BIAC is pleased to provide the following Discussion Points and Compendium to the OECD Competition Committee Working Party 2 on Competition and Regulation for the Roundtable on Competition and Hospital Services addressing key factors for competition in hospital markets.

I. Key Factors in Hospital Markets – The European Perspective

A. Conditions For and Repercussions of Price or Quality Competition

1. Nowadays, the main challenge for industrialized countries is to introduce entrepreneurial behavior into healthcare systems, in order to gain the advantages of market efficiency, without neglecting the welfare principles. While all of OECD countries face rising costs in the hospital sector, it is important to stress the necessity of maintaining a balance between the need to preserve the competitiveness of the health care services and to adequately respond to health needs by an equitable access to services provided.

2. In this perspective, the hospital sector is an important area, as hospital costs still account for the greatest share of total healthcare costs. Nevertheless, it is crucial to consider health facilities’ performances not only from the viewpoint of health expenditure, but also from the perspective of the systems global efficiency and of the health protection for citizens, taking into account the costs resulting from an inadequate quality of care. By this reason, it is important to consider also health care economic effects on the global social expenditure, considering that it represents a service intended to preserve the human capital, which is of the greatest importance for modern society.

3. A kind of competition limited to prices only can be hazardous for the quality of services and, consequentially, for patients. Therefore, any future research with respect to competition in health care services, has to analyze competitive mechanisms in a broad manner, which extends to competition on prices, on services provided, on speed of response, and on quality of care, evaluating the productivity and responsiveness of the whole system. By consequent, the
problem of cost must not prevail on quality concerns; it is of the highest importance to examine the appropriate connection between these two determinants.

**B. Demand Side Factors and Effective Competition on Price and Quality**

4. Within EU, citizens’ right to freely choose the doctor and the hospital - through the offer of a real alternative set up by a plurality of providers - is a “society choice”. In principle, the access to services must depend only on the real need of the treatment, on the speed of obtaining it and on the quality guaranteed. In fact, the majority of European citizens are favorable to a system, in which individual free choice and plurality of providers, in a relationship of competitive collaboration, strives for a constant progress in therapy standards and assistance, within available resources.

5. In such a framework, the role of the consumer choice has not only to be assured as a fundamental right, but also to be examined in its consequences, because the concrete opportunity to freely choose the doctor and the hospital is a driving force for quality, stimulating providers to improve their performances in order to be chosen by patients.

**C. Supply Side Factors and the Promotion of Effective Competition on Price and Quality**

6. For the future, it would be important to study competition methods and effects on the supply side, deepening the approach of almost-markets. On the side of services production, particularly within the hospital sector, the connection between cost - quality - benefits must be examined in depth. In fact, the sustainability can be attained also through a better use of the existing wealth of facilities, professionals, health workforce, technological equipment, promoted by a fair competition. This search for enhanced productivity supposes permanent progress in the hospital sector, supported through relevant reward systems. Therefore, competitive incentives must be evaluated with reference to quality standards and productivity performances, resulting from an efficient management.

7. Sustained enhanced productivity allows the same results to be obtained with lower costs, and consequently it is the appropriate answer to cost pressure, because it can have a positive impact on expanding resources and finding answers to new needs, within health care systems which have an emphasis on quality and create an environment favorable to new and adaptable schemes of funding.

8. Improved efficiency and rational allocation of resources are among the most effective tools to achieve better value for money, while questionable cost cuttings and particularly budgets caps have negative effects on equity of access and quality of care. Applying top-down budget caps on spending, without having to renegotiate agreements with hospitals is unfair for providers and it is dangerous for patient safety, risking to lower quality standards.

9. In this perspective, the separation between purchaser and provider functions within the competent authorities would be essential in order to further health system goals in health
delivery, avoiding wastes due to unfair competition and poor management. To meet this aim, it is crucial to guarantee the parity of rights and duties among all the providers, publics and privates, in regard to accreditation rules, remuneration methods, as DRGs, quality control on the responsibility of a third independent organization – like in France (HAS) and in UK.

10. In the framework of a rigorous analysis of cost, quality and remuneration criteria, competition among providers - on the supply side - and consumer choice - on the demand side - can contribute to maintain a satisfactory quality level, squeezing out wastes caused by inefficiency.

D. Institutional Frameworks and Policy Reforms to Enhance Competition in Hospital Services?

11. The misguided perspective in which health expenditure is conceived only as a cost and not as an investment has conditioned national governments to balance public budgets, through distorted competition. As a result, the rationalization of health expenditure has often resulted in the rationing of health services. In this framework, unfortunately competitive mechanisms were implemented in order to put pressures on providers to constrain expenditure, particularly in the hospital sector. In our opinion, if costs constraint is the major or the only concern, health care sector is considered an unproductive investment and not an important employer, consumers of goods and leader in the field of innovation, research and development, as it is in fact. Although it is necessary to improve the cost efficiency, no OECD country can afford to consider its health system only as a burden and an expenditure to curb or even to cut down, without previous and accurate analysis.

12. The hospital sector, which responds to the collective health demand, is also an important competitor in the economy, as long as health care services are well managed, productive and quality driven. On the contrary, a possible involution of the policy trends is very dangerous, as long periods of budget restraint may make it more difficult to create conditions for making progress.

13. At this regard, the industrial and entrepreneurial world, operating in healthcare field, is seriously concerned about a possible regression, highlighting the importance to identify opportunities for:

   a. Productivity increase in the health care sector, including improvement of management;
   b. Competition in and between both the public and the private segments of the healthcare sector;
   c. Enhanced organizational innovation;
   d. More efficient health care coverage through a better balance between private and public insurance;
   e. Increasing patients’ involvement and responsibility for their health; and
f. Regulatory reforms.

14. The main thread in the reform initiatives implemented by many European countries in the last decades was to introduce entrepreneurial behavior in healthcare systems, in order to gain the advantages of market efficiency, without neglecting the principles of universality, equity, solidarity, security guaranteed through the policy direction, control and responsibility exercised by the State.

15. To reach these goals, a policy focused on innovation was pursued:
   a. New models of management were implemented;
   b. Incentives for competition were injected into public structures, in order to improve their performances;
   c. Private hospitals were incorporated into the general health system under public control;
   d. Public hospitals’ management was entrusted to private operators; and
   e. Public-private partnerships came into operation, achieving good results.

16. Nowadays, despite the differences of national healthcare systems, within EU and other industrialized countries common principles are emerging for a better model of healthcare service, which try to reach a balance between access, quality of treatments and financial viability, taking in due consideration the complexity of healthcare as a sector of considerable social values, but also of economic interest.

17. In brief, a model of healthcare service, responding to the obligations of a general interest service financially viable, can be based on a public - private mix, fairly managed and able to guarantee:
   a. Citizens’ right to freedom of choice;
   b. Plurality and equality of providers, public or private, that offers citizens concrete alternatives;
   c. Abolition of monopolistic (or quasi monopolistic) regimes;
   d. Fair competition based on quality, because in periods of budget constraints, institutions offering the best at compatible costs must be supported with stimulating incentives;
   e. Effective use of the available resources;
   f. Adequate and rapid answer to the demand;
   g. Quality improvement; and
   h. Independent control institutions (Authorities) in order to guarantee quality standards and a fair and effective competition.
18. If these conditions are fully respected, competition among a plurality of providers can increase the amount of available resource and stimulate productivity, in order to improve general performances in a viable system.

19. Continuing attention should be paid to the conditions and the efficiency of competition and the State should play a special role in ensuring that no actor in the hospital sector bypasses the rules relating to competition in order to benefit from various forms of granted privilege. From this viewpoint, the role of the State is to set the rules for a fair competition, facilitating:

a. Equity in access conditions for citizens and in accreditation conditions for providers;
b. Quality through rigorous and equal controls for all providers;
c. Financing, determined by correct and homogenous remuneration criteria for all the contributing providers, private and public hospitals, in order to reach an efficient funding; and
d. Information for citizens about services supply and transparency for the financing agency about services quality and costs of healthcare providers.

20. These principles can be implemented in a mixed system, composed by a plurality of competing institutions, public and private, for profit and not for profit, among which the citizens can choose, while it is very hard to achieve them in a monopoly regime, as it is demonstrated by the former failure of quasi – monopolistic systems.

21. If almost-market reforms have not always achieved all the expected results that is due principally to the reason that the experiments with competition were too often discontinued after a relatively short period and more time has been needed for positive results to appear. Moreover, the positive impact of such policies has most often been weakened by continued central control.

II. Issues in Hospital Markets – The U.S. Experience

22. In the United States, providers of health care services, including hospitals, are reimbursed for their services by commercial health insurance companies, other health coverage plans, government health plans such as Medicare (for seniors and individuals with qualifying disabilities) and Medicaid (for low-income people) (collectively “payors”). The Federal Trade Commission and U.S. Department of Justice Antitrust Division (the “Antitrust Agencies”) monitor and regulate competition issues relating to health care providers with the goal of protecting consumers of health services from increased prices or reduced quality or output, and within this structure, a number of competition issues have arisen.¹

¹ For more background on the U.S. experience, please see the attached Addendum. BIAC extends its appreciation to the American Bar Association’s Section of Antitrust Law and, in particular, Section Chair Richard Steuer for this compilation of materials.
A. Hospital Mergers

23. There have been a number of challenges to hospital mergers in the United States in recent years. Mergers of hospitals often can eliminate redundancies and create efficiencies. In some instances, however, the Antitrust Agencies have alleged that a hospital combination results in consolidation that would be harmful to consumers. The issues presented in these instances include how to define markets and measure concentration in hospital services, how much concentration is too much, and how to assess prospects for new entry and the creation of efficiencies. Other issues include the nature of available remedies and the value of undertakings by hospitals to limit price increases.

B. Exclusivity

24. Physicians and groups of physicians commonly become affiliated with one or more hospitals in their locale. In some instances, hospitals require affiliated physicians to agree not to affiliate with competing hospitals. In certain instances, hospitals require that insurers to which they provide services agree not to obtain similar services from competing hospitals in the same region. All of these amount to forms of exclusive dealing arrangements. The issues these arrangements pose are whether other hospitals are unreasonably foreclosed from competing, especially if the other hospitals have less capacity or offer a more limited range of services.

C. Most Favored Nation Provisions

25. Sometimes, insurers ask hospitals to promise not to charge lower rates to any competing insurer. This provides insurers with assurance that no competing insurer is paying less for the same services. However, such “most favored nations” provisions allegedly can prevent hospitals from fostering the growth of new insurers, to compete against existing insurers, by offering those fledgling insurers better rates, even temporarily. The Department of Justice has pursued several cases based on such allegations and recently initiated such a case alleging that an insurer demanded better prices than hospitals charged any competing insurer. The issue such cases present is whether most favored nations provisions are competitively neutral or unreasonably restrain competition in these circumstances.

D. Accountable Care Organizations

26. Recently, Congress passed the Patient Protection and Affordable Care Act and the Centers for Medicare and Medicaid (“CMS”) issued a Final Rule under the Act to facilitate greater accountability for patient care among providers. In response to this legislation and guidance, the Antitrust Agencies issued the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in Medicare Shared Savings Program (“Policy Statements”) to provide additional guidance to providers seeking to form Accountable Care Organizations (“ACOs”), which permit providers to join together in ventures to negotiate fees and other terms with insurers and other health plans under the new legislation without running afoul of antitrust and competition laws. Under the Policy Statements, if such “ACOs” meet certain criteria, they qualify for limited immunity from antitrust liability. The issues raised
by ACOs include how to interpret the new guidelines and how to treat ACOs that do not qualify for immunity.

E. Hospital Joint Ventures

27. Over the years, hospitals in the United States frequently have formed joint ventures to provide particular services. Often, these ventures create efficiencies, permitting more services to be provided at lower cost. Sometimes, however, these ventures may be adopted in situations in which it would be preferable for hospitals to provide such services independently and in competition with one another. The issue raised in these situations is how to distinguish anticompetitive ventures from ventures that are precompetitive or competitively neutral.

F. Hospital Group Purchasing Organizations

28. It has become common for hospitals in the United States to join group purchasing organizations (referred to as “GPOs”) or other joint purchasing arrangements. These ventures can enable purchasers of medical supplies and equipment to negotiate lower prices, but also can create concerns about the formation of ologopsony power. There also may be issues as to which hospitals and alternative care facilities are included in or excluded from these groups.

G. Information Exchange Among Hospitals

29. A recurrent issue involving competing hospitals in the United States is the extent to which they may exchange information about the rates they charge, the salaries they pay, and the costs they incur. The U.S. Department of Justice and Federal Trade Commission issued a policy on this topic in 1996 and there has been some litigation claiming antitrust violations in particular situations. The issue raised is how to distinguish between anticompetitive exchanges of information and precompetitive or competitively neutral exchanges.

III. Conclusions

30. In the OECD countries it is fundamental to gain better understanding of health’s impact on economic growth and sustainable development, providing guidance on the economic implications of health, for improving the cost efficiency of health care systems. Positioning health as a driver for reaching these goals necessarily implies the promoting of the optimal use of resources in health.

31. In this perspective, it is of the greatest importance to enhance the effectiveness and efficiency of healthcare systems, providing a solid evidence base, in order to face the challenge of health expenditure, avoiding unfair competition, rationing of health services and waiting lists, caused in many countries by the shortage of services because of economical reasons.

32. Within public expenditure for health, the contribution of private resources is necessary as capital and human resources provided by private initiative play a key role in the provision of care services. Private hospital sector adds complementary means allowing the State to save capital investment and to impose a tax on earnings; moreover it plays the role of moderator in health
expenses, through efficient management. In these circumstances, the contribution of private sector is fundamental in order to balance public budgets, because private hospitals takes part in the supply of services for the social insurance or for the national healthcare service, increasing the opportunities of access and allowing a better protection of health.

33. A rational and effective allocation of the resources - based on a better use of the structural, technological and professional equipment, both public and private - will make health system of the industrialized countries able to guarantee a real improvement of the macroeconomic situation, as considered necessary. Private capital could help health care facilities especially if supported in order to build long-term medical infrastructure and not submitted to a short term strategic planning. Effective management and modern entrepreneurial criteria, both in public and private institutions, provides the concrete possibility to guarantee at the same time equity of access and financial sustainability of the system. Besides, the improvement in access to health related services occurs also in conjunction with a greater reliance on private health insurance.

34. The success of the change to reach a sustainable development depends on the managerial innovation, sustained also by regulatory reforms, and on the correct implementation of pro-competitive incentives within a welfare market. In a healthcare system where the State sets the rules of a fair and collaborative competition the private sector can assure a function of general interest. Private hospitals if they accept the same obligations as public ones are entitled to the same rights in an mix and integrated system.

35. Without attempting to arrive at a final conclusion, it is suitable to evaluate each local or national health system’s trends according to the following general indicators:

   a. The degree to which competition between public and private operators is implemented. This indicator depends on the payment system per service, including the equalization for all hospitals, as well as the degree of free choice left up to the users.

   b. The right granted to citizens for freely choosing the hospital and the doctor.

   c. The ratio between research expenditure and investments versus overall running expenditure.

   d. The degree of a health care facility’s autonomy, which implies for example that no action has been taken in favor of those hospitals with a deficit position.

36. These parameters, taken as a whole, give us a pointer as to the system’s ability to profitably use available resources.

37. The industrialized countries are going towards grater running efficiency and encouraging long-term investments within their healthcare systems. For this process to be supported by the market, the hospital sector must acquire even greater competitive abilities.
Finally, talking about competition is not enough. It is necessary to find out and concretely implement the conditions for an impartial management of the public-private mix at the basis of most western health care systems. Only in this way the competitive mechanisms will be able to improve the overall performance of the health care services. As a result the same mechanisms can contribute to ensure not a formal, but a real protection of welfare principles, progressing from a theoretical declaration of rights to an adequate answer to citizens' concrete needs, through the best possible use of the available resources, in the perspective of a sustainable growth.
Addendum

Compendium of Materials on Hospitals and Competition in the United States

Prepared by American Bar Association
Section of Antitrust Law

The aforementioned competition issues in the U.S. have been addressed in materials published by the Section of Antitrust Law. These materials reflect the views of their individual authors and should not be construed as representing the position of either the American Bar Association or the Section of Antitrust Law. Nevertheless, these materials may provide useful background to policymakers outside the United States as they consider options for designing efficient policies for hospital competition within their own jurisdictions.

Hospital Mergers


**Exclusivity**


Shankar Iyer, *Antitrust Damages in Exclusionary Practices Cases*, 7 ECONOMICS COMMITTEE NEWSL. (A.B.A. Sec. of Antitrust Law, Chic., Ill.) No. 2, at 23 (Fall 2007)


**Most Favored Nations Provisions**

Kenneth Glazer & Catherine Larose, *No Longer Waiting: The Antitrust Division Comes to Life with the Amex and Blue Cross Cases*, ANTITRUST, Vol. 25, No. 2 (Spring 2011).

Scott A. Westrich, *Most Favored Nation Clauses in Health Care: Are They Legal or Not?* THE PRICE POINT, PRICING CONDUCT COMMITTEE NEWSL., (A.B.A. Sec. of Antitrust Law, Chic., Ill.), Vol. 9, No. 2 (Summer 2010).

**Accountable Care Organizations**


**Hospital Joint Ventures**


**Hospital Group Purchasing Organizations**


**Information Exchange Among Hospitals**

*Hospital Information Exchange Program Will Not Be Challenged By DOJ*, HEALTH CARE AND PHARMACEUTICALS COMMITTEE RECENT DEV. (A.B.A. Sec. of Antitrust Law, Chic., Ill.), May 2010, at 13.

