The regulation of competition between publicly-financed hospitals

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Summary

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