I. INTRODUCTION

The dimensions of competition

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 not only from the viewpoint of health expenditure, but also from the perspective of the system's global efficiency and of the resulting health protection for citizens, considering that social costs resulting from an inadequate quality of care must be taken into account. Within any future research in this area, competitive mechanisms, particularly with respect to competition in healthcare markets, must be analysed in a broad manner, which extends to competition on prices, on services provided, on speed of response, and on quality of care.

The problem of cost must not prevail over quality concerns, and it is of the highest importance to examine the appropriate connection between these two determinants.

A kind of competition limited to prices only can be hazardous for the quality of services and consequentially, for patients. In the framework of a rigorous analysis of cost and remuneration criteria, competition among providers - on the supply side - and consumer choice - on the demand side - can contribute to maintaining a satisfactory quality level, reducing waste caused by inefficiencies. By consequence, competitive incentives within the hospital sector must be evaluated with reference to quality standards and productivity performances, both which result from efficient management.

In addition, the role of the consumer choice has to be examined, not only because healthcare is a fundamental right, but also because the right to freely choose one’s doctor and hospital is the driving force for quality, through the offer of real alternatives set up by a plurality of providers.
The role of the State is to set the rules for fair competition, facilitating:

- equity in access conditions for citizens and in accreditation conditions for providers,
- quality through rigorous and equal controls for all providers,
- financing, which is determined by correct and homogenous remuneration criteria for all the contributing providers – private and public hospitals – in order to attain efficient funding,
- information for citizens about services supply and transparency for the financing agency of healthcare providers about service quality and costs.

If these conditions are fully respected, competition among a plurality of providers can increase the amount of available resources and stimulate productivity, and general performance in a viable system. Within this framework, the promotion and measurement of quality need to be tracked in accordance with the productivity and responsiveness of the health care system. In fact, quality must be defined positively as a method of management and a decisive factor within the health system’s performance, beyond the traditional ‘command and control’ method. It would be also essential to measure outcomes, but this kind of evaluation it is not always reliable as it requires a multi-faceted analysis approach.

**The effects of competition**

**Productivity gains**
Sustained enhanced productivity allows the same results to be obtained with lower costs, and consequently, it is the appropriate answer to cost pressure. For BIAC, the permanent search for productivity gains is a positive factor for stimulating economic growth. Thus, productivity must become a standard for the management of health systems, because it can have a positive impact on expanding resources and in finding answers to new needs.

This search for enhanced productivity supposes permanent progress in the hospital sector, relevant reward systems and positive incentives, and in health care systems which have an emphasis on quality.

**Sustainability and funding**
The long-term sustainability of health care depends also upon effective funding, which will become increasingly the condition for well-functioning health systems. By improving quality, productivity and responsiveness, OECD countries will create an environment favorable to the success of new and adaptable schemes of funding. While all of these 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 industry and to adequately respond to health needs by an equitable access to services provided.

**Positive impacts on economic growth**
The hospital sector, which responds to the collective health demand, also serves at the same time as an important sector of the economy, as long as health care services are well managed, productive and quality driven. No OECD country can afford to see its healthcare system only as a burden.

It is important to study competition methods and effects also on the supply side. Particularly in the hospital sector, the relationship between cost, quality and benefits must be examined in depth by the OECD.
II. HEALTH SYSTEMS REFORMS AND COMPETITION

The main thread through different reform initiatives implemented by many European countries over the two last decades has been to introduce entrepreneurial behavior into healthcare systems, in order to gain the advantages of market efficiency, without neglecting the principles of universality, equity and solidarity (in other words, the social justice that is obtained through the policy direction, control and responsibility exercised by the State.)

To reach this objective, a policy focused on innovation was pursued: new models of management in the health sector were implemented; incentives for competition and entrepreneurial behavior were injected into public structures, and private structures were incorporated into the general health system under public control.

The OECD document on “Health care systems: lessons from the reform experience” underlines that “efforts to introduce competition” outside the United States have not achieved the expected results. Consequently, the attempts at active competition in healthcare markets in Europe have been reduced.

OECD research has emphasised that competitive mechanisms were implemented in order to put pressures on providers to constrain expenditure, particularly in the hospital sector. In our opinion, when cost constraint is the major or the only concern, the healthcare sector is considered an unproductive investment, as opposed to an important employer, a consumer of goods, and a leader in the field of research and development. Moreover, healthcare represents a service intended to preserve the fundamental resource of modern society: human capital. Thus, it is important to also take its economic effects on global social expenditure into account.

A possible involution of the policy trends is very dangerous, OECD research warns that “long periods of budget (or wage) restraint may make it more difficult to create conditions conducive to change, particularly where improvements depend on investments in human and physical capital.” In this regard, the BIAC Task Force on Healthcare Policy, representing the industrial and entrepreneurial world, is seriously concerned about a possible reversal and, in its statement, would like to highlight the importance of identifying opportunities for:

- productivity increases in the healthcare sector, including improvement in management;
- competition in and between both the public and private segments of the healthcare sectors;
- enhanced organisational innovation;
- more efficient health care coverage through a better balance between private and public insurance;
- increasing patients’ involvement and responsibility for their health; and
• regulatory reform in the health care sector.

These principles can be implemented in a mixed system, composed of a plurality of competing institutions, public and private, for profit and not for profit, among which citizens can choose. This is very hard to achieve in a monopoly regime. If quasi-market reforms have not achieved all the expected results that is due principally to the reason, pointed out in the OECD research: the experiment with competition was “discontinued after a relatively short period, more time has been needed for positive results to appear. The positive impact of such policies has most often been weakened by continued central control”. Moreover, the former failure of quasi-monopolistic systems must not be neglected.

III. THE NEED FOR AN IMPROVED REGULATORY ENVIRONMENT

In a mixed system, the relationship between public and private sector must be based on free entry and a qualifying role for all providers, without any other distinction than the quality of services offered to citizens.

The implementation of effective competition between the public and private sectors in Europe is still a matter of national perspectives. Analysing the different national situations with respect to the concrete equality in competitive schemes between public and private hospitals, a European survey shows the specificities of the situation.

The results highlight an inadequate implementation of a fair competition. A greater convergence in the treatment of public and private institutions emerges with regard to:

• the evaluation of the quality of services provided;
• the control of the compulsory prerequisites (architectural and security obligations, equipment, organization, quality standards, personnel);
• the introduction of new health-related technologies without a previous authorisation

According to this enquiry, the actual situation concerning competition is characterised, within the countries examined, by a limited and sometimes unfair use of competitive mechanisms.

IV. CONCLUSION

1. It is necessary for OECD countries to gain a better understanding of the impact of health on economic growth and sustainable development, in order to provide guidance on the economic implications of health, namely improving the cost efficiency of health care systems.

In this context, it is important to focus on enhancing the effectiveness and efficiency of healthcare systems. In so doing, a solid base of evidence would be created, which could be used to overcome the misguided perspective in which health expenditure is conceived only as a cost and not as an investment. Such a perspective has conditioned national governments to
balance public budgets through distorted competition between the public and private sectors. As a result, the rationalisation of health expenditure has often resulted in the rationing of health services.

The creation of competition in this sector will, for example, avoid waiting lists. This problem has plagued many countries because of the shortage of services that arise due to economic reasons. If the private hospital sector takes part in the supply of services – as they relate to social insurance or the national healthcare service – access opportunities for citizens will increase, broadly resulting in better health protection – a fundamental human right.

2. Positioning health as a driver of economic growth and sustainable development implies that it is necessary to promote the optimal use of resources in the healthcare sector. In light of the public expenditure on health, the contribution of private resources allow the State to save capital investment and to impose a tax on earnings. Moreover, the private hospital sector can help to contain health expenses through efficient management. Capital and human resources provided by the private sector play a key role in the provision of healthcare services, and are a complementary measure to national publicly funded care.

A rational and effective allocation of resources – based on a better use of structural, technological and professional equipment (both public and private) – will ensure that the health systems of industrialised countries contribute to a real improvement in their macroeconomic situations. Private capital could help health care facilities build long-term medical infrastructure.

3. Effective management and entrepreneurship, in both public and private institutions, provides the concrete possibility of guaranteeing equity of access to, and financial sustainability of the system.

The success of the move towards a sustainable development approach will depend on managerial innovation, as well as by regulatory reforms, and on the correct implementation of pro-competitive incentives within a welfare market. In a healthcare system where the State sets rules for promoting fair and collaborative competition, the private sector can ensure a function of general interest. Private hospitals if they accept the same obligations as public ones are entitled to the same rights in an integrated system.

The State should play a special role in ensuring that no actor in the hospital sector bypasses the rules relating to competition rules in order to benefit from various forms of monopoly.

Continuing attention should be paid to the conditions and the efficiency of competition. This will have a significant impact on public health.

4. Despite the differences of national healthcare systems, a significant model is emerging; it gives due consideration to the complexity of healthcare, and reaches a balance between access, quality of treatments and financial viability.

The common principles for a better model of healthcare service are:

- citizens’ right to freedom of choice
- plurality of providers, public or private, that offers citizens concrete alternatives
• **competition based on quality**, because in periods of budget constraints, institutions offering the best at compatible costs must be supported with stimulating incentives;

• **independent control institutions** (Authorities) in order to guarantee quality standards and a fair and effective competition.

BIAC states that a model of healthcare service, responding to the obligations of a general interest service (universality, equity, solidarity, security) and financially viable can be based on a public-private mix, fairly managed and able to guarantee:

• free choice of citizens

• equality of all providers

• fair competition

• abolition of monopolistic (or quasi-monopolistic) regimes

• better use of public and private sector

• effective use of the resources

• adequate and rapid answer to the demand

• quality improvement
ANNEXES

Annex 1: Other perspectives

In research by the University of Pavia concerning “Competition in Italy, in the European Union, in the World”, the importance of subsidiarity in healthcare is highlighted. This fundamental principle within the European Union inspires an institutional convergence in the direction of giving the State a less pervasive role. In a health system in which the state is able to reinterpret its role, without necessarily identifying it with the direct management of services, competition criteria can be successful in achieving satisfactory results, as research based on OECD Data (2000) concludes. In a mixed system, the relationship between the public and private sectors must be based on free entry and the qualifying role for all the providers, without any other distinction than the quality of services offered to citizens.

In a report - “Hospitals & Health” (OSPEDALI & SALUTE), published in 2004 by the Italian research Institute, ERMENEIA, a chapter concerns the implementation of effective competition between the public and private sectors in Europe. The purpose is to analyze the different national situations with respect to the concrete equality in competitive schemes between public and private hospitals, through a survey based on interviews with a panel of opinion leaders representing the national associations of the private hospital sector in a few European countries.

The results highlight an inadequate implementation of fair competition. A greater convergence in the treatment of public and private institutions emerges with regard to:

- the evaluation of the quality of services provided;
- the control of the compulsory prerequisites (architectural and security obligations, equipment, organisation, quality standards, personnel);
- the introduction of new health-related technologies without previous authorisation.

Within this framework, Italy is on average in one of the lower positions, but it is important to consider that there are different regional health systems with different laws and approaches.
<table>
<thead>
<tr>
<th>Does full freedom of establishment for hospitals exist?</th>
<th>Does full equalization exist between the financing of public and private hospitals providing services for the national system?</th>
<th>Does full freedom exist in opening whatever specialty in the accredited hospitals?</th>
<th>Does an equal system exist between public and private in order to introduce new equipment for diagnostics without a specific authorization?</th>
<th>Does a fully equal system exist for allocating resources (on the basis of DRG or other systems) between the public and private sectors?</th>
<th>Does an equal system exist between the public and private sectors concerning the payment of the services (with regard to waiting times and methods)?</th>
</tr>
</thead>
</table>
| **France** | Evaluation: 0  
A public authorisation is needed and it is necessary to comply with national and regional planning. | Evaluation: 0  
At present, criteria and tariffs are different: public hospitals are paid on the basis of a global budget and not on the activity provided, while the private ones are remunerated by DRG. | Evaluation: 1  
You don't need authorisation only for the conventional diagnostic, but you must request one for new technologies (scanners, nuclear medicine) | Evaluation: 1  
Since January 2005, the DRG system was implemented, but it will be applied to the public sector in eight years. | Evaluation: 1  
Payment conditions are not equivalent, but at present are satisfying |
| **Belgium** | Evaluation: 1  
In theory it exists, but the planning has an impact on the freedom of the establishment of hospitals which need to obtain the authorisation | Evaluation: 1  
It exists within the laws, but deficiencies of public hospitals are made up by the State. | Evaluation: 0  
Authorisation is necessary for new diagnostics equipment (new technologies) | Evaluation: 1  
The remuneration is based on activity (number of admissions, length of stay etc.). DRG are only used as an evaluation method. Principles are the same, but public hospitals' deficiencies are made up by the State. | Evaluation: 1  
The system is the same, but tariffs are different. |
| **Austria** | Evaluation: 2  
It really exists, but is limited, because the authorisation depends on many conditions: hospital aims, pathologies treated, doctors’ qualifications, number of patients admitted. | Evaluation: 0  
An Austrian DRG-System was implemented first in the public sector. From 2002 the same method is in force also in the private hospital sector, but the worth of a point is lower than for the public hospitals. | Evaluation: 0  
The documentation is the same, but the tariffs are not equivalent. | Evaluation: 0  
Within the private sector, budgetary or activity volumes are limited by law. | Evaluation: 0  
Times and conditions are different at the regional level, but generally are long (6 months, 1 year). |
| **Italy** | Evaluation: 0  
Public authorisation is needed. | Evaluation: 1  
In principle, DRG are the same for public and private hospitals, but deficiencies of public hospitals are made up by the State. | Evaluation: 0  
It doesn’t exist | Evaluation: 2/3  
The implementation of a new technology depends on an autonomous decision, but only for in-patients. For the use of new equipment for out-patients, authorisation is requested. | Evaluation: 0  
|

**Comparative evaluation of competition by a panel of representatives of private hospitals.**
Does an equal system exist between the public and private sectors concerning the control of the characteristic required by law (architectural and security conditions, equipment, personnel)?

<table>
<thead>
<tr>
<th>Country</th>
<th>Evaluation: 3</th>
<th>Evaluation: 3</th>
<th>Evaluation: 3</th>
<th>Evaluation: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>Laws for the control of the conditions of the characteristics required are effectively comparable and a formally independent body exists which is responsible.</td>
<td>The standards required are effectively equal.</td>
<td>Equality is complete and real.</td>
<td>It exists in the laws, but controls are bureaucratic and not always so rigorous within public hospitals as in private ones.</td>
</tr>
<tr>
<td>Belgium</td>
<td>The evaluation of services is really equal in the public and private sectors.</td>
<td>The equality is complete and real.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
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<tr>
<td>Italy</td>
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</tr>
</tbody>
</table>

0 = It doesn’t exist; 1 = It exist only in the laws, but not in the administrative practice; 2 = It exists in fact, but partially; 3 = It exists in facts, completely and effectively.

According to this enquiry, the actual situation concerning competition is characterised by limited and sometimes unfair use of competitive mechanisms, within the countries examined.
Annex 2

Within the EU, citizens’ right to freely choose their doctor and hospital – through the offer of a real alternative set up by a plurality of providers – is a “society choice”. In principle, access to services must depend only on a real need for 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 a plurality of providers, in conjunction with competitive collaboration and available resources, strives for a constant improvement in therapy standards and assistance.

Without attempting to arrive at a final conclusion, but in order to direct research towards suitable parameters, it is interesting to reflect on the indicators proposed within the above mentioned research by the University of Pavia, “Competition in Italy, in the European Union, in the World”. According to this approach, each local or national health system’s position can be evaluated with reference to the balance between long term investment and short term solidarity. These trends can be measured by integrated use of some indicators.

The first indicator is represented by the degree to which competition between public and private operators is triggered. This indicator depends on the payment system per service – equalized between all hospitals – as well as the degree of free choice left up to users. A significant parameter to quantify the first indicator is the public versus private hospital bed ratio.

A second indicator is the ratio between research expenditure and investment versus overall running expenditure.

A third indicator is the degree of a healthcare facility’s autonomy, which implies for example that no action has been taken in favor of those hospitals with a deficit position.

These parameters, taken as a whole, give an indication as to the system’s ability to profitably use available resources.

It emerges from the research that industrialised countries are moving towards greater 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 implement the conditions for impartial management of the public-private mix which is the basis of most western healthcare systems. Only in this way can competitive mechanisms be able to improve the overall performance of healthcare services. The same mechanisms can ensure the real protection of welfare principles, allowing a progression from a theoretical declaration of rights to an adequate answer to citizens’ concrete needs, through the best possible use of the available resources, and within a perspective of a sustainable growth.