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COMPETITION IN HOSPITAL SERVICES

-- Chile --

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1. Health sector: institutions and framework

1. A trend towards private sector involvement in health services began in Chile at the end of the seventies, as part of a broader move towards privatization, deregulation and market reform. As a consequence, the public sector lost its exclusivity in supplying health services and in managing resources for health services. From then onwards people could switch to the private system provided they could afford it[1] [2].

2. In 1981, with the establishment of private health insurers, called "ISAPRES"[3], working population was allowed to contribute to an Isapre instead of staying affiliated to the public managed sector. By 2011, the Isapres industry is composed by 6 competing companies which offer health insurance plans priced according to risk of diseases, age and other factors[4].

3. The resources for the public system are managed by "FONASA"[5]. During the first years of the mixed system, FONASA also played the role of regulator of Isapres. FONASA stopped playing these dual functions when a Regulator for Isapres was created in 1990. The latter was replaced in 2005 by a Health Regulator (*Superintendencia de Salud*) whose powers extend not only to supervise Isapres and Fonasa but also to legal duties with respect to direct suppliers of health services such as public hospitals and private health centers[6] [7].

4. In the segment of suppliers of health services the described trend towards privatization and market reform has resulted into significant private investment in private health centers during the last 30 years.

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1 Independent workers or people out of work are not obliged by law to have a health insurance neither in the public nor in the private systems, i.e. they have the option to pay directly to the providers, for the health assistance they need. Conversely, dependent workers should pay monthly at least a 7% of their gross income for health coverage purposes, whether to Fonasa or to an Isapre.

2 For lower income workers the public system grants better benefits and coverage than the private system at the same price.

3 Acronym for "*Instituciones de Salud Previsional*"

4 An accusation of collusion against 5 of the 6 existing Isapres motivated a proceeding before Competition Authorities in 2007, but the case was dismissed in a divided ruling by the Competition Tribunal first and then by the Supreme Court. See a summary of the case in the Appendix.

5 Acronym for *"Fondo Nacional de Salud"*

6 Those described as public and private systems are the main but not the only systems for health services available in Chile. In addition, several 'closed' Isapres offer insurance plans to employees of specific companies, either public or privately owned. Further, armed forces and the police have their own health systems. According to a government survey, in 2009, 78,8% of people were affiliated to Fonasa, 13,1% to Isapres and 6,3% to other systems and uninsured. Less than 2% did not know or did not answer. Available on-line at: http://www.ministeriodesarrollosocial.gob.cl/casen/definiciones/salud.html
According to an OECD report, the total expenditure in Health for 2009 was a 8,4% of the GDP, where 3,9% was public expenditure and 4,5% was private. Available on-line at: http://www.isapre.cl/?cat=3

7 The Health Regulator is divided in two branches: A branch in charge of the insurers sector (Isapres and Fonasa) and another branch in charge of the health suppliers. The powers of the Health Regulator include (i) supervising, monitoring and controlling Isapres and ensuring compliance with their legal, regulatory and contractual duties; (ii) supervising, monitoring and controlling Fonasa in some specific issues; and, (iii) regulating all health providers, both public and private, with respect to their accreditation and certification, as well as ensuring compliance with standards specified by the accreditation.

5. Individuals affiliated to the public system, in order to receive health services, may attend the network of public providers (hospitals and health centers). In case of higher earnings, affiliates can opt for private health centers under a system called "free choice", within Fonasa[8] [9].

6. Individuals affiliated to the private system, according to their insurance plan receive a partial or full coverage for health services and may choose to be treated either by public or private health providers. However, there are asymmetries in the coverage of the Isapres' plans in the private and in the public sector which favors the use of private health suppliers. It is worth noting that Isapres form alliances with private hospitals and in several cases they are even vertically integrated with them.

7. Few cases in the health sector have called for the intervention of the Competition Authorities in the past; the most important ones are described in the Appendix. Fiscalía Nacional Económica (or "FNE) is the competition agency, administrative in nature, in charge of investigating cases and litigating them before the Competition Tribunal. The FNE has also powers in the field of competition advocacy. The Competition Tribunal (or "TDLC") is a judicial body with adjucative powers in the field of competition law. The TDLC may also issue non-binding recommendations of pro-competitive regulatory reforms.

8. Notwithstanding the relatively low number of competition law cases in the health sector, the FNE lead a team of consultants that carried out a market study on private providers of health services between 2008 and 2009. The health regulator provided comments and feedback on the study. Even though the research was limited to private providers, (i.e. competition between public and private health suppliers was not explored), this research provides useful insights for the purposes of this roundtable. Another market study in the health sector will be carried out for the FNE by external consultants, during 2012.

9. In the remaining part of this contribution we elaborate on the structure of relevant markets identified by the above mentioned market study and on the key factors of competition in these markets, according to the current institutions and framework for the health sector in Chile. Regulatory amendments in the health sector are briefly described in section VI.

2. Health Care Services suppliers: Relevant Markets

10. A market study in the sector of private providers of health services was carried out during 2008 and 2009, by the FNE with feedback and comments from the Health Regulator. Several reasons at that time led to concentrate the efforts of the research in the private sector. First, in a proceeding against five private health insurers in 2007, the TDLC held that for consumers earning above USD 800, there was a low degree of substitution between private and public providers[10]. Second, previous researches conducted by the Health Regulator found that providers of the public system do not compete among themselves, because patients should attend the public provider corresponding to his geographic area. In addition,

8 In the last few years new mechanisms allowing public system affiliates to receive health services provided by private suppliers, have been implemented. For instance, this is the case of the "Bono AUGE", a kind of voucher that consumers of public hospitals may use before private suppliers when public suppliers' services are unsatisfactory or untimely.

9 Affiliates to the public system are divided in four groups: A, B, C and D. A and B, i.e. the poorer, receive health services for free (i.e., without paying a deductible) from public suppliers. B, C and D may receive services from private suppliers under the "free choice" system. However, for B affiliates, attending private health suppliers is costly, and in the case of C and D the deductibles they must pay to the private providers are significantly higher than the one they must pay to the public supplier. Thus, the budgetary restrictions and price incentives of the public system lead affiliates to request health services from the available public suppliers.

10 TDLC, July 17th, 2007, Ruling No 57/2007, Rc. 53°.

Isapres' affiliates attending public providers are very few and the same is true for Fonasa affiliates attending private providers. Besides, a very small proportion of the population is uninsured. Hence, most people have access to health services whether through Isapres or Fonasa. Thus, the system of insurance was crucial for determining the health suppliers available. All these reasons led to focus on private providers of health services which offer the most extended segments where competition takes place.

11. Research activities for elaborating the market study used a mix of qualitative and quantitative techniques aimed at collecting different and complementary information[11] [12].

12. The final purpose of the determination of relevant markets was then to identify the private suppliers of health services considered as substitutes by consumers.

2.1. Product relevant market

13. From the point of view of the product, relevant markets consider health services providers. This broad definition includes by and large ambulatory health care consultations (treatments, diagnosis or interventions) as well as non-ambulatory interventions (i.e. hospitalizations), and hence on the supply-side consider medical practices, joint practices, general health centers, laboratories, specialized health centers, private hospitals, public hospitals, etc.

14. As a matter of definition, an outcome of the study revealed that Isapres' consumers commonly associate the concept of health services with services in the health sector in which they trust as a mean for solving their health problems.

15. Due to similarities in proceedings and techniques used, health services can be grouped in three 'fields:

- **Health care consultations**: including general consultations, consultations of medical specialties and medical urgent care;
- **Hospitalizations**: in-patient treatment;
- **Medical tests**: tests performed by laboratories, including blood tests, images, X-rays, etc. aimed at diagnosis;

16. Within each of these fields specific health care services may be grouped:

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[11] Considering the low levels of information available when this market study was initiated, the use of the SSNIP test was not feasible. So, research purposes were oriented towards identifying consumers' evaluating criteria when choosing a provider. This research strategy allowed identifying relevant competitive variables.

[12] On the one hand, research activities aimed at developing an understanding of consumers' underlying motives driving the selection of a health services supplier (taking into account consumer's age, family life cycle, and socioeconomic group) and, on the other hand, on the basis of expressed preferences of a statistically significant sample, research activities aimed at identifying effective substitution among different private suppliers of health services, for different categories of relevant medical services.

Fields	Specific health care services
Health care consultations	General consultations Specialties consultations Urgency consultation Clinical psychologist consultation Psychiatric treatments
Hospitalizations	Surgeries Services associated with giving birth Beds rental Inputs and other chirurgical materials
Medical tests	Echotomography X-rays

17. The decision process for choosing a certain health supplier is driven by different values associated with the service and the supplier. Evaluations and expectations of users include rational and emotional aspects.

18. On the rational side, the alternatives opened to users depend on the agreed contract with the Isapre. Thus, if the affiliate is facing a brief treatment and/or a diagnosis that does not derivate complications or the service is considered mere routine, the determinant variables driving affiliates in choosing a supplier are linked to costs (measured as the amount of the complementary fee paid by the consumer –the deductible, or as the time used by the consumer in the service supplying, or as the availability of other facilities such as parking space).

19. Emotional aspects appear in more complex health services including interventions having higher risk of death, and those services needing higher levels of doctor-patient trust, such as those provided in the medical branches of gynecology and pediatrics. The selection of a supplier in these cases is oriented to the best provider available according to consumer's budget.

20. Thus, the decision about a health services provider depends on expectations and budgetary restrictions, which are reflected in the coverage of each individual health insurance plan.

21. As a consequence, on a provider level, determining the substitutes depends on alternative insurance plans provided by each Isapre and the Isapres' alliances with health services providers. Besides, since Isapres' insurance plans have been designed on the basis of different income levels of consumers, substitution among health services suppliers will be strongly segmented according to socioeconomic features of the corresponding group of consumers.

2.2. Geographic relevant market

22. A relevant market extends geographically until the point where a specific supplier has no more substitutes from the point of view of consumers, able to discipline non-transitory increases in prices by the first supplier. In case of health services markets, geographic elements of relevant markets are linked to the influence area of the supplier.

23. The influence area may be considered as a function of the maximum duration a consumer is willing to accept for displacement to an alternative supplier.

24. The research revealed that willingness for displacement depends on the expected seriousness of the illness or expected complexity of the intervention. Thus, in case of expected simple health services or

light illness or general treatment, the duration of displacement variable is determinant and the patients are likely to prefer to receive the services by the provider most nearly located. Conversely, in case of expected complex health services or serious illness, as well as in case of diseases that last for long periods, the duration of displacement becomes a less relevant variable, since patients tend to be more interested in receiving care by the best or most specialized health provider and hence are willing to travel even to another city.

25. The elements appearing relevant for the purposes of product and geographic market definition led to the conclusion that using the methodology known as 'brand/price trade off analysis' (BPTO) could bring more accurate outcomes than the SSNIP test. According to BPTO, cross-elasticity is calculated by identifying hypothetically the consumers' maximum willingness to pay when a limited number of suppliers are compared, instead of identifying cross-elasticity by the actual data of consumers' reactions when facing small but significant non-transitory increases in price[13].

3. Key factors for competition in health care services: conditions for and repercussions of price or quality competition

26. As mentioned in the above section, it seems that objective aspects such as price or quality could not be clearly and directly identified as the only driving factors of competition in health services sector. These variables may be prevalent in some simpler health services, but in more complex services, subjective or emotional factors appear to influence decision making.

27. In addition, the system of insurance (public or private) and the features of the plan are key factors in the identification of the 'available providers'[14]. In the case of medical tests and simpler health care consultations, variables associated with costs (cost of deductible, expediency in service, location, facilities, etc.) seem to be determinant. In the case of hospitalizations and health care consultations that may trigger subsequent interventions, other, more subjective factors are usually more relevant.

28. The consumer's decision depends on his expectations triggered by his illness. Indeed, very often, services belonging to different 'fields' need to be combined. For instance, a medical consultation might trigger a hospitalization (e.g. a pregnant woman consults a gynecologists but gives birth in hospitalization); and medical consultations are also linked to medical tests since the latter contribute to diagnosis, a chain that may also involve hospitalization. The need of these combinations is part of the consumers' expectations defined ex-ante on the basis of the likelihood of complexity of the health care needed[15]. These linkages should be considered when defining markets.

29. As an industry reaction to these circumstances, major developments of integral suppliers (i.e. suppliers providing health services belonging to the different 'universes' mentioned above) have taken

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13 The BPTO methodology was used in an actual case where a private health care center was accused of tying the rental of facilities for giving birth with the professional team in charge of providing health care services in giving birth. The accusation was dismissed by the FNE because the facts neither satisfied the legal standards of tying nor of refusal to deal. Besides, bundling facilities with professional health care services associated efficiencies, particularly those related with risks mitigation. Using BPTO methodology allowed concluding that 75% of ISAPRES's affiliates were not sensitive to price increases, so this segment of consumers was locked-in and similar providers were not able to discipline it. The decision ordering to file this case is available here: http://www.fne.gob.cl/wp-content/uploads/2011/05/arch_0052_2010.pdf

14 Alternative providers do often exist but they do not appear convenient for the consumer due to the higher costs of the deductible.

15 E.g. "If I have the flu I'd attend to this supplier whereas if I have a pain on my breast I'd attend to this other one".

place. Regarding incentives in the case of integral suppliers, loyalty strategies are frequently used. For instance, these private health centers develop a 'complementary insurance' or 'scholarly insurances' for children. These strategies may reduce costs for service users once they face the need of health care services but at the same time increase the likelihood of getting locked-in to the corresponding health care center.

30. Thus, according to the report the most important variables for defining relevant markets and for evaluating competition are the following:

- Isapre's insurance plan held by the consumer, particularly, in case of lower income consumers[16];
- Consumer's expectations about the complexity of his illness;

31. So, price and quality variables of competition are reflected indirectly through the above mentioned variables. In what follows some specific factors on the demand side and the supply side are identified.

4. Relevant demand side factors in health care services

32. The market study revealed that according to consumers' perceptions, features of best medical suppliers include:

a) Reputation on the basis of objective data (e.g. acquisition of advanced equipment and technology);

b) Affiliations with universities or recognized national or international centers;

c) Experience and good references (e.g. successful interventions) and absence of negative ones;

d) General facilities (e.g. parking);

e) Profile of average user (i.e. attendance by higher income users turns into a perception of quality about the services provided);

f) Prices are considered as a proxy of quality and facilities: the higher the prices, the better the quality and facilities perceived.

5. Relevant supply side factors in health care services

33. The health service providers' industry in Chile has experienced several changes since privatization started thirty years ago. On the basis of interviews with main players in the private health sector, today's industry structure in health services is the outcome of changes in the health insurance sector. According to interviewees, when analyzing the supply side it seems useful to consider distinctions between ambulatory and hospitalization services, between simple and complex interventions, and different capital intensity of services provided.

34. As to medical consultations, for instance, in the eighties these services used to be provided by isolated doctor practices spread along the cities, but since the mid nineties, a model of consolidated

[16] Indeed, the research revealed that in the case of lower income consumers, they choose the insurance plan first and only thereafter they define the health supplier. In case of higher income consumers, they choose the supplier first (the clinic, hospital or health facility) and only thereafter they define the insurance plan more convenient for the already chosen suppliers.

ambulatory health care centers concentrated the supply providing consultations for different specializations in the same building. At the same time, these centers included medical test services achieving economies of scale and scope and costs reductions and time savings for patients. Today this structure is quite similar to a one-stop-shop: in most cases it is not even necessary to go to the Isapre since these centers include offices or online insurer facilities were patients can ask questions about coverage and pay deductibles.

35. Another common feature of these private health centers is that they provide a wide range of specialties. Conversely, specialized health centers have not proliferated and seem successful only in some areas such as ophthalmology and cosmetic medicine.

36. Even though some integral suppliers have been able to include hospitalizations and complex interventions into the packet composed by ambulatory services and medical tests, these are most commonly provided by more sophisticated suppliers in a segment of the industry having different features. Indeed it is traditionally considered as a segment with less output (available places for hospitalization) and with higher levels of concentration.

37. Vertical integration between Isapres and health care centers is another principal characteristic of the industry. Most Isapres own shares of private health centers though the opposite is forbidden by law (health centers owning an Isapre).

38. Entry barriers were not clearly identified by the research. Some sources identified overcapacity as a possible entry deterrent in some health care services but additional inquires would have to be done in order to test this hypothesis. Reputation was another factor identified by sources as a significant condition that may delay expedient entry, but this factor is also present in other industries.

6. Institutional and regulatory pro-competitive reform in health care services

39. Incorporating a private insurance model as a mechanism for financing health services was a significant change for the health sector in Chile. Even though not exempted from criticism, the private health system has triggered significant private investments in facilities for supplying health care services in the last 30 years[17].

40. The Isapres have been criticized for the absence of transparency and extreme heterogeneity of the plans they offer, which turns into a significant obstacle when comparing services. Remedies such as imposing a homogenization of insurance plans and limiting the number of alternatives available in the market as well as creating an on-line automatic comparative calculator of health services prices (deductibles) have been proposed in the past in order to solve these problems.

41. Another important criticism has been the lack of transparency in the methodologies Isapres use when increasing insurance prices. Subsequent law amendments have tried to reduce the Isapres' discretion in this process and to introduce an equity pillar in order to protect the more 'expensive' or riskier affiliates[18]. However, these regulatory solutions have not ended dissatisfaction and interventions from the judiciary power have been increasingly requested since 2010[19].

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17 An illustration of this as a remaining trend in 2005 may be found here: http://businesschile.cl/es/noticia/reportaje-principal/el-vigoroso-crecimiento-de-las-clinicas-privadas-en-chile

18 At the beginning of the system, the tariffs of the plans were the result of a base price multiplied by a risk factor grounded on sex and age. But plans informed just the final tariff and not the factors grounding its calculation. Act N. 19.381/1995 introduced the obligation to maintain the same relation of prices by age and sex established by the original contract. The purpose was to protect older affiliates and to introduce an

42. This situation led the government in December 2011 to submit a bill before the Congress aimed at introducing significant reforms in the private health care system. The major amendments included in this bill consider the duty of each Isapre of supplying a Basic and Standard Health Insurance Plan (*Plan Garantizado de Salud* or *PGS*) with a flat tariff (i.e. without weighting age, sex, or individual health condition) defined by each Isapre and available to every affiliated member. Isapres will be able to offer complementary benefits over this standard. In addition, mechanisms ensuring objectivity in PGSs' price increases would be introduced such as the calculation of statistical indicators of variations in health services prices, of variations in the frequency of use of health services and of variations in the expenditure for disability benefits. These reforms will be complemented by the work of an expert group in charge of calculating annually indexes of variation on the basis of the above indicators.

43. These suggested amendments aim at introducing more competition and transparency into the system. If passed, they will change relevant elements of the framework under which the private health sector has developed, so some changes in the industry may be expected in the future.

equity element into the system. However, different charts of factors designed by each Isapre made difficult for consumers to compare alternative plans. Thus, Act N. 20.015/2005 regulated the mechanism for determining tariffs of health insurance plans: tariffs are now determined by multiplying a base price by the risk factor of the corresponding affiliate according to a chart of factors designed by the Isapre. Each plan may be associated with only one chart of factors and each Isapre may have a maximum of two charts of factors in total. These amendments aimed at designing a mechanism of limited variability of the tariffs of the plans along the life cycle of affiliates, a mechanism predictable for consumers at the time of subscribing the plan.

[19] One of the major decisions was issued by the Constitutional Tribunal. In August 2010 (file number 1.710), this Tribunal held that several recitals of a section of an Act regulating the structure of the chart of factors, were contrary to the Constitution, violating the constitutional rights to health protection and social security. In addition, a huge number of increases in Isapres' plans tariffs have been declined by Court of Appeals and the Supreme Court on the grounds of absence of justification for these increases. This has created a significant judicial workload for the industry, since it is relatively easy for affiliates to obtain judicial representation for challenging these increases.

APPENDIX: MAIN COMPETITION LAW ENFORCEMENT CASES IN THE HEALTH SECTOR

ISAPRES CASE

1. In 2005, the FNE submitted charges against the major private health insurance companies (ISAPREs), accusing them of colluding for reducing the percentage of coverage of the benefits of their marketed health plans, harming their affiliates. Until May 2002 plans offering 100-80 coverage (i.e. 100% coverage in hospitalizations and 80% in ambulatory services) represented 96,7% of Isapres' sold plans. From May 2002 onwards until 2004 after a serial of constant reductions by each defendant Isapre, 100-80 coverage plans became only a 7,5% of the sold plans whereas 90-70 plans reached a 90,6% of the total selling. In addition to these changes in the available plans offered in the market, increases in Isapres' benefits were identified.

2. However, the FNE's case did not succeed due to insufficient evidence for satisfying the standard of proof of the existence of an agreement[1]. Notwithstanding the dismissal, the TDLC endorsed the FNE's position that information flows regarding the companies' sales teams and periodical reports about the insurers and their insurance plans disclosed by the sector regulator, were an expeditious information channel leading to parallel conduct.

[1] TDLC, Ruling No 57/2007. Spanish text available at: http://www.tdlc.cl/Portal.Base/Web/VerContenido.aspx?ID=794&GUID=