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Designing Publicly Funded Healthcare Markets

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

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Designing Publicly Funded Healthcare Markets[*]

Governments around the world provide public funding for healthcare to address the failures that arise when healthcare markets are left to their own devices. However, public funding alone, does not incentivise high quality efficient healthcare. Most OECD countries have therefore moved away from command-and-control systems, separated their role as buyer from the role of providing services, and sought to incentivise providers, using regulation to ensure a minimum acceptable level of quality, while using choice and competition to incentivise providers to become more efficient and to invest savings in improving the quality of care.

However, variations in indicators of clinical quality and patient centred care (the provision of care that focuses on the needs of the patient) suggest these incentives are often too weak. Moreover, the role of choice and competition can become marginalised, particularly when budgets are tight and patient-centred care comes to be perceived as an expensive luxury. This paper therefore argues that there is a need for competition agencies to become more active and effective advocates for the use of choice and competition in publicly funded healthcare markets. It suggests that the need for strong regulation will not shrink or disappear, as it might do in a utility, and so advocacy should not focus simply on deregulating, but instead on designing smarter regulations that create markets that incentivise competition on aspects of the service that patients and payers care about most. Drawing on the literature and different examples of pro-competitive reforms that have been undertaken in different countries, it identifies 10 key policy decisions that make a difference when introducing or reforming competitive forces in healthcare markets.

[*] This paper was prepared by Chris Pike of the OECD Competition Division.

Executive Summary

1. This paper argues that there is a need for competition agencies to become more active and effective advocates for the use of choice and competition in healthcare markets. It suggests that this advocacy should not focus simply on deregulating, but instead on smarter design and regulations that build upon the solutions to key market failures by using choice and competition more effectively to resolve the failure of command and control policies to achieve the desired goals. For example, a number of key suggestions emerge which competition agencies may wish to reflect upon in their advocacy.

2. Firstly, giving patients the right to make meaningful choices wherever possible (rather than having procurers choose for them) creates stronger competitive incentives on the aspects of the service that matter to patients, leading care to become patient-centred. Empowering patients to make these choices means not only giving them the information they need, but also personalised advice on interpreting it, and partially reimbursing travel costs.

3. Secondly, at an institutional level it is fundamental that the split between purchasers and providers be maintained and be strengthened where possible. For instance, if providers are to be given an additional purchasing role, for instance a capitated budget from which to purchase care for their patients, then competition between these provider/insurers must be assured. As the FTC have shown in US in respect to the new Accountable Care Organisations, there is a role for competition agencies to provide guidance on this. Competition agencies can helpfully clarify whether or not public hospitals are single economic entities, or indeed undertakings, and which competition rules apply in publicly funded healthcare markets. For example, this may help them to educate healthcare providers (and particularly primary care practitioners) on their duty to comply with competition law. The split between purchasers and providers should also apply to regulation where there should be no conflicts of interest between those responsible for incentivising providers to compete and those with interests in the financial stability of publicly owned providers.

4. Thirdly, on payment systems, if prices are regulated it is important that the units of payment that providers compete to supply are defined to reflect an efficient use of resources. In some cases this might mean capitation (e.g. for primary care services and those with long-term conditions). In others, it will mean a bundle of services that goes beyond the small bundles that are currently used and includes readmissions and follow-ups related to the treatment in question. Since enabling insurers to selectively contract does not appear, as yet, to have driven down prices, there would seem to be a good case for an independent regulator to set a fixed price level for each bundle of services. We argue that any regulated prices should be set at levels that ensure that there is an incentive to compete for each patient. This happens naturally when prices are unregulated. However, if prices are regulated this will require detailed patient level cost data and should be supported by a prohibition on providers selecting the patients they want to treat, since selecting low-cost patients distorts competition.

5. Fourth, it should be recognised that there are different types of healthcare services, and that the best solutions for some services are not the same as for all. This is not the case for mental health services, though patients have often been denied the same rights to choose, and to have providers compete for their choices, that have been given to patients requiring physical health services. However, it is the case for emergency services, which require a very different use of competitive mechanisms from planned care. For example,

there is a good case for fixed price procurements of these emergency services. Furthermore, if in those cases procurers are unsure of their ability to hold bidders to the promises they make during the bidding, then there may even be a case for limiting the bidders to non-profit making providers. In such cases, it is especially important that there be a clear accounting separation between the emergency services that would then be provided under a public service obligation, and the planned care market in which all providers should be licensed to compete.

6. Finally, barriers to entry such as the ability for qualified providers to obtain a contract to offer services, or to expand their capacity, need to be addressed in order to enable innovation and increased capacity onto the market, to reduce waiting times and drive competition on quality. In these markets, created and funded by governments, there is perhaps an additional question of whether these subsidies can be too easily captured by firms, thereby creating a straight transfer from taxpayers to shareholders that can be expected to drive rent seeking. Hence, whether licenses should be available to profit-making firms or only to non-profits will depend on market specific factors. For instance, whether patients have adequate information on quality, whether at the point of choice patients choose based on the factors they care about, and whether firms can in practice be effectively held to deliver the quality described in their bids for contracts.

7. More important from a competition perspective is that failing providers that are unable to provide good services in an efficient fashion need to be allowed to exit the market. Special administration regimes will be required to ensure that in these instances the transition to a new operator of the hospital or facility in question occurs smoothly and with disrupting the care of patients. This should recognise that the closure of emergency departments is a politically sensitive issue and these decisions should be taken by purchasers on the basis of transparent needs assessments, and should not follow as a consequence of provider failure (since this punishes patients in the local area for the failures of the hospital's management).

1. Introduction

8. Access to quality healthcare is an essential input into leading a productive, fulfilling, and satisfying life. However, it has long been accepted by economists that free markets cannot deliver the healthcare services that a society needs, due to the failures that arise when healthcare markets are left to their own devices (Arrow, 1963).[1] At the same time, where government has adopted a command-and-control approach to providing these services, this has generally led, predictably, to services that are both unresponsive to patients and inefficient (government rather than market failure).[2] The result has been a move towards a pragmatic third way, in which governments have created and shaped healthcare markets through the provision of subsidies, the application of minimum regulatory standards, and the careful use of choice and competition.[3] Indeed, while those systems with poor coverage or high co-payments have moved towards universal coverage, few healthcare systems in the OECD now persist with the idea that the incentives created by choice and competition do not play a role in improving the quality and efficiency of healthcare services.[4]

9. However, in practice this role can be marginalised, particularly when budgets are tight and patient-centred care (the provision of care that focuses on the needs of the patient) comes to be perceived by policymakers as an expensive luxury. Since healthcare systems across the OECD now face unprecedented challenges in terms of the demands that aging

populations place upon them, and tight budgets that remain in place following the financial crisis, *there is a need for competition agencies to be active and effective advocates for the use of choice and competition in these markets*.

10. Over the last 20 years, there has been a lot of progress and experimentation with different pro-competitive reforms in publicly funded healthcare markets, using market mechanisms in different ways to achieve more efficient and more equitable outcomes. These reforms have strengthened competitive incentives and enabled providers and insurers to respond to those incentives. For example, they have separated providers from payers and made the incomes of providers (or insurers) dependent on choices made by patients and/or their referring doctor. They have also given greater autonomy to state-owned entities to respond to competitive incentives; they have loosened restrictions on entry and expansion by others into providing services; and they have given patients information to help them choose better providers, and insurers the ability to selectively contract with providers. At the same time, they have sought to shape incentives to encourage competition on aspects of the service that patients and payers care about most. For example, by setting the unit of payment, setting price levels, and giving patients information and guidance so that they can choose their provider, while making sure that providers cannot choose their patients.

11. However, while there are some exceptions, competition agencies have been remarkably quiet, at least in public, in advocating for and advising on the design of these reforms. This has left a vacuum in which critics of choice and competition have advocated for a more paternalistic approach, and have dismissed pro-competitive reforms as resting upon a - so-called - 'neo-liberal' faith in markets being the answer to every policy problem that arises (Pollack et al, 2016, Monbiot, 2016, Toynbee, 2013).[5]

12. This criticism, however, is to ignore the fact that those designing pro-competitive reforms in this area have shown themselves to be acutely aware of the different reasons that healthcare markets fail. As a result, these pro-competitive reforms have not sought to question, challenge or undermine the fundamental role that the state has to play in funding healthcare services. Indeed, they have run in parallel with progress to towards increasing universal healthcare coverage in OECD countries. Instead, these reforms have focused on finding a way to resolve the manifest failures of the command-and-control approach (wide variation in quality, access and inefficiency) to providing these services, while at the same time taking care not to damage the effective solutions that states have put in place to address the market failures identified by Arrow.

13. In essence, the case for state intervention to resolve first order market failures has been accepted. The state's role in buying healthcare is a crucial one and that will not change. Instead, the policy debate has moved onto the best way to resolve the second order failures of direct government command-and-control to improve services. These efforts therefore seek not to remove, but to build upon, and improve the effectiveness of, the state intervention that is required for the delivery of high quality, efficient, patient centred services.

14. By learning the lessons from the reforms that have taken place, competition agencies can become more confident and effective in their advocacy in these markets. While healthcare can be a political minefield, this is precisely why a strong and well-informed voice from competition agencies is required for good regulation and good policymaking. Moreover, to the extent that choice and competition reform of publicly funded services becomes discredited in an uninformed public debate, this undermines public support for the use of market mechanisms throughout the economy, and leads to

regulatory action as a first and not last resort. This means that agencies must overcome any understandable reluctance to get involved.

15. The effectiveness of agencies' advice is particularly important because in these markets, the rationale for regulation is not a transitory one, and so the need for strong regulation will not shrink or disappear, as it might do in a utility. Therefore, competition agencies should not advocate simply for deregulation. Instead, they need to advocate for smarter regulation and market design that uses choice and competition alongside regulation to create a coherent set of incentives.

16. Agencies should recognise that there is not always a singular right answer, and so they should also listen to and engage with policymakers, and tailor their advice to the objectives of the policymakers. For example whether quality, cost efficiency, or cost containment are a priority, whether increasing access or reducing health inequalities are also important goals, and whether patient-centred care is a priority or whether basic standards need to be achieved first. They should also be realistic on how the system will function in practice, and anticipate that in their advice. For example, it is important to understand how much provider risk is acceptable to policymakers in order to improve outcomes and whether the safeguards against supplier-induced demand are strong enough (or whether in practice they will end up being backstopped by crude distortionary rules that limit capacity).

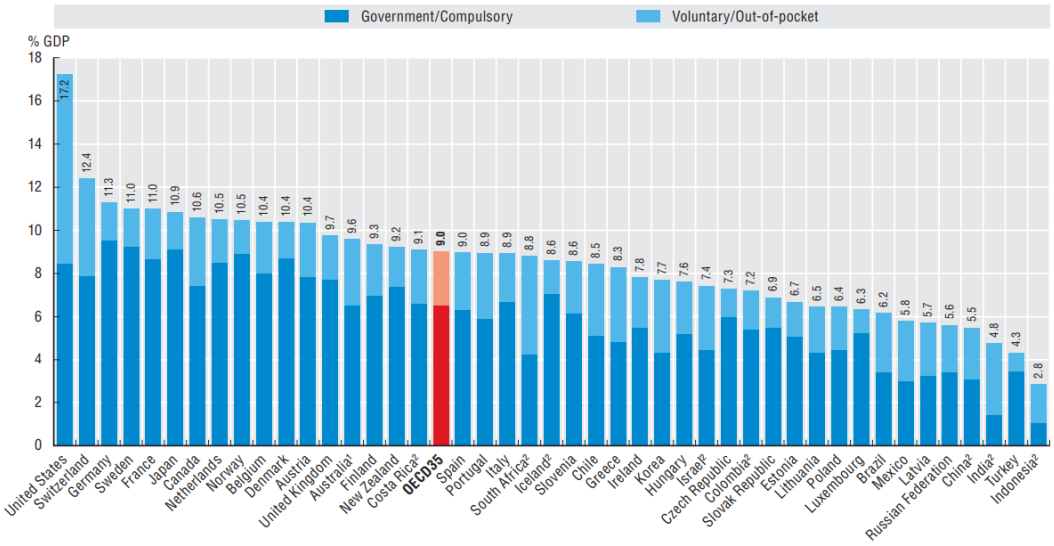
17. In this background note, we first provide some context on the comparative performance of different systems, and then explore some of the different examples of pro-competitive reform of healthcare services that have taken place in OECD countries. We identify the ways in which these reforms have generally complemented the policies that resolve first order market failures, as well as the extent to which those reforms create additional costs. Drawing on these examples and the literature we then identify 10 key decisions that make a difference when introducing or reforming competitive forces in healthcare markets.

2. Context

18. Expenditure on publicly funded healthcare differs significantly amongst OECD countries (see Figure 1). This reflects the different choices and priorities in different systems, and inevitably has an important impact on what can be achieved in terms of quality. However, as we will see there is not a reliable relationship between expenditure and outcomes, and so simply increasing funding may not achieve the improved outcomes that policymakers might be looking for. Choice and competition are one of a number of different policy tools that are therefore used to improve outcomes without increasing the funding of the system.

19. At the same time, expenditure is also driven by the efficiency, or lack of efficiency with which services are provided. Choice and competition therefore also offer an important way to incentivise providers to become more efficient. This efficiency, rather than rationing care is what ultimately enables systems to do more with less.

Figure 1. Health Expenditure as a share of GDP, 2016 (or nearest year)

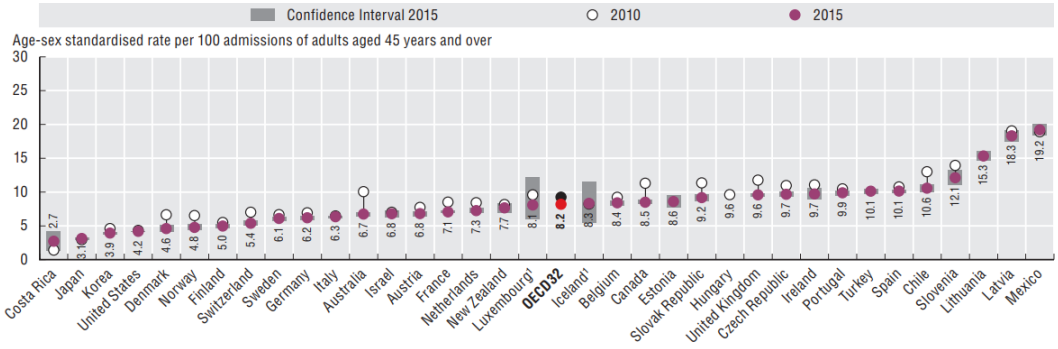


Note: Expenditure excludes investments, unless otherwise stated.
1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.
2. Includes investments.
Source: OECD Health Statistics 2017, WHO Global Health Expenditure Database.

20. There are many different health outcome measures, and as we note in section 4.2 the OECD is currently in the process of building internationally standardised measures of patient outcomes and experiences through its Patient Reported Indicators Survey (PaRIS). However, mortality rates for diseases that have been treated in hospital can be used as indicators of the effectiveness of hospitals and/or systems. These can vary significantly depending on the particular disease or condition, and this multi-dimensional aspect of quality makes the formulation of composite quality indicators a very difficult task. To illustrate we provide below in Figure 2 the 30-day mortality rate after admission to hospital for a stroke or a heart attack. We also provide the mortality rate for those with breast cancer which reflect on the effectiveness of both hospital and primary care.

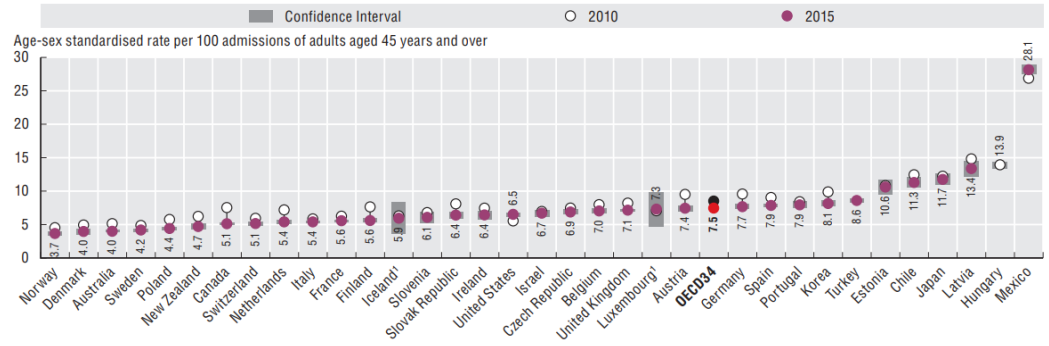
21. Notably there is no clear mapping between those that spend most (see Figure 1) and those that achieve the best outcomes (see Figure 2, Figure 3 and Figure 4). Moreover there is an inconsistent picture across outcome measures reflecting the fact that each system has its own strengths and weaknesses, and may face its own particular challenges. Moreover, in each system there are substantial differences in outcomes across different providers. In each system, policymakers will therefore be asking themselves how they plan to achieve better outcomes. Some might simply plan to spend more and hope that the additional expenditure is used wisely; others might combine this with raising the minimum regulated standards of the services. Where competition agencies can help is by identifying the advantages of decentralising decision-making and creating incentives that allow providers the opportunity to work out how best to improve outcomes.

Figure 2. Thirty-day mortality after admission to hospital for ischaemic stroke based on unlinked data, 2010 and 2015 (or nearest year)



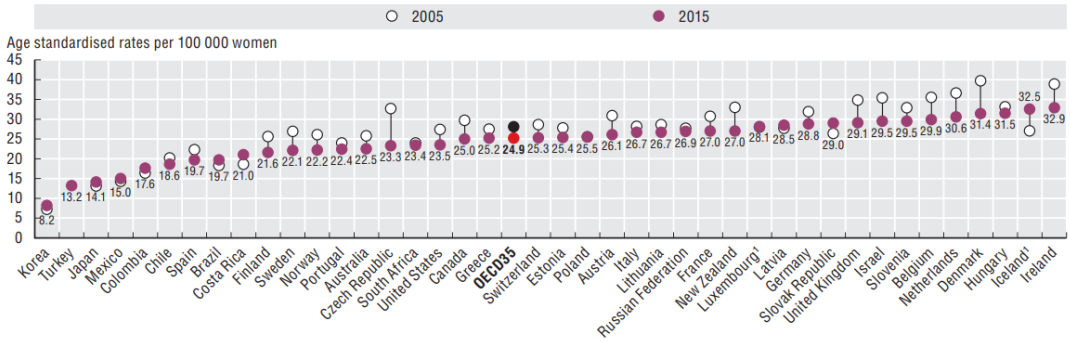
Note: 95% confidence intervals have been calculated for all countries, represented by grey areas.
1. Three-year average.
Source: OECD Health Statistics 2017.

Figure 3. Thirty-day mortality after admission to hospital for AMI based on unliked data, 2010 and 2015 (or nearest years)



Note: 95% confidence intervals have been calculated for all countries, represented by grey areas.
1. Three-year average.
Source: OECD Health Statistics 2017.

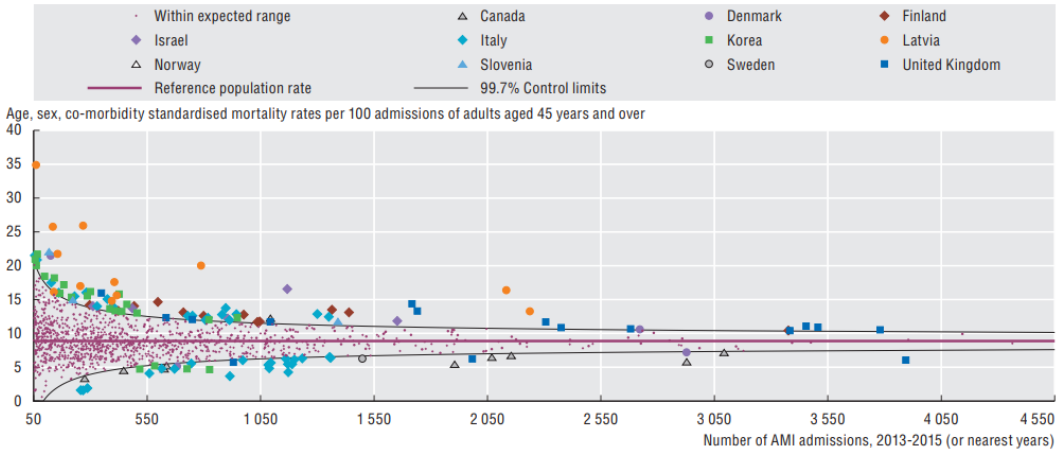
Figure 4. Breast cancer mortality in women, 2005 and 2015 (or nearest years)



Note: 1. Three-year average.
Source: OECD Health Statistics 2017.

22. The same wide variation is visible within systems (see Figure 5).

Figure 5. Thirty-day mortality after admission to hospital for AMI based on unlinked data, 2013-2015 (or nearest years)



Note: Each dot in the figure represents a single hospital, unless otherwise stated. Results for Canada do not include deaths outside of acute care hospitals. UK data are limited to England and is presented at trust-level (i.e. multiple hospitals).
Source: OECD Hospital Performance Data Collection 2017.

23. In contrast to physical healthcare, outcome measures for mental health conditions are collected by fewer countries, and rarely at the provider level. However, some countries are beginning to do so, and this information is, as we will discuss, key to allowing patients and their carers to make meaningful choices. Notably, if, as appears in the figure below, there are significant difference in outcomes by gender, then this might suggest that there are different relevant markets for the provision of some healthcare services to men and women (see Figure 6).

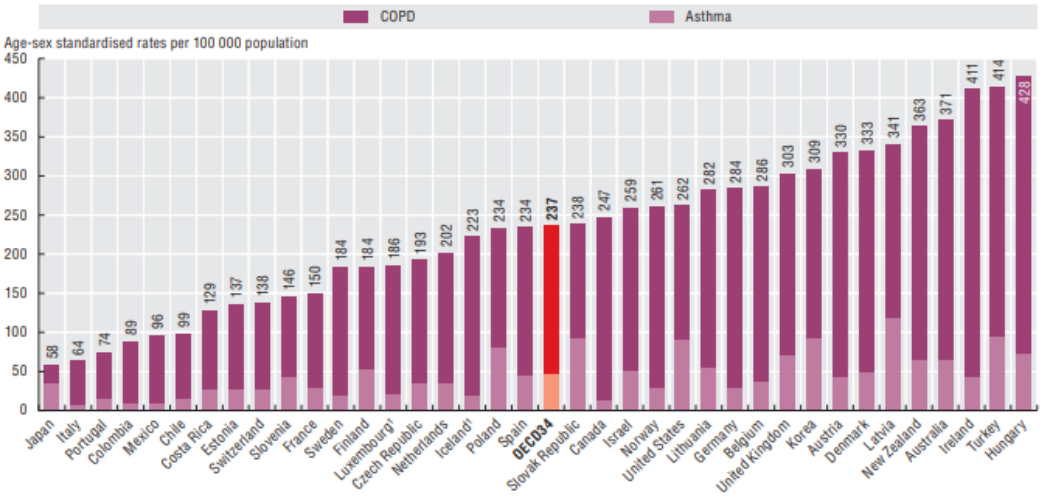
Figure 6. Excess mortality from schizophrenia, 2014



Note: Three-year average for all countries.
Source: OECD Health Statistics 2017.

24. The best measures of the quality of primary care services look at the extent to which these services reduce the need for more expensive treatment by specialists in hospital. Hospital admissions for conditions like asthma that should be treatable by primary care are therefore helpful for comparing the quality of a provider, or a system (see Figure 7).[6]

Figure 7. Asthma and COPD hospital admissions in adults, 2015 (or nearest year)



Note: Three-year average.
Source: OECD Health Statistics 2017.

25. Despite these wide variations in outcomes and costs of different systems, the ICN market study catalogue suggests that at the start of 2016 only the US, Sweden, Norway, Colombia and Estonia had undertaken studies of these markets (though more have done so since then, e.g. the Netherlands and Germany).[7] While the variations between countries and those within countries will no doubt reflect a range of different factors, they may well suggest that competitive incentives are too weak. It is therefore surprising that competition agencies do not appear, at least in public, to have taken a more active role in examining these markets and advocating for changes that would improve their efficiency and effectiveness.

3. Case Studies

26. In this section, we examine a range of case studies and explore who chooses, who pays, how payments are structured, and the nature of the supply side of the market. We look at the pro-competitive reforms that have been implemented, their apparent impact and what this might tell us about the specific choices that were made by those designing the reforms.

27. We look both at reforms that affect competition between healthcare providers, and, where it exists, competition between healthcare insurers. It is necessary to consider both, as they are each different ways to incentivise the final provider of healthcare services to improve the quality and value of its services. In the insurance case, stimulating choice and competition between insurers can give insurers a stronger incentive to act on their patients' behalf and drive competition between providers (e.g. through selective contracting and steering). In the single payer case, the patient can themselves drive competition through the choices they make, perhaps with the help of an impartial referrer.

3.1. France[8]

28. In France, there is a clear purchaser provider split. Patients in the publicly funded system are free to choose their provider but not their public insurer. Approximately 95% of the population has additional supplementary insurance (which accounts for just 5.5% of hospital expenditure), including some 7% whose supplementary insurance is publicly subsidised.

29. For hospital services, a patient's insurer pays a bundled payment to the provider that is selected by the patient (meaning that providers' income depends on the choices made by patients). This covers the expected cost of treating a typical patient with a given diagnosis (as classified under a system of Diagnosis-Related Groups, DRGs). It may therefore differ from the actual cost incurred in treating the patient (this is referred to as fee-for-service).

30. The provider market is mixed, nearly 40 percent of hospitals are operated by profit-making firms. However, these receive approximately 60 percent of admissions for surgical services, with the remainder provided by autonomous state owned enterprises (SOEs) or not-for-profit providers.

31. A national tariff which removes the possibility of price competition is set by the regulator, though different tariffs are set for SOEs and profit-making firms (despite the difference in the level, the income of an SOE still depends on the choices made patients).[9] Patient choice depends on both convenience and quality of a hospital as perceived by

patients and the family doctors that refer them. Sources include the rankings that are published in the news magazines (Le Point and L'Express), word of mouth, and an official website (www.scopesante.fr) that provides comparative information on 231 indicators on the quality of processes and simpler composite measures. Outcomes are not reported for fear of triggering a strategic response from hospitals and the difficulty in controlling for case-mix variations.

32. The activity-based bundled payments were introduced in a 2008 reform. This moved the system away from a fixed budget based on historic activity and local population to one where payment follows activity, and hence reflects changes in market share, rewarding the providers that patients prefer to use. The reforms therefore significantly strengthened competitive incentives for those hospitals facing competitive threats.

33. Researchers have explored the impact of these activity-based payment reforms that strengthened the link between provider income and patient choice. Choné et al (2013) find that public hospitals exposed to competition from private clinics responded to the reform by reducing their average length of stay by 4.4%, while isolated public hospitals did not. They also found that the strengthening of competitive incentives led to an increase in perceived quality – both at not-for-profit hospitals, as seen in a 9% expansion of their catchment area, and at profit-making hospitals that responded to the improved performance of not-for-profit hospitals. Interestingly, not-for-profit hospitals facing competition from other not-for-profits increased their catchment by another 9%, suggesting that the direct effect (the increased incentive to attract patients) was doubled by the competitive response (the need to increase quality to prevent the loss of patients to rivals whose own incentive to increase market share had increased).

34. Similarly, Or et al (2016) find that pro-competitive payment reform, and new regulations on minimum activity volumes, led to an increase in the quality of treatment provided in cancer surgery. This suggests that regulatory barriers to providing low-volumes can make sense in specialties where clinical evidence shows that surgeons need to conduct a high volume of cases in order to increase the quality of the treatment they provide.

35. The strength of competitive incentives in France prompted government to put public hospitals into groups or chains in order to encourage cooperation, while preserving competition between different chains. Given the highly fragmented nature of the hospital market in France, concentration is however not a major concern, and so the Autorité de la Concurrence has rarely needed to intervene.

36. A further important reform was the strengthening of the independence of the price-setting regulator in 2015 in order to address the complaint that tariffs were set with reference to their effect on hospital revenues and the relative competitive position of certain providers (or type of provider). This demonstrates the importance of prices being set by a regulator that is entirely independent of the regulator or department that oversees the financial stability of providers (in contrast to the UK). The differences in the tariff paid to profit-making firms and SOEs has led to state aid complaints to the European Commission.

37. The complaint was that the payments give public providers an unfair advantage in both the market for publicly funded healthcare and the market for privately funded healthcare (e.g. the public subsidies can be used to reduce the prices charged in the privately funded market as well as to improve the offer made in the publicly funded market). As a result, the government has required separate accounting for services of general economic interest and commercial services.[10] It appears that in doing so it has defined all publicly funded healthcare services as services of general economic interest, rather than only those

services that would not be supplied in the absence of public funding. It remains unclear however why state aid subsidies have quite rightly been prevented from distorting the commercial or privately funded healthcare market (and hence reducing quality and efficiency), but are still allowed to distort the publicly funded healthcare market.

38. In primary care, in addition to GPs, patients can also consult paediatricians, ophthalmologists, gynaecologists, and psychiatrists directly without referral. These tend to be self-employed on 'sector 2' contracts that give them some freedom to set their own fees (except for low-income patients). In contrast, 'sector 1' contracts set the fee that can be charged. Public insurance covers 70% of these fees with the remainder met by supplementary insurance or out-of-pocket.

39. Choné et al (2014) find that gynaecologists, paediatricians and ophthalmologists set their prices to reflect the structure of the local market in which they operate (reducing prices where they face more rivals). This would appear to underline the importance of qualified physicians and GPs not being restricted from obtaining a contract to enter into local markets with higher prices or lower quality. However, it might also suggest that removing quota restrictions on the number of physicians in training would help to reduce prices.

3.2. Korea

40. In 1999, Korea merged all the public insurers into a single payer (the health insurance corporation). This single payer purchases from a competitive provider market. Prior to doing so administrative costs for the health insurers ranged from 4.8% to 9.5% of total costs, and by 2006 this had been reduced to 4% (Kwon, 2009). The reduction in the number of insurers did not however reduce competition since there had been no consumer choice between the 350 public insurers and hence there was no loss of competition. As in Japan, about 90 percent of hospitals and 85 percent of beds are privately owned (Chun et al. 2009).

41. It then separated the provision of medical services from pharmacy dispensing in order to remove the scope for 'supplier-induced demand' in which firms created additional demand by prescribing a need for additional products that they sold. This structural separation of roles helped to solve the principal-agent problem created by the asymmetry in the information on what treatment is required between the payer and the prescriber.

42. The reforms continued in 2002 when payments for a small bundle of expected services were introduced (Diagnosis-Related Groups, DRGs) and began to replace the fee-for-service payment system (this reimburses the actual costs incurred in treating each patient). Pilots suggested these payment reforms had the expected result of reducing length-of-stay and the number of tests that were ordered. However, this proved controversial and unpopular with providers and health care professionals. In 2009, it was expanded, but it remained optional for hospitals until it became mandatory in 2013. The intensity of competition in local markets affected the way in which providers reacted to the payment reform. In particular, researchers suggest that the bundling of payments led providers in more competitive areas to compete to reduce readmissions after surgery by providing additional outpatient follow up appointments. They therefore suggest expanding the bundled payment to include these follow-up appointments (Kim et al, 2016, Jung et al, 2018).

43. While competition between providers in the Korean system is credited with delivering higher quality and greater efficiency (Peng & Tiessen, 2015, Kim et al, 2014),

the system's low cost is primarily because it requires the largest proportion of direct funding from households in the OECD (37%, see OECD, 2016). However, the impact of such co-payments exposes households to the highest risk of "catastrophic health expenditure" in the OECD, and this has led the current government to propose further reform (so-called 'Mooncare') to dramatically reduce co-payments on expensive treatments and extend the treatments that are subject to fixed prices (Jang, 2018).

44. As the OECD noted in its 2010 Economic Survey of Korea, "it is important to provide more information to consumers to enhance competition and to improve the behaviour of suppliers. Data on patient outcomes, adjusted for the severity of illness, need to be disclosed to the public to encourage informed choices, thereby facilitating quality competition among providers." Indeed, in 2005 the government started to publish lists of hospitals and clinics that overused injectable drugs and antibiotics (Kwon & Reich, 2005). However, the review notes that opposition from health providers hindered the introduction of transparency.

3.3. Norway[11]

45. Norway spends more on its publicly funded healthcare services than any other country and so has comprehensive coverage and limited co-payments. It also has some of the best quality outcomes in the world. Insurance is nationalised and there is a single-payer system so there is no competition between insurers. However, a series of reforms have introduced competition both between hospitals, and between general practitioners.

46. In the past, there was no patient choice and instead patients were allocated to a hospital. Hospitals were therefore local monopolies and were given block contracts to treat all the patients in their area (or equivalently, capitated contracts without patient choice). In 1997, the payment system was reformed and activity-based payments in the form of small bundled payments (Diagnosis-Related Group of services, DRGs) were introduced, and these partially replaced the block contract that hospitals had previously received. These prices were regulated and set on the basis of the average costs of delivering each DRG in a sample of hospitals. However, the system remains a hybrid of these two payments with hospitals receiving 50% of their revenues from activity-based payments and 50% from a guaranteed payment (a global sum). Since the global sum is a fixed guaranteed payment that does not vary with the number of patients, a unit price set at 50% of cost means that at the margin, hospitals are likely to lose money with each additional patient that chooses to use their service (though they may not end the year in loss). In addition, mental health care is paid for entirely via the global sum and so there is no incentive for providers to compete to improve the quality of these services.

47. In 2001, a patient's right to choose was recognised. Patients were allowed to choose any hospital in the country, and were reimbursed for travel costs while the GPs who refer them for care within a hospital were given quality indicators in order to help them choose. These helped make the choice a more meaningful one by addressing firstly the lack of information on quality and secondly the private cost to the patient of choosing a non-local provider (which constitutes a huge price increase relative to the local provider). At first hospitals were allowed to ration care by refusing to treat out-of-area patients, however this was later prohibited and hospitals ability to choose their patients was eliminated. Half of GPs reported that these reforms changed their referral patterns and half of out-of-area patients reported that they had made the choice to do so themselves (Ringhard et al, 2015). Researchers suggest that patients were using their right to choose to select hospitals with shorter waiting times (Bjorvatn & Ma, 2011, and Ringard & Hagan, 2011, and Andersen

et al, 2012). This appears to have led to a dramatic reduction in average waiting time from 250 days to 70 days in the post-reform period (Ringard & Hagan, 2011).

48. In 2002, hospitals owned by the counties were transferred to the state and turned into quasi-autonomous trusts (known as regional health enterprises). These could borrow (through the state) and transfer surpluses and losses across years. Most operational decisions that might affect patient choice were therefore to be made at the hospital level. However, despite the competition between these trusts, they are considered to be branches of the same enterprise (the state), and so they are not subject to merger control, and anti-competitive agreements between them would not constitute a cartel. However, abuse of dominance may be a concern, particularly since in 2015 private providers were offered the opportunity to enter into the provision of planned (elective) care, subject to them meeting the same minimum quality regulation as the publicly owned hospitals.

49. In primary care, the right of patients to choose was well established; however, GPs were allowed to refuse patients until 2001 when that option was removed. This required that GPs could only choose their list size and could not refuse any new patient while they had open slots on their list (41% had open lists in 2015, see Brekke & Rune Straume, 2017). This means they cannot define catchment areas to soften competition with neighbouring GPs. The reform also introduced capitated payments so that payment followed the patient (replacing the mixture of fixed budget and fee-for-service payments that they had previously received). As in most countries 95% of GPs in Norway are small businesses whose revenue derives from their contracts with the publicly funded system (Brekke & Rune Straume, 2017). Researchers suggest that waiting times for GPs in competitive markets fell and patient satisfaction increased (Sandvik, 2006). Referrals also increased, however there is no available research on whether these were referrals for conditions that can be treated in primary care (ambulatory care sensitive conditions) or those that cannot and hence should be referred. This may therefore reflect improved quality, or less strict gatekeeping (or both).

3.4. United States

50. In the US, most people get health insurance as a benefit from their employer who usually pays part of the monthly cost (the premium). Some of the others qualify for Medicaid (a publicly funded insurance scheme) because their incomes are low; others are older than 65 and so receive Medicare. They pay premiums that the federal government subsidises. Prior to the 2010 reforms this left somewhere between 32 and 50 million people who did not have health insurance. If these uninsured patients were admitted to hospital, they often did not pay the bill. This meant the hospital charged the cost to an emergency Medicaid plan.

51. When the US introduced the Affordable Care Act (ACA) in 2010, a key objective was to increase competition in the individual insurance market in order to provide health insurance to uninsured citizens.[12] The reform had three key aspects that were designed to work together to address the failure of the market for the provision of health insurance to individuals whose employer did not provide health insurance. Firstly, rules to prevent insurers from denying coverage or raising premiums based on pre-existing conditions, secondly a mandatory requirement (in fact an incentive) that everyone buy insurance and, thirdly means-tested subsidies to make that insurance affordable.

52. The mandatory requirement and online exchanges formed the pro-competitive aspect of the reform package. By incentivising the uninsured to buy from the market

(through subsidies, expanded minimum coverage, and a tax penalty for not doing so) the reform increased the competitive incentives for insurers to reduce prices to sign up patients. The larger volume of patients that would purchase low cost health plans would increase the rewards to offering these plans. This therefore represented an effort to use market mechanisms to reduce prices, rather than simply extending coverage by expanding the coverage offered by Medicaid.

53. Online exchanges were set up in each state where plans could be compared and purchased. In addition to these pro-competitive reforms, there were also coverage reforms; for example, the minimum coverage of plans was also increased. After much debate, the government decided not to offer its own plan (a public option). Since lower cost health plans were still more expensive than no health plan at all, the reform expanded publicly funded subsidies to cover the cost of the health plan for those on low incomes. The reform therefore reduced the cost of publicly funding insurance for these additional patients, and thereby allowed the public system to increase the number of patients that it offered to insure.

54. It is not possible to observe the impact that the mandatory purchasing of healthcare insurance had on prices in the individual insurance market since the non-discrimination clause and subsidies that were introduced have changed the nature of the product that is offered. This change has consequently also changed the volume and characteristics of the patients that are purchasing. However, there is no reason to think that the introduction of the mandatory requirement to purchase insurance has had an effect different from the pro-competitive effect that was expected. This means that insurance prices for less healthy patients can be expected to be lower than they would have been. It also means that prices for healthier patients that purchase insurance can be expected to be lower than the prices that they would have paid if the ban on discriminating on pre-conditions had been applied without an accompanying mandatory requirement to purchase. This of course does not rule out that those individuals may be paying higher prices as a result of the ban on discrimination.

55. What impact the ban on discriminating on pre-conditions had on the overall cost of the system is a separate question. Inevitably, prices for low-risk patients will have increased, while prices for high-risk patients will be lower than they would have been. The net impact is therefore ambiguous. Debate over the impact on the cost of the system is again difficult absent an estimate of the counterfactual cost of extending coverage by simply subsiding the insurance of those that have now acquired insurance. Whether or not the reform was a success or not will depend on the value placed on the increase in healthcare coverage.

56. What can be seen is that insurers that expected the removal of the mandatory requirement to purchase healthcare insurance were increasing premiums by between 1.2 and 20 percent in 2018 (Kaiser Family Foundation, 2017). The end of the mandatory requirement in 2019 can be expected to spread those prices increases across the market, for instance the Congressional Budget Office estimate the price increase will turn out to be around 10 percent (CBO, 2017).

57. It is also clear that the tax for those not abiding by the mandate was set at such a low level that it failed to encourage approximately 6 million uninsured patients to purchase (thereby keeping prices higher than they could have been).[13] In this respect, the level of the tax for breaching the mandate is key to increasing competition. Under the ACA it stood at approximately $695 per adult or 2.5 percent of household income. In contrast, in the Netherlands if a patient has no insurance after 13 months they are fined 773 euros and

registered to the cheapest insurance plan (the payments are automatically deducted from their salary).[14]

58. There have also been pilots of Medicare payments that expand the bundle of Diagnosis-Related Group (DRG) services to include follow-up care (Porter & Kaplan, 2016). The idea here is that these changes shift providers towards competing to provide care that appeals to patients but reduces the likelihood of the patient needing readmission. This illustrates the balance to be struck between incentives for patient centred care (which might lead providers to take a greater risk of readmission in order to invest in less clinically valuable aspects of the service) and incentives for care that reflects the additional costs for all patients that can be caused by unnecessary readmissions.

3.5. Netherlands[15]

59. The Netherlands also has a system of mandatory health insurance. Its 2006 reforms set up a system in which all patients are required to purchase health insurance. It provides subsidies to ensure those on low income can meet the costs of purchasing this insurance. Having guaranteed demand from the entire population, it then requires private insurers to provide at minimum a basic insurance package that prohibits discrimination based on pre-existing conditions (as in the US). Insurers are then incentivised to compete for patients by purchasing better quality healthcare from providers at lower prices. They can contract selectively with providers (hence not all hospitals need be included within an insurance plan) and steer patients into certain providers as a means to negotiate lower prices (for example by reducing the patient co-payment on using certain hospitals). Some insurers have started to use payment for performance contracts that pay premiums for improving quality as measured through outcome indicators.

60. It appears that insurers have not contracted selectively with hospitals or GPs. One suggestion is that this is because patient preferences will not allow them to profitably do so (Boonen & Schut, 2011). Another is that the court's ruling that the reimbursement for out-of-network hospitals must still be sufficient to allow a patient to use any hospital in the country. This limits the ability of the insurer to introduce profitable reimbursement differentials that steer patients into within-network hospitals. Nevertheless, insurers have introduced selective contracting by specifying minimum volumes for more specialised treatment. This is often considered to increase quality though the evidence is often unclear on this point (Mesman et al, 2015).

61. In addition to any competing for contracts from insurers, hospitals also compete directly for patients. Researchers find that readmission rates, reputation and waiting times each play a role in the choice made by patients, even if the transport price is the most important (Varkevisser et al, 2012, Beukers et al, 2014). Notably transport costs are not reimbursed and so this is unsurprising. In 2015 the government mandated the publication of standardised mortality ratios, waiting times and other outcome indicators in order to help improve transparency.

62. Mergers between hospitals are examined under the competition act. Public-owned hospitals are considered sufficiently independent that they constitute enterprises in their own right and hence mergers between them are considered relevant merger situations. By June 2015, 26 of 27 mergers had been approved, this led academics to criticise merger control as too permissive (Loozen et al, 2014, Schmid et al 2016). The authority has since undertaken ex-post assessments of its decisions on mergers and in 2016 issued its first block on a proposed merger. The government has announced a number of measures to strengthen

competition enforcement in the sector, including the transferral of powers from the market regulator to the competition authority, and the formation of a special healthcare taskforce within that authority.

63. Researchers suggests that hospital price-cost margins are higher where hospital's market shares are higher (Halbersma et al, 2011), but others find that neither provider concentration nor insurer's buyer power explain price differences (Heijnk et al, 2013). While price competition has not been found to harm quality thus far (Roos, 2018), it is equally not yet clear that the addition of an insurance market to the healthcare market is having any success in reducing prices. Indeed the government appears increasingly likely to exercise its buying power, and for example has legislated for, but not yet triggered, a balancing measure that would cap aggregate hospital expenditure.

64. GPs in the Netherlands are small businesses that play a gatekeeper role and refer patients for more specialist treatment when necessary. GPs are free to set up wherever they like provided they meet the minimum quality standards required to obtain a license. They receive a capitated payment and a fee-for-service for each appointment (insurers can negotiate this payment but it is highly regulated). GPs are able to refuse to register patients if they wish. Bundled payments were introduced in 2010 for patients with diabetes (type II), COPD and vascular risks. These are negotiated between insurers and care groups (these groups act as a lead contractor for a group of approximately 50 GPs). Some research suggests these payment reforms have led to significant reductions in both mortality rates and costs.[16] However, the negotiation of these prices by groups of GPs appears likely to reduce competition between GPs.

65. In 1998, the national GP association applied for an exemption from the cartel prohibition in the Dutch competition law. This application was rejected, but in 2006 the association nevertheless published guidance for its members on how to control the entry of new practices to avoid over-provision of services (and this guidance was adopted by many GP groups). The publication of this guidance led in 2011 to the competition authority imposing a fine of 7.7 million euro. This was overturned by the appeal court who in 2015 said that the competition authority had failed to show that the guidance had a harmful effect on competition between GPs. Following this, the competition authority issued a document stating that it would be reticent in applying the law to GPs, and that it would first encourage them to change their behaviour before issuing fines. While GPs have continued to seek an exemption from the competition act this has been rejected by an independent commission.

3.6. England

66. In England, patients have a right to choose their GP, their hospital, or their provider of mental healthcare services.[17] A split between purchasers and providers was established in 1990 and GPs were allowed to negotiate a price at which to purchase services for their patients. This experience with price competition reduced length of stay and hence costs, however this came at the expense of quality of service. Having removed these contracting mechanisms, and observed the subsequent failure of the system to deliver improvement in the absence of incentives to do so, the New Labour government delivered a series of pro-competitive reforms between 2001 and 2005.[18]

67. Following the London choice pilot in 2002 patients were given a free choice of any hospital in the country.[19] However, unlike the choice pilot no support for transport was provided.[20] This led to transport costs (proximity) becoming the most important factor for most patients (Beckert et al, 2016), and so hospitals often competed for patients by offering

outpatient appointments closer to home (Pike, 2012). However, researchers have found that quality is also important to patients and a single standard deviation increase in PROMs can lead to a 10 percent increase in demand (Gutacker et al 2016).

68. In 2003, well run public hospitals were allowed to become autonomous Foundation Trusts that had operational freedom to retain surpluses for reinvestment, to borrow from private markets, to set pay and to establish private companies. These quickly expanded, both increasing market share and entering into foreign markets.

69. From 2004 onwards payment reform lead to hospitals being paid on the basis of their results, those results being measured, as in other markets, by the number of patients that choose to use their services. The payments were made according to a small bundle of services (Healthcare Resource Groups, HRGs, similar to the DRG system used in other countries). The price level was set using average cost, including labour, equipment and capital cost (Mason et al, 2011)

70. In 2004 an independent quality inspectorate, the Healthcare Commission was founded to grade hospitals and in 2007, a website NHS Choices, was set up to help patients choose. League tables were also developed by firms like *Dr Foster*, and these became regular features in the national press.

71. Licensing restrictions were removed and private hospitals around the country were given contracts to provide publicly-funded healthcare. Private and publicly run hospitals were also given guaranteed volume contracts in exchange for building additional capacity. The need for these guaranteed payments was heavily criticised. Moreover, the contracts specified that these new units could only treat patients with fewer complications. This meant that only these patients were able to choose these new units, leaving incumbents with the more complex cases. This need not have been a problem, except that the regulated payment system failed to properly account for these complexities, meaning that hospitals tended to lose money by 'attracting' these patients (Cooper et al, 2016).

72. Finally choice, competition and procurement rules were put in place to guard against mergers leading to excessive concentration, abuse of dominance, and anticompetitive procurement practices from impartial purchasers.[21] A number of studies looked at the impact of these reforms. They found that those areas with more competitive market structures saw improved outcomes and greater efficiency (Cooper et al. 2011; Gaynor et al. 2013; Bloom et al. 2015).[22] In line with the quality indicators that were available to patients during the period and in international comparisons such as those in section 2, they used mortality rates following hospital admissions as an indicator for hospital quality. A key transmission mechanism appears to be the impact that competition on the quality of hospital management (Bloom et al. 2015), however qualitative research suggests there are a broad range of different ways in which hospitals in practice change their decision-making when they face competitive incentives (Pike 2012).

73. As an example, one recent study of a specific service identified that choice and competition policies, rather than a coordinated policy towards centralisation, has been the most significant drivers in the reconfiguration of prostate cancer surgical services in the NHS (Aggarwal, 2018). It found that patients valued convenience, but also innovative technologies and clinicians with better reputations, and often travelled further to obtain these. Consequentially, the absence of these factors increased the probability of hospitals closing their units and hence drove the market towards a reconfiguration of services in which the more specialised hospitals provided a greater volume of treatment. Notably clinical research suggests that increased volumes in radical prostatectomy are associated

with better outcomes (Trinh et al, 2013, Gershman et al, 2017, and Leow et al, 2017). In contrast, in emergency services, purchasers ran competitive tenders to decide which centres to designate as specialist centres for paediatric heart surgery and hyper-acute stroke centres (Davie et al, 2013).

74. In primary care, patients can choose between different GP practices, these are private profit-making small businesses who are paid a capitated payment for each patient they register. However, access to contracts for new entrants is heavily restricted (Monitor, 2015), there is a severe lack of GPs (due to inadequate training numbers and pay levels that are low relative to hospital-based doctors),[23] and very little information for patients, leading to the perception that all providers offer essentially the same quality of service. Providers are also allowed to select their patients through the use of catchment areas, protected from new entry, and encouraged to merge in the belief that greater scale will deliver greater efficiency and/or quality.[24] Nevertheless, choice and competition, presumably through word-of-mouth and local reputation appear to have driven a small improvement in the quality of services, as measured by the number of unnecessary referrals to hospital for conditions that an effective primary care provider should be able to treat (Pike, 2010).

75. The pro-competitive reforms of community and hospital services began however to unwind in 2012 when the new coalition government passed new legislation and budget cuts began to effect services. The legislation took the responsibility for buying services away from the regional purchasing groups and gave it to small groups of GPs (who often also jointly provide services within community settings). It also created a new regulator with a conflict of interest between its market regulation function, which dealt with pricing and competition matters, and its SOE oversight function, which assured the financial sustainability of the SOEs that competed in the market that it was regulating.

76. In 2013, a scandal in one of the autonomous trusts led the government to begin to remove the operational independence of these trusts.[25] Then in 2016, the market regulator and the National Commissioning Board announced purchasers were free to stop using the regulated price list. However, instead of providing options such as the larger bundled payments that other countries were experimenting with, the organisation announced that local purchasers were free to decide how to pay those hospitals that treated their patients (Timmons, 2018, p76). This would therefore include reverting to fixed lump sum payments that guarantee the local budget of both the local purchaser and the provider. This was followed in 2017 by the same organisations announcing that the purchaser provider split would effectively end in large parts of the country, thereby removing competition and meaningful choice for patients (Timmons, 2018).[26] Strangely, there has been no change in legislation to support this rollback of competition, which has instead been agreed by the regulator and the purchasers.

3.7. Germany[27]

77. In Germany, there are more than 100 sickness funds to which patients were allocated until 1996, at which point they were given a choice as to which one they wanted to join. These funds are quasi-public entities and not-for-profit organisations that are able to selectively contract, but which must cover a range of treatments that is set by government. These funds receive a capitation payment for each patient that chooses them. This is funded by an income tax (social contributions payable by employees and employers) levied by the government at 14.6% of income but capped at a maximum of just over 4000 euros in 2016. The capitated payment is adjusted to reflect age, gender, disability and morbidities. Funds can compete, for example on the additional percentage of income that

they charge patients (between 0.3 and 1.7 percent in 2016). Information on prices and treatments covered are available to patients but there is no information on the quality of outcomes that each fund has achieved for its patients.

78. Patients on higher incomes are able to opt-out of the sickness funds and purchase private insurance instead (if they opt out the purchasing of private insurance is mandatory). By opting out, they avoid paying the income tax, and can use the saving and their other income to buy a more expensive private insurance policy. This opt-out, a version of which was also applied by the Thatcher government in the UK in the 1980s, means that the government effectively subsidises private health insurance for those that can afford it (though there is no direct subsidy). This creates a topping-up problem in which, as explained in Biggar & Fels (2017), the wealthiest top-up the subsidy with their own contribution in order to ensure they receive better access and potentially better quality services than those on low incomes. This approach undermines the ability of choice and competition to help deliver the common policy goal of reducing health inequalities (in the way that, for example, the New Labour reforms did in the UK). It therefore illustrates the way in which pro-competitive reforms can either help or hinder inclusivity, depending on the detailed design of the reforms.

79. The hospital sector in Germany is made up, in almost equal proportions, by SOEs, profit-making firms, and not-for-profit firms. Providers have since 2004 received activity-based or DRG payments, up to the point at which they reach a revenue cap that is set for each specific hospital. The level of these payments is fixed and, as in other countries, is set by taking the average cost of providing the same activity across a sample of hospitals. The payment is then weighted by a regional price factor that is collectively negotiated by all the sickness funds in the region. These collective contracts are exempted from competition law. While some sickness funds provide guidance for patients who are choosing a hospital there is little data with which to compare the performance of different hospitals. Mandatory quality reports are produced by the hospitals themselves but few patients are aware of the existence of this information.

80. In primary care, the German system does not require GPs to play a gatekeeping role. While Sickness funds can – in principle – selectively contract, this has in practice not happened in primary care, perhaps since the funds anticipate that patients would not react well to not being able to use their longstanding GP practice. GPs are paid a fee-for-service up to a cap that is set for each specific practice. Prices paid to GPs by the sickness funds are collectively negotiated by the association of family doctors and include both a capitation element and activity-based payments. Entry into the provision of publicly funded GP services is highly regulated on a federal and regional level, the intention being to create equity in access to GPs in all parts of the country.

4. Ten key decisions

81. In this section, we draw out some key decisions facing those designing reforms that appear to make a difference when introducing or reforming competitive forces in healthcare markets. Competition agencies advocating for pro-competitive reform may therefore wish to use this framework within their advocacy to those parts of government that are responsible for leading reforms.

4.1. Should patients choose their provider?

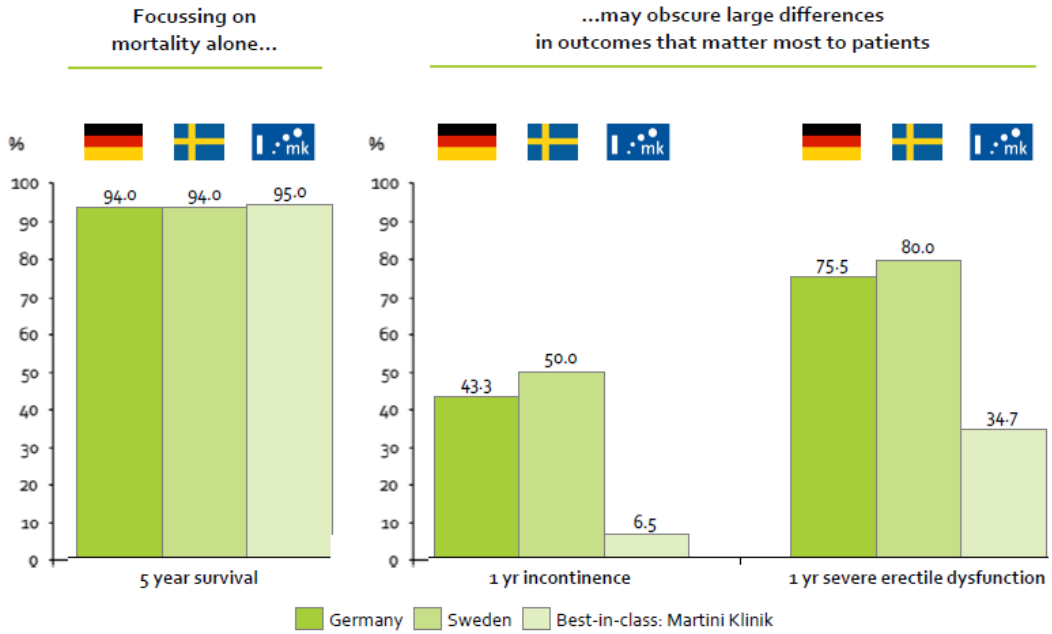
82. A fundamental principle of a publicly funded healthcare market is that the set of organisations that provide healthcare services be structurally separated from those that pay for services. This separation creates scope for competition between providers to provide better services. If purchasers and providers are allowed to integrate, this scope is removed and the provision of the service is monopolised by an 'in-house' provider, which has no incentive to provide a service better than the minimum regulated standard, other than professional pride (Le Grand, 1997).[28,29]

83. Market mechanisms promote consumer sovereignty, which means that they incentivise providers to compete on the dimensions of the service that the chooser cares about (Stevens, 2011). Services therefore become more patient-centred where the patients are able to make the choice themselves. These choices can then reflect the relative value that the user places upon the different aspects of the service. For instance in hospital services, some patients may care only about waiting times and can choose to be treated by the provider that can see them soonest. Meanwhile other patients may think it worthwhile to wait a little longer in order to be treated at a hospital with a better safety record, or better treatment outcomes, or that has more nurses, or better facilities.

84. However, for this to happen, the choice that a patient makes needs to be a meaningful one. The patient (or their guardian) must have different options to choose between, they must have easily understandable information on the quality and price of those options (see the case study on France, Germany and Norway above), and the time to weigh the different options (meaning patient choice will never be effective in generating competition between hospital's emergency departments). Note that even when patients do not need to pay a co-payment, the patient will nevertheless face a transport cost for accessing the service. Patient responsiveness to these transport prices have repeatedly been shown to be extremely significant (reflecting the fact that the increase may tend towards infinity if transport to the closest option is almost costless). The most effective way to drive competition on quality (rather than convenience) will therefore be to pay for or reimburse a large proportion of the patient's transport costs (See Norway and the London choice pilot).[30]

85. An example of the difference that patient-centred care might make is provided by the case of outcomes after prostate cancer surgery (see Figure 8). Here, as the OECD's health division illustrate on the webpage for these new indicators, the performance of systems or providers can be very good on important outcomes like mortality, but may not tell the full story in relation to those outcomes that are likely to matter more to patients than to payers or referring GPs.

Figure 8. Outcomes after prostate cancer surgery



Source: http://www.oecd.org/health/paris.htm.

86. When compared to competition for contracts, patient choice creates a more immediate and more credible threat to providers that underinvest in the quality of their services. It also removes the need to run a procurement to obtain a contractor to provide the service, and to replace any contractor that finds that it cannot fulfil the terms of its contract. However, ensuring that patients are in practice given a choice can be challenging, particularly where gatekeepers disapprove of the principle of empowering patients to choose (Dixon et al, 2010).[31] This may for example happen if it reduces the gatekeepers' own power to shape the local system, for instance by preventing them from protecting the income streams of poorly performing local providers.

87. Indeed the introduction of patient choice is particularly important for those on low-incomes that lack the option of purchasing private care when the quality of care at their local facility deteriorates. As Tony Blair put it: "*The overriding principle is clear. We should give poorer patients… the same range of choices the rich have always enjoyed. In a heterogeneous society, where there is enormous variation in needs and preferences, public services must be equipped to respond*" (Blair 2003). Indeed, research suggests that the introduction patient choice and competition did not increase health inequalities and appeared to have slightly reduced them (Cookson, 2011).[32]

88. Where the patient that will use the service cannot make a meaningful choice, as, for example, when they require emergency care, the choice must instead be made by the payer. The payer can choose the best available contractor(s) to provide such services by running a competitive procurement process.[33] This however poses a question as to how well the interests of the payer are aligned with those of the patient. Where the payer is an insurer (or a GP who holds the budget for their patients) with competitors, the patient at least has the opportunity to hold them to account by choosing to switch to a different insurer (or GP) where they fail to represent his or her interests in choosing the contractor(s).

89. As we have seen, in the large majority of OECD healthcare systems the purchaser/provider split is well established. There are however, worrying isolated instances in which policymakers appear to be reverting to an old-fashioned system based on command and control (see for instance the UK). Patient choice is also overwhelmingly accepted as a basic right for hospital and primary care services (as long as a referring gatekeeper has certified that there is a clinical need). However, as we discuss in the next section, in practice the information available to patients is often still weak and difficult to evaluate. Patient choice in mental health services is also less common.

4.2. What tools should be given to empower patients to effectively drive competition?

90. In order for patient choice to incentivise competition on the dimensions that patients care about, a large proportion of patients need to able to make meaningful choices, and consider switching if performance deteriorates. As set out above, this means that the patient (or their guardian) must be aware of the performance of the different providers on the different dimensions of the service. They therefore need to be able to access easily understandable information on the quality (and price) of those options. However, being able to access the information is not enough if their perceptions are inaccurate. For instance, there is often a widespread presumption that performance on many dimensions is largely the same across the market, despite this being demonstrably wrong (Monitor, 2015).

91. Asymmetric information is one of the basic market failures in healthcare as well as in many other markets for experience or credence goods (goods in which the quality of the specific service is not clear at the time of choosing, and is only identified afterwards if at all). Standard solutions include the use of independent advisors, who typically test the service, or aggregate data on outcomes and experience, in order to inform an accurate expectation of the likely quality of the service.[34]

92. In healthcare, the same approach can be taken, though notably the dimensions of quality are many and varied. Most countries have worked to develop better indicators to help patients choose. However getting the right balance between detail and simplicity remains a challenge. For instance, patients may well need detailed information on the quality of a specific doctor's surgical outcomes, while also wanting information on the hospital ward's infection rate, the department's waiting time, and the effectiveness with which the hospital cooperates with providers of other services to ensure a smoothly integrated experience (as with interoperability of many other goods and services).[35] Notably, the OECD is in the process of building internationally standardised measures of patient outcomes and experiences through its Patient Reported Indicators Survey (PaRIS).[36]

93. Overarching traffic light scores for a provider can be an easy-to-understand indicator at a hospital or provider level, but are less useful for those with a specific diagnosis that requires a specific treatment or investigation by a particular department (see France). Therefore, good data and an independent advisor are important to helping to empower patients and to incentivise the right type of competition. This avoids inefficient competition on more superficial factors that are more visible but matter less to the patient. Notably, this means that the advisor cannot be integrated within a provider since this creates a clear incentive to direct patients towards that provider (see Korea).

94. A final aspect of a meaningful choice is that providers must be able to build the capacity to treat those that would choose to use their service. Restrictions that payers might place on investment in capacity can therefore seriously damage competition. However, in

order to remove the payer's incentive to impose such restrictions it must be the case that the risk of making speculative investments lies with the provider.

95. Similarly, publicly funded systems need to ensure that the supply of trained staff is sufficient for the needs of their population. Shortages of trained staff inevitably increase staffing costs, but also damage competition since the lack of capacity they create removes the important incentives for providers to attract patients to choose their service.

96. Finally, we have focused in this section on measures of quality. However, as previously noted, even in the absence of co-payments, the price of the service includes any transport cost payable by the patient. This cost can rapidly increase (and so a provider located an hour away can represent an almost infinite price increase for a patient with a hospital in their local area). This is likely to account for the strong preference of patients for local services (particularly when combined with the mistaken assumption that most services are of equal quality). Competitive incentives for providers will therefore be hugely strengthened where the payer also reimburses the costs of travel to a selected provider.

4.3. Should prices be fixed?

4.3.1. Single-payer systems

97. In single payer systems, the patient is the user, but the state or its delegated insurer is the payer. If the payer chooses for the user (as in a procurement), then, in the absence of regulated fixed prices, the providers are incentivised to focus on reducing prices (which are easy to observe), without worrying about the quality of service, except to ensure it meets minimum regulated standards.[37] This is not only because the quality is much harder to observe, but also because the chooser (the state) does not use the service, and hence is unlikely to make the same trade-offs that patients would do, knowing that they will use the service. This focus on price-competition is likely to lead providers to cut prices not only by increasing efficiency (thus increasing value), but also at the expense of quality (decreasing value). [38]

98. Fortunately, incentives to make efficiency-enhancing cost reductions can be preserved if cost data are used to set a regulated average price.[39,40] This allows the provider to retain the additional margin made by achieving efficiencies (see Germany and the UK).[41] These efficiencies can then be extracted in future years, as their downward impact on costs deflates the prices that are set. Higher cost providers meanwhile would be incentivised to exit, again putting downward pressure on the prices that are set.

99. This suggests that in a single payer system, the state, or preferably an independent authority less vulnerable to special pleading (see section 4.10), should set a fixed minimum price, in order to prevent undesirable price competition that risks creating a 'race to the bottom' on quality (see UK). However, if price is set too low then providers can be expected to compete to reduce their market share and exit provision where possible. In contrast, in a mandated insurance system, there should not be the need to set a minimum price for the providers, who should be able to negotiate with insurers that are able to assess quality and decide upon the type of package they wish to offer patients.

100. If the patient is also the chooser then, in the absence of a maximum price, there is little or no incentive for provider to make any attempt to hold prices down. The incentive for a provider or insurer is instead to compete by over-investing in (gold-plating) those aspects of the service that patients care about, without worrying about the cost incurred in doing so, since these can be charged to the state. Given limited budgets (which are

themselves reliant on funding through taxation which has its own efficiency cost), the state should therefore also set a maximum price.

101. In single payer systems where there is patient choice and no co-payment by the patient, no provider would set anything other than the maximum price. Therefore, the maximum price should equal the minimum price, and hence there should be a fixed price.

4.3.2. Multi-payer mandated insurance systems

102. In contrast, in mandated insurance systems the patient is the payer, the user, and the chooser. Prices are therefore an important part of the offer that providers and insurers make to patients who weigh the importance of price alongside quality. If the insurance and provider markets are competitive, there should therefore be little need for regulating price. However, out-of-network emergency treatment might be capped given the market power created by the lack of opportunity to make a meaningful choice. Similarly prohibiting the setting of higher prices based on pre-existing conditions will be necessary to resolve the basic market failure of inadequate coverage.

103. While co-payments offer one way of helping to reduce unnecessary demand,[42] they inevitably contradict the equitable access goals of many publicly funded healthcare systems. They therefore typically require the addition of a means-tested subsidy system in order to ensure that those on low-incomes are not denied access. Where co-payments are used they are typically designed as a percentage payment with a price ceiling. This is because a flat co-payment which patients could then top-up may simply inflate the prices that would otherwise be set by firms (see Germany).[43] Notably co-payments are neither required, nor helpful for the introduction of choice and competition (though policymakers may favour them for other reasons).[44]

4.4. What unit of payment should be used?

104. If prices are regulated, then the unit of payment must also be set. At one end of the spectrum this can be a year of care for a patient (capitation), at the other end of the spectrum it can be a fee for each service that is used.

4.4.1. Emergency services

105. For publicly funded emergency services where patients have little or no opportunity to exercise meaningful choice between different providers, the state (or the insurer) has to choose a set of options on their behalf. This means purchasing access to a network of geographically-differentiated emergency units of differing levels of sophistication.[45] It may switch membership of this network to other units, or replace the provider that operates the unit from time to time (or change their specialist level), depending on their performance against clinical and access measures. However, it is not feasible for patients to make an informed choice of provider when they urgently require a specific emergency treatment. Moreover, fee-for-service or activity payments create no incentive for earlier or less specialist intervention. Therefore, it may make sense to agree a single price based on best estimates of likely demand, and to include within that price the fee for preventative and emergency walk-in primary care for that population, as well as emergency hospital care. If non-emergency primary care were to be included, this would risk removing the independence of the referring GP and hence lead to the steering of patient referrals into the same hospital. However, it may be possible to provide patients with an independent choice advisor that is independent of the gatekeeping GP.

106. In effect, this means that the unit of payment is a bundle of emergency services for a local population (as noted this should not include planned services). This then gives the provider with the incentive to organise the different tiers of its services in a way that minimises the cost of treatment (e.g. investing in low cost preventative and primary care to reduce the use of higher cost emergency hospital care),[46] while also meeting quality targets to avoid heavy contractual penalties (e.g. on waiting times). Without such penalties providers will have an incentive to ration the care they provide by using long waiting times to discourage the use of the service by any but those that are most desperately in need. While there are few incentives to improve the quality of care for patients outside of these targets, as noted in section 4.3, the payer might increase such incentives by setting a fixed price, and taking bids from providers on their promises (and record of delivering) better outcomes.

4.4.2. Planned services

107. In contrast, in planned care there is the possibility of meaningful patient choice, which can create a stronger incentive for providing high quality, patient-centred services.[47] The unit of payment can then be set, not as a large contract that covers all the necessary treatment of thousands of patients in an area, but on the basis of the bundle of services that a patient with a certain diagnosis might need. That payment can then follow the choice of the patient, and flow to the provider with whom the patient entrusts his or her care. Most OECD countries favour such payments for groups of services, often known as Diagnosis-Related Group of services (DRGs). However, these remain relatively small groups of services, and so pilots are under way to trial the bundling of payments for larger groups of services that cover a whole care cycle, which includes follow-up treatment at different locations (see United States). At their largest, these groups can begin to look like the full package of services that would be required for a disease-specific capitated payment.

108. This leads some experts to recommend going the whole way and bundling all the services a patient might possibly need into a single capitated payment made to an insurer or a group of healthcare providers, or a lead provider.[48] They argue this allows the state to shift all the risk of unexpectedly high demand onto the organisation that plays this insurance role.[49] These capitated payments can then deliver strong incentives for healthcare providers to compete for market share by investing in quality and efficiency of their services to attract patients and insurers as long as patients are still able to make a meaningful choice between organisations that play this insurance role. However, if large geographic groups of GPs were able to compete for this capitated fee, then patients may find it difficult to choose to switch their capitated payment to a different organisation (since this might prevent them using any of the local GP services). This would therefore risk largely removing the competitive incentives to provide better quality, more patient-centred services (See UK).

4.4.3. Cross-subsidies

109. As described, the bundle of emergency care services could be procured competitively. If however, for any reason they are not, it becomes important to have transparency in the accounting of the emergency and planned services in order to avoid cross-subsidisation between the two. Such cross-subsidies risk distorting competition and lead to patients, usually those requiring planned healthcare, suffering as a result of the provider's inefficiency in providing emergency services that it is unwilling to cease providing. It may for example see economies of scope in offering both services. However if there are such efficiencies it should not enjoy the advantage of not having to compete to provide those emergency services.

4.5. Should providers be allowed to select patients?

110. If publicly-funding healthcare services is a policy response to the first order market failure of inadequate coverage, and choice and competition in publicly-funded healthcare services are a policy response to the second order failure of command and control systems to improve quality and efficiency, then it should not be a surprise that there will also be third order (quasi-market) failures. Where prices are fixed the most important of these, as described by Biggar & Fels (2017) is referred to as 'cream-skimming'.

> *"Cream-skimming arises from an underlying problem of information asymmetry: In many cases, the cost of providing a service of a given quality varies widely from one customer to the next and, moreover, the service provider is often in a position to observe that cost more easily than the government who sets the fixed fee. Service providers therefore have another strong incentive – not just to provide quality and to reduce expenditure – but an incentive to identify and serve only the customers with the lowest cost to serve, while denying service to customers with a higher cost to serve.*
>
> *These problems arise wherever the identifiable customer costs vary by more than the size of the fixed fee reimbursement. This is plausible in many circumstances. For example, let's suppose an individual has a heart attack. The cost of restoring that individual to a reasonable level of health depends on a wide range of factors including the age, overall state of health, co-morbidities (such as diabetes), previous history of heart conditions, and lifestyle. The variation in the cost of providing this health service from one individual to the next could be substantial. If a health provider is offered a flat fee for service, the provider will have a strong incentive to actively seek out lower-cost-to-serve customers will denying service to those with the highest cost-to-serve in each class."*

111. In addition it is worth noting that this creates an incentive for providers to invest in finding better ways to identify high cost patients, and hence to enable the provider to earn a margin from that extra information. These information rent-seeking investments produce no value and lead to productive inefficiency since it is not the most efficient provider that serves patients, but the one that spent the most rent seeking. It may also foreclose other firms that lack that information and hence reduce the competitive constraints upon the informed firms.

112. A two-pronged strategy is required to address these issues. First, providers can be prohibited from selecting their patients, and be obliged to treat all patients (which also helps empower patients, since nothing discourages patients from choosing more than being rejected by a provider they have chosen).

113. Second, where prices are regulated more specific payment units can be defined to better estimate the cost of treating different groups of patient. Providers may for example remove themselves from the list of options for more expensive patients by deciding against investing in the additional staff or equipment that is required to safely treat higher cost patients (e.g. having an on-site intensive care unit). Therefore, the prices of the bundle of services must differentiate between higher and lower cost patients in order to create incentives for efficient providers to compete to attract each of them.

114. Providers may also select patients by setting out priority catchment areas. For example geographic areas that include predominantly low cost patients. Setting catchment

areas should therefore be prohibited as part of the duty of a provider accepting public funding not to discriminate (See Norway).

115. Where prices are not fixed, for example in a mandated insurance system, insurers have the freedom to set a price to ensure they make a profit when they attract a patient. However, this price might be very high for some high-risk patients, and these patients might be exposed to a percentage of that price. Therefore to preserve access to care the state may limit that price by preventing insurers from reflect existing conditions in their pricing, or refusing coverage to higher costs patients. In effect, this forces risk-pooling, and discourages insurers from cream-skimming.

4.6. Who should be able to compete?

116. Across the vast majority of OECD countries there is a diverse mix of public, non-profit and for-profit providers. While the proportion of for-profit providers varies across countries, non-profit providers are a key part of almost all healthcare systems.

4.6.1. Entry

117. Part of the introduction of choice and competition has often been the opening of those markets to new providers. These have often included private profit-making firms as well as not-for-profit firms if these were not already providing services to patients. Removing barriers to the entry of profit-making firms may bring the advantage of new capacity that increases competitive incentives, new ideas and innovations that incumbents will respond to, and help stimulate competition since as outsiders and new entrants these have nothing to lose and so are prepared to unsettle incumbents and compete to attract patients.

118. However, to some degree, these advantages can also be achieved by removing restrictions on the ability of non-profits to enter and provide services. This may be preferable if quality remains largely unobservable. Besley and Malcolmson (2018) for example, suggest that retaining the presence of a non-profit provider is important for maintaining quality and efficiency. Their model is based on there being a distinction between observable and unobservable quality. In the model, for-profit providers minimise investment in unobservable quality while the preferences of non-profit providers lead them to provide positive investment in unobservable quality. This leads them to recommend that policymakers maintain a mixed market, and not to award contracts to profit-making providers in the absence of effective competitive constraints from non-profit making providers.

119. They also look at the policy implications if providers know what is good for patients better than patients do. For instance if patients want high quality outcomes but in practice base their choice on aspects of service (car-parking charges, bedside TV and so on). If this is to some degree true, then they suggest there may be a case for policymakers restricting entry to not-for-profit providers. Though as noted in 4.2 an alternative is an advisor that can help the patient understand what the quality information means for them.

120. A different type of concern is the suggestion that even well-aligned financial incentives to improve quality, may not, as supposed, build upon the intrinsic altruistic motives of health workers to provide better quality services for users (Benabou & Tirole, 2003). Instead, if these motives can be undermined or crowded out by additional rewards for doing so (e.g. the commodification of effort), then the introduction of financial incentives for staff may have ambiguous effects. This might for example suggest that

performance-related-pay for healthcare workers is not a useful tool. However, firms and providers are not the same as individual staff, and evidence suggests that not-for-profit healthcare firms, SOEs and profit-making healthcare firms (e.g. GP practices) each respond to additional financial incentives (Capps et al, 2017).

121. Note however, that this is not to say that non-profit-making providers will not themselves make decisions that damage quality when there are non-aligned financial incentives. That is, when there is a financial incentive to reduce quality. For example, a fine for missing a waiting time target may induce a provider to reduce quality of service in order to meet the target and avoid that fine, particularly if it can do so safe in the knowledge that other patients cannot observe the reduced quality and choose a different provider.

122. In addition to any limitations on the profit-making nature of the enterprise that can be licensed, there may also be licensing restrictions on the ability for non-profit-making enterprises to enter into the provision of a given service. For example, a primary care service that specialises in paediatrics. Some of these restrictions relate to minimum regulated standards for staff, premises and equipment. However, beyond meeting the same necessary standards to be a qualified provider (which might, for example, include the provider's surgeons each having conducted a minimum volume of a specific type of surgery in previous years),[50] and being available for inspection in the same way that incumbent providers are, it is not clear why any further licensing restrictions would be required.

123. However, a lack of additional licencing restrictions for entrants does not mean that other barriers to entry such as fixed set-up costs should be reimbursed. These costs should rest with the provider itself, who must make a decision as to whether the activity that it expects to attract is sufficient to warrant such an investment. Placing such a duty on the payer would inevitably lead to inefficient and excessive entry. Furthermore, if the payer does decide to sponsor entry in specific areas, for instance in inadequately served areas, it would need to be transparent and rigorous in applying criteria to assess the need for sponsorship. Failing to do so would risk supporting entrants over incumbents and hence distorting the level playing field.

4.6.2. Expansion

124. Setting aside which types of enterprise can be licensed to provide planned healthcare services, there may remain restrictions on their ability to autonomously expand capacity. This is because payers often believe that increasing capacity and hence improving access increases demand, which then increases their expenditure. This is sometimes referred to as '*supply*-induced demand'[51] though in fact it simply reflects the standard characteristic of almost all markets that demand is responsive to quality.[52] In this case, this means that improvements in the quality of access will likely attract patients that would have otherwise opted to purchase private insurance. This increases the cost of the publicly funded system but does not represent an inefficiency, rather it is the inevitable price of creating a successful system that does not ration through the provision of poor quality care.

125. A related concern is '*supplier*-induced demand' which is a separate risk that occurs when suppliers are able to use their informational advantage (only the consultant) to fraudulently increase the number of units of a profitable service that they provide in order to increase their profit. Means of addressing this risk include the use of gatekeepers whose referral is required for specialist treatment, and random audits of the clinical thresholds used to determine the need for further treatment.

126. In both cases restrictions on providers ability to expand (or reduce) capacity as a way to control demand are misguided and harmful and need to be removed in order for choice and competition to improve services (see Netherlands).

127. Expansion may also occur through mergers and acquisitions. Such acquisitions often reflect the exit of less successful providers that are absorbed into better performing organisations. They may therefore represent the result of competition in action. However, acquisition by a local rival, rather than remaining an independent competitive force, or being acquired by an alternative acquirer, might also reduce the options for patients to switch to in the event that the provider or the acquirer reduced its investment in its services. This might increase the likelihood that such a reduction would occur (or that unregulated prices would rise). A strong merger control regime is therefore necessary, particularly since unwinding excessive concentration within local markets is extremely difficult and expensive. The independence of this regime will be important since challenging hospital mergers has proved difficult across a range of different countries, and in some this has been exacerbated by regulators of quality or financial stability having a formal role in merger control.

4.7. What incentives should there be to compete?

128. Beyond the question of who should be permitted to enter and expand, there is also a question of what incentives should be created for providers of any type to enter and expand. This is particularly important where the majority of services are provided by state owned enterprises or not-for-profit enterprises. In the absence of shareholders, these organisations may lack the profit motive that we find in standard economic models of the market.[53] This might mean they have weaker incentives to expand, though policymakers might consider that these are worth trading off if they mean less risk of cost cutting that has difficult to observe, but real, effects on quality. However more importantly it might also mean weaker incentives to act early to tackle failure.

129. For example, the lack of shareholders means that there are no long-term investors to provide oversight on the long-term consequences of the board's decision-making. The boards themselves are also unlikely to remain in place over a long period of time. Therefore there is a risk that while the consequences of bad decisions will be borne by a future version of the current organisation (as in any market), that future version will be one which the current management have no significant interest in (financial or otherwise, for example its prospects will not affect today's share price).[54] Since the financial crash, we have learned about the effects of short-termism in the private sector and the way that regulation can encourage that bias. In this case, however, it is a problem of public (and third sector) short termism. Fortunately, some of the same techniques applied to the private sector might apply here. For instance, the pay and pension of senior managers in autonomous state-owned enterprises might be made conditional (subject to claw-backs) upon the long-term performance of that organisation in order to help create the accountability that is required.

130. A lack of accountability can also arise regardless of the nature of the organisation (state-owned, for-profit, or otherwise) if the state is unwilling to allow efficient exit when it is necessary. For example, such a refusal may in practice arise from the consequences of any discontinuity in service that occurs as a result of a necessary exit of a provider. For instance, an inefficient hospital that ceases to provide services would leave thousands of patients in the midst of treatment plans. This prospect understandably drives governments towards short-term measures to prop-up and support failing organisations. However, the prospect of such financial support, and the absence of exit risk that it brings creates a moral

hazard problem. This undermines the incentive for failing organisations to address the challenges they face, knowing they will in any case be bailed out. It also undermines the incentive for successful organisations to invest in expanding given the likelihood that this will trigger support that is designed to prevent a loss of market share by a weaker rival.

131. Therefore a special administration regime is required that goes further than protecting the value of the business as an ongoing concern (as a standard administration procedure would, see UK). Such a regime must have a duty to protect existing and potential users, which is not part of the remit for a standard administrator (except to the extent that this affects the goodwill value of the business). It must therefore be triggered much earlier in the process, and be capable of taking on management of the service while a new provider is contracted to take on the operation of the service.

132. In the case of state-owned enterprises, they may also lack the autonomy of a profit-making firm. They may face public-sector pay constraints that restrict their ability to attract more or better staff, they may not be able to borrow in order to invest. Most importantly, they may find that when politicians change, their autonomy quickly vanishes despite the rules that were intended to protect it being unchanged (see UK). Such restrictions and uncertainties are likely to reduce the strength of the competitive incentives for these organisations to invest in improving the quality and efficiency of their services.

4.8. How should cooperation between providers be delivered?

133. Critics of choice and competition in healthcare services argue that competition prevents healthcare providers from working together to deliver smoothly integrated services.[55] For example, that patient notes are not shared and patients need to repeatedly provide the same information, that tests are repeated, and that referrals between providers happen slowly or are sometimes lost entirely. They also argue that competition discourages providers from intervening early to prevent a distinct provider incurring costs further down the line.

134. While healthcare services are not products that are assembled like a car, it is notable that markets are generally very efficient at incentivising firms to work together to produce efficient and high quality products despite the complexity of having numerous components made by different firms in different countries. Moreover, these incentives rely on competition, and so granting exemptions to competition laws tends to harm consumers rather than help them.

135. However, in some cases cooperation may not emerge naturally from competitive incentives. For example, where accountability for failing to cooperate is unclear a firm may not invest as much in in cooperating as the consumers might like. This might be the case in managing switching processes between firms as the firm that the consumer is leaving may lack an incentive to cooperate as well as expecting that the consumer may hold the new firm accountable for the delay. Similarly, when airlines do not have a credible alternative airport from which to fly, luggage handling by airports may be affected to the extent that consumers hold airlines, rather than airports, accountable for lost baggage.

136. If accountability were a problem in healthcare markets, then one solution in such cases would be to introduce indicators that identify for patients and their referring GPs those providers that are uncooperative. The key being to ensure the behaviour is reflected in their quality indicators. For example in England, delayed transfers of care are measured and categorised on the basis of the cause of the delay. Such an indicator could be given prominence (and due weighting in any composite indicator). Since a seamless and well-

coordinated experience is something that patients value, such transparency could be expected to affect the volume of patients that choose to be treated by the provider and hence to make underinvestment in cooperation an unprofitable decision.

137. However, as in the case of switching, it may be that it is also necessary to impose a duty to cooperate that is backed by fines for failing to do so. As in most aspects of quality in healthcare services, the solution can therefore be a combination of regulatory and competitive incentives. In contrast, exempting providers from competition rules does not create an incentive for better cooperation. At best, it might allow providers to discuss the way they cooperate without fear of colluding. However this does not require an exemption from the rules, it can be achieved by providing advice on which discussions they can and cannot have. Indeed such advice is in any case sensible in a market where non-profit-making firms and SOEs may be under pressure not to spend money on legal advice.

4.9. How should costs be controlled?

138. Fixed budgets give administrators confidence that they can stick to the spending limits they agree with governments. Moving to activity-based payments that create competitive incentives can therefore be unnerving for those that are responsible for the budget (see Korea).

139. In the longer term, choice and competition incentivise more efficient provision and lower costs which will help the system to stay within its budget. However, in the short term there may be a greater risk, even where prices are regulated, that mistaken estimates of the demand for services may create budgetary pressure.

140. In these cases, it is important that rationing is not driven by the need to balance budgets within the year. Such arbitrary accounting driven rationing creates a risk that vital treatment may be withheld from those that need to receive it quickly. In such cases, the best solution is to be transparent about the treatments that will need to be rationed the following year if the current years demand outstrips the allocated budget. That rationing (of next year's services) should be driven by clinical assessment of those treatments that are of limited value. These would then be applied equally across all patients.

141. It is also preferable that balancing measures are not used (See Netherlands). Balancing measures retrospectively deduct a percentage of the activity-based payments from all providers when the actual aggregate demand exceeds the estimated demand. These measures can be damaging both if prices are regulated, and if they are not. If prices are unregulated, then the possibility of a deduction will incentivise providers to increase their own price in order to reduce the impact of any deduction that occurs (see Schut & Varkevisser, 2017). If prices are fixed, the prospect of a deduction may lead providers to expect that each patient they attract might turn out to be unprofitable once the impact of the deduction is considered. This might lead them to conclude that their financial position will be better if they decide not to compete to attract additional patients and so increase their market share. Instead, they might act to discourage patients from choosing their service by allowing waiting times to increase.

142. If there is no confidence in the estimates then capitated payments may make sense. These would require a patient to choose perhaps a GP, a hospital or an insurer to manage their healthcare for the year (and therefore to use that funding to cover all care required within the year). As discussed, if patients have a meaningful choice of providers, then capitated payments can push this risk onto insurers and/or providers without damaging competitive incentives. This helps ensure that budget holders know their expenditure at the

start of the year. This is because when patients move from one provider to another, the payment to these providers is deducted from their previous provider. The impact on the budget as a whole is therefore neutral. This does not remove the risk that the provider that receives this capitated payment might misestimate demand and break their budget, therefore policymakers would need to be ready for the higher likelihood that these organisations might go bankrupt, and be ready to intervene when they do. In general, it is therefore preferable that the larger risk sits with those organisations that are best placed to estimate demand.

4.10. Which institutions do you need to regulate the market?

143. In light of the above, a publicly funded healthcare market will need a number of institutions. It will need a quality regulator to ensure adherence to a minimum acceptable level of quality (see for instance the Netherlands and the UK). Such a regulator would be required for any healthcare system whether or not market mechanisms are adopted.

144. If there are autonomous state-owned enterprises providing services, then there will need to be an oversight body to monitor the financial stability of those enterprises, and a special administrator for when they get into difficulties (see Norway and the UK). In effect, these same functions would be required under a command and control system and so these would also not add cost to the system.

145. Given the peculiarities of the market there will need to be a market regulator (or a specialised unit within the authority in the case of combined competition authorities) to enforce choice rules, assess mergers, investigate anticompetitive conduct and agreements, and to enforce a sector-specific competitive neutrality framework. This market regulator would regulate both the provider and insurance markets (if there were an insurance market). If prices are to be regulated then this should also be within the functions of this market regulator. The market regulator (or the combined competition authority) needs to be structurally independent of the regulator of SOEs, the quality regulator and government ministers in order provide trust that it will not make decisions in the interest of supporting SOEs or indeed any incumbent provider.

146. In single payer systems where there is no insurance market, there will need to be oversight of and support for the procurement activities of the non-competing insurers. This will likely be provided by a national purchasing board, subject to occasional checks by the relevant auditing board for public expenditure.

147. Notably the Netherlands and the UK have each experimented with different institutional arrangements and these continue to change. In the Netherlands the market regulator (the Nederlandse Zorgautoriteit, NZa) sets prices, and until recently was responsible for merger control. The Autoriteit Consument & Markt (ACM) created a health taskforce in 2015, and turned that into a department of the organisation in 2018 when it took on responsibility for merger control.

148. Following the 2005 reforms the UK set up a market advisor (the Cooperation and Competition Panel) that advised the department of health on competition and merger control until 2012 when it took on concurrent competition powers, and price setting powers, and was merged into the body that provided oversight on the financial stability of healthcare SOEs (Monitor, later NHS Improvement). This conflict of interest was somewhat mitigated by the Competition and Markets Authority (the CMA) moving to take on merger control, though Monitor/NHS Improvement continued to assess and advise on the benefits of proposed mergers. Worryingly however, the conflicts of interest appear set to multiply

since the market regulator and oversight body for the financial stability of healthcare SOEs (Monitor/NHS Improvement) has recently announced that it will integrate (though not formally merge) its functions with the National Commissioning Board (NHS England).

5. Conclusions

149. Variations in quality, access and efficiency both between healthcare systems and within individual systems are significant. This suggests that there is a big opportunity to use choice and competition to improve quality and efficiency in these key services.

150. A range of different reforms have been carried out in different countries. These experiences illustrate that different choices made when designing competitive systems can lead to different results. Competition authorities appear to have played a quiet role in these markets and in many of these reforms. This paper therefore argues that competition agencies can and should step up their efforts to advocate for the use of well-designed choice and competition incentives in publicly funded healthcare markets. It suggests that this should not be simply about deregulating, but instead about smarter design and regulation that builds upon the solutions that resolve key market failures by using choice and competition more effectively to resolve the failure of command and control policies to achieve the desired goals.

151. The key points that emerge on the detail of design are as follows.

- Firstly, giving patients the right to make meaningful choices wherever possible (rather than having procurers choose for them) creates stronger competitive incentives on the aspects of the service that matter to patients, leading care to become patient-centred. Empowering patients to make these choices means not only giving them the information they need, but also personalised advice on interpreting it, and partially reimbursing travel costs.

- Secondly, at an institutional level it is fundamental that the split between purchasers and providers be maintained and be strengthened where possible. For instance, if providers are to be given an additional purchasing role, for instance a capitated budget from which to purchase care for their patients, then competition between these provider/insurers must be assured. As the US FTC have shown in respect of Accountable Care Organisations, there is a role for competition agencies to provide guidance on this. Competition agencies can helpfully clarify whether or not public hospitals are single economic entities, or indeed undertakings, and which competition rules apply in publicly funded healthcare markets. For example, this may help in educating healthcare providers (and particularly primary care practitioners) on their duty to comply with competition law. The split between purchasers and providers should also apply to regulation where there should be no conflicts of interest between those responsible for incentivising providers to compete and those with interests in the financial stability of publicly owned providers.

- Thirdly, on payment systems, if prices are regulated it is important that the units of payment that providers compete to supply are defined to reflect an efficient use of resources. In some cases this might mean capitation (e.g. for primary care services and those with long-term conditions). In others, it will mean a bundle of services that goes beyond the small bundles that are currently used and includes

readmissions and follow-ups related to the treatment in question. Since enabling insurers to selectively contract does not appear, as yet, to have driven down prices, there would seem to be a good case for an independent regulator to set a fixed price level for each bundle of services. We argue that any regulated prices should be set at levels that ensure that there is an incentive to compete for each patient. This happens naturally when prices are unregulated. However, if prices are regulated this will require detailed patient level cost data and should be supported by a prohibition on providers selecting the patients they want to treat, since selecting low-cost patients distorts competition.

- Fourth, it should be recognised that there are different types of healthcare services, and that the best solutions for some services are not the same as for all. This is not the case for mental health services, though patients have often been denied the same rights to choose, and to have providers compete for their choices, that have been given to patients requiring physical health services. However, it is the case for emergency services, which require a very different use of competitive mechanisms from planned care. For example, there is a good case for fixed price procurements of these emergency services. Furthermore, if in those cases procurers are unsure of their ability to hold bidders to the promises they make during the bidding, then there may even be a case for limiting the bidders to non-profit making providers. In such cases, it is especially important that there be a clear accounting separation between the emergency services that would then be provided under a public service obligation, and the planned care market in which all providers should be licensed to compete.

- Finally, barriers to entry such as the ability for qualified providers to obtain a contract to offer services, or to expand their capacity, need to be addressed in order to enable innovation and increased capacity onto the market to reduce waiting times and drive competition on quality. In these markets, which have been created and funded by governments, there is perhaps an additional question of whether these subsidies can be too easily captured by firms, thereby creating a straight transfer from taxpayers to shareholders that can be expected to drive rent-seeking. Hence, whether licenses should be available to profit-making firms or only to non-profits will depend on market specific factors. For instance whether patients have adequate information on quality, whether at the point of choice patients choose based on the factors they care about, and whether firms can in practice be effectively held to delivering the quality described in their bids for contracts.

- More important from a competition perspective is that failing providers that are unable to provide good services in an efficient fashion need to be allowed to exit the market. Special administration regimes will be required to ensure that in these instances the transition to a new operator of the hospital or facility in question occurs smoothly and with disrupting the care of patients. This should recognise that the closure of emergency departments is a politically sensitive issue and these decisions should be taken by purchasers on the basis of transparent needs assessments, and should not follow as a consequence of provider failure (since this punishes patients in the local area for the failures of the hospital's management).

Endnotes

[1] For the purposes of this note, we take healthcare services to include not only hospital-based services, but also services delivered outside a hospital setting including primary and community care services (e.g. general practitioners or family physicians) and mental healthcare services (again both hospital based services and those delivered outside a hospital setting.

[2] Command-and-control refers to the top-down, centrally directed management of a health system in which the state both funds and provides services. Such systems demand changes rather than incentivising them. Dissatisfaction with the quality and efficiency of healthcare services produced under these systems is evident in the decisions of countries to adopt pro-competitive reforms that dismantled these command-and-control systems.

[3] Except where specifically noted we refer to competition as being between any providers of the same publicly funded healthcare services.

[4] As the OECD noted in 2010, more and more OECD countries healthcare systems rely on a mixture of choice, competition and regulation, though a handful of OECD countries still rely heavily on centralised command-and-control systems to deliver healthcare (e.g. Mexico and Portugal)

[5] In fact as Wren-Lewis (2016) notes, "to describe the promotion of competition within the NHS as neoliberalism is confusing and alienating"

[6] These are known as ambulatory care sensitive conditions.

[7] http://www.internationalcompetitionnetwork.org/working-groups/current/advocacy/amsis.aspx

[8] Much of the context cited in this section is based on Choné (2017)

[9] Choné (2017) reports that DRG-prices differ in level and scope across public and private providers. The major difference is that physician fees are included in the tariff for the public sector while they reimbursed separately in the private sector. However, even controlling for scope differences, DRG prices are typically significantly higher in the public sector than in the private one.

[10] Services of general economic interest (SGEI) are economic activities that public authorities identify as being of particular importance to citizens and that would not be supplied (or would be supplied under different conditions) if there were no public intervention (http://ec.europa.eu/competition/state_aid/overview/public_services_en.html).

[11] The context cited in this section is based on Brekke & Rune Straume (2017)

[12] We take this objective as a given in what follows since this is a policy decision over which others may disagree. We focus instead on the impact on competition in the individual insurance market.

[13] These paid the penalty tax instead.

[14] https://www.iamexpat.nl/expat-info/insurances-netherlands/dutch-health-insurance

[15] The context and evidence cited in this section is based on Schut & Varkevissar (2017)

[16] Though there was little sign of a reduction in diabetes: http://www.oecd.org/els/health-systems/paying-providers.htm

[17] With certain exceptions, see page 8: https://www.england.nhs.uk/wp-content/uploads/2018/02/choice-in-mental-health-care-v2.pdf

[18] It rejected the proposed restoration of tax breaks for those that opted out of the publicly funded system, recognising the impact on health inequalities this would have.

[19] See Dawson et al 2004; Burge et al 2005; Coulter et al 2005; Ferlie et al 2005.

[20] https://www.theguardian.com/uk/2005/jul/05/nhs.politics1

[21] https://www.ccpanel.org.uk

[22] In line with the quality indicators that were available to patients during this period and in international comparisons such as those in section 2, these studies look at the impact on mortality rates following hospital admissions as an indicator for hospital quality. It is worth noting that recent Cross-sectional analysis has not identified the same effect on Patient Reported Outcome Measures (PROMs, see Skellern, 2018), despite the evidence that demand is highly sensitive to improved PROMs (Gutacker et al, 2016)). This suggests that the market structure variables used are not picking up the intensity of competition. For example, the management of the hospital might be more important than the market structure in determining whether a hospital reacts to the competitive incentives created by the reforms. Fixed effects analysis would then be better able to identify the effects of the reforms (as indeed they have done for other quality indictors).

[23] http://www.bristol.ac.uk/news/2016/april/gps-workload-increase.html

[24] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-mergers-gp.pdf

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf.

[26] It was suggested that this represented the adoption of the "Accountable Care Organisations" model that had developed in the US following the Affordable Care Act. However, this is misleading as there are guidelines from the FTC/DOJ in the US on how they will assess the formation of ACOs, including the proportion of physicians that can be part of an ACO (https://www.ftc.gov/news-events/press-releases/2011/10/federal-trade-commission-department-justice-issue-final-statement). This is in order to ensure that patients can choose to join the ACO or not, and hence to protect the competitive incentives. In contrast, in the UK every GP in a large area is part of a monopoly ACO, and so there is no realistic choice to opt out.

[27] The context and evidence cited in this section is based on Kifmann (2017)

[28] In a system with competing insurers, the insurers are providers who compete to be paid by the state and/or the individual. However, in a system with defined (non-competing) insurers the insurer is the payer. Hence, whether insurers can integrate with hospitals and other service providers depends on the nature of the insurance system.

[29] Some critics maintain that no further incentive is required despite the overwhelming evidence that healthcare professionals and charitable and state-owned organisations, reliably respond to financial incentives to change their behaviour.

[30] For London choice pilot see Dawson et al 2004; Burge et al 2005; Coulter et al 2005; Ferlie et al 2005.

[31] https://www.kingsfund.org.uk/sites/default/files/Patient-choice-final-report-Kings-Fund-Anna_Dixon-Ruth-Robertson-John-Appleby-Peter-Purge-Nancy-Devlin-Helen-Magee-June-2010.pdf

[32] Though this is put at risk where referrers have the ability in practice not to offer choice to patients they do not believe would value it. See for instance the kings fund interviews with GPs that find them failing to offer choice to the elderly and those on lower incomes, despite these being the very type of patients that most valued the opportunity to exercise their right to choose.

[33] In single payer systems, this means running a competitive process to identify which providers should operate the limited number of units in an area. For example emergency stroke, or major trauma units.

[34] For example, restaurant reviewers, customer reviews and star ratings systems.

[35] Delayed transfers of care, outpatient follow-ups.

[36] https://www.huffingtonpost.com/oecd/putting-people-at-the-cen_b_14247824.html?guccounter=1. Building upon PROMs and PREMs http://www.oecd.org/health/health-systems/PaRIS-Booklet.pdf

[37] In some cases, reducing costs may increase quality – e.g. reducing unnecessary follow-ups or readmissions. However, the incentive to reduce price will not distinguish between quality improving cost cutting, and the simple cutting of costs through reduced investment in quality (e.g. staffing levels, up to date equipment).

[38] Proper & Burgess find it did in the UK, but Roos (2018) does not find evidence of the same in the Netherlands. Gaynor, Ho & Town (2014) find the evidence to be mixed.

[39] The protocols for the collection of standardised cost data can be set out and enforced by the body responsible for price setting (see the UK and see section 4.10 in which we discuss the institutional setting).

[40] Notably the gathering of good cost data is in any case necessary for cost control in a command and control system and so is not a cost that is only incurred when using market-based mechanisms.

[41] For example in other regulated industries forward looking long run average incremental cost (LRAIC) are used to reimburse efficiently incurred fixed costs. https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32009H0396

[42] More effective is the use of gatekeepers for more specialised care

[43] See Biggar & Fels (2017)

[44] A common but misleading attack by critics is to link choice and competition with the introduction of charges (which may run the risk of undermining the equitable access objectives of a publicly funded healthcare system).

[45] This might ensure patients across the country are able to access a standard emergency unit within a certain time, while also being able to access a more sophisticated unit that deals, for example, with large volumes of hyper-acute stroke cases, within a given time period.

[46] The same principle applies to both physical and mental health care systems in which prevention or early intervention can forestall the need for later more expensive treatment once a condition has developed.

[47] This would depend on what patients care about – safety, outcomes, experience, waiting time.

[48] In light of the unsatisfactory experience in the US with HMOs (Health Management Organisations), some suggest the capitation fee should be paid directly to a group of providers, or a lead provider (James & Poulsen, 2016). In that case, these providers take on a dual role as an insurer as well as a direct provider.

[49] In contrast, paying a fee for each service leaves the risk with the payer.

[50] See for example paediatric heart surgery in which the retention of surgeons with minimum surgical volumes have been required in order to licence providers. Notice that it is not the volume at the hospital that matters, but the volume conducted by the individual surgeon across multiple organisations.

[51] This is distinct from 'supplier-induced demand', which is a separate risk that occurs when suppliers are able to fraudulently increase the number of units of a profitable service that they provide in order to increase their profit. Means of addressing this risk include the use of gatekeepers whose referral is required for specialist treatment, and random audits of the clinical thresholds used to determine the need for further treatment.

[52] The elasticity of demand with respect to quality of access

[53] While it would be convenient to model them as enterprises whose objective is to maximise profit so as to reinvest it, this may be wishful thinking. Objectives might more likely include expanding the output of and employment within the enterprise, increasing the welfare of users, or increasing the salary of the senior managers.

[54] As well as the local community that rely on the services that the organisation provides.

[55] One definition of coordinated care is provided by National Voices, a patients charity in the UK who describe it from the perspective of a patient receiving coordinated care: 1) 'I only need to tell my story once.' 2) 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.' 3) 'I am supported to understand my choices and to set and achieve my goals.' 4) 'The professionals involved with my care talk to each other. We all work as a team.' 5) 'I am told about the other services that are available to someone in my circumstances, including support organisations.' 6) 'I have information, and support to use it, that helps me manage my condition(s).'

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