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Incentivising competition in public services – Note by Carol Propper

This paper by Professor Carol Propper (Imperial College London) was submitted by the author as part of the background material in support of their presentation at the Workshop on Competition in Publicly Funded Markets on 28 February 2019.

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More documentation related to this discussion can be found at:

<http://www.oecd.org/daf/competition/workshop-on-competition-in-publicly-funded-markets.htm>

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1. Introduction

1. Policy makers, particularly in the field of public services, where public finance generally plays a high role, are concerned about cost and productivity. A common reform approach is to promote competition, either in or for the market. This has a simple political appeal in heavily regulated public service markets that are characterised by high levels of public spending, low productivity growth and low levels of responsiveness to users. However, consolidation in many markets, including those for public services has raised questions about the functioning of markets in these services. The big question is therefore is competition whether competition is welfare enhancing.

2. The state of play in academic research on competition in public services is such that this large question is at present unanswerable. However, it is possible to look at the various tools that have been used to competition in public services and ask whether they have brought about gains for consumers. This is really an empirical question and this paper provides an overview of the lessons from research. As it turns out that institutional details matter, the empirical research here relates primarily to healthcare markets.

2. The nature of competition

3. For many public services, direct competition to provide a service is possible. Even for goods for which distance to a provider matters to consumers, the scale of the provider may be small enough that several providers can co-exist. Such services include primary healthcare, nursing homes, schools, social services provided in a community setting and secondary care healthcare providers. The role of the government in these cases is to set the rules by which public service providers compete to provide publicly funded services. In cases where multiple providers are not sustainable, then competition for the market is possible.

4. The case is made more complex when the service providers also include providers who are public sector employees (which may be labelled state owned enterprises or SOEs). The reason is that these organisations often have been established as monopolies, either because the economics of production means that only one firm is viable in a market, or because they were established as the sole provider of services for a population in a geographical area. As SOEs, these organisations often have to meet multiple goals, including equity as well as efficiency goals. In addition, they often use labour whose price is negotiated at central or local level rather than set by individual firms.

5. One further complication is that for some services consumers are not the direct buyers of these services. Instead purchase decisions are made on their behalf by insurers (often part or fully publicly funded). Consumers may or may not have choice of who is their insurer.

3. Tools to achieve competition in public services

6. The various tools that governments have used to promote competition in public services include:

- Autonomy from central or local control over decision making (this is relevant to those organisations that are within the public sector)

- The provision of information to allow buyers and/or users of these services to allow them to compare service providers
- The use of this, or other information, to promote yardstick competition on quality (for example, through the creation of league tables accompanied by financial or non-financial rewards and penalties)
- Use of centrally regulated prices

4. Evidence

7. The case studies considered here relate to attempts to promote competition in European healthcare markets, though not all the evidence is confined to European healthcare markets and in some cases the evidence can probably be read across to other non-healthcare providers who share features of demand and supply with healthcare suppliers. In all these markets, geographical location is an important component of provision. In European healthcare systems, state funded or partially state funded insurance covers the costs of consumers of use of these services, so competition between suppliers is mostly in terms of quality rather than price.

8. Within these markets, there are firms over which consumers have direct choice and those for which an insurer organisation channels consumer demand (to a greater or lesser extent). The former are providers of primary care (healthcare taken in the community) so are family doctors and – in some healthcare systems – specialists. The latter are providers of secondary – in hospital – care. In their scale, healthcare providers encompass many other public service providers where location is an important dimension of the service and for which consumers are fully or partially co-insured by the state. Family doctors are smaller than schools, nursing homes, providers of community social and healthcare services. Hospitals are larger than almost all other providers of public services.

9. Separation of provision from funding has been an important dimension of pro-competitive policy, though it is not necessary for competition in healthcare markets. One possible reform model is competition between vertically integrated insurers and healthcare providers (the USA HMO model). However, no governments in Europe have implemented such a system. In some systems there is choice over the insurer, on other systems there is not.

10. Separation of provision from funding is also accompanied by giving producers of care more control over production. This may be in terms of prices of outputs, prices and quantities of inputs, distribution rules over surpluses, and greater autonomy from central or local government control.

4.1. Issues in competition in financing of healthcare

11. In NHS type systems (e.g. the Nordic countries, the UK, Italy, Spain) there is generally no choice of insurer by the consumer. This means there is no role for consumer pressure to make the insurer body more efficient or responsive to local needs. Autonomy over what is purchased varies between systems. In the UK for example, while nominally delegated to local level, it is often overridden by central government regulation or intervention. In the Nordic countries, more decisions are made at local (country council or region) level.

12. In social and private insurance system, there is consumer choice of insurer and pro-competitive policies have increased this competition. However, to meet equity concerns, such competition is accompanied by high levels of risk adjustment, designed to prevent insurers selecting patients on the basis of (low) risk. This in turn limits the incentives for competition between insurers. Insurer competition may also be limited by government regulations designed to allow free choice of secondary care providers (for example, Switzerland mandated that all insurers must include all hospitals in their insurance packages).

13. In practice, in the system which is most developed in terms of competition on the insurance side (the Netherlands) has seen considerable consolidation of insurers, with the exit of smaller insurers. This development is not confined to the Netherlands: it has also occurred on a large scale in the USA. The impact of this consolidation on consumer welfare is not necessarily negative: insurers may need to be larger in order to bargain successfully with hospital chains. The issue is then how much of these gains are passed to consumers. There is little evidence for Europe on this.

4.2. Price regulation of outputs

14. In setting the ‘rules of the game’ regulators can either set centrally regulated prices for services (known as prospective payments) or allow negotiated contracts between supplier and insurer. The key example of the former is DRG pricing used in the USA to provide central government funding for care for the elderly under the Medicare system). Prospective prices are a means to encourage yardstick competition in supply. There are several European versions of the DRG system.

15. Prospective payments give incentives to keep down costs and increase volumes if the regulated prices are above marginal cost. They are meant to allow negotiations to focus on quality as prices are fixed. However, they also given incentives to skimp on quality if payments for readmissions are above marginal cost. The evidence from a variety of studies suggest:

- Prospective prices are accompanied by an increase in (some aspects of) quality (Norway, UK), increased activity (UK, USA) and appear to have no impact on equity (defined in terms of access and distribution of outcomes) (UK evidence)

16. The effect on quality of negotiated contracts covering volume and quality depends on relative elasticities of price and quality. These elasticities will depend on how sensitive buyers are to price and how much information there is on quality. If the former is high and the latter is low, it is more likely that competition will be in terms of price, thus driving down quality.

- Evidence is primarily from USA and UK (where in the latter they appear to have decreased unmeasured quality but increased volume)
- Little robust evidence from Netherlands and Germany as publication of quality metrics were only introduced at the same time as pro-competitive policies were enacted.

4.3. Price and other regulation of inputs

17. Prices of inputs are frequently regulated in healthcare markets through either national or local wage bargaining. This is justified on the grounds of reducing transaction

costs for small employers, but is more often undertaken for equity reasons (“a healthcare worker in location A does the same tasks as a healthcare worker in location B, so should be paid the same amount”). The problem is that adjustments for local cost differences in wages are often not updated to reflect local market conditions. The evidence suggests that

- National wage regulation decreases quality (health and education) and this may be net welfare reducing
- Constraints on entry give providers rent but empirically there is relatively little evidence of rent/welfare trade-off

4.4. Autonomy over surpluses, inputs, and production

18. This is generally part of pro-competitive reform packages for SOEs. In practice, these are often subsequently eroded, limiting scope for gains from competition.

19. There is widespread use of targets to focus the activities of SOEs on government objectives, inside and outside of healthcare production. All targets have potentially unintended (negative) consequences and frequently changing targets may limit suppliers to meet them. For healthcare, there is evidence from the UK that suppliers respond to waiting times targets. The most robust evidence suggests that this has reduced waiting times without negative consequences for consumers.

20. Granting suppliers greater autonomy over production may result in gains. For example, there is evidence that managerial quality, which can be thought of as either an input into production or the quality of inputs, raises productivity in non-healthcare settings. In healthcare it has been shown in many contexts to be positively associated with wide range of hospital outcomes. Empirical evidence from one study for the UK suggests that managerial quality is higher for hospitals located in more competitive markets.

4.5. Promoting of competition by increasing private sector entry

21. This policy has been adopted in several public service markets (prisons, schools, healthcare) to increase capacity. It is also related to the ‘make or buy’ decision where all production is contracted out to the market. It is beyond the scope of this review to survey the wide experience. In healthcare, this issue is more controversial in NHS type healthcare systems than in social insurance systems. Opponents argue that allowing private providers alongside public providers allows the former to cream skim, with negative equity consequences. In fact, the evidence (mainly from the UK) suggests that while private providers do focus their attention on healthier patients, there is less evidence that these patients benefit more or that public patients are harmed. However, this is still a very open issue.

5. More general issues in promotion of competition in healthcare markets

22. Markets across Europe (and the USA) display strong trends to consolidation on both the insurer and provider sides of the market (e.g. Germany, UK and Netherlands). Studies of mergers between providers in USA and UK conclude that mergers between providers led to price rises in the case of hospitals, with limited consumer benefits. This is, given the large increase in consolidation, an area that needs much more research in Europe.

23. On the insurer side, the widespread use of risk adjustment limits competition. There is perhaps a need to think about using higher subsidies to support poorer consumers and reducing risk adjustment.

24. In terms of evidence, the fact that multiple policies are often introduced at the same time (for example, provision of information accompanies other pro-competitive policies) makes robust policy evaluation difficult. In addition, most studies to date have not been able to undertake welfare analyses: instead they have examined whether a small number of factors change after a policy has been implemented.