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MECHANISM OF COMPETITION IN HEALTHCARE SECTOR

ABSTRACT. The competition problems in the sub-sector of stationary health care presented in this paper induce a reflection that competition types and instruments applied are a derivative of the organisation of a given healthcare system as well as of the specificity of health care per se. The author considers the problems of obtaining competitive advantage in the sub-sector of stationary health care. Therefore, the fundamental objective of this paper is constituted around identification the types and instruments of competition with respect to stationary healthcare establishments. The remarks done in the paper can be useful both for Polish and Ukrainian healthcare sector.

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Introduction

The scale of changes taking place in modern world (and their dynamics) like competition in the labour market, new approach to earning or playing professional and social roles and demographic trends (like late maternity) cause that interest in individual health as a resource grows, being vested with which is in hands of individual himself / herself and not of external forces (genes, environment).

Health becomes a kind of capital, being in which co-decides about competitiveness of individual at the labour market, broadly speaking about the quality of life. One of the contemporary healthcare economists, R. Freeman, has written in the foreword to his book that: […] *Health matters more than at any time. It is one of the basic subjects of concern of modern societies"*[1].

Not only the way of seeing the health has changed but also that of seeing the disease as a kind of "risk syndrome"[2]. Apart from exogenous factors like housing conditions or crime level, this syndrome includes also self-creation elements like tobacco, alcohol or drug abuse. Derivative of awareness transformations is the changing approach to the role which should be fulfilled both by service provider and patient in the relation connecting them.

[1] R. Freeman. *The Politics of Health in Europe*, Manchester University Press, Manchester 2000, p. VII.
[2] *Organizacja przyszłości*, edited by: F. Hesselbein, M. Goldsmith, R. Beckhard, Fundacja Druckera, BusinessPress, Warszawa 1998, p. 384.

In connection with the above, it is possible to put forward a hypothesis that an important element of the healthcare sector will be competition, its types and instruments. The importance of this element consists in that that patients (articulating their preferences through selection and representing demand for health care) will be interested in health services of high quality and broad availability, payers (being indirect administrators of financial resources appropriated for health care, i.e. so called third party) will be oriented towards purchasing services with a favourable cost-quality relation, whereas service providers (representatives of health care supply) will aim at maximisation of their participation in the internal market of health care.

Areas of the occurrence of competitiveness are connected with the occurrence and configuration of the aforesaid participants of the healthcare sector and therefore they depend on the healthcare system practised in a given country. From point of view of the healthcare system organisation, competition can be focused on the financial side of the system, i.e. where demand is being created, on the production side of services, i.e. where supply will be created, or also on allocation mechanisms, i.e. those which link supply with demand.[3].

It is assumed in the present paper that this system is created by:
- patients of the stationary health care,
- providers if this health care (mostly hospitals),
- third party payer, and
- providers of the ambulatory health care represented by primary care doctors / family doctors and specialists.

Competition for patients

Competition mechanism has a possibility to manifest itself to the fullest, fulfilling at the same time the conditions specified above, in those healthcare systems where stationary health care is paid for on the retrospective principles and in relation to medical services and procedures being just paid for in this way. This is because the formulas of retrospective paying for services favour "flow of money following a patient", therefore his / her decisions settle the size of financial stream supplying service provider from the side of payer.

This situation basically refers to systems where services are directly paid for by a third party payer/ payers or a payer reimburses the patient for incurred expenses on the retrospective principle. In all European Union countries presented (Tab. 1), also a situation is possible when a patient pays in part or fully for a given service from his /her personal earnings.

Competition for patients refers to those areas of the stationary health care or to ambulatory care provided within it where a patient himself / herself is able to take decision about hospitalisation or taking ambulatory advice. Thus, here, it is about relatively not complicated cases where a patient, basing on available information, makes an independent selection himself / herself.

This can be for example a visit to hospital's reception room in emergency, a visit to hospital outpatient department, or hospitalisation connected with childbirth. With that type of services, hospitals compete directly against each other trying to win over as large number of prospective patients as possible.

One can include into basic sources of competitive advantage in the hospital sub-sector as follows: reputation (scientific achievements, functional quality), personnel (expertise, training), uniqueness of services, quickness of service, technology, process (specific way of

[3] W.C. Włodarczyk, *Reforma opieki zdrowotnej w Polsce. Studium polityki zdrowotnej*, Vesalius, Kraków 1998, p. 23.

work organisation), price (refers to financial sector directly from individual earnings of patient).

The sources of competitive advantage presented above allow drawing out a suggestion that it mostly depends on non-material values (like reputation, quality and image in the environment), rarity of resources and difficulties with imitation.

Competition for doctors

Other hospitalisation cases have not been addressed above since patients do not have information which would allow them to make rational decision. Relations of patients with service providers of the stationary health care are characterised in these circumstances by large information asymmetry. Patients are not equipped with tools allowing them to measure the value of service which is usually measured by a ratio of the price to the quality of given advice or procedure. Contrary to many other areas of life, patients in the sector of healthcare services (here: especially hospital services) do not have information about future either. In their choices (as for service type and its quality), they have a chance to make use of the experiment base.

This is because many healthcare episodes are of unrepeatable or incidental character. In such circumstances, decision about hospitalisation is taken on behalf of patient by a primary care doctor or specialist. In the health care systems where a *gatekeeping* is obligatory, this doctor fulfils a function of the gatekeeper who authorises the necessity of hospitalisation by issuing a referral. A far important competition than that for final service beneficiaries is the competition for doctors (patient rights advocates, their agents) who, through a system of referrals, have a control over the flow of patients. Such a mechanism becomes started up in the systems where hospital incomes depend on the number of granted services (retrospective methods) and accepted cases (DRG method – homogenous patient groups).

Cooperation, i.e. a specific symbiosis between hospitals and doctors, has mainly place in the insurance systems (Austria, France). There, stationary healthcare institutions make endeavours after the best specialists offering to them subsidised reception rooms as well as a certain number of beds (so called professor's beds) in a given hospital ward where a doctor can place his patients. The quality of provided services and their technological advancement becomes a tool instrument of competition for doctors. This is because a doctor cooperating with a reputable [renowned] hospital can build on this basis the image of his own medical practice. On the other hand, this is the cooperation with a well-known specialist that affects the perceived quality of hospital services and reputation of this establishment[4].

Apart from the competition for doctors as patient agents, also the competition for doctors as providers of labour factor is possible between hospitals. In this case, a helpful instrument of competition is technology as well as service contract / working agreement (salary, position, bonuses, etc.).

The sources of competitive advantage presented above allow drawing out a suggestion that competition for doctors is primarily of the qualitative character.

Competition for contracts

In the healthcare systems where the function of administrator of funds assigned for health care financing is fulfilled by a third party (public or private insurance institution, or the budget itself), hospitals compete not directly for patients but for a payer. This is him on whom

[4] H. Luft, J. Robinson, D. Garnick, S. Maerki, S. McPhee, *The role of specialized clinical services in the competition among hospitals,* ''Inquiry'' 1986, No. 23(1), p. 85.

their earnings depend. Services provided at the level of stationary health care are then paid for, as a rule, in the score system (every procedure is attributed with a relevant number of points, while every point with a specific amount of money) on the grounds of contract concluded earlier. Contracts are frequently accompanied by limits (e.g. Poland), i.e. limitations in the amount of benefits possible to be granted that will be financed from public funds.

Depending on the organisation of healthcare sector, different intensity of competition is possible on the side of the representative of demand for medical services. In the monopsonic model (Poland – National Health Fund, Great Britain – Regional Trusts), no competitive structure on the side of demand limits strongly the scope of applied and payer-accepted competition instruments. Under such conditions, the basic factor of success is price which decides about accepting the hospital's offer by payer. In the systems where there is a multitude of third party payers (public or private, e.g. Germany or Slovakia), competition for contracts can also assume other forms (qualitative competition or information competition).

The sources of competitive advantage presented above allow drawing out a suggestion that competition for contracts with a third party payer is primarily of the price character (monopsonic model). In case of diversification of the payer [paymaster] market, competition is moving in the non-price direction, i.e. qualitative and information one.

Dilemmas referring mechanism of competition

Despite the advantages flowing from competition commonly stressed in literature (innovativeness, efficiency, client satisfaction) in the sector of healthcare services, also that of stationary healthcare ones, there are certain dilemmas connected with starting up that mechanism.

Firstly, competition with technology in the hospital sub-sector, both for patients and doctors, does not have to be favourable either from point of view of the patient's interests or from a perspective of payer interested in the cost control, contrary to many other areas of economic activity. Some researchers put forward a hypothesis about "medical arms-race"[5] which can lead to escalation of costs, surplus of resources and discrimination of poorer patient segments.

Transfer of non-price competition into areas of technology is an important threat for service providers limited by their budgets as well as for patients themselves, for whom the validity of consumption of highly technologically advanced services is unknown as a rule. This phenomenon can be a real threat for effectiveness objectives in the event of introducing private commercial insurance.

Endeavour for capital-intensive investments is repeatedly dictated by a willingness to win the best specialists as well as next patients. Up against the absence of reliable analysis of the effects of modernizations and investments being implemented, qualitative competition raises well-grounded dilemmas connected with cost escalation and the phenomenon of demand induction by supply. Surpluses of the resources of service providers, being a result of historical events (e.g. surpluses of bed number in some Polish hospitals) or of irrationally conducted investment policy (too large number of medical equipment in relation to possibilities of using it), generate high standing costs.

The existence of such establishments at the market induces a strong pressure on creation of demand in order to use the owned medical base and equipment, while this phenomenon does not favour effectiveness objectives set forth before competition

[5] M. Gaynor, D. Haas-Wilson, *Change, consolidation and competition in health care markets*, Working Papers 6701, National Bureau of Economic Research (NBER), Cambridge, August 1998, p. 29.

mechanism.

To mitigate negative phenomena connected with the "medical arms-race" the activity of public forces should be used that promotes qualitative competition (e.g. through a system of certificates) and creates organization and legal frames for entering of particular service providers, including private ones, into partnership agreements with respect to financing and exploitation of capital-intensive investments.

Secondly, even the system model of gatekeeper in the form of a doctor who issues a referral is not capable of preventing from information imperfections through directing patients to well-known service providers of stationary health care (here: a primary care doctor or a specialist). As a rule, this group does not include all available hospitals, while recommendations are not supported by reliable information about obtained results but rather by personal preferences. Therefore, this is the absence of adequate information allowing comparative analyses and not the complexity of medical services *per se* that does not allow taking rational decisions.

The aforesaid circumstances cause that health care establishments are able to compete only on the grounds of what is observable and this does not necessarily have to be expressed by clinical results obtained.[6]. Such attributes like the atmosphere prevailing in an establishment, saturation with medical equipment of a new generation or kind attitudes of personnel admittedly affect the level of patient satisfaction but they are not synonymous with long-term successes in giving treatment which is the core of medical service. Therefore, there is a need for developing a system of making information about hospital activity result available to the concerned parties so that their decisions can be supported by comparative analysis of available alternatives.

This however proves to be done in practice with difficulty. One of not many positive examples is Sweden[7] where there are about fifty databases on the quality of health care, on the basis of which annual reports are being prepared on medical treatment results in selected areas of medicine. These reports are made available, among others, in the Internet.

Thirdly, it is difficult to find in the healthcare sector – contrary to the sector of earning enterprises – an objective method of making comparisons between hospitals. Profit as measure of results is a hardly useful criterion in the competition struggle because majority of hospitals are public institutions or social organisations. Such indicators like the number of effected services, health promotion programmes or mortality statistics have been repeatedly attempted to be used. However, there is a consensus as for this that these measures are incomplete and frequently inadequate and misleading. Therefore, there is a need for developing a moderately objective system to measure the achievements of stationary healthcare establishments.

Some examples from Polish hospital system

An impulse [A stimulus] liberating competitive behaviours among Polish hospitals has become departure from the integration relation in favour of the contract relation. The formal-legal bases of this modification have been included in the Act on General Health Insurance of 1997. According to this legal act, as well as following ones, both public and private health care establishments, including stationary ones, can enter into contracts. There are limits for most services and procedures provided in the stationary healthcare system, while competition between service offers (where its fundamental assumptions have been fulfilled) is primarily

[6] E. Teisberg, M. Porter, G. Brown, *Making competition in health care work*, „Harvard Business Review" 1994, July-August, p.134.

[7] G. Andersson, *Szwedzki system ochrony zdrowia – przykład decentralizacji*, „Zdrowie i Zarządzanie" 2000, Tom II, No. 3-4, p. 96.

carried on for contracts. However, due to the fact that hospitals do not have a secured demand (request) for all their services they have also to compete in the area of quality. Strong position of payer during negotiations makes intersectoral competition to be illusory in large measure. As a rule, private hospitals do not participate in contracting the services financed from public funds, the main reason of which is restrictive approach of payer to prices and score system.

Studies carried out in the period of autumn 2003-spring 2004 by the team of K. Obłoj on the behaviour of hospitals under medical reform conditions delivered interesting information on competition types and instruments applied. Their exemplification is presented in Table 1.

Table 1 Exemplification of competition types and instruments used by Polish hospitals

Competition area	Competition type	Instruments applied	Examples of practical activities
Competition for contracts	Price competition (in the area of allocation)	Price – its lowering through reduction of costs	Budgeting, consortia for purchasing medicines, ambulances and medical products, hospital pharmacopeias, outsourcing of accessory services, connection of organization units, restructurisation of employment, modification of the working system of medical personnel, new arrangement of wards so that those using similar diagnostics are situated close to each other.
Competition for contracts as well as doctors and their patients	Technological competition (in the area of allocation and on the side of supply)	Product innovations	New medical procedures, new wards [departments / units], new outpatient clinics, purchase of new equipment (e.g. a mammography equipment).
Competition for doctors and their patients	Qualitative competition (on the side of supply)	Improvement of service quality and patients' service	Training of employees, epidemiological standards and procedures, ISO quality certificates and CMJ accreditation, anesthesiology standards and procedures increasing patient safety in the operating room, accreditation from the Ministry of Health for carrying out trainings, cooperation with prestigious clinics national consultants, examination of patient satisfaction.

Source: own work based on: K. Obłój, M. Ciszewska, A. Kuśmierz, *Strategie szpitali w warunkach reform*, Wyd. WSPiZ im. L. Koźmińskiego, Warszawa 2004, p. 99, 123, 142 i 165.

One can expect that competition in the sub-sector of stationary health care will intensify and differentiate together with convergence of European healthcare systems and intensification of the free flow of patients within the single European market. While deriving

benefits from starting up the mechanism of competition in different sectors of health care, it should be necessary to remember about dilemmas connected with it.

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