Health Policy 121 (2017) 103–110

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Policies towards hospital and GP competition in five European countries

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ARTICLE INFO

Article history:
Received 11 July 2016
Received in revised form 7 November 2016
Accepted 15 November 2016

Keywords:
Competition
Patient choice
Hospitals
GPs
Quality

ABSTRACT

This study provides an overview of policies affecting competition amongst hospitals and GPs in five European countries: France, Germany, Netherlands, Norway and Portugal. Drawing on the policies and empirical evidence described in five case studies, we find both similarities and differences in the approaches adopted. Constraints on patients' choices of provider have been relaxed but countries differ in the amount and type of information that is provided in the public domain. Hospitals are increasingly paid via fixed prices per patient to encourage them to compete on quality but prices are set in different ways across countries. They can be collectively negotiated, determined by the political process, negotiated between insurers and providers or centrally determined by provider costs. Competition amongst GPs varies across countries and is limited in some cases by shortages of providers or restrictions on entry. There are varied and innovative examples of selective contracting for patients with chronic conditions aimed at reducing fragmentation of care. Competition authorities do generally have jurisdiction over mergers of private hospitals but assessing the potential impact of mergers on quality remains a key challenge. Overall, this study highlights a rich diversity of approaches towards competition policy in healthcare.

1. Introduction

Governments have introduced elements of competition in the health sector across several European countries. Competition is a multifaceted *process* whereby producers strive to attract customers from their rivals by providing a more appealing combination of price and quality. In conventional markets this process may lead to greater efficiency to keep prices down, and consumers will benefit via lower prices, products that better suit their needs and a greater variety of products. Patients may also place an intrinsic value on having a choice of provider [1].

Healthcare markets differ in that "consumers" (patients) are usually insulated from costs by third-party payers operating through public or private insurance and healthcare providers may compete for the business of an insurer, rather than for patients. Depending on the objectives of the insurer and the contracts they are offered, providers may not be concerned with attracting more patients. Not only the target of competition but also its mechanisms are different in health care. If prices are set by the insurer then providers can only compete on quality. But patients may find it difficult to judge the quality of healthcare. Hence, the question "what do we expect or want of competition?" is not so easily answered in healthcare settings, and the analogy with other sectors may fail. Within the healthcare

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http://dx.doi.org/10.1016/j.healthpol.2016.11.011

sector, institutional details matter and differ across services and countries.

The diversity of institutional details and concepts of competition motivate this study. We illustrate how policies affecting competition have been implemented and promoted in five countries: France, Germany, the Netherlands, Norway and Portugal. We restrict attention to primary (GP) and secondary (hospital) services, since arrangements for other services, especially pharmaceuticals, raise novel but separate issues.

Generally policy towards competition in healthcare markets appears to be based on acceptance of the argument that competition is *potentially* beneficial in driving down costs and improving quality. That argument receives some, though not complete, endorsement from economic models of healthcare delivery. In particular, most models suggest that when providers face regulated prices greater competition will drive up quality [2,3]. There is a general move towards introducing policies intended to increase competition but just as there is a diversity of what exactly competition is across different settings, there is also a variety of policy responses.

The next sections outline and discuss the results from the case studies, reflecting the diversity of country settings and healthcare systems, the healthcare services to which policies have been applied, the types of policies and existing evidence. We are careful not to use the term *competition policy* because this is often synonymous with controls over mergers based on antitrust law. Instead we refer more broadly to policies which enhance competition, for example relaxing constraints on patient choice of provider or encouraging providers to compete on quality by ensuring that their revenue increases if they attract more patients.

2. Materials and methods

We draw on detailed case studies in five countries (France, Germany, Netherlands, Norway and Portugal) chosen to reflect differences in financing arrangements (social insurance versus tax-based systems), provider ownership, regulatory frameworks, gatekeeping by GPs, and patients' ability to choose a provider. The case studies were written by independent academics following a common template and constitute the remainder of this Special Issue of *Health Policy*.

The template asked authors to: focus on primary and secondary care; identify the dimensions over which providers compete; define relevant markets; investigate the interplay between competition and patient choice; explain the role of antitrust authorities; review, synthesise and analyse evidence, including academic and grey literature; describe and analyse the role of private providers and public-private partnerships; assess intended and unintended consequences; and explore how competition interacts with initiatives aimed at improving coordination between primary and secondary care. The case studies were presented at a conference in April 2016 and each discussed by an invited policymaker from the relevant country.

Despite considerable international policy interest in the role of competition in health care [4], the published empirical evidence is mixed and based mainly on the US and UK [5,6]. US studies are also often difficult to translate to publicly-funded systems. There is very limited evidence in published literature from other countries. This study fills a gap in knowledge, and overcomes language and other barriers that impede knowledge transfer about experience in other countries. A brief overview of salient features of healthcare systems and policies is provided in Table 1.

3. Results: review of policies and related empirical evidence

3.1. Wider choice of hospital is increasingly common

Some countries have relaxed constraints on patient choice of healthcare provider. In **Norway** from 2001 patients were given the right to choose their hospital rather than being referred to the closest hospital. Information on waiting time for selected procedures is provided and since 2012 hospital quality indicators have been published. In 2015 patient choice was reinforced by removing constraints on hospital volumes and allowing private providers to treat publicly-funded patients. Patients are now allowed to choose hospitals in other regions, with the home region paying the DRG-price to the receiving region, resulting in increased mobility across regions [7]. Patient choice of hospital is responsive to waiting times and greater choice may have contributed to the marked reduction in waiting times [8].

Patients have traditionally had free choice of hospital in **France**. Recent policies have facilitated hospital choice by providing public information on process measures of quality and hospital activity [9]. The website http://www.scopesante.fr/has over 450 indicators including generic process measures, such as hospital-acquired conditions and catering services, and condition specific measures (e.g. acute myocardial infarction, haemodialysis). Activity indicators include number of stays, length of stay and the C-section rate. Health outcomes are not included due to concerns over risk adjustment and potential strategic response by hospitals, such as underreporting of negative outcomes. In 2015 the site had 340,000 visitors.

In the **Netherlands** the government has introduced mandatory publication of hospital waiting times, standardised mortality ratios and other outcomes [10]. Evidence suggests that angioplasty patients are more likely to choose hospitals with a good (overall and cardiology) reputation and low readmissions after treatment for heart failure [11]. Patient choice of hospital for hip replacement is affected by information in the public domain on reputation and waiting times, as well as travel time [12].

In **Germany** hospitals are required to publish quality reports. However, these are lengthy documents not easily accessible to patients and provide limited information [13]. There is no official platform which allows patients to compare hospitals, though some sickness funds provide guidance online. Some hospitals voluntarily publish quality data and one study found that these attract more patients if quality is above average [14]. There is also evidence that coronary bypass patients are willing to travel further to hospitals with better reputation [15].