de distorsion? Ou a-t-on envisagé envisager d'autoriser la pratique privée à l'intérieur des hôpitaux publics?

Un délégué taïwanais a répondu que depuis 1996 Taïwan a mis en place un système obligatoire très exhaustif et pratiquement universel d'assurance des soins médicaux. En conséquence, Taïwan dispose d'un système national d'assurance dont la fonction est un rôle d'intermédiaire entre les prestataires de services médicaux et les patients. Comme vous pouvez l'imaginer, le résultat de la mise en œuvre d'un tel système est une concurrence au niveau des prix dans le secteur médical pratiquement inexistante car tous ces prestataires sont des établissements médico-hospitaliers qui sont en concurrence pour travailler avec le système national d'assurance. A Taïwan, tous les patients ont librement accès à tous les hôpitaux et à toutes les cliniques, de sorte que le système d'orientation n'est pas très répandu. La plupart des établissements sont des hôpitaux renommés appartenant à l'Etat. Tous les grands centres médicaux fonctionnent de manière très intégrée ; ils proposent une gamme complète de services, depuis les opérations très pointues du cerveau jusqu'aux services à grande échelle à des patients externes. Parmi tous les paiements effectués au titre du système d'assurance, des paiements importants sont liés au service des patients externes. En conséquence, les centres médicaux ne sont guère désireux d'offrir des services complémentaires aux médecins qui exploitent leur propre clinique privée. Comme nombre de ces centres médicaux sont exploités par l'Etat, les médecins ne sont traditionnellement pas autorisés à travailler à temps partiel dans leur propre cabinet privé. Il y a donc une ségrégation et une concurrence entre les centres médicaux nationaux à grande échelle et les cliniques privées. Une solution serait d'encourager la concurrence entre les médecins exploitant leur propre clinique et les centres médicaux à grande échelle, par exemple, par le biais d'une réglementation imposant aux hôpitaux nationaux de fournir aux médecins privés des prestations complémentaires si ceux-ci en font la demande. Mais une autre solution pourrait être d'éliminer les restrictions qui empêchent les médecins travaillant à plein temps pour des centres médicaux nationaux d'exercer une activité privée. Si ces solutions possibles peuvent être souhaitables, des problèmes plus structurels peuvent se poser à cause du système fermé de concurrence dans lequel il ne serait peut être pas idéal d'imposer par la force un environnement concurrentiel. A Taïwan, le marché des services médicaux génère en effet une sorte de fuite des cerveaux pour certaines spécialités médicales ; il y a dix ans, par exemple, la spécialisation la plus populaire auprès des étudiants en médecine était la chirurgie, l'anesthésie par exemple. Mais aujourd'hui les spécialisations les plus populaires ont évolué au profit de domaines tels que l'anatomo-pathologie, l'oto-rhino-laryngologie et la chirurgie esthétique. L'une des raisons de cette évolution est, bien entendu, le système de rémunération. Etudiants ou médecins craignent de galérer et de voir leurs revenus diminuer s'ils choisissent la chirurgie comme spécialité.

Le Président est passé ensuite à un sujet différent à l'intérieur de la solution réglementaire. De nombreux pays, en particulier ceux qui financent les services hospitaliers par l'impôt, sont en train de passer d'un système de dotation globale à un système dans lequel les hôpitaux sont remboursés pour les services qu'ils offrent effectivement. Au Danemark, par exemple, la médecine est généralement gratuite. Mais le rapport danois a déjà mentionné le fait que les pouvoirs publics ont instauré une autorité de contrôle indépendante pour l'évaluation de la qualité et le rapport parle souvent de la concurrence comme de l'élément moteur de la réforme récente. Par exemple, pour améliorer l'efficacité des hôpitaux dans les budgets fondés sur le résultat, un système de financement par groupes de diagnostics a été mis en place en 2002. Conséquence : 20% du financement des hôpitaux repose désormais sur des activités et, selon le rapport, ce pourcentage passera à 50% en 2007. La nouvelle procédure budgétaire incite financièrement les hôpitaux à accroître leur activité et à être plus efficaces. Mais, étant donné que les hôpitaux font partie de l'administration publique comment peut fonctionner le système des incitations? Quel est l'effet de ces incitations si les hôpitaux n'ont pas de problèmes de financement du fait que ce sont des établissements publics.

Un délégué du danois a répondu que pour inciter les hôpitaux à être performants et à accroître leur activité, on pourrait penser que des contrats fortement incitatifs seraient nécessaires. Or, au Danemark, ce type de contrat n'est pas encore utilisé. La procédure du budget fonctionnel implique que lorsqu'un hôpital accroît son activité, le montant du financement qu'il reçoit augmente et donc l'hôpital dispose de ressources plus importantes. La direction de l'hôpital est généralement incitée à accroître l'activité et à gérer efficacement l'hôpital car elle est responsable des performances. L'hôpital peut-être menacé de fermeture. Depuis les années 80, plusieurs petits hôpitaux peu performants ont été fermés. En outre, les hôpitaux qui ne sont pas performants risquent de perdre leur personnel du fait d'une baisse de leur financement. Il existe donc des incitations véritables à développer son activité et à être performants. Pour l'instant, il ne s'agit pas véritablement d'incitations fortes liant directement le salaire des dirigeants de l'hôpital aux performances de l'hôpital. Mais l'utilisation de ces contrats se développe.

Le Président a fait observer qu'en Norvège des pourcentages de DRG ont été introduits récemment pour accroître l'efficacité. Toutefois, la concurrence et l'efficacité de ce changement requièrent que les hôpitaux performants se développent et que ceux qui ne le sont pas puissent fermer. Mais cette attitude est-elle cohérente avec le caractère public des hôpitaux norvégiens?

Un délégué norvégien a répondu que les entreprises régionales de santé propriétaires d'hôpitaux sont tenues de présenter des comptes équilibrés. Mais, chaque année, si le résultat économique est négatif, ces entreprises peuvent émettre un emprunt pour combler l'écart. Ces émissions d'emprunts doivent toutefois être acceptées par le ministère. Sur le long terme, les comptes doivent donc être équilibrés et certaines années les entreprises doivent rembourser les emprunts. La réforme est entrée en vigueur en 2002 et désormais toutes les entreprises régionales ont des résultats négatifs et des emprunts relativement importants ; il reste donc à voir comment elle gèreront le problème dans les années à venir et si elles rembourseront réellement ces emprunts. Les entreprises de santé et les hôpitaux trouvent en effet les contraintes budgétaires plus grandes qu'avant la réforme.

Le Président a observé que depuis 2004, la France met en place un système de remboursement reposant sur des groupes de diagnostics, ce qui modifie profondément la nature du financement des hôpitaux. Comme dans d'autres pays, les taux seront calculés sur la base du détail des activités mais la France aura un niveau de paiement différent pour les établissements publics et pour les établissements privés. En outre, les paiements au titre des soins d'urgence seront effectués séparément. Parfois, il peut être difficile d'évaluer de manière indépendante si un épisode de soins constitue ou non une urgence.

Un délégué français a répondu que les hôpitaux, publics et privés, qui participent au service public sont rémunérés selon le même barème. Les hôpitaux privés en question peuvent être gérés par des associations ou par des organismes à but non lucratif. En revanche, les hôpitaux privés à but lucratif sont rémunérés selon un barème différent. De tout temps, les hôpitaux du service public ont reçu des paiements incluant la rémunération des médecins alors que les hôpitaux privés à but lucratif recevaient des paiements n'incluant pas la rémunération des médecins. Cette différence persiste et donc, pour le moment, il existe deux barèmes différents. L'un des objectifs de la réforme est d'améliorer la comparabilité entre les différents types de prestataires. L'intention est d'avoir au bout du compte un barème uniforme. Les hôpitaux publics sont en train d'adopter progressivement un financement basé sur le résultat mais, pour le moment, l'essentiel de leurs fonds provient toujours de dotations globales. Une étude récente de la CAM donne à penser que les hôpitaux privés à but lucratif ont pris une partie du marché des hôpitaux de service public, en particulier par le biais de la chirurgie ambulatoire.

Le Président a ouvert la séance de questions et commentaires.

Un expert belge a fait observer que le paiement à l'acte sans contraintes majeures accroît effectivement l'activité et l'offre et peut engendrer une surutilisation ou une mauvaise utilisation, mais en

revanche il génère souvent un degré élevé de satisfaction des clients. Le paiement par DRG est assurément un progrès par rapport au paiement à l'acte mais il n'est pas très utile pour juger de la qualité et de la pertinence des soins, par exemple pour la chirurgie ambulatoire. En Belgique, on observe un niveau élevé d'arthroscopies ambulatoires et pourtant on ne dispose guère d'indices que les personnes s'en portent mieux. Les essais de contrôles aléatoires donnent à penser qu'il n'y a guère de différence en terme de handicaps fonctionnels entre une arthroscopie, aucune opération et peut être une chirurgie fictive. Quelle que soit la réforme engagée, il faut mettre en place un système de suivi. La transition prend du temps, les réformes prennent du temps mais l'évaluation de l'impact requiert un contrôle des effets secondaires et des résultats médicaux et cliniques.

Un délégué du BIAC a déclaré que les assureurs font un effort considérable pour améliorer la qualité des pratiques médicales. En France, par exemple, le système public d'assurance maladie envoie ses médecins dans les cabinets des praticiens pour y examiner les prescriptions et procédures dans le but d'évaluer si ceux-ci ont fait trop ou trop peu de prescriptions et de procédures.

Application des lois antitrust

Le Président est passé à la section finale de la table ronde, centrée sur l'application des lois antitrust. Dans de nombreux pays, le caractère public des services hospitaliers a souvent empêché une implication active des autorités antitrust dans le secteur hospitalier. En Italie, par exemple, les hôpitaux publics font partie de l'administration publique et ne sont pas soumis à un examen antitrust minutieux, à l'exception des hôpitaux privés et des activités d'achats ou d'approvisionnements. De fait, les questions des marchés publics ou les questions liées aux négociations tarifaires tombent effectivement sous le coup des lois antitrust. Au Brésil, par exemple, le CADE est intervenu un certain nombre de fois contre les listes de prix de l'association médicale brésilienne au niveau national, au niveau des Etats ou au niveau local. Ce qui est frappant c'est que le rapport brésilien donne à penser que ces violations ont augmenté après l'intervention du CADE et que si elles sont devenues plus fréquentes c'est peut-être parce que le CADE possédait plus d'informations sur ces incidents.

Un délégué brésilien a déclaré que deux grandes pratiques de la région ont conduit à des actions en justice : l'une est la fixation des prix pour les prestations des médecins et l'autre est une forme d'exclusivité horizontale imposée principalement par les coopératives de médecins. Dans les deux cas, ces pratiques sont des violations des lois et, d'après ce que nous comprenons, leur résultat est analogue à celui obtenu lorsqu'on donne aux médecins la liberté de négocier collectivement avec des organisations médicales concurrentes. Les médecins disent qu'ils doivent s'organiser eux-mêmes contre les compagnies d'assurances ou les plans de santé, s'ils ne veulent pas être victimes d'abus. Ils s'organisent donc pour exercer une sorte de force d'équilibre. Outre les formes d'entente horizontale, le fait d'appliquer des prix uniformes et d'accorder à tous les praticiens la même rémunération économique quelles que soient leurs compétences, réduit l'intérêt de la formation ou la propension à utiliser des procédures innovantes. Ces contraintes dissuadent également les nouveaux médecins de se mettre sur le marché. Le CADE a donc bien compris que cette force d'équilibre aurait un impact négatif sur le bien-être social des consommateurs. Dans le même temps, un nombre croissant de violations a été identifié. Cela tient au plus grand nombre d'investigations effectuées mais également au fait que le CADE acquiert une renommée dans ce domaine. Aucune amende n'a été infligée au titre de ces violations. La raison en est que les tribunaux sont passés outre nos décisions. Pourquoi ? Parce que les juges évaluent la relation entre les médecins et l'entreprise de soins de santé mais qu'ils ne prennent pas toujours en compte le bien-être social. Ils ont donc le sentiment que le CADE ne concentre pas ses efforts sur les bonnes questions et ils s'opposent au recouvrement d'amendes. La loi sur les coopératives ne dit pas que celles-ci sont exemptées de l'application de la loi antitrust mais le juge pense parfois qu'elles le sont. Le CADE cherche à discuter ces questions avec les juges afin que des amendes puissent être infligées et de tels comportements découragés.

Le Président a déclaré que les autorités argentines font état d'une action antitrust dans le secteur hospitalier. Le sanatorium n'apportant aucune assistance aux personnes affiliées à l'agence de sécurité sociale, seuls les patients affiliés à un service de sécurité sociale bénéficiaient de ses services. On ne comprend pas très bien les raisons d'une telle situation dans la mesure où il est dans leur intérêt d'accepter des patients.

Un délégué argentin a expliqué que les services sont payés par les agences de sécurité sociale de la Union. En n'offrant pas de prestations aux patients affiliés aux agences de sécurité sociale de la Union ayant passé contrat avec d'autres cliniques et n'étant pas membres de cette association, ils contraignent ces agences à ne passer contrat qu'avec les cliniques affiliées à l'association. C'est pourquoi ce comportement excluait du marché les cliniques et autres associations.

Le Président en est venu au problème de la Nouvelle-Zélande dont le rapport décrit en détail une fusion intervenue entre deux hôpitaux d'Auckland. Concernant la définition du marché, le rapport argue que, pour certaines activités, hôpitaux publics et hôpitaux privés sont sur le même marché mais qu'en même temps les hôpitaux privés sont différents, en particulier pour la chirurgie électorive, car alors que les hôpitaux publics fournissent le service sur une base de coût total les hôpitaux privés ne fournissent que les installations et le patient doit négocier avec un médecin privé le coût de l'intervention. Il me semble toutefois que le fait que les deux produits soient différents ou distincts ne signifie pas qu'ils ne sont pas sur le même marché et en fait les autorités néo-zélandaises ont conclu que les produits étaient effectivement en concurrence en dépit du fait qu'ils étaient fournis de manière différente. Ce qui me semble encore plus intéressant dans la discussion du cas de la Nouvelle-Zélande c'est qu'il est fait état d'une forte élasticité de la demande de chirurgie électorive, ce qui implique que le degré de substitution est beaucoup plus important qu'on ne devrait s'y attendre. Le Président se demandait si cela avait eu des effets sur la définition du marché car lorsque l'élasticité de la demande est grande, le marché est normalement vaste.

Un délégué néo-zélandais a confirmé qu'en fait la Commission faisait une distinction entre le marché des travaux financés sur fonds publics et le marché des travaux financés sur fonds privés, estimant que les hôpitaux privés sont directement en concurrence avec les hôpitaux publics pour la chirurgie électorive alors que seule une faible quantité de travaux financés sur fonds privés est effectuée dans les hôpitaux publics. Le gouvernement a annoncé récemment une limitation de l'autorisation pour les hôpitaux publics de fournir des locaux aux chirurgiens du privé dans l'avenir. Du fait de ce changement récent de politique, la Commission a adopté une approche prudente de la définition du marché qui constitue véritablement un exercice pragmatique. Elle est là pour révéler tous les problèmes de concurrence pouvant résulter d'une proposition de fusion. La Commission a reconnu qu'il y avait à tout le moins des arguments en faveur d'un marché plus large mais elle a estimé que si ces arguments étaient forts ils aboutiraient de toute façon à une analyse de la concurrence. Lorsqu'elle a entrepris d'analyser la concurrence, la Commission a conclu in fine à l'existence d'une certaine contrainte générée par les hôpitaux publics, car la demande est relativement plus élastique qu'on ne s'y attendait. C'est pourquoi la Commission a entrepris une analyse de l'entrée sur la base d'un marché plus étroit et constaté en effet que l'entrée s'était produite récemment et que les barrières à l'entrée étaient faibles compte tenu également de certaines contraintes des systèmes publics. En conséquence, la Commission a pu donner son feu vert à la fusion. Si ces contraintes n'avaient pas existé, la Commission aurait été contrainte de demander plus de temps pour étudier la proposition de fusion. La question de l'ampleur du marché est particulièrement délicate dans le cas de la chirurgie électorive. Plus récemment, la Commission a étudié d'autres marchés sur lesquels les hôpitaux, publics et privés, sont en concurrence et dans chaque cas la pertinence d'une définition étroite du marché est apparue plus clairement.

Le Président a fait observer qu'en Italie le secteur hospitalier a connu certain nombre d'affaires de marchés publics pour les fournitures hospitalières et les médicaments, mais qu'il n'y a pas eu d'application de la loi antitrust pour les services hospitaliers en tant que tels du fait du caractère public de ces services

dans le pays. Toutefois, les autorités italiennes ont lancé récemment une investigation sur le rôle joué par l'interface public/privé dans les services hospitaliers. Le Président a demandé ce qui avait motivé cette investigation.

Un délégué italien a répondu qu'il existe deux grands domaines d'intérêt ou de plainte pour le secteur privé. Les hôpitaux privés peuvent demander aux autorités sanitaires locales un agrément ce qui signifie qu'ils sont autorisés à être remboursés sur des fonds publics pour des prestations rendues à leurs clients. L'accès à ce processus d'agrément est un facteur clé de l'intégration au secteur public de la santé. Dans certaines régions responsables de la prestation de services de santé, il n'y a eu aucune évaluation de demandes d'agrément en vingt ans. S'il n'y a pas de procédure d'agrément pendant un certain nombre d'années, les hôpitaux privés titulaires ne sont soumis à aucune pression concurrentielle. L'évaluation régionale des demandes d'agrément des différents hôpitaux fait donc l'objet d'une enquête.

Le deuxième domaine sur lequel porte l'enquête est le rôle des autorités sanitaires locales. En effet, ce rôle est double : elles payent tous les services financés sur fonds publics que ceux-ci soient dispensés par des hôpitaux publics ou par des hôpitaux privés agréés mais, en même temps, elles exploitent, gèrent et supervisent les hôpitaux publics. Les hôpitaux privés nous ont donc demandé d'examiner comment le système fonctionne dans les faits car les autorités locales ont tendance à favoriser les hôpitaux publics en termes de quantité de services remboursés. En fait, chaque année, les autorités sanitaires publiques décident du montant qui ira aux hôpitaux privés agréés et ce montant est établi sur la base de leur budget résiduel. Ainsi, il existe un tarif établi sur la base des DRG mais sa mise en œuvre prendra 12 ans, ce qui signifie qu'elle sera terminée à l'horizon 2010. Certains hôpitaux publics sont payés sur la base de leurs coûts historiques ce qui signifie qu'il reste un peu d'argent pour les hôpitaux privés agréés. Et ces derniers ne peuvent en aucune façon estimer, chaque année, l'argent qui sera affecté à leurs services dans le cadre du système public de santé. C'est donc là un autre domaine à examiner pour établir si des outils concurrentiels pourraient améliorer la situation.

Le Président a souligné que la Commission européenne est la seule délégation à avoir abordé la question des aides publiques dans sa contribution. La Commission fait appliquer au sein de l'UE les règles relatives aux aides publiques, en particulier l'article 86 du Traité CE qui admet, sous réserve que certaines conditions soient respectées, que l'on déroge à ces règles lorsqu'elles entraveraient la prestation d'un service d'intérêt général. En conséquence, le financement public des hôpitaux est autorisé dans l'UE s'il est nécessaire pour financer le coût de services de santé d'intérêt économique général et si l'indemnisation est limitée à ce coût. En revanche, il n'est pas possible d'utiliser des fonds publics pour subventionner des activités commerciales. Un certain nombre de questions se posent. Tout d'abord, qu'est-ce qu'une activité commerciale dans le secteur des services hospitaliers où il existe de fait un certain nombre de coûts fixes à affecter et où, comme on le sait, il n'existe pas de moyen mécanique d'allouer ces coûts d'une manière significative ? La manière la plus efficace d'affecter ces coûts consiste à utiliser les règles de Ramsey qui établissent que ces coûts sont inversement proportionnels à l'élasticité de la demande mais ces règles sont relativement difficiles à mettre en œuvre pour les soins de santé.

Un délégué de la Commission européenne a fait remarquer qu'étant donné le coût élevés des investissements dans ce domaine, il est fondamental de contrôler les subventions croisées potentielles. Dans de nombreux Etats membres de l'Union, une intervention de l'Etat se fait à deux niveaux. D'une part, les Etats membres financent largement les investissements en rapport avec la sécurité sociale effectués par les hôpitaux participant au système de soins de santé. Mais l'intervention de l'Etat ne s'arrête pas là, elle va bien au-delà ; dans bon nombre de cas, et pas seulement pour les hôpitaux publics, les Etats membres accordent également des subventions d'exploitation couvrant éventuellement les pertes des hôpitaux. Dans ce cas, le risque est en fait très grand que l'argent accordé initialement pour financer la sécurité sociale ou les services publics interfinancent des activités sur des marchés ouverts à la concurrence et où opèrent à la fois des hôpitaux publics et des hôpitaux privés. D'autre part, le matériel des hôpitaux a en fait une double

utilisation : vous pouvez l'utiliser pour des patients que vous traitez dans le cadre du système de sécurité sociale mais vous pouvez aussi l'utiliser pour des patients venant d'autres secteurs du marché ouverts à la concurrence. Il est donc fondamental de mettre en place des contrôles suffisants du système d'affectation des frais communs utilisé par les hôpitaux. Quant au mode d'affectation des coûts entre les marchés ouverts à la concurrence et les marchés réglementés, il fait largement débat. En fait, la Commission européenne a commencé à intervenir dans ce domaine et pense que les Etats membres doivent faire un effort pour clarifier la définition des tâches qui sont confiées aux hôpitaux concernant le système de sécurité sociale mais aussi en termes de transparence quant aux moyens mis à la disposition de ces hôpitaux pour couvrir les coûts de ces activités. Selon la situation de l'hôpital et selon le matériel, la Commission pourrait discuter avec les autorités des Etats membres de moyens appropriés d'affectation des coûts communs de ce matériel qui fait l'objet de cette double utilisation.

Le Président s'est demandé si l'on pourrait fournir un exemple de service commercial au sein d'un hôpital qui devrait être protégé par les règles relatives aux aides publiques.

Un délégué de la Commission européenne a affirmé que la réponse dépend de la position de l'Etat membre car, selon la législation communautaire, il incombe aux Etats membres de définir le champ des services publics à fournir dans certains domaines de l'activité économique. Dans le domaine de la santé publique, il incombe aux Etats membres de définir les activités de soins de santé qui relèvent du système de sécurité sociale. Selon la législation communautaire et la jurisprudence, cette partie de l'activité sort du cadre d'application des règles sur les aides publiques et la concurrence. Bien entendu, il y a d'autres activités qui vont au-delà de ces activités : ce sont les services d'intérêt économique général. Il appartient à l'Etat membre de définir le champ de ces services. La Commission peut commencer à appliquer l'article 86-2 et fondamentalement le rôle de la Commission serait de garantir qu'il n'y a pas surindemnisation des coûts liés à la fourniture de cette activité. La réponse à votre question dépend donc du choix de l'Etat membre car celui-ci peut choisir le champ de ces services d'intérêt économique général dans le système de soins de santé.

Discussion générale

Le Président a donné le signal de la discussion générale.

Un délégué de la Nouvelle-Zélande déclare que, depuis un certain nombre d'années, le secteur de la santé est une priorité de la Commission néo-zélandaise du commerce. Comme l'ont constaté certains de nos collègues, ce domaine englobe un grand nombre d'actions préoccupantes, en particulier côté application. La Commission a obtenu gain de cause dans certaines procédures contre les ophtalmologues et la société qui les représente. Dans une deuxième affaire contre les ophtalmologues, une décision est attendue de la Haute Cour concernant l'acceptation d'un accord qui a été trouvé et aux termes duquel ils reconnaissent, une fois encore, leur responsabilité pour une nouvelle infraction à la législation néo-zélandaise sur le commerce. Au moins six autres investigations sont en cours en Nouvelle-Zélande au sein des professions médicales. Parallèlement, on assiste à l'émergence de la concurrence dans certains domaines. Bien souvent, cette concurrence apparaît en amont et en aval des hôpitaux publics. Il est important que cette concurrence perdure. L'un des problèmes qui a été récemment porté à l'attention de la Commission est une tendance des hôpitaux publics à ne vouloir négocier qu'avec une seule partie dans le secteur privé. Ils passent des contrats de longue durée pouvant aller bien souvent jusqu'à 10 ans. S'efforcer de réaliser des profits à court terme et ne pas chercher à voir d'où viendra la concurrence dans l'avenir témoigne d'une attitude très court-termiste. Les parties privées disent constamment à la Commission de prendre en compte la force d'équilibre du secteur public. Pourtant la manière dont les contrats sont conclus et dont les appels d'offres sont organisés n'indiquent guère que le secteur public utilise cette force d'équilibre comme on pourrait s'y attendre ou l'espérer dans un contexte de concurrence. Dans le même temps, le secteur privé argue de plus en plus que le système de santé en général devrait être exempté de

l'application du Commerce Act. Le gouvernement a certes fait quelques pas dans ce sens mais jusqu'ici il a résisté. Le délégué a déclaré qu'il est essentiel qu'un organisme comme ce Groupe de travail renforce l'importance de la concurrence et de loi sur la concurrence dans le secteur de la santé.

Un délégué des Etats-Unis a noté qu'une caractéristique des marchés hospitaliers américains mérite d'être soulignée. Aux Etats-Unis, les hôpitaux se font concurrence comme d'autres acteurs du marché dans d'autres secteurs. En conséquence, ils ont souvent des comportements qui conduisent à craindre des violations des lois antitrust. Pendant des décennies, les hôpitaux se sont impliqués dans l'application des lois antitrust, mais ils l'ont également conduite. Les commentaires du délégué néo-zélandais sur le rôle des médecins dans cette concurrence sont importants car une caractéristique très visible de la concurrence en milieu hospitalier est la manière dont les médecins influencent le choix d'un hôpital par les patients. Et s'il est un domaine dans lequel le Département américain de la Justice (DOJ) et la Commission fédérale américaine du Commerce ont été très actifs c'est celui de la protection contre une orchestration des hôpitaux par les médecins de sorte que non seulement les médecins s'entendent sur les prix mais qu'ils ne soient plus des facilitateurs de la concurrence entre hôpitaux. Les hôpitaux en position dominante prendront les médecins dans leur staff médical et les organiseront de telle sorte que les acheteurs ne puissent se servir de la concurrence pour mettre au pas ces hôpitaux. Une autre mesure observée récemment aux Etats-Unis est l'utilisation par les hôpitaux de l'accès à l'hôpital comme moyen de mettre au pas les médecins qui ne privilégient pas cet hôpital ou qui s'efforcent d'orienter les patients vers des hôpitaux en concurrence avec l'hôpital imposant les restrictions. Non seulement le gouvernement a mené des investigations dans ce domaine mais de nombreux médecins ont intenté ou menacé d'intenter des actions à titre privé contre les hôpitaux ayant ce type de comportement monopolistique.

Le Président a conclu que, selon les commentaires du délégué néo-zélandais, il y a place pour la concurrence dans les services hospitaliers dans tous nos pays mais de nombreux membres sont en plein processus de transition ce qui n'est pas facile. La concurrence dans les services hospitaliers requiert un cadre réglementaire actif qui promeut la concurrence. De nombreux pays se dirigent vers un remboursement par DRG. Si l'adoption d'un nouveau système de rémunération n'améliore pas les finances des hôpitaux, alors les gains de qualité et d'efficacité ne sont pas pour demain.

L'exemple italien a montré clairement que lorsque l'autorité réglementaire est en même temps propriétaire et contrôleur des hôpitaux publics, il devient très difficile pour elle d'être indépendante. Le Danemark a discuté de l'évaluation de la qualité. Mais l'indépendance est également un problème important, en particulier pour la diffusion d'informations sur les rapports relatifs à la qualité. La qualité elle-même est difficile à mesurer. Il y a encore beaucoup à faire avant que la concurrence dans les services hospitaliers soit pleinement effective dans la plupart des pays. Lorsque cela est bénéfique, la réglementation doit être ajustée pour autoriser la concurrence et la promouvoir. La rivalité, même au sein d'un système public, peut avoir des effets bénéfiques importants pour les citoyens.