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Competition policy for health care provision in Portugal

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ABSTRACT

We review the role of competition among healthcare providers in Portugal, which has a public National Health Service (NHS) at the core of the health system. There is little competition among healthcare providers within the NHS. Competition among NHS primary care providers is hindered by excess demand (many residents in Portugal do not have a designated family doctor). Competition among NHS hospitals has been traditionally limited to cases of maximum guaranteed waiting time for surgery being exceeded. The Portuguese Competition Authority enforces competition law. It has focused on mergers between private hospitals and abuse of market power (including cartel cases) by private healthcare providers. The Healthcare Regulation Authority produced several reports on particular areas of activity by private healthcare providers. The main conclusion of these reviews was lack of conditions for effective competition, with the exception of dentistry. Within the NHS, the use of tendering procedures was able to create "competition for the market" in particular areas though it was not problem free. Details in the particular design adopted matter a lot.

Overall, the scope for competition policy and for competition among healthcare providers to have a main role in a health system based on a public National Health Service seems limited, with more relevance to "competition for the market" situations than to "competition in the market".

1. Introduction

The Portuguese healthcare system has at its core the National Health Service (NHS), created in 1979. In 2015 health expenditure per capita in Portugal was €1.967 (for the EU28, health expenditure per capita is €2.781). Portugal's health care expenditure as share of GDP stands at 8,9% which is below the EU28 average of 9,9% [1].

The design of the National Health Service limits the development of competition between healthcare providers, as in many other countries with a similar option. When the NHS was created there were already in place private providers, mostly individual and small-office medical practices, and profession-based health insurance schemes (Barros et al. [2], provide more details). The evolution of the private sector, more prone to existence of competition, occurred in non-medical services (laboratorial and imaging tests, small clinics, etc.).

An assessment of the role and scope for competition in the Portuguese health system is presented in this paper. Section 2 describes the institutional set-up of the Portuguese health system. Next, Section 3 provides a review of the current role of competition in the Portuguese health system. Finally, Section 4 reports the key lessons and implications.

2. Institutional set-up

This section provides a brief snapshot of the Portuguese health system. Further details can be found in Barros et al. [2] and Oliveira and Pinto [3], among

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others. The Portuguese National Health Service covers 58,4% of total funding for health in Portugal and other Government funding covers an additional 8,1% of total funding.[1] The other Government funding includes tax benefits for private health care expenditures (2,97%), social security funds (1,17%), and civil servants and armed forces health insurance coverage provided in addition to the NHS (3,98%). Out-of-pocket payments from households account for 27% of total funding. The remaining private funding includes voluntary health insurance (3,5%), private health subsystems (1,8%), non-profit social institutions (0,04%) and other corporate funding (0,85%). A considerable proportion of out-of-pocket results from copayments required by the NHS, namely in pharmaceutical products and exams performed by private providers who are contracted by the NHS. Pharmaceutical copayments are the major out-of-pocket expenditure, especially for lower income families.

The NHS provides universal and comprehensive coverage, with user charges set to play a demand-moderating role in several NHS services, with exemptions in place to ensure that no person in need is denied access to healthcare due to financial barriers.

Voluntary health insurance (VHI) is offered in the private market, under both individual and group policies. VHI allows faster access to healthcare, mainly medical specialists and exams. Occupational-based health insurance schemes ("health subsystems") exist as a legacy from the pre-NHS period. There are both private and public health subsystems. Private health subsystems evolved toward a voluntary health insurance model as a result of decreasing employer contributions, linked to parent companies' business strategies.

The most important of public health systems is the civil servants protection system (ADSE), as it covers around 1.3 million beneficiaries (in a population of about 10 million). The main advantage of subsystems is the ability to go to a specialist consultation without a referral from primary care and have quicker access to private providers (under a reimbursement model or under a copayment). ADSE does not have its own services and contracts with private healthcare providers.

A final layer of (implicit) health insurance protection is provided by tax benefits for private healthcare expenditures. The income tax code allows households to deduct from income tax a certain amount of health expenditures.

Primary healthcare in Portugal is organized mainly within the National Health Service. The NHS has three different models of group practices: traditional primary care centres (UCSP—*Unidades de Cuidados de Saúde Personalizados*), Family Health Units – A (*Unidades de Saúde Familiar*/USF-A) and Family Health Units – B (*Unidades de Saúde Familiar*/USF-B). Family Health Units are smaller multidisciplinary groups of health professionals (physicians/GPs, nurses and administrative staff). The type A and type B models differ in their remuneration system, with a pay-for-performance component present in USF-B. All primary care groups have a list of registered patients. Patients may choose a family doctor and enrol on his/her list if there is a vacancy. Currently, there is a shortage of GPs in certain areas, and not all residents in Portugal have access to an assigned family doctor. Patients are still treated in primary care (at UCSP) by the GP available at the time. Patients also have the possibility to visit a private practice doctor paying out-of-pocket. Individual and small private group practices of doctors have fallen in number over time, and are now (2016) a small fringe of providers.[2]

The NHS as a provider of health care has a network of primary care units, described above, a network of hospitals and, since 2006, a network of continued care providers. The NHS hospitals include traditional public-sector hospitals, hospitals under statutes close to private sector management rules (in particular, related to human resources management), and public–private partnerships. Hospitals are included in referral networks from primary care units, for the most part, based on geographical proximity. Local Health Units are a specific institutional arrangement within the NHS that bring together a hospital (or hospital centre) and the primary care units in its catchment area under the same management. This intends to increase coordination between these two levels of health care providers within the same geographical area. There are six Local Health Units, covering in total about 9,3% of the population.

The NHS uses a variety of mechanisms to pay healthcare providers. NHS primary care units and hospitals are funded mainly by global budget. The budget for primary care is set based on a contracting procedure between the healthcare units and the NHS administration, setting targets for activity and quality indicators according to the type of primary care unit (for some units, *USF-B*, there is a pay-for-performance element). Funds for the NHS originate from the State Budget, user charges paid by patients (relatively minor overall), and services paid for by private insurers and private health subsystems. Global budgets for NHS hospitals are calculated on a prospective basis, based on predicted (or negotiated) volume of activity and predetermined prices, using Diagnosis Related Groups (DRG) information (computation of a case-mix index included in the funding formula). The DRG patient classification system is not used to directly pay hospitals by episode. Local Health Units are paid by (demographic) adjusted capitation over the population of a pre-defined catchment area.

Private sector providers, whether they provide services to the NHS, to private patients directly or to both, are regulated in several ways, including licensing. Prices of private services provided to NHS are negotiated between the financial body of the NHS (ACSS—*Administração Central do Sistema de Saúde*) and private providers, often organized in professional associations. Health subsystems and health insurance companies negotiate prices directly with private providers.

[1] All values computed using the National Health Accounts by Statistics Portugal [4] which are publicly available.

[2] Further details about recent evolution in primary care in Portugal can be found in Barros et al. [5].