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Pricing and competition
in Specialist Medical
Services: An Overview for
South Africa

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**PRICING AND COMPETITION IN SPECIALIST MEDICAL SERVICES:
An Overview for South Africa**

Ankit Kumar, Grégoire de Lagasnerie, Frederica Maiorano and Alessia Forti

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ABSTRACT¹

Major disparities in the cost of health care have made the pricing of specialist and hospital services a contentious issue in South Africa, particularly in the private sector. To help inform policy debate, this paper profiles selected experiences on the pricing of health services, competition policy and models of buying specialist health care services from the private sector across the OECD. Firstly, South Africa is compared to OECD countries to identify countries where voluntary private health insurance – the major source of financing for private hospitals – plays a similar role. Second, this paper provides an overview of price setting across OECD health care systems. It then covers the economic rationale and the institutional arrangements which OECD countries have established to set prices, before moving to an overview of competition policy considerations surrounding these arrangements. Finally, the paper highlights a few models of buying services from the private sector for public patients, with a particular focus on Mexico and Turkey. It is argued that South Africa should separate the task of establishing a schedule of medical services from negotiations over overall payments to medical professionals.

RÉSUMÉ

La tarification des services spécialisés et hospitaliers est devenue en Afrique du Sud, en particulier dans le secteur privé, une question controversée suite à d'importantes disparités dans le coût des soins de santé. Pour éclairer le débat politique, ce document décrit différents exemples de tarification des services de santé, de politique de concurrence et des modèles d'achat de services de soins spécialisés au secteur privé dans la zone OCDE. Dans un premier temps, l'étude compare l'Afrique du Sud à d'autres pays de l'OCDE pour identifier les pays où l'assurance-maladie volontaire privée - la principale source de financement pour les hôpitaux privés en Afrique du Sud - joue un rôle similaire. Il donne ensuite un aperçu de la fixation des prix dans les systèmes de santé de l'OCDE. Puis, il aborde la logique économique et les dispositifs institutionnels mis en place par les pays de l'OCDE pour fixer les prix, avant de présenter une vue d'ensemble de la réflexion concernant la politique de la concurrence autour de ces arrangements. Enfin, le document expose quelques modèles d'achat de services au secteur privé pour les patients du secteur public, en développant plus particulièrement les exemples du Mexique et de la Turquie. Il apparaît que l'Afrique du Sud devrait séparer d'un côté l'élaboration d'une liste de services médicaux et de l'autre les négociations faites sur l'ensemble des paiements des professionnels de santé.

¹ This paper has been produced at the request of WHO South Africa and authored by members of the OECD Secretariat working on health and competition policies. The opinions expressed and arguments employed here are the responsibility of the authors and do not necessarily reflect those of the OECD or the WHO. Figures used in this paper are sourced from OECD Health Data 2013, unless otherwise specified. The authors wish to thank Tomas Roubal, Sarah Barber and Joseph Kutzin from WHO for supporting this project and for their guidance. At the OECD, the authors wish to thank Valérie Paris, Kees van Gool, Michael Mueller, Divya Srivastava, Francesca Colombo, Sean Ennis and Mark Pearson for their comments and suggestions. The authors are also indebted to a number of people working in health and competition policy in South Africa who kindly gave up their time to speak with us about health policy in South Africa.

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EXECUTIVE SUMMARY

The pricing of specialist and hospital services is a contentious issue in South Africa today. To help inform this debate, this paper provides international experiences on the pricing of health services, competition policy and models of buying specialist health care services from the private sector. As South Africa's health care system increasingly bifurcates, questions of pricing shall be central to striking a balance between public and private that can best meet the country's health care needs.

South Africa's challenges in health are substantial. Compared to most OECD countries, South Africa has fewer doctors and nurses, limitations on revenues and challenges with delivery capacity in the public sector. This occurs within the backdrop of significant inequality and poverty. Over time, these factors have contributed to the emergence of a large private health care sector. Access to the large number of doctors working in South Africa's private health care facilities is largely determined by the ability to pay. The most common means of financing access to private health care services is voluntary private health insurance.

This paper presents the experiences of OECD countries in grappling with comparable challenges in four distinct sections. It begins by looking at voluntary private health insurance, to highlight where South Africa is most different to OECD countries and identify countries where private health insurance has a similar role. The second section provides an overview of price setting across public and private health care facilities. The third covers the economic rationale for fixed prices and detailed information about the policies and institutions through which these have been implemented. The fourth looks into competition policy considerations surrounding price setting in health care. The final section provides four case studies of how countries have sought to contract with private health care facilities to deliver services to public patients. Across these sections, it is argued that:

1. South Africa has a higher share of spending on private voluntary health insurance than any OECD country, and this serves a smaller share of the population.
2. In most OECD countries the public sector tends to have some form of price setting for specialist medical services, this is used to purchase services from the private sector and can provide benchmarks for private insurers.
3. Regulation in OECD countries generally enables collective bargaining on hospital prices. Competition policy distinguishes between public insurers with a social purpose and private insurers, and allows co-ordination among providers under specific circumstances.
4. Developing credible prices and large increases in public spending have been common to OECD countries that have drawn on private sector facilities to expand access to hospitals in recent years.

A suggestion from this review of OECD countries is that South Africa should separate the 'technical' task of establishing a schedule of medical services ranked according to their complexity from 'political' negotiations over overall payments to medical professionals. A technically sound price schedule is a common feature of OECD country health systems. It brings clarity for doctors, those that pay them, and ultimately, the patients that these institutions serve. Today, the South African health care system lacks this clarity. This makes it hard for the public sector to draw on private health care services to expand access to care, and makes negotiations between private insurers and private facilities a more difficult process.

1. WHY PRICING MATTERS: THE LARGE ROLE OF PRIVATE HEALTH INSURANCE IN SOUTH AFRICA

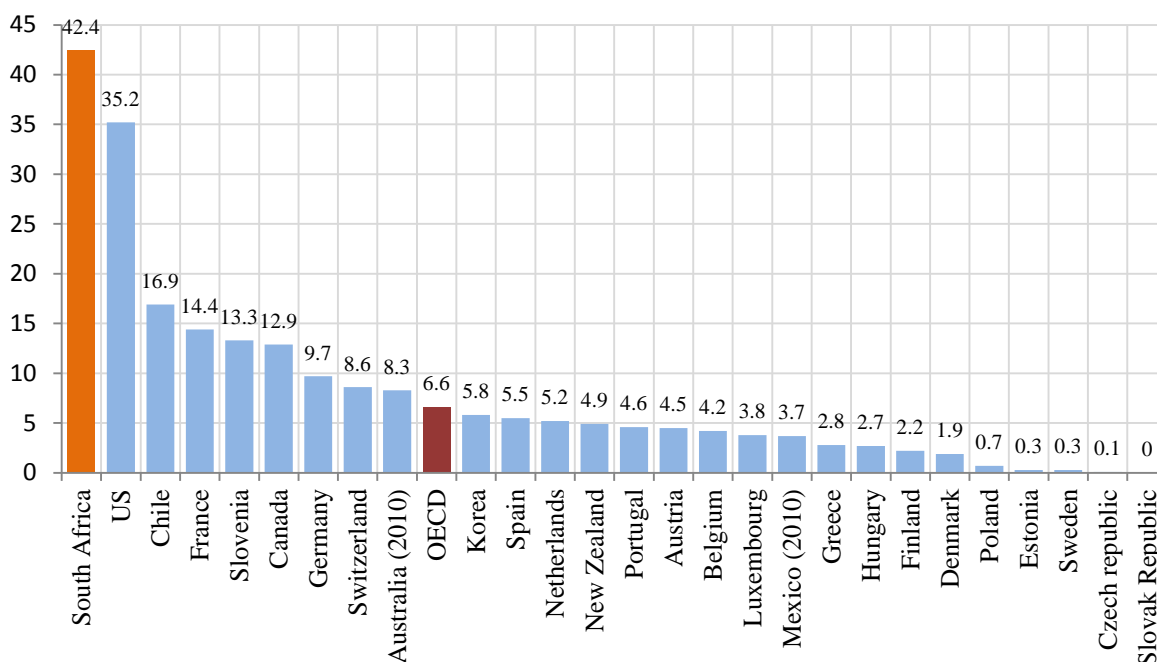
1. Concerns about the pricing of specialist and hospital services in South Africa emerge from the dominant role of the private sector. Negotiations between private voluntary health insurance and private hospitals determine how a large section of the country's funds for health are spent, and sets norms with which the public sector must contend as it competes for medical personnel. This section seeks to compare the economic significance and role of private health insurance and private health care services in South Africa with OECD countries. It argues that:

- South Africa spends more on private health insurance than any other OECD country, especially considering the small share of the population this serves. This has helped attract a disproportionate share of medical specialists to the private sector.
- There are some OECD countries which have a similar role for voluntary private health insurance, notably Australia, Finland, Ireland, Italy, New Zealand, Portugal, Spain and the United Kingdom. However, in none of these countries is voluntary private health insurance as economically significant.
- Private health insurance has made controlling costs more difficult across OECD countries.

South Africa spends more on private health insurance and for a smaller share of the population

2. Every South African has the ability to turn to government funded and run public health care providers, whose quality and availability vary considerably. Alongside the public sector is a system of voluntary private health insurance², with people able to purchase a policy from one of 92 medical schemes (Council for Medical Schemes, 2013). Many of these medical schemes began as funds for specific occupational groups to gain reimbursement for services in private hospitals. However, reforms have transformed most into 'open' schemes, which people can voluntarily enrol in, should they be able to pay for them.

² From herein the term 'private health insurance' shall be used interchangeably with 'voluntary private health insurance' in the interests of brevity. It is important to note that there are no population wide obligations for individuals to purchase private health insurance in South Africa.

Figure 1: Private health insurance as a share of total current health expenditures (%), 2011 or latest available

Note: South Africa data from WHO, 2011
Source: OECD Health Statistics 2013

3. Voluntary private health insurance is more economically significant in South Africa than in any OECD country. Accounting for 42% of total health spending, this is higher than the United States (35%) and seven times the OECD average of 6.6% (Figure 1). It is also higher than Brazil (21%), India (3.5%), the Russian Federation (2.8%) and China (2.6%) (WHO, 2011).

4. The high level of spending on private health insurance is particularly remarkable given how small a share of the population it covers. Around 16% of the population (8.7 million people) are enrolled in a medical scheme in South Africa. In contrast, spending on private health insurance covers more people across the US (61% of the population), Canada (68%) and Australia (53%).

South Africa has a comparatively larger private health care sector

5. The major beneficiaries of the high level of spending on private health insurance are South Africa's private hospitals and the medical specialists that work within them. Though private hospitals account for only 26% of the country's total hospital bed capacity, they engage 55% of doctors (Health Systems Trust, 2010). The high proportion of spending on private sector facilities and their major role in engaging doctors mean that prices set in the private sector have an enormous impact across the health care system. It affects the affordability of private health insurance, and sets norms for doctors' wages that can constrain the public sector's expansion efforts. In this context, it is not surprising that the pricing of health care services is a highly contested issue. Other than the United States, there is no other OECD country that has to grapple with such a situation in a similar magnitude.

There are some OECD countries which have a similar role for private health insurance

6. While comparators are limited when it comes to spending, some countries share similar roles for private health insurance. It is worthwhile to distinguish between the diversity of roles played by private health insurance across the OECD. Private health insurance may (Box 1):

- (1) Provide **primary health care cover** (i.e. where an individual would not otherwise have public health care);
- (2) **Duplicate** coverage for those services already offered in the public sector;
- (3) **Complement** public cover (generally through covering co-payments);
- (4) **Supplement** public cover by reimbursing services not included in the public scheme.

Box 1. Defining Private Health Insurance

Primary private health insurance: When private insurance represents the only available access to basic health cover because there is no public health insurance, individuals are not eligible to cover under public health insurance (principal cover), or they are entitled for public coverage but have chosen to opt out of such coverage (substitute cover).

Duplicate cover: private insurance that offers cover for health services already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service. It does not exempt individuals from contributing to public health insurance.

Complementary cover: private insurance that complements coverage of publicly insured services or services within principal/substitute health insurance, which is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed (e.g., co-payments).

Supplementary cover: private health insurance that provides cover for additional health services not covered by the public scheme. Depending on the country, it may include services that are uncovered by the public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service - i.e. the medical component - are covered by the public system).

Sources: OECD (2004) and, Thomson S, Mossialos E. (2004).

7. These categories are not mutually exclusive and many countries have private health insurance that plays more than one of these roles. South Africa's medical schemes are argued in this paper to offer duplicate and supplementary private health insurance on a voluntary basis. This is because they principally finance an *alternative* to seeking care in the public sector, by reimbursing private hospitals and private medical specialists. At the same time, they often cover a range of benefits not provided in public health care services (e.g. such as optometry and orthodontics). There are a number of OECD countries where private health insurance plays a similar role to that in South Africa. Each of Australia, Finland, Ireland, Italy, New Zealand, Portugal, Spain and the United Kingdom provide access to public health care services for all, but offer individuals the choice of purchasing voluntary private health insurance that reimburses care in a private facility. In these countries, the value propositions for accessing private facilities include upgraded hospital accommodation, luxury services, choice of treating doctors, lower waiting times and perception of higher quality services (OECD, 2012d). As in South Africa, in every one of these countries this private health insurance also extends to supplementary services not provided by the public sector (OECD, 2013 and 2004). Among this group of comparator countries, the proportion of the population covered in Australia, Ireland, New Zealand and Portugal are higher than in South Africa (16%), while Finland and Spain are below (Table 1).

Table 1: Population covered by Private Health Insurance, 2011 (or nearest year)

	PHI as a percentage of Total healthcare expenditure in 2011	Population covered by PHI, %	Types of private coverage
Australia	8.3 (2010)	52.5	Supplementary, duplicate
Austria	4.5	34.2	Supplementary
Belgium	4.2	79.6	Complementary
Canada	12.9	68	Supplementary
Chile	16.9	17	Primary
Czech Republic	0.1	n.a.	Supplementary*
Denmark	1.9	20.8	Complementary
Estonia	0.3	n.a.	n.a.
Finland	2.2	14.2	Duplicate, complementary, supplementary*
France	14.4	96.1	Complementary
Germany	9.7	32	Primary, complementary
Greece	2.8	12	Duplicate
Hungary	2.7	n.a.	Supplementary*
Iceland	n.a.	0.2	Primary
Ireland	n.a.	47.5	Duplicate
Israel	10.1 (2009)	80	Supplementary
Italy	1.0	n.a.	n.a.
Japan	2.4 (2010)	n.a.	n.a.
Korea	5.8	51.1	Complementary
Luxembourg	3.8	54	Complementary
Mexico	3.7	6.9	Primary
Netherlands	5.6	89	Supplementary
New Zealand	4.8	30.8	Complementary
Norway	0 (2003)	n.a.	
Poland	0.7	n.a.	Supplementary*
Portugal	4.9	19.8	Duplicate
Slovak Republic	0.0	n.a.	n.a.
Slovenia	13.6	73	Complementary, supplementary, duplicate
Spain	5.7	13.4	Primary, Duplicate
Sweden	0.3	n.a.	n.a.
Switzerland	8.6	29.5	Supplementary
Turkey	n.a.	4.6	Primary
United Kingdom	4.1 (2002)	n.a.	Duplicate, supplementary*
United States	35.2	60.6	Primary, complementary

*Latest information available in OECD, 2004

Source: OECD, 2013 and OECD, 2004

8. The OECD countries with a high share of the population covered tend to have different types of private health insurance to South Africa. In France, the Netherlands, Switzerland, Israel, Belgium, Slovenia and Luxembourg, private insurers principally focus on covering the gap between public reimbursements and charges and/or providing access to enhanced services. Germany is more unusual in that it has public social insurance but some 11% of the population³ choose to opt-out of this and receive cover from a private health insurer. Similarly, United States has a tradition of employer and self-financed health insurance and two major public programmes for the poor and the elderly (Medicare and Medicaid).

Private health insurance has made controlling costs more difficult in OECD countries

9. Across the OECD, private health insurance has not assisted in cost containment and can often create cost pressures. Private health insurance brings more financial resources into the health care system. The array of cost-control measures – such as global budgets, price regulation and capacity controls – that are used across the public sector in most OECD countries often do not exist in the private sector (OECD,

3 Only a share of the population has the possibility to do so. One of the criteria is the gross salary. In 2012, above a gross salary of 50,850 euros, people could choose between public social health insurance and private health insurance.

2004). Cost control has also been more problematic with multiple competing payers, including most private health insurance markets (OECD, 2004). It is only in some exceptionally concentrated markets that insurers can exert strong pressure, as in the case of Ireland. The combination of the lesser economic significance of private health insurers and the fewer tools at their disposal has meant that in most OECD countries, the public sector has generally been the frontrunner in price setting.

2. AN OVERVIEW OF PRICE SETTING IN OECD COUNTRIES: COMPARING PRIVATE AND PUBLIC

10. This section provides an overview of price setting among OECD countries. In doing so, the scope of this paper is services provided by specialist doctors. These are usually delivered in hospitals but can also be delivered in the community. Implicit in this overview is the notion that payment systems for health care incorporate some notion of ‘pricing’ the value of work undertaken (detailed in section three). This section highlights that across OECD countries:

- Regulation of private health insurance is extensive, and generally relates to financial matters and ensuring access to insurance products for certain consumers.
- Through their role as public payors (or providers), governments are very influential in determining the level of prices for specialist medical services.
- Efforts at price setting in the public sector sets an important centre of gravity for private health insurers and health care providers on what a reasonable price for a service might be.

Regulation of private health insurance is extensive

11. Government regulation of private health insurance varies considerably across the OECD. A review found that all OECD countries with private health insurance had regulation in financial and prudential matters in common, but the existence of regulation in other domains varied substantially (OECD, 2004). Generally, private health insurance regulation was based on the prominence of private health insurance in the health system and covered provisions on access to private health insurance coverage, premiums and the content of insurance contracts. Many governments also intervene to provide some form of risk equalisation to support the financial viability of covering high risk persons or subsidies towards the cost of premiums.

12. Countries with a similar role for private health insurance such as that in South Africa do not prescribe prices in the private sector but they also tend to have much larger public health care systems. None of the eight countries where private health insurance plays a similar role to that in South Africa (Australia, Finland, Ireland, Italy, New Zealand, Portugal, Spain and the United Kingdom) directly intervened to regulate prices of medical services settled between private health insurers and private hospitals. Recognising the role of private health insurance as a voluntary product for those with the capacity and willingness to pay for additional services, the scope of regulation is focused on assuring the financial position of private health insurers (prudential regulation) and reducing scope for some consumers to face discrimination in accessing insurance products.

Box 2: Regulating prices between private health insurers and private medical specialists: the contrasting experiences of Germany and Slovenia

Germany and Slovenia are the two OECD countries that have sought to regulate prices settled between private health care providers and private insurers.

In Germany, there is a separate list of prices physicians are allowed to charge patients with private health insurance (or those willing to pay out of pocket), which was established in 1982. This list is decreed by the Federal Ministry of Health after consultation with German Medical Association and the association of private insurers and other stakeholders. This list of prices for physicians and dentists⁴ specifies the relative weight of a range of different procedures, ranked by their number of 'points'. The monetary conversion factor of the 'points' is stipulated in the decree. Physicians and dentists are allowed to multiply the conversion factor by 1.7 to 3.5, to take into account differences in the complexity of the individual service provision. This provides price flexibility for the private sector within reasonable limits and nestles this within a technically robust approach to price setting.

In contrast, Slovenia's attempt to establish minimal limits and provide flexibility for pricing above this ran into competition policy concerns. The Medical Chamber of Slovenia, which represents doctors and dentists, was responsible for setting the prices for services provided by private providers, which were then confirmed by the Minister of Health (Albrecht *et al.*, 2009). In 1995, the Medical Chamber of Slovenia adopted a Regulation specifying minimum prices along with sanctions for those doctors and dentists who wouldn't comply. Both regulations were obligatory upon all doctors and were valid until 2012. However, the Slovenian Competition Protection Office (CPO) found that these rules implied that the chamber had set prices and other conditions for conduct of business on the market for dental and medical services. The CPO's obliged the Chamber to inform members that the rules were null and void (OECD, 2012b).

Price setting is a dominant feature of public health care

13. Price setting is a common feature of public health care systems. Most OECD countries today use some form of implicit 'price' or 'cost'⁵ for specialist and hospital services, which are either directly used in payments on the basis of 'fees' for work undertaken or an input into the calculation of budgets for hospitals. For specialist outpatient services, fourteen countries operate fee-for-service payments which reimburse doctors for the activities they undertake. For inpatient hospital services, nineteen OECD countries employ either some payment based on activities undertaken, or payments adjusted for patient complexity (DRGs). Conceptually, both these payment mechanisms are built upon classifying health care services from the most to least complex in order to attribute a price to them. Many countries using global budgets have also developed notions of price that are used to determine budget allocations.

Price setting in the public sector sets an important centre of gravity for private health insurance markets

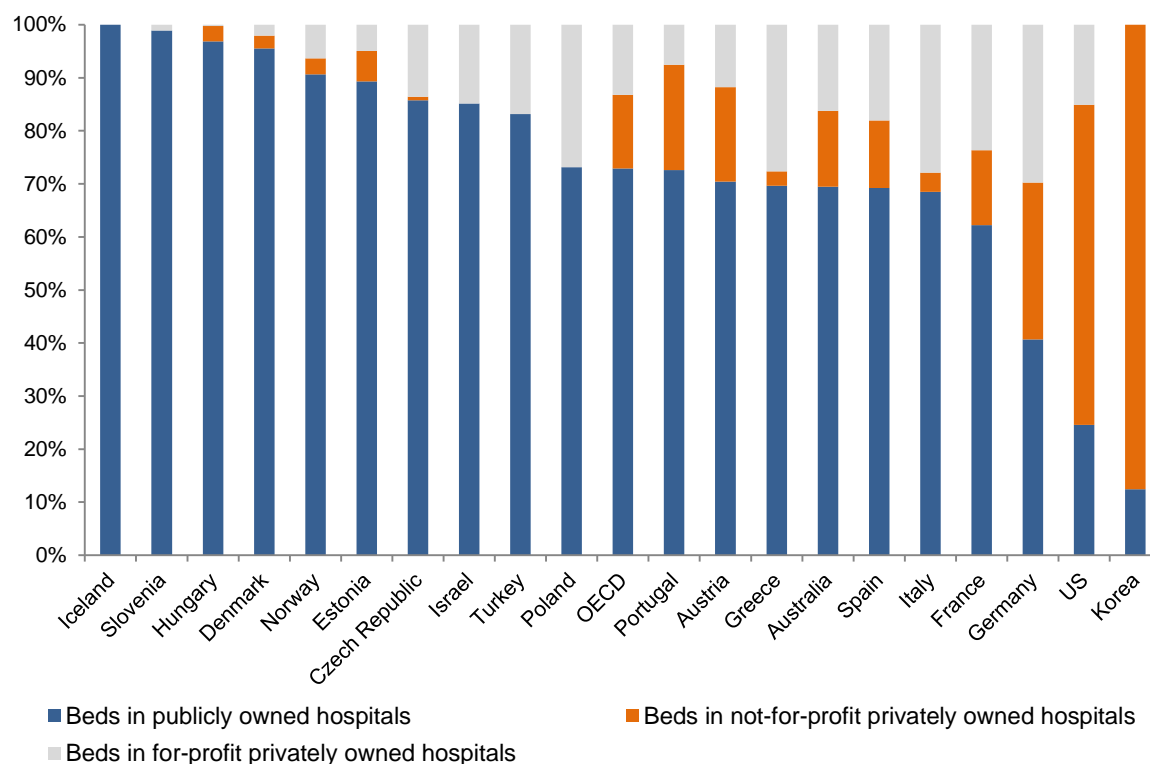
14. For a number of OECD countries, private providers are paid to deliver services to persons as part of their public entitlement to health care. Countries such as Korea, the United States, Germany and France have a high proportion (ranging from 85% to 40%) of their hospital bed capacity in either for-profit or not-for-hospitals (Figure 2). In these countries, public health insurers are the largest source of financing for hospital services and what public health insurers' pay will often form the floor for that sought by private hospitals from private health insurers. Many of these countries will also have voluntary private health insurance to cover complementary costs. Nonetheless, as public insurance generally covers the bulk of a

⁴ Respectively called the catalogue of Tariffs for Physicians (Gebührenordnung für Ärzte, GOÄ) and (Gebührenordnung für Zahnärzte, GOZÄ)

⁵ For the purposes of clarity, herein 'prices' may refer to the rate of reimbursement for a medical service or the value at which it is costed in budgeting. Implicit in both these ideas is that a value is being placed on a medical service – which is the phenomena of interest for this paper.

hospital visit, the public sector continues to have a significant influence over the total prices charged by hospitals.

Figure 2: Hospital beds in publicly and privately owned hospitals as a percentage of total beds in OECD countries (%), 2012 or latest available



Note: Figures for *Beds in for-profit privately owned hospitals* are not available in the Netherlands, Japan and the UK. Figures for *Beds in non-for-profit privately owned hospitals* are not available in Chile, Mexico, Finland, Japan, UK

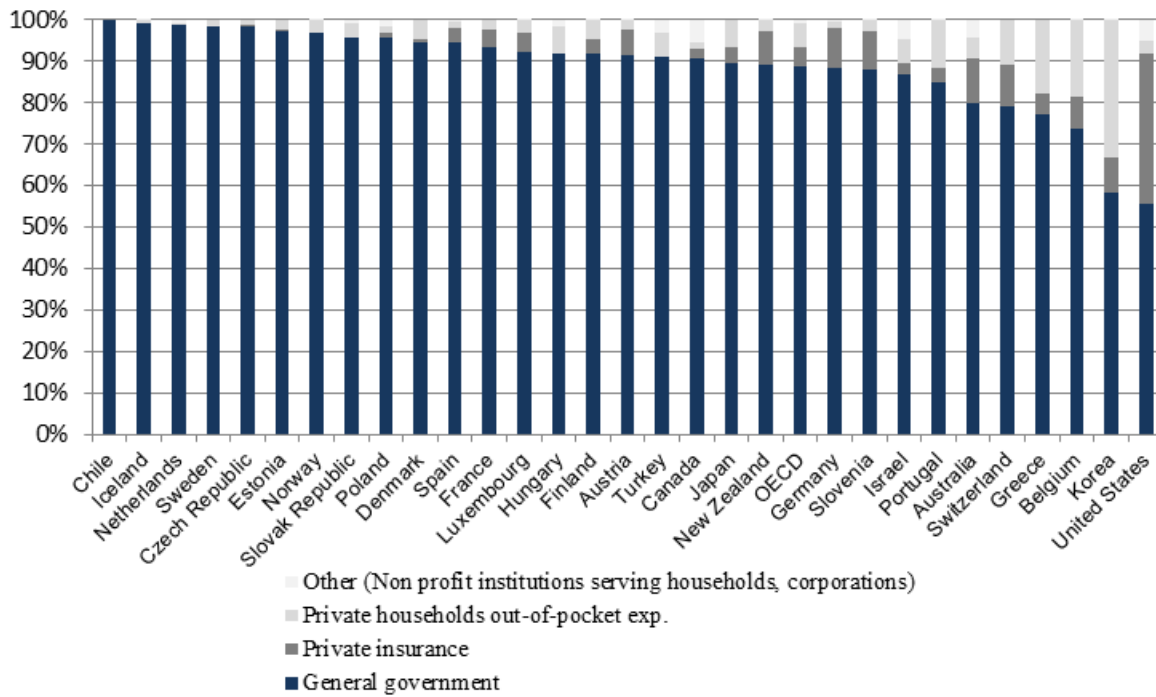
Source: OECD Health Statistics, 2013

15. Even where services are not extensively bought from the private sector, public sector prices are likely to influence prices negotiated between private providers and private health insurance. Among the eight OECD countries with private health insurance that plays a similar role to that in South Africa,⁶ Australia has the highest level of private insurance spending on hospitals at 11%, followed by New Zealand (8%), Finland (4%) and Spain (3%) (Figure 3).⁷ In contrast to South Africa though, in these countries the public sector remains (by far) the dominant buyer of hospital services given them greater influence in setting payment and wage norms. In these countries, the operational starting point for private hospitals and private insurers is generally to pay some premium over the prices paid by the public sector.

⁶ Australia, Finland, Ireland, Italy, New Zealand, Portugal, Spain and the United Kingdom

⁷ Data was not available for Ireland, Italy, Portugal and the United Kingdom

Figure 3: Share of public and private per capita spending on hospitals, 2011 or earliest available



Source: OECD Health Statistics, 2013

3. HOW PRICES ARE SET ACROSS OECD COUNTRIES: THE RATIONALE AND INSTITUTIONAL ARRANGEMENTS

16. That some form of price setting is implicit in payments for specialist and hospital services across OECD countries reflects several decades of policy development. This section provides a detailed look at how prices for hospital based and other specialist medical services in select OECD countries are determined. It argues that:

- The economic rationale for setting prices is to control costs, foster competition on quality and mitigate against excessive financial claims.
- Governments generally steer the process of ranking medical services based on their relative complexity and cost, and engage clinicians in this process.
- Whether reimbursement prices cover the full cost of a service is an important policy lever that influences the affordability of health care services to individuals.
- Several countries have set up specialised independent agencies to separate the technical task of determining costs from the more political exercise of negotiating how much to pay for medical services.

3.1. The economic rationale for fixed prices

Pricing of health care services reflects an attempt to overcome the imperfections of healthcare markets

17. There is a long and established literature arguing that health care (and hospitals) are far from being classic markets for general goods and services. Health care is characterised by patients that have imperfect information, which provides providers (and insurers) with a disproportional influence (Blomqvist, 1991). This occurs as patients have an interest in healthcare providers, notably physicians, acting as their agent. Physicians have the ability to recommend services which determine their own reimbursement. Insurers (whether public or otherwise) are interested in providers of healthcare services economising on the use of services in order to reduce their expenditure. This combination of information asymmetry and diverging motivations have often justified a greater degree of price regulation in health as governments seek to ensure socially optimal levels of service delivery, and promote efficiency in production (Ellis and McGuire, 1993).

18. It is generally accepted across OECD countries that governments or public authorities play a proactive role in fostering the setting of prices in order to reach policy objectives. Research suggests that setting prices encourages providers to compete for quality, helps share financial risks between insurers and the provider; and can proactively prevent increases in prices of health care services in highly concentrated markets.

19. Price regulation is used to control the costs of healthcare. There exists a considerable economic literature on the heterogeneity of production costs across providers, and the asymmetric information between healthcare providers and their regulators (Newhouse, 1996). The 'yardstick competition' model (Shleifer, 1985) analyses this issue. By assuming that all providers produce a homogeneous product,

Shleifer (1985) shows that each provider will produce efficiently if paid at the average of all other firm's marginal cost. At the same time, providers may invest the socially optimal amount of effort if they keep the full reward from doing so. Even if new models introduce refinement to this first model (Ma, 1994), all of them rely on the implementation of competition with a shadow provider which produces healthcare services at the average cost of the market.

20. Building on this is a substantial literature that suggests competition for quality amongst providers (hospitals) is more likely to occur when prices are fixed. When prices are fixed, providers have to compete on other parameters than prices. Providing there exists standards on quality, price signals provide an incentive to improve efficiency and can encourage competition on quality. Gaynor (2012) has suggested that the expected impact of competition in hospital markets depends on how prices are determined. In markets with price competition, where hospitals can set their own prices, increasing the number of competitors could be predicted to improve or harm clinical quality depending on the ability of patients to perceive both quality and price. As hospital quality is often difficult to measure and observe, competition on prices and quality in the hospital sector may lead to reductions in prices and quality if consumers are more able to observe price than quality. In markets where prices are fixed by a regulator, as long as the reimbursement rate is higher than hospitals' marginal costs, increased competition should improve hospital quality (Gaynor, 2012).

21. Fixed price systems allow transferring the treatment risk from the insurer to the provider (OECD, 2012c). For instance, if the patient requires a certain treatment that is only partially covered by the fixed price, the provider has to bear the additional cost. The risk sharing between the insurer and provider is a function of the aggregation of the services included in the price. Indeed, prices can be set up at a finely disaggregated level (e.g. fee-for-services payments) or at a more highly aggregated level (e.g. global budgets or capitation payments). If the price is highly disaggregated, the risk sharing is in favour of the providers, who have the ability to cover costs by billing more services. Conversely, when the fixed price includes numerous services or even the treatment for a patient for a year, the risk sharing is in favour of the insurer, who is protected from additional costs. However, this raises its own challenges. If prices are too low, providers can have the incentive to choose 'less risky' patients. Consequently, fixed prices in the hospital sector are often adjusted for patient complexity in order to improve the balance of risk sharing between providers and insurers.

22. Fixed prices are also used in order to avoid the impact of perverse market consolidation in the hospital sector where increases in prices in some regions could create inequalities in the cost of care. The literature suggests that consolidation often leads to higher prices (see Dranove and Satterthwaite, 2000; Gaynor and Vogt, 2000; Vogt and Town, 2006; Gaynor and Town, 2011, for reviews of the evidence). Similarly, studies in the US have shown that increasing concentration in the hospital market in some states and districts as a result of mergers have led to higher prices or faster increases in prices (Wilson and Garmon, 2011, Tenn, 2011 and Gaynor and Town, 2011). Merger control is also a key tool in this effort (detailed in Annexe B).

23. For these reasons, governments have often been amenable to allowing for the setting of price norms or regulating prices in health than in other parts of the economy. The following section shall describe how the theoretical rationale for price setting has been realised in payment systems for hospitals and specialist outpatient services across OECD countries.

3.2. The technical and institutional arrangements for setting prices in OECD countries

24. The notion of 'pricing' sits at the heart of payments for specialist and hospital services across most OECD countries today. Though payments reflect considerable diversity in both the factors taken into account (e.g. wage levels, budgetary considerations, varying service delivery costs, patient complexity) and

their role (e.g. whether they are indicative, partial reimbursements or binding). This section provides an overview of payment systems across OECD countries today to show how they incorporate efforts to price health care services. Critical to this are three factors: the influence of history, technical efforts and negotiation between health care providers and payers. A distinction is made between services delivered in hospital (inpatient care) and services delivered in the community (outpatient care).⁸

3.2.1 Price setting for outpatient services

The purchasing of outpatient services is commonly undertaken through fee-for-service payments, which rank services on their relative complexity

25. As in South Africa, in many OECD countries specialist doctors working on a private basis and in the community are the key source of patient referrals to hospital. Fee-for-service payment systems are generally the dominant means of paying for such specialist services (Table 2). Whether provided by an independent practitioner or a group, a reimbursement schedule detailing the prices for different services is used in Austria, Belgium, Canada, Czech Republic, France, Germany, Greece, Luxembourg, Switzerland, Australia, Iceland, the Netherlands and the United States. In most of these countries, this fee for service schedule is similar across several public payers. However, in countries such as Canada, Germany, Switzerland, the Netherlands and the United States these may vary according to the payer or by region.

⁸ The focus of this paper is on services delivered specialist doctors as this is of greatest interest to South Africa. This normally occurs in hospitals, but also in out of hospital settings where specialist doctors might deliver 'hospital like services' or refer patients into a hospital, known as 'outpatient settings'. The comparability of methods for pricing and payment for hospital based services across OECD countries is better than that for services delivered outside of hospitals. Data reported by OECD countries for out of hospital care may include services delivered by generalist doctors as well as specialist doctors. This does not change the means of payments or the principles underpinning them, but implies that payments to specialist doctors may be paid at higher prices than those made to generalist doctors.

Table 2: The dominant form of ambulatory/out-patient specialist services provision and payment methods used by key purchasers

Predominant mode outpatient specialist	Countries	Remuneration of provider setting				Remuneration of physicians	
		Fee-for-service	Pay-for-performance	Global budget	Other	Salary	Fee-for-service
Private group practice	Australia	●	○	○	○	○	●
	Iceland	●	○	○	○	○	●
	Japan*	●	○	○	○	○	○
	Netherlands	●	●	○	○	○	●
	United States	●	●	●	○	●	●
Private solo	Austria	●	○	○	○	○	●
	Belgium	●	○	○	○	○	●
	Czech Republic	●	○	○	○	○	●
	France	●	●	○	●	○	●
	Germany	●	○	○	○	○	●
	Greece	●	○	○	○	○	●
	Korea	●	●	○	○	○	●
	Luxembourg	●	○	○	○	○	●
	Poland	○	○	○	●	●	●
	Slovak Republic	●	○	○	○	○	●
Switzerland	●	○	○	○	○	●	
Public multi-specialty	Chile	●	○	●	○	●	○
	Israel	○	○	●	○	●	●
Outpatient department of public hospital	Canada	●	○	●	●	●	●
	Denmark	○	○	○	●	●	○
	Estonia	●	○	○	○	●	○
	Finland	●	○	○	○	●	○
	Hungary**	●	○	○	○	●	○
	Ireland	○	○	●	○	●	○
	Italy	●	○	●	○	●	●
	Mexico	●	○	●	○	●	○
	New Zealand	○	○	●	○	●	○
	Norway	●	○	●	○	●	○
	Portugal	○	●	●	○	●	○
	Slovenia	●	○	○	○	●	○
	Spain	●	○	●	○	●	●
	Sweden	●	●	●	○	●	○
Turkey	○	○	●	○	●	○	
United Kingdom	○	●	●	●	●	○	

* Paris et al. (2010)

** Classified here as fee-for-service for comparability though in national context referred to pay-for-performance

Source: OECD, 2014.

26. Implicit in a fee-for-service schedule is a ranking of the relative value of health care services. A relative value scale ranks a number of reimbursable medical procedures according to their complexity and resources used. Early efforts to develop such a ranking occurred in the United States, which was then used this to form the basis for reimbursements under Medicare – the insurance scheme for the elderly. Medicare

reimburses a number of specialist services, including office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. Since 1992, the price of such services has been calculated based on ‘Relative Value Units’. Relative Value Units were developed with extensive input from the physician community and their development was driven by the United States Department of Health and Human Services and academics. These efforts worked with a panel of experts and physician speciality groups to rank specialist medical services according to two variables:

1. **Physician work:** This involves a judgement of the relative amount of time, level of skills and training, and intensity of work that goes into providing a given service. It is targeted for review at least every five years.
2. **Practice expenses:** This component addresses the costs of maintaining a practice including rent, equipment, supplies and non-physician staff costs.

27. A number of adjustments are made to this ranking of services to transform them into prices used for payment. A common conversion factor is used to convert ‘relative value units’ into dollar amounts and updated annually. Payments are adjusted to reflect geographical differences in input costs for medical and non-medical staff, using Geographic Practice Cost Indices (GPCIs, reviewed by the Centers for Medicare and Medicaid Services at least every 3 years).

28. It is important to recognise that doctors in the United States do not have to accept these reimbursement rates as they are not obliged to accept Medicare patients. Nonetheless, Medicare is significant payer of specialist health care services and was able to use its influence to foster clinical engagement and introduce such a method of payments. Ensuring that relative values remain current to clinical and technological developments is an ongoing task which is critical to maintaining the integrity of Medicare’s payments to health services.

29. Undoubtedly, Medicare’s reimbursements reflect negotiations with the medical profession and historical norms about doctors’ salaries. However, the virtue of separating the ‘technical’ process of ranking services has allowed for negotiations to occur around an informed hierarchy of prices. This principle behind the US approach – establishing a ranking of services and then associate them with prices – underpins payment systems for specialist and hospital services across many OECD countries.

Through their different institutions, Germany, Australia and France each engage clinicians in setting price levels

30. The process by which countries determine prices often reflects their domestic institutions. Germany also uses a relative value scale, which is decided through representative committees of key organisations, reflecting the country’s cooperativist tradition. Specialists must be accredited by social health insurers to be allowed to provide services that attract reimbursement. At the centre of the German health care system is the Federal Joint Committee which is authorised to issue legally binding directives. It represents physicians, hospitals, dentists, sickness funds and patients. A sub-committee of the Federal Joint Committee decides which services are covered and listed in the Uniform Value Scale (‘Einheitlicher Bemessungsmaßstab’, EBM).

31. Germany has a separate ‘Valuation Committee’ responsible for determining the ranking of services in its Uniform Value Scale. The Valuation Committee consists of social health insurers (the National Association of Statutory Health Insurance Funds) and doctors (the National Association of Statutory Health Insurance Physicians). Two independent members and one independent chairman can be appointed in situations where the Committee fails to achieve consensus. The Committee attributes a number of ‘points’ to each medical service based on a judgment of time and technical skill involved and

determines a nation-wide conversation rate as a benchmark. This benchmark serves as a basis for annual negotiations between regional associations of SHI Funds and regional associations of SHI medical specialists. In this manner, negotiations over the relative weights of specific services are undertaken informed by technical considerations of complexity, and separated from wide reaching decisions on the levels of reimbursements across the health system.

32. Australia provides a contrast to Germany in that the Government is the major player in setting prices. In Australia, the Federal Government's 'Medicare' provides reimbursement for the medical expenses associated with a visit to a privately practising doctor or a private health care facility. As in Germany and the United States, benefits for services provided by medical practitioners are based on a fee schedule. This fee schedule is administered by a statutory government body but overseen by the Federal Department of Health, which plays a role in ensuring that reimbursements take into account factors such as the technical difficulty encountered in performing the service and the length of time it takes to perform the service. In doing so, the Department of Health engages with the medical profession and relevant specialist societies, and draws on the advice of an expert panel, but decisions to increase or reduce reimbursement rates are ultimately made by Government. In practice, the Department of Health works with specialist associations to determine specific fees for individual services and negotiates with representatives of the medical profession when discussing the rate at which all fees are indexed.

33. France combines characteristics of negotiation with the public purchaser playing a key role in establishing relative prices. In technical terms, each of the components on France's relative value scale can be divided into two parts: the work intensity based on effort required by a doctor and practice costs (e.g. rent and medical equipment). Work intensity is expressed in a number of 'points' assigned to each medical procedure depending on the duration of the procedure in minutes and three "subjective" components (stress, mental effort and technical skill) (KCE, 2013). Critical to the determination of fees in France are persistent differences between historical fee levels and fee levels targeted by the public purchaser. While efforts have been made towards gradual convergence of historical fees to target rates, this has been difficult to achieve as medical groups have been reluctant to endorse reductions in fees for procedures that have been assessed as being over-priced.

34. The four countries discussed demonstrate that while the principle of a fee schedule is the common means of pricing outpatient services, how these prices are set often reflect domestic institutions that grapple with difficult judgements. Irrespective of whether prices are set through consensus, through government decision or some mix of the two, a commonality is that there is clinical consultation and involvement in the ranking of medical services according to their complexity. It is important to recognise that in each of these countries, efforts to set up fee schedules were led by the public sector which had a dominant role in the financing of health care.

Fee setting generally occurs at a national level

35. The structure of fees is generally a centrally negotiated outcome between health care service providers and payers. Across a diversity of countries (Austria, Belgium, the Czech Republic, France, Greece, Denmark, Japan, Korea and Norway, Luxembourg, Iceland) fees are determined at a central level (Table 3). Reflecting their federalist traditions, Germany, Canada, New Zealand, and Switzerland these fees are negotiated at a regional level. Australia is a particular case as fees for specialists working privately are negotiated at a central level while these same specialists work with public hospitals (sometimes on visiting arrangements) where salaries and payments are determined at the state level.

Table 3: Regulation of prices/fees of specialists' services, selected OECD countries

Fees/prices paid by third-party payers (basic primary health coverage)	Fees/prices billed by providers (to private health insurance or to patients)		
	Must be equal to prices/fees paid by third-party payers + "statutory copayments"	Can exceed prices/fees paid by third-party payers and statutory copayments in some circumstances	Can always exceed prices/fees paid by third-party payers and statutory copayments
Fees/prices⁽¹⁾ set unilaterally by third-party payers at central level	Poland ⁽²⁾		Australia
Fees/prices negotiated at central level between third-party payers and/or government and providers	Czech Republic, Iceland, Japan, Korea, Luxembourg, Netherlands, Norway	Austria, Belgium, France, Greece ⁽⁴⁾	
RBRVS⁽⁶⁾ established at central level and local negotiation on point value	Switzerland, Germany		
Fees/prices negotiated at local level	Canada	New Zealand	
Fees/prices are negotiated with each insurer	Slovak Republic ^(2,7)		
Capitation or salary unilaterally set by third-party payer or government at central level		Hungary ⁽⁴⁾	
Capitation or salary negotiated by interested parties at central level	Denmark, Italy, Portugal, Spain, Turkey	Finland ⁽³⁾ , Ireland ⁽³⁾ , Mexico ⁽³⁾ , United Kingdom ⁽³⁾	
Capitation or salary negotiated by interested parties at local level	Sweden		

Note: ⁽¹⁾ Fees/prices can include or not "statutory copayments"

⁽²⁾ Physicians can charge any price if they do not participate to the national or health insurance systems or provide not-covered services, but those circumstances are considered to be of marginal importance

⁽³⁾ For private services paid on a fee-for-service basis, physicians are most often free to charge any price they will.

⁽⁴⁾ Physicians are not allowed to charge extra-fee in principle, but informal payments are common practice.

⁽⁵⁾ For 2/3 of the population, GPs set freely their prices.

⁽⁶⁾ RBRVS : Resources-Based Relative Value Scale

⁽⁷⁾ A RBRVS is set at central level, health insurers negotiate volume caps and point values.

Source: Paris et al. (2010)

Countries have different approaches to whether prices are binding and cover the full cost of a service

36. A critical policy variable in setting prices is whether negotiations over fees cover the total cost of the procedure or a reimbursement for part of cost of the procedure. Different policy approaches reveal the extent of flexibility a government has been willing to allow and can influence the level of out of pocket costs. In France, Greece and Australia, while providers and purchasers will negotiate the level of reimbursement, all or some specialists are free to charge the prices they wish (Table 4).

Table 4: Select OECD countries providing providers with freedom to set their own prices

Australia	<p>The Government's 'Medicare' details the amount reimbursed to doctors. However, doctors' fees are not restricted, creating potential for out-of-pocket expenses where a doctor's fee is greater than the Medicare reimbursement.</p> <p>Private health insurance is prohibited for services that are reimbursed by Medicare and are provided out-of-hospital. Hence, doctors face some competitive pressure for fees they charge above the Medicare reimbursement. This has seen out of pocket costs remain low in primary care, but been less successful for specialist consultations. If doctors accept the Medicare reimbursement as full payment, they can "bulk-bill" Medicare Australia, which saves the patient from having to seek reimbursement and face any out of pocket costs.</p>
France	<p>Negotiations occur between the public health funds and the main unions of independent medical practitioners by speciality (e.g. physicians, nurses, pharmacists). For each profession, agreements are signed to cover a period of four or five years, although annual amendments take place every year to reflect budgetary decisions (Chevreul et al., 2010). However, some physicians (41% of doctors in 2010) are allowed to charge higher prices than the social security tariff, with private health insurance or out of pocket costs accounting for the difference.</p>
Greece	<p>There are often large differences between the official reimbursement rates and the fees paid to providers. In theory, the Ministry of Health and Social Solidarity and the Ministry of Economy and Finance set the same fees for both public and private contracted hospital services. Nonetheless, in practice fees set by private hospitals are much higher and the difference is covered by patients' OOPs (Economou, 2010).</p>

37. In other OECD countries, such as in Japan and Korea, private providers and purchasers negotiate in order to establish the level of reimbursement as well as the price billed to patients. As a consequence, these countries effectively regulate the co-payments their citizens may face (Table 5).

Table 5: Select OECD countries that regulate both prices billed to patients as well as determine reimbursements

Germany	<p>Since 2009, the payment of medical specialists outside of hospital is based on a capped fee for service system. Regional medical specialist associations receive a global payment from social health insurance funds for their insured patients in this region, based on average utilization of services. The physician associations are responsible for distributing these payments to their members based on the services they have provided. Over the course of a year, a physician accumulates a number of 'points' associated with the services they provide, which is then converted into payments by fixing a conversation rate per point. This conversion rate per point is determined by annual negotiation between insurers and medical specialist associations at the national level. For services provided beyond this ceiling, reimbursement is provided at much lower rates (KCE, 2013).</p>
Japan	<p>A national uniform fee schedule applies to all public and private providers. This schedule is reviewed every two years through negotiations between a number of stakeholders, such as the federations of insurers, professional organisations (such as medical, dental, pharmaceutical and nursing associations), hospital organizations and consumer organisations.</p> <p>Most providers have no choice but to enter in contractual relations with the Social Health Insurance (SHI) because Japan's SHI does not reimburse any non-participating providers, making it very difficult for providers to practice without such a contract. Through this national uniform fee schedule, the government exerts a powerful control over prices (Tatara and Okamoto, 2009).</p>
Korea	<p>Fee setting largely occurs through a centralised National Health Insurance Policy Deliberation Committee, that has system-wide implications and can make decisions about the level of cost sharing and what is included in the benefit package. Korea's National Health Insurance Corporation (NHIC) and provider representatives then negotiate contract terms for fee-for-services on an annual basis. Negotiations take place three months before the expiration of contracts. The NHIC has different contracts with each medical association but all providers are required to contract with the NHIC and by law may not reject the NHIC's proposals. The Health Insurance Review Agency (HIRA) seeks to monitor the reasonability of health care billing. While the Government has considerable levers over fees, the retrospective and uncapped nature of the payment system means they are exposed to increases in volumes. Cost sharing is also comparatively high (OECD, 2012a).</p>

3.2.2. Price setting for hospital services

38. Conceptually, many hospital payment systems share the same principles as fee for service reimbursements for outpatient care. They are based on a ranking of different services and negotiations over fees. However, in recent years several countries shifted towards Diagnostic Related Group (DRG) based pricing which takes into account patient complexity, variations in costs structures by hospital and regions, and budgetary considerations. Such payment systems are very data intensive, demanding a complex array of variables that can influence prices. This section shall seek to demonstrate that cost studies from large samples of hospitals are important inputs in establishing DRG based prices and highlight some good practice examples.

A growing number of OECD countries use DRG systems to remunerate in-patient services in both public and private hospitals

39. The origins of DRGs were to adjust procedure based reimbursements to account for patient complexity so that services can be clustered in homogenous groups. At first, this provided a means by which to improve the transparency and comparability of services from one hospital to another, to see whether certain hospitals maintained higher or lower average cost structures and provide a basis by which to compare quality of care outcomes across hospitals. This then evolved into a form of payment as the notion of paying for a ‘case’ of services delivered was seen as a tool to avoid the unnecessary or inefficient services that could be billed under a fee for service based payment system. Even in many countries that have a tradition of global budgets, DRGs have been introduced as a means of calculating budgets that reflect the mix of services delivered and patients seen by a particular hospital.

40. Either case or procedure based payments are increasingly becoming the norm across OECD countries. Some 19 out of 34 OECD countries for which information is available use some form of payment on the basis of cases of services (DRGs) or payments based on procedures delivered for payments to public hospitals (Table 6). Among countries that identify themselves as setting a global budget, such as Denmark and New Zealand, some form of DRG based classification of hospital services exists, even if it is not the primary means by which hospitals are reimbursed. This is not dissimilar in payments to private hospitals. Over the 31 OECD countries studied, twenty-one countries use the same payment mechanisms for public and private hospitals. Within these, fifteen countries used payment per case (DRG-like) to purchase healthcare services from not-for-profit or for-private hospitals.

Table 6: Payment methods used by key payors¹ for acute inpatient health care services, public and private sectors

	Public hospitals	Private not-for-profit hospitals	Private for profit hospitals
Australia	DRG	Procedure service payment	Procedure service payment
Austria	DRG	DRG	DRG
Belgium	Prospective global budget	Prospective global budget	n.a.
Canada	Prospective global budget	Prospective global budget	Prospective global budget
Chile	DRG	DRG	line-item remuneration
Czech Republic	DRG	DRG	DRG
Denmark	Prospective global budget	n.a.	DRG
Estonia	DRG	n.a.	n.a.
Finland	DRG		
France	DRG	DRG	DRG
Germany	DRG	DRG	DRG
Greece	DRG	DRG	Procedure service payment
Hungary	DRG	DRG	Procedure service payment
Iceland	Prospective global budget	n.a.	n.a.
Ireland	Prospective global budget	Prospective global budget	
Israel	Procedure service payment	Procedure service payment	Procedure service payment
Italy	Prospective global budget	DRG	DRG
Japan	DRG	DRG	n.a.
Korea	Procedure service payment	Procedure service payment	n.a.
Luxembourg	Prospective global budget	Prospective global budget	n.a.
Mexico	Prospective global budget	Procedure service payment	Procedure service payment
Netherlands	DRG	DRG	n.a.
New Zealand	Prospective global budget	n.a.	n.a.
Norway	Prospective global budget	Prospective global budget	DRG
Poland	DRG	DRG	DRG
Portugal	Prospective global budget	Procedure service payment	Procedure service payment
Slovak Republic	Procedure service payment	Procedure service payment	Procedure service payment
Slovenia	DRG	DRG	DRG
Spain	line-item remuneration	Prospective global budget	
Sweden	Prospective global budget	Prospective global budget	Prospective global budget
Switzerland	DRG	DRG	DRG
Turkey	Prospective global budget	Prospective global budget	Prospective global budget
United Kingdom	DRG	Procedure service payment	Procedure service payment
United States (Medicare)	DRG	DRG	Procedure service payment

Note: (1) Recognising that there is considerable variation across OECD countries, this table reports the dominant payment mechanism for acute inpatient care without prejudice to which entity or entities (e.g. national or state government, insurance or multiple insurance funds) are responsible for setting payment rates and paying health care providers.

Source: OECD, 2012d

Establishing DRGs across OECD countries: some characteristics that distinguish DRGs

41. There are enormous differences on how DRGs have been set up and used across OECD countries. The details of how DRG systems are structured and operate from one country to the next is the subject of a considerable literature (Busse et al., 2011, Kobel et al., 2011, Schreyögg et al., 2006), Busse et al. (2011) have identified four main features of such systems:

1. **Information:** This covers the extent to which diagnoses and procedures are coded and how they are categorised into different groups.
2. **The scope of payments:** DRG based payments are suited to services which are discrete and can be clearly diagnosed, and where hospitals have sufficient activity to justify payment on this basis. In this regard, where diagnosis is often not a good predictor of costs (such as mental health) and highly specialised services (such as trauma care) can be difficult to cost. Similarly, key issues include: the extent to which teaching, research and capital are included in DRGs; how novel (and expensive) technologies are reimbursed; and reimbursement for emergency departments.
3. **Adequacy of payments:** For DRGs to be successful, prices need to strike a balance between being enough to cover the costs of treatment but not so generous that providers have little incentive to improve their efficiency. Countries generally employ a combination of ‘micro-costing’ based on a sample of information from hospitals along with ‘top down’ approaches based on general norms of hospital spending.
4. **Granularity of payment:** The extent to which a country seeks to strike a balance between having a large number of highly detailed groups each with their unique price or fewer groups is an important policy decision. This can be significant in terms of the data requirements, and affect the ease by which hospitals may ‘up-code’ to seek higher payments.

42. These four main features are important policy considerations which need to be taken into account in developing a DRG-based pricing system. Detailed information about how selected OECD countries have sought to implement these is included in Annex 1. Critically, a large amount of data is needed to successfully operate a DRG system, including coding of diagnoses, procedures, institutional characteristics of hospitals, cost information across a number of facilities and patient information.

43. A common approach to gaining key information is to have a sample of costs from hospitals around the country. The conversation of services into prices is usually informed by data collected from a representative group of hospitals. Countries have generally sought to attribute prices through one or a combination of the following means:

1. Individually ‘cost’ different DRGs;
2. Attribute economic significance to DRGs by developing a general conversion factor that attributes a price to the hierarchy of services (e.g. if a cataract has a weight of 1 and attracts a payment of 100 euros, then other services with a higher weight can attract proportionately higher reimbursement).

44. Whether either or both paths are used, attributing prices to hospital services is an important factor in determining the overall revenue of hospitals and remuneration of specialist doctors. In the United States, the Center for Medicare and Medicaid services (CMS) collects cost information from hospital reports. All Medicare providers have to submit an annual cost report to Medicare. Each hospital case is categorized

into a diagnosis-related group (DRG), which has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The DRG tariffs calculated by the CMS generally distinguish between labor costs (which may vary across different parts of the country) and a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area.

A number of OECD countries have sought to locate the technical work for developing DRGs within independent agencies that are also responsible for collecting information on costs

45. A recent trend across OECD countries has been the establishment of independent agencies to develop and maintain DRG schedules. These agencies, now present in France, Germany, Netherlands and Australia seek to locate the task of setting the DRG schedule outside the direct operational responsibility of government ministries, in part motivated by an attempt to ‘de-politicise’ this task (Table 7). The establishment of national independent agencies can work to ensure comparability and a harmonisation of clinical classification across hospitals, and in some countries, between public and private hospitals.

46. These agencies are generally part of government or key health sector bodies (such as public insurers) and are responsible for estimating costs associated with individual services. In France, in 2002 the Technical Information Agency of Hospitalization (ATIH) was created in order to collect data and to categorise all DRGs, and is an independent public administrative institution co-funded by the government and the national health insurance funds. In Germany, the Institute for the Payment system in Hospitals (InEK) was established by the self-governing bodies (the Federal Association of Sickness Funds, the Association of Private Health Insurance, and the German Hospital Federation). Similarly, Australia’s Independent Hospital Pricing Agency reports to a board chosen by the national and state and territory governments.

Table 7: Examples of technical agencies in OECD countries

Name	Description and key actors	Tasks
France – Technical Information Agency of Hospitalization (ATIH) created in 2002	<ul style="list-style-type: none"> • Independent public administrative institution that is co-funded by government and national health insurance funds. • Supported by an advisory committee, involving representatives of public and private health care facilities • Under the control of the Social and Budget Ministries. 	<ul style="list-style-type: none"> • Responsible for collecting data on hospital activity in order to establish a national cost schedule. • Undertakes financial analysis of health care facilities and of the health system at large. • Advised by an expert group composed mainly of physicians and statisticians in order to update the DRG system to take into account changes in medical practices and innovation.
Germany – Institute for the Payment system in Hospitals (InEK) created in 2000	<ul style="list-style-type: none"> • Founded by self-governing bodies: the Federal Association of Sickness Funds, the Association of Private Health Insurance, and the German Hospital Federation 	<ul style="list-style-type: none"> • Receives data from hospitals before 1 July in order to develop the Case Fee Catalogue for the following year. • Uses data on 253 hospitals that follow a standardized cost accounting approach (13% of all hospitals) in order to calculate the costs of treating individual patients (Quentin et al., 2013). Hospitals receive a fixed allowance for participating in the cost accounting data sample. • Administers a ‘proposal process’ (a form of structured dialogue) whereby medical experts are asked to contribute their knowledge from clinical practice in order to refine certain DRGs.
The Netherlands – DBC Maintenance (‘Onderhoud’, DBC-O)	<ul style="list-style-type: none"> • Independent foundation responsible for adjusting and updating the DBC system • The board includes key health sector organisations: health insurers, physicians, hospitals and patients 	<ul style="list-style-type: none"> • Collects data on resource use from all hospitals but data on unit costs only from a sample of hospitals (24% of the total). • Hospitals are obliged to provide their data to the DBC information system, consisting of: <ul style="list-style-type: none"> ○ the resource-use information from the minimum basic datasets (MBDS) collected by all hospitals; ○ the unit cost information from a varying number of hospitals.

The nature of the contracting relationship between payers and providers determines how DRGs are used

47. Once the relative priority of different services is determined, this sets the basis for negotiations on the combination of fiscal, operational and political considerations that are taken into account in arriving at prices. There is considerable diversity in how insurers and governments seek to contract across OECD countries, beyond what can be exhaustively covered in this paper. Five key models – from Korea, France, Germany, Switzerland and Netherlands – that represent a spectrum of different approaches are detailed in Table 8.

Table 8: Contracting between payers and hospitals – five examples

Countries	Description
Korea	All providers are required to contract with the National Health Insurance Corporation (NHIC) and by law may not reject the NHIC's proposals. Though this method ensures that all providers contract, there is no limitation of healthcare services volume produced.
France	The hospital sector has to meet a macro-economic budgetary target which allows a soft form of controlling the volume of services. Using the national cost study, an average tariff is calculated in order to inform the price schedule. While relative prices are settled through a technical process of measurement, the overall level of prices is influenced by a political decision process. To comply with its macro-economic budgetary target, the Ministry may update prices once a year.
Germany	In Germany, an individual sickness fund does not have the ability to vary prices or volumes. Contracts with hospitals are undertaken at two levels, the setting of an overall price tariff structure (detailing the relative weights of different services) at a national level and negotiations on the overall level of prices at the regional level. All German hospitals are obliged to 'contract' collectively with sickness funds on an annual basis, with contracts detailing a negotiated amount of volumes. This continues the tradition of helping hospitals manage financial risk by signalling a minimum amount of expected revenue, but hospitals face a reduction in DRG reimbursement rates if they undertake more cases than negotiated (Kumar <i>et al.</i> , 2013).
Switzerland	In Switzerland, regions (cantons) play an important role in setting the base rate. A schedule of relative values for DRGs has been computed from data taken from 40 hospitals (accounting for 60% of hospitals' activity). The canton-based rates for these values will be negotiated between hospitals and insurers within each canton, and approved by cantonal governments.
Netherlands	In the Netherlands, payers and providers can contract for a part of the healthcare services. For some medical specialties, fees are negotiated between individual third-party payers and providers, whereas for other specialties fees are unilaterally set by central government. A growing share of the DBCs (DRG system in the Netherlands), known as the 'B-segment', allows for free negotiation of prices and volumes between health insurers and hospitals. The share of segment B has increased from less than 10% in 2005 to more than 30% in 2011 and 70% following the 2012 reform of hospital revenue (Schut <i>et al.</i> , 2013). The remainder of the DBCs, called the A-segment, have prices set at national level (Schäfer <i>et al.</i> , 2010). Insurers are not obliged to contract all hospitals for list B DBCs. Current practice suggests that negotiations take place annually, but that either party can reopen negotiations if required by the circumstances (KCE, 2013).

4. EXPERIENCES IN COMPETITION LAW ACROSS OECD COUNTRIES

48. It is the norm across OECD countries that the pricing of hospital services involves organisations representing doctors, hospitals or health insurers negotiating on behalf of their members. Many OECD countries have grappled with distinguishing between worthwhile collective negotiations and concerted pricing practices. As this has been an area of considerable concern in South Africa, this section shall provide an overview of how competition law is applied in the health sector across OECD countries. It highlights that:

- While doctors and hospitals operate in markets and are economic entities, public health insurance is recognised to have a social function that might warrant different regulatory treatment.
- There exist legislative frameworks authorising collective negotiation between providers and purchasers to set prices, with the Netherlands being the most sophisticated example.
- There is a small but noteworthy record of cases in France, Korea, Australia, Netherlands, Switzerland and Korea relating to coordination of pricing or negotiation among key health sector bodies and the circumstances under which this is appropriate.

49. This section shall first look at competition law in health care, where European countries generally have the most extensive combination of legislation and regulation to govern relationships in the health sector. It will then provide summaries of opinions and decisions issued by competition authorities across OECD countries, with a particular focus on cases relating to collective bargaining and pricing.

4.1 Legislative frameworks for the health sector across OECD countries

Competition law in the European Union recognises that doctors and hospitals are economic entities within a market, but that public health insurance can often have a social purpose

50. One of the central issues in the application of competition law to the health care sector is whether the entities operating in the sector can be considered as ‘undertakings’ or not. For the purposes of EU competition law, “any entity engaged in an economic activity, that is, an activity consisting in offering goods or services on a given market, regardless of its legal status and the way in which it is financed, is considered an undertaking. To qualify, no intention to earn profits is required, nor are public bodies by definition excluded” (European Commission, 2002).

51. For instance, the European Court of Justice concluded that independent medical specialists performed services in a market. The conclusion was based, among others, on the consideration that doctors were remunerated for their services and assumed the financial risk associated with this activity. Another important criterion that has been used in EU case law is the consideration of the actual or potential offering of services in competition. In another case, the European Commission has concluded that “services provided by the public hospitals concerned constituted economic activities as similar services were offered by private health care operators” (Sauter and van de Gronden, 2010).

52. However, the approach of competition law towards providers of health insurance differs significantly from the approach taken for doctors and hospitals.⁹ These entities are often not regarded as undertakings in light of their role in pursuing a social function, the absence of a profit motive and the degree of public involvement, among other criteria. For instance, in the AOK case concerning German sickness funds, the European Court of Justice ruled that they were not undertakings since they performed a social function based on the principle of solidarity, despite a degree of competition on the rates charged by the insurers to attract customers.¹⁰ Similar conclusions were reached in another case, FENIN, regarding the management bodies of the Spanish national health system, when the Court accepted that the provision of services by the national health system was “purely of a social nature”. The bodies’ activities as purchasers of medical goods and equipment were not analysed separately from their core activity and, as a result, were not considered economic activities (Sauter and van de Gronden, 2010).¹¹ These judgements reflect the strong tradition of the administration of public health insurance in Europe being vested in bodies independent to Government.

Some OECD countries have a legislative framework particular to the health sector

53. While doctors and hospitals may be recognised as entities operating in a market, some countries have established legislation which authorises collective negotiations between providers and purchasers to set prices to help meet public policy objectives. In France, the Social Security Code allows for negotiations between the medical associations and the National Union of Health Funds (*Union nationale des caisses d’assurance maladie*).¹² This is also the case in Switzerland, where the Federal Health Act allows for negotiations between medical associations and insurers’ associations.¹³ In addition, the Swiss Cartel Act explicitly excludes from its application the “statutory provisions that do not allow for competition in a market for certain goods or services.” In particular, these provisions take precedence over the Cartel Act and include the provisions that “establish an official market or price system.”¹⁴

54. In most cases, national competition authorities have not issued opinions on this legislation. Switzerland represents an exception in that the competition authority (Wettbewerbskommission, WEKO) issued an opinion on the price-setting mechanism in the regulated part of their health care system.¹⁵ Under Swiss federal legislation, medical associations can negotiate schemes of fees with insurers. Fees have to be approved by cantons (regional government units) or by the Confederation (national government). Given that the regulated sector is not subject to the Cartel Act, the competition authority does not have enforcement powers in the regulated sector but can issue opinions. Using this power, the competition authority has recommended introducing selective contracting in order to increase price pressure and provide greater incentives to hospitals and doctors to deliver quality health care. In addition, it has recommended holding negotiations at the level of individual health funds and providers, or between small groups, instead of umbrella associations (generally at a regional level) and to remove the role of the state in

⁹ EU case law covers both public payers and not-for-profit bodies: private not-for-profit organisations offering statutory insurance (e.g. AOK case) and public bodies / national health system (e.g. FENIN).

¹⁰ Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01, AOK Bundesverband et al. v Ichthyol-Gesellschaft.

¹¹ Case C-205/03 P, Federación Española de Empresas de Tecnología Sanitaria (FENIN) v Commission [2006] ECR I-6295

¹² Article L.162-5, Code de la sécurité sociale.

¹³ Article 42 and following, Federal Health Act.

¹⁴ Federal act on cartels and other restraints of competition of 6 October 1995.

¹⁵ Wettbewerbskommission (2004), Révisions de la Loi sur l’assurance-maladie-procédure de consultation, Droit et Politique de la Concurrence, 2004/3.

approving the prices. Finally, the authority has suggested reviewing the way hospitals are funded. At the moment, cantons are both owners of hospitals and at the same time have considerable negotiating influence and the power to approve the reimbursement fees due by health insurers. However, many of these recommendations have not been implemented to date.

55. There have been important cases at EU level involving the German health care sector. The two most recent cases concern public health insurers. In *AOK*,¹⁶ quoted above, the European Court of Justice concluded that social health insurers were not to be considered undertakings. This ruling was confirmed in *Oymanns*,¹⁷ when the court stated that public health insurers are governed by public law, since they are mostly publicly funded. As such, they are subject to the public procurement regime and not to competition law. The 2011 German Act on the Reform of the Market for Medicinal Products (AMNOG) extends the application of German antitrust law and European Public Procurement Law to agreements between statutory health funds and pharmaceutical companies. Moreover, the AMNOG states that civil courts, instead of social security courts, should be competent on antitrust matters¹⁸.

56. Following a landmark decision by the Regional Social Court of Hesse on 15 September 2011, ruling that any antitrust competence over statutory health insurance funds required a statutory basis, the German competition authority discontinued its merger control supervision in this sector. Subsequently, the 2013 Eighth Amendment to the German Act against the Restraints of Competition (Gesetzes gegen Wettbewerbsbeschränkungen, GWB) explicitly provided for the role of the competition authority in mergers between statutory health insurance funds, even though in consultation with the relevant supervisory authority of health insurance funds. Moreover, in the same amendment it was determined that decisions prohibiting mergers could only be appealed before social security courts, instead of civil courts as is the case in other decisions¹⁹.

The Netherlands has the most extensive regulation for competition in the health sector and covers cooperation and agreements between providers

57. Reflecting the extent of competition for publicly financed health care services in the Netherlands, the Dutch Competition Authority is more active than in many OECD countries. The Dutch competition authority has issued guidelines on agreements among market participants, negotiations between health insurers and health care providers, abuses of dominant position and concentrations between undertakings.²⁰ The guidelines were first published in October 2002, building on the assessment carried out by the

¹⁶ Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01, *AOK Bundesverband et al. v Ichthyol-Gesellschaft*.

¹⁷ Case C-300/07 *Hans & Christophorus Oymanns GbR, Orthopädie Schuhtechnik v AOK Rheinland/Hamburg*.

¹⁸ Source: McDermott, Will and Emery, *An end to free pricing in the German pharmaceuticals market*, Lexology, 22 November 2010.

¹⁹ Source: Clifford Chance (2013), *8th Amendment to German Competition Law – Key Changes*, *Newsletter*, June 2013. Source: Clifford Chance (2013), *8th Amendment to German Competition Law – Key Changes*, *Newsletter*, June 2013.

²⁰ The Netherlands Competition Authority (NMA) merged with the Netherlands Consumer Authority and the Netherlands Independent Post and Telecommunications Authority (OPTA) in April 2013 to create the Authority for Consumers and Markets (ACM). Authority for Consumers and Markets (2010), *Guidelines for the health care industry (Richtsnoeren voor de zorgsector)*, Den Haag. Authority for Consumers and Markets (2010), *NMA has revised its guidelines for the health care industry*, Press release, 12 March 2010.

competition authority of more than 390 cases.²¹ As a general approach, the competition authority considers that “where co-operation increases efficiency and quality and does not unnecessarily limit competition, such agreements are to the advantage of the consumer and are permitted under the Competition Act.”²² In particular, an agreement would be considered permissible if the following criteria were met:²³

- The agreement must contribute to an improvement in the efficiency of production or distribution, or to technical or economic innovation;²⁴
- The efficiencies resulting from the agreement should benefit consumers, at least in part;
- Any restrictions must be proportionate to the objective to be achieved; and
- The agreement should not entirely eliminate competition in the market.

58. As well as these principles, the Dutch guidelines set out the types of agreements that restrict competition, such as price agreements, agreements to divide markets and co-ordinated boycott campaigns. While it is not the norm, Dutch health care providers may negotiate jointly where their joint turnover does not exceed the threshold of EUR 908 000. For example, health care providers working within partnerships (e.g. a group of hospitals) are permitted to negotiate jointly since they are not separate undertakings, but entities where the policy and the financial risk are shared among the individual members. Similar rules apply to providers that co-operate very closely, for example by sharing the same premises, computer system and secretarial support. The competition authority considers that agreements in the health care sector fall within regulation that grants a block exemption for specialisation agreements.²⁵ In line with this regulation, exceptions apply to provider groups whose market share does not exceed 20%.

59. Negotiations between health care providers and insurers can also be facilitated by brokers, in accordance with the guidelines of the Dutch competition authority. However, the activities of a broker should not result in the sharing of sensitive information among providers. Providers can be assisted by a single broker in specific circumstances, for instance: (i) a partnership of professionals; or (ii) a group of maximum eight competing health care providers that fall within the threshold of EUR 908 000; or (iii) providers operating in different product or geographic markets.

²¹ OECD (2005), Enhancing beneficial competition in the health professions, Contribution from the Netherlands, [DAF/COMP\(2005\)45](#), Paris. Authority for Consumers and Markets (2002), NMa approves guidelines for the health care sector, Press release, 25 October 2002.

²² Authority for Consumers and Markets (2002), NMa: Consultation with the health care sector on co-operation guidelines, Press release, 28 March 2002.

²³ Authority for Consumers and Markets (2010), Guidelines for the health care sector, March 2010.

²⁴ In 2009, the competition authority cleared a merger between two hospitals (Case no. 6424/427, Ziekenhuis Walcheren / Oosterscheldeziekenhuizen, 25 March 2009) having accepted a claim by the parties that the transaction would lead to efficiency gains. As in most jurisdictions, under the Netherlands competition law efficiency claims can be accepted when three conditions are simultaneously fulfilled: (i) efficiencies must be passed on to consumers; (ii) they must be merger-specific and (iii) verifiable. In the merger case, the authority accepted that the efficiencies were merger-specific. However, the parties had to offer remedies to address the other two criteria. In order to ensure that benefits would be passed on to consumers, the parties committed to certain conditions regarding price and quality of service. OECD (2012), The role of efficiency claims in antitrust proceedings, Background note, [DAF/COMP\(2012\)23](#).

²⁵ Commission Regulation No. 1218/2010 of 14 December 2010 on the application of Article 101(3) of the Treaty on the Functioning of the European Union to certain categories of specialisation agreements.

60. Taking account of the trend towards specialisation and concentration in the hospital sector, the competition authority recognises that there may be a role for agreements between hospitals. On the one hand, agreements to specialise in specific clinical activities are likely to breach competition law. On the other hand, hospitals can apply for an exemption from the prohibition of cartels if they consider that the benefits of an agreement outweigh the reduction of competition following from co-ordination. Under the Dutch system, private health care insurers can contract with health care providers on a selective basis. According to the competition authority, health care insurers have an important role in the process towards specialisation and concentration. If health insurers are effective in selecting health providers, this should lead to more efficient choices by hospitals in terms of specialisation and concentration, therefore reducing the need for agreements and concerted practices between hospitals.²⁶

4.2 Case law on processes of price setting for health across OECD countries

61. While detailed regulatory and legislative approaches are less common across OECD countries outside of Europe, there are a number of cases relating to the process of price setting between payers and providers. Though these cases are highly specific to their national contexts, they demonstrate that many countries grapple with making a distinction between worthwhile collective negotiation and concerted pricing practices.

France

62. French courts have grappled with the role of medical associations and the extent to which they are subject to competition rules. The approach of the *Autorité de la Concurrence* (Competition Authority) indicates that medical associations are subject to competition rules, but the courts have disagreed in some cases. Case law has established that professional associations related to health care are not always subject to competition law, even when setting prices. The most recent case concerns the *Syndicat National des Ophthalmologistes de France* (the national union of ophthalmologists, SNOF) when the *Autorité* found that the SNOF had advised its members to boycott opticians that belonged to a certain network.²⁷ In this decision, the competition authority concluded that the professional association was subject to competition law.

63. In a similar decision, the *Autorité* found that seven medical associations engaged in concerted practices aimed at increasing their fees and as a result overcharged patients over a prolonged period, from the end of 2001 to the beginning of 2005.²⁸ The background to the agreement was the failure to set new and higher rates in the negotiations between the medical associations and the National Union of Health Funds (*Union nationale des caisses maladie*). The association encouraged doctors in private practice to increase their fees by resorting to “one-time overcharging”, a mechanism provided for by the legislation under exceptional circumstances. According to the decision, the recommendation issued by the medical associations amounted to an agreement on prices which contravened competition law. However, the decision was reversed with the Paris Court of Appeal ruling that the doctors’ practices did not fall under competition law. The decision was underpinned by the consideration that by design there is no price

²⁶ OECD (2012), Competition in hospital services, Contribution of the Netherlands, DAG/COMP(2012)9.

²⁷ *Autorité de la Concurrence* (2010), Décision n. 10-D-11 du 24 mars 2010 relative à des pratiques mises en oeuvre par le Syndicat national des ophtalmologistes de France (SNOF) concernant le renouvellement des lunettes de vue.

²⁸ *Autorité de la Concurrence* (2008), Décision n. 08-D-06 du 2 avril 2008 relative à des consignes syndicales de dépassement des tarifs conventionnels par les médecins spécialistes de secteur I.

competition among doctors whose prices are set by central negotiation between the medical associations and the National Union of Health Funds.²⁹

Korea

64. Korea's competition authorities have pursued medical associations for instructing members to increase their prices. One case in 2005 concerned the Seoul doctors' association, which advised its members to increase fees charged for providing medical certificates. In a more wide ranging case, on 25 July 2008 the Korea Fair Trade Commission fined six regional dentist associations belonging to the Korea Dentist Association for concerted practices.³⁰ These practices took place from 2000 until 2007 and were: (i) encouraging members of the association to set medical fees in line with instructions of the association in order to increase prices; (ii) limiting the size and method of advertisement; (iii) setting the wage level of its members' employees. In particular, each regional dentist association held a regular annual meeting and decided how to increase their general medical fee, known as the 'non-insurance service fee'.³¹ Subsequently, the dentist association sent a table with increased rates to its members (or uploaded it on their website). After the price table was sent to members, the non-insurance service fee was observed to have increased by a minimum of 11.1% to a maximum of 60% compared to previous levels.

Australia

65. In somewhat the inverse of the French and Korean scenarios, market developments in Australia have seen the introduction of authorisation for collective bargaining among small private hospitals. The Australian Competition and Consumer Commission (ACCC) has recently assessed and approved co-ordination agreements among hospitals and among general practitioners. The Private Hospital Collective Bargaining Group was authorised to collectively negotiate contract terms with suppliers on behalf of small independent private hospitals (i.e. hospitals with up to 200 beds) and small private hospital groups.³² This authorisation was granted for a fixed duration, until September 2017, and subject to the condition that the group does not consist of more than 75 private hospitals in total and additional requirements on the number of hospitals by state or territory. The ACCC also granted an authorisation to a group of hospitals to engage in collective bargaining with health insurers, collective boycott activity and exclusive dealing arrangements.³³ However, the significance of this second case is limited given that the hospitals in question function as part of a single economic entity but do not constitute a single legal entity. Moreover, the group has a limited share of about 5.5% of private hospital beds nationally. This share rises to 6.7% in New South Wales. Finally, the Australian Medical Association (AMA) submitted an application with the ACCC

²⁹ Cour d'Appel de Paris, Première Chambre, Arrêt du 18 Mars 2009, 2008/08385.

³⁰ Korea Fair Trade Commission (2008), Activities of six regional branches of the Korean Dentist Association (case number: 2008광사0201, 2008 광사0203, 2008광사0204, 2008광사0205, 2008광사0206, 2008광2007), 26 August 2008.

³¹ The non-insurance service fee is not applied to the national health insurance so that normally each dentist could decide the price of medical service fees independently. The service fees are related to the treatment of filling, crown, cleaning, orthodontics, implant etc.

³² Australian Competition and Consumer Commission (ACCC) (2012), Determination, Authorisation A91293.

³³ Australian Competition and Consumer Commission (ACCC) (2012), Determination, Authorisations A91295 - A91297.

to allow intra-practice price setting and collective bargaining.³⁴ This application covers general practitioners (GPs) working under specific arrangements³⁵ in a single general practice.

Netherlands

66. In the Netherlands the competition authority has been active in pursuing a few cases in the health care sector, including decisions on medical associations, pharmacists and on long-term care. In particular, the Dutch National Association of General Practitioners (LHV) was recently fined more than EUR 7.7 million over illegal establishment recommendations.³⁶ The association advised GPs on the policy they should adopt towards new GPs entering their territory, either by setting up a new practice or by joining an existing practice. The associations' recommendations would enable GPs to control entry into the market and ensure that they had a sufficient number of patients. In an older case in 2001, the Dutch competition authority found that the collective negotiations by the National Association of General Practitioners were in conflict with the Competition Act.³⁷ In particular, following the introduction of market elements in this part of the health care sector, health insurance funds are not required to contract with every health care provider. As a result, health care providers have to compete with each other to be among the suppliers of health insurance funds. The competition authority found that agreements with regards to prices and the division of the market did not comply with the Competition Act.

67. In a similar case regarding price fixing by psychologists and psychotherapists, the local organisations were found in breach of the Competition Act in 2005. However, the decision was subsequently overturned on appeal because the court ruled that the competition authority should have "investigated more fully whether in this sector price was a relevant competition parameter" (Sauter, 2012).

Switzerland

68. The Swiss competition authority conducted an investigation into the agreement between the Association of Private Clinics in Geneva (ACPG) and the health funds.³⁸ Based on this agreement, all the clinics would charge the same prices for certain services. The authority found that this agreement fell under its remit under the Cartel Act and concluded that it led to a restriction of competition. In consequence, the ACPG committed not to renew the agreement under investigation. Similar cases involved the following: (i) an agreement between the Health Department of the canton of Aargau, some hospitals belonging to the

³⁴ Australian Competition and Consumer Commission (ACCC) (2013), Determination, Authorisation A91334.

³⁵ These arrangements are as follows:

- The GPs "share three or more of the following: patient records, common facilities, a common trading name and/or common policies and procedures"; and
- The GPs work within one of the following business structures: a partnership of two or more GPs where not all partners are natural persons; two or more GPs are associated; other business structures involving two or more separate legal persons.

³⁶ Nauta Dutilh (2012), National Association of General Practitioners fined by the NMa, Lexology, 21 May 2012.

³⁷ Authority for Consumers and Markets (2001), NMa prohibits agreements on tariffs and on the setting up of practices by general practitioners, Press release, 12 April 2001.

³⁸ Wettbewerbskommission (2004), Decision du 5 avril 2004 en l'affaire enquête selon l'article 27 de la Loi sur les cartels et autres restrictions à la concurrence du 6 octobre 1995 concernant l'Association des cliniques privées de Genève relatif à un accord illicite selon l'article 5 LCart, Droit et Politique de la Concurrence, 2004/3.

Association of hospitals of Aargau and some insurance funds; (ii) an agreement between some insurance funds, private clinics and the medical association of Aargau.³⁹

Turkey

69. In Turkey the competition authority has not submitted formal opinions on the institutional set-up for price negotiations. However, it has issued decisions concerning minimum fees and price setting by medical associations.⁴⁰ In these decisions, the professional bodies have been considered as undertakings and are therefore subject to competition law. In a case against opticians' associations, the authority found that the organisations set two different price schedules at the beginning of each year, one for purchases covered by the social security institutions and one for individual purchases. These price lists were mandatory for the members of the associations. The authority ruled that the associations had infringed competition law and issued a fine.⁴¹

³⁹ Wettbewerbskommission (2008), Tarifvertrag mit öffentlichen Spitälern in der halbprivaten Zusatzversicherung im Kanton AG, Droit et Politique de la Concurrence, 2004/4. Wettbewerbskommission (2008), Tarifvertrag mit Privatkliniken in der halbprivaten Zusatzversicherung im Kanton AG, Droit et Politique de la Concurrence, 2004/4.

⁴⁰ OECD (2005), Enhancing beneficial competition in the health professions, Contribution from Turkey, [DAF/COMP\(2005\)45](#), Paris.

⁴¹ Turkish Competition Authority (2001), Decision number 01-42/424-103.

5. BUYING SERVICES FROM THE PRIVATE SECTOR: FOUR MODELS FROM OECD COUNTRIES

70. Many OECD countries have a long tradition of public payers contracting with private hospitals to deliver services. South Africa does not have such a tradition at a national level. In recent years, some OECD countries have overcome challenges similar to that which South Africa faces and drawn on the private sector as part of their efforts to deliver universal health coverage. This section shall highlight two examples that may be of interest to South Africa:

1. Mexico carefully costed individual services to determine the extra resources provided to state (similar to provinces in South Africa) governments, who were allowed to contract negotiate with private hospitals to supplement capacity in the public sector.
2. Turkey's public insurance reimburses private hospitals at the same rate as public hospitals but allows private hospitals to charge higher rates (therefore charging patients' with co-payments).

71. Following these two case studies, this section will provide a brief overview of some alternative approaches in Australia and France. These two countries separate hospital and medical costs and reimburse only part of the cost of public patients visiting a private hospital. These policies are part of an implicit bargain to retain medical specialists in the public sector, and exist alongside other incentives that make it attractive for private medical specialists to work in the public sector. All of these countries have invested heavily in developing a credible price schedule for payments to public hospitals and specialists. This has played an influential role in contracting and paying for services in private hospitals.

5.1. Opportunistic contracting with private hospitals: Mexico's Seguro Popular

Mexico undertook a major programme to expand access to health care services

72. Mexico provides one of the most successful examples of expanding health coverage in a federal context in recent history. Considerable concern about the impoverishing effects of health costs saw the government increase public funding for health by 1% of GDP over seven years and establish the 'Seguro Popular'. At the heart of the Seguro Popular is an innovative intergovernmental transfer between central and state governments that links funding to the expansion of coverage. This has helped provide access to health care for 45 million Mexicans who had not benefitted from the country's existing social health insurance programs. In doing so, it has drawn on private as well as public health care facilities.

73. The Seguro Popular was targeted at the self-employed and those in the informal sector. It is financed through federal government and state governments. Families are also asked to make a modest contribution, with the poorest 20% of families excluded. Most of the funds (89%) were allocated to states to fund the essential package of services, but certain funds were retained centrally to support high cost services (8%), build health infrastructure and respond to temporary fluctuations in demand (3%) (Bonilla-Chacin et al., 2013).

A key step was carefully costing individual services to determine the resources provided to state governments

74. The Seguro Popular guarantees access to an explicit and comprehensive package of essential services in public and accredited private providers. The package of essential services has grown to 284 in 2012 from 91 interventions in 2004, and covers treatment for most services provided in ambulatory units and general hospitals. Even though the Seguro Popular aimed to cover most of the services provided in hospitals, a ‘benefit package’ was developed by the Mexican Ministry of Health, which selected procedures on the basis of cost-effectiveness, affordability, financial protection, opinion of the scientific community, demand and supply, and social acceptance (Gonzalez et al., 2006, Knaul et al., 2012). A benefit package also made people aware of their entitlements from the health care system, an understanding that previously may have been absent as poorly educated populations engaged with well-educated providers.

75. Defining a benefit package was critical to developing costs and estimating the resources that were provided in the form of intergovernmental transfers to access to health care. These transfers were made based on the payment of each service provided to members. The payment schedule is based on an estimate, based on aggregate data, of direct and in some cases indirect costs of the services included. A group of experts was engaged in analysing the incidence and prevalence of each intervention and defined their cost. Clinical intervention guidelines that account for the various phases of the medical decision making process were used to create this estimate.

76. The significant efforts in developing costing were largely led by national level bodies. The Mexican Directorate General of Managing Health Services was supported by the National Commission for Social Protection in Health (a statutory government agency responsible for delivering health services). This cost analysis included a detailed analysis of needed inputs and all the diagnostic and medical procedures each service may include. These were broken down into variable costs such as laboratory analysis, drugs, medical devices and fixed costs which included human resources, and infrastructure such as hospital building, capital costs (instrumental, equipment and furniture costs) and basic services (electricity, water supply, maintenance, taxes). On this basis per capita annual costs of treatment are calculated and paid to state level organisations to finance medical services from authorised providers.

State bodies were given limited freedom to use funds in contracting with the private sector

77. The provision of health care services has been decentralised to state governments (similar to provinces in South Africa), who are also the providers of many public health care services. State level organisations are responsible for forming and coordinating the network of health service providers. The Seguro Popular enables state level administrators to outsource with private-sector providers when public clinics are unable to deliver the services guaranteed in the plan, which they do through yearly contracts. Certain high cost services are reimbursed from a national fund that directly pays public and private providers a predetermined fee.

78. The hallmark of Mexico’s success in engaging with the private sector lies in the effort placed on costing critical health care services and scaling up payments to sub-national governments to do this. This approach has helped narrow disparities between poorer and richer states and provided them with the economic resources to engage private hospital services. Such an approach is all the more remarkable as Mexico, like South Africa, is characterised by high levels of income inequality and a considerable disparity in costs between high-end private hospital facilities and public hospitals.

5.2. Extending public payments to the private sector: Turkey's Health Transformation Programme

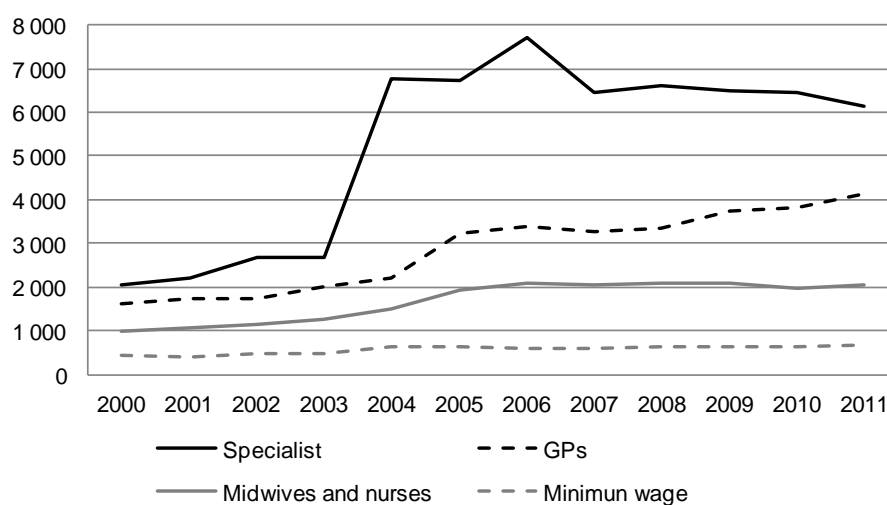
79. Turkey has pursued a more open-ended way of drawing on the resources of the private sector to deliver services to public patients. Turkey allowed private hospitals to access reimbursement at equivalent rates to that which it provides public hospitals but gave private hospitals additional freedom in the prices they can charge patients.

80. As part of the Government's Health Transformation Programme introduced in 2003, a number of health insurance schemes have been consolidated into a single payer – the Social Security Institution (SSI). At the same time, this forced a split between organisations that paid for health care and those that ran health care services. Public hospitals dominate the institutional landscape, accounting for 83% of Turkey's 21.1 hospital beds per 100,000 people in 2011. This is down somewhat from 91% a decade ago as the number of private sector hospitals has grown to account for 17% of total hospital beds in 2011.

81. The establishment of a single payer has seen policy efforts directed at establishing case-based financing that is provided to public or private hospitals. Turkey has developed a tariff schedule of "package rates" that provides prices for outpatient and inpatient services and are negotiated annually between the SSI and the Ministry of Health (as the largest hospital service provider). Private hospitals are entitled to "extra billing" when they deliver services to public patients, and can charge up to 30% (initially 90%) above the price paid by the SSI to a public patient. The difference between the price charged by private hospitals and the price reimbursed by the SSI is paid by patients on an out-of-pocket basis. This has made the Ministry of Health a very influential player in hospital financing as it is both the largest purchaser of hospital services and the rates it negotiates flows through to the maximum rates which private hospitals may charge public patients. It has provided a large number of citizens with access to private hospitals.

82. A critical enabler for these reforms is that at the same time the Turkish Government invested significant public resources towards making public sector doctors' salaries more competitive. A new pay for performance scheme was added to previous monthly wages and has come to account for 52% of the average public hospital doctor's total income. The effect of this has seen total income for medical specialists employed in Ministry of Health hospitals rise from TRL 2 665 (around \$US 1,255) a month to TRL 6 122 (\$US 2,890) a month between 2002 and 2011 (Figure 4), with the majority of this increase occurring in 2003 and 2004. Along with major increases in the utilisation of hospital services across both public and private hospitals, spending on hospitals per person was 70% higher in 2008 than in 2003, after holding prices constant. Health care spending per capita has grown at 7.7% a year on average since 2002, placing Turkey equal first with Korea in terms of the fastest rising health spending, and more than doubling the OECD average of 3.6% a year over the same period. This substantial increase in spending has made public sector work more rewarding and competitive in relation to the private sector.

Figure 4: Evolution of remuneration for Ministry of Health personnel (salary plus bonus) Turkish Lira (adjusted at 2011 price levels),



Source: Turkey Public Hospitals Institution, Ministry of Development.

5.3 Separating medical and hospital costs: the French and Australian approach to purchasing from private hospitals

83. While undoubtedly at higher levels of income, France and Australia have unique approaches to paying for services in private facilities that may be of interest to South Africa. In France, two different sets of hospital tariffs are set annually at the national level: for public (including private-non-profit) hospitals and for private for-profit hospitals. Tariffs for public hospitals cover all of the costs linked to a stay (including medical personnel, accommodation, tests and procedures provided etc.), while those for the private sector do not cover medical fees paid to doctors, which are paid on a fee-for-service basis and the cost of biological and imaging tests, which are billed separately (Table 9). When a public patient visits a private hospital, the cost of medical specialists is paid through fee for service and is not included in the DRG payment received by the private hospital. The patient is separately reimbursed by social security for the fees charged by the medical specialist, and medical specialists have the possibility to charge a higher price than the social security tariff.

Table 9: Components of DRG tariffs for public and private hospitals in France

		PUBLIC SECTOR TARIFFS	PRIVATE SECTOR TARIFFS
Payment of medical staff	Salary	Yes	-
	Physician fees	-	No
	Extra-fees	-	No
Payment non-medical staff		Yes	Yes
Biological and imaging tests		Yes	No
Administrative costs (logistic, accommodation...)		Yes	Yes
Expensive or new drugs/implantable medical device		No	No
Medical transportation costs		Yes	No

Source : *Cour des comptes, 2011*

84. Australia's approach also makes a distinction between hospital and medical costs for services in private hospitals, but provides a public reimbursement towards medical costs. While every Australian is entitled to visit a public hospital and receive care at no cost, many choose to visit private hospitals where they can often choose their own doctor, avoid waiting lists or have extra services (such as a private room). When a patient visits a private hospital, the Government provides a reimbursement towards physician fees associated with the patients stay. Private health insurance policies cover the remaining hospital and medical costs, including general hospital ward costs (including nursing), some drugs, accommodation and other administrative costs.

85. Australia and France's approaches maintain the independence of private doctors and encourage practice in both public and private sectors simultaneously. Critically, in both of these countries, public hospitals tend to be larger and more diverse than private hospitals as well as the focal point for research, teaching and highly specialised activities. Paying for specialist medical fees avoids the public payer underwriting advanced technologies or superior accommodation that may be part of the private sector's service offering. In France, this policy gives the public sector some influence over the level of medical fees charged in private hospitals. Similarly, in Australia, Medicare reimbursement rates for doctors implicitly act as guidance of prices, and are used by state governments as benchmarks when they negotiate the remuneration of doctors working in the public sector. In both countries, both public and private providers are subject to common standards on quality.

86. It is important to keep in mind that developing a system that subsidises medical care in private facilities has brought its own set of challenges. A large private health sector can lead to competition on wages with the public sector, where capacity to shift costs onto patients is more limited. As a result, both France and Australia have introduced benefits paid through the tax system to make it more attractive for private medical specialists to contract (or work) with public providers. This has come at additional fiscal costs. The concentration of private hospitals in urban areas can also make it more difficult to maintain a regionally balanced distribution of medical specialists.

87. A commonality across the four countries is that they have each invested in developing a credible price schedule that in the first instance was for the benefit of providing services to public patients. Once established, these price schedules have come to play an influential role across both public and private sectors. In the cases of Mexico and Turkey in particular, it is important to recognise that efforts to improve purchasing from the private sector was combined with historically large investments in the public sector. The role these investments played in helping ensure that the public sector provides a credible alternative to private care should not be underestimated.

6. CONCLUSION

88. That pricing in the private sector is such a contested issue in South Africa is in part a reflection of the economic significance that negotiations between private doctors and private health insurers have today. Most OECD countries with similar institutions to South Africa have generally featured a dominant public sector and a medical profession that has seen the virtue of developing a technically informed but undoubtedly politically negotiated pricing regime. Competition authorities have broadly accepted the public interest in collective bargaining with public payers who are entrusted with the social objective of delivering health care. The private sector in these OECD countries – generally smaller than in South Africa – has drawn upon benchmarks provided by the public sector, with whom they compete for medical professionals. In considering technical issues about the possibility of price setting and the feasibility of their application in South Africa, it is difficult to escape the reality that South Africa's public sector does not have the privilege of the same levels of spending as its OECD counterparts.

89. With South Africa aspiring to some form of DRG-based financing for public hospitals, a lesson from OECD countries is that getting the necessary data in place is essential. DRG based financing in OECD countries has been introduced following considerable efforts to code hospital activity, most notably patient diagnoses and procedures. Effort should be made to ensure that hospitals have the information systems and the people needed to accurately code services.

90. More broadly than hospitals, examining good practices in OECD countries suggests that establishing some form of price setting or guidance could help improve the transparency of how funds are spent and provide norms against which private sector prices can be compared. One of the means by which OECD countries have sought to address the difficult exercise of pricing medical services is by establishing independent technical agencies. These agencies are charged with developing a credible price schedule which seeks to group and then order services according to their complexity in a way that reflects a country's resource costs, clinical practices and patient needs. Critical to the work of such an agency is input and close collaboration with medical specialists, key providers and payers. The virtue of such an approach is that it can disentangle the 'technical' task of establishing a schedule of medical services from 'political' negotiations over overall payments to medical professionals.

91. The experience of OECD countries demonstrates that price schedules can be useful public goods. They can be used by the public sector to better link payments or budgets with activity. They can create a basis on which the public sector can draw on private services, and they can be used by private insurers to scale prices to reflect their commercial objectives. Above all, pricing benchmarks provide certainty to doctors and patients. Given the extent of distrust between key health care actors in South Africa today, better pricing could help push forward on good policy.

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ANNEXE A: IMPLEMENTING DRG SYSTEMS IN OECD COUNTRIES

This annexe provides further technical information on the implementation of a DRG based hospital financing system.

The collection of information

Patient classification systems are the critical first step to establishing a DRG based financing system. In some OECD countries, the patient classification system was implemented before the implementation of a payment per case. The process to define the basis of information for determining DRG payments relies on creating a patient classification system which is clinically and economically meaningful.

Three types of OECD countries can be identified in the way they adopted their patient classification system. Some countries which introduce DRG systems, among them Spain, Portugal and Ireland, imported the DRG classification system from another countries. For instance, Spain and Portugal implemented All-Patient DRG (AP-DRG) system which was widely applied in the United-States in 1988. Other countries like Germany or Australia chose to use as a basis the AP-DRG and the All Patient Redefined-DRG⁴² a new version of the AP-DRG in order to create their own DRG systems. Thus Australia created the Australian National – DRG (AN-DRG) system and Germany implemented the German–DRG (G-DRG system). Lastly, other countries decided to create their own patient classification systems. For instance, the Nordic countries defined a common DRG system which is called the NordDRG even if some country-specific modifications are added. England, Austria and the Netherlands also decided to develop their own patient classification system.

The basic characteristics of these DRGs can be compared at three levels (Table A1). First, the number of groups appears quite different between the different DRGs. Whilst the number of groups reaches 518 groups in the patient classification system used by Poland, it reaches 2297 in the French one called “Groupe Homogène de Malade” (GHM) which can be translated as “Homogeneous group of patients”. However, every patient classification system has a similar number of major diagnostic categories (MDC) which help to categorize the different groups defined. The major diagnosis category are for instance “Nervous system”, “Eye”, “Circulatory system”, “Vascular diseases”. This consistency in the number of major diagnostic categories can be explained by the fact that each category represents one organ system. Consequently the category structure parallels the structure of medical speciality. In the majority of patient classification systems the number of major diagnosis category is around 25. In order to reach more homogeneous groups, all patient classification systems, except the one in the Netherlands, divide the cases into different kind of treatment like surgical, medical. This separation is called partitions. In order to code diagnoses, the majority of countries and notably France, Germany, Austria, the Netherlands, England use the 10th revision of the WHO’s International Classification of Diseases (ICD-10). However each country has introduced country-specific modifications to the classification and also use unique procedure coding.

⁴² AP-DRG was refined by changing the determination of severity levels in order to respond to demand for more accurate basement of case severity notably.

Table A1: Groups, major diagnosis category and partitions in different patient classification system

	AP-DRG	AR-DRG	G-DRG	GHM	NordDRG	HRG	JGP	LKF	DBC
Groups	679	655	1200	2297	794	1389	518	979	30000
MDCs/Chapters	25	24	26	28	28	23	16	-	-
Partitions	2	3	3	4	2	2*	2*	2*	-

Source: Busse et al.(2011)

* HRG, the DRGs system for England, JGP, the DRGs system for Poland and LKF the DRGs system for Austria do not define partition per se but distinguish between treatment and diagnosis-driven episodes.

The field of application of DRGs system

92. The second objective that needs to be determined is the desired scope of hospital payments. First, countries have to define which services should be covered by DRGs systems. When analysing the developments of DRG systems, it appears that they are progressively being applied to settings that are beyond the acute care hospital inpatient sector. Indeed, there are a growing number of countries which has implemented the DRGs system in order to pay day-cases. For instance, the French GHM system splits DRGs according to the length of stay in order to identify day-cases as cases with a length of stay equal to zero. Some countries have also decided to withdraw some activities from the scope of DGRs system. The exclusion of some (medical) specialties and/or hospital services have sensibly occurred as incentives to reduce length of stay could be harmful (for example, intensive care); the coding is too complex (for example, for multiple trauma care); if diagnosis is not a good predictor of the costs (for example, psychiatric care). In Australia and France, public services like emergency care are not in the DRG payment system. Furthermore, lump sum payments are often allocated to cover fixed costs.

93. The scope of hospital payment refers also to the level of aggregation of services in the DRG system. Even if DRG-based payment systems cover all costs of services during a hospital stay, the scope of payments in numerous countries, notably England, France, Germany or the Netherlands, extends beyond twenty-four hours after discharges. For instance, in Germany since 2004, the DRG-based payment includes costs for readmission to hospitals for the same diagnosis. Readmission is defined per DRG or refers to a readmission of the patient within 30 days after discharge. Furthermore, in most countries using DRGs system, all services provided by clinicians (surgeons, anaesthesiologists, radiologists) or capital costs are covered by DRG-based payment. However, in France in private hospitals, DRGs system does not cover the physician fees that are paid through fee-for-service.

94. Lastly, in order to promote innovation and to ensure that expensive services required are adequately reflected in the grouping process, all DRG systems have developed mechanisms to provide additional payments for certain innovative technologies, including expensive orphan drug or services as chemotherapy, radiotherapy and renal dialysis. All DRG systems have developed “trimming methods” to account for cases with much higher or much lower resource consumption (outliers) than resource consumption planned in the DRG-based payment. To be able to deal with such particularly expensive cases, some systems, such as the one currently in force in Germany, introduced a ceiling based on the length of the hospital stay. If the duration exceeds this threshold, hospitals are reimbursed on a daily rate basis for the period exceeding the threshold. This helps balance the distribution of the risk between hospitals and insurers.

The cost accounting methods to value DRGs

95. The third objective of payment mechanism is to provide adequate payments. Indeed, if DRG payments are too low to cover treatment costs, the providers could try to select patient or reduce quality of

treatment. If payments are too high, providers have no incentive to produce efficiently. Methods for calculating costs in health care can be divided into three main groups: bottom-up microcosting, top-down microcosting and gross costing. The bottom-up microcosting is characterized by the identification of patient-specific resource use and hospital specific unit costs. The top-down microcosting is characterised by the identification of patient-specific resource use and nationally representative tariffs as unit costs. Gross costing is characterised by the identification of resource use of inpatient days only and hospital-specific unit costs.

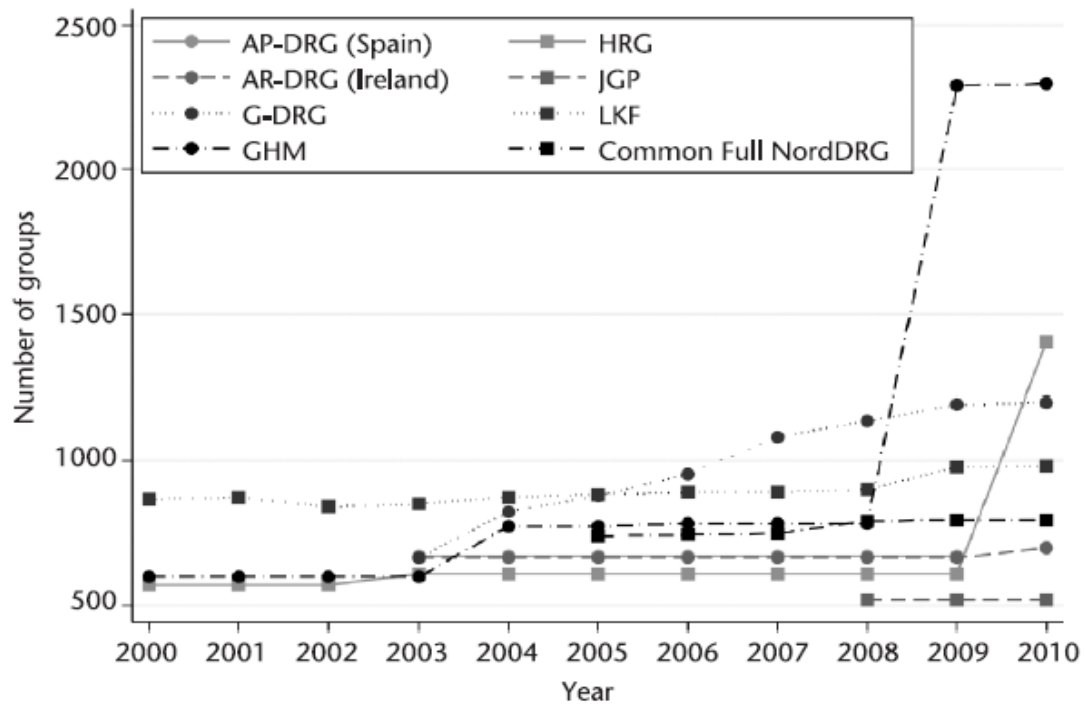
96. In the case of DRG systems, bottom-up costing studies could be used to calculate the average cost per DRG using patient level activity data. For instance, Germany uses data on 253 hospitals that follow a standardized cost accounting approach (13% of the total number of hospital) in order to calculate costs of treating individual patients (Quentin *et al.*, 2013). These hospitals receive a fixed allowance for participating in the cost accounting data sample. This approach is also used by the Netherlands, where data is collected on resource use from all hospitals but data on unit costs only from a sample of hospitals (24% of the total number of hospital).

97. Due to the difficulty of collecting data, there is a generally a time lag between data collected and the determination of the payment rate. In the United States, the cost data are three years old whereas they are two years old in France, Germany, Sweden, the Netherlands, between two and three years old in Spain and Portugal, between one and two years old in Estonia. The frequency of updates are annual (England, Finland, France, Germany, the United States), biennial (Spain) or irregular (the Netherlands, Poland, Portugal, Estonia). Update regularity plays a key role as it allows taking into account innovation and new treatments.

The classification variables to refine DRGs

98. The last objective of DRGs system is to find the right balance in the fineness of payments. The fineness of DRGs payment system refers to the information included in the DRG system notably about the patient, the providers and the service characteristics. Some variables are used in order to take into account the difference between patients. The introduction of these classification variables explains a part of the increase in the number of groups in DRGs system in European countries and notably in Germany (Figure A1). In France, the 1986 version was inspired from the AP-DRG (450 DRGs). Complications and co-morbidity were added as well as specific DRGs for ambulatory surgery and procedures. The latest and 11th version was introduced in 2009. It associates up to 4 degrees of severity to 606 “base cases” to make up a total of 2,297 DRGs (the previous version had a total of 784 DRGs) The “severity” level depends on the type of co-morbidity associated with the main diagnosis, the LOS and in some cases the patients’ age (below 2, above 69). In all DRG systems except the one built in the Netherlands (DBC), age is a classification variable. Some variables defining the severity and the complexity levels of the patient are also used in all DRGs system except in the DBC system. The number of levels is not-limited in the G-DRG or in the Austrian DRG system. For instance in Germany, a base-DRG can be divided into six DRGs according to the presence of very severe complications, treatment of multidrug-resistant pathogens and age (below 3 years, between 3 and 5 years old and over 5 years old). The number of possible severity levels is limited to five in the French DRGs system and 4 in the AR-DRG (Australia).

Figure A1: Trends in the number of groups in DRG-like PCSs in Europe



Source: Busse et al. 2011

ANNEXE B: HOSPITAL MERGERS AND COMPETITION LAW

This annexe shall focus on how competition law treats the issue of hospital mergers across OECD countries. It does so through summaries of opinions and decisions issued by competition authorities across the OECD. This annexe mainly describes the different market definition used across OECD countries and the different thresholds defined in OECD countries for the notification of mergers.

Concentration trends

Pricing pressure and the need to exploit cost advantages have been among the factors leading to hospital consolidation in a number of countries. The concentration trend observed in the hospital sector in South Africa is not a unique feature. Other countries with a large share of privately-owned hospitals, including Germany, the Netherlands, and the US, have experienced an intense merger process.⁴³ Given market trends and the regulatory framework, which in many countries involves price regulation, the role of competition law is often to focus on competition in non-price dimensions, in particular on quality. Merger control is a primary tool in this effort.

Over the eight-year period to 2012, the Bundeskartellamt in Germany reviewed about 150 hospital merger cases, most of which were cleared at the first phase of analysis and only four were prohibited.⁴⁴ In Germany, no merger has been prohibited where the combined market shares of the merging entities were below 50%.

In the Netherlands, the number of hospitals has fallen from 117 in 1997 to 94 in 2010. However, this has been in part counterbalanced by an increase in independent outpatient treatment centres, which have increased from 37 in 2005 to 184 in 2010.⁴⁵ The competition authority has investigated more than 150 proposed concentrations in the health care sector between 2004 and 2012.⁴⁶ Of these, only a sub-set concerned hospitals. Between 2004 and 2009, nine hospital mergers have been notified, two have been subject to a substantive assessment by the authority and both have been cleared.⁴⁷ In 2011, the competition authority blocked a merger for the first time.

In France, where the share of private hospitals is lower than in the Netherlands and Germany, the sector has also undergone a process of concentration, following a wave of hospital closures and of mergers among private hospitals since the 1990s. Concentration trends can be expected to continue also due to policy measures aiming at rationalising the sector and encouraging co-operation between hospitals.⁴⁸

⁴³ OECD (2012), Competition in hospital services, [DAF/COMP\(2012\)9](#), Paris.

⁴⁴ OECD (2012), Competition in hospital services, Contribution from Germany, [DAF/COMP\(2012\)9](#), Paris.

⁴⁵ Dutch Healthcare Authority; OECD (2012), Competition in hospital services, Reform, competition, and policy in hospital markets, Paper by Martin Gaynor, [DAF/COMP\(2012\)9](#), Paris.

⁴⁶ ⁴⁶ OECD (2012), Competition in hospital services, Contribution from the Netherlands, [DAF/COMP\(2012\)9](#), Paris.

⁴⁷ Varkevisser, M. and F. T. Schut (2009).

⁴⁸ Chevreur *et al.* (2010).

Transactions in the Turkish market have included a few foreign acquisitions of local hospitals (e.g. Argus Capital Partners – Memorial Health Group, Carlyle – Medical Park Hospital Group) but also some mergers that have involved local players and increased market concentration (e.g. Goztepe Safak, Antalya Deva – Memorial, Acibadem and Integrated Healthcare Holdings). However, the market is still considered relatively fragmented by the competition authority.⁴⁹ The five main players in the private sector controlled a combined share of less than 5% of hospitals across the country at the end of 2010, but this figure may underestimate the degree of concentration in the larger cities where privately-owned hospitals are mostly located.

In the UK, in the period between 1997 and 2006 alone, 112 NHS hospital mergers took place.⁵⁰ Since the establishment of the Co-operation and Competition Panel (CCP) in 2009, the body has reviewed over 50 merger cases in the NHS.⁵¹ In the small part of the overall health sector that is funded privately, the Competition Commission has recently found evidence of high concentration both among hospital groups and private medical insurance providers.⁵² At a national level, the “five main hospital groups account for approximately 70% of privately funded health care revenues in the UK.” The market for private medical insurance is also concentrated and the four largest insurers account for about 87% of insurance premium revenue.

Market definition

As part of assessing competition in a market, an initial step in the analysis is usually to undertake a market definition exercise. In simple terms, the process consists in identifying close substitutes for the product on the demand side and on the supply side. While from a patient’s perspective there is limited, or no, substitutability across types of treatment, in some cases supply-side substitution could act as a constraint on health care providers. In fact, “competition authorities in different jurisdictions and US courts (in merger cases in particular) have often aggregated individual services into clusters based on them being provided by a common set of competitors” (Oxera, 2011).⁵³ Market definition has been among the most debated issues in hospital mergers so far. Many of the papers on the subject analyse the experience in Germany and in the Netherlands.⁵⁴ In consequence, this section mostly focuses on the approach to market definition in these two countries.

In Germany, the relevant product market has been usually defined as including all regular hospital services, including all specialties. The exceptions to this approach are gynaecology, obstetrics and ophthalmology services, which can be considered as separate markets. The geographic market is defined at local level, on the basis of information on patient flow data. This assessment is based on historical data, i.e. actual patient visits to hospitals. The methodology adopted by the Bundeskartellamt consists of two stages. Firstly, the catchment area of each hospital, located within 100 – 120 kilometres around the merging hospitals, is preliminarily identified. Secondly, data on patient visits are analysed. Only patients travelling

⁴⁹ Turkish Competition Authority (2011), Decision on the merger between Integrated Healthcare Holdings and Acibidem, 11-64/1659-589.

⁵⁰ Gaynor, M., Laudicella M. and Carol Propper (2012), Can governments do it better?, *The Centre for Market and Public Organisation*, Working Paper 12/281.

⁵¹ Gaynor, M. (2012), Reform, competition, and policy in hospital markets, Roundtable on Competition in hospital services, [DAF/COMP\(2012\)9](#).

⁵² UK Competition Commission (2013), Summary of provisional findings, 28 August 2013.

⁵³ Oxera (2011), Techniques for defining markets for private healthcare in the UK – Literature review, *Prepared for the Office of Fair Trading*, November 2011.

⁵⁴ The US experience has also been widely studied and indeed has been a precursor to the European cases.

to the hospitals of the merging parties are taken into account, as opposed to the patients that travel to all the hospitals in the geographic market. The Bundeskartellamt concludes that areas belong to the same geographic market when there are significant patient flows between them, but does not define ex ante fixed thresholds to be used in this assessment. As a result of considering actual patient visits only to the merging hospitals, fewer patients are considered to travel from other areas to the geographic market than if all the hospitals were considered. Therefore this approach tends to define smaller geographic markets than would otherwise be the case.⁵⁵

The courts have confirmed the definition of the Bundeskartellamt. In 2005, the competition authority prohibited the acquisition of two public hospitals (Bad Neustadt and Mellrichstadt) by Rhön-Klinikum AG, one of the main private hospitals group in Germany. The approach in defining the relevant market in the case was confirmed by a Higher Regional Court and subsequently by the Federal Court of Justice (BGH) in 2008.⁵⁶

Geographic market definition in Dutch cases has proved to be less consistent over time and has involved a variety of approaches. The first case that the NMa, the Dutch competition authority at the time,⁵⁷ assessed in detail was the merger between two general hospitals, Hilversum and Gooi-Noord, in 2004. The transaction was cleared by the NMa.

Two product markets were identified, one for inpatient and one for outpatient general hospital care. An initial analysis of the geographic market was carried out based on standard methodologies used in US cases⁵⁸ and resulted in a narrowly defined market. The NMa considered that further analysis was required to take account of patients' prospective behaviour, if the merging parties were to exercise market power. The additional analysis included interviews with general practitioners (GPs), other hospitals and health insurers. Empirical work was also conducted to investigate patients' stated and revealed preferences. The findings of the additional analysis were ambiguous, in particular revealed preferences pointed towards a small geographic market while according to stated preferences, patients declared that they would be increasingly willing to travel in the future in response to lower quality or higher prices, could not be ignored. On balance, the NMa considered that there was not enough evidence to define a small geographic market.

In other cases, the average travel times to the merging hospitals and to their potential competitors have been assessed.⁵⁹ When a large share of patients of the merging hospitals has the option of at least one hospital which is closer or equally close as the merging parties, then it is considered that the merger is unlikely to significantly lessen competition.

In decisions by the Revabet Kurumu, the Turkish competition authority, the relevant market has been defined as "private hospital services" overall, i.e. not split by specialty. It does not appear that the competition authority has taken a clear stance on the definition of geographic markets. For instance, in the Acibadem and Integrated Healthcare Holdings decision, market shares for different geographic markets

⁵⁵ Varkevisser, M. and F. T. Schut (2009).

⁵⁶ Beschluss VI-Kart 6/05 (V), Oberlandesgericht Düsseldorf, Düsseldorf. BGH, Decision of 16.1.2008, KVR 26/07 – Kreiskrankenhaus Bad Neustadt, Bundesgerichtshof, Bonn.

⁵⁷ The Netherlands Competition Authority (NMa) merged with the Netherlands Consumer Authority and the Netherlands Independent Post and Telecommunications Authority (OPTA) in April 2013 to create the Authority for -Consumers and Markets (ACM).

⁵⁸ The Elzinga-Hogarty (E-H) test begins with a narrow market and then expands it until certain thresholds are reached for patient inflows and outflows.

⁵⁹ Varkevisser, M. and F. T. Schut (2009).

have been used, such as national, Istanbul Europe, Istanbul Anatolia and Turkey excluding Istanbul. Although the figures themselves are confidential, the decision states that “in none of these markets the share of Acibadem exceeds [...]” and “no player has a share more than [...] and the market has a number of small players and is fragmented.”⁶⁰

In recent decisions on UK mergers, the relevant geographic market has been defined on the basis of patient catchment areas and isochrones.⁶¹ The catchment area analysis is based on “the distance around the hospital from which a certain percentage of the hospital patients originate, often taken as 80% - 90%.” The geographic market is defined as the area within a fixed drive-time (i.e. isochrone) around a hospital. The same approach was also followed in the most recent hospitals merger in the UK, between the Royal Bournemouth and Christchurch with Poole Hospital. The geographic market was defined on the basis of isochrones. In particular, evidence indicated that the merging parties attracted patients from areas within a 17 – 22 minutes’ drive. In the services market, each specialty was found to constitute a separate market.⁶² In addition, within each specialty outpatient and inpatient services were treated as separate markets, as were non-elective and elective activities.

In many European countries, hospitals compete directly for patients. As a result, the extent to which hospitals are substitutable, and therefore included in the same market, depends on patients’ willingness to travel. In Australia, market definition needs to take account of the different setting in the hospital sector. In recent merger cases assessed by the Australian Competition and Consumer Commission (ACCC), the authority defined two separate markets, one for “the supply of private hospital services to health funds” and one for “the supply of private hospital services to patients (with doctors acting as agents).”⁶³

Buyer power

In 2012, the Dutch Authority for Consumers and Markets cleared three hospital mergers in which the parties committed to self-imposed annual price ceilings. One of the arguments in the decision was that the health insurers had sufficient bargaining power to balance the impact of the mergers on the market. This argument is related to a change in the institutional set-up of the sector which has resulted in greater incentives for health insurers to purchase efficient health care services. The largest health insurers were also in favour of the mergers, since they expected that consolidation would deliver benefits in terms of price and quality, and claimed that they had already conducted negotiations with the merging hospitals on these grounds.⁶⁴

⁶⁰ Turkish Competition Authority (2011), Decision on the merger between Integrated Healthcare Holdings and Acibidem, 11-64/1659-589.

⁶¹ General Healthcare Group – Abbey (2010), General Healthcare Group – Nuffield (2008), Spire – CHG (2008).

⁶² Competition Commission (2013), A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013.

⁶³ Australian Competition and Consumer Commission, Informal review of 1 June 2010, Sydney Adventist Hospital - proposed acquisition of Dalcross Private Hospital. Australian Competition and Consumer Commission, Public competition assessment of 14 March 2007, Mater Misericordiae Hospital – proposed acquisition of the Wesley Hospital, Townsville. Australian Competition and Consumer Commission, Informal review of 9 November 2007, Health Care Australia Pty Ltd - proposed acquisition of Central Lakes Equities Pty Ltd and East Maitland Private Hospital Pty Ltd.

⁶⁴ Consumer and Market Authority (ACM) (2013), Market outlook, Den Haag.

Thresholds for the notification of mergers

Mergers in the health care sector in the Netherlands are subject to the application of lower notification thresholds compared with companies in other sectors. As a result of these lower thresholds, it is estimated that the Authority for Consumers and Markets has reviewed twice as many transactions over a four-year period that would have been the case otherwise. The merging parties are required to notify the Authority for Consumers and Markets if, in the previous calendar year:⁶⁵

- At least two of the companies involved generated a turnover of more than EUR 5.5 million each in the provision of health care services;
- The combined global turnover of the companies involved was greater than EUR 55 million; and
- At least two of the companies involved in the transaction generated a turnover in the Netherlands of at least EUR 10 million.

This provision was due to be repealed in January 2013 but has been extended by five years. A lower notification threshold can be explained by the low turnover of many health care companies, which would otherwise fall outside the thresholds applicable to all sectors. In addition, despite the low turnover the merger may affect competition since the relevant geographic markets affected are often quite narrow.

⁶⁵ De Brauw Blackstone Westbroek (2013), Healthcare concentrations: ACM keeps finger on pulse?, Lexology, 9 May 2013.

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