

# Competition Policy for Health Care Provision in Portugal

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## Abstract

Country experiences can highlight the role of competition among healthcare providers and of competition policy in delivering a better allocation of resources. We review the role of competition among healthcare providers in Portugal, a country that has a public National Health Service at the core of the health system. There is little competition among healthcare providers within the NHS. The role of “competition for the market” is more relevant than “competition in the market”, due to the use of tendering procedures. Details in the particular design in each case of “competition for the market” matter a lot. Within the National Health Service (NHS), competition among primary care providers is hindered by excess demand (many residents in Portugal do not have a designated family doctor). Competition among NHS hospitals has been traditionally limited to cases of maximum guaranteed waiting time for surgery being exceeded. The Portuguese Competition Authority enforces competition law. It has focused on mergers between private hospitals and abuse of market power (including cartel cases) by private healthcare providers. The Healthcare Regulation Authority produced several reports on particular areas of activity by private healthcare providers. The main conclusion of these reviews was lack of conditions for effective competition, with the exception of dentistry. Overall, the scope for competition policy and for competition among healthcare providers to have a main role in a health system based on a public National Health Service seems limited, with more relevance to “competition for the market” situations than to “competition in the market”.

Keywords: hospitals; general practitioners; competition policy; Portugal; competition for the market;

## 1. Introduction

The Portuguese healthcare system has at its core the National Health Service (NHS), created in 1979. In 2015 health expenditure per capita in Portugal was €1.967 (for the

EU28, health expenditure per capita is €2.781). Portugal's health care expenditure as share of GDP stands at 8,9% which is below the EU28 average of 9,9% (OECD/EU, 2016). The design of the National Health Service limits the development of competition between healthcare providers, as in many other countries with a similar option. When the NHS was created there were already in place private providers, mostly individual and small-office medical practices, and profession-based health insurance schemes (Barros et al., 2011, provide more details). The evolution of the private sector, more prone to existence of competition, occurred in non-medical services (laboratorial and imaging tests, small clinics, etc.).

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

## 2. Institutional set-up

This section provides a brief snapshot of the Portuguese health system. Further details can be found in Barros et al. (2011) and Oliveira and Pinto (2005), among others. The Portuguese National Health Service covers 58,4% of total funding for health in Portugal and other Government funding covers an additional 8,1% of total funding.<sup>1</sup> The other Government funding includes tax benefits for private health care expenditures (2,97%), social security funds (1,17%), and civil servants and armed forces health insurance coverage provided in addition to the NHS (3,98%). Out-of-pocket payments from households account for 27% of total funding. The remaining private funding includes voluntary health insurance (3,5%), private health subsystems (1,8%), non-profit social institutions (0,04%) and other corporate funding (0,85%). A considerable proportion of

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<sup>1</sup> All values computed using the National Health Accounts by Statistics Portugal (2016) which are publicly available.

out-of-pocket results from copayments required by the NHS, namely in pharmaceutical products and exams performed by private providers who are contracted by the NHS. Pharmaceutical copayments are the major out-of-pocket expenditure, especially for lower income families.

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

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

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

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

Primary healthcare in Portugal is organized mainly within the National Health Service.

The NHS has three different models of group practices: traditional primary care centres

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

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

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<sup>2</sup> Further details about recent evolution in primary care in Portugal can be found in Barros et al. (2015).

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

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

### **3. Review of competition policies**

There are no systematic and specific studies in competition and its effects on the Portuguese health system. As such, the review reported in this section is based on the few works that contribute to our knowledge on this matter, covering both published scientific articles and “grey” literature. On the discussion of the role of competition in

health systems, the interested reader is referred to Barros et al. (2016) and the references therein. Competition is an instrument available to authorities and it is unlikely to achieve simultaneously all objectives that health systems have. The impact of competition is context-dependent, making it worthwhile to review country experiences as a learning process.

### **3.1 Competition policy in Portugal**

The Competition Authority, a body independent from Government, enforces competition policy. Portuguese Competition Law closely follows European Union Competition Law. The Competition Authority has jurisdiction over all areas of economic activity, including the healthcare sector, and covers restrictive practices and merger control. The jurisdiction of the Competition Authority includes mergers that involve private hospitals but mergers among NHS hospitals are excluded from scrutiny. Mergers and creation of hospital centres (or creation of Local Health Units) within the NHS are seen as administrative acts and do not trigger a review by the Competition Authority. This is because there is no change in the agent that exerts economic control of their activity. For sectors in which a specific regulator exists, the regulator is consulted before a decision is made. Accordingly, the Portuguese Healthcare Regulation Authority must produce an opinion (non-binding) on notified mergers and acquisitions.<sup>3</sup>

### **3.2 Competition in the market**

To assess the role of competition in the Portuguese health system, it is helpful to make a distinction between the scope for competition inside the National Health Service, which provides most of the primary care and hospital services, and competition in the private

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<sup>3</sup> The Portuguese Competition Law (Law No 19/2012 of 8 May) is available from the web site of the Portuguese Competition Authority (<http://www.concorrência.pt>).

sector, either on primary care or hospital services, which takes place for patients that are paying out of pocket or have health insurance double coverage.

The discussion is organized by type of care. We consider first competition for the first contact by the patient (when he/she feels ill). Then, we address in turn competition among primary health care providers, competition between hospitals, competition in long-term care and, finally, other healthcare services.

### **3.2.1. Competition in the market: patients' first contact**

At the first contact with the health system by a patient feeling ill, there is a choice between several services available: the NHS call line, primary care services in the public sector, individual or small medical practices in the private sector (which includes both GPs and other specialists), private hospital services, and public hospital (emergency) services. They all compete for this initial contact. NHS providers have regulated prices to patients (user charges) and regulated opening hours. The global budgets allocated to each NHS units have little or no impact from patients' choices.<sup>4</sup>

Private health care providers can set their prices and opening hours. Patients when deciding the first contact with a healthcare provider face several trade offs: higher price and faster access in the private sector relative to the NHS is the most obvious one but also the trade off between the ability to do all exams (laboratory and/or imaging) in one single place versus going to several places. NHS hospitals are more likely to offer a faster "one-stop shop" than other providers. Private providers may compete for patients that have health insurance covering use of private healthcare facilities by providing faster access. Patients' choices over the years show that some scope for competition exists, even if NHS providers do not have the freedom to set key elements and often do not

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<sup>4</sup> See ACSS (2016a, 2016b) for details on the financing mechanisms of NHS hospitals and primary care units.

have any budget gain from serving more patients.

Within the public sector, from 2013 to 2015 there was an increase in scheduled visits at primary care and a decrease in the use of emergency services of the NHS (Barros et al., 2015). In the private sector there was an increase in the use of private hospital unscheduled and emergency services, with a decrease in the individual (or small) private practices. Choices of patients within each sector have apparently changed, with mainly intra-sector changes and not by inter-sector competition (Barros et al, 2015). The opening of large private hospitals in the main cities allowed large private providers to grow at the cost of traditional (small) independent medical practices. The main instruments behind this shift were both reputation building regarding quality and the role of double coverage health insurance (which contracted favourable copayments for their beneficiaries selecting large private providers). Thus, competition in the market between private healthcare providers did exist. However, its relevance at the system level is not large as the funding flows associated with it in the Portuguese health system are small, as presented in the previous section.

### **3.2.2 Competition in primary care services**

In primary care provided by the NHS there is no price competition, as patients pay user charges set by the Government. User charges are equal across regions and types of primary care units. The services provided by primary care units are regulated. Competition occurs through quality of service provided, which includes quality of facilities, scheduling systems, and patient experience. Incentives to attract new patients are low, as there is excess demand for GPs, and GPs who are working at full capacity to their list cannot take on more patients. Incentives are explicitly used in the USF-B model, allowing for higher remuneration to GPs through meeting quality targets. Thus, there is no competition in market for primary care services provided by the NHS.

### 3.2.3 Competition in hospital services

NHS hospitals have well-defined regional catchment areas (local monopoly). As catchment areas are defined by place of residence, patients who wish to choose a different hospital may declare a false residential address corresponding to their choice, or ask for a referral from the hospital of their area or from their GP. The magnitude of this informal choice by patients/competition is not known.<sup>5</sup> In May 2016 the Ministry of Health introduced an element of patient choice. Doctors, together with patients, may choose hospitals for elective procedures more freely. There is still no explicit competition associated with these choices, as the patients' flows do not yet lead to financial flows. It may, nonetheless, be a starting point for competition in the market between NHS hospitals.

Competition amongst NHS hospitals works through hiring health professionals that bring clinical reputation to the hospital and development of specific medical specialties (usually determined by the interests and specialization of existing doctors).

For certain elective procedures the possibility exists of choosing a different hospital for surgical intervention when waiting time exceeds a pre-determined value. NHS hospitals compete to attract this demand, which brings extra payment to the team and the hospital. Since 2012, the origin hospitals pay for the patients that have surgery in another accredited hospital (public or private) under transfers due to excessive waiting time. This allows for some, limited, competition in the market among hospitals, based on waiting times for elective surgery.

The creation of Public Private Partnerships (PPP) for the construction of new hospitals in the first half of the 2000s and the emerging role of private corporations in managing large hospitals provided increased competition both among health insurance companies

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<sup>5</sup> There is anecdotal evidence reported in newspapers and low response rates in surveys mailed to patients' have been attributed to this issue.

(to add these hospitals to their networks of providers) and for private patients. In major urban centres, the private hospitals compete with NHS hospitals for patients (elective procedures and non-scheduled visits).

The hospitals managed by private entities under PPP contracts are part of the NHS, as they are similar to any other NHS hospital from the patients' perspective. Competition takes place only for the PPP contract. Given the requirements to be admitted to the PPP contests, only large economic groups involved in health care provision stand a chance of competing. As it will be detailed below, a competitive stance seems to have prevailed among contestants. The PPP contracts open the possibility of competition for the market, which will be discussed in more detail below.

Private hospitals compete mainly in two ways. Firstly, they compete on price and quality of services to win contracts with insurance companies or with health subsystems. Secondly, private hospitals compete to attract patients covered by private voluntary health insurance or health subsystems, using as competition instruments perceived clinical quality and availability of services, as health insurance coverage takes price competition to the contract stage.

Some indirect evidence on the role of price competition driven by private for-profit hospitals emerged during the years 2012-2014. The increase of user charges in NHS hospitals in 2012 led the beneficiaries of the ADSE public health subsystem to attend private hospitals as the associated copayment was smaller than the user charge prevailing in the NHS hospitals. Private hospitals directed their advertising strategies to ADSE beneficiaries, competing with NHS hospitals for these patients. ADSE patients were sensitive to the price competition element, and in the major urban areas redirected their demand towards private hospitals (Midões et al, 2015).

### 3.2.4 Competition in long-term care services

Long-term care services are part of the national network of continued care, which has NHS units and contracts with private entities, both for-profit and non-profit. These are mainly nursing homes or recovery facilities. The role of organizations that help people with long-term care conditions at home is negligible. Many of the non-profit organizations involved in long-term care are associated with local faith-based charities, which have a long tradition of caring for the elderly in Portugal. There is a shortage of long-term care beds, so there is not much competition (existing supply of facilities is below demand). Payment for services provided to the long-term care network is the responsibility of the NHS, in some cases shared with the Ministry of Social Affairs. There is a grey area of cases with respect to who has the payment responsibility. Competition aspects are not regarded as part of the design of the long-term care network.<sup>6</sup> Licensing requirements and authorizations play a much larger role. These licensing requirements are equally applicable to public and private providers, but less explicitly enforced in the case of public providers.

### 3.2.5 Laboratories, imaging and other health services

Competition exists when the NHS buys services such as laboratory tests and imaging services from external private providers. Historically, many of these services are provided through an 'any-willing-provider' contract model. As long as the provider meets the requirements of the National Health Service, a service contract is signed, with no quantity volume set. This means that competition in the market should be present for these services.

A particular service in which competition between private providers developed is dental care, which is mostly privately provided and paid mainly out-of-pocket. The market

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<sup>6</sup> Competition among providers or market mechanisms are not mentioned in the Strategic Plan for the long-term care network, see MH/MESSS (2016).

structure is generally unconcentrated at the regional level, with a large number of providers present in the market, and competition among providers apparently takes place.

Small private sector healthcare providers compete in the market, usually by location and service quality (including scheduling convenience for patients). This has considerable geographical variations. The existence of public sector capacity, often more expensive than the private sector provision and underused, creates a natural limit on market power in regions with a small number of private providers.

### **3.2.6 The role of price-discount cards**

In recent years, demand aggregation services have been introduced. By subscribing to a specific card plan, a citizen pays a fixed amount and enjoys a price discount when selecting a provider that has joined the supply side of the plan. These plans are closer to discount cards than to health insurance. They involve mainly services (provided by medical doctors and nurses), ranging from home visits to laboratory analyses, annual check-ups and second opinions. These card plans promote competition in the market between private healthcare providers.

## **3.3 Competition for the market**

### **3.3.1 Public-private partnerships**

The first wave of Public Private Partnerships (PPP) for hospitals in the Portuguese health system appeared in 2002, including replacement of old facilities and opening hospitals in new locations. A main feature was including clinical services in the scope of the PPP, in addition to infrastructure services. Each PPP involves two contracts of different length. One contract relates to building, operating and maintaining the infrastructure and lasts 30 years. The second contract is for 10 years, with the possibility of renewal, and pays

for clinical services management.<sup>7</sup>

The role of competition for the market was present in the bidding process to select the private partner in the PPP contracts. The procedure involved a first phase with sealed bids, and a second phase between the two best bidders for a best-and-final-offer. This second stage led to better proposals, with one case of position reversal (the second best bidder in the first phase outbid the other candidate in the second phase, and won).

A general perception is that success in attracting bidders was largely associated with the model adopted, with inclusion of both infrastructure and clinical services management. The annual costs of running clinical activities can be approximately four to five times the annual costs of building and maintaining the infrastructure (Gouveia and Raposo, 2012). The possibilities to innovate and achieve savings and better quality of care are greater when the PPP manages clinical services.

Bundling clinical services and infrastructure into the PPP provides the scope for competition between bidders to result in lower prices of services provided. Quality of care is controlled by a large array of indicators set in the contract. The application of fines according to such indicators in the early years of the PPP contracts created credibility of the public sector sticking to the contract. It also helps that reputation concerns on the private side, as holders of the PPP contracts have more activities in the Portuguese health sector, are a likely deterrent of opportunistic behaviour.

The main lessons from the PPP experience, as competition for the market, are a) the existence of a learning curve to establish a PPP and the technical expertise required within the public sector to manage the process; b) the importance of attracting several interested parties to the tendering procedure; and c) the need to monitor the PPP once

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<sup>7</sup> See ERS (2016), Simões (2004), Simões et al. (2009), Tribunal de Contas (2009, 2013, 2014), among others, on the experience of Portuguese PPP.

the contract has started, which requires consistent attention from the public sector.

### **3.3.2 Procurement for health care services**

The use of tendering procedures by the NHS to create competition for the market is more recent (started in 2011), with a specific body of the Ministry of Health in charge of developing electronic platforms (or to contract out such platforms) for bidding to take place. Examples of tendering include pharmaceuticals and consumables to hospital production.

### **3.3.3 An experiment that went wrong**

Some hospitals sought to create competition for the market by allowing private pharmacies to serve the general public on their premises. A poor design of the procedures allowed for unrealistic bids to win contracts. The winning bids involved payments to the host hospital on sales of prescription-only pharmaceuticals that were larger than the margin the latter would receive in sales. Such contracts ultimately revealed themselves as business disasters, leading to bankruptcy and closure of these pharmacies.

## **3.4 Competition and healthcare in Portugal: what do we know?**

### **3.4.1 Reports by the Portuguese Healthcare Regulation Authority**

There have been reports from the Portuguese Healthcare Regulation Authority (ERS) over the years regarding the conditions required for competition to function in several services (ERS 2008, 2009a, 2009b, 2011, 2012, 2013a, 2013b). Market concentration measures were calculated at regional level and reviewed alongside price and quality information when available (or collected by the ERS). According to the ERS, competition may arise for imaging (X-ray, ultrasound, CAT, MRI, etc.), cardiology, gynaecology /obstetrics, laboratory tests, radiotherapy, rehabilitation medicine and radiology only in the three major urban centres (Lisbon, Oporto, and Coimbra). Other areas do not have

enough providers for competition to be effective. Dialysis services are highly concentrated, with two major companies being dominant (CEGEA 2007). Competition amongst healthcare providers, in general, does not seem strong in this group of services. Quality assessments performed through collection of indicators and/or audits by the ERS show, in general and across services, that quality is above the minimum standard levels set by regulation.

Provision of dental care services is substantially different from the other markets (ERS 2009c). There is much lower concentration than in other services and this has decreased over time. Pricing seems to have followed production costs (as one would expect in a market with effective competition). On other effects, clinical practice is seen to differ according to the payer and the price of each procedure in the price list agreed with each payer, showing that dental care providers react to the price incentives they face.

#### **3.4.2 The role of the Competition Authority**

Several decisions regarding mergers among health care providers were taken by the Competition Authority over the years. These decisions relate to acquisitions of small hospitals by large economic groups. The recent acquisitions were of small units located in medium-sized cities. The competition authority defined, in the sense required for application of competition law, both downstream (regional provision of healthcare services) and upstream markets (health insurance and workplace accident insurance). The relevant geographical market was typically defined as regional markets, instead of a single national market. Mergers of private hospitals located in different regions, which are different markets as they serve distinct populations, have no impact of market concentration. As such, these mergers did not raise concerns of reduced competition.

Traditionally, the Portuguese Medical Association had reference prices for services, which precluded competition between individual (or small) medical practices. The

Competition Authority challenged this practice. Similar interventions by the Portuguese Competition Authority took place relative to Deontological Code dispositions of the Portuguese Psychologists Association (November 2016) and of the Portuguese Dental Association (June 2005).<sup>8</sup>

Since the creation of the National Health Service, competition policy has never been an instrument explicitly used to improve performance in the healthcare sector. Prospective payment and NHS internal contracting have been the dominant policy instruments since 2000. Contracting is done within the NHS, to establish targets and funding for healthcare units (hospitals and primary care). There is no competitive element in the choice of provider.

Audit mechanisms, in particular fraud detection, have gained momentum under the Government of the 2011-2015 period. It is expected that mechanisms put in place will remain active. Quality regulation is actively pursued by several public agencies.

Competition Policy does not rank high in the political agenda in general. This is reflected in the relatively low level of competition in the Portuguese economy (Amador and Soares, 2013). In healthcare provision, planning by the Ministry of Health is often regarded as the main instrument to regulate the conduct of public and private providers, instead of decentralized decisions and competition policy.

The Portuguese Competition Authority reviewed one high profile case of collusion among providers of diabetes testing strips sold to NHS hospitals in 2005. Several major international companies were fined, and the leniency programme of the Portuguese Competition Authority was used to settle the case quickly. The leniency programme allows fine reductions to firms (undertakings) that bring forward enough information to

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<sup>8</sup> The Portuguese Competition Authority provides information on these decision on its web site (<http://www.concorrenca.pt>).

build and successfully conclude a case against market collusion by firms.

### **3.4.3 The role of health insurers in competition among healthcare providers**

Large private hospitals may reap the benefits of economies of scale and of scope (in cross-services like laboratory tests, imaging, etc.) leading to lower prices.<sup>9</sup> Pressure from insurance companies and health subsystems on private hospitals may also force prices down relative to prior levels. To our knowledge, there has been no systematic review of price changes in private healthcare provision in the last decade and whether, or not, these healthcare payers created significant competition amongst healthcare providers.<sup>10</sup>

### **3.4.4 Barriers to competition in the market among NHS healthcare units**

A major barrier to development of competition within the National Health Service is the (political) difficulty in closing down services. Although in principle the Ministry of Health can determine the closure of facilities (either hospital or primary care units) due to low quality of care, or replace failing hospitals' or primary care units' management, this has not been done. Closure of facilities usually faces strong public opposition even in the presence of evidence of likely quality improvements from that decision. Threat of closure is not part of the implicit or explicit incentives framework for performance in the NHS.

### **3.4.5 International competition and the EU Cross-Border Healthcare Directive**

As in other EU countries, the Cross-Border Healthcare Directive did not produce any change in competition (or of competitive pressure). Another door for competition through EU-wide action is the definition of European Reference Centres. This may create pressure on national healthcare providers to improve their performance in order to be part of these networks. Reference networks are likely to attract patients in highly

<sup>9</sup> The existence of such economies of scale and scope is documented in Gonçalves and Barros (2013).

<sup>10</sup> The information on Silva (2009), that reviews the role of voluntary private health insurance in Portugal, shows the role of the private economic groups involved in healthcare provision. Barros et al. (2015) document the change in use of private providers over the last years, with a decrease of individual practice and an increase of large private hospital use by patients.

specialized cases, involving low numbers of patients per specialty.<sup>11</sup>

### 3.5 Competition policy and public opinion

The Flash Eurobarometer 403, resulting from a survey in 2014, outlines the perceptions of citizens on competition policy. The Portuguese population views competition as an instrument to gain more consumer choice, with 90% of people in Portugal sharing this position. This is aligned with most other European countries. The Portuguese population identifies lower prices, more innovation and higher quality as benefits from competition. Portuguese citizens perceive the relative lack of competition in relation to health-related products and services (including pharmaceuticals) as less problematic than the lack of competition in other sectors. And they are also less concerned about competition in health care than most of the citizens in other European Union countries. The main concern from lack of competition across all sectors lies more with high prices, and less with low quality.

These general perceptions may differ when dealing with provision of healthcare. Based on informal and anecdotal evidence, at a more general level, public opinion seems to be in favour of patient choice, though at the same time is suspicious of competition, particularly between the public and the private sector. Privatization (of NHS healthcare provision units) is often seen negatively.<sup>12</sup> A major dividing line in discussions is whether the private sector should be supplementary to the public sector or compete with the NHS unit. Competition between private providers in services that are supplementary is often seen as good for patient choice. On the other hand, competition of private providers with the NHS units is considered to be harmful to the NHS.<sup>13</sup>

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<sup>11</sup> See for example Helena (2016).

<sup>12</sup> See Matos (2012) and Deloitte (2011).

<sup>13</sup> These views are based on the results of Lopes e Magalhães (2006) and Deloitte (2011).

Several barriers to competition driven by patient choice exist: scarce information comparing providers' performance, difficulties in sharing information about patients between public and private providers (electronic health data is in its infancy), and low scrutiny on prices and on value added of medical equipment (both small devices and "big-ticket" machines).

#### **4. Key lessons and policy implications**

The Portuguese health system has the (public) National Health Service as its backbone. The two main dimensions over which competition may take place between healthcare providers are price and quality. In the NHS healthcare provision, prices are regulated or determined administratively. Quality is subject to regulation and monitoring by Government agencies. Active competition amongst healthcare providers is limited to the private market. In most of the NHS there is no competition in the market, although some competition for the market is present.

For primary care, the excess demand for NHS primary care physicians precludes competition from actually taking place. It is quite unlikely that competition in primary care will be considered for a major policy initiative. The focus is on the promotion of a stable and long-term relationship between the general practitioner (GP) and the patient, which is contradictory to frequent changes of GP by patients. The possibility of an initial choice of GP, when moving place of residence, for example could be envisaged, but it is hard to consider in the current context in which GPs' patient lists are full.

Hospitals have well-defined catchment areas, which do not overlap and access to these services are largely defined by citizens' residence. For some elective procedures, some choice mediated by the medical specialist can exist, especially when referral to a different hospital for a highly specialised procedure is required. There is also choice

associated with place of elective surgery when a threshold for waiting time is exceeded. Legislation from May 2016 introduces elements of choice for elective procedures, exerted by joint decision of patients and their doctors.

On the other hand, private hospitals compete to contract with insurance companies and health subsystems, with an emphasis on price negotiations with third-party payers and the use of quality arguments to guide demand.

The development of centralized purchasing of products and services in the NHS introduces competition for the market, although more than one provider may actually co-exist for the same product and time period. The tendering procedures are used to create competition and bring prices down in services contracted by NHS units.

Health subsystems give more freedom to patients in the choice of provider. There is no evidence that such freedom produces better results, and it carries a moral hazard effect of more use of medical specialists (Barros et al, 2016).

Competition policy can, conceptually, influence health policies in two very different ways. The first is the design of health policies to incorporate competition policy principles. The second is the ex-post control of healthcare providers by the Competition Authority, as in any other economic sector. The experience of the Portuguese health system suggests that neither of these two forms of competition are important drivers.

The concept of patient choice is supported by several groups of the population but is not unanimously endorsed in political and policy circles. The full implications of patient choice are seldom explained, including closure of providers if not selected, contributing to a blurry picture of what its development would mean for the National Health Service.

The small size of (regional) markets cannot sustain a sufficiently large number of providers to bring substantial competition benefits in several services reviewed by the Portuguese Healthcare Regulation Authority. Only in dental care does the minimum

efficient size for providers appear to be sufficiently small to lead to an effective degree of competition.

From the Portuguese experience whenever good process design and ability to attract competitors was present, competition produced good performance. For other services, competition between private providers that operate on the fringes and gaps of the National Health Service do not seem to have produced significant results (no clear benefit in terms of lower prices, no cost in terms of lower quality).

Overall, the good examples for the role of competition are mostly associated with some form of “competition for the market”. In the case of tendering procedures, the “competition for the market” does not exclude “competition in the market”, as several providers are selected to contract with the National Health Service. In competition for the market, details in design have a strong impact, whereas competition in the market is harder to develop in the context of the NHS.

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