The regulation of competition between publicly-financed hospitals

Stefanie Ettelt
Sarah Thomson
Ellen Nolte
Nicholas Mays

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Main findings

1. This report describes the nature, extent and regulation of competition between hospitals in the public sector in 12 countries (Australia, Canada, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Spain, Sweden and Switzerland). It is based on a rapid review, with information provided by experts from the International Healthcare Comparisons (IHC) network in response to a set of questions addressing issues identified by the Department of Health (see appendix). The report provides a brief overview of the position in each of the countries. In the time available, it has not been possible to collect data on the impact of competition or the consequences of different forms of pro-/anti-competitive regulation.

2. The report focuses on competition between hospitals in the publicly-financed hospital sector. Definitions of 'public sector' and boundaries between the public and private sectors vary between countries. In this report, public sector hospitals are defined as predominantly publicly financed, but may be publicly or privately owned.

Competition for patients

3. We distinguish between two forms of competition: competition for patients and competition for the contracts of purchasers. Conceptually, competition for patients requires patient choice of provider. Choice of hospital may be restricted to a region (as in Switzerland) or may apply to hospitals throughout a country (as in Germany).

4. However, patient choice only provides hospitals with an incentive to compete for patients if hospital payment is in some way associated with activity, for example when 'money follows the patient' through fee-for-service reimbursement or activity-based funding in the form of diagnosis-related groups (DRGs). Hospitals paid entirely or mainly through global budgets (as in Canada) are unlikely to compete for patients. In many countries activity-based funding of hospitals is gradually being phased in [1], which may have an impact on their competitive behaviour in future. The impact of activity-based funding on competition may also be influenced by the proportion of activity-based funding in relation to other methods of funding hospitals.

5. In Canada, Finland, Spain, Sweden and Switzerland hospitals in the public sector appear not to compete for patients; however, the scope for competition may increase in Switzerland following the introduction of activity-based funding in 2008.

6. Limited forms of competition for patients exist among publicly-financed hospitals in France, Germany and Italy (with the potential exception of the Lombardy region, where competition may be more prominent). In France and Germany patients have traditionally been allowed to select any hospital for treatment, but only recently has hospital reimbursement begun to reflect activity; previously public hospitals in France were funded through global budgets, while in Germany hospitals were reimbursed via budgets and per diem payment. Consequently, the incentive to compete for patients has been small. However, incentives to compete may increase when activity-based funding is fully implemented (2009 in Germany and 2012 in France).

7. A number of countries have recently begun to increase the scope for competition through the expansion of patient choice of hospital, with the wider aim of lowering waiting times for hospital care. These countries include Denmark, Lombardy in Italy and Norway, all with tax-funded health systems similar to the English National Health Service (NHS). Competition between hospitals (and between statutory health insurance funds)

has also been actively promoted in Germany and in the Netherlands, reflecting a preference for market-based incentives to improve the efficiency of health care delivery.

Competition for contracts

8. Competition for contracts involves hospitals competing to provide hospital services for a defined group of people on behalf of a particular funding agent, for example, members of a particular sickness fund or people living in a particular area.

9. Only a few countries actively promote competition between publicly-financed hospitals for contracts. Although this has been a longstanding policy in Australia, its application in Europe is more recent. Since 2005 in the Netherlands, for example, hospitals have been allowed to negotiate prices with individual health insurers for a limited number of elective services (the so-called 'Segment B'). The 2007 health reforms in Germany have widened the scope for hospitals to form agreements with individual sickness funds for a number of outpatient services. As yet the scope for competition for contracts is very limited in both countries.

Competition vs capacity planning

10. Despite sharing the objective of improving provider performance, capacity planning and competition are often viewed as opposing concepts. Countries with a strong tradition of central or regional planning, such as Canada, France, Italy (except Lombardy) and Switzerland, have not (as yet) encouraged competition between hospitals, although activity-based funding may lead to competition in future.

11. All countries reviewed here plan hospital capacity to some extent. With the possible exception of the Netherlands, most planning is performed by central or regional authorities with the aim of ensuring that publicly-financed hospital care is equitably distributed and accessible. Cost containment (for example, reducing excess capacity and promoting efficiency and cost-effectiveness) is frequently an additional objective [2].

12. In some countries in which competition has recently been promoted, planning by a central or regional authority has either been abolished (Netherlands) or is expected to be modified in future (Germany) [3]. However, this is not always the case. In Denmark, for example, the National Board of Health is expected to be more strongly involved in central planning in future, even though choice and competition are encouraged by central government policy. It is also worth noting that competition among publicly-financed hospitals in the Dutch health system – arguably the most committed to employing market-based incentives in the health sector in Europe – is heavily regulated. Health care authorities in the Netherlands have retained the authority to intervene and impose additional rules relating to competition should the market approach fail to deliver desirable results.

Regulation of competition

13. In countries with very limited competition between publicly-financed hospitals, issues arising from anti-competitive behaviour are likely to be regulated by the central or regional health authorities (e.g. canton departments in Switzerland, health departments in Italian regions, the National Board of Health in Denmark and regional hospital authorities in France).

14. Other countries, including those in which competition between hospitals has traditionally existed (e.g. in the case of privately-owned hospitals in Australia) or where competition has recently been encouraged (Netherlands), tend to regulate hospital competition via a

national competition authority responsible for overseeing a variety of markets. This distinction may reflect different perceptions of the hospital sector either as a market for health care or as a public service sector.

15. Countries vary in the extent to which they are proactive or reactive in regulating anti-competitive behaviour among hospitals. The most commonly and systematically regulated area is mergers and acquisitions (with the intention of avoiding abuse of a dominant market position). In some countries hospital mergers require the approval of the national competition authority (for example Germany, the Netherlands and Spain). Approval is not officially required in Australia, but hospitals tend to consult the competition authority in advance to avoid litigation. In other countries hospital mergers require authorisation from the relevant health authority (Canada and France) and/or are part of a regional planning process (France).

Competition vs integration of care

16. The relationship between competition among publicly-financed hospitals and co-operation among providers has not been systematically evaluated here. Corresponding to their preference for competition or planning (although this may not be the only reason for differences in integration of care), most countries appear to fall largely into two categories: those with a strong tradition of planning tend to have more experience of promoting clinical pathways and co-operation between providers (Canada, Sweden) than countries that have traditionally favoured more provider competition (Australia, competition among office-based physicians in Germany).

17. In Denmark the promotion of choice and competition coincides with the central government's commitment to improve clinical pathways and to enhance co-operation between health care providers. Regional health authorities are now charged with implementing both (potentially conflicting) agendas. However, some have argued that competition and co-operation may not be contradictory goals because competition is promoted among providers of the same services (e.g. hospitals), while co-operation is mainly encouraged between providers of different services (e.g. between general practitioners and hospitals or between secondary care hospitals and tertiary care hospitals).

The impact of European Union (EU) competition law

18. The role of EU competition law has not been systematically assessed in this report, in part because its application to publicly-financed hospitals is less well described and does not appear to be as clear-cut as its application to statutory health insurance, which has featured prominently in the case law of the European Court of Justice (ECJ).

19. On the basis of the information compiled here we make three country-specific observations. Publicly- and privately-owned hospitals in Germany are subject to competition law based on their definition as 'undertakings', reflecting a key principle of EU competition law. Competition law in Finland also applies to publicly-owned hospitals if they are involved in 'economic activity' (in other words, if they are undertakings). However, in practice this has rarely been of consequence and the application of the law depends on whether the activities of a hospital are defined as 'economic'. In contrast, Spain has exempted publicly-financed hospitals (both publicly- and privately owned) from competition law in reference to Article 86 of the EC Treaty, which allows the exclusion of 'undertakings entrusted with the operation of services of general economic interest […] insofar as the application of such [competition] rules does […] obstruct the performance, in law or in fact, of the particular tasks assigned to them'.

20. The complexity of the evolving ECJ case law is illustrated by the case of FENIN (an association representing the majority of supplies of medical goods and equipment in Spain) vs the European Community, which was decided by the Court of First Instance, a court that resolves disputes attached to the European Court of Justice, in March 2004. FENIN challenged a decision by the Community in favour for the Spanish National Health Service (SNS), claiming that the SNS abuses its dominant market position by unduly delaying payment for purchased goods. The Court endorsed the decision, pointing out that 'it is the nature of the use to which the goods purchased are subsequently put […], which determines whether or not a purchase is made as part of an economic activity. Consequently, when a body or organisation purchases goods or equipment for use in an activity which is not economic in nature, for example one which is purely social, it is not acting as an undertaking, even if it wields considerable economic power.'[1]

1 See http://curia.europa.eu/en/actu/communiques/cp03/aff/cp0312en.htm

Australia

Judith Healy

Competition between publicly-funded hospitals

Competition is a prominent feature of the Australian health system, with competition between hospitals actively pursued and regulated. Competition policies mainly apply to private rather than public providers such as state-owned hospitals. Private hospitals and clinics fall into two categories: private for-profit and private not-for-profit, with the latter often run by charitable organisations. Both private and public hospitals receive state-funded subsidies (i.e. are at least partly publicly funded). In recent years the differences and boundaries between public hospitals, private for-profit hospitals and private not-for-profit hospitals have become increasingly blurred; for example, many publicly-funded hospitals outsource 'non-core' (i.e. non-clinical) services to private firms [4].

Competition, including competition between hospitals, is regulated through the Trade Practices Act 1974, the Competition Policy Reform Act 1995 and equivalent legislation in the states and territories. The Trade Practices Act prohibits anti-competitive behaviour including market share and price fixing agreements, abuse of dominant market position, exclusive dealing, resale price maintenance, some mergers or acquisitions and unconscionable (unfair) conduct (with the possibility of exceptions). Section 50 of Part IV of the Trade Practices Act prohibits mergers that are likely substantially to lessen competition in a market. The Trade Practices Act applies to all hospital mergers/acquisition in which a hospital changes its ownership status. It would not apply if two public hospitals owned by the same state government were merged, but would regulate mergers between two autonomous incorporated hospitals (hospitals with a status similar to NHS foundation trusts), since these hospitals have two different (and quasi-independent) owners.

Several types of potential anti-competitive behaviour by hospitals are of particular concern to Australian policy-makers: hospital mergers that potentially undermine competition (i.e. which would lead to a dominant market position); collusion on fee-setting in relation to contracts with private health insurance companies; collusion related to employment arrangements for health professionals; and risk of market-sharing arrangements between hospitals. Vertical mergers appear to be less of a concern, mainly because they are supposedly rare – there is little vertical integration of payers and providers in the Australian health system.

Responsibility for regulating competition

Competition between hospitals and other health care providers falls under the remit of the Australian Competition and Consumer Commission (ACCC)[2]. The ACCC oversees and regulates all commercial activities; its main role is to protect the rights of consumers and businesses and it does so by encouraging vigorous competition in the market place and by enforcing consumer protection and fair trading. The ACCC is also responsible for overseeing mergers and acquisitions and gives authorisation for certain types of anti-competitive behaviour (including exceptions from anti-merger jurisdiction) on the grounds of 'public benefit' (i.e. when the benefit to the public outweighs the potential negative effect of anti-competitive behaviour). There are no exemptions for abuse of market power [5].

2 See http://www.accc.gov.au/content/index.phtml/itemId/142.

Box 1 The definition of public benefit

Public benefit is not defined by legislation (the Trade Practices Act), so what constitutes a public benefit appears to be a matter of interpretation. The authoritative view taken by the Australian Competition Tribunal, the decision-making body of the ACCC responsible for approving merger applications, has been summarised as 'anything of value to the community generally, any contribution to the aims pursued by the society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress' [6]. This definition applies to virtually all markets and is not specific to the health sector. In practice, the concept of public benefit has been applied to economic benefits arising from, for example, increased economic productivity and positive effects on employment and export. The concept has also been used to account for non-economic public benefits related to issues of public health and safety and environment protection, as well as related to the implementation of specific policies (e.g. deregulation of certain industries). According to the Chairman of the ACCC, Allan Fels, the concept of public benefit in Australian law appears to go beyond the definition used in the European Union [6].

The ACCC acts both pro-actively and reactively (following a complaint). Hospitals usually seek legal advice prior to a merger to evaluate whether the ACCC would oppose the transaction. They might then seek formal confirmation from the ACCC that the public benefit outweighs the negative effects of anti-competitive behaviour. If the ACCC objects to a merger, the enterprise/hospital has the option to 'offer an undertaking' – that is, to reduce its market share to avoid a dominant market position (see Box 2). The role of the ACCC is therefore largely to negotiate and mediate, while weighing the interests of businesses, consumers and patients. However, it also has the capacity to enforce its actions and to take offenders to court.

Box 2 The Mayne Nickless merger

In 2001 the ACCC opposed the acquisition of several hospitals in Australia. If it had gone ahead, the merger would have increased the share of the private hospital company Mayne Nickless to almost 90 per cent in one region (Gold Coast) and to 40 per cent in Melbourne. After the ACCC declared its opposition to the merger, the company offered to divest four hospitals, bringing their market share in Melbourne down to 30 percent and maintaining their market position on the Gold Coast unchanged. Through this undertaking health insurers would continue to have the option to contract hospitals not owned by Mayne Nickless.

Source: ACCC Update 12 Health part 3, available from http://www.accc.gov.au

A separate organisation, the National Competition Council (NCC), oversees the implementation of the Competition Policy Reform Act (1995). The NCC is funded by the central government but is accountable to the states (see http://www.ncc.gov.au). Its role is that of a policy advisory body that supervises and assesses the progress made by the states and territories in maintaining and protecting competitive markets. The NCC also makes recommendations to the central government on competition payments, i.e. payments of the central government to the states and territories to incentivise the implementation of the Competition Policy Reform Act[3].

3 These payments are made on a per capita basis and reflect the progress made by a state or territory on implementing the Act. The rationale of this policy is to distribute the gains of the competition across the states/territories, as much of the economic benefit of competition accrues to the central government through increased taxation revenue reflecting greater economic activity [7].

Canada

Carl-Ardy Dubois

Competition between publicly-funded hospitals

In Canada competition between publicly-funded hospitals is very limited. Most publicly-funded hospitals are private not-for-profit organisations funded by provincial governments on the basis of budgets. In most provinces, private health insurance is not allowed to cover services provided under provincial health plans.

Although there is an ongoing debate about the role of competition, there have been few attempts to promote competition between hospitals. The Ministry of Health in Alberta has recently approved private surgical facilities to provide a limited set of procedures within the framework of provincial services. Similar developments have been observed in Quebec. However, these steps appear to be tentative. Most recent initiatives in the hospital sector have instead focused on: improving the coordination of care by integrating hospitals into local or regional provider networks; performance measurement; and modifications to the budgeting system. Overall, there is an emphasis on co-operation and integration among service providers rather than on competition.

Responsibility for regulating competition

Given the limited role of competition between publicly-funded hospitals, there is no health-specific regulator for competition. Most hospitals receive a global budget to fund their activities, negotiated with the provincial government. Provincial governments also regulate the acquisition of major equipment and facilities and determine the fees for physicians, whose services are separately reimbursed in addition to the hospital budget. Many provinces have devolved responsibility for organising hospital care to regional health authorities.

Generally, regulation of hospitals falls under the jurisdiction of the provinces. However, the basic principles of health care provision and administration are defined at the national level through the Canada Health Act (CHA), which specifies the terms and conditions the provincial health plans must meet in order to qualify for their full share of the federal health subsidy. The federal Minister of Health is required to report to parliament about the administration and operations of CHA on an annual basis (Canada Health Act Annual Report). The focus of this legislation is on access and equal distribution of hospital services rather than on competition between hospitals.

At the provincial level most of the recent major initiatives relating to hospital regulation have concentrated on measuring and publishing information on hospital performance. Ontario, for example, began to publish annual reports on hospital performance in 1998. These reports cover a broad range of services including acute care, emergency care, complex continuing care, rehabilitation and mental health (http://www.hospitalreport.ca/index.html). Hospital Report Cards provide information for patients to help them to choose the hospital that provides the best care for their needs (http://www.hospitalreportcareds.ca).

Mergers and acquisitions need the approval of the provincial ministries of health. In practice, however, most mergers have been part of the process of vertical or horizontal integration and the formation of local health networks. Regional health authorities therefore play a key role in promoting the institutional integration of care.

Denmark

Allan Krasnik, Mikkel Bernt Nielsen, Martin Strandberg-Larsen and Hans Okkels Birk

Competition between publicly-funded hospitals

Most hospitals in Denmark are publicly funded (through national and local taxation) and owned and operated by the 5 regions (formerly 15 counties, including the city of Copenhagen). Privately-owned hospitals and clinics play a minor role and mainly offer elective services, although they may also be publicly-funded. Publicly-owned hospitals are reimbursed through global budgets and diagnosis-related groups (DRG), with nationally-uniform prices set by the National Board of Health.

Since the 1990s there has been a gradual move towards competition and the introduction of other market elements. However, these changes represent a modification to the publicly-funded health system rather than a fundamentally new approach. As in many other countries, purchaser and provider functions have been separated. Regions and publicly-owned hospitals enter into agreements about the volume and quality of care to be provided, including targets for research and teaching and specific targets for areas deemed to require further development. Although an agreement is not legally binding, compliance is incentivised through additional funds available on implementation.

Activity-based funding
Activity-based funding through DRGs is now used for several purposes. First, regions receive 5% of their revenue based on activity measured in DRG points. DRGs are also used as a reimbursement mechanism between regions, for example when patients receive treatment in a region in which they are not resident. Regions therefore have an interest in ensuring that residents/patients are satisfied with the care they provide.

Secondly, activity-based funding is used to pay hospitals and departments (many hospital departments receive separate budgets). Central regulation stipulates that at least 50% of hospital funding must be distributed based on activity measured in DRG points. Overall budgets are capped, so if a hospital's activities exceed the budget ceiling it receives less for each extra DRG point. Finally, privately-owned hospitals are reimbursed through activity-based funding if they provide publicly-funded treatment. In contrast to publicly-owned providers, no budget ceiling applies to private providers, providing an incentive for flexible production; however, privately-owned providers have no budgetary certainty and therefore carry the full financial risk of their operations.

Patient choice
Patient choice of provider has been introduced as a patient right. Patients referred to hospital by a general practitioner can choose to be treated in any Danish publicly-owned hospital. If the waiting time for a particular service is expected to exceed two months (one month from October 2007), patients may also choose to be treated in a privately-owned clinic or in a hospital abroad. If the patient opts to receive treatment in a private facility, this service will be reimbursed by the region in which the patient is resident. Private clinics are required to enter into an agreement with the region to be eligible for reimbursement, but as the central government encourages the regions to engage more with private providers, it is easy for private providers to enter the market.

There is a perception that the number of patients making use of choice has increased over time, although official data do not permit accurate measurement to confirm a trend. Based on data from the National Patient Register, one official study shows that the proportion of non-acute patients treated outside their home county (now region) has risen from 8% in 1997 to 11.3% in 2003. However, the study does not give a complete picture as it does not provide data on

choices made within counties and it includes patients who were treated outside their home county because the home county did not offer some form of highly-specialised treatment.

In 2004 a study funded by the Ministry of Health concluded that the number of patients who made use of the 'extended choice scheme' (i.e. the option to use the services of a private hospital if the waiting time exceeds a threshold) had risen from 2,000 in 2002 (third quarter) to 6,000 in 2004 (fourth quarter). Eye surgery, orthopaedic surgery, ear, nose and throat treatment and plastic surgery largely accounted for this increase. Although the number of treatments has tripled and waiting times still persist in some areas, the data indicate that waiting times are less pronounced than in other countries. However, the limited use of choice may also be influenced by other variables such as travel costs, limited availability of information on quality of care and patients preferring to be treated close to home.

The idea of patient choice appears to contradict some of the organisational aspects traditionally associated with the Scandinavian welfare model, in which decentralised entities (counties, now regions) are responsible for delivering care to a geographically-defined population. Patient choice challenges the established way of thinking about production capacity, while increasing the financial risk of regions by allowing patients to vote with their feet. This in turn requires regions to co-ordinate the benefits they provide, particularly with regard to highly-specialised services and investment in new treatments and technologies. Despite these challenges, most political parties in Denmark have embraced the concept over the past decade and patient choice is now established as valuable in its own right.

A 2006 survey of hospital managers and hospital department managers indicated that a large proportion of hospital managers perceived the environment in which hospitals operate as competitive; the perception of competition increases proportionately to the geographical concentration of hospitals (see www.sundhedsreform.ku.dk).

Patient information
Patient information plays a key role in competition. Lack of information, which prevents patients from exercising their right to choose a health care provider, is one of the government's main concerns. Hospital departments have to inform patients about their options and their right to receive services from an alternative hospital when writing to confirm a referral made by a general practitioner.

In 2006 the Ministry of Health and the National Board of Health established a joint website (sundhedskvalitet.dk) providing information about all publicly-owned hospitals, including data on waiting times, patient satisfaction and quality of care (similar to the star-rating system in the English NHS). The website also provides information about alternative treatment options in the private sector to allow patients to choose a private provider if their waiting time exceeds the limit.

Responsibility for regulation of competition

At present there is no perceived need to regulate competition. However, if regulation were seen to be necessary, the Ministry of Health and the National Board of Health would be most likely to be given this task, as the National Competition Authority (National Competition Authority: http://www.ks.dk) is responsible for overseeing competition in the private sector only. The National Competition Authority is an independent body of the Danish Ministry of Economic and Business Affairs responsible for regulating competition matters, as well as the energy sector, public procurement and state aid. The Authority is also charged with the implementation and administration of EU directives in public procurement and it co-operates with the EU Directorate General for Competition (and with other national competition authorities) on a number of tasks (see http://wwwks.dk).

Mergers in the public sector are encouraged rather than seen as an issue for regulation. For example, in January 2007 the central government restructured the public administrative system by merging the 15 counties into 5 regions. In the health sector it is hoped that this move will address the issue of excess capacity in publicly-owned hospitals.

So far, there have been no concerns that vertical integration of services could undermine competition or choice. This is mainly for institutional reasons; patients are referred to hospital by general practitioners who are directly paid by the regions and are economically independent from hospitals. The level of vertical integration is therefore low.

In January 2007 the central government expanded the role of the National Board of Health in planning the capacity of specialised services in hospitals. This planning function now applies to both private and public facilities. Prior to 2007 the National Board of Health developed guidelines and made suggestions for the division of tasks between publicly-owned secondary and tertiary hospitals, although these were not binding. Privately-owned hospitals were not previously subject to planning and had been allowed to provide any service. It is not clear yet to what extent the central government will use its authority to plan the service capacity of private providers.

Competition vs. integration of care

There is a general concern that integration between providers of different health services could be improved. The central government has frequently criticised regions (previously counties) for the lack of co-operation between hospitals and has also emphasised that the future of the regions (whose core responsibility is the administration of the public health sector) depends on their ability to improve the integration of care. In particular, integration of care is considered to be desirable between general practitioners and hospitals and between secondary and tertiary hospitals (e.g. for cancer patients operated on at secondary hospitals and referred to tertiary hospitals for radiotherapy). Tools that have been developed to promote integration of care include referral guidelines for GPs, the employment of GP 'liaison officers' in many hospital departments and improved IT-based communication tools for GPs and hospitals. Also, a detailed description of the division of tasks between secondary and tertiary hospitals has been provided to improve care pathways involving several hospitals.

From the regions' perspective it may seem paradoxical to be required to promote competition while also being expected to improve integration of care. However, it could be argued that care pathways have always been insufficient, even before competition was actively promoted. It is also worth noting that competition is most likely to involve providers of the same service such as secondary care hospitals in different areas/regions, while integration and co-operation is mainly desired among providers of different types and levels of care.

Regulation of advertising

Hospitals are allowed to advertise. Hospital advertising is regulated by the same rules that apply to all sectors and by an additional law specifically applicable to hospitals and clinics (Lov om markedsfoering af sundhedssydelser, 6 May 2003). Advertising in the health sector is overseen by the National Board of Health as the general regulatory body was considered to be insufficiently equipped to regulate health care advertising.

Private hospitals regularly advertise their services, e.g. in 'Dagens Medicin', a free weekly magazine distributed to all physicians. Public hospitals rarely advertise and they have little incentive to do so as: most have more patients than they can treat within the national waiting time target; they would be likely to be questioned by taxpayers and politicians on whether advertising constituted an appropriate use of public resources; and they might also have to defend themselves for implicitly criticising the services of other public hospitals.

Finland

Juha Teperi

Competition between hospitals

To date, the issue of competition has been of minor importance in the Finnish health system, where hospital care is predominantly provided by publicly-financed hospitals owned and regulated by hospital districts (the joint administration of a group of municipalities). There are few privately-owned hospitals and they typically have a complementary rather than competitive relationship with public hospitals (e.g. private hospitals may provide services that public hospitals do not provide or do not provide beyond a certain volume). The advent of new forms of public hospital ownership and governance such as 'public corporations' (organisations owned by municipalities and managed as enterprises) has not been tested under competition legislation.

Responsibility for regulating competition

Health care has no special status in national competition legislation. As soon as an organisation acts as an 'undertaking' it is subject to competition law, irrespective of its ownership. National competition law is in line with EU competition law, thus an 'undertaking' is defined based on whether or not it carries out economic activities. However, in the public hospital sector interpretation of 'economic activity' is not entirely clear cut. From the competition regulator's perspective, a public hospital acts as an undertaking as soon as it: engages in 'selling' products to customers; negotiates prices; and markets its activities to customers other than to the municipality that owns it (hospitals are allowed to advertise their services). Thus, the same set of rules applies to both public and private hospitals, provided the public hospital engages in entrepreneurial behaviour. In practice, however, the competition regulator has hardly ever intervened in a case of hospital reorganisation.

At the highest level the Ministry of Health is responsible for supervising hospitals. The Ministry is most likely to intervene in changes of hospital ownership (or reorganisation) if the change poses a threat to access to or quality of care. Competition or anti-competitive behaviour has not yet been perceived as a major challenge.

There appear to be no cases in which a regulator has opposed a merger. Mergers are neither systematically investigated nor do they require approval. Mergers have mainly involved 're-organisation', with public providers trying to streamline services by merging facilities.

Attempts to improve efficiency and to contain the costs of hospital care tend to focus on the integration of services rather than on competition. Vertical integration of primary and secondary care providers is actively encouraged and pursued as a policy goal. However, officials involved in the regulation of competition expect that ownership of hospitals will diversify in future, requiring a new approach to regulation.

France

Isabelle Durand-Zaleski

Competition between hospitals

Competition between hospitals is very limited in France, reflecting a strong tradition of regional or central planning. Hospitals in France are mainly public or private not-for-profit organisations. Private for-profit hospitals play a minor role, mainly in the provision of minor surgical procedures. Most hospital services are publicly funded through statutory health insurance, irrespective of a hospital's ownership status. Hospitals are regulated and overseen by regional hospital authorities (*Agences régionales d'hospitalisation,* regional administrative bodies accountable to the Ministry of Health) who exercise a strong role in planning regional hospital capacity for both public and private hospitals. In contrast to regional health authorities elsewhere, regional hospital authorities in France do not consider themselves to be purchasers of health services; rather they see themselves as representatives of the state responsible for ensuring that health services are provided equitably throughout the country.

Responsibility for regulating competition

To the extent that it exists, competition between hospitals is regulated through regional planning, a process involving a range of regional stakeholders overseen by the regional hospital authorities. The main planning tool is the *Schema régional d'organisation sanitaire*, SROS, which determines the type and level of activity in each service area and is negotiated by a range of regional stakeholders, including representatives of the public, private for-profit and private not-for-profit hospitals.

As services are funded through statutory health insurance, the main concern of regulators is to maintain (and improve) the quality of care and to ensure access to care across regions. Consequently, competition is not officially regarded as desirable or encouraged. In practice, however, competition may exist between certain types of providers, for example privately-owned clinics specialising in profitable services such as day surgery and sports medicine. On the other hand, hospitals often argue that they need more funds for (arguably less profitable) activities such as emergency care, transplants and teaching and research. Some private hospitals also have concerns about being required to provide (potentially unprofitable) services in remote areas (for example, emergency care).

The SROS scrutinises hospital mergers and other changes in service infrastructure. Mergers and acquisitions have to be approved by the regional hospital authority, which considers the costs incurred by the merger, changes in service provision to the population living in that area, the potential for economies of scale and information on hospital activities derived from the hospitals' accreditation reports. Regulation associated with the SROS applies to both public and private hospitals and both types of hospitals have to undergo accreditation with the regional hospital authority based on the same set of criteria. Until recently, public and private hospitals were funded through different mechanisms. However, funding mechanisms are intended to converge by 2012, when the implementation of the diagnosis-related groups system is completed.

Germany

Stefanie Ettelt and Ellen Nolte

Competition between hospitals

Competition between hospitals has traditionally been limited in Germany. Hospitals fall into three categories of ownership: public, private not-for-profit and private for profit. About 90% of the German population have statutory health insurance; consequently, hospitals are mainly publicly funded. Hospitals are reimbursed based on activity using diagnosis-related groups, which have gradually been replacing budgets and per diem funding since 2004 and are expected to be fully implemented by 2009.

Hospitals have only recently been allowed to compete for contracts and only for a limited range of services. For most services, hospitals included in a region's (*Land*) hospital plan are collectively contracted by the regional association of sickness funds. Prior to 2004 these contracts covered the entire spectrum of hospital services. Since 2004 individual hospitals are allowed to contract with individual sickness funds for certain types of care, such as outpatient care for patients with specific chronic diseases (for example, cancer, cystic fibrosis and HIV/AIDS).

Despite the limited scope for competition for contracts, hospitals are expected to compete for patients through the quality of the care they provide. Competition has also been encouraged in the latest health system reform (legislation was passed by the *Bundesrat* in February 2007), although the reform mainly focuses on competition between health insurers and hospitals have been only marginally affected. Anecdotal evidence suggests that hospitals increasingly target office-based doctors in ambulatory care (for example, through personal visits from the head of the hospital or hospital department) to influence their referral behaviour.

Regulation of competition between hospitals

The past 15 years have seen an increasing number of publicly-owned hospitals being sold to private hospital firms (with Rhön, Asklepios, Sana and Helios being the largest chains). Between 1990 and 2003, the number of hospital beds in private for-profit hospitals more than doubled and the share of private for-profit hospital beds increased from 3.7% to 9.4%[4]. At the same time the total number of hospital beds in Germany fell by 19%.

Public hospitals are owned and operated by a variety of public entities, such as municipalities, districts (*Kreise*) or regions (*Länder)*. For various reasons, partly reflecting the costs of the unification and general economic constraints, public entities across Germany have accumulated substantial budget deficits, a circumstance that has made it difficult for public owners to finance and maintain public infrastructure. The financial strain has affected hospitals in two ways: first, by limiting investment in hospital facilities and major technology, which is a responsibility of the *Länder* in relation to all (i.e. public and private) hospitals; and secondly, for public hospitals, through limited financial capacity to finance general maintenance and smaller investments. Changes in the funding of hospitals' operational costs through the introduction of DRGs have increased the volatility of hospital budgets, shifting additional financial risk from sickness funds to hospitals/hospital owners. Thus, public owners have regarded selling a hospital as a welcome strategy to relieve public budgets of financial obligations and shift the risks associated with hospital ownership.

Mergers and acquisitions of hospitals have to be approved by the *Bundeskartellamt* (Federal Cartel Authority), the overall regulator of competition in Germany. The mandate of the Federal

4 Source: Reinhard Busse, personal communication.

Cartel Authority is based on the national Competition Act ('Act against the Restraint of Competition', 1958), which applies to all markets and all entities participating in economic activity. Thus, the Act applies to all private and public hospitals and any hospital merger requires approval provided the hospital changes ownership. In practice, however, the Act has only been applied to private hospitals who are the main 'buyers' in the market, while public hospitals are mainly the object of purchase. No approval is needed when public hospitals take over other public hospitals (as in the case of Viventes in Berlin)[5]. Although critics (i.e. mainly private hospital firms) have argued that all hospitals should be exempt from competition law, since their operations are primarily publicly financed, the normative interpretation of the law is that hospitals operate as undertakings as they compete for patients rather than for (public) payers.

With the growing presence of private hospital firms in the health care market, competition law has become increasingly relevant, particularly for the regulation of hospital mergers. In recent years the Federal Cartel Authority has considered several hospital mergers. In some cases it has denied a merger or has required the buyer to offer an undertaking so as to avoid or reduce a dominant market position.

Approval of hospital mergers is denied if the acquisition of a hospital creates (or increases) the dominant market position of a private firm. On this ground the Federal Cartel Authority prohibited the acquisition of three district hospitals in the district of Rhön-Grabfeld (northern Bavaria) by the private hospital firm Rhön-Klinikum AG in 2005[6]. The decision took into account the fact that the acquisition would allow the company to expand further its already extensive market share in the district (where Rhön already owned a number of general and specialist hospitals). The legal justification of the decision was as follows:

(1) Definition of the geographic market: Rhön operates several hospitals in the same area, with the relevant area defined through postcode districts and a calculation of market shares in the geographic market to determine whether consumers/patients in this area can choose among a sufficient number of competitors.

(2) Definition of the product market: Several hospitals owned by Rhön in this area operate in the same product market (the market for acute care). In its statement, the Authority applied a relatively broad definition of the product market, which was to the detriment of the applicant. The definition included all providers of secondary/tertiary acute care, including specialist hospitals; it excluded rehabilitation and long-term care facilities. According to this definition many of the potential competitors were general or specialist hospitals already owned by Rhön. This definition of the product market was subsequently challenged by Rhön in court following the denial of the merger.

(3) Dominant market position: The Federal Cartel Authority argued that the firm had already developed a dominant market position, with a market share of between 39.8% and 57.2%. Compared with its competitors, hospitals owned by Rhön were considered to have several (undue) advantages, including opportunities for vertical integration (e.g. with a local Medical Care Centre also owned by Rhön); potential economies of scale in negotiations with sickness funds about services associated with integrated outpatient care; competitive advantages related to its financial power and ability to invest in expensive technology (in contrast to public hospitals); and through possibilities to negotiate lower prices with suppliers due to its high volume of services.

Based on these arguments the Federal Cartel Authority concluded that the merger would increase Rhön's market share and would lead to an expansion of its market position that would

5 Source: Reinhard Busse, personal communication.
6 The similarity of the name is not entirely coincidental as the hospital firm presumably started its business in the 'Rhön' region.

undermine patients'/consumers' ability to choose among different providers of hospital care. The firm appealed to the Federal Minister of the Economy, who has the authority to approve the merger, by arguing that the transaction would be in the interest of the public (e.g. by creating/sustaining employment opportunities; securing provision of health care). Following a review of the case by the Monopoly Commission, a federal commission responsible for overseeing the application of cartel law in all markets, the Minister rejected the appeal. Rhön then appealed to a regional-level court; the case is still to be decided and a final ruling is expected in April 2007. The court is expected to reject the appeal, leaving Rhön with the option of challenging the decision by appealing to the federal administrative court (which seems likely given the fact that the case itself is likely to set an important precedent)[7].

Regulation of advertising

Advertising of hospitals and hospital services is strictly regulated by the *Heilmittelwerbegesetz* (Law on Advertising in the Health Care System, 1965). The law mainly focuses on pharmaceutical advertising but also establishes conditions for advertising in the health sector in general.

The law outlaws the dissemination of any information that may mislead patients/consumers or that entails any health promise or health scare. The target group for advertising is largely restricted to medical personnel (e.g. physicians targeted by pharmaceutical detailers). Furthermore, it is not permitted to advertise medical services relating to conditions associated with (notifiable) infectious diseases, malign neoplasms, substance abuse (except tobacco) and maternal health issues.

In addition, the law defines the standards for any advertising of pharmaceuticals and medical services (to the extent that they are allowed), for example by precluding the use of suggestive pictures and illustrations of diseases, 'patient success stories' (whether true or false), 'thank you' statements or health scare messages.

Italy

Walter Ricciardi

Competition in the public hospital sector

Competition between hospitals is very limited in the Italian National Health Service, with the possible exception of the region of Lombardy, the largest and richest region with more than 9 million inhabitants generating over 20% of national GDP. Following a purchaser/provider split in Lombardy in 1997, hospitals and other specialist care facilities were taken out of the remit of Local Health Authorities and transformed into free-standing Public Hospital Trusts. Hospital trusts now directly compete for patients, both with other hospital trusts and private hospitals. This move towards competition was much appreciated by the public as it increased the level of quality of care and substantially reduced waiting times.

In most of the other regions competition is very limited (although the respective regional government may state otherwise).

7 Horst Greiffenberg (Monopolkommission) and Franz Heistermann (Bundeskartellamt), personal communication.

Responsibility for regulating competition

Regional authorities (i.e. health departments of regional governments) are responsible for overseeing competition in the public health sector, including mergers and acquisitions. In Lombardy individual cases of mergers or acquisitions are followed-up, frequently in response to a complaint. Regulation is based on regional laws; if regional legislation conflicts with national legislation, the Constitutional Court may be called upon.

Given the limited impact of competition in the public sector, anti-competitive behaviour and other potential side-effects of competition are of little public or political concern.

Netherlands

Eveline Klein-Lankhorst

Competition in the hospital sector

Competition among providers and payers features highly in the Dutch health system and several far-reaching reforms have recently been introduced to strengthen its role. This is best illustrated by the 2006 reform of the statutory health insurance scheme for curative care (non-long-term care), which replaced a system involving quasi-public sickness funds with a system based on competing insurers of private (for-profit and not-for-profit) status (including many former sickness funds). However, this change has not meant complete liberalisation of the Dutch health insurance market and private health insurance is heavily regulated. For example, all insurance funds have to provide a statutory package of essential curative health services and are also required to accept every resident in their area of activity. 'Premiums' are also regulated; the income-related component is set by the government and, while individual insurers are free to set the rates of the (much smaller) non-income-related flat-rate fee, the fee they set must apply equally to all their members.

As for provider competition, the introduction of Diagnosis Treatment Combinations (DBC), the Dutch version of diagnosis-related groups, in 2005 allows hospitals to compete on price for the first time. DBCs fall into two parts, Segment A and Segment B. Segment A DBCs account for 90% of a hospital's total budget, with prices being determined centrally by the Dutch Health Care Authority (NZa); hospitals are required to charge this national rate to all insurers. In contrast, DBCs in Segment B are not set centrally but negotiated between individual hospitals and insurers, allowing for selective contracting between insurers and hospitals for Part B services [8][8]. Thus, at present, competition is restricted to Segment B. Its overall impact has so far been fairly limited, with Segment B DBCs accounting for only around 8-10% of hospital revenue. However, this share is expected to increase to 60% in 2008 and may therefore stimulate the development of a more competitive hospital market. Depending on the success of price competition in Segment B, central price-setting in Segment A may eventually be abolished.

The rationale behind the introduction of competition in the hospital sector is to create a situation in which 'money follows the patient' when hospitals compete for health insurance contracts. Income generated from Segment B directly reflects the number of patients treated in this segment and there is an expectation that this will give hospitals an incentive to increase the quality of the care they provide [9].

8 At present, Segment B DBCs only cover elective procedures (e.g. associated with hip and knee arthrosis, diabetes, cataract and inguinal hernia) and comprise 1,376 categories across 15 specialties covering 28 diagnoses.

Hospital mergers
In 2004 the hospital sector in the Netherlands comprised 84 general hospitals, 8 academic hospitals and 10 specialist ('categorical') hospitals [10]. The fall in the number of hospitals since the early 1980s is the result of a series of hospital mergers that took place during the 1980s and early 1990s, with 48 mergers registered between 1980 and 1994 [11]. At that time mergers were encouraged and aimed to generate economies of scale in the hospital sector and to promote the efficient use of hospital budgets. Mergers have been less frequent in recent years, reflecting the comparatively small number of hospitals in the Netherlands, relative to population size.

Regulation of competition

Three organisations are involved in regulating competition in the Dutch hospital sector: the Dutch Competition Authority (*Nederlandse Mededingingsautoriteit*, NMa), the Dutch Health Care Authority (*Nederlandse Zorgutoriteit*, NZa) and the government through the Ministry of Health.

The Dutch Competition Authority (NMa)
The NMa is the general regulator of competition, responsible for overseeing all markets and for enforcing the Competition Act (1997). The NMa also monitors competition in the health sector for this services where competition is permitted (i.e. Segment B). The authority investigates whether health care organisations intentionally or unintentionally impede competition by entering into anti-competitive agreements or through undue concentration of market power [12]. The Competition Act prohibits the formation of cartels, abuse of a dominant market position and non-NMA-authorised mergers among undertakings.

In the hospital sector the NMa mainly oversees mergers. The NMa applies a merger control policy to prevent anti-competitive behaviour and proposed hospital mergers require approval. Since the introduction of the 'regulated provider/insurance market' in 2005, several applications for hospital mergers have been submitted. In 2005 the NMa investigated three hospital mergers to ensure compliance with the Competition Act. Two of the three hospitals involved were required to obtain a licence for the intended merger, subject to detailed investigation by the NMa. Permission for two of the mergers was eventually granted, while the third application remains under investigation [12-14].

The Dutch Health Care Authority (NZa)
The NZa was established on 1 October 2006 by merging the Health Care Tariff Board (CTG) and the Health Insurance Supervisory Board (CTZ). Its mandate is based on the Health Care Regulation Act (WMG) of October 2006. Its role in competition regulation is mainly supervisory, defining the conditions under which market forces operate and ensuring enforcement where necessary, for example by increasing opportunities for individual price negotiations in the DBC Segment B.

It has a limited set of legal tools available to permit it to play a supervisory role in the health care market. For example, it scrutinises the quality of information provided by health care providers and insurers to service users and, if this is found to be unclear or insufficient, it may impose rules on the standards of health care information provided to patients.

The NZa monitors the impact of competition on the health sector and proactively analyses what is happening within the system. In contrast, the Competition Authority (NMa) reacts to specific complaints or problems related to competition and does not pursue a proactive role in regulating all markets.

Ministry of Health
The Ministry of Health is responsible for overseeing the health system. It regulates access to the health care market and as a health care regulator its main role is to protect the interests of service users. The newly-introduced Act on Admission for Health Care Providers (WTZi) passed

in 2007 has attenuated the Ministry of Health's role as a health care regulator by setting out its provisions as a health care market regulator.

The WTZi stipulates that hospitals, private clinics and other health care institutions are not allowed to make a profit if they provide publicly-funded care (e.g. through compulsory health insurance covering the statutory package of essential curative health services). Private health care providers that do not provide publicly-funded services are allowed to make a profit, but require a licence to do so. Market entry is strictly regulated, requiring health care organisations (private and public) to meet specific conditions, such as providing equal access to acute care and to ensure transparency of governance structure and management.

Concerns regarding anti-competitive behaviour
The main concerns regarding anti-competitive behaviour within the regulated health care market in the Netherlands are the following:

Excessive pricing: There is a general concern that hospitals with a dominant market position may abuse their position to apply disproportionate prices. The NZa monitors hospitals' pricing behaviour for potential misuse; as yet the Competition Act does not provide adequate guidelines to define what constitutes 'excessive pricing'. In cases of excessive pricing, the NMa can intervene and fine the organisation in question. The NZa also aims to prevent excessive pricing behaviour by publishing best practice and information on prices negotiated by hospitals to allow hospitals to benchmark themselves [15].

Predatory pricing: A second concern is predatory pricing by hospitals with a dominant market position. Predatory prices create a barrier for competitors to enter the market and thus reinforce a dominant market position. Hospitals could potentially apply predatory pricing in Segment B and subsidise related services through income generated through Segment A. The NZa monitors predatory pricing and cross subsidising of hospitals, but as with excessive pricing, predatory pricing is difficult to identify [15]. Section 24 of the Competition Act prohibits the use of predatory pricing. This section is based on an ECJ ruling, the so-called the AKZO case (AKZO Chemicals versus the European Commission).

Price discrimination/differentiation: The NMa is allowed to take action in case of price discrimination [15] (individual health insurers are required to offer the basic package of care at the same price to all their members, although insurers can set their own flat-rate premiums).

Anti-competitive agreements: Hospitals with a dominant market position could potentially negotiate agreements with health insurers that may negatively affect competition, for example through the use of long-term contracts. A particular concern in the Netherlands is 'conditional sale', for example by forcing an insurer, through contractual agreement, to purchase health care from Segment B on the condition of also purchasing services in Segment A. This behaviour is monitored by the NZa [15].

Vertical and horizontal co-operation: All forms of co-operation are inspected by the NMa to ensure compliance with the Competition Act [15].

Advertising in the health care sector
Hospital advertising is a relatively new phenomenon in the Netherlands and its regulation is under discussion. There are some concerns that advertising of hospital services may adversely affect service users, while others argue that advertising is an ingredient of any 'healthy' market economy. As with any organisation using advertising, hospitals must comply with the Dutch Advertisement Code. The Code prohibits, among other things, false claims and any form of misinformation in advertising.

A recent study by the *Raad voor de Volksgezondheit and Zorg* (RVZ) concluded that, to date, the impact of advertising in the hospital sector has not had any visible negative effects. Thus, the regulator has not yet intervened, reserving the right to introduce regulation at a later stage if required [16].

Norway

Odd-Arild Haugen

Competition between public hospitals

Health services in Norway are predominantly publicly provided and financed. While primary care services are provided by office-based general practitioners who work on a private for-profit basis, specialised care is mainly provided by publicly-owned hospitals.

Although competition between publicly-owned hospitals has traditionally been very limited, the central government has recently begun to introduce a number of market elements and incentives to stimulate competition between specialist providers (mainly hospitals). Specific policies included:

- the implementation of activity-based funding in 1997;
- the introduction of patient choice of hospital (2001); and
- the transfer of ownership of public hospitals from the counties to national institutions in 2002; in a second step, hospital ownership was devolved to the five regions (now four).

In spite of these reforms the publicly-financed health sector is still predominately a regulated rather than a competitive system [17].

Patient choice
Following the introduction of patient choice in 2001 publicly-owned hospitals have begun to compete with each other for patients. Patients are also allowed to receive care outside their 'home' region. However, it is not clear what motivates patients to seek care outside their region. One assumption is that patients choose providers on the basis of the quality of the services they provide, but in some areas quality may be difficult to compare as the benefits package offered by the regions vary (e.g. with regard to highly-specialised care). Thus, cross-regional mobility may also reflect existing variations in service distribution or waiting times.

In response to this lack of data the Norwegian parliament has recently decided to replace the existing register of health records with one that allows the identification of individual patients, to permit the tracking of patient flows across regional borders.

Waiting times
Waiting lists have often been used to support calls for more competition. However, the Norwegian government has tended to take a different approach to the issue. On one hand, resources for health care have been increased in each region to expand the capacity of publicly-funded services; this increase has mainly been used to improve access to highly-specialised treatment. On the other hand, services associated with day surgery, laboratories, radiology and technical assistance have been opened up for competition by giving private providers a stronger role in provision; consequently, private providers are contracted by regional authorities for providing services that are publicly financed. A possible exception is rehabilitation, which is

perhaps the most competitive segment of the health care market, despite being complex and highly specialised.

Merging regions
In response to existing overcapacity in hospital care in and around the city of Oslo (in the south of Norway), and to simplify the administrative and financial transactions arising from patient mobility across regions, the two largest regions (Health East and Health South) have recently been merged. As the capital, Oslo is home to several large and specialised hospitals such as the university hospital Rikshospitalet-Radiumhospitalet (previously in the Health South region) and the Ullevål University Hospital in Oslo (previously in the Health East region). Given the proximity of these major hospitals, it is likely that competition for patients will increase in future. It is hoped that the board of the newly merged 'mega-region' will be able to co-ordinate the distribution of services between hospitals and across the region so as to reduce overcapacity and improve the use of health care resources.

Responsibility for regulating competition

The Norwegian Competition Authority (*Konkurransetilsynet*) is responsible for regulating competition (on the basis of national competition law) and for lowering barriers to competition. It has become increasingly interested in health care, but there are few health care cases in which it has actually been called upon, and the application of competition law to the health system is very restricted.

In one case, the Association of Private Hospitals filed a complaint against the regional health authorities arguing that their policy of automatically applying the lowest price negotiated with any private hospital to all contracts with private hospitals is unlawful and undermines competition. The competition authority rejected this view, stating that as long as the state was the 'owner' of the regional health authorities, these should be regarded as a single unit.

Box 3 The 2004 EEA Competition Act

On 19 May 2005 a new Competition Act of the European Economic Area (EEA) came into force, replacing the EEA Competition Act of 1992. Reflecting the changes in EEA competition rules the Norwegian Competition Act was revised accordingly. The new EEA Competition Act provides the Competition Authority with the competence to apply Articles 53 and 54 of the EEA Agreement alongside the Surveillance Authority of the European Free Trade Association (EFTA) and the European Commission. As the sections regulating anti-competitive behaviour (e.g. anti-competitive agreements; abuse of a dominant market position) are almost identical in the EEA Agreement and the revised Norwegian Competition Act the enactment of the new EEA Competition Act was expected to have little impact on the application of the law by the Norwegian Competition Authority.

Source: http://www.konkurransetilsynet.no

Regulation of advertising

Hospitals are allowed to advertise but publicly owned hospitals rarely make use of this option as demand often exceeds the supply of services (i.e. waiting lists exist). Smaller private clinics, which may be publicly contracted, are more likely to involve in advertising.

Spain

Antonio Duran

Competition between publicly-owned hospitals

In the Spanish National Health Service publicly-owned hospitals are not considered to be in competition with each other. Instead they are required to provide health services to a geographically-defined population. Competition is regulated in the private health sector, as well as between private or public providers and private suppliers (e.g. when a public hospital is involved in anti-competitive behaviour by discriminating against private suppliers in favour of public suppliers)[9].

Regulation of competition

Competition is regulated by the Court for the Defence of Competition (*Tribunal de Defensa de la Competencia*, TDC, http://www.tdcompetencia.es/) based on EU Competition Law. As yet competition law only applies to private hospitals (for profit or not-for-profit) purely operating in the private sector. Public hospitals, as well as private hospitals contracted by a public authority, are not regulated by competition law; instead private hospitals operating in the public sector are subject to legislation of contracts with public administration. This also applies to new public entities such as foundation hospitals that do not fall under competition law, although they operate under private law in other areas such as service contracting, human resources and asset management. Thus, new public entities have the advantage of being only partly regulated by private law (excluding competition), while also being free from the stringent regulatory mechanisms of the public sector (e.g. related to budget control).

So far hospitals in the public sector have been exempt from competition law in accordance with Article 86 of the European Community Treaty (stating that services of general economic interest are excluded from competition law). There is awareness that this interpretation may not remain unchallenged, as ECJ rulings in favour of the principles of the common market have indicated. Currently, however, hospitals in the public sector remain beyond the reach of the TDC.

The TDC mainly responds to complaints but also investigates some economic sectors from time to time. Competition law is based on the General Law on the Defence of Competition[10]. The TDC also investigates mergers following a request or complaint. It must be notified of mergers if the financial value of the merging companies exceeds a threshold. Two cases TDC has decided in recent years are the complaint of a private hospital (Hospital de Madrid) against ASISA, Spain's largest private health insurance company and the merger of two private insurance companies. In the first case the hospital claimed that the insurance company had engaged in anti-competitive behaviour by establishing its own hospitals through subsidiary companies, thus horizontally integrating providers and payers. In January 2003 the TDC ruled that the insurance company acted lawfully following the logic of the insurance market. In September 2005 the TDC approved the merger of two private insurance companies, the Igualotorio Medico Quirurgico SA de Seguros and Iquimesa Seguros de Salud. However, the newly-created company was required to contract with hospitals that do not belong to the group.

9 An example for anticompetitive behaviour of a public provider in relation to its suppliers is the case of La Princesa University Hospital (a public hospital) versus a private undertaking company, the Asociacion Funeraria de Espana. The private supplier of undertaking services took the public hospital to court claiming that it unduly favoured a public-private undertaking firm, the Empresa Mixta de Servicios Funerarios de Madrid, S.A.

10 Law 16/1989 of 17 July, "de Defensa de la Competencia", modified by Law 62/2003 of 30 December, "de medidas fiscales, administrativas y de orden social" (Official Gazette B.O.E. 313 of 31 December).

Regulation of advertising

Hospitals are generally allowed to advertise. Public hospitals sometimes conduct image campaigns though they rarely advertise their services as they have little need to attract additional patients given that they are required to provide care to a defined population. In theory, public institutions are prohibited by law from advertising referring to their management achievements (Law on Institutional Advertisement and Communication). However, this law has never been strictly applied to image campaigns of public hospitals.

Advertising of private hospitals is regulated through the General Law on Advertising and the Royal Decree on Advertisement and Commercial Promotion of Products, Activities or Services in Health Care (Real decreto 1907/1996 of 2 August 1996, *sobre publicidad y promocion commercial de prductors, actividades o servicios con pretendida finalidad santaria*). The 1996 Royal Decree precludes, among other things, any advertising of health services that may mislead consumers.

Sweden

Ingvar Karlberg

Acute care hospitals in Sweden are financed, owned, and operated by the public sector with the exception of three hospitals: Sankt Goran's hospital and Ersta hospital in Stockholm and Lundby hospital in Gothenburg. These private hospitals are contracted by the county in which they are based and receive fee-for-service payments and some basic financial support for their activities. Contracts are negotiated with cost estimates based on the production costs for similar services in the public sector (using diagnosis-related groups, DRGs). Thus, within the regulatory framework of the public sector, competitive behaviour among public or private hospitals is very limited.

Competition is more prevalent in the long-term care sector, among nursing home services contracted by municipalities. Public and private providers are in direct competition for tenders and contracts for nursing homes and in 2006 it was estimated that half of all nursing home beds were provided by private facilities. As both types of providers are contracted their scope for anti-competitive behaviour is restricted.

In contrast to hospital care, most primary care providers are privately-owned and operated centres contracted by the counties, so there is some competition for contracts in the primary care sector. Some counties have begun to allow primary care providers to tender for contracts; there have been cases where continuity of care has been interrupted as patients have had to change their primary care practitioner as a result of a contract with a new provider. New primary care providers are usually chosen based on price; challenging this practice, one (more expensive) provider has taken a county council to court arguing that the comprehensiveness and higher quality of its services had not been sufficiently taken into account. It is expected that the legal ambiguities associated with tendering will only be diminished after a number of cases has been decided by the courts.

Switzerland

Alberto Holly

Competition between publicly-financed hospitals

Competition between publicly-financed hospitals is very limited in Switzerland and is not encouraged. Publicly-financed hospitals are either owned by a public entity (e.g. cantons, municipalities, a group of municipalities or an independent foundation) or are privately-owned hospitals included in the cantonal list, which gives them the right to claim statutory health insurance reimbursement for their services [18].

Health insurance funds usually contract hospitals collectively through their respective cantonal associations (i.e. hospital associations and health insurance associations). Although individual hospitals are allowed to form agreements with individual health insurance funds (selective contracting), this option has rarely been used, which reflects the non-competitive attitude of hospitals in the publicly-financed sector. So far hospitals have had little incentive to compete and competition is not officially encouraged.

Publicly-financed hospitals are funded through a dual funding mechanism. The 26 cantons fully finance capital investment and partially reimburse treatment costs incurred by patients in public wards for all hospitals included in cantonal lists; the remaining costs are covered through statutory health insurance and patients' direct payments. The share of cantonal contributions to treatment costs is fixed by law at a minimum of 50%, but the actual share varies among cantons, reflecting variations in reimbursement negotiated between hospitals and health insurance funds. The predominant method of paying hospitals is per diems. In 2008 this payment method will be replaced by DRG payment, linking the level of funding to the volume of services provided in hospital.

Legislation has recently been proposed to allow patients to be treated at hospitals outside their canton, in effect widening their choice to any hospital in Switzerland (currently patient choice is restricted to hospitals in the canton of residence). With the introduction of DRGs and an increase in patient choice, hospitals may have a stronger incentive to attract patients, potentially leading to more competition.

Regulation of competition and mergers

As yet there is no specific regulation of competition in the publicly-financed hospital sector and no separate regulator. Regulatory issues in the publicly-financed hospital sector are mainly addressed through cantonal planning. Cantons are responsible for organising and planning hospital care so as to ensure the provision of sufficient services. Health insurance funds and the central government are also involved in the planning process, although the role of the central government tends to be restricted to issues concerning the nationally-defined benefits package. The basic objectives of the planning process are not explicit and may vary among cantons, but there is an emphasis on planning services to meet the needs of the population and on lowering excess capacity to contain costs [19]. In this way efficiency and cost-effectiveness are addressed through planning rather than through market-based incentives, an approach that has almost entirely precluded competition between hospitals in the publicly-financed sector. Cantonal hospital planning also encourages co-operation between hospitals, for example between acute and long-term care providers or between hospitals providing different levels of specialised health care.

Cantonal hospital planning covers hospital mergers. In the publicly-financed sector mergers have been promoted to increase efficiency and economies of scale and to increase the safety and quality of services by raising service volumes. The number of hospitals in the private sector

(i.e. those that are entirely privately funded) is small and it is not common for these to merge with or purchase a public sector hospital. Hospital mergers have not been subject to competition law.

Publicly-financed hospitals do not advertise their services and have no incentive to do so as they do not compete with each other for patients.

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Appendix

Questions on competition addressing issues identified by the Department of Health

1. To what extent does competition between publicly funded hospital play a role (and is a matter of regulation) in your country?

2. Who is responsible for regulating competition in the hospital sector?

3. On what legal and/or regulatory basis is competition of hospitals regulated?

4. How pro-actively (or passively is competition regulated? Does the regulator systematically investigate cases or does he only act upon receiving a complaint? Do hospitals need official approval in cases of mergers and acquisitions?

5. Does the same regulation apply to public and private hospitals or are there different sets of rules for competition of public and private providers?

6. If competition is regulated, what are the main concerns of regulators regarding anti-competitive behaviours?

7. How is advertising of health care services regulated? Is it through self-regulation, health care specific regulation or a national competition or advertising regulator? (selected countries only)

8. How is appropriate co-operation between competing providers managed? (selected countries only)

Project and contributors

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Reinhard Busse	Department of Health Care Management, Institute of Health Sciences, University of Technology, Berlin, Germany
Carl-Ardy Dubois	Faculty of Nursing Sciences, University of Montreal, Canada
Antonio Duran	Tecnicas de Salud, Spain
Isabelle Durand-Zaleski	Hôpital Henri Mondor, Paris, France
Odd Arild Haugen	Special Advisor on Health Services and Health Systems, Blommenholm, Norway
Judith Healy	Regulatory Institutions Network (RegNet), Research School of the Social Sciences, Australian National University, Australia
Alberto Holly	Institute of Health Economics and Management, University of Lausanne, Switzerland
Ingvar Karlberg	Centre for Health Systems Analysis, Gothenburg, Sweden
Niek Klazinga	Department of Social Medicine, University of Amsterdam, Netherlands
Allan Krasnik	Institute of Public Health, University of Copenhagen, Denmark
Nicholas Mays	London School of Hygiene & Tropical Medicine and part-time Policy Adviser with the New Zealand Treasury
Walter Ricciardi	Department of Hygiene and Public Health at the Catholic University of the Sacred Heart in Rome, Italy
Juha Teperi	STAKES National Research and Development Centre for Welfare and Health, Helsinki, Finland