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English/French

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FOREWORD

This document comprises proceedings in the original languages of a Roundtable on Competition in the Health Sector: Enhancing Beneficial Competition in the Health Professions, which was held by Working Party N°2 of the Competition Committee in October 2004.

It is published under the responsibility of the Secretary General of the OECD to bring information on this topic to the attention of a wider audience.

This compilation is one of a series of publications entitled "Competition Policy Roundtables".

PRÉFACE

Ce document rassemble la documentation dans la langue d'origine dans laquelle elle a été soumise, relative à une table ronde sur la Concurrence et Réglementation dans le Secteur de la Santé: Les professions de santé et la concurrence qui s'est tenue en octobre 2004 dans le cadre du Groupe de Travail N°2 du Comité de la Concurrence.

Il est publié sous la responsabilité du Secrétaire général de l'OCDE, afin de porter à la connaissance d'un large public les éléments d'information qui ont été réunis à cette occasion.

Cette compilation fait partie de la série intitulée « Les tables rondes sur la politique de la concurrence ».

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EXECUTIVE SUMMARY

In light of the written submissions, the background note and the oral discussion, the following points emerge:

Health Care Professions and Competition

(1) Restrictions on entry into the health professions serve an important purpose of protecting consumers from unqualified health care practitioners. However, at times the actual restrictions go too far.

The need to protect consumers from charlatans has led to professional licensure in the health care professions, often endorsed in varying degrees by the government. The restrictions inherent in obtaining and maintaining professional licensure both serve as a means of ensuring quality of care and, at the same time, as a limit on competition. Evaluating the impact of apparently anti-competitive behavior in the health professions thus requires careful balancing: the existence of health professions and professional associations serves many beneficial purposes for patients. Nonetheless, at times the actions of health care practitioners, professional associations and even government regulations have effects that appear to be less related to enhancing quality for consumers than with ensuring high reimbursement for practitioners or limited choice for consumers.

Policy makers can change regulations and take enforcement actions to eliminate restrictions whose primary purpose appears to be anti-competitive. Such changes can generate substantial reductions in spending on care without substantial reductions in quality of care. As health care spending continues to be a major source of private and public spending among OECD Members, there is an increasing drive towards increasing the efficiency of health care delivery, to ensure that a nation's health care spending has the most beneficial effect. Various studies indicate that changed practices can result in savings, for specific types of care, on the order of 5-33%. These numbers are significant, given that the average OECD country spends about 8% of GDP on health care and that, were costs to be reduced by just 0.1% across the OECD as a result of improved treatment for the health professions, OECD health care payors would save USD 2.8 billion per year.

Not all forms of competition would be beneficial in the health care professions, so great care must be taken in weighing the costs and benefits of particular restrictions on competitive activity. Health care professions in which governments do not reimburse care are particularly prone to unduly restrictive rules, because governments do not have a direct stake in reducing the costs of such care. These liberalized health professions vary from one country to another, but often include audiologists, dentists, optometrists and pharmacists. Even in those professions that are directly reimbursed by government, however, increased consideration of competition may be beneficial at times.

Unrestricted free market outcomes in the health professions may not achieve the dual goals of broad health care coverage and limited spending, in large part because of (1) the consumption distorting effect of insurance (which leads consumers to seek care whose cost is lower than the value to them), (2) imperfect and incomplete consumer information because of the credence good nature of many aspects of health care and (3) externalities (notably of contagious disease).

Qualification, Quantity and Geographic Entry Limits

(2) The limits on entry to a profession govern the qualifications and skills of practitioners as well, sometimes, as the quantity and geographic locations of practices. These limits may, at times, be excessive, overly restricting competition and raising healthcare costs.

Professions have an incentive to require greater qualifications than are actually socially desirable, in order to ensure a scarce supply of practitioners (and a high earnings for practitioners.) Quantity limits are often established with co-operation of a health ministry, with a stated objective of ensuring that health care is provided to those with greatest need or in least-served areas. Geographic entry limits are particularly common for pharmacies, ostensibly to ensure that rural areas continue to receive good pharmacy coverage. Competition agencies have at times objected to the locational restrictions that exist.

In Italy, for example, the number of yearly positions for specialized training is set by government. In the UK and France, the number of national medical training places is set by the government. These restrictions are not unusual in the OECD. The restrictions are best justified when the government seeks to limit an excess supply of professionals who would provide low-value care, whether as a result of physician-induced demand or insurance-generated demand.

In contrast, when the profession itself seeks to limit the number of qualified practitioners, there is a significant likelihood that the consumers' best interests are not represented. For consumers who pay out-of-pocket for their care, as with dental care or optometrist care in many countries, the rationale for national quantity limits is questionable.

Rights of Para-Professionals and Alternative Professionals

(3) Para-professionals and alternative professionals are often unduly restricted in both the types of work that they can perform and in their freedom to operate in an autonomous or semi-autonomous environment. Sometimes these restrictions are created by the professionals with whom the para-professionals would partially compete.

Para-professionals are typically not trained in the same way as the "higher-level" professional, but at times may actually have superior training for certain types of care. Para-professions include nurse practitioners, nurse midwives and dental hygienists. Alternative professionals include chiropractors and acupuncturists. The rights of para-professionals and alternative professionals to practice and operate independently of a supervising professional are often limited by law, regulations or payment rules. At times, the right of para-professionals or alternative professionals to exist at all is limited. Professionals have an incentive to limit the practice rights of para-professionals, who might otherwise compete with them for certain types of health care. As a result, unnecessary restrictions on competition may exist when professional associations are given control over the practice rights of affiliated para-professions. Particularly if there is a scarcity of professionals in the future, the importance of para-professions could increase substantially.

In Ireland, the Dental Council has control over when and how dental auxiliaries practice. The Council is composed primarily of dentists. Up to this time, the Dental Council has not produced any rules or regulatory scheme for registration of dental auxiliaries that would allow them to practice independently. Denturists, for example, are not permitted to make false teeth and sell them without a dentist's supervision. In the United States, the South Carolina State Dental Board, which exists as a result of state legislation, determined that dental hygienists could not provide preventative dental hygiene in school unless students had undergone a timely prior examination by a dentist. 7 of the

Board's 9 members are dentists and elected by dentists. The U.S. Federal Trade Commission concluded that these board activities were really private activities and not government actions and filed a complaint against these activities. In Finland, dental hygienists have the legal right to practice independently, but their work was covered by the national health insurance only when performed under the supervision of a dentist, leading to a European Commission action. There is substantial evidence that where the number and behavior of dental auxiliaries is limited, prices of a number of common dental services are 5-11% higher.

Requirements for Purchase of Health-Related Products

(4) Health related products, such as eyeglasses, contact lenses, hearing aids, non-prescription drugs and dentures, are sometimes made unavailable unless consumers have first undergone tests that are not directly related to the provision of the product or unless they purchase products from specific suppliers.

While there are health conditions that may be diagnosed only through examinations, the requirement for examinations can raise costs to patients and deter them from obtaining products that they would otherwise seek. Decisions to limit access to a given product are best based on an appropriate weighting of medical risks and benefits, with due respect for consumer choice. These considerations are not weighted in the same way in all instances. For example, in Ireland, eyeglasses are only made available to persons with a recent examination by an optometrist or optician, even when the consumer is simply replacing a broken pair of glasses. In contrast, in other Members, such as Australia, the U.S. or Italy, eyeglasses can be purchased "over-the counter" as well as from optometrists and opticians.

In Denmark, a recent decision to permit supermarkets to sell non-prescription drugs was very beneficial for consumers. After the sale of non-prescription drugs in supermarkets was permitted, 20-25% of the sales of these products occurred in supermarkets and other approved shops, while prices lowered by between 5-15%.

Access to Medical Facilities and Records

(5) One type of restriction that is intended to limit consumer choice and whose effect may be primarily to limit competition is for established professionals to refuse to grant access to facilities, equipment or records that might be relevant to patients and important for alternative professions or alternative sellers. Such refusals can serve to raise the costs to patients of seeking treatment or fulfillment from alternative providers. Higher costs, in turn, are likely to lead patients to seek less care.

Limits on access to medical records and facilities often arise for alternative professionals. When dental hygienists or chiropractors seek X-rays for their patients, the patients are often required by law to obtain a prescription from a dentist or medical practitioner. At times, these professions may refuse to make X-rays available to alternative professions. In Italy, for example, chiropractors have not been able to prescribe and directly receive patient X-rays. Physicians have often refused to prescribe X-rays. Even when X-rays are made available, patient costs of alternative care are significantly increased. Given the anticompetitive purposes of raising the cost of alternative treatments that may be associated with denials of access, it may be appropriate for refusing parties to bear the burden of proof to justify a refusal.

Limits on access also apply to prescriptions. In the U.S., problems have arisen with respect to the release of prescriptions for eyeglasses and contact lenses. As a result, the U.S. FTC has established rules that require vision testers to release a prescription to patients for their potential use with alternative suppliers at no additional charge. Even with these rules, there is a potential for abuse by

vision testers. When contact lens prescriptions can be filled by any seller of the prescribed lens, some prescribers may write prescriptions for a lens that that is a prescriber-specific brand name (even though that exact type of lens is broadly available under a different national brand name.) This may ensure that consumers purchase their contact lens through the prescriber rather than cheaper alternative sources. The medical harm from such practices must be considered, since patients are sensitive to price and typically reduce their consumption of goods in response to higher prices. The result of higher prices for contact lenses is that consumers may not replace lens as frequently as they otherwise would, which can produce eye inflammation and eye infections.

Conduct Rules, including Advertising and Promotional Restrictions

(6) Professional associations often introduce rules that govern the commercial behaviour of members which do not protect consumers. Rather, such restrictions raise prices to consumers and increase profits for providers.

Rules on commercial behaviour include limiting advertising of services and prices to consumers, or limiting the ability to solicit consumers. The main arguments cited by the associations for such limits are that they eliminate deceptive advertising, make it more difficult for low quality providers to gain customers and prevent wasteful advertising that would raise costs to the members. However, conduct limits, such as advertising prohibitions and customer solicitation restrictions are among the most problematic of professional rules. There is little evidence that such constraints actually benefit consumers, but substantial evidence that such rules result in higher prices to consumers and greater profits for providers.

The most careful study of the impacts of such advertising constraints was the U.S. FTC's eyeglasses study, which involved hundreds of actual eyeglass purchases across the country. Testers purchased from different eye examiners and eyeglass vendors from locations that experienced a variety of different restrictiveness of rules. A number of quality indicators were measured, such as thoroughness of the eye examination, accuracy of the prescription, accuracy and workmanship of eyeglasses and the extent of unnecessary prescribing. For each indicator, the cities without commercial practice restrictions had performance that was, on average, about the same or better than that of the cities with restrictive rules. While quality did not appear to be increased as a result of restrictive rules, the study found that average prices charged for an eye examination and eyeglasses were 33.6% higher in the cities with the most restrictive rules than in the cities with the least restrictive rules.

Fee Setting

(7) Health professional associations often seek to co-ordinate or suggest fees for their members. Such co-ordination typically has the effect of raising prices rather than protecting consumers from price abuses.

Fee-setting activities can involve both positive actions (recommended fees) as well as negative actions (forbidding discounting.) These fee-setting activities are rarely consistent with the national goals of broad, accessible health care regimes and often have the effect of a cartel among professionals. Fee-setting activities by health professionals have been subject to competition law enforcement by a number of countries.

Australia, Brazil, The Netherlands and the U.S., among others, have experience with competition law enforcement against medical associations and with smaller groups of doctors. At times, fee-setting activities have been pursued through creative means. These include the establishment of "ethical rules" that prevented physicians from setting prices that were significantly below the common price

for the service in a geographic area. Even building lease arrangements that forbid discounting and restrict patient visiting hours have been found to serve as a mechanism that can produce harmful anti-competitive effects. The negative impact of such practices, when not endorsed by the government, can merit prosecution under cartel laws although the practices have been shielded in some jurisdictions under the cloak of government action.

A number of mediating factors may justify joint fee setting, such as sharing of financial risk in a way that would improve quality of medical care and that does not involve the majority of health practitioners in a geographic area.

SYNTHÈSE

Les points ci-après ressortent des communications écrites, de la note d'information et des débats :

Les professions de santé et la concurrence

(1) La limitation de l'accès aux professions de santé a un objectif important, à savoir protéger le consommateur des praticiens non qualifiés. Cela étant, les restrictions imposées vont parfois trop loin.

La nécessité de protéger le consommateur des charlatans a conduit à soumettre l'exercice des professions de santé à autorisation, ce que les pouvoirs publics entérinent souvent à des degrés divers. Les restrictions inhérentes à l'obtention et au maintien de l'autorisation d'exercer servent à la fois à garantir la qualité des soins et à limiter la concurrence. L'évaluation des conséquences d'un comportement apparemment anticoncurrentiel dans les professions de santé exige que l'on fasse la part des choses : l'existence des professions de santé et des associations professionnelles est, à bien des égards, utile aux patients. Il n'en reste pas moins que les mesures prises par les praticiens et les associations professionnelles, voire par les pouvoirs publics, semblent parfois avoir pour effet non pas d'améliorer la qualité offerte aux consommateurs mais de garantir une rémunération élevée aux praticiens ou de limiter le choix des consommateurs.

Les décideurs peuvent modifier les réglementations et prendre des mesures d'exécution pour supprimer des restrictions qui semblent avoir pour principal but d'être anticoncurrentielles. Ces changements peuvent se traduire par une diminution notable des dépenses de santé sans entraîner pour autant une baisse sensible de la qualité des soins. Comme les dépenses de santé demeurent une source importante de dépenses privées et publiques dans les pays de l'OCDE, on se soucie de plus en plus d'accroître l'efficience des soins de santé dispensés pour que les dépenses de santé d'un pays aient les effets les plus profitables. Il ressort de diverses études que la modification des pratiques peut entraîner, pour certains types de soins, des économies de l'ordre de 5 à 33 %. Ces chiffres ne sont pas négligeables d'autant qu'en moyenne un pays de l'OCDE consacre environ 8 % de son PIB aux dépenses de santé et qu'une réduction, ne serait-ce que de 0.1 %, dans la zone OCDE, grâce à une amélioration de la réglementation des professions de santé, permettrait d'économiser 2.8 milliards de dollars des Etats-Unis par an.

Toutes les formes de concurrence ne seraient pas bénéfiques dans le secteur des professions de santé, d'où la nécessité d'apprécier avec soin les coûts et les avantages de telle ou telle restriction à l'activité concurrentielle. Les professions de santé dont les services ne sont pas remboursés sont particulièrement enclines à adopter des règles excessivement restrictives, car les pouvoirs publics ne sont pas directement intéressés par une réduction du coût de ces services. Ces professions libéralisées varient d'un pays à l'autre mais concernent, souvent, les audiologistes, les dentistes, les optométristes et les pharmaciens. Cependant, même dans les professions dont les services sont directement remboursés par un mécanisme public, il peut parfois être utile de prendre en considération l'aspect concurrentiel.

Le libre jeu de la concurrence dans le secteur de la santé ne permet pas toujours d'atteindre le double objectif d'une vaste couverture de santé et de dépenses limitées, essentiellement en raison (1) de la distorsion de la consommation liée à la couverture par une assurance (qui pousse les consommateurs à consommer des soins dont ils ne supportent pas intégralement le coût), (2) d'une information imparfaite et incomplète du consommateur parce que la plupart des soins et services de santé ont le caractère de biens impliquant une relation de confiance et (3) d'externalités (notamment en cas de maladies contagieuses).

Mesures d'encadrement qualitatives, quantitatives et géographiques

(2) Les limitations de l'accès à une profession déterminent les qualifications et les compétences des praticiens, de même que, parfois, leur nombre et leur lieu d'implantation. Elles peuvent, dans certains cas, être excessives, restreindre exagérément la concurrence et augmenter le coût des soins de santé.

Les professions sont incitées à exiger des qualifications supérieures à celles qui sont en réalité souhaitables du point de vue social pour limiter l'offre de praticiens (et leur garantir des revenus élevés). Les mesures d'encadrement quantitatives sont souvent prises en coopération avec un ministère de la santé dans le but déclaré de veiller à ce que les soins de santé soient dispensés à ceux qui en ont le plus besoin ou qui se trouvent dans les zones les moins bien desservies. Des restrictions géographiques sont très souvent appliquées aux pharmacies, officiellement pour que les zones rurales continuent d'avoir un nombre suffisant d'officines. Les institutions chargées de la concurrence se sont parfois élevées contre les restrictions géographiques qui existent.

En Italie, par exemple, le nombre annuel de places de formation spécialisée est fixé par l'Etat. Au Royaume-Uni et en France, le nombre des étudiants en médecine, au niveau national, est déterminé par l'Etat. Ces restrictions sont courantes dans les pays de l'OCDE. Elles se justifient parfaitement lorsque les pouvoirs publics cherchent à limiter une offre excédentaire de professionnels qui dispenseraient des soins peu utiles, que ce soit du fait d'une demande induite par les médecins ou d'une demande induite par les assurances.

Par contre, lorsque la profession elle-même cherche à restreindre le nombre de praticiens qualifiés, l'intérêt du consommateur risque fort de ne pas être pris en compte. Pour les consommateurs qui supportent eux-mêmes la dépense, comme c'est le cas pour les soins dentaires ou l'optométrie dans de nombreux pays, on peut s'interroger sur le bien-fondé des mesures d'encadrement quantitatives imposées au niveau national.

Droits des professions paramédicales et des professions parallèles

(3) Les professions paramédicales et les professions parallèles voient souvent le type d'actes qu'elles peuvent effectuer et leur liberté d'exercer de façon autonome ou semi-autonome exagérément restreints. Ces restrictions sont parfois dues aux professions avec lesquelles les professions paramédicales sont en partie en concurrence.

Les para-médicaux ne sont d'ordinaire pas formés comme les professionnels « de plus haut niveau », mais il arrive parfois qu'ils soient, en fait, mieux formés pour certains types de soins. Relèvent des professions paramédicales les infirmières, les sages-femmes et les hygiénistes dentaires. Les professions parallèles comprennent les chiropracteurs et les acupuncteurs. Le droit des professions paramédicales et parallèles d'exercer et d'intervenir sans être supervisées par un professionnel de santé est souvent restreint par la législation et la réglementation ou par les règles de facturation. Il peut arriver que les professions paramédicales ou parallèles ne soient pas autorisées. Les professionnels de santé sont incités à limiter le droit d'exercice des professions paramédicales afin

d'éviter d'être concurrencés pour certains types de soins de santé. La concurrence peut donc être inutilement limitée lorsque les associations professionnelles contrôlent le droit d'exercer des professions paramédicales apparentées. Les professions paramédicales pourraient gagner en importance dans l'avenir, notamment s'il y avait pénurie de professionnels de santé.

En Irlande, le Dental Council contrôle l'activité des auxiliaires dentaires. Il est essentiellement composé de dentistes. A ce jour, il n'a mis au point aucune règle ni système réglementaire aux fins de l'inscription des auxiliaires dentaires, inscription qui leur permettrait d'exercer à titre indépendant. Les prothésistes dentaires, par exemple, ne sont pas autorisés à faire des prothèses ni à les vendre s'ils ne sont pas supervisés par un dentiste. Aux Etats-Unis, le Dental Board de l'Etat de Caroline du Sud, créé en application d'une loi de l'Etat, a décidé que les hygiénistes dentaires ne pouvaient pas dispenser des soins d'hygiène dentaire préventifs dans les établissements scolaires si les élèves n'avaient pas auparavant été examinés par un dentiste. Sept des 9 membres du Dental Board sont des dentistes élus par des dentistes. La Federal Trade Commission des Etats-Unis a conclu que les activités de ce conseil étaient véritablement des activités privées, sans caractère public, et il a porté plainte contre ces activités. En Finlande, les hygiénistes dentaires sont autorisés, de par la loi, à exercer indépendamment mais leurs actes ne sont pris en charge par l'assurance maladie que s'ils sont effectués sous la supervision d'un dentiste, ce qui a donné lieu à une action de la Commission européenne. Tout prouve à l'évidence que lorsque le nombre et les actes des auxiliaires dentaires sont limités, les prix d'un certain nombre de services dentaires courants sont supérieurs de 5 à 11 %.

Conditions d'achat des produits de santé

(4) Il arrive que des produits de santé, comme les lunettes, les lentilles de contact, les prothèses auditives, les médicaments en vente libre et les prothèses dentaires, ne soient disponibles que si les consommateurs ont subi des examens qui n'ont pas de lien direct avec la fourniture des produits ou se les procurent auprès de fournisseurs désignés.

Si certaines pathologies ne peuvent être diagnostiquées qu'à la suite d'examens, la nécessité de procéder à des examens peut augmenter le coût pour le patient et le dissuader de se procurer un produit qu'il aurait souhaité dans d'autres circonstances. Les décisions de limiter l'accès à un produit donné reposent, au mieux, sur une évaluation appropriée des risques et des avantages du point de vue médical, qui tient dûment compte du choix du consommateur. Ces éléments ne sont pas toujours appréciés de la même façon. En Irlande, par exemple, seules les personnes qui ont récemment été examinées par un optométriste ou par un opticien peuvent se procurer des lunettes, et ce même si elles ne font que remplacer une paire de lunettes cassée. Par contre, dans d'autres pays Membres, comme l'Australie, les Etats-Unis ou l'Italie, il est possible d'acheter des lunettes en vente libre ou de se les procurer auprès d'un optométriste ou d'un opticien.

Au Danemark, la récente décision d'autoriser les supermarchés à vendre des médicaments en vente libre a été très profitable aux consommateurs. A la suite de cette décision, 20 à 25 % des produits ont été vendus dans des supermarchés et d'autres magasins agréés, et les prix ont baissé de 5 à 15 %.

Accès aux équipements et aux dossiers médicaux

(5) Un type de restriction destiné à limiter le choix des consommateurs, qui a sans doute pour principal effet de limiter la concurrence, est dû aux professionnels agréés qui refusent d'accorder l'accès à des équipements, du matériel ou des dossiers pouvant être utiles aux patients et importants pour des professions ou des points de vente parallèles. Ces refus peuvent augmenter le coût du traitement pour les patients qui souhaiteraient s'adresser à une profession parallèle. Le surcoût risque de dissuader les patients de se soigner.

La limitation de l'accès aux dossiers et aux équipements médicaux est fréquente pour les professions parallèles. Lorsque des hygiénistes dentaires ou des chiropracteurs demandent à leurs patients de faire des radiographies, ceux-ci doivent souvent, de par la loi, demander une ordonnance à un dentiste ou à un médecin. Il arrive que ces professionnels refusent de prescrire des radiographies pour des professions parallèles. En Italie par exemple, les chiropracteurs ne peuvent pas prescrire de radiographies ni recevoir directement les résultats. Les médecins refusent souvent de prescrire des radiographies. Même lorsqu'il est possible de faire des radiographies, le coût des soins parallèles augmente sensiblement pour les patients. Comme l'augmentation du coût des traitements parallèles liée au refus d'accès peut répondre à une volonté de limiter la concurrence, il serait sans doute justifié que la partie à l'origine du refus ait à motiver son refus.

La limitation de l'accès s'applique aussi aux ordonnances. Aux Etats-Unis, la délivrance d'ordonnances pour des lunettes et des lentilles de contact a posé des problèmes. C'est pourquoi la FTC a exigé que le praticien qui procède à l'examen de la vision délivre au patient une ordonnance que celui-ci pourra éventuellement présenter à d'autres fournisseurs sans frais supplémentaires. Cela étant, même avec ces règles, les praticiens qui pratiquent les examens peuvent commettre des abus. Lorsque les lentilles de contact prescrites peuvent être obtenues n'importe où, il arrive que le praticien prescrive des lentilles de sa propre marque (même si ce type précis de lentilles est aisément disponible sous une autre marque). Ainsi, le consommateur achète ses lentilles de contact par l'intermédiaire du prescripteur et n'a pas accès à d'autres sources meilleur marché. Il faut tenir compte des effets nocifs sur la santé de ces pratiques, car les patients sont sensibles au prix et réduisent d'ordinaire leur consommation lorsque les prix sont élevés. Si les lentilles de contact sont plus onéreuses, le consommateur en changera sans doute moins souvent, ce qui peut provoquer une inflammation et une infection de l'œil.

Règles déontologiques, limitation de la publicité et des promotions

(6) Les associations professionnelles fixent souvent des règles qui régissent le comportement commercial de leurs membres mais qui ne protègent pas les consommateurs. En fait, ces restrictions ont pour effet d'augmenter les prix à la consommation et d'accroître les bénéfices des fournisseurs.

Les règles déontologiques impliquent la limitation de la publicité sur les services proposés et sur les prix, ou la limitation du démarchage auprès des consommateurs. Les principaux arguments avancés par les associations pour justifier cette limitation sont les suivants : la publicité mensongère est ainsi évitée, les prestataires médiocres ont plus de mal à trouver des clients et la publicité inutile, qui aurait pour effet d'augmenter les coûts pour la profession, disparaît. Toutefois, l'interdiction de la publicité et la limitation du démarchage auprès des clients font partie des règles professionnelles qui posent le plus de problèmes. Il ne semble pas qu'elles bénéficient véritablement aux consommateurs et plusieurs éléments montrent, au contraire, que ces règles renchérissent le coût pour les consommateurs et augmentent les bénéfices des fournisseurs.

L'étude la plus approfondie des effets de ces restrictions sur la publicité a été celle que la FTC, aux Etats-Unis, a consacrée aux lunettes, et qui a porté sur des centaines d'achats de lunettes dans tout le pays. Les enquêteurs ont acheté des lunettes à différents endroits soumis à diverses règles restrictives. Un certain nombre d'indicateurs de qualité ont été évalués, comme la rigueur de l'examen de la vue, l'exactitude de la prescription, la qualité de la réalisation des lunettes et la part de prescriptions injustifiées. Au regard de chaque indicateur, les villes qui n'imposent pas de restrictions commerciales ont affiché, en moyenne, des résultats équivalents, voire supérieurs, à ceux obtenus par les villes qui imposent de telles restrictions. Si la qualité n'a apparemment pas augmenté sous l'effet de règles restrictives, il ressort de l'étude que le prix moyen de l'examen de la vue et de la paire de

lunettes dans les villes qui imposent les règles les plus restrictives est de 33.6 % supérieur à celui pratiqué dans les villes imposant les règles les moins restrictives.

Fixation des honoraires

(7) Les associations professionnelles cherchent souvent à coordonner les honoraires de leurs membres ou à en préconiser. Cette coordination a d'ordinaire pour effet d'augmenter les prix et non de protéger les consommateurs contre des prix abusifs.

Les activités de fixation d'honoraires peuvent se pratiquer dans une optique positive (honoraires recommandés) ou dans une optique négative (interdiction des rabais). Elles sont rarement compatibles avec les objectifs nationaux de vastes régimes de santé accessibles et se traduisent souvent par des ententes entre professionnels. Les activités de fixation des honoraires par les professionnels de la santé ont été soumises au droit de la concurrence dans un certain nombre de pays.

L'Australie, le Brésil, les Pays-Bas et les Etats-Unis, notamment, ont appliqué le droit de la concurrence contre des associations médicales et des groupements plus restreints de médecins. Les moyens utilisés pour fixer les honoraires ont parfois été ingénieux : recours à des « règles éthiques » interdisant aux médecins de pratiquer des prix sensiblement inférieurs aux prix habituels du service dans une zone géographique. Il a même été constaté que les conventions de location des locaux qui interdisent les rabais et limitent les heures d'ouverture aux patients pouvaient avoir des effets anticoncurrentiels dommageables. Les conséquences négatives de ces pratiques, lorsqu'elles ne sont pas approuvées par les pouvoirs publics, peuvent motiver des poursuites en application de la législation contre les ententes, mais ces pratiques ont parfois bénéficié de l'aval des pouvoirs publics.

Un certain nombre de facteurs de médiation peut justifier une tarification commune, par exemple la volonté de mutualiser le risque financier de façon à améliorer la qualité des soins médicaux sans impliquer la majorité des praticiens d'une zone géographique.

BACKGROUND NOTE

1. Introduction

Health professions are overseen by a vast array of rules and regulations that are justified by the need to protect consumers from unqualified practitioners. The most common method of ensuring practitioner quality is professional licensure. Because health care expertise is necessary to establish the appropriate program of study, training, and examination for new professionals, a licensed profession often directly or indirectly controls its own licensure rules. In this process of self-regulation, a profession exercises its legitimate interest in maintaining the quality of its members. But a self-regulating profession also has the potential to abuse its control over who can practice in order to enhance member income. Examples of such abuse can include limiting the number of practitioners, limiting competition between its own members, and hindering other potentially competing professions from practice.[1]

When a profession enhances its own income at the expense of its patients, consumers and other payors are harmed and national health care expenses increase without offsetting benefits. The difficulty for policy makers is to ensure that the limitations needed to protect consumers and broad social objectives are not more extensive than the minimum that is necessary and appropriate. This paper is designed to help policy makers assess which types of professional rules and regulations are in the public interest and provides a number of policy responses that may be appropriate for increasing efficiency and competition in the health professions.

Increasing efficiency in the delivery of health care is of paramount importance in OECD countries because of the current high levels of spending on health care and the expected increased spending on health care in the future due to ageing populations. As the ratio of retirees to workers increases, the health care burden of workers (who cover the costs of pay-as-you-go health care systems) will increase dramatically. On average, OECD countries will go from having 3.3 workers per retiree to 1.75 workers per retiree between 2000 and 2050. In some OECD countries, including Canada, France, Germany, Italy, and Japan, the number of retired persons to workers is expected to double between 2000 and 2050.[2] These figures imply that workers contributions to health care spending for retired persons will increase by about 90% per worker. In order to keep the increased spending per worker under control, and because health care expenses are already such a large share of GDP for OECD countries (averaging about 8% of GDP in the OECD), all potential efficiency-enhancing solutions merit serious consideration.

One important efficiency-enhancing solution is improved regulation of the health professions. Inefficiencies associated with professional rules, regulations, and best practice can result in substantial costs to consumers and payors without significant improvements in health care quality, particularly in professions in which governments do not control fees for practitioners. These liberalized health professions vary from one country to another, but often include (audiologists, chiropractors, dentists, dental auxiliaries, nurse midwives, ophthalmologists, optometrists, and psychotherapists).[3] These health professions that operate in a more liberalized environment are the primary subject of this paper, for it is in these professions that rules may limit competition in ways that harm consumers the most.

A number of careful studies have documented the impacts of various types of health professional restrictions on prices and quality. To cite a few:

- Advertising restrictions and prohibitions on corporate ownership are associated with prices for eye exams and eyeglasses that are 33.6% higher in high-restriction regions while average quality of eye exams and eyeglasses is about equivalent in high and low restrictions regions. (Bond et al. (1980))

- Increased difficulty of entry exams for dentists are associated with prices for dental service that are 11% higher than in regions with less difficulty, but dental care quality is not lower as result. (Morris and Kudrle (2000))

- In regions with restrictive rules over what para-professionals can do for dentists, costs are 5-11% greater than elsewhere. (Liang and Ogur (1987))

- Regions that restrict movement of professionals by not recognizing qualifications from other regions have prices for dental services that are 8.5-18% higher than elsewhere. (Shepard (1978))

These studies show that professional restrictions can have significant impacts on patient costs. While these studies are focused on the professions that often feature relatively little government oversight of fees, professions with extensive government oversight also sometimes offer significant opportunities to increase efficiency, for example through enhanced use of para-professionals and changed "best practice" standards that may, at times, refer patients away from diagnosing specialists to other specialties for cheaper treatment, and giving 'gatekeeping' general practitioners oversight of funds to spend for patient care.

A policy of evaluating professional restrictions and eliminating those which are harmful could yield significant gains to both consumers and other payors, and could help to reduce health care spending without substantial reductions in health care quality. The aggregate impact of potential changes in regulation over health care professionals is difficult to estimate, particularly because possible changes in each profession require weighing costs of a potential change against its benefits. If improvements are possible and even if they yield much lower returns than those specific ones identified above, the potential value to OECD economies of reducing inappropriate regulations of health professions is still significant because health care spending is so large. For example, if improved health profession regulation were to reduce health care costs by 0.1%, OECD health care payors would save USD 2.8 billion per year.[4]

There are few natural advocates of efficiency-enhancing professional regulation. To the extent that efficiency enhancements, such as increased competition, often reduce the income of health professions and may be claimed to lower the quality of care, significant political opposition to change is guaranteed. Competition and consumer authorities are well-placed to advocate changes that are likely to benefit consumers and that are not explicitly focused on the health-related elements of care. Especially when consumers pay for care and services out of pocket, more direct competition is likely to be helpful. A number of competition authorities have actually engaged in advocacy and litigation activities in the health professions in the past; but further, targeted efforts would likely be beneficial in the future. In conjunction with the ministries responsible for health care spending and oversight of health professions, important steps forward in regulation of health care professionals are feasible and could make a contribution to keeping health care spending under control.

This paper identifies mechanisms that can be used to increase competition and productive efficiency in health professions, but the listing of a mechanism should not be interpreted as a blanket endorsement of that mechanism. A variety of factors must be considered in deciding on public policies to the health professions, including health impacts, government regulatory costs, industry compliance costs, higher prices due to reduced competition, reduced quality variation, increased search costs, efficiency losses from different types of regulation, impacts on patient-provider relationships and impacts on broad social goals. Different countries may legitimately come to different conclusions over the best policy approaches to the

same profession. Nonetheless, given the importance of increasing productive efficiency in the future, four points stand out:

- Increased roles are merited for para-professions (professions with less training than the "highest level" professions);
- Increased mutual recognition of qualifications across international boundaries is important, especially for dealing with expected professional shortages of the future;
- Increased consumer choice over the quality of service received is critical for reducing the cost and intensity of privately purchased services and products; and
- Reduced professional regulation over advertising, discounting and ownership can frequently have beneficial impacts for non-insured services.

2. Social goals

The health care sector in most OECD Members has one over-riding social goal: making health care broadly accessible to those who need it. The government often acts to ensure the access to care for people who could not otherwise afford health care, such as the poor, the elderly, the disabled and the chronically ill. Total payments for healthcare vary but they account for both a significant share of government spending and GDP in all Members. (See Table 1.) The healthcare system can be viewed as a mechanism to redistribute income in pursuit of broad coverage.

Table 1. Selected Statistics Related to Health and Health Professions, 2002

	Life expectancy	Total Health Care Spending % of GDP	Health care spending per capita, USD**	Public health care spending per capita, USD**	Public share of health care spending	Physician density***	Pharmacist density***	Consultations per physician
Australia	80	9.1*	2504*	1708*	68.2%*	2.5*	0.7	2480
Austria	78.8	7.7	2220	1551	69.9%	3.3	0.6	2030
Belgium	78.1	9.1	2515	1790	71.2%	3.9	1.1	2000
Canada	79.7*	9.6	2931	2048	69.9%	2.1	0.7	2952*
Czech Republic	75.4	7.4	1118	1022	91.4%	3.5	0.5	3686
Denmark	77.2	8.8	2580	2142	83.0%	3.3	0.5	2152
Finland	78.2	7.3	1943	1470	75.7%	3.1	1.5	1387
France	79.4	9.7	2736	2080	76.0%	3.3	1.1	2091*
Germany	78.5*	10.9	2817	2212	78.5%	3.3	0.6	n/a
Greece	78.1	9.5	1814	960	52.9%	4.5*	n/a	n/a
Hungary	72.6	7.8	1079	757	70.2%	3.2	0.5	3719
Iceland	80.4	9.9	2807	2357	84.0%	3.6	1.3	1556*
Ireland	77.8	7.3	2367	1779	75.2%	2.4	0.8	n/a
Italy	79.9	8.5	2166	1639	75.7%	4.4	1.1	n/a
Japan	81.8	7.8*	2077*	1696*	81.7%*	2	1.2	7250*
Korea	76.4*	5.9*	931*	506*	54.4%*	1.5	n/a	7067
Luxembourg	78.2	6.2	3065	2618	85.4%	2.6	0.8	2385
Mexico	74.6	6.1	553	249	45.0%	1.5	n/a	1667
Netherlands	78.4	9.1	2643	n/a	n/a	3.1	0.2*	1806
New Zealand	78.5*	8.5	1857	1447	77.9%	2.1	n/a	2095*
Norway	79	8.7	3083	2628	85.2%	3*	n/a	n/a
Poland	74.6	6.1	654	474	72.5%	2.3	0.6	2435
Portugal	77.2	9.3	1702	1201	70.6%	3.2*	0.8*	1125*
Slovak Republic	73.9	5.7	698	621	89.0%	3.6	0.5	3611
Spain	79.4	7.6	1646	1176	71.4%	2.9	0.9	3000*
Sweden	79.9	9.2	2517	2148	85.3%	n/a	n/a	n/a
Switzerland	80.4	11.2	3445	1994	57.9%	3.6	n/a	944
Turkey	68.6	n/a	n/a	n/a	n/a	1.3	0.3	3000

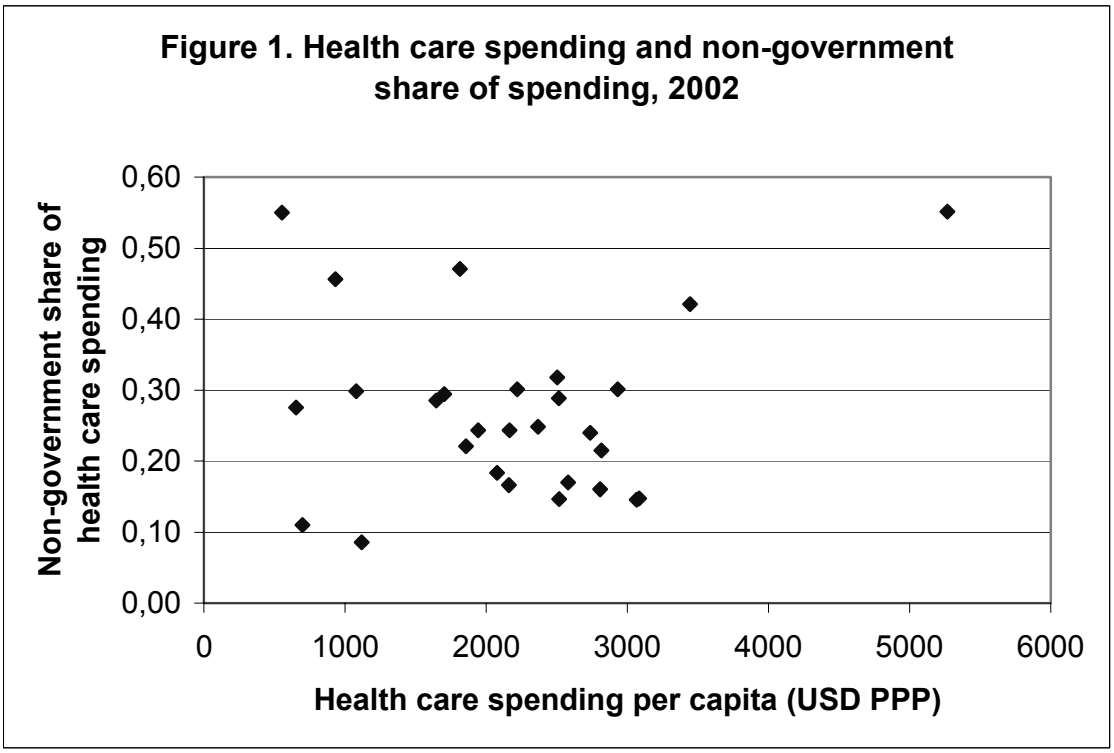
	Life expectancy	Total Health Care Spending % of GDP	Health care spending per capita, USD**	Public health care spending per capita, USD**	Public share of health care spending	Physician density***	Pharmacist density***	Consultations per physician
United Kingdom	78.1*	7.7	2160	1801	83.4%	2.1	0.5	n/a
United States	77.1*	14.6	5267	2364	44.9%	2.4*	n/a	3708

* data from 2001, ** USD purchasing power parity, *** Density of practitioners per 1000 population

Source: OECD Health Care Data, 2004

Because of the large financial interest of the state in health care and the limited financial resources of governments, most Member governments play a large role in determining the financial structure of payment for many health professionals and also play a role in determining the training structure for new health professionals in traditional medical fields (such as general practitioners, medical specialists, nurses, and surgeons). One major consideration in these calculations is reducing the government's cost of delivering health care services. [5]

The social and financial goals of rules governing the health care professions must be kept in mind when evaluating the restrictions that may exist in a profession, particularly for those professions that receive extensive state support. An unconstrained free market outcome would not achieve the broad health care coverage that is a primary motivator of policy for many Members. Moreover, it appears that private spending (and private markets) do not necessarily lower total costs or noticeably improve measured outcomes, such as expected lifespan.[6] Figure 1 shows that some of the Members with highest private contribution to health care payments have some of the highest costs.[7]



Source: OECD Health Care Data, 2004

There are a number of health professions that receive much lower levels of state support in most Members than medical doctors and nurses. These include audiologists, chiropractors, dentists, dental auxiliaries, nurse midwives, ophthalmologists, optometrists, and psychotherapists. Why does the social objective of national insurance not apply equally to these professions in many Member countries? One reason for the limited applicability may be the limited potential financial risk from absence of coverage. While a heart attack could have financially devastating impact for a family with no insurance, a dental cavity, for example, will have a much smaller financial impact. Thus with limited financial risk, broad access may nonetheless be achieved even without insurance. Other reasons for lack of extensive state coverage may include uncertainty over efficacy and the desire to avoid over-consumption, especially in professions where improvement is difficult to measure such as psychotherapy.

3. Market imperfections

This paper does not suggest that unfettered competition is always the best method of providing health care services and overseeing health care professions. While in most sectors, we expect that competition will generally act to increase efficiency, the benefits of competition in the health professions are less certain.

Even in absence of distributional goals, a free market outcome in health care would not achieve the highest level of social and consumer welfare. The primary reasons for this are:

- Consumption-distorting insurance;
- Imperfect and incomplete consumer information;
- Increased willingness for risk in presence of insurance; and
- Externalities.

Perhaps because of these market imperfections, countries with high government finance in the health sector may have lower levels of reimbursement for physicians and lower total health care costs, but similar health outcomes as countries with high reimbursement and high levels of direct competition.

3.1 Consumption-distorting insurance ("moral hazard")

Insurance is widespread in the health care sector. Clearly, the impact of insurance is to reduce the costs to an individual of receiving health care. This means that, even if an individual knows the full extent of benefits and costs from a given treatment, the individual perceives the financial cost of treatment at a much lower level than the actual financial cost. Suppose, for example, that an individual pays a fixed percentage of actual financial costs (say, 20%.) Then perceived cost will be 20% of the actual cost, plus any additional "non-financial" costs, such as travel costs, costs of not working, and discomfort.

For inexpensive procedures and practitioner visits, the non-financial costs may be substantial enough that the "perceived" cost to the consumer is close to the actual financial cost. But for more expensive visits, the cost perceived by the consumer will typically be much lower than the actual cost. Unless health care is rationed by practitioners or payors so that consumers do not receive care when the costs are greater than the expected benefits, consumers will have an incentive to incur health care expenditures whenever the cost to them is lower than their perceived benefits. The result is that in a system with insurance, consumers will demand excessive care, unless constrained in some way, as illustrated in Box 1. (Arrow (1963), Feldstein (1973) and Pauly (1974))

Box 1. on Over-consumption and Insurance

Suppose that, in absence of insurance, the demand curve for care is given by DD. The cost for care is given by a fixed marginal cost of C*. Assuming a competitive market that equates price with cost, Q* units of care will be demanded. Area A represents the social surplus that arises in absence of insurance. In the presence of insurance with a 20% co-payment by the patient, the patient demand curve pivots to the right, so that the patient perceives a price of .02C*, and demands Q' procedures. The demand curve with insurance is then given by D'D'.

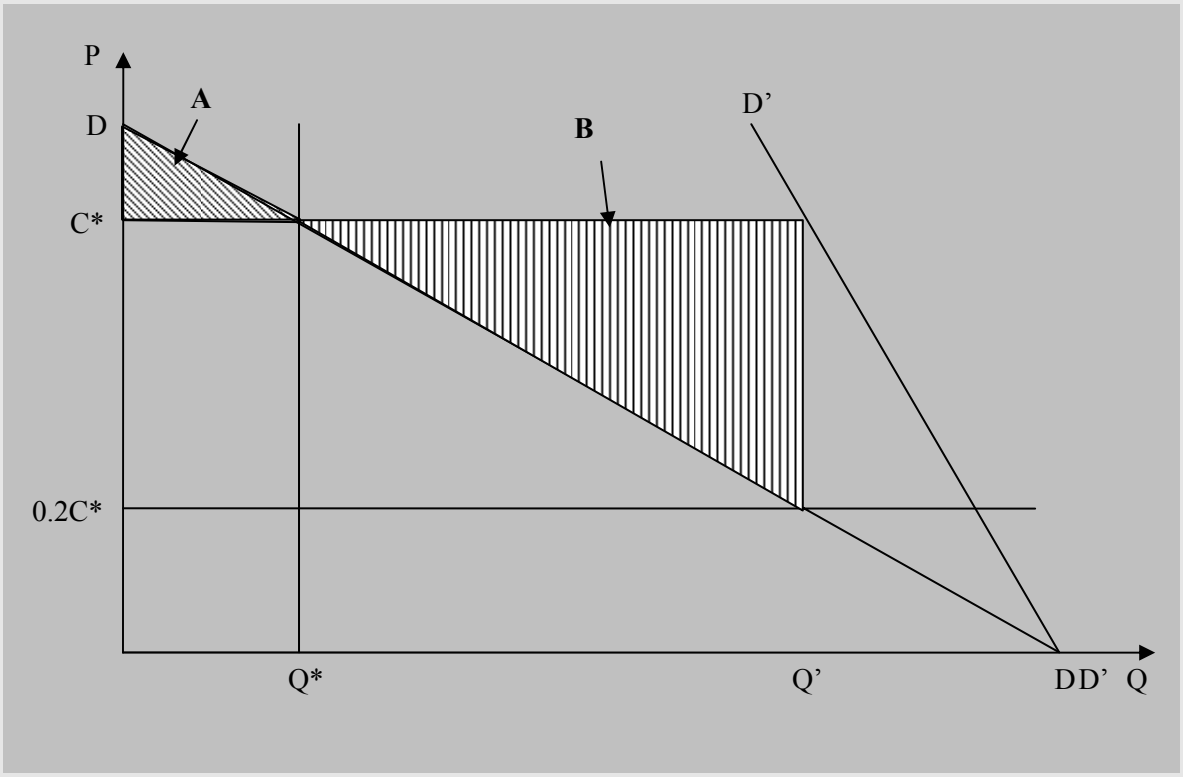
Area B represents the decline in social welfare that arises from unconstrained health insurance. The diagram suggests that the loss can be large in comparison to the social benefits (A) that arise in an uninsured state.

There are three caveats to note about the simple model that is illustrated:

- This is a model with perfect expandability of supply. In a model with limited supply (e.g. of physicians), movements away from the no-insurance equilibrium also arise from doctor margins increasing (as the effect of insurance is to make patient demand much less elastic.)

- If patient demand is completely fixed, there is no increase in quantity of care as a result of insurance. However, extensive research suggests that even for conditions that would seem to have little variation in patient occurrence, there is significant regional variation in quantity of care.

- The model assumes that consumer demand accurately represents the value of care to the consumer. This assumption is likely not true in some cases, either because patients do not have sufficient foresight to realize the long-term impact of health problems or because budget constraints prevent them from spending an amount equivalent to their true value of care.



The insurer, whether the state or a private provider, faces a dilemma: should costs be permitted to exceed value of treatment or should the quantity of care available to patients be constrained in some way. One alternative is to permit patients to receive all the care they desire under a system of insurance. But this will lead to extensive over-consumption where waste is defined as services delivered in which cost is greater (at least by a cost-benefit criterion of consumption). Given the percentage of GDP devoted to health care, encouraging over-consumption on such a scale is likely impermissible. Another alternative is to ration care. One mechanism of rationing is to leave health care professionals to decide how much care to deliver. They may impose limits out of interest for the patient's well-being, in order to avoid over-treatment, and sometimes because they have financial incentives to prevent over-consumption by their patients.[8] But often health care professionals have a conflict of interest; if they deliver more care than is strictly needed, they will receive larger payments. Another method of rationing is to allow one set of professionals (such as primary care physicians) to serve as gatekeepers and determine the amount of specialty care that will be received, thus separating the financial gain from the referral for care. Another method of rationing is simply to fix total resources for health care at a given level and then let health care managers allocate the quantity of different types of care that will be offered. (This could occur, e.g., by fixing total financial resources or the total number of trained professionals.) In all cases, however, the rationing solution to the insurance dilemma involves a departure from the free-market mechanism of consumer choice. More complex financial incentives to induce rationing can take the form of fixed payments for a patient (as with capitated payments) as well as with allocated spending accounts, when general practitioners (GPs) receive an allocated amount of funding meant to cover all of their patient expenses.

3.2 Consumer information

A second major problem related to health professions is that consumer information is limited in at least three respects: ordinary consumers are often not able to fully assess

- The quality and capabilities of their practitioner;
- The ex ante appropriateness of the care suggested; and
- The ex post effectiveness of the care.

Health care services are often "credence" goods: even after buying them, a consumer may not be able to judge their quality adequately. This feature of health services arises both because of imperfect consumer information about the physical outcome of care and the fact that appropriateness of care and outcomes are not perfectly correlated. Sometimes appropriate care yields poor outcomes and inappropriate care yields good outcomes.

These information problems mean that consumers must often rely on external sources for judgments about care.

External views may come from the chosen practitioner (who has an incentive to say that a procedure is necessary), from other practitioners (as when a general practitioner recommends a specialist), from insurers (who frequently have an incentive to say that a procedure is not necessary), from second opinions by specialists who would receive no financial benefit from a procedure, or from a third-party information source. For example, some governments provide physician-specific quality indicators for some types of care, such as cardiac care. In their crudest form, indicators could look at survival rates from high-risk surgeries which however, given that the best surgeons often see the most difficult cases, a perverse result could arise in which survival rates for the best surgeons could be lower than those of the worst surgeons.

For "credence" goods, two important effects may arise that distort full-information outcomes. First, sellers may have an incentive to reduce the quality of the services they offer.[9] This is because when consumers are not able to judge quality well, providers may have an incentive to provide low quality services and will try to do so at a "high quality" price. The prevalence of this type of response by producers may mean that consumers come to expect low quality services and refuse to pay high quality prices. Lower-quality services may then predominate and the market for high-quality service may fail. (See Akerlof (1970).)

A second problem that may arise with credence goods is over-treatment. Providers may recommend high quantities of their service when such high quantities for service are not necessary. For example, a common fear of health care payors is that psychotherapists and physical therapists will recommend high numbers of visits for their patients. This problem is distinct from the over-treatment that may arise from insurance, because over-treatment could arise even in absence of insurance, as patients have difficulty assessing their need for a service and their benefits from it.[10]

3.3 Increased willingness for risk in presence of insurance

Individuals with insurance that covers a given condition experience a lower financial loss from an adverse event (such as a dental cavity) than people without insurance. One result of this is that having insurance changes people's behavior with respect to avoiding adverse events. As an example, someone with dental insurance may be less concerned with the financial costs of cavities or other avoidable tooth problems than someone without insurance.[11] There are limited means of avoiding this effect. One is not to provide insurance. Many governments with national health insurance systems have only limited coverage for dental work. Eliminating insurance may be appropriate when the total financial exposure from the occurrence of risky events is relatively limited. In contrast, not providing insurance has rarely been selected as a means of deterring smoking, even though smoking is a behavior that can be avoided and that significantly enhances the risks of adverse events such as lung cancer. Treatment for lung cancer can be very expensive and unaffordable to many smokers. Thus not providing insurance would impede the social goal of providing medical treatment to all in need.

3.4 Externalities

Markets may not deliver the socially desirable outcome in health care because of externalities. Public health programs, such as vaccinations and water treatment, reduce the incidence of contagious diseases and have a positive effect by reducing the impact of contagious diseases on others. For example, with respect to tuberculosis an individual may not follow the recommended treatment of a physician because treatment is inconvenient or medication is expensive. The consequences of this individual conduct could be increased infection for others. That is, non-treatment by a person with contagions can have a negative externality.[12] The interest of these others, or society more broadly, may suggest that the professional treating such a patient should act for the social good and provide treatment that is more extensive than the patient wishes.

4. Responses to market imperfections, their problems, and possible pro-competitive solutions

In order to reduce the problems of information that can arise from a free market outcome, health care professions are often created, with associated licensure rules, product rules, and ethical codes.[13] A profession can be defined as an area of expertise whose practitioners have specific training or qualifications. By law, many health-related services can only be performed or prescribed by a person with the appropriate professional license. The main feature of occupational licensure is the creation of impediments to entry and practice in order to establish quality controls.[14]

The beneficial impacts of occupational licensure include:

- Reducing consumer uncertainty about the quality of the product. (Arrow (1963))
- Encouraging investment in human capital that enhances quality of service. (Shapiro (1986))

The rules that govern health care professions are extensive and often inter-linked in complicated ways. For example, in Italy, only medical doctors can prescribe an X-ray and X-rays of humans must be taken under the supervision of certified radiologists. In the U.S., the Hearing Aid Rule of 1977 requires that before hearing aids can be fitted, medical exams must be undertaken or patients must sign a waiver administered by a dispenser of hearing aids based on (21 CFR §801.421). In addition, most U.S. states require that hearing aid dispensers be licensed and administer tests prior to sale and fitting of hearing aids. (See FTC (1998).) Because of these inter-linkages, the full constraints of rules can only be assessed from a complete consideration of the inter-related impacts of multiple laws and rules.

Some observers argue that health care professions create unnecessarily stringent barriers to practice, entry and consumer information in order to protect or raise incomes of existing professionals. (See, e.g., Blevins (1995) and Cox and Foster (1990).) The goal of these "unnecessarily stringent" rules is to raise income. For example, White (1978) studies clinical laboratory personnel wages in regions with and without licensing and finds that licensing increases the relative wages of licensees by 16 percent.

Professional rules and regulations with an effect on competition can be divided into structural and behavioural rules as follows:

- Structural
  - Quality, quantity and geographical entry limits
  - Exclusive rights
  - Organizational rules
  - Regime for consumer redress
- Behavioural framework
  - Advertising limits
  - Fee setting and no discount rules

The ultimate effects of unduly restrictive rules can include high prices, limited variation in quality, and increased consumer search costs. In the rest of this section, types of rules will be discussed and ways of reducing anti-competitive impacts will be identified. Note that these possible methods of improving competition must be carefully assessed in the context of specific situations and will not always be appropriate.

4.1 Structural

Structural rules, regulations and standard practices govern the formal structure of a profession and its legal situation, including requirements for entry and exit, rights to practice, legal form of ownership rules, and legal redress for consumers.

4.1.1 Qualification, quantity and geographic entry limits

Entry into a profession is governed by qualification rules and, at times, by quantity and geographic distribution rules. Quality rules may serve both to raise quality and as implicit quantity rules because the effect of high quality (imposed through lower pass rates of licensure exams) is presumably a reduction in the supply of practitioners.[15]

4.1.1.1 Qualification restrictions

In order to ensure treatment quality, some hurdles to entry and practice are necessary. These can include: training requirements, apprenticeship requirements, knowledge exams, and skill exams. For example, in the U.S., all states require applicants for medical doctor licensure to be graduates of an approved medical school and complete the United States Medical Licensing Exam. States then require an additional 12-18 months of internship prior to receiving licensure. In Ireland, the Medical Council is responsible for licensure rules. Registration with the Medical Council requires the attendance of a medical school (in Ireland, this is at least a 6 year program) followed by at least one year of internship. EU trained doctors can receive qualification in Ireland, based on European Commission directives, and there are mutual recognition agreements in place with Australia, New Zealand, and South Africa. Non-EU trained persons can sit exams if they have accepted international training, but a more common route for non-EU trained persons is to sit the Transfer Exam of the General Medical Council in London. After passing this exam, persons are eligible to practice throughout the EU.

At times, excessive qualification limits may be required by a profession, given the tasks to be performed.[16] For example, longer and more detailed training may be required than is actually necessary to carry out the tasks of the profession. If "excess" qualifications would act as an impediment to entry and create scarcity of supply, careful review of licensure requirements may be merited.[17] Such review is particularly important because "[e]mpirical studies have found that licensing regulation increases costs for consumers."[18] For example, Kleiner and Kudrle (2000) find that U.S. states with the lowest pass rates for dental examinations have prices for dental services that are about 11% higher than states with low or medium restrictiveness.[19] Moreover, based on dental examinations of air force recruits, they find that states with lower restrictiveness do not have significantly more cases of uncorrected dental deterioration. That is, states with easier exams do not have worse dental outcomes. Shepard (1978) found that the effect of more restrictive dental licensure led to prices that were 8.5-18% higher than in less restrictive areas. When scarcity is created by reducing pass rates, the result can be higher prices to consumers and unavailability of cheaper and potentially equal-quality services. While the higher prices might not benefit consumers, they likely do benefit the profession: Kleiner and Kudrle (2000) find that dentists in the most restrictive states earn 11% more than in the least regulated states.

A notable problem that has been identified with respect to qualifications is that licensure boards are often comprised largely of members of the regulated professions.[20] In Ireland, for example, the Opticians Board need not have any consumer/patient representation.[21] Thus there is typically little independent oversight of determinations of applicant eligibility requirements, standards of practice, and disciplinary actions within the profession. Shaked and Sutton (1981) show that, as a theoretical matter, professions are likely to choose quality levels that are too high and sizes that are too small. That is, a profession will only set the socially optimal quality level if it cares solely about consumer welfare and not professional income. Cox and Foster (1990) make a similar point: "Although the professions may seek to benefit consumers, the possibility of a conflict of interest exists. The regulators, in many cases, have a financial interest in the profession they are regulating. Since professionals' self-interest may not coincide with the public's best interest, many have come to regard self-regulation with a growing skepticism." (p. 1)

The Institute of Medicine, an independent scientific advisor to the U.S. government, recommended that, in response to the presumed lack of independence, "[l]icensing boards should draw at least half of their membership from outside the licensed occupation; members should be drawn from the public as well as from a variety of areas of expertise such as health administration, economics, consumer affairs, education, and health services research." (IOM (1989))

Some boards have attendees who represent the legal service of the government. Others mandate that some members shall not be from the licensed profession, as with Ireland's Medical Council that reserves at least three out of 25 seats for non-physicians who are explicitly requested to protect the public interest.

Possible approach to reduce competition problems:

One possible approach to improve the market for health professional services that is related to the governance of licensure is:

- The boards responsible for licensing and determining educational requirements may by law include representatives whose interests are not aligned with the financial interests of the occupation in question, such as consumers, payors, and health services researchers.[22]

4.1.1.2 Quantity controls

In addition to quality-based entry requirements, some professions are subject to quantity and geographic controls. Quantity controls include:

- Explicit limits on the number of training places that are available;
- Limiting the number of educational institutions that are certified to provide training;
- Requirements of a centralized decision of a professional body for the creation of a new job opening, for example in a hospital; and
- Limiting the number and location of places of business or practitioners.[23]

Quantity controls are frequently justified by arguing:

- They are necessary in order to ensure adequate incentives to provide services in sparsely populated regions;[24] or
- They are necessary to limit the overall population of practitioners for (i) reducing professional-generated demand and (ii) reducing over-consumption resulting from insurance.

The justification for guaranteeing high returns for practice in sparsely populated areas is a form of guaranteeing access to goods of special social value. The argument requires that the difference between profits is set at a level higher than would otherwise be obtained. In absence of the quantity control, returns to operations of profession in a given place would be lower and more areas would be unserved.[25]

The justification of quantity limits in order to reduce over-consumption has merit. Over-consumption might arise either from supplier-induced demand or from insurance-based demand. Supplier-induced demand likely exists in many OECD members. In U.S. data, Fuchs (1978) found that the number of surgical operations rose 0.3% in the when the surgeon to population rate increased by 1%. In Japan, Izumodo et al (1999) find that "a 1% increase in physicians per capita leads to a 0.8% increase in inpatient

demand and a 0.4% increase in outpatient demand." For France, Delattre and Dormont (2002) find strong support for the existence of physician-induced demand. But Grytten and Sorenson (2001) find no evidence for physician-induced demand in Norway. Delattre and Dormont (2002) speculate that the reason for finding no physician-induced demand in Norway may be that there is a much greater scarcity of physicians per capita in Norway than in France or the U.S.. For the case of over-consumption resulting from insurance ("moral hazard"), the problem of over-treatment is likely quite significant. If individual recommendations by health professionals cannot be overseen, then quantity rationing may enhance social welfare, on the assumption that rationed care will go to the highest value use. Thus it appears that quantity restrictions may be justified. This is not to say that they are always desirable, but simply that the costs and benefits of such restrictions merit examination by policy makers for different professions.

One example of quantity restrictions has been that of Irish pharmacists. Restrictions exist on the number of training places and also existed, from 1996 to 2001, on the geographic distribution of pharmacies. Until recently, Irish pharmacist training rules limited the number of spaces to 70 at Trinity College, Dublin. When the government sought to increase the number of spaces nationally to 120, the applicant college was initially not accredited by the professional association, though two applicant colleges have now received accreditation and the first year of Irish-based training outside Trinity College, Dublin was 2003-2004. Because of EU mutual recognition agreements, individuals seeking to become pharmacists can train in other countries, such as the U.K., and then migrate back to Ireland. When they do so, working restrictions over foreign-trained pharmacists prevent them from ever working in a pharmacy less than three years old (and thus from starting a new pharmacy.) Given that most pharmacies have only one pharmacist and that pharmacist typically own a pharmacy, this makes establishing a career with foreign training difficult (OECD (2001))

Geographic limits deter the opening of new pharmacies. The geographic placement rules in Ireland included 3 "public health need" tests:

- The ratio of pharmacies to populations had to be at least 1:4000 in urban areas and towns over 3 000 in population and at least 1: 25000 in rural areas
- No other pharmacies within 250m in urban areas or within 5km in rural areas
- No adverse affect on the viability of existing community pharmacies in the area

These limits appear to have significant effects on new openings. Between 1996 and 2001 (when the 1996 rules were rescinded), only 48 new pharmacies were granted permission to open in Ireland.

Geographic restrictions are not unique to Ireland. Other countries, including Italy, Spain, Hungary, Norway, France, Australia and the UK, have restricted the number or location of pharmacies. (OECD (2001))

Automatic recognition of qualifications from other countries can significantly reduce the ability to unduly limit access through quantity restrictions. In the EU, for example, the European Commission and European Parliament have overseen the development of profession-specific mutual recognition rules. There are rules concerning mutual recognition of diplomas, certificates and other evidence of formal qualifications for dentists, doctors, midwives, nurses and pharmacists (Directives 78/686/EEC, 93/16/EEC, 80/154/EEC, 77/452/EEC, and 85/433/EEC respectively.) Any person with a qualification for a medical profession that exists in two or more member states will have mutual recognition rights for that profession in other states. Absence of automatic recognition rights can have significant effects. Shepard (1978) finds that lack of reciprocity in dental qualifications between U.S. states raises prices by 8.5-18 percent.

Possible approaches to reduce competition problems:

Some possible approaches to improve the market for health professional services related to entry limitations are:

- Quantity limits and geographic limits can be reviewed. Especially when a government seeks to limit entry to reduce over-consumption, however, such limits may still be worthwhile.

- Nationality or prior residence requirements can be eliminated. Such requirements restrict international trade in professional services.

- Mutual recognition of equivalent or superior qualifications across state or international boundaries can be implemented.

4.1.2 Exclusive rights

A given profession may have the *de jure* or *de facto* exclusive right to perform a given service. *De jure* exclusivity may apply, for example, when dental hygienists have a qualification system, but are not allowed to practice independently from a dentist. *De facto* exclusivity may occur when a procedure is reimbursed only when performed by a "qualified" specialist. As a result, consumers would not be reimbursed when services were performed by someone without the officially designated qualification. [26]

Exclusivity over performance of services can help to ensure the quality of the services. For example, Holen (1978) finds that licensing reduces the likelihood of adverse outcomes and increases the quality of care for dental services. Shapiro (1986) argues that licensing will benefit the segment of consumers that value high quality, in part because consumers who seek high quality will have a greater likelihood of receiving the high quality services.

However, exclusive rights can also lead consumers to eliminate some potential less-costly/less-trained providers from their search for a certain type of health care (e.g., midwives or dental hygienists) and focus only on those with a license (e.g. obstetricians or dentists).

Exclusive rights can prevent potential competitors (such as para-professionals) from performing an activity and can prevent potential competitors from fitting health care products. In particular, granting exclusive jurisdiction over the determination of performance rights to professional associations may lead to questionable exclusions. Exclusive rights may merit review to ensure they are necessary.

4.1.2.1 Limiting para-professionals and alternative professionals

When professions have an exclusive right to perform or oversee an activity that can equally well be performed by someone with significantly less training, there is a possibility of the creation of a para-profession. Para-professions are professions that are trained to support, complement, or supplement the work of other health professionals. Examples of para-professions include dental auxiliaries, medical technicians, and nurse midwives. Shaked and Sutton (1981) find that para-professions will improve consumer welfare and that, in fact, consumer welfare is most improved when the number of para-professionals is at the level that leads to the greatest loss of income for the members of the original profession.

Few studies have empirically examined the impact of limiting para-professional activity in health care. One that does make this comparison is Liang and Ogur (1987). The authors examined the impacts of

restrictions on use of dental para-professionals ("auxiliaries".) The study finds that restrictions on use of para-professionals raise costs but do not increase quality, as shown in Box 2.

Box 2. Dental auxiliary restrictions

Dental auxiliaries can be classified as hygienists, assistants, or expanded-function dental auxiliaries (EFDAs). A dental hygienist must complete a two-year post-secondary school program and then pass a state licensure examination. The hygienist's traditional functions are tooth cleaning, taking x-rays, and giving fluoride treatments. Dental assistants often have no formal licensure requirement and have a primary task of helping dentists, for example by passing them tools. An EFDA is a hygienist or assistant with additional training or experience that permits them to perform expanded functions, such as completing the filling of a cavity.

While U.S. states do permit auxiliaries to perform dental services (almost always inside a dentist office), the nature of the rights are often limited. Two types of restriction are most significant: limitations on the number of auxiliaries who can work for a dentist and limitations on the functions that an auxiliary can perform. For example, some states restrict the number of auxiliaries that a dentist can hire, limiting each dentist to no more than two auxiliaries. Some states limited the functions that can be performed by a dental auxiliary, including limits on performing preliminary oral examinations, taking radiographs, giving fluoride treatments, and completing amalgam restorations.

Dentists can then be viewed as both the suppliers of an input (their direct dental services, such as filling cavities) and the residual claimant of the profits of the dental services firm (profiting from the work of employees such as auxiliaries.) Auxiliary use restrictions can prevent dentists from achieving the most efficient combination of inputs.

Examinations of data from 1970 and 1982 find that prices of dental visits are 6-7% higher in states with restrictions on the number of auxiliaries per dentist and that prices of a number of services are also higher, by between 5-11%. These services include seven of ten procedures studied in 1970 and five of ten procedures studied in 1982, such as oral exams, teeth cleaning, fluoride treatments, and amalgam restorations.

Liang and Ogur (1987) note that an extensive literature based on experiments involving public health, university, military, and private dentistry practices suggests that there is no statistically significant difference between the technical quality of procedures performed by a trained EFDA and those performed by dental students or dentists.

Source : Liang and Ogur (1987)

Restrictions on para-professional practice are not just related to legal rules and regulations but can also be based on billing practices. For example, the Canadian Dental Hygienists Association (2002) reports that "provincial regulations now allow dental hygienists to practice in alternative settings" outside a dentist office. "However, the majority of insurance companies still do not recognize existing regulations and there is a misalignment between insurance company policies and provincial regulations. As a result, even in British Columbia where dental hygienists legally work unsupervised and can have their own practice, insurance companies still require the signature and billing number of a dentists before any payment is provided." (p. 16)

4.1.2.2 Limiting access to health-related products

The customization and consumer delivery of health care products, such as hearing aids, eyeglasses, and contact lenses, are often governed by a variety of rules that require the close involvement of associated professions. The main rationale for this involvement is that it ensures patients with diseases are identified and treated, ensures that products are properly fitted, and avoids the dispensing of unnecessary products by profiteers.

When professions have the exclusive right to prepare a consumer for use of a health-related product, careful consideration must be given to the question of whether and when the professional involvement is really necessary. Select issues related to eyeglasses, contact lenses, and hearing aids are reviewed below.

Eyeglasses – non-prescription glasses and prescription recency

In eye care, for example, there is an argument that optometrists or ophthalmologists should examine all patients with deteriorating vision to ensure there is not a troublesome and treatable medical cause for the deterioration such as glaucoma. One mechanism for leading such patients to the appropriate medical care is to require optometrists to examine all patients who seek new eyeglasses. Consequently, some Members require that all eyeglasses be purchased from optometrists or opticians. In Ireland, for example, "under Part VI of the Opticians Act, 1956, the High Court in 1990 granted an order restraining four retailers from selling readymade reading spectacles as they were not registered opticians or registered medical practitioners." (Indecon (2002)) In contrast, in Australia, the U.S., and certain other Members, readymade glasses can be purchased in pharmacies and other outlets.

Holding a "recent" prescription is normally necessary, even for vanity purchases. Laws frequently require that a new set of prescription glasses cannot be issued without a recent prescription. As a result, even when consumers do not detect any reduction in their acuity of vision, if they seek new glasses for reasons of style or replacement, they are forced to undergo and pay for an eye examination.

Contact lenses – distribution and mail order licensing

The availability of contact lenses through mail order services has raised new competition issues in recent years. For example, the U.S. state of Connecticut considered implementing a rule requiring the licensure of stand-along sellers of contact lenses, including out-of-state sellers, as optical establishments.

Offering consumers cheaper contact lenses can yield both financial benefits to consumers and health benefits. Some consumers experience health problems because they do not replace their lenses as frequently as they should. Disposable lenses are designed to be worn for a given period of time and then thrown away. However, many users wear their lenses longer than the proper time then suffer increased eye inflammation and eye infections. In a survey of consumers, 57 percent stated "they would replace their lenses more frequently if they cost less." Frequent replacement of lenses would reduce eye inflammation and eye infections. (FTC (2004))

Contact lenses were cheaper from mail order sources than others. In 1998, "the average price of a six-lens multipack purchased via mail order was 19.90 USD compared to an average of 23.76 USD for lenses purchased from ophthalmologists, optometrists, and optical chains – a 19 percent difference." (Federal Trade Commission 2004, pp 12-13.) The mail order price was actually very close to that of mass merchant discounters. So the primary advantage of mail order discounters was the reduction in travel time that results from mail order purchases. The Federal Trade Commission estimated that travel time to purchases lenses was valued between 10.96 USD and 26.00 USD. "Therefore, the convenience costs of policies that impede entry by mail-order replacement lens sellers could be substantial." (Federal Trade Commission (2002))

Forcing mail order firms to undergo expensive and burdensome licensure processes would deter their participation in the market and raise their costs, likely leading to higher prices.

The FTC concluded that "requiring stand-alone sellers of replacement contact lenses to obtain Connecticut optician and optical establishment licenses would likely increase consumer costs while producing no offsetting health benefits." (Federal Trade Commission (2002))

Hearing aids – over the counter model

In a recent proposal to the U.S. Food and Drug Administration (FDA), a third party requested that the FDA consider establishing a new hearing aid category that could be sold over the counter. (Killion (2003)) Existing hearing aids are governed by the Hearing Aid Rule of 1977. This rule requires consumers to see a physician prior to receiving a hearing aid. Alternately, adults can bypass a physician if they sign a waiver but then in most states the waiver and fitting have to be administered by a state-licensed hearing aid dispenser. Currently, state-licensed hearing aid dispensers and audiologists are the two primary sources of hearing aids.

Prices for hearing aids in the U.S. are high, with the average cost of a pair of hearing aids now reaching $2200. (WSJ, 24 March 2004) Under professional association standards, large batteries of tests are required when fitting hearing aids.

Largely because of this cost, only about 20% of those who would benefit substantially from hearing aids actually have them.[27] While it is unlikely that all potential beneficiaries would obtain hearing aids if they were cheaper, it is likely that adoption of hearing aids would increase substantially were hearing enhancement available at substantially lower prices.

Simple hearing aids that do not have custom earpieces and programming capabilities would be much cheaper to consumers and are technically feasible. For example, customizable digital hearing aids cost the NHS about GBP 70. (Hansard (2004)) Listening products with similar technology to hearing aids (used by hunters) retail for USD 149. The FDA recently rejected a proposal to sell standardized hearing aid products over the counter and to eliminate the physician screening requirement, instead maintaining the rule that, combined with professional association rules, may raise the price of hearing aids by more than 1000%.[28]

The FDA rejected the proposal to create a new category of hearing aid. In the rejection letter (Rothstein (2004)) the FDA does not consider the effect that lower prices would have on increasing the number of consumers with hearing aids. The FDA does note that the current system is more likely to diagnose treatable health problems. “Without appropriate screening for red flag conditions by a licensed physician, persons with hearing loss may purchase hearing aids to remedy their problems and may even experience some relief, while continuing to have serious medical conditions that should be properly diagnosed and treated. In some cases, this lack of, or at best delayed, diagnosis can lead to irreparable damage, further deterioration of hearing, or increased risks of surgery for the hearing aid user.” The FDA also notes that, prior to the existence of training requirements for selling hearing aids, many consumers were sold hearing aids by unqualified practitioners through aggressive selling methods.[29]

In contrast, European countries have more liberal rules that permit sales of standardized earpieces and thus have lower costs even for privately purchased hearing aids. Denmark and Germany, for example, are known for having low cost hearing aids. The National Health Service in the UK now provides free digital hearing aids fitted on high street locations.

The decision on whether to issue over-the-counter hearing aids involves a tradeoff between low price/greater distribution and the consequence of over-the-counter sales that some medical conditions that would now receive treatment will go untreated if consumers were not required to see a specialist.

4.1.2.3 Denying access to medical facilities and records

At times, professionals refuse to grant access either to facilities, equipment, or records that would be relevant to patients. These refusals may arise from purely individual behavior or coordinated behavior across the profession.[30] These limits are especially common (1) for paraprofessionals and alternative

professions that are not fully respected by more established professions as well as with paraprofessionals and (2) for associated health care products.

Alternative professions

When an alternative care profession, such as a dental hygienist or chiropractor, seeks access for their patients to facilities (such as X-ray labs) and to the X-rays and reports, many countries do not permit such access, but require a doctor or dentist to prescribe the X-rays and do not make them available to persons outside of the "approved" professions, even when the patients are willing to pay for private delivery of these services. In Italy and France, for example, chiropractors have not been able to prescribe and directly receive patient X-rays. Preventing direct access increases costs to patients or payors (by forcing patients to see other professionals with the "right" to prescribe, perform, and deliver X-rays) and, consequently reduces the probability of patients seeking their preferred treatment. Such denials raise rivals patient costs.

Legitimate reasons for denial of access might include an expectation of misuse or patient harm by rights of access. But given the potential anticompetitive purposes that may be associated with denials of access, it may be appropriate for refusing parties to bear the burden of proof to justify their refusals.

Health care product related records

At times, professionals may refuse to supply patients with information about their condition that could be used to purchase products from other sources. For example, in the U.S., there have been problems with release of prescriptions for eyeglasses and contacts. Some optometrists and ophthalmologists would not give the patient a written prescription for use at alternative suppliers of eyeglasses and contacts. This reduced the ability of patients to shop for alternative sources of supply for products. The U.S. Federal Trade Commission judged that such bundling practices were harmful to consumers and in the Eyeglass Rule, required that vision testers release a prescription to patients for their potential use with alternative suppliers. This rule did not apply to contact lenses, and contact lens prescribers frequently refused to release the prescription. So in the recent Contact Lens Consumers Act of 2003, and in the recent implementing rule of August 2, 2004, the Federal Trade Commission:

- Requires prescribers (such as optometrists and ophthalmologists) to provide patients with a copy of their contact lens prescription immediately upon completion of a contact lens fitting at no additional charge;

- Requires prescribers to provide or verify contact lens prescriptions to any third party designated by a patient;

- Prohibits prescribers from placing certain conditions on the release or verification of a contact lens prescription;

- Requires contact lens sellers either to obtain a copy of a patient's prescription or verify the prescription before selling contact lenses, and deems a prescription "verified" if, among other things, a prescriber fails to respond to a seller's verification request within eight business hours; and

- Establishes minimum expiration dates for contact lens prescriptions of one year, unless there is a special medical reason for a shorter prescription.

This rule is designed to ensure that "verification" requirements are not abused by prescribers for anticompetitive purposes with refusals to verify. A problem that can arise in the context of mail order sales

was the requirement that a contact lens seller receive a prescription from a licensed prescriber. This requirement can be interpreted in ways that promote competition or ways that restrict competition. For example, a broad interpretation of the requirement would allows consumers to mail in, call in, fax in, or provide in electronic form their prescription and, if prescription verification were necessary, allow the seller to contact the prescriber directly to verify the prescription. In contrast, requiring that prescriptions be verified in few or specific ways may limit competition.[31]

As rules have been introduced that require prescribers of contact lenses to release prescriptions to patients, some prescribers respond by issuing prescriptions that call for the use of a "private-label" lens. Private-label lenses do not carry the name of a national brand but instead are available for purchase only through that practitioner or associated retailer and thus limit the competition between contact lens sellers for that patient. However, private-label lenses can be the same lens as a national brand, but simply sold under the name of a prescriber practice. (Federal Trade Commission (2004)) Given that there are medical differences between contact lenses, and some may not serve a given consumer as well as others, there are legitimate medical reasons to prescribe specific types of lens (or prevent the filling of a prescription with certain types of lenses.) Some practitioners use private-label lenses in order to make customers reluctant to buy lenses elsewhere. (Federal Trade Commission (2004), p. 29) In the Fairness to Contact Lens Consumers Act, the issue of private-label lenses is addressed by requiring that prescriptions for private-label lenses include "the name of the manufacturer, trade name of the private label brand, and, if applicable, trade name of equivalent brand name." (16 CFR 315.2 (h))

Possible approaches to reduce competition problems:

Some possible approaches to improve the market for health professional services related to exclusivity are:

- Para-professions can be created where there is a clearly defined set of practices that require less training than the original profession and where quality of care will not be unduly reduced.
- Para-professionals can be given the right to practice independently and receive payments directly.
- Regulation of health-related products can be limited to the least anti-competitive restrictions that achieve the health care objective, considering both the potential costs of the restrictions (higher patient costs, reduced consumption) as well as the potential gains in medical evaluation that are promoted by the given profession.
- When not harmful, lower cost options can be permitted, such as (a) less-extensive testing and training for fitting low-danger health care products and (b) over-the-counter delivery of standardized products.
- The ability of professional associations to control whether competing professions will have ability to prescribe and receive private diagnostic services should be limited when limitations are dangerous to patients and are likely designed to damage potential competitors.
- Full information on prescriptions can be provided to consumers by law.

4.1.3 Organizational structure

Regulations governing the professions frequently limit the extent to which members of a given profession can group together to form a larger entity and also limit the corporate forms that are possible for a given profession, by limiting (i) the extent to which professionals are able to combine with other

professionals in the same area of specialty, (ii) the extent to which professionals can form a business venture with professionals from another area of specialty, (iii) the corporate form that can be adopted by members of a profession (e.g. partnership, limited liability), or (iv) the number of outlets that can be owned by one entity (as with many pharmacy regulations).

Such rules exist for at least three reasons:

- A belief that independent health professionals will have the best incentives to maintain quality and serve patient interests when there is no external force, such as an employer, urging them to increase revenues;

- A belief that local owners will have the greatest incentive to maintain professional standards (because loss of professional standing in their location would drive them out of business);[32] and

- Avoiding conflict of interest by preventing one branch of professionals from receiving financial gains from the activities of another branch.

Such rules limit potential efficiency enhancements that may arise from scale and vertical integration. As a result, they merit careful review.

Ownership and employment restrictions

One example of organizational structure restrictions is rules that prevent corporate ownership of pharmacies. Pharmacies can be owned by corporate agents in the U.S., Canada and the U.K., but in many other jurisdictions, pharmacies must, by law, be owned by pharmacists and the number of pharmacies that can be owned by a pharmacist is limited. Looking to the country with the largest corporate ownership of pharmacies, a recent study by Consumer Reports magazine checked prices for a basket of five drugs at 130 U.S. pharmacies and received feedback on over 40,000 pharmaceutical purchase experiences by more than 32,000 readers. (Consumer Reports (2003)) The study found that quality of service was perceived as lower at corporate pharmacies than supermarket pharmacies, mass merchants or independently-owned drugstores.[33] Drugstore chains and supermarkets were more likely to be out of a requested drug. "When a drug was out of stock, independents were able to obtain it within one day 80 percent of the time, vs. about 55 to 60 percent for other types of stores." Interestingly, the corporate pharmacies had low quality ratings, but among the highest prices of the pharmacies tested. Independently-owned pharmacies had the highest quality ratings and almost the highest prices.[34] Prescriptions were filled most cheaply at Internet pharmacies and mass merchants. Thus corporate ownership is associated with lower prices when pharmacies are inside other stores.

For at least some services, corporate ownership is likely beneficial for consumers. For example, the FTC study of eyeglasses and optometrists (Bond et al. (1980)) described in Box 3 below, found that corporate-owned facilities offered a price-quality combination that was not available outside of chainstores, namely lower quality glasses and exams at significantly lower prices than other locations. Importantly, the study did not suggest that quality falls overall after the entry of chain stores selling eyeglasses and providing eye exams. Rather, the entry of chain stores produces a different quality/price option, thus increasing consumer choice.

Affiliated financial interests

One of the objectives of health care regulatory regimes is to control costs and reduce the role of financial incentives in affecting the course of health care treatment. Commonly, physicians are prevented from holding financial interests in entities to which they refer their patients. These prohibitions are

designed to prevent kickbacks for referrals. In the U.S., the Stark law prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of "designated health services" if the physician (or a member of the physician's immediate family) has a direct or indirect financial relationship with the entity. There are eleven categories of designated health services, including, for example, laboratory, radiology, physical therapy, home health, outpatient prescription drugs and inpatient and outpatient hospital services.

Some restrictions on affiliation with other financial interests may yield inefficient delivery mechanisms. But the European Court of Justice (ECJ) has given significant latitude to professions to determine whether associations between different professions are appropriate. In the Wouters judgment, the ECJ examined a professional rule (by the lawyer's professional association of the Netherlands) that forbade partnership practice with other professions, including accountants, and limited a group of lawyers from practicing with accountants. The general principle that was articulated likely applies to the health care professions and is that professional rules shall be allowed only insofar as necessary to protect the proper functioning of the professions. Specifically, "For the purposes of the application of that provision to a particular case, account must […] be taken of its objectives […], qualifications, professional ethics, supervision and liability, in order to ensure that the ultimate consumers of legal services and the sound administration of justice are provided with the necessary guarantees in relation to integrity and experience." (Wouters Judgment, paragraph 97.)

Possible approaches to reduce competition problems:

Some possible approaches to improve the market for health professional services related to organizational structure are:

- Permit corporate employment of professionals in uninsured professions that deliver commoditized products, such as eyeglasses, contact lenses, hearing aids, and dentures
- If financially abusive over-treatment is common in the prescribing of "affiliated products," consideration should be given to a "conflict of interest" rule that prevents a prescriber from having a financial interest in the sales of prescribed products.
- Review restrictions on organizational form with a view to achieving economies of scale and scope.

4.1.4 Consumer redress

Some critics argue that licensure is not necessary for health professions and that market solutions are sufficient to maintain quality. One market solution would be based on liability and guarantees, in which substandard provision of services would result in financial losses to health care practitioners (or their insurers). Such a system would provide insurers with the incentive to verify quality and could deter low-quality practitioners from practice while maintaining the maximum amount of practitioner competition.

A "high liability" regime exists in the U.S., especially in certain states that do not limit the amounts of non-economic damages that can be obtained from patient malpractice claims. It is worth examining this regime to see the extent to which it maintains quality or increases costs.

The high-liability regime has significant direct and indirect effects on health care costs. The direct effects of the high-liability regime consist of increased costs to physicians as a result of payment of insurance premiums. In 2000, physician premiums amounted to USD 6.3 billion (or about USD 10,100 per physician.)[35] State regulations that limit non-economic damages have a significant impact on the costs for

some professions. For example, an obstetrician in Florida paid USD 143-203k for liability insurance in 2001, while an obstetrician in California paid USD 23-72k. (U.S. Department of Health and Social Services (2002)).

The indirect effects are estimated to be much larger than the direct effects. Overall, the Department of Health and Social Services estimates that federal spending is increased by USD 28.6-47.5 billion USD as a result of the high liability regime in the U.S., primarily as a result of defensive medicine costs of USD 23.7-42.6 billion.[36] One major study suggests that health care costs in the U.S. could be reduced by 5-9% without adversely affecting quality of care by limiting malpractice liability. (Kessler and McClellan (1995))

While health care costs are likely increased substantially by high liability regimes, the benefits for consumers from these regimes are modest, particularly because the claims system is unpredictable, slow, and costly.

- Only a small percentage of patients injured by medical negligence actually file a claim; one study estimates that this figure is 1.53%. (Localio and Lawthers (1991)) Thus most injured consumers do not receive any recompense;

- Successful claimants typically do not receive anything on average until five years after the injury. (US Department of Health and Social Services (2002); and

- The costs of system administration, legal expenses, and litigation are so large that only 28% of what is paid for medical malpractice insurance actually goes to patients. (US Department of Health and Social Services (2002))

Liability systems do have an advantage in dealing with professions when there is little willingness to require exit of low-quality of practitioners. Insurers can raise rates for low-quality practitioners or refuse coverage. This can provide a financial incentive for low-quality practitioners to exit service provision, but this beneficial impact is difficult to quantify.

4.2 Behavioural rules

Behavioural rules govern publicity, solicitation, and fee-setting. They are among the most egregious limitations of competition because they do not appear to produce many consumer benefits and can yield substantial consumer harms.

4.2.1 Conduct rules

Professional organizations often introduce rules that govern the behaviour of members, such as limiting advertising of services and prices to consumers or, more generally, limiting the ability of a professional to solicit customers.

The main rationale for advertising limits is that they:

- Eliminate deceptive advertising that would mislead consumers;

- Make it more difficult for low quality providers to gain customers; and

- Prevent wasteful advertising that would simply raise costs for members of a profession. In particular, once one professional advertises, then other professionals may also feel the need to

advertise. Professions may then argue that advertising will raise their costs, and ultimately those of payors.

Conduct limits such as advertising restrictions and customer solicitation limitations are among the most problematic professional rules. There is no evidence that these serve to benefit consumers and there is evidence that the elimination of restrictions is beneficial to consumers. Restrictions that prevent truthful advertising limit information available to consumers and raise search costs. Advertising limits are especially harmful because they make successful entry of a new professional into a local geographic market difficult.

Some associations, for example, have a points system for membership that illustrates the importance attached to conduct rules. According to Benham and Benham (1975):

> "Eligiblity for membership in the Michigan Optometric Association is based upon a point system. Initially, 65 points will the minimum required for membership application. Members entering the association with fewer than 85 points must improve their point count standing a minimum of five (5) points each calendar year until at least 85 points are achieved. Thereafter, a minimum of 85 points must be achieved yearly in order to maintain membership.
>
> The point evaluation plan of the association, in condensed form, is as follows:

Table 2. Total points possible for

Not advertising (refers to media advertising, telephone book listings, and window displays)	30
Location in a profession of office building as opposed to "an establishment whose primary public image is one of reduced prices and discount optical outlet"	25
Limiting office identification sign to approved size and content	15
Educational activities	14
Physical facilities	8
Functional facilities	8

> Note that out of the 100 possible points, information constraints account for 70." (p. 425)

While information constraints have been common in many professions, not just health care professions, there is little evidence that these constraints actually benefit consumers. As a theoretical matter, rules that constrain truthful price advertising or solicitation of customers raise search costs and likely yield higher prices.[37] In fact, the FTC eyeglass study (as detailed in Box 3) showed that price advertising of eyeglasses and eye exams lowers prices without significant reductions in average quality.[38]

Box 3. FTC optometry study on the relationship between advertising restrictions, prices, and quality of eye exams and eyeglasses

In 1980, the U.S. FTC published a staff report on the effects of restrictions on advertising and commercial practice in the optometry profession (Bond et al., 1980). The study sought to better understand the relationship between advertising restrictions, price, quality of service, and corporate ownership. It merits review because it is one of the best studies of competitive impacts of restrictions that arise in the health care professions. It took advantage of the fact that regulation of optometry and eyeglass sales is not uniform across the U.S.: in some areas, advertising is restricted, while in other areas, advertising is permitted. The study's basic results compare price and quality of service in cities with strong advertising limits and no corporate ownership ("Restrictive cities") to areas with price advertising of eyeglasses and non-price advertising of eye examinations in the presence of large chain optical firms ("Nonrestrictive cities"). The results suggest that average prices were substantially lower in cities with the least restrictions on advertising but that average quality of service did not suffer.

The study involved sending survey research experts ("testers") to undergo eye examinations and purchase eyeglasses

in cities around the United States. 434 observations serve as the basis for the results, with each observation representing an examination and potential purchase of eyeglasses. The FTC took great care to develop medically appropriate quality measures by involving senior optometrists and optometry schools in the design, preparation, and evaluation of results.[39]

Prices

Prices were based upon receipts collected by the subjects for the 280 instances in which both examinations and eyeglasses were purchased. Subjects were requested to purchase a particular type of unisex metal frame, if available, in order to minimize cost variation. The study found that average prices of an eye examination and eyeglasses in the most restrictive cities were, on average, 33.6% higher in the most restrictive cities than in the least restrictive cities and that this difference was statistically significant. Table 1 summarizes these results.

Table 1. Estimates of Average Prices Charged for Examination and Eyeglasses

	Restrictive cities	Non-restrictive cities
All optometrists	$94.46	$70.72
Non-advertisers*	$94.64	$73.44
Advertisers	None	$63.57
Chain firms	None	$61.37

*Excludes optometrists who advertise on site

Quality

Many professionals would argue that simple price comparisons fail to take account of quality differences and that an assumption of equal quality between most restrictive cities and least restrictive cities would be unjustified. In particular, some observers might predict that advertising would lead professionals to lower the quality of service they offer and that, in response, even non-advertising professionals would lower their quality of service. In order to measure quality, subjects filled out a form after each visit that asked questions about the details of the examination. Glasses that were purchases were collected and evaluated for quality. Moreover, each subject was examined by two optometry schools in order to determine the appropriate prescription, so that this could be compared with optical prescriptions found in the field. The study assessed four different quality measures: (1) the thoroughness of the eye examination (2) the accuracy of the prescription (3) the accuracy and workmanship of the resulting eyeglasses and (4) the extent of unnecessary prescribing.

Thoroughness

The estimates of thoroughness of eye examinations found that (1) “Examinations purchased from optometrists in restrictive and non-restrictive cities are, on average, of about equal thoroughness” (2) “Examinations purchased from large chain firms and advertising optometrists are, on average, less thorough than examinations purchased from the nonadvertising optometrists in non-restrictive cities” and (3) “Examinations purchased from nonadvertising optometrists in non-restrictive cities are, on average, more thorough than examinations purchase from nonadvertising optometrists in restrictive cities.” Table 2 summarizes these results.

Table 2. Estimates of average thoroughness of eye examinations (FTC Index out of 100)

	Restrictive cities	Non-restrictive cities
All optometrists*	58.5	61.6
Non-advertisers	58.8	70.0
Advertisers	None	47.4
Chain firms	None	51.6

* Excludes optometrists who advertise on site.

These results may appear confusing. But the most interesting point is that the variation in thoroughness in restrictive cities is actually quite broad (and similar to that of non-restrictive cities.) Thus the average and the variation of thoroughness are actually very similar in both types of cities, but in the non-restrictive cities, consumers can better predict in advance whether practitioners that will provide the better quality product (the nonadvertisers had better quality.)

Optometrists giving thorough examinations were not driven out of the market in cities with advertising. About 55% of optometrists in non-restrictive cities do not advertise.

Accuracy of prescription

The prescriptions received by subjects were forwarded to two optometry schools, without identifying information of the name, location and affiliation of the prescribing optometrist. The faculty were then asked to judge whether each prescription was appropriate using a pass-fail standard. The results suggested that advertisers and chain firms produced prescriptions that were equally or more appropriate than those of optometrists in restrictive cities.

Table 3. Estimates of the percentage of prescriptions judged appropriate by one or both schools

	Restrictive cities	Nonrestrictive cities
All optometrists*	82	88
Non-advertisers	82	88
Advertisers	None	90
Optical chain firms	None	86

* Excludes optometrists who advertise on site.

Accuracy and workmanship of eyeglasses

The eyeglasses produced were evaluated for their quality of workmanship by ANSI standards (highly technical standards that are very demanding, hence the high rate of inadequate glasses.) Eyeglasses from restrictive cities did not appear to be of higher quality than those from non-restrictive cities.

Table 4. Estimates of the percentage of eyeglasses judged adequate by ANSI standards

	Restrictive cities	Nonrestrictive cities
All optometrists*	50	64
Non-advertisers	50	64
Advertisers	None	70
Optical chain firms	None	52

* Excludes optometrists who advertise on site.

Extent of unnecessary prescribing

One particular concern often expressed is that commercially-owned organizations (such as optical chain stores) will be more likely to prescribe eyeglasses when they are not really needed than non-commercial organizations. This is one basis for limiting the rights of commercial organizations to employ professionals such as optometrists. To evaluate this concern, the study developed a special scenario to test this hypothesis. 123 examinations were taken by 5 subjects who arrived at their examinations wearing eyeglasses that the FTC's consulting optometrist believed to be appropriate. The subjects were instructed to tell the optometrists they wanted new glasses only if they would make a real difference in their ability to see. The results do not provide a basis to believe that chain stores would be more likely to recommend inappropriate eyeglasses. If anything, they suggest that restrictive cities are more likely to prescribe unnecessarily, but there are not sufficient observations to determine this with a high degree of confidence.

Table 5. Estimates of the percentage of optometrists prescribing unnecessarily

	Restrictive cities	Nonrestrictive cities
All optometrists*	32	12
Non-advertisers	32	9
Advertisers	None	18
Optical chain firms	None	14

* Excludes optometrists who advertise on site.

Source : Bond et al. (1980)

Advertising limits may sometimes be narrowly tailored so that they permit price advertising but prevent certain forms of truthful advertising, such as comparative advertising. In the Indecon (2002) study, the authors discuss Ireland's comparative advertising limits in optician/optometry services and state "we are of the view that the current restrictions on advertising by optometrists/opticians are likely to be harmful to competition in the profession. In particular, the restrictions on comparative advertising are likely to be harmful to normal competitive behaviour within the marketplace." (p. 479)

Possible approach to reduce competition problems:

One possible approach to improve the market for health professional services related to advertising is:

- Permit truthful advertising by health care professionals and companies.

4.2.2 Fee setting

Representatives of a profession may suggest fees for their members. Fee-setting may occur directly, through published price lists, or indirectly, through mechanisms that prevent discounting. A pro-consumer justification for such a practice is to provide clarity to consumers and to prevent consumers from being overcharged for services. However, common fee setting can be one of the most troublesome activities of health professions.

Instances of joint fee setting occur in health care professions across many jurisdictions, as can be documented from a number of different antitrust cases.

- In October 2003, the Dutch competition authority announced initial findings in an investigation of psychological service provision. The authority found that four regional psychology and psychotherapy associations were setting recommended prices for their members. These organizations represented 60% of the relevant markets and their recommendations were followed, leading to higher prices for the services of interest. The recommendations were thought to have an impact in part because they enhanced the ability of a professional to predict competitor pricing and reduced the probability of low prices. (NMa (2003, 2004))

- In Brazil, in March 2002 CADE imposed restrictions to the Coopanest/GO due to price fixing. According to the petition, the association of anesthetists in the state of Goiás was establishing a uniform price for services. (OECD (2002))

- In December 2001, the Australian Federal Court ordered the medical association's Western Australia branch and two officer to pay penalties and costs totaling $285,000 for price fixing and primary boycott breaches of the Trade Practices Act for problems relating to services by visiting doctors and the Joondalup Health Campus in Perth.

Fee setting actions do not always involve announcing a fee target but can also involve preventing discounting. Mechanisms can include "ethical rules" or even lease arrangements. The "ethical rules" method was identified in the US Federal Trade Commission's American Medical Association case (1979) when the Commission held that the American Medical Association had illegally restrained competition, by, among other means, instituting "ethical guidelines" that prevented physicians from setting prices for a service that were significantly below the common price for the service in their geographic area.[40] A lease arrangement that prevented competition was identified in Australia, in March 2003, when a federal court declared that a doctor had been coordinating a boycott of bulk-billing and after hours service through lease agreements in a medical building that imposed obligations on general practitioners not to provide bulk-billing except to a limited set of patients and not to provide medical service to patients after 8 p.m. Monday through Saturday or after 1 p.m. on Sundays.

One proposal to improve the efficiency of physician fee bargaining with multiple insurers is to permit physicians to hire a shared bargaining agent who does not communicate the proposed prices of any individual practice to other practices but simply serves as a messenger.[41] When fees are set through such a bargaining agent, there is nonetheless a risk that the agent will not act as a neutral arbiter but instead as a joint negotiator.[42] The identification of illegal joint fee-setting can then be based on rule of reason, rather

than per se analysis. Joint fee-setting is legal in some jurisdictions, as long as a proposed organizational form has efficiency effects (that may arise, for instance from risk-sharing arrangements) and the joint fee setting is deemed necessary for the achievement of efficiencies.

Uninformed consumers may sometimes derive comfort from standard fee schedules, because they assume that overcharges will be less likely under a fee schedule. Standard fee schedules can serve to protect uninformed customers who do not know what a fair price would be for a given service.[43]

Possible approach to reduce competition problems:

Some possible approaches to improve the market for health professional services related to fees and discounting are:

- Do not allow professionals working for different entities to determine fee schedules or recommended maximum fee schedules jointly (when there is no agreement by persons or organizations representing the consumer and payor interest) unless there is an efficiency justification for doing so.

- Do not permit professional associations to ban discounting of fees relative to other professionals.

5. Proactive methods to reduce imperfections and increase beneficial competition

In the previous section, solutions to various competition problems arising from common practices in the health professions are identified. In addition, some more general policies can be considered, including:

- Improving consumer information;

- Creating contractual mechanisms that encourage competition; and

- Competition law enforcement and advocacy.

5.1 Consumer information

One of the most fundamental problems in the health professions is that information on the quality of practitioners is difficult to find. As a result, consumers often select their providers of care by a number of non-objective methods, such as referrals, recommendations by acquaintances, institutional reputation, and random selection. While referrals may yield good practitioners, not all practitioners have good referral networks. Enhancing the information available to consumers may permit them to make more informed choices and identify low-quality practitioners. This is particularly important in the area of life-threatening diseases and medical procedures with significant risk, such as open-heart surgery. Thus there have been a number of initiatives, often opposed by professions, to provide practitioner-specific information to potential consumers. The thought is that such information will both increase the market share of higher-quality providers and lead low-quality providers to improve their quality.

Providing objective information on skill level is difficult. The most obvious measures to assess quality would look at patient outcomes. However, the initial patient complexity influences the subsequent probabilities of successful treatment and the initial complexity is difficult to assess in a systematic way across patients. For some procedures, such as heart surgery, patient outcomes may be measured with high accuracy (e.g., frequency of death within a specified period of time.) But if the higher-skilled professionals treat the more complex cases, the frequency of patient death can, at least in theory, be higher for the more-skilled professional than for the less-skilled professional.

One impact of "report cards" can be that lesser-skilled professionals will seek to move their sicker patients to other professionals. As a result, the ability of report cards to distinguish lesser-skilled professionals may decline, although part of this may involve a more appropriate division of patients, so that lesser-skilled professionals see fewer sick patients. The other impact is that higher-skilled professionals may also not want to treat sicker patients because of the likely impact on their rating. This can leave the more problematic patients without treatment.

A recent study has carefully examined the short-term impacts of physician report cards and finds disappointing results. Provider-specific "report cards" have been issued for heart surgeons performing coronary artery bypass grafts (CABG) surgery in two states of the U.S., New York and Pennsylvania. The reports list, for each surgeon, the mortality rate of their patients and the "risk-adjusted" mortality rate. The risk adjustment is based on clinical information that exceeds that provided by discharge databases. Dranove et al. (2003) found that:

- A higher proportion of complex cases receive treatment in teaching hospitals;
- In total, fewer complex cases receive CABG surgery;
- The time between a heart attack and surgery increases substantially, for both complex and non-complex cases; and
- More non-complex cases receive CABG surgery.[44]

Thus while there is some movement of patients to better professionals, one major effect of report cards is a reduction in the number of complex cases that received CABG.[45] These results are consistent with survey evidence in which 59% of cardiologists stated that report cards made it more difficult to place severely ill candidates for CABG. (Schneider and Epstein (1996))

Information about price can often be improved without fear of negative effects. For example, many practitioners do not provide price information to consumers in advance of performing procedures, not even estimates that are subject to change. This limits the ability of consumers to shop around for cheaper providers because they only find out ex post what their charges are. The U.K. has recently imposed an obligation on dentists to ensure price information is produced to the party responsible for payment in advance of procedures (except in cases of emergency.)[46]

Another information enhancing mechanism can be second opinions. When an expensive procedure is recommended by one specialist, it can be worthwhile to encourage second opinions. Second opinions are beneficial because the opinion provider receives no financial gain from recommending an expensive procedure as opposed to a cheaper alternative.

5.2 Contracts to promote competition

In the health professions, contractual mechanisms between providers and payors determine the financial incentives of professionals to provide appropriate services. Even in government-financed environments, contractual arrangements can be developed that give good incentives to providers of services to deliver at lower cost or more quickly. For example, general practitioners can be given a "fund" to spend for their patients, as described in Box 4 on fundholding. This approach is feasible in systems with a primary care gatekeeper, as in Denmark, Italy, the Netherlands, Norway, Spain, and the U.K.

Box 4. Fundholding

The UK's National Health Service introduced a fundholding option into general medical practice in 1991. The concept is that general practitioners are given a fund to pay for the services of their patients. The size of the fund is determined based on the practice's number of patients, the patient demographics, and spending prior to the practice's adoption of fundholding. GPs would direct their patients to particular providers of services, and payments would be made to those providers from the fund. Any surplus funds remaining could be used for improving the GP's services to patients, for example by improving practice premises. While such payments are not direct income, they can be converted into capital upon sale of a practice. The funds were meant to permit GPs to purchase the same bundle of services they had purchased prior to fundholding.

The fund would have two main effects. The first was to allow GPs to direct patients to specialists and hospitals that could, in one way or another, offer a better ratio of quality to price. The second was that GPs would act with an explicit notion of rationing in their decisions on how to allocate care to patients, the idea being that GPs would be in a better position than anyone else to determine the degree of necessity of teats and treatments for patients. Not all general practitioners entered into fundholding, and not all procedures were covered out of the fundholding budget, but a significant amount of spending on the GPs patients was covered. By 1997, over 50 percent of the population was registered with a fundholding practice and fundholding expenditure accounted for 15% of National Health Service expenditure on secondary care. (Dusheiko et al (2004a), p.3) Note that fundholders would not pay for all secondary care, especially the most expensive procedures.

There was a major problem with the system. The hospitals who received funds from the fundholders did not risk going bankrupt if they did not cover their costs, because of safety nets from the government, and they did not get to keep the gains from fundholding, because central NHS managers would reduce hospitals' "excess funds" whatever the origin. So while the GP had a number of good incentives to seek careful and better care for patients, hospitals did not have an incentive to respond. (LeGrand (1999))

Fundholding was eliminated in 1999. This permitted researchers to examine on a national basis how formerly fundholding practices behaved when the fundholding constraint was removed. After 1999, elective admissions in categories covered by the scheme increased by 3.9% for the former fundholding practices. Overall research suggests:

- "The results suggest that budgets had a small but significant effect on the admission rates of practices which chose to become fundholders." (Dusheiko et al (2004a) p.1)
- Waiting list times were reduced for the patients of fundholding physicians (Dowling (1997))
- Patient satisfaction appears to have decreased somewhat as a result of fundholding. Dusheiko et al (2004b)

While the original fundholding system was eliminated, it has been replaced by a modified system that includes all general practices within large primary groups, known as Primary Care Trusts.

5.3 Role of competition law and advocacy

Professions may seek to enhance their market power and incomes in a variety of ways, including mergers, price-agreements, and unionization. There are substantial problems in detecting and enforcing abuses of market power by the health professions. One reason for this is that physician group mergers are rarely reported to competition authorities and often are too small to merit agency analysis on an individual level. Many authorities nonetheless vigorously apply competition laws (1) to professional association rules whose primary effect is to undermine competition and (2) to professionals who seek to achieve market power for the purpose of setting prices or co-ordinating boycott activities.

Medical professionals sometimes argue that they should not be subject to competition law and that competition law is inconsistent with the ethical obligations of doctors to patients. But as a Commissioner for the ACCC said about Australian health professions, "[a]ll sectors of the Australian economy, including

taxpayers, have a legitimate interest in health professionals competing fairly so they are provided with better quality services at competitive prices." (Bhojani (2002))

Applying competition laws to health care professions can have beneficial effects for consumers. In recognition of this, in some jurisdictions, antitrust exemptions for health care professions have been eliminated, as they were in Australia in 1995 when health professions were placed under the oversight of the Trade Practices Act of 1974. In contrast, in other jurisdictions, attempts have been made to introduce exemptions where they did not exist before. For example, in the U.S., a series of laws to provide antitrust exemptions for physicians were proposed on a federal level, although none passed.[47]

Areas of competition agency litigation have included: agreements not to compete, agreements on price or price-related terms, agreements to obstruct innovative forms of health care delivery or financing, restraints of advertising, including private association restraints, licensure board restraints, illegal tying and restrictions on access to hospitals and medical facilities. The U.S. has been the most active OECD jurisdiction in competition law enforcement, because of its large health care private sector and the competitive environment of health professionals in this jurisdiction. Defendants in government-led cases have included many areas of health care practice including anesthesiologists, chiropractors, dentists, hospital medical staff, medical associations, obstetricians, optometrists, osteopaths, pharmacy associations, pharmacy networks, physicians, physician contracting networks, podiatrists, psychologists, radiologists, and surgeons. (Federal Trade Commission (2004))

Competition advocacy and policy transparency can be extremely important and effective in the health care professions. Transparency is important because there is a frequently a high degree of uncertainty by health care practitioners about what behaviors are illegal. Agencies can develop programs to provide information to the health professions on activities that are problematic both towards the profession by other economic actors and by the profession. For example, the Australian Competition and Consumer Commission recently issued an extensive packet of information for delivery to medical professionals called the ACCC Info Kit for the medical profession. (ACCC (2004a, 2004b, 2004c, 2004d, 2004e, 2004f, 2004g)) This packet was developed in consultation with the ACCC's Health Services Advisory Committee that includes representatives of medical and health–related professions as well as health consumers. The Kit includes leaflets addressing topics such as: what sorts of behaviors are inappropriate towards doctors by other fee-setting organizations, establishing joint activities between independent doctors (specifically medical rosters), and talking with patients about expected costs. Another form of transparency involves the issuance of guidance letters in response to specific questions submitted by health care practitioners or their legal counsel. The U.S. agencies have a long history of dealing with health care issues in their advisory "business review" letters that serve as the response to questions by the private sector.[48]

Advocacy efforts can focus on providing advice to professional associations, lawmakers and rulemakers when activity being considered or already taken would harm beneficial competition. In response to recent efforts to create central bargaining units for physicians in the U.S., the Federal Trade Commission submitted testimony to Congress stating that in response to central bargaining, "we can expect prices for health care services to rise substantially." (Pitofsky, 1999) The FTC has also issued letters to legislatures of at least four states that were considering legislation that would enable collective bargaining by physicians. Many agencies are newer to the health professions and have not engaged in advocacy, especially because many health professions are already overseen by the government. The importance of advocacy, such as letters and briefing for relevant rulemakers and lawmakers, should not be underestimated. In the rules and regulation process, there are often few representatives of consumer and competition interests.

In addition to government antitrust actions and advocacy, private antitrust actions by professional associations, where permitted, can have substantial beneficial impacts on competition in addition to

government actions. Established professions can take actions that limit the ability of related professions to practice, especially para-professionals or alternative associated professions, such as chiropractic. See Box 5 for information on actions that a medical professional association is alleged to have made with respect to another profession and how the alleged violations were dealt with by a court.

Box 5. Wilk et al. vs American Medical Association (AMA)

The case of Wilk et al. vs AMA was a private antitrust suit filed in 1976 and ultimately resolved in 1987. The plaintiffs alleged that the defendants (representing established medical professions in the U.S.) acted to limit the rights of their members to associate with chiropractors with a view to containing and eliminating the chiropractic profession. The defendants were the AMA, the American Hospital Association (AHA), the American College of Surgeons, the American College of Radiology, the American Academy of Orthopaedic Surgeons, and the Joint Committee on Accreditation of Hospitals. The 5 plaintiffs were chiropractors from states where chiropractic was a licensed health care profession and there were no laws prohibiting chiropractors from practicing in a hospital setting or laws preventing hospitals from providing x-ray and laboratory services to chiropractors or making reports and x-ray films available to chiropractors. The case went to trial by jury in 1980, and to appeal in 1983. The appellate court set forth the standards of a "patient care defence" that defendants would have to satisfy at re-trial.

If a plaintiff established an otherwise illegal combination in restraint of trade, the defendants would be excused and not liable if they could show:

- In their opposition to chiropractic, they were genuinely concerned for the use of proper scientific method in the treatment of patients;
- This concern was reasonable;
- This concern was the dominant motivating factor in the potentially problematic conduct; and
- This concern could not have been adequately satisfied in a manner less restrictive of competition.

In its findings of fact, the court stated that by September 1963, the AMA set an objective of "the complete elimination of the chiropractic profession." (p.10) To this end, the AMA established a Committee on Quackery.[49] In trial, the director of the Committee stated its objective was not the elimination of chiropractic but chiropractic as a health hazard. But the court found the Committee worked to discourage colleges, university, and faculty members from cooperating with chiropractic schools and established an ethical framework that would frustrate and prevent professional association between medical professions and chiropractors. The AMA member rules: (1) made it unethical for a physician to associate with an unscientific practitioner, (2) passed a resolution by the AMA House of Delegates that deemed chiropractic an "unscientific cult", and (3) issued an opinion by the AMA Judicial Council that stated it was unethical for a physician to associate professionally with a chiropractor. "Associating professionally" included making or accepting referrals, providing any services (such as x-rays or patient records), practicing together in any form, and taking part in educational programs with chiropractors.

The AMA was then found to have worked with other professions to enact similar bars to professional cooperation and in the 1970s, the Joint Committee on Accreditation of Hospitals told hospitals enquiring about the role of chiropractors in hospitals that "the Commission would withdraw and refuse accreditation of a hospital that granted privileges to chiropractors."

The 1987 Judgement found that the AMA had not met either point (b) or (d) of the patient care defense. As a result, the AMA was enjoined from "restricting, regulating or impeding…the freedom of any AMA member, institution, or hospital to make an individual decision as to whether or not that AMA member, institution, or hospital shall professionally associate with chiropractors, chiropractic students, or chiropractic institutions."

Prior to the issuance of the 1987 Judgement, the AHA settled with the chiropractors and adopted a policy statement declaring that individual hospitals were free to determine their own policy toward chiropractic services in a hospital setting.

6. Conclusion

Health care professionals provide services of great value to society, but the rules that govern their professions and licensure sometimes have anti-competitive effects, such as:

- Increasing prices to payors, particularly outside of an insured environment;
- Limiting information that is available to consumers for making choices;
- Limiting the quality/price tradeoffs that can be made by payors;
- Reducing competition between providers within a profession; and
- Preventing other professions from performing their tasks independently.

In many OECD Members, government actions relating to the health professions have legitimate public policy objectives but unduly enhance market power and increase entry barriers. Governments should take great care when awarding exclusive authority to perform certain types of procedures to certain professions, and when preventing professionals from establishing independent offices or new locations. While competition agency officials are likely not qualified to review all health-oriented aspects of the health professions that may limit beneficial competition, there is a likely need to prevent the professions themselves from controlling all the structural and behavioral aspects of their professions.

Mechanisms for reducing the harmful practices of professions can include:

- Ensuring that consumer, government and payor representatives have a voice in decisions on licensure;
- Reviewing laws or rules that give legal or de facto exclusivity to perform procedures to a single profession and, where appropriate, modifying them;
- Preventing practitioners from setting fees jointly, whether via professional associations or other means, when a fee schedule is not overseen by payors;
- Enhancing comparative information available to consumers;
- Reducing or eliminating requirements for associated health care professionals to be involved with the customization and delivery of health care products;
- Enhancing access to medical facilities and records by patients and their chosen health care practitioners;
- Giving gate-keeping physicians a limited fund for spending on their patients' care;
- Eliminating limits on truthful advertising.

These possible solutions are not universal recommendations. Rather, because of the great variety of financing schemes and social values inherent in OECD member health schemes, there is a complex web of interests and health impacts that can arise from a given recommendation in a particular profession or country. This paper thus provides a basic, non-exhaustive list of approaches that may be considered for increasing competition. Decisions about whether to implement such approaches can be based on weighing

health impacts, government regulatory costs, industry compliance costs, high prices due to reduced competition, reduced desirable quality variation, increased search costs, efficiency losses from different types of regulation, impacts on patient-provider relationships and impacts on broad social goals. One point is clear: decisions about health care regulation are complex and inherently involve tradeoffs between quality, spending, and outcomes. Simple solutions are rare, if they exist at all.

Nonetheless, while simple solutions are unlikely, one basic economic imperative is clear: increasing productive efficiency of the health professions is of paramount importance as Members face an ageing population that will need more health care than any Member has the current financial or professional capacity to treat. Given the importance of increasing productive efficiency in the future, four points stand out:

- Increased roles are merited for para-professions;
- Increased mutual recognition of qualifications across international boundaries is important, especially for dealing with expected professional shortages of the future;
- Increased consumer choice over the quality of service received helps reduce the cost and intensity of privately purchased services and products; and
- Reduced professional regulation over advertising, discounting and ownership can frequently have beneficial impacts for non-insured services.

NOTES

1 Note that rules, regulations and practice norms are not the sole determinants of whether a health professional market works well. Enforcement and patterns of practice matter as well. Rules can be quite restrictive, and appear to limit competition, when competition is in fact more vigorous than in jurisdictions with less restrictive rules.

2 See OECD Economic Outlook (1998). The figures assume that male and female workforce participation rates will remain at 1995 levels.

3 The discussion of efficacy of alternative health care providers, such as chiropractors and midwives, is beyond the scope of this paper.

4. Total OECD health care expenditures across the OECD were about USD 2.83 trillion in 2001 using purchasing power parity. Note that the figures cited above are significantly larger than 0.1% but are not focused on the medical professions.

5 Hammer and Sage argue that increased focus should be given to monopsony problems in health care markets. (Hammer and Sage (2004)) Their assumption that a socially harmful supply reduction would exist as a result of monopsonistically low reimbursements to physicians may not be correct, however, because medical doctors have an unusual profession in which "non-financial" aspects of the job, notably prestige, ensure that the number of good candidates for training will almost always exceed the number of physicians who need to be trained in a given year based on medical need. (This is one rationale for quantity limits.) In contrast, nurses have a less prestigious profession and are more numerous than physicians, so their reimbursement levels need to be fully competitive with other potential employment in order to attract a sufficiently large pool of candidates to training. In short, for certain health professions with "prestige," such as M.D.s, the government can reduce the level of wages below the "market level" without reducing the quantity of qualified professionals. This gives the government an ability not to accede to certain professions' desire for higher fees. Note, though, that professionals may work harder and more effectively under different reimbursement mechanisms than a monopsonist mechanism. That is the output per physician may be higher in a non-monopsonistic regime. (For arguments that monopsony is harmful, see Danzon (1992).

6 These statistics should be interpreted with care. Medical spending is only one of many factors that influence lifespan; other important factors are related to lifestyle, such as exercise, diet, and smoking.

7 Private contributions are non-government payments. They therefore include amounts paid by employers or other sources besides the consumer.

8 Part of the moral code of physician practice is exemplified by the modern Hippocractic oath, which forbids overtreatment.

9 This result assumes that low quality services are cheaper or easier to provide.

10 Japanese doctors at one time prescribed more medications than doctors in other countries, perhaps because they owned the pharmacies as part of their doctor offices and selling medicines was a major source of income for doctors. (See OECD (1999) p.18.)

11 Clearly, dental problems will still cause pain, even if they generate little financial damage. The possibility of pain may reduce risky behavior. But even for risk averse consumers, the tradeoff between the effort necessary to avoid risk and the financial effect of less caution will generally be affected by the reduced financial exposure from an adverse event.

12 See Goldman and Lightwood (2002) for a recent discussion of the appropriate treatment levels for tuberculosis and how these vary with population-wide levels of sickness.

13 Litigation/guarantees and certification are two non-regulatory methods of assuring quality. That is, the incompetent professional could face the threat of private lawsuits or provide guarantees of outcomes with the understanding that if the guaranteed outcomes are not achieved, patients will not pay or will receive compensation. However, these non-regulatory mechanisms are likely not sufficient to ensure quality in many health care situations, in part because the same problems that make it difficult to assess practitioner quality make it difficult to assess incompetence. Moreover, the consequences of such ex post mechanisms would often be irreparable harm. Certification is an option that provides a unique right to a title (such as psychotherapist) to those who have met a certain set of standards, but does not limit others from providing similar services as long as those others do not falsely claim the certification.

14 Such impediments to entry may actually enhance competition by increasing consumer willingness to search for low prices. "[I]t may even be that the market operates more competitively because the "minimum quality" guarantee that licensure produces may increase consumer willingness to search for lower prices." (Phelps (1977), p. 243.)

15 See Shaked and Sutton (1981) in which the authors consider "quality" requirements as determining the size of the profession. Note also that excessive quality may involve best practice standards that lead professionals to perform relatively low-value but time-consuming tests that effectively limit supply.

16 This paper takes no position on what professions may fall into this category, as such judgments would require specialized health care or medical knowledge.

17 Clearly, judgements about excessive qualification requirements are difficult for non-practitioners to make.

18 See Federal Trade Ccommission and Department of Justice (2004) Chapter 2, p. 27 for quote and Kleiner (2003), and Cox and Foster (1990) for reviews.

19 Restrictiveness is measured by pass rates for licensing exams, adjusted for initial quality of dental student population.

20 See Federal Trade Commission and Department of Justice (2004) Chapter 2, p. 26 for this statement for the U.S. and Indecon (2002) for a discussion of Irish health care professions including physicians, dentists and optometrists.

21 Indecon (2002) states that "[w]hile representation of the profession on the Board is necessary to ensure that policy is informed by the knowledge and experience of practitioners, sufficient explicit consumer representation should be guaranteed through having appropriate consumer representation on the Board." (p. 480)

22 An approach like this has recently been recommended by the U.S. competition agencies in Federal Trade Commission and Department of Justice (2004).

23 For example, the location and number of pharmacies is limited in some countries.

24 European Commission (2004) mentions this as one rationale that has been put forward by advocates of quantity limits but does not endorse this rationale.

25 The argument is distinct from that for universal service obligations provided by a monopolist. In those arguments, the monopolists receives excess rents in one area in order to subsidize unprofitable operations in another. In contrast, these quantity restrictions involve ensuring that there are few competitors so that the rural areas are actually profitable. Thus there is no expectation of a cross-subsidy from profitable areas to unprofitable ones.

26 For example, many national health systems and insurance companies have medical directors who oversee the determination of appropriate credentialing for delivery of different services. Typically, these directors are trained medical doctors. While this paper would certainly not suggest that medical directors should be non-doctors, the physician qualification may lead them to prefer reimbursing physicians over other potential practitioners of a service.

27 Were purchase costs lower or broadly subsidized, this figure would likely be higher. The U.S. government's health insurance plan for the elderly, Medicare, does not cover hearing aids, and neither do most private insurance plans.

28 The proposal is Killion (2003) and the FDA rejection letter is Rothstein (2004) in U.S. FDA Docket 2003P-0362.

29 Mechanisms do exist for reducing problems of aggressive selling, such as mandating 30-day money back guarantees.

30 For example, the American Medical Association is alleged, in the past, to have restricted access by "non-scientific" practitioners to radiology facilities by discouraging medical doctors and hospitals from associating with "non-scientific" practitioners.

31 Note that prescribers may frustrate the objectives of a verification requirement by refusing to respond to verification requests. The "Fairness to Contact Lens Consumers Act" addresses this problem by stating that non-response to a verification request by a seller within 8 business hours constitutes verification.

32 See Pharmacy Guild of Australia (2004).

33 Internet pharmacies were not rated for quality of service.

34 The average online store had a price of 412 USD, the average mass merchant a price of 416 USD, the average supermarket a price of 464 USD, the average independent a price of 470 USD, and the average drugstore chain a price of 481 USD.

35 According to OECD Health Data (2004), there were 623,217 practicing physicians in the U.S. in 2000.

36 U.S. Department of Health and Social Services (2002). Other costs include $3.91 billion in liability insurance costs for federal programs, $246 million in liability insurance paid through health benefits for employees and retired persons, and $778 million in lost tax revenue from self-employed and employer-sponsored health insurance premiums.

37 Beggs and Klemperer (1992) show that switching costs result in increased prices (and profits) in a duopoly.

38 Note that these results were derived by focusing on sectors without significant insurance. Advertising in sectors with full insurance could more easily lead to quality-increasing and cost-increasing effects.

39 The lead practitioner was Dr. Kenneth Myers, Ph.D., O.D., the Director of the Optometric Service of the Department of Medicine and Surgery of the U.S. Veterans Administration. He developed an index to weight the different elements of each examination in conjunction with the College of Optometry of the State University of New York and the Pennsylvania College of Optometry. Optometrist professional associations were invited to present additional sets of weights, but only the commercial optician and optometrist association consented; other associations declined.

40 American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2D 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982), 100 F.T.C. 572 (1982) and 114 F.T.C. 575 (1991)).

41 This approach is called the "messenger model." See the health care guidelines of U.S. Department of Justice and Federal Trade Commission (1996).

42 A number of legal actions have been brought against medical practitioners that combine price-fixing with refusals to deal. In one example, a consent decree was issued May 4, 1999 for Mesa County Physicians Independent Practice Association [IPA], Inc. in Mesa County, Colorado. "The [U.S. Federal Trade] Commission issued a revised complaint and final order against the Mesa County Physicians Independent Practice Association [IPA], Inc., an organization whose members comprise 85% of all physicians and 90% of the primary care physicians in Mesa County, Colorado. According to the complaint, the IPA acted to restrain trade by combining to fix prices and other competitively significant terms of dealing with payers, and collectively refused to deal with third party payers, thereby hindering the development of alternative health care financing and delivery systems in Mesa County. The complaint alleged that the IPA, through its alliance with the Rocky Mountain Health Maintenance Organization, created a substantial obstacle to the ability of other payers to contract with a physician panel in Mesa County. The complaint also alleged that the IPA's Contract Review Committee negotiated collectively on behalf of the IPA's members with several third party payers, using an IPA Board-approved set of guidelines and fee schedule, and that a similar organization formed after the proposed consent order was issued in 1998 engaged in the same conduct." (See Federal Trade Commission (2004b))

43 In contrast, when payors are generally well-informed about appropriate charges for given services, such as governments or insurers, the potential benefit of avoiding the risk of overcharge through recommended fee schedules may not be important.

44 These results do not focus on the potential long-term effect of raising the quality of service of the less-skilled providers.

45 Some prior studies suggested that report cards led to better outcomes of CABG (i.e. lower mortality rates), but this could be because the effect of report cards was to increase the number of CABG surgeries for relatively healthier patients, while reducing surgeries (and increasing mortality) for the sicker patients. This explanation is consistent with the results of Dranove et al (2003).

46 This requirement emerged from the OFT study on dentistry (Office of Fair Trading (2002)).

47 These included the Quality Health-Care Coalition Act of 2000, HR 1304.

48 One weakness of this opinion letter system is that, when a negative letter is likely, the request for an opinion is often withdrawn, and no official letter published.

49 In 1964, one member of this Committee stated that "it would be well to get across the point that the doctor of chiropractic is stealing the young medical physician's money."

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NOTE DE RÉFÉRENCE

1. Introduction

Les professions de santé sont régies par un ensemble de textes réglementaires qui se justifient par la nécessité de protéger le consommateur des praticiens non qualifiés. La méthode la plus courante de garantir la qualité des praticiens consiste à conditionner l'exercice d'une profession à une autorisation. Dans le domaine de la santé, du fait que des compétences sont nécessaires pour établir les programmes d'études et de formation ainsi que les examens d'entrée, les professions soumises à l'octroi d'une autorisation d'exercer contrôlent directement ou indirectement les règles qui président à ce droit d'exercice. En s'auto-réglementant ainsi, une profession poursuit son intérêt légitime à préserver la qualité de ses membres. En même temps, l'auto-réglementation peut également induire la profession en question à abuser du pouvoir qu'elle détient de décider du droit d'exercice afin d'augmenter les revenus de ses membres. Limiter le nombre de praticiens, restreindre la concurrence entre ses propres membres, ou encore interdire la pratique à des professions potentiellement concurrentes sont autant d'exemples de tels abus[1].

Lorsqu'une profession accroît ses revenus aux dépens de ses patients, ce sont les consommateurs et les organismes payeurs qui en font les frais, et les dépenses nationales de santé augmentent plus que l'avantage qu'en retire la collectivité. Pour les décideurs, il est difficile de garantir que les restrictions qui s'imposent pour protéger le consommateur et réaliser les grands objectifs sociaux n'aillent pas plus loin que nécessaire. Le présent document a pour objet d'aider les décideurs à apprécier quel type de réglementation va dans le sens de l'intérêt public et propose un éventail d'options pour guider l'action publique de nature à renforcer l'efficience et la concurrence dans les professions de santé.

Dans le domaine de la santé, il est d'une importance capitale pour les pays de l'OCDE d'accroître l'efficience du fait de l'ampleur des dépenses et de leur accroissement prévu sous l'effet du vieillissement démographique. Alors que la proportion de retraités par rapport aux actifs augmente, la charge que doivent supporter les travailleurs (qui contribuent à financer les régimes d'assurance maladie par répartition) va augmenter de façon spectaculaire. En moyenne, les pays de l'OCDE devront passer entre 2000 et 2050 d'un ratio de 3.3 travailleurs pour un retraité à un ratio de 1.75. Dans certains pays membres, comme l'Allemagne, le Canada, la France, l'Italie et le Japon, la proportion de retraités pour un travailleur devrait doubler entre 2000 et 2050[2]. Il ressort également de ces chiffres que les cotisations salariales nécessaires pour couvrir les dépenses de santé des retraités devront augmenter d'environ 90 % par travailleur. Dans le souci de contenir l'accroissement de la dépense par travailleur, et compte tenu de la part du PIB que représentent déjà les dépenses de santé dans les pays de l'OCDE (environ 8 % du PIB en moyenne dans la zone OCDE), toutes les solutions de nature à améliorer l'efficience méritent d'être sérieusement examinées.

L'une de ces solutions consiste à améliorer la réglementation des professions de santé. Les inefficiences imputables aux pratiques, règles ou réglementations professionnelles peuvent coûter cher aux consommateurs et aux organismes payeurs, sans pour autant que la qualité des soins en soit nettement améliorée, en particulier dans les professions où l'État ne contrôle pas les tarifs des praticiens. Ces professions varient d'un pays à l'autre, mais audiologistes, chiropracteurs et ostéopathes, dentistes, auxiliaires dentaires, infirmières sages-femmes, ophtalmologistes, optométristes et psychothérapeutes en font souvent partie[3]. Ces professions de santé, qui exercent dans un contexte plus libéral, sont le principal

sujet du présent article, étant donné que ce sont surtout dans ces professions que les règles peuvent restreindre le champ de la concurrence, avec le plus de conséquences dommageables pour le consommateur.

Un certain nombre d'études sérieuses portant sur les professions de santé ont permis de donner des éclairages sur l'impact de diverses formes de restrictions sur les prix et la qualité, parmi lesquelles on peut citer les suivantes :

- Les restrictions qui s'appliquent à la publicité et les interdictions relatives à la constitution de sociétés vont de pair avec une majoration de 33.6 % du prix des examens ophtalmologiques et des lunettes dans les régions soumises à des restrictions très rigoureuses pour une qualité moyenne du même ordre quelle que soit l'ampleur des restrictions. (Bond et al. (1980))

- Chez les dentistes, la difficulté accrue des examens à l'entrée va de pair avec une majoration de 11 % du prix des services dentaires par rapport aux régions où l'accès à la profession est moins difficile, mais la qualité des soins n'y est pas moindre pour autant. (Morris et Kudrle (2000))

- Dans les régions qui restreignent de façon très stricte les actes que peuvent réaliser les auxiliaires paramédicaux pour assister les dentistes, les coûts sont entre 5 et 11 % supérieurs. (Liang et Ogur (1987))

- Dans les régions où la circulation des professionnels est restreinte du fait que la non-reconnaissance des qualifications acquises dans d'autres régions, les prix des services dentaires sont entre 8.5 et 18 % plus élevés. (Shepard (1978))

Ces études montrent que les restrictions appliquées par la profession peuvent avoir un impact considérable sur le coût pour les patients. Si ces études portent en général sur des professions dont les tarifs sont peu réglementés par l'État, les professions dont les tarifs sont au contraire très réglementés peuvent parfois se prêter à d'importants gains d'efficience, par exemple grâce à un plus large recours au personnel paramédical et à une évolution des « meilleures pratiques » de façon à détourner certains patients des spécialistes établissant le diagnostic vers d'autres spécialités où ils pourront recevoir un traitement mois coûteux, et à confier aux médecins généralistes, qui jouent un rôle de filtrage, le soin de contrôler le montant de ressources à dépenser pour les soins des patients dont ils ont la responsabilité.

L'évaluation des restrictions applicables à une profession donnée dans l'optique d'éliminer celles qui ont des effets préjudiciables peut bénéficier au consommateur comme aux organismes payeurs, et présenter en outre l'avantage de contribuer à réduire les dépenses de santé sans entraîner pour autant une baisse sensible de la qualité des soins. L'impact global des changements susceptibles d'être apportés à la réglementation des professionnels de la santé est difficile à estimer, du fait notamment que dans chaque profession, il faut apprécier le coût de ces éventuels changements au regard des avantages à en attendre. Si des améliorations sont possibles, et même si les résultats effectifs ne sont pas aussi importants que ceux évoqués précédemment, les économies de l'OCDE ont néanmoins intérêt à débarrasser les professions de santé des aspects dommageables de leur réglementation étant donné l'ampleur de leurs dépenses de santé. A titre d'exemple, si l'amélioration de la réglementation des professions de santé permettait de réduire le coût des soins de 0.1 %, les payeurs économiseraient 2.8 milliards USD par an[4].

L'argumentation en faveur d'une réglementation professionnelle favorable à l'efficience rallie généralement peu de partisans. Dans la mesure où l'amélioration de l'efficience, due par exemple à une intensification de la concurrence, contribue souvent à une contraction du revenu des professions de santé et est souvent accusée d'entraîner une dégradation de la qualité, il est logique qu'elle suscite une vive opposition sur le plan politique. Les autorités de la concurrence et les organismes de protection des

consommateurs sont bien placés pour prôner des changements susceptibles de bénéficier aux consommateurs qui ne sont pas nécessairement en rapport avec les aspects des soins liés à la santé. Surtout lorsque les consommateurs paient directement les soins et services qui leur sont dispensés, une concurrence plus directe est probablement souhaitable. Les autorités de la concurrence d'un certain nombre de pays ont de fait participé dans le passé à des campagnes d'information et été saisies d'affaires faisant intervenir des professions de santé, mais il serait souhaitable dans l'avenir que les efforts déployés dans cette direction soient intensifiés et mieux ciblés. En concertation avec les ministères responsables des dépenses de santé et de la réglementation des professions de santé, d'importantes avancées pourraient être faites, qui pourraient en outre contribuer à contenir les dépenses de santé.

Le présent document recense quelques mécanismes de nature à renforcer la concurrence et induire une efficience plus productive dans les professions de santé ; le fait de citer un mécanisme donné ne doit pas pour autant être interprété comme une approbation sans réserve de ce mécanisme. Les politiques publiques concernant les professions de santé doivent prendre en compte tout un éventail de facteurs, en l'espèce l'impact sur la santé, le coût de la réglementation publique, le coût de la mise en conformité de la profession, la hausse des prix induite par une moindre concurrence, l'uniformisation de la qualité, l'augmentation du coût induit par la recherche du professionnel compétent, des pertes d'efficience dues aux différents types de réglementation, les effets sur la relation patient-fournisseur de soins, et les effets sur la réalisation des grands objectifs sociaux. Différents pays peuvent parvenir en toute légitimité à différentes conclusions quant aux meilleures pratiques à retenir pour la même profession. Nonobstant, étant donné l'impérieuse nécessité d'accroître dans l'avenir l'efficience dans le sens d'une plus grande productivité, quatre points doivent être mis en avant :

- Les professions paramédicales doivent se voir confier un rôle accru (c'est-à-dire les professions nécessitant une formation moins approfondie que les professions "les plus qualifiées") ;

- Il importe d'améliorer la reconnaissance mutuelle des qualifications entre les pays, en particulier pour remédier aux pénuries de professionnels de santé auxquelles il faut s'attendre ;

- Un choix plus ouvert pour le consommateur en ce qui concerne la qualité du service dispensé est essentiel si l'on veut réduire le coût et l'intensité des services et produits acquis à titre privé ; et

- Un allégement de la réglementation professionnelle relative à la publicité, aux rabais pouvant être consentis ou à la forme juridique que les professionnels peuvent donner à leur exercice pourrait fréquemment avoir un impact bénéfique pour ce qui est des services non couverts par une assurance.

2. Objectifs sociaux

Dans la plupart des pays de l'OCDE, la finalité première du secteur de la santé est de rendre les soins de santé largement accessibles à ceux qui en ont besoin. Les pouvoirs publics interviennent souvent pour garantir l'accès aux soins à tous ceux qui ne pourraient autrement se le permettre, à savoir les plus démunis, les personnes âgées, les handicapés et les patients atteints de maladies chroniques. Le coût total des soins est variable, mais représente une part importante à la fois des dépenses publiques et du PIB dans tous les pays membres (voir tableau 1). Le système de santé peut être considéré comme un mécanisme de redistribution du revenu allant dans le sens d'une plus large couverture.

Tableau 1. Quelques statistiques relatives à la santé et aux professions de santé, 2002

	Espérance de vie	Total des dépenses de santé en % du PIB	Dépenses de santé par habitant, USD**	Dépenses publiques de santé par habitant, USD**	Part des dépenses publiques de santé dans les dépenses totales	Densité de médecins ***	Densité de pharmaciens ***	Nombre de consultations par médecin
Australie	80	9.1*	2504*	1708*	68.2%*	2.5*	0.7	2480
Autriche	78.8	7.7	2220	1551	69.9%	3.3	0.6	2030
Belgique	78.1	9.1	2515	1790	71.2%	3.9	1.1	2000
Canada	79.7*	9.6	2931	2048	69.9%	2.1	0.7	2952*
Rép. tchèque	75.4	7.4	1118	1022	91.4%	3.5	0.5	3686
Danemark	77.2	8.8	2580	2142	83.0%	3.3	0.5	2152
Finlande	78.2	7.3	1943	1470	75.7%	3.1	1.5	1387
France	79.4	9.7	2736	2080	76.0%	3.3	1.1	2091*
Allemagne	78.5*	10.9	2817	2212	78.5%	3.3	0.6	n/a
Grèce	78.1	9.5	1814	960	52.9%	4.5*	n/a	n/a
Hongrie	72.6	7.8	1079	757	70.2%	3.2	0.5	3719
Islande	80.4	9.9	2807	2357	84.0%	3.6	1.3	1556*
Irlande	77.8	7.3	2367	1779	75.2%	2.4	0.8	n/a
Italie	79.9	8.5	2166	1639	75.7%	4.4	1.1	n/a
Japon	81.8	7.8*	2077*	1696*	81.7%*	2	1.2	7250*
Corée	76.4*	5.9*	931*	506*	54.4%*	1.5	n/a	7067
Luxembourg	78.2	6.2	3065	2618	85.4%	2.6	0.8	2385
Mexique	74.6	6.1	553	249	45.0%	1.5	n/a	1667
Pays-Bas	78.4	9.1	2643	n/a	n/a	3.1	0.2*	1806
Nouvelle-Zélande	78.5*	8.5	1857	1447	77.9%	2.1	n/a	2095*
Norvège	79	8.7	3083	2628	85.2%	3*	n/a	n/a
Pologne	74.6	6.1	654	474	72.5%	2.3	0.6	2435
Portugal	77.2	9.3	1702	1201	70.6%	3.2*	0.8*	1125*
République slovaque	73.9	5.7	698	621	89.0%	3.6	0.5	3611
Espagne	79.4	7.6	1646	1176	71.4%	2.9	0.9	3000*
Suède	79.9	9.2	2517	2148	85.3%	n/a	n/a	n/a

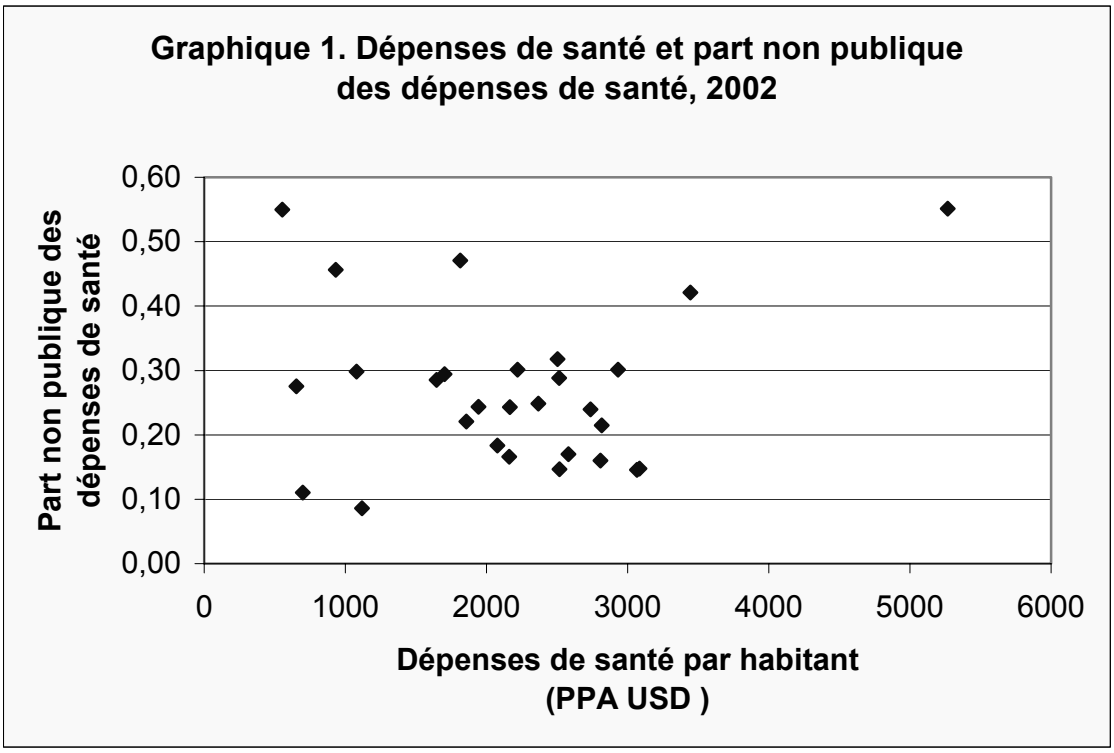
	Espérance de vie	Total des dépenses de santé en % du PIB	Dépenses de santé par habitant, USD**	Dépenses publiques de santé par habitant, USD**	Part des dépenses publiques de santé dans les dépenses totales	Densité de médecins ***	Densité de pharmaciens ***	Nombre de consultations par médecin
Suisse	80.4	11.2	3445	1994	57.9%	3.6	n/a	944
Turquie	68.6	n/a	n/a	n/a	n/a	1.3	0.3	3000
Royaume-Uni	78.1*	7.7	2160	1801	83.4%	2.1	0.5	n/a
États-Unis	77.1*	14.6	5267	2364	44.9%	2.4*	n/a	3708

* données relatives à 2001, ** parité de pouvoir d'achat en USD, *** densité de praticiens pour 1000 habitants

Source: Eco-Santé, 2004

Étant donné l'enjeu financier que représente le coût de la santé pour l'État et les ressources financières limitées dont disposent les gouvernements, la plupart des pays membres interviennent largement dans les choix opérés quant à la structure financière de la rémunération de nombreux professionnels de santé et quant à l'organisation de la formation des nouvelles recrues dans les principales filières médicales (médecins généralistes, spécialistes, infirmières et chirurgiens). Parmi les considérations prises en compte dans ces calculs figurent en bonne place la nécessité pour les gouvernements de réduire le coût de la fourniture des services de santé[5].

Lors de l'évaluation des restrictions en vigueur dans une profession, en particulier les professions qui reçoivent un large soutien de l'État, il convient de garder à l'esprit les objectifs sociaux et financiers qui sous-tendent les règles applicables aux professions de santé. L'absence totale de réglementation ne permettrait pas la large couverture des soins qui est à la base de la politique menée par un grand nombre de pays membres. En outre, il apparaît que les dépenses privées (et les marchés privés) n'ont pas nécessairement pour effet d'abaisser le coût total ou d'améliorer sensiblement les résultats quantifiables, comme l'espérance de vie[6]. Le graphique 1 montre que certains des pays membres dont la contribution privée au financement des soins est la plus élevée sont également ceux où le coût est le plus élevé[7].



Source : Eco-Santé OCDE, 2004

Un certain nombre de professions de santé reçoivent dans la plupart des pays de l'OCDE beaucoup moins d'aide de l'État que les médecins et les infirmières. Il s'agit notamment des professions suivantes : audiologistes, chiropracteurs et ostéopathes, dentistes, auxiliaires dentaires, infirmières sages-femmes, ophtalmologistes, optométristes et psychothérapeutes. Pourquoi l'objectif social poursuivi par les systèmes nationaux d'assurance ne s'applique-t-il pas également à ces professions dans de nombreux pays membres ? La raison est peut-être liée au fait que le risque financier associé à l'absence de couverture est limité. Si une attaque cardiaque peut avoir un impact financièrement dévastateur sur une famille non couverte par une assurance, cela n'est pas le cas d'une carie dentaire, par exemple. Le risque financier étant

limité, on peut obtenir un large accès même sans couverture par une assurance. Parmi les autres raisons pouvant expliquer la faible couverture fournie par l'État peuvent figurer par exemple les incertitudes quant à l'efficacité et la volonté d'éviter la surconsommation, en particulier dans les professions où l'amélioration de l'état du patient est difficilement mesurable comme dans le cas de la psychothérapie.

3. Imperfections du marché

Le présent document ne se veut pas un plaidoyer en faveur d'une concurrence sans restriction, qui n'est pas toujours la meilleure option pour ce qui est de l'offre de services et de la supervision des professions de santé. Si, dans la plupart des secteurs, on peut penser que la concurrence aura pour effet de renforcer l'efficience, les avantages de la concurrence dans le secteur de la santé sont moins évidents.

Même en l'absence d'objectifs de redistribution, le libre jeu de la concurrence dans le secteur de la santé n'est pas nécessairement la solution optimale pour le bien-être de la collectivité et du consommateur, et ce, pour plusieurs raisons essentielles :

- La distorsion de la consommation liée à la couverture par une assurance ;
- L'information imparfaite et incomplète du consommateur ;
- Une moindre aversion au risque du fait de la couverture par une assurance ; et
- Les externalités.

Peut-être du fait de ces imperfections du marché, dans les pays où le secteur de la santé est largement financé par l'État, la rémunération des médecins peut être moindre et le coût total des soins de santé moins élevé pour une situation sanitaire comparable à celle de pays où les médecins sont mieux rémunérés et où la concurrence directe est plus vive.

3.1 Distorsion de la consommation liée à la couverture par une assurance ("aléa moral")

Le secteur des soins de santé est très couvert par l'assurance. A l'évidence, l'effet de l'assurance est de réduire le coût à la charge d'un individu lorsqu'il reçoit des soins, ce qui signifie que, même lorsqu'une personne est parfaitement informée des avantages escomptés et du coût d'un traitement donné, elle a une perception du coût financier du traitement bien inférieure à son coût effectif. Supposons qu'un individu paie un pourcentage fixe du coût effectif (20 % par exemple), le coût perçu correspondra donc à 20 % du coût effectif, à quoi il faudra ajouter les coûts "non financiers" tels que coût du déplacement, coût du non-travail et inconfort.

En ce qui concerne les actes peu coûteux et les visites chez le médecin généraliste, les coûts non financiers peuvent être suffisamment élevés pour que le coût "perçu" soit voisin du coût financier effectif. Mais pour ce qui est des consultations plus onéreuses, le coût perçu sera généralement inférieur au coût effectif pour le consommateur. Sauf lorsqu'il y a rationnement des soins par les praticiens ou les organismes payeurs, situation dans laquelle le consommateur ne reçoit pas les soins lorsque le coût est supérieur à l'avantage escompté, le consommateur sera incité à prendre à sa charge ses dépenses de santé tant que le coût reste inférieur à l'avantage perçu. Dans un système d'assurance, il s'ensuit que la demande de soins de la part des consommateurs est excessive, sauf si elle est restreinte d'une façon ou d'une autre, comme l'illustre l'encadré 1 (Arrow (1963), Feldstein (1973) et Pauly (1974)).

Box 6. Surconsommation et assurance

Supposons que, en l'absence de couverture par une assurance, la courbe de la demande soit représentée par DD. Le coût des soins est donné par un coût marginal fixe C*. Dans l'hypothèse d'un marché concurrentiel où le prix est égal au coût, Q* unités de soins sont demandés. La surface A représente le surplus de bien-être collectif engendré en l'absence de couverture par une assurance. Si par contre il existe un système d'assurance où le patient finance les soins prodigués à hauteur de 20 % sous forme de paiement direct, la courbe de la demande pivote vers la droite, de sorte que le coût pour le patient est de 0.02 C*, et que le nombre d'unités de soins demandés passe à Q'. La courbe de la demande lorsqu'il y a couverture par une assurance est alors représentée par D'D'.

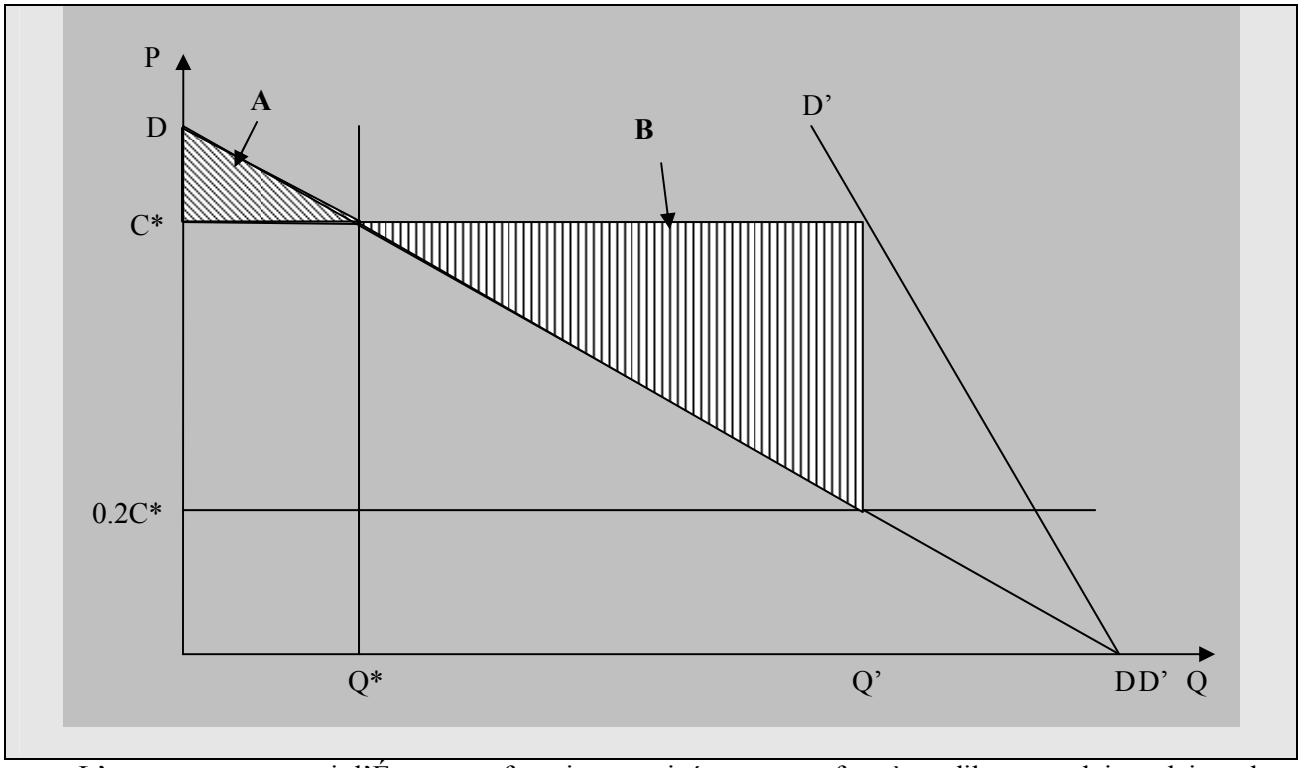
La surface B représente le recul du bien-être collectif lorsqu'il y a couverture par une assurance soumise à aucune restriction. Le diagramme suggère que la perte peut être importante par rapport à l'avantage collectif (A) retiré en l'absence de couverture.

Ce modèle simple représenté graphiquement ci-dessous appelle trois réserves :

- C'est un modèle de parfaite capacité d'expansion de l'offre. Dans un modèle où l'offre (de médecins, par exemple) est limitée, les déplacements par rapport à l'équilibre dans une situation d'assurance zéro proviennent également de l'accroissement des marges des médecins (du fait que l'assurance a pour effet de rendre la demande nettement moins élastique).

- Si la demande est totalement fixe, il n'y a pas d'augmentation de la quantité de soins résultant de la couverture par l'assurance. Cependant, de nombreuses études donnent à penser que même dans les situations qui ne devraient pas induire une importante variation de la fréquentation des patients, on constate des variations sensibles de la quantité de soins d'une région à une autre.

- L'hypothèse du modèle est que la demande donne une représentation fidèle de la valeur des soins pour le consommateur. Il est probable que cette hypothèse ne se vérifie pas dans tous les cas, soit parce que les patients n'ont pas une idée précise de l'impact de leurs problèmes de santé à long terme, soit parce que des contraintes d'ordre budgétaire les empêchent de dépenser le montant correspondant à la valeur véritable des soins dispensés.



L'assureur, que ce soit l'État ou un fournisseur privé, se trouve face à un dilemme : doit-on laisser les coûts dépasser la valeur du traitement ou doit-on limiter d'une façon ou d'une autre la quantité de soins offerts aux patients ? Une solution de rechange consiste à permettre aux patients de bénéficier de tous les soins qu'ils souhaitent dans le cadre d'un système d'assurance. Cela peut néanmoins conduire à une importante surconsommation et à un gaspillage, défini comme la prestation de services dont le coût est supérieur à l'avantage qui en découle (au moins selon un critère de choix de consommation faisant intervenir le rapport coût-avantage). Compte tenu de la part que représentent les dépenses de santé dans le PIB, encourager une surconsommation de cette ampleur est intolérable. Une autre solution consiste à rationner les soins. L'une des options est de laisser les professionnels de santé décider de la quantité de soins délivrée. Ceux-ci peuvent imposer des restrictions dans l'intérêt du patient, afin d'éviter les traitements inutiles, et parfois simplement parce qu'ils sont financièrement incités à empêcher une surconsommation de la part des patients[8]. Souvent, les professionnels de santé sont en proie à un conflit d'intérêts, puisque leur rémunération augmente s'ils dispensent plus de soins que le strict nécessaire. Un autre moyen de rationner les soins est de permettre à une catégorie de professionnels (comme les médecins de premier recours) de jouer un rôle de contrôleur d'accès et de déterminer en conséquence les soins qui devront être dispensés par des spécialistes, ce qui dissocie le gain financier de l'opération d'aiguillage vers le spécialiste. Une autre méthode de rationnement des soins consiste tout simplement à fixer le montant total de l'enveloppe allouée aux soins de santé et de laisser les gestionnaires répartir quantitativement les différentes catégories de soins dispensés. (Ce qui peut être fait, par exemple, en fixant le montant total de l'enveloppe budgétaire ou le nombre total de professionnels formés). Dans tous les cas, toutefois, répondre au dilemme de l'assureur par la solution du rationnement impose de se démarquer de la logique du libre choix du consommateur. Des incitations financières plus complexes en vue d'induire un rationnement des soins peuvent prendre la forme de paiements forfaitaires (cas de la capitation, par exemple, ou des comptes de dépenses préaffectés, où les praticiens généralistes reçoivent une enveloppe préaffectée censée couvrir l'ensemble des dépenses de leurs patients.

3.2 Information du consommateur

Un autre problème majeur lié aux professions de santé tient au fait que l'information du consommateur est limitée à trois égards au moins; de fait, le consommateur lambda est souvent dans l'incapacité de bien évaluer :

- La qualité et les compétences de son praticien;
- *Ex ante*, le bien-fondé du soin préconisé ; et
- *Ex post*, l'efficacité du soin.

Les services de santé sont souvent des biens impliquant une relation de confiance. Même a posteriori, le consommateur n'est pas toujours en position d'apprécier dûment la qualité du service rendu. Cette caractéristique des services de santé provient de l'information imparfaite du consommateur quant au résultat matériel des soins et également de la corrélation imparfaite entre la justification des soins et les résultats obtenus. Des soins adéquats peuvent en effet ne pas aboutir à de bons résultats, tout comme des soins inadéquats peuvent ne pas donner de mauvais résultats.

Du fait de ces problèmes d'information, les consommateurs doivent souvent s'en remettre à un avis extérieur pour apprécier la qualité des soins dispensés.

Cet avis extérieur peut venir du praticien choisi (qui est incité à dire que l'acte préconisé est nécessaire), d'autres praticiens (lorsque le généraliste recommande un spécialiste, par exemple), des assureurs (qui ont souvent intérêt à dire que l'acte préconisé n'est pas nécessaire), d'un spécialiste à qui est demandée une seconde opinion et qui n'aurait aucune incitation financière à ce que l'acte soit réalisé ou non, ou d'une source d'information tierce. A titre d'exemple, certains gouvernements établissent des indicateurs qualitatifs applicables aux médecins pour certains types de soins, comme les soins cardiaques. Dans leur forme la plus crue, de tels indicateurs pourraient renseigner sur le taux de survie après des opérations chirurgicales à haut risque, ce qui, étant donné que ce sont les meilleurs chirurgiens qui opèrent souvent les cas les plus délicats, aboutirait à un résultat pervers, puisque ces chirurgiens pourraient avoir des taux de survie inférieurs à ceux des mauvais chirurgiens.

En ce qui concerne ces biens fondés sur une relation de confiance, deux aspects importants peuvent fausser les résultats par rapport à une situation de pleine information. En premier lieu, les vendeurs peuvent être incités à réduire la qualité des services offerts[9]. Lorsque les consommateurs ne sont pas capables de bien juger de la qualité, les fournisseurs peuvent être tentés d'abaisser la qualité des services, tout en pratiquant des prix correspondant à des soins de qualité. Si ce type de réaction de la part des fournisseurs de soins est courant, il peut arriver que les consommateurs en viennent à s'attendre à des services de piètre qualité et refusent de payer pour un service de qualité, d'où une généralisation de services de qualité inférieure et une disparition du marché des services de qualité (Voir Akerlof (1970)).

Le second problème associé aux biens s'articulant autour d'une relation de confiance est le risque de traitements inutiles. Les fournisseurs peuvent en effet recommander leurs services alors qu'ils ne sont pas strictement nécessaires. Par exemple, les organismes payeurs craignent que les psychothérapeutes ou les kinésithérapeutes ne recommandent à leurs patients un trop grand nombre de consultations. C'est une autre forme de surconsommation que celle liée à la couverture par une assurance, car elle peut survenir même en l'absence de couverture du fait que les patients ont du mal à évaluer et l'opportunité du service recommandé et les avantages qui peuvent en découler[10].

3.3 Une moindre aversion au risque du fait de la couverture par une assurance

Les personnes ayant une assurance couvrant une affection donnée perdent moins sur le plan financier lorsque survient un problème (comme une carie) que les personnes non assurées. Le fait d'être couvert par une assurance modifie le comportement des consommateurs qui cherchent moins à éviter l'apparition de problèmes. Ainsi, une personne bénéficiant d'une assurance couvrant les soins dentaires se préoccupera moins du coût financier du traitement d'une carie ou d'un autre problème dentaire évitable qu'une personne non assurée[11]. Il n'y a guère de moyens d'éviter cet écueil. L'un d'entre eux consiste à ne pas assurer les soins. Dans de nombreux pays, par exemple, le système national d'assurance maladie ne couvre que partiellement les soins dentaires. Supprimer l'assurance peut être une solution lorsque les frais engagés sont relativement faibles. En revanche, cette solution est rarement retenue comme moyen de lutte contre le tabagisme, alors même que fumer est un comportement qui peut être évité et qui aggrave considérablement les risques d'affections telles que le cancer du poumon. Le traitement du cancer du poumon est coûteux et peut être inabordable pour de nombreux fumeurs. Le choix de la non-couverture irait à l'encontre de l'objectif social qui consiste à offrir un traitement médical à tous ceux qui en ont besoin.

3.4 Externalités

En termes de santé, les marchés peuvent ne pas permettre d'obtenir les résultats souhaités sur le plan social en raison des externalités. Les programmes de santé publique, tels que les campagnes de vaccination ou le traitement de l'eau, réduisent l'incidence des maladies contagieuses et ont donc un effet positif en ce qu'ils réduisent l'impact des maladies contagieuses sur la collectivité. Dans le cas de la tuberculose, par exemple, il peut arriver qu'un patient ne suive pas le traitement prescrit par le médecin pour des raisons de commodité ou parce que les médicaments coûtent cher. Ce comportement individuel peut avoir pour conséquence d'accroître le risque d'infection pour la collectivité. L'absence de traitement d'un malade contagieux peut donc s'accompagner d'une externalité négative[12]. Dans l'intérêt des personnes risquant d'être contaminées, et de la société dans son ensemble, le médecin traitant le patient en question doit agir pour le bien de la collectivité et proposer un traitement de plus vaste portée que ce que souhaite le patient.

4. Réponses aux imperfections du marché, problèmes posés et solutions envisageables dans le sens de l'ouverture à la concurrence

Dans le souci d'atténuer les problèmes d'information qui peuvent se faire jour dans un contexte de libre concurrence, les professions de santé ont souvent mis en place, parallèlement aux règles régissant le droit d'exercice ou les produits, des codes déontologiques[13]. Une profession peut se définir comme un domaine d'expertise dont les membres ont reçu une formation ou des qualifications spécifiques. De par la loi, de nombreux services de santé ne peuvent être réalisés ou prescrits que par une personne habilitée. La principale caractéristique du droit d'exercice d'une profession est qu'elle crée des obstacles à l'entrée dans la profession ou à la pratique de la profession de façon à permettre un contrôle de la qualité des soins et services dispensés[14].

L'octroi d'une autorisation d'exercice a notamment pour avantage de :

- Limiter l'incertitude des consommateurs quant à la qualité du produit. (Arrow (1963))
- Favoriser l'investissement dans le capital humain qui permet de rehausser la qualité du service. (Shapiro (1986))

Les règles qui gouvernent les professions de santé sont multiples et souvent imbriquées de façon complexe. A titre d'exemple, en Italie, seuls les docteurs en médecine peuvent prescrire une radiographie, et les radiographies d'êtres humains ne peuvent être pratiquées que sous la supervision de radiologues

agréés. Aux États-Unis, la Hearing Aid Rule de 1977 impose un examen médical avant la pose d'une prothèse auditive, faute de quoi les patients doivent signer une décharge auprès du fournisseur de prothèses auditives, conformément aux dispositions du Code des réglementations fédérales ((21 CFR §801.421). En outre, la plupart des États américains exigent des fournisseurs de prothèses auditives qu'ils aient reçu un agrément et qu'ils pratiquent une batterie de tests avant la vente et la pose des prothèses (voir FTC (1998)). En raison de toutes ces imbrications, on ne peut apprécier le caractère contraignant de la réglementation qu'à l'issue d'un examen complet de toutes les implications des multiples textes législatifs et réglementaires en vigueur.

Selon certains observateurs, les professions de santé érigent des barrières exagérément strictes à l'entrée dans la profession, à la pratique de la profession et à l'information du consommateur afin de protéger ou de relever le revenu des praticiens en exercice. (Voir Blevins (1995) et Cox et Foster (1990)). La finalité de ces règles "exagérément strictes" est la majoration du revenu. Pour White (1978), qui a étudié les salaires du personnel des laboratoires cliniques dans des régions exigeant, ou non, une autorisation d'exercice, a constaté que les salaires relatifs des titulaires de l'autorisation étaient supérieurs de 16 %.

Les règles professionnelles agissant sur la concurrence entrent dans l'une ou l'autre des catégories ci-dessous :

- Règles structurelles
  - Mesures d'encadrement qualitatives, quantitatives et géographiques
  - Monopole
  - Règles organisationnelles
  - Régime applicable aux recours des consommateurs
- Règles de comportement
  - Restrictions de la publicité
  - Règles relatives à la fixation des tarifs et à l'interdiction des remises

L'existence de règles par trop restrictives peut se traduire par une hausse des tarifs, une uniformisation de la qualité et une augmentation du coût pour le consommateur de la recherche du praticien souhaité. La suite de la section analyse divers types de règles en vigueur et recense les moyens d'en réduire les effets contraires à la concurrence. Il faut noter que ces options susceptibles de renforcer le champ de la concurrence doivent être examinées avec soin dans des contextes bien spécifiques, et ne sont pas la solution à retenir dans tous les cas.

4.1 Règles structurelles

Les règles, réglementations et normes de pratiques d'ordre structurel sont celles qui régissent la structure formelle d'une profession et son statut juridique, y compris les obligations à remplir pour y entrer et en sortir, le droit d'exercice, les formes juridiques données à l'exercice, et les voies de recours à la disposition des consommateurs.

4.1.1 Mesures d'encadrement qualitatives, quantitatives et géographiques

L'entrée dans une profession est régie par des règles relatives aux qualifications et, parfois, par des règles applicables au nombre de praticiens et à leur répartition géographique. Les règles d'ordre qualitatif peuvent servir à rehausser la qualité tout en opérant implicitement une régulation quantitative car le niveau de qualité (par le biais par exemple d'un numerus clausus appliqué au niveau des examens requis pour avoir le droit d'exercer) peut avoir pour effet de limiter l'offre de praticiens[15].

4.1.1.1 Mesures d'encadrement qualitatives

Il est indispensable, pour garantir la qualité des traitements, d'imposer des restrictions à l'entrée dans une profession et à la pratique de la profession : exigences de formation et d'apprentissage, et examens de validation des connaissances et des compétences. Aux États-Unis, par exemple, tous les États exigent des étudiants qui souhaitent obtenir le droit d'exercer la médecine d'être diplômés d'une faculté de médecine agréée et de passer avec succès le United States Medical Licensing Exam. Les États imposent ensuite un stage d'internat d'encore 12 à 18 mois avant l'obtention du droit d'exercer. En Irlande, c'est le Medical Council qui définit les règles d'autorisation d'exercice. Pour pouvoir s'inscrire au Medical Council, il faut avoir suivi la formation dispensée par une faculté de médecine (soit un cursus de 6 ans), et avoir accompli ensuite un stage d'internat d'au moins un an. Les médecins formés dans les pays de l'Union européenne peuvent faire valider leurs qualifications en Irlande, conformément aux directives de la Commission européenne, et il existe des accords de reconnaissance mutuelle avec l'Afrique du Sud, l'Australie et la Nouvelle-Zélande. Les médecins formés à l'extérieur de l'UE peuvent s'inscrire à des examens s'ils ont suivi une formation acceptée sur le plan international, mais la voie la plus courante pour ces médecins consiste à passer un examen pour obtenir une équivalence de diplôme (Transfer Exam du General Medical Council ç Londres). Ce diplôme en poche, ces médecins sont habilités à exercer dans toute l'Union européenne.

Il arrive parfois qu'une profession donnée, eu égard à la difficulté des tâches à exécuter, impose des critères encore plus stricts en termes de qualifications[16]. A titre d'exemple, il est parfois obligatoire de suivre une formation plus longue et plus approfondie que ce qui serait nécessaire pour réaliser les tâches propres à cette profession. Lorsque ces qualifications "excessives" jouent comme un obstacle à l'entrée et créer une insuffisance de l'offre, il peut être justifié de revoir les critères d'attribution du droit d'exercer[17]. Une telle révision est d'autant plus importante que des "études empiriques ont montré que la régulation du droit d'exercice accroît le coût pour le consommateur"[18]. Kleiner et Kudrle (2000), par exemple, ont constaté que dans les États américains où les taux de réussite aux examens dentaires sont le plus bas, les tarifs des services dentaires sont d'environ 11 % plus élevés que dans les États considérés comme peu ou moyennement restrictifs[19]. De surcroît, d'après les auteurs, à en juger par l'état de la dentition des recrues de l'armée de l'air, on ne dénombre pas plus de problèmes dentaires non corrigés dans les États les moins restrictifs. En d'autres termes, les États où les examens sont le moins difficiles n'ont pas de pires résultats que les autres du point de vue de l'état dentaire de la population. Pour Shepard (1978), le caractère plus restrictif de l'octroi du droit d'exercer la profession de dentiste est responsable d'une majoration des prix d'entre 8.5 et 18 % par rapport aux régions appliquant des règles moins strictes. Lorsque la rareté est induite par la réduction du nombre de diplômés, cela peut avoir pour conséquence de faire augmenter les prix pour le consommateur et de faire disparaître des services moins coûteux mais qui peuvent être de qualité égale. Si des prix plus élevés ne bénéficient pas nécessairement au consommateur, ils bénéficient en revanche à la profession : Kleiner et Kudrle (2000) ont montré que les dentistes exerçant dans les États les plus restrictifs gagnaient 11 % de plus que leurs confrères installés dans les États les moins réglementés.

S'agissant des qualifications, les instances chargées d'octroyer les autorisations d'exercice soient souvent composés pour une grande part de membres de la profession réglementée, ce qui peut s'avérer problématique[20]. En Irlande, par exemple, il n'est pas prévu de représentation des consommateurs/patients

au Conseil des opticiens (Opticians Board) [21]. Les principes qui régissent les exigences requises pour être admis dans la profession, les normes à respecter ou encore les actions disciplinaires au sein de la profession ne font généralement pas l'objet d'une supervision de la part d'une instance indépendante. Shaked et Sutton (1981) montrent que, d'un point de vue théorique, les professions ont tendance à fixer des normes qualitatives trop élevées et des normes quantitatives trop basses. Une profession ne définira un niveau de qualité optimal pour la collectivité que si elle s'intéresse exclusivement au bien-être du consommateur et pas au revenu des professionnels. Cox et Foster (1990) font valoir un argument du même ordre : "Même si les professions recherchent le bien-être du consommateur, la possibilité d'un conflit d'intérêt n'est pas à exclure. Les instances chargées de la réglementation, bien souvent, ont des intérêts dans la profession qu'ils réglementent. Étant donné que l'intérêt des professionnels ne coïncide pas nécessairement avec l'intérêt public, les réglementations professionnelles suscitent de plus en plus de scepticisme". (p. 1)

Pour pallier le risque de manque d'indépendance, l'Institute of Medicine, organe de conseil scientifique indépendant auprès de l'administration américaine, recommande que "les conseils chargés des autorisations d'exercice recrutent leurs membres au moins pour moitié à l'extérieur de la profession en question : dans le public ou dans divers domaines d'expertise (administration de la santé, économie, affaires de consommation, éducation et recherche en services de santé, par exemple)". (IOM (1989))

Certains conseils comptent parmi leurs membres des représentants des services juridiques de l'administration. D'autres exigent dans leurs statuts que leurs membres ne soient pas tous issus de la profession réglementée, comme le Conseil de l'Ordre des médecins irlandais qui réserve au moins trois sièges sur 25 à des non-médecins qui ont explicitement pour mission de protéger l'intérêt public.

Approche possible pour réduire les problèmes de concurrence :

Une approche possible pour améliorer le marché des services des professions de santé, en rapport avec la procédure d'agrément, consisterait en ceci :

- Les instances chargées de délivrer l'agrément et de déterminer les exigences requises en termes de formation pourraient, de par la loi, être tenues de compter dans leurs rangs des représentants dont les intérêts ne coïncideraient pas avec les intérêts de la profession concernée – consommateurs, organismes payeurs et chercheurs en services de santé, par exemple.[22]

4.1.1.2 Mesures d'encadrement quantitatives

En plus des exigences qualitatives à l'entrée, certaines professions sont soumises à des mesures d'encadrement quantitatives et géographiques. Ce peut être :

- Des limites explicites au nombre de places de formation disponibles ;
- Une limitation du nombre des établissements d'enseignement autorisés à dispenser une formation ;
- Obligation d'obtenir une décision centralisée de la part d'une instance professionnelle pour créer un nouveau poste, dans un hôpital, par exemple ; et,
- Limitation du nombre et de l'implantation des lieux d'exercice ou des praticiens.[23]

Les mesures d'encadrement quantitatives sont souvent justifiées par les arguments suivants :

- Elles sont nécessaires pour créer les incitations adéquates pour assurer l'offre de services dans les régions à faible densité de population ;[24] ou bien,

- Elles sont nécessaires pour limiter l'effectif global de praticiens, afin (i) de réduire la demande induite par l'offre de services, et (ii) de limiter la surconsommation liée à la couverture par une assurance.

La justification qu'il y a à garantir de hauts revenus aux praticiens établis dans les zones à faible densité de population constitue une forme de garantie d'accès à un bien qui a une valeur collective particulière. Il faut qu'il y ait un avantage à choisir ce type d'implantation. En l'absence de mesures d'encadrement quantitatives, l'intérêt qu'il y aurait à exercer une certaine profession en un lieu donné serait moindre et un plus grand nombre de zones géographiques seraient dépourvues de services.[25]

Les mesures d'encadrement quantitatives peuvent aussi se justifier par le souci d'éviter la surconsommation. La surconsommation peut être induite par l'offre de services ou par la couverture d'assurance. Il est probable qu'il y a une part de demande induite par l'offre de services, dans de nombreux pays Membres de l'OCDE. Fuchs (1978) a observé qu'aux Etats-Unis le nombre d'interventions chirurgicales augmente de 0.3 pour cent lorsque le rapport du nombre de chirurgiens à la population augmente de 1 pour cent. En ce qui concerne le Japon, Izumodo et al. (1999) ont constaté qu'une augmentation de 1 pour cent du nombre de médecins par habitant induit une augmentation de 0.8 pour cent de la demande de services avec hospitalisation et de 0.4 pour cent de la demande de services en mode ambulatoire. En France, Delattre et Dormont (2002) estiment que des éléments solides amènent à conclure à l'existence d'une demande induite par les médecins. En revanche, Grytten et Sorenson (2001) ne voient par d'indications d'une demande induite par les médecins en Norvège. Delattre et Dormont (2002) pensent que, si l'on n'observe pas cette relation en Norvège, c'est peut-être parce que la densité de médecins par habitant y est beaucoup plus faible qu'en France ou aux Etats-Unis. En ce qui concerne le phénomène de surconsommation lié à la couverture par une assurance (« aléa moral »), on peut penser que le problème des traitements inutiles n'est pas négligeable. S'il n'est pas possible d'ignorer les recommandations des professionnels de santé concernant un cas individuel, alors le rationnement quantitatif peut être un moyen de maximiser le bien-être collectif, l'hypothèse étant que les soins rationnés iront là où ils seront le plus utiles. Des restrictions quantitatives peuvent donc, apparemment, se justifier. Elles ne sont pas toujours souhaitables mais il est justifié que les responsables publics s'interrogent sur le rapport coût/avantage.

On a un exemple de mesures de restriction quantitatives avec les pharmaciens, en Irlande. Des restrictions s'appliquent au nombre de places de formation et des mesures de restriction se sont aussi appliquées, de 1996 à 2001, à l'implantation géographique des pharmacies. Jusqu'à une date récente, la profession des pharmaciens, en Irlande, limitait le nombre de places de formation à 70 au Trinity College de Dublin. Les pouvoirs publics ont voulu porter le nombre de places de formation à 120 à l'échelon national. Dans un premier temps, l'association professionnelle n'a pas donné son agrément au collège qui s'est porté candidat pour dispenser cette formation, mais deux collèges ont maintenant reçu l'agrément et c'est en 2003-2004 que, pour la première fois, une formation de pharmacien à été dispensée ailleurs qu'au Trinity College de Dublin. En raison des Accords de reconnaissance mutuelle (ARM) de l'UE, les personnes qui souhaitent devenir pharmacien peuvent suivre une formation dans un autre pays, par exemple au Royaume Uni, et ensuite revenir en Irlande. Les personnes qui le font sont alors soumises aux restrictions applicables aux pharmaciens formés à l'étranger et elles n'ont pas le droit de travailler dans une pharmacie qui a moins de 3 ans d'antériorité (ce qui signifie qu'elles n'ont pas le droit de créer une pharmacie). La plupart des pharmacies ne comptant qu'un pharmacien et le pharmacien étant généralement propriétaire de sa pharmacie, il est donc difficile pour les pharmaciens qui ont suivi une formation à l'étranger de s'installer [OCDE (2001)].

Des limites géographiques freinent les créations de pharmacies. En Irlande, trois critères s'appliquent :

- Le rapport du nombre de pharmacies à la population doit être d'au moins 1 pour 4 000 dans les zones urbaines et les villes de plus 3 000 habitants et d'au moins 1 pour 25 000 dans les zones rurales ;

- Il ne doit pas y avoir d'autre pharmacie dans un rayon de 250 mètres en zone urbaine ou de 5 km en zone rurale ;

- Il ne doit pas y avoir d'impact négatif sur la viabilité d'une pharmacie existante dans la zone.

Ces limites semblent avoir un réel impact sur les créations de pharmacies. Entre 1996 et 2001 (date à partir de laquelle les règles de 1996 ont cessé d'être applicables), il n'a été autorisé que 48 créations de pharmacies en Irlande.

Les restrictions géographiques ne sont pas l'apanage de l'Irlande. D'autres pays également, notamment l'Italie, l'Espagne, la Hongrie, la Norvège, la France, l'Australie et le Royaume Uni, limitent le nombre ou l'implantation des pharmacies [OCDE (2001)].

La reconnaissance automatique des qualifications acquises dans un autre pays peut notablement réduire la possibilité de limiter indûment l'accès à une profession par des mesures de restriction quantitatives. Au sein de l'UE, par exemple, la Commission européenne et le Parlement européen surveillent l'application des règles de reconnaissance mutuelle dans certaines professions. Des règles existent pour la reconnaissance mutuelle des diplômes, certificats et autres titres, pour les dentistes, les médecins, les sages-femmes, les infirmières et les pharmaciens (Directives 78/686/CEE, 93/16/CEE, 80/154/CEE, 77/452/CEE et 85/433/CEE respectivement). Toute personne possédant une qualification pour une profession médicale qui existe dans au moins deux Etats membres bénéficiera d'un droit de reconnaissance mutuelle pour exercer cette profession dans les autres Etats. L'absence de droit de reconnaissance automatique peut avoir des conséquences non négligeables. Shepard (1978) estime que l'absence de réciprocité concernant les qualifications en soins dentaires entre les différents Etats des Etats-Unis augmente les prix de 8.5 à 18 pour cent.

Approches possibles pour réduire les problèmes de concurrence :

Certaines approches possibles pour améliorer le marché des services des professions de santé, en rapport avec les limitations à l'entrée, consisteraient en ceci :

- Les limites quantitatives et géographiques peuvent être soumises à réexamen. De telles limites peuvent toutefois conserver leur intérêt, surtout lorsque le but des autorités est de limiter l'entrée pour réduire la surconsommation.

- Les critères de nationalité ou de résidence antérieure peuvent être supprimés. Ces critères limitent les échanges internationaux de services professionnels.

- La reconnaissance mutuelle des qualifications équivalentes ou supérieures entre Etats ou zones géographiques peut être mise en œuvre.

4.1.2 Droits exclusifs

Une profession peut avoir, de jure ou de facto, le droit exclusif de fournir un certain service. Il y a exclusivité de jure lorsque, par exemple, des hygiénistes dentaires, qui ont pourtant un système de qualification propre, ne sont pas autorisés à exercer indépendamment d'un dentiste. Il peut y avoir exclusivité de facto lorsqu'un acte n'est remboursé que s'il est exécuté par un spécialiste « qualifié ». Le consommateur ne peut être remboursé lorsque le service est presté par une personne qui n'a pas la qualification officielle.[26]

L'exclusivité du droit d'exercice peut aider à garantir la qualité des services. Par exemple, examinant les services dentaires, Holen (1978) observe que la procédure d'agrément réduit les risques et augmente la qualité des soins. Shapiro (1986) fait valoir que la procédure d'agrément profitera au segment de la population qui valorise la qualité, notamment parce que les consommateurs qui recherchent la qualité seront davantage susceptibles de bénéficier de services de qualité.

Cependant, le droit d'exclusivité peut aussi conduire les consommateurs à se détourner de certains prestataires potentiels, moins coûteux et éventuellement moins bien formés, pour certains types de soins (sages-femmes ou hygiénistes dentaires, par exemple) et à ne s'adresser qu'à ceux qui auront un agrément (obstétriciens ou dentistes, par exemple).

Le droit d'exclusivité peut empêcher des concurrents potentiels (par exemple, des professions paramédicales) d'accomplir certains actes et empêcher des concurrents d'adapter des produits de santé. En particulier, reconnaître aux associations professionnelles toute faculté de déterminer le droit d'exercice peut conduire à des exclusions contestables. Il peut y avoir lieu d'examiner le droit d'exclusivité pour voir s'il se justifie.

4.1.2.1 Limiter les professions paramédicales et les professions parallèles

Lorsque des professionnels ont le droit exclusif d'accomplir ou de superviser certains actes qui pourraient tout aussi bien être accomplis par un intervenant nettement moins formé, on peut envisager de créer une profession paramédicale. Les professions paramédicales sont destinées à accompagner, compléter ou assister le travail d'autres professions de santé. Entrent, par exemple, dans cette catégorie les auxiliaires dentaires, les techniciens médicaux et les infirmières sages-femmes. Shaked et Sutton (1981) concluent que les professions paramédicales sont de nature à améliorer le bien-être du consommateur et qu'en fait le bien-être du consommateur est maximisé lorsque les effectifs de paramédicaux atteignent le niveau qui entraîne la perte de revenu maximale pour les membres de la profession médicale d'origine.

Rares sont les études qui ont examiné de façon empirique l'impact d'une limitation de l'activité des professions paramédicales sur les soins. Cependant, Liang et Ogur (1987) ont étudié cet aspect. Ils ont examiné l'impact des restrictions visant le recours à des auxiliaires dentaires. Leur conclusion est que ces restrictions renchérissent les coûts mais n'améliorent pas la qualité, comme indiqué dans l'encadré 2.

Box 7. Restrictions applicables aux auxiliaires dentaires

Les auxiliaires dentaires se répartissent en spécialistes de l'hygiène buccale, assistants dentaires et auxiliaires dentaires à compétences étendues. Un hygiéniste dentaire doit suivre une formation post-secondaire de deux ans avant de pouvoir se présenter à l'examen d'État lui conférant le droit d'exercer. C'est lui qui est chargé de nettoyer les dents, de prendre des radiographies et d'administrer des traitements au fluorure. L'assistant dentaire, quant à lui, n'a pas d'obligations formelles à remplir pour obtenir le droit d'exercer, sa principale tâche étant d'aider le dentiste dans son travail, par exemple en lui passant les ustensiles. Un auxiliaire dentaire à fonctions étendues est un hygiéniste ou un assistant qui a reçu une formation supplémentaire ou acquis une expérience lui permettant d'accomplir certains actes, comme les plombages simples.

Si les États américains autorisent les auxiliaires dentaires à dispenser certains services dentaires (presque toujours dans le cabinet du dentiste), les droits qui leur sont accordés sont souvent limités, soit d'un point de vue quantitatif, par le nombre des auxiliaires autorisés à travailler pour un dentiste, soit d'un point de vue qualitatif, par la nature des tâches qui leur sont confiées. Certains États, par exemple, limitent à deux le nombre d'auxiliaires par dentiste. D'autres restreignent l'éventail des tâches dont ils peuvent être chargés : examens préliminaires de la bouche, radiographies, traitement au fluorure et obturations à l'amalgame.

Les dentistes peuvent donc être considérés à la fois comme les fournisseurs d'un produit (le service dentaire à proprement parler, comme le plombage) et l'ayant-droit résiduel des bénéfices du cabinet dentaire (bénéficiaire du travail des salariés tels que les auxiliaires.) La limitation du recours aux auxiliaires peut empêcher les dentistes de mettre en place la combinaison de facteurs la plus efficiente.

Selon des données couvrant la période 1970-1982, les tarifs des consultations des dentistes sont entre 6 et 7 % plus élevé dans les États qui limitent le nombre d'auxiliaires par dentiste, de même que les tarifs d'un certain nombre de services, plus élevés d'entre 5 et 11%. Parmi ces services, on dénombrait sept actes codifiés sur les dix étudiés en 1970 et cinq sur dix en 1982, tels que les examens bucco-dentaires, le nettoyage des dents, les traitements au fluorure ou les obturations à l'amalgame.

Liang et Ogur (1987) notent que, d'après de nombreux documents traitant des pratiques dentaires recensées (santé publique, médecine universitaire, médecine militaire, ou cabinets privés), il n'y a pas de différence statistiquement significative entre la qualité technique des actes réalisés par les auxiliaires dentaires confirmés et par les étudiants en dentaire ou les dentistes.

Source : Liang et Ogur (1987)

Les restrictions à l'activité des professions paramédicales ne sont pas seulement liées à la réglementation mais peuvent aussi être liées aux pratiques en matière de facturation. Par exemple, l'Association canadienne des hygiénistes dentaires (2002) signale que les réglementations au niveau des provinces autorisent désormais les hygiénistes dentaires à exercer dans un cabinet distinct, en dehors du cabinet d'un dentiste. Mais la majorité des compagnies d'assurance ne reconnaissent toujours pas ces réglementations et il y a décalage entre la politique des compagnies d'assurance et les réglementations au niveau des provinces. Ainsi, même en Colombie britannique où les hygiénistes dentaires sont autorisés par la réglementation à travailler dans un cabinet indépendant, hors supervision d'un dentiste, les compagnies d'assurance continuent d'exiger la signature et le numéro d'identification d'un dentiste avant tout versement.

4.1.2.2 Limiter l'accès aux produits de santé

L'adaptation et la délivrance aux consommateurs de produits de santé tels que les prothèses auditives, les lunettes et les lentilles de contact, sont souvent soumises à diverses règles qui exigent l'étroite collaboration de plusieurs professions. La raison d'être de cette situation est de garantir que le patient porteur d'une maladie soit diagnostiqué et traité, de garantir la bonne adaptation du produit et d'éviter les abus en dispensant des produits inutilement.

Lorsque des professions ont le droit exclusif de préparer un consommateur à utiliser un produit de santé, il faut vraiment se demander si, et dans quels cas, l'intervention de ces différentes professions est réellement indispensable. On examinera ci-après trois exemples : lunettes, lentilles de contact et prothèses auditives.

Lunettes – lunettes sans prescription et prescription récente

On juge, par exemple, souhaitable que les optométristes ou les ophtalmologistes examinent tous les patients dont l'acuité visuelle se dégrade pour s'assurer qu'il n'y a pas un problème médical traitable à l'origine de leur baisse d'acuité visuelle, un glaucome par exemple. Dans cette optique, on peut demander que les optométristes examinent tous les patients qui veulent de nouvelles lunettes. Et c'est pourquoi certains pays Membres exigent que toutes les lunettes soient achetées auprès d'un optométriste ou d'un opticien. En Irlande, par exemple, en vertu d'une loi de 1956 visant la profession d'opticien, la High Court, en 1990, a interdit à quatre détaillants de vendre des lunettes pré-montées au motif qu'ils n'étaient ni opticiens ni praticiens médicaux enregistrés [Indecon (2002)]. Par contre, en Australie, aux Etats-Unis et dans certains autres pays Membres, les lunettes pré-montées peuvent être achetées en pharmacie et dans d'autres points de vente.

Une prescription récente est normalement indispensable, même pour un achat motivé par un souci d'esthétique ou de mode. Il est souvent exigé une prescription récente pour un renouvellement de lunettes. Par conséquent, même si le consommateur ne constate pas de baisse de son acuité visuelle, s'il veut de nouvelles lunettes, simplement pour remplacer ses anciennes lunettes, il doit subir un examen des yeux et en supporter le coût.

Lentilles de contact – distribution et achats par correspondance

La vente de lentilles de contact par correspondance a soulevé des problèmes de concurrence nouveaux, ces dernières années. Par exemple, l'Etat du Connecticut, aux Etats-Unis, a envisagé de faire appliquer une règle exigeant que les vendeurs indépendants de lentilles de contact, y compris ceux situés dans un autre Etat, soient enregistrés comme établissements d'optique.

Permettre aux consommateurs de se procurer des lentilles de contact à moindre coût peut être bénéfique, à la fois sur un plan financier et sur le plan de la santé. Certains consommateurs prennent des

risques avec leur santé parce qu'ils ne remplacent pas leurs lentilles de contact aussi souvent qu'il le faudrait. Les lentilles jetables ne doivent pas être portées plus qu'un certain temps. Et pourtant, de nombreux utilisateurs les portent plus longtemps qu'ils ne devraient, s'exposant à des risques d'inflammation et d'infection de l'œil. Dans une enquête, 57 pour cent des porteurs de lentilles ont déclaré qu'ils remplaceraient leurs lentilles plus souvent si elles coûtaient moins cher. Un remplacement plus fréquent des lentilles réduirait les risques d'inflammation et d'infection de l'œil [FTC (2004)].

Les lentilles de contact sont moins coûteuses lorsqu'elles sont achetées par correspondance. En 1998, le coût moyen d'un pack de 6 lentilles commandé par correspondance était de 19.90 USD contre un coût moyen de 23.76 USD pour le même pack acheté auprès d'un ophtalmologiste, d'un optométriste ou d'une chaîne d'optique – soit un écart de prix de 19 pour cent. (Federal Trade Commission 2004, pages 12-13). Le prix d'achat était en fait très proche de celui pratiqué chez un discounteur. Par conséquent, le principal avantage résidait dans la commodité puisque le consommateur n'a pas à se déplacer. La Federal Trade Commission estimait entre 10.96 USD et 26.00 USD le temps qu'il fallait consacrer à un déplacement pour aller acheter des lentilles. Par conséquent, le fait d'interdire l'entrée de fournisseurs de lentilles par correspondance pourrait avoir un coût de commodité non négligeable. [Federal Trade Commission (2002)].

Contraindre les sociétés de vente par correspondance à se soumettre à des procédures longues et coûteuses pour obtenir un agrément les dissuaderait d'intervenir sur le marché et augmenterait leurs coûts, ce qui se traduirait vraisemblablement par des prix plus élevés.

La FTC a conclu qu'exiger des fournisseurs indépendants de lentilles de contact qu'ils obtiennent le statut d'opticien et d'établissement d'optique dans l'Etat du Connecticut entraînerait probablement une hausse des coûts pour le consommateur sans avoir en contrepartie d'effets bénéfiques sur le plan de la santé [Federal Trade Commission (2002)].

Prothèses auditives – modèles en vente libre

Dans une proposition récente à la Food and Drug Administration (FDA), aux Etats-Unis, un organisme tiers a demandé que la FDA envisage de créer une nouvelle catégorie de prothèses auditives qui pourraient être en vente libre. (Killion (2003)) Les prothèses auditives existantes relèvent des dispositions de l'Hearing Aid Rule de 1977. Cette réglementation exige que les consommateurs voient un médecin avant de recevoir une prothèse auditive. Les adultes peuvent se soustraire à cette obligation s'ils signent une décharge. Mais alors, dans la plupart des Etats, l'adaptation doit se faire chez un distributeur agréé. Actuellement, les distributeurs agréés par l'Etat et les audiologistes sont les deux principales sources de prothèses auditives.

Les prothèses auditives coûtent cher aux Etats-Unis : le coût moyen d'une paire de prothèses auditives atteint aujourd'hui 2 200 USD. (WSJ, 24 mars 2004) Les normes de l'association professionnelle exigent que toute une batterie de tests soient réalisés pour adapter des prothèses auditives.

En raison de ce coût élevé, 20 pour cent seulement environ des personnes qui auraient grand intérêt à être appareillées le sont effectivement.[27] On peut douter que toutes les personnes qui auraient intérêt à se faire appareiller le soient même si les prothèses auditives étaient meilleur marché, mais on peut néanmoins penser que beaucoup de gens seraient susceptibles de bénéficier d'appareils destinés à améliorer l'audition si ceux-ci étaient nettement moins cher.

Des aides auditives simples, non réalisées sur mesure et sans capacité de programmation, seraient beaucoup moins coûteuses pour le consommateur et elles sont techniquement réalisables. Par exemple, les aides auditives numériques personnalisables coûtent environ 70 GBP au NHS, au Royaume-Uni. (Hansard (2004)) Les appareils d'écoute (utilisés par les chasseurs) qui font appel à la même technologie

se vendent au détail 149 USD. Récemment, la FDA a rejeté la proposition tendant à ce que des prothèses auditives standard puissent être proposées en vente libre et elle a maintenu l'obligation de voir un médecin ce qui, avec les règles de l'association professionnelle, peut avoir pour effet d'augmenter le prix des prothèses auditives de plus de 1 000 pour cent.[28]

La FDA a rejeté l'idée de créer une nouvelle catégorie de prothèses auditives. Dans la lettre signifiant son refus (Rothstein (2004)), elle ne prend pas en compte l'effet qu'une baisse des prix aurait sur le nombre de consommateurs appareillés. La FDA note que le système actuel permet sans doute mieux de diagnostiquer les problèmes de santé qui peuvent être traités. « Faute de dépistage par un médecin, les personnes qui ont une perte d'audition risquent d'acheter des prothèses auditives pour corriger leur problème et ressentiront peut-être même un mieux tout en continuant à souffrir d'une affection médicale grave qui devrait être convenablement diagnostiquée et traitée. Dans certains cas, l'absence de diagnostic ou le retard au diagnostic peuvent conduire à des dommages irréparables, à une dégradation durable de l'audition ou à un risque accru de chirurgie pour le porteur de la prothèse auditive. » La FDA note, par ailleurs, qu'avant qu'il soit exigé une formation pour les vendeurs de prothèses auditives, de nombreux consommateurs ont acheté des prothèses sur l'insistance de praticiens non qualifiés employant des méthodes de vente agressives.[29]

Les pays européens, par contre, ont une réglementation plus libérale qui autorise la vente d'appareils auditifs standard qui induisent des coûts moindre, même pour des prothèses auditives achetées à titre privé. On sait, par exemple, que les prothèses auditives sont bon marché au Danemark et en Allemagne. Au Royaume-Uni, le National Health Service fournit maintenant des prothèses auditives numériques gratuites dans des points de distribution grand public.

La décision d'autoriser ou non les prothèses auditives en vente libre implique un arbitrage entre un faible prix/une distribution plus large et le fait que certains problèmes médicaux ne seront pas traités si le consommateur n'est pas tenu, au préalable, d'aller consulter un spécialiste.

4.1.2.3 Refus d'accès à certains équipements et au dossier

Parfois, les professionnels de santé refusent d'autoriser l'accès aux équipements ou au dossier. Cela peut résulter d'un comportement strictement individuel ou du comportement de la profession.[30] Ces limites sont particulièrement fréquentes (1) pour les professions paramédicales et les professions parallèles qui ne sont pas pleinement respectées par les professions établies, et (2) pour des produits de santé connexes.

<u>Professions parallèles</u>

Lorsqu'une profession parallèle, comme les hygiénistes dentaires ou les chiropracteurs, sollicite l'accès à certains équipements (appareils de radiographie, par exemple) pour ses patients et demande à avoir communication des résultats, dans bien des pays ce n'est pas possible : c'est un médecin ou un dentiste qui doit prescrire la radiographie et personne en dehors des professions « autorisées » ne peut avoir accès aux résultats, même lorsque le patient est prêt à payer lui-même ce type de service. En Italie et en France, par exemple, les chiropracteurs ne peuvent pas prescrire de radiographies ni recevoir directement les résultats. Empêcher l'accès direct augmente le coût pour le patient ou l'organisme payeur (puisque le patient est obligé de s'adresser à un professionnel habilité à prescrire et accomplir l'acte) et, par conséquent, réduit la probabilité que le patient cherche à recevoir le traitement de son choix. Le refus d'accès a un coût pour le patient.

Le refus d'accès peut se justifier parce qu'on craint une mauvaise utilisation ou qu'il y ait préjudice pour le patient. Mais, le refus d'accès pouvant répondre à une volonté de limiter la concurrence, la charge de la preuve pourrait incomber à la partie qui refuse l'accès qui devrait avoir à justifier son refus.

Accès au dossier

Parfois, les professionnels de santé peuvent ne pas communiquer l'information aux patients sur leur état alors qu'ils pourraient utiliser cette information pour se procurer des produits auprès d'autres sources. Par exemple, aux Etats-Unis, il y a eu des problèmes avec la délivrance de prescriptions pour les lunettes et les lentilles de contact. Certains optométristes et ophtalmologistes refusent de fournir aux patients une prescription écrite qu'ils pourront utiliser chez d'autres fournisseurs. Cela réduit les possibilités de choix du fournisseur pour le patient. Aux Etats-Unis, la Federal Trade Commission a estimé que ces pratiques étaient dommageables pour le consommateur et la réglementation (Eyeglass Rule) exige que le praticien qui contrôle la vision délivre une ordonnance au patient que celui-ci pourra éventuellement utiliser auprès d'un autre fournisseur. Cette réglementation ne s'applique pas aux lentilles de contact et, souvent, les praticiens qui prescrivent les lentilles de contact refusent de délivrer une ordonnance. C'est pourquoi, avec le Contact Lens Consumers Act de 2003 et une réglementation du 2 août 2004, la Federal Trade Commission :

- Exige du prescripteur (optométristes et ophtalmologistes) qu'il remette aux patients un exemplaire de la prescription immédiatement après avoir effectué un examen pour l'adaptation de lentilles de contact, et cela sans surcoût pour le patient ;

- Exige que le prescripteur fournisse ou vérifie une prescription communiquée à un tiers désigné par le patient ;

- Interdit que le prescripteur fasse état de certaines affections sur la prescription de lentilles de contact qu'il délivre ou vérifie ;

- Exige que le vendeur de lentilles de contact obtienne un exemplaire de la prescription ou vérifie la prescription avant de vendre les lentilles, et la prescription est réputée « vérifiée » si le prescripteur n'a pas répondu à la demande de vérification du vendeur dans un délai de 8 heures, un jour ouvrable ;

- Fixe à un an au minimum la durée de validité des prescriptions pour des lentilles de contact, à moins qu'il y ait une justification médicale à ce que la prescription soit valable moins longtemps.

Cette règle vise à éviter les abus des prescripteurs dans un but anticoncurrentiel si ceux-ci refusaient de procéder à une « vérification ». Un problème qui peut se poser, en cas d'achat par correspondance, réside dans l'obligation, pour le vendeur de lentilles de contact, de recevoir une prescription délivrée par un prescripteur autorisé. On peut voir dans cette exigence une mesure de nature à promouvoir ou, au contraire, restreindre la concurrence. Par exemple, on peut en donner une interprétation large en prévoyant que le consommateur peut communiquer la prescription par divers moyens (courrier, appel téléphonique, fax ou mél) et en prévoyant, si la vérification est nécessaire, que le vendeur contacte directement le prescripteur. A l'inverse, on peut limiter la concurrence en restreignant les formes de vérification de la prescription.[31]

La réglementation exigeant que le prescripteur de lentilles de contact fournisse une prescription au patient, certains prescripteurs délivrent des prescriptions sur lesquelles ils spécifient qu'il faut acheter des lentilles d'une certaine marque. Il ne s'agit pas d'une marque nationale mais d'une marque du praticien ou du distributeur avec lequel il est associé, ce qui limite la concurrence. Pourtant, les lentilles vendues sous marque propre peuvent être les mêmes que celles vendues sous marque nationale, mais en étant simplement vendues sous le nom du cabinet du prescripteur. (Federal Trade Commission (2004)) Etant donné que toutes les lentilles de contact ne se valent pas, en termes de propriétés médicales, et que certaines peuvent ne pas convenir aussi bien que d'autres à un consommateur, il peut se justifier,

médicalement, de prescrire expressément certains types de lentilles (ou d'en exclure d'autres). Certains praticiens ont recours au système des marques propres pour décourager le consommateur d'acheter ses lentilles ailleurs. (Federal Trade Commission (2004), page 29) La loi Fairness to Contact Lens Consumers Act traite la question des lentilles de marque propre : il est exigé que soit précisé sur la prescription le nom du fabricant, le nom de la marque propre et, le cas échéant, le nom d'une marque équivalente. (16 CFR 315.2(h))

Approches possibles pour réduire les problèmes de concurrence :

Certaines approches possibles pour améliorer le marché des services des professionnels de santé, en rapport avec la question de l'exclusivité, consisteraient en ceci :

- On peut créer des professions paramédicales habilitées à prester des services clairement définis n'exigeant pas la même formation que la profession d'origine sans que cela ait d'incidence dommageable sur la qualité des soins.

- Les paramédicaux peuvent être autorisés à exercer en toute indépendance et à être rémunérés directement.

- La réglementation des produits de santé peut être limitée aux restrictions qui limitent le moins la concurrence tout en servant l'objectif de santé, compte tenu du coût potentiel des limitations (surcoût pour le patient, consommation réduite) ainsi que du gain potentiel en termes d'évaluation médicale.

- Lorsqu'elles ne sont pas dangereuses, les options moins coûteuses peuvent être autorisées, par exemple (a) essais et formation moins étendus lorsque l'adaptation d'un produit ne présente pas un grand danger, et (b) vente libre de produits standard.

- La capacité des associations professionnelles de contrôler la possibilité, pour des professions concurrentes, de prescrire et de recevoir des services de diagnostic privés devrait être limitée lorsque les limitations sont dangereuses pour le patient et destinées, vraisemblablement, à écarter les concurrents potentiels.

- La loi peut exiger une totale information du consommateur sur les prescriptions.

4.1.3 Structure organisationnelle

Les réglementations régissant les professions de santé limitent fréquemment les possibilités de regroupement entre professionnels pour constituer une plus grande entité et limitent aussi les formes juridiques que l'exercice peut prendre. C'est ainsi que les réglementations limitent (i) la mesure dans laquelle les professionnels de santé peuvent se regrouper avec d'autres praticiens de la même spécialité ; (ii) la mesure dans laquelle les professionnels de santé peuvent s'associer avec des praticiens d'une autre spécialité ; (iii) la forme juridique que les professionnels de santé peuvent adopter (partenariat, responsabilité limitée, par exemple) ; ou (iv) le nombre de points de vente qu'une seule et même entité peut posséder (réglementations visant les pharmacies).

Ce type de réglementation existe pour au moins trois raisons :

- Sentiment que des professionnels de santé indépendants seront davantage incités à préserver la qualité et à servir les intérêts du patient s'il n'y a pas de force extérieure comme un employeur pour faire pression sur eux pour qu'ils augmentent les recettes ;

- Sentiment que les acteurs au niveau local seront davantage incités à préserver des normes professionnelles (un manquement aux règles professionnelles dans leur localité leur ferait perdre leur activité) ;[32]

- Éviter les conflits d'intérêts en empêchant qu'un secteur d'activité ne bénéficie des gains financiers d'un autre secteur d'activité.

Ces règles limitent les gains d'efficience potentiels qui peuvent résulter des économies d'échelle et de l'intégration verticale. C'est pourquoi elles méritent d'être attentivement examinées.

Restrictions visant le régime de propriété et l'emploi

Parmi les restrictions visant la structure organisationnelle, il y a les règles qui interdisent la constitution en société pour les pharmacies. Les pharmacies peuvent être une propriété en nom collectif aux États-unis, au Canada et au Royaume-Uni, mais, dans beaucoup d'autres pays, elles doivent être la propriété d'un pharmacien et le nombre de pharmacies qu'un même pharmacien peut posséder est limité. En ce qui concerne les États-unis, pays qui compte le plus grand nombre de pharmacies constituées en société, une étude récente du magazine Consumer Reports a recensé les prix pratiqués pour un panier de cinq médicaments dans 130 pharmacies et il a reçu les réactions de plus de 32 000 lecteurs pour plus de 40 000 achats de produits pharmaceutiques. (Consumer Reports (2003)) L'étude a révélé que le service était jugé de moins bonne qualité dans les pharmacies constituées en société que dans les pharmacies de supermarché, dans les points de vente de masse ou dans les drugstores indépendants.[33] Les chaînes de drugstores et les supermarchés étaient les points de vente qui étaient le plus susceptibles de ne pas avoir le médicament demandé. « Lorsqu'un médicament était manquant, les indépendants étaient, dans 80 pour cent des cas, en mesure de l'obtenir le jour même, alors que la proportion n'était que de 55 à 60 pour cent pour les autres types de magasins. » Il est intéressant d'observer que les pharmacies constituées en société obtenaient une mauvaise évaluation alors que leurs prix étaient parmi les plus élevés. Les pharmacies indépendantes étaient celles qui obtenaient le meilleur score sur le plan de la qualité du service et les prix pratiqués étaient presque les plus élevés.[34] C'est par les pharmacies Internet et par les points de vente de masse que les prescriptions étaient servies au moindre coût. La forme juridique de la société va de pair avec les prix moindres lorsque les pharmacies se trouvent à l'intérieur d'autres magasins.

Pour certains services au moins, le régime de société est vraisemblablement bénéfique pour les consommateurs. Par exemple, l'étude de la FTC portant sur les lunettes et les optométristes (Bond et al. (1980)), décrite dans l'encadré 3 ci-après, a conclu que les points de vente constitués en société offraient un rapport qualité/prix qui n'était pas accessible en dehors des magasins de chaîne, à savoir des lunettes et des examens de moindre qualité mais pour un coût nettement moindre que dans d'autres points de vente. Il est intéressant de noter que l'étude n'indique pas que la qualité baisse, globalement, lorsque des magasins de chaîne font leur entrée sur le marché des lunettes et des examens de la vue. L'entrée de magasins de chaîne amène un autre rapport qualité/prix, ce qui accroît le choix du consommateur.

Liens financiers

L'un des objectifs de la réglementation en matière de santé est de limiter les coûts et de réduire le rôle des incitations financières dans la dispensation des soins. En règle générale, il est interdit aux médecins d'avoir des intérêts financiers dans les entités auxquelles ils adressent des patients. Cette interdiction vise à éviter qu'il n'y ait rétribution en retour. Aux Etats-Unis, la loi Stark interdit qu'un médecin dirige les patients couverts par Medicare ou Medicaid, pour la fourniture de certains services, vers une entité avec laquelle le médecin (ou un membre de sa famille immédiate) a un lien financier, direct ou indirect. Il y a ainsi onze types de services désignés : examens de laboratoire, radiologie, kinésithérapie, soins à domicile, médicaments de prescription en mode ambulatoire et services hospitaliers avec hospitalisation et en mode ambulatoire, etc.).

Certaines restrictions à l'association avec d'autres intérêts financiers peuvent entraîner des inefficiences dans la prestation. Mais la Cour européenne de justice a laissé une grande latitude aux professions de santé pour déterminer si des associations entre professions sont souhaitables. Dans l'arrêt Wouters, la Cour européenne de justice a examiné une règle professionnelle (édictée par l'Association professionnelle des avocats aux Pays-Bas) qui interdisait les collaborations intégrées entre avocats et experts-comptables. Le principe général qui a été énoncé est très certainement applicable aux professions de santé : les règles professionnelles ne sont autorisées que pour autant qu'elles sont nécessaires pour préserver le bon fonctionnement des professions. L'arrêt est ainsi formulé : « Aux fins de l'application de cette disposition à un cas d'espèce, il y a lieu tout d'abord de tenir compte du contexte global dans lequel la décision de l'association d'entreprises en cause a été prise ou déploie ses effets, et plus particulièrement de ses objectifs, liés en l'occurrence à la nécessité de concevoir des règles d'organisation, de qualification, de déontologie, de contrôle et de responsabilité, qui procurent la nécessaire garantie d'intégrité et d'expérience aux consommateurs finaux des services juridiques et à la bonne administration de la justice. » (Arrêt Wouters, paragraphe 97)

Approches possibles pour réduire les problèmes de concurrence :

Certaines approches possibles pour améliorer le marché des services des professions de santé, en rapport avec la structure organisationnelle, consisteraient en ceci :

- Autoriser la constitution en société des professionnels de santé dans les professions non assurées qui dispensent des produits tels que les lunettes, lentilles de contact, prothèses auditives et prothèses dentaires.

- En cas de sur prescription, il conviendrait d'envisager une règle destinée à éviter les conflits d'intérêts qui interdirait à un prescripteur d'avoir des intérêts financiers dans la vente des produits qu'il prescrit.

- Réexaminer les restrictions à la forme organisationnelle en vue de réaliser des économies d'échelle et de gamme.

4.1.4 Voies de recours ouvertes au consommateur

D'aucuns estiment que l'agrément n'est pas nécessaire pour les professions de santé et que les solutions marchandes sont suffisantes pour garantir la qualité. Une solution marchande reposerait sur le principe de la responsabilité, une prestation non satisfaisante pouvant entraîner une perte financière pour le praticien (ou son assureur). Un tel système inciterait les assureurs à contrôler la qualité et pourrait dissuader les praticiens de moindre qualité d'exercer tout en maintenant le maximum de concurrence entre praticiens.

Un régime fortement judiciarisé existe aux Etats-Unis, surtout dans certains Etats, qui ne limitent pas le montant de l'indemnisation du préjudice moral qui peut être accordée à un patient en cas de faute médicale. Il est intéressant d'examiner ce régime pour voir dans quelle mesure il joue en faveur de la qualité ou alourdit les coûts.

Ce régime fortement judiciarisé a des effets, directs et indirects, non négligeables sur les coûts en matière de santé. L'effet direct se traduit par un renchérissement des coûts d'assurance pour le praticien. En 2000, les primes d'assurance acquittées par les médecins s'élevaient à 6.3 milliards USD (ou bien encore 10 100 USD environ par médecin).[35] Les réglementations au niveau des Etats qui limitent le montant de l'indemnisation du préjudice moral ont un impact notable sur le coût d'exercice de certaines professions. Par exemple, un obstétricien payait entre 143 000 et 203 000 USD en primes d'assurance responsabilité en Floride, en 2001, contre 23 000 à 72 000 USD en Californie. (Department of Health and Social Services des Etats-Unis (2002)).

On estime que l'effet indirect est beaucoup plus important que l'effet direct. Au total, le Department of Health and Social Services estime que les dépenses au niveau fédéral se sont accrues de 28.6-47.5 milliards de dollars du fait de la forte judiciarisation du système aux Etats-Unis, ce qui a notamment pour effet d'inciter les médecins à pratiquer une médecine défensive, pour un coût estimé à 23.7-42.6 milliards de dollars.[36] Une grande étude indique que les coûts de la santé, aux Etats-Unis, pourraient être réduits dans la proportion de 5 à 9 pour cent, sans effet négatif sur la qualité, par une simple limitation des possibilités de mise en cause de la responsabilité des médecins. (Kessler et McClellan (1995))

Si la forte judiciarisation augmente notablement les coûts de la santé, le bénéfice pour le consommateur est modeste, en particulier parce que le système des indemnisations est aléatoire, lent et coûteux.

- Un faible pourcentage seulement des patients victimes d'une négligence médicale demandent effectivement réparation ; la proportion est estimée à 1.53 pour cent. (Localio et Lawthers (1991)) Par conséquent, la majorité des consommateurs victimes d'une faute médicale ne perçoivent aucune indemnisation ;

- En règle générale, les demandes d'indemnisation qui aboutissent ne donnent lieu au versement d'une indemnité que cinq ans après que le préjudice a été subi. (Department of Health and Social Services des Etats-Unis (2002)) ; et

- Les frais d'avocat et de procédure sont si élevés que 28 pour cent seulement de ce qui est payé par l'assurance en cas de faute médicale va effectivement au patient. (Department of Health and Social Services des Etats-Unis (2002))

Les systèmes judiciarisés présentent un avantage lorsqu'il n'y a guère volonté d'exiger des praticiens non performants qu'ils cessent d'exercer. Les assureurs peuvent augmenter les primes pour les praticiens qui n'ont pas un niveau de qualité suffisant ou refuser de les assurer. Cela peut inciter les praticiens médiocres à cesser d'exercer, mais cet aspect bénéfique est difficile à quantifier.

4.2 Principes de comportement

Des règles de comportement régissent la publicité, la sollicitation et la fixation des honoraires. Ce sont des mesures de limitation de la concurrence tout à fait exceptionnelles car elles ne semblent pas produire de grands bénéfices pour le consommateur et peuvent, en revanche, lui nuire.

4.2.1 Règles déontologiques

Les organismes professionnels imposent souvent des règles déontologiques à leurs membres : limitation de la publicité sur les services proposés et les prix ou bien, de façon plus générale, limitation des possibilités pour un professionnel de santé de solliciter les clients.

Les principaux arguments qui militent en faveur d'une limitation de la publicité sont les suivants :

- Cela évite les publicités mensongères ;
- Cela fait qu'il est plus difficile pour les praticiens médiocres d'avoir une clientèle ; et,
- Cela évite la publicité inutile qui aurait simplement pour effet d'augmenter les coûts pour une profession. En effet, à partir du moment où un professionnel de santé fait de la publicité, les autres se sentiront, eux aussi, obligés d'en faire. On peut estimer que la publicité alourdit les coûts d'exercice et, en fin de compte, renchérit les coûts pour les organismes payeurs.

Les limitations à la publicité et à la sollicitation font partie des règles professionnelles qui posent problème. Rien n'indique qu'elles soient bénéfiques pour le consommateur et plusieurs éléments indiquent, au contraire, que leur suppression lui est bénéfique. Les règles qui interdisent une publicité honnête limitent l'information et renchérissent le coût d'accès à l'information pour le consommateur. Les limitations à la publicité sont particulièrement néfastes lorsqu'elles empêchent un nouveau professionnel de réussir son implantation sur un marché local difficile.

Certaines associations, par exemple, appliquent un système de points à leurs membres qui montre l'importance attachée au comportement. Selon Benham et Benham (1975) :

> « L'Association des optométristes du Michigan applique un système de points. Au départ, un candidat à l'adhésion doit obtenir au minimum 65 points. Les candidats qui adhèrent à l'association en ayant obtenu moins de 85 points doivent améliorer leur score de cinq points au minimum chaque année, jusqu'à arriver à 85 points. Ensuite, ils doivent se maintenir à ce niveau de 85 points au minimum pour rester membres de l'association.
>
> La grille de points appliquée par l'association est en résumé la suivante :

Table 3. Total de points possible pour

Pas de publicité (publicité dans les médias, inscription sur l'annuaire téléphonique et affichage en devanture)	30
Implantation en un lieu banal par opposition à un lieu dont l'image auprès du public serait essentiellement d'être un point de vente d'optique à prix cassés	25
Respect de certaines normes de signalétique (taille et contenu)	15
Activités de formation	14
Equipement matériel	8
Moyens fonctionnels	8

> On notera que, sur un total qui est au maximum de 100 points, les restrictions à l'information représentent 70 points. » (page 425)

Si les restrictions à l'information sont courantes, dans de nombreuses professions et pas seulement dans les professions de santé, il n'y a guère d'éléments qui indiquent qu'elles soient effectivement bénéfiques pour le consommateur. En théorie, les règles qui empêchent une publicité honnête sur les prix ou la sollicitation des clients renchérissent les coûts d'accès à l'information et se traduisent par une

augmentation des prix.[37] De fait, l'enquête de la FTC sur les lunettes (voir l'encadré 3) montre que la publicité sur les prix des lunettes et des examens de vue a pour effet de faire baisser les prix sans entraîner de baisse notable de la qualité moyenne du service.[38]

Encadré 3.Optométrie : étude de la FTC sur les relations entre l'encadrement de la publicité, les prix et la qualité des examens optiques et des lunettes

En 1980, la Federal Trade Commission (FTC) aux États-Unis a publié un rapport interne sur les effets des restrictions sur la publicité et les pratiques commerciales en optométrie (Bond et al., 1980). Cette étude avait pour objet de mieux comprendre la relation entre l'encadrement de la publicité, les prix, la qualité du service et la structure juridique de la société pourvoyeuse des services. Elle mérite qu'on s'y arrête car c'est une des meilleures études jamais réalisées quant à l'impact sur la concurrence des restrictions en vigueur dans les professions de santé. L'étude a mis à profit les disparités de la réglementation de l'optométrie et de la vente de lunettes sur le territoire des États-Unis : dans certaines régions, la publicité est encadrée alors que dans d'autres, elle ne l'est pas. L'étude compare dans un premier temps les prix et la qualité du service dans les villes encadrant très strictement la publicité et interdisant la constitution en société ("villes restrictives") d'une part, et dans les villes autorisant la publicité sur les lunettes et la publicité sur les examens oculaires autre que sur les prix là où existent de grandes chaînes d'optique ("villes non restrictives"), d'autre part. D'après les résultats, les prix moyens constatés étaient sensiblement inférieurs dans les villes encadrant le moins strictement la publicité, sans que la qualité moyenne n'en souffre.

L'étude s'est déroulée de la façon suivante : des experts ("les enquêteurs") ont été envoyés dans différentes villes des États-Unis pour y subir un examen visuel et pour acheter des lunettes, ce qui a donné lieu à 434 observations. Chacune de ces observations correspondait à un examen et à l'achat potentiel de lunettes. La FTC avait pris grand soin d'établir un étalonnage de la qualité satisfaisant sur le plan médical en associant des optométristes confirmés et des écoles d'optométrie à la conception et à la préparation de l'étude, ainsi qu'à l'évaluation des résultats[39].

Prix

Les prix ont été recensés à partir des reçus donnés aux enquêteurs dans les 280 cas où il y a eu à la fois examen visuel et achat de lunettes. Il avait été demandé aux enquêteurs d'acheter un type donné de monture métallique unisexe, dans la mesure du possible, pour réduire au maximum les variations de coût. L'étude a montré que le prix moyen de l'examen visuel et de la paire de lunettes dans les villes les plus restrictives était en moyenne de 33.6 % plus élevé que dans les villes les moins restrictives, et que cette différence était statistiquement significative. Le tableau 1 propose une synthèse de ces résultats.

Tableau 1. Estimations du prix moyen facturé pour l'examen et les lunettes

	Villes restrictives	Villes non restrictives
Ensemble des optométristes	$94.46	$70.72
Ne pratiquant aucune publicité*	$94.64	$73.44
Pratiquant une publicité	Néant	$63.57
Magasins appartenant à une chaîne	Néant	$61.37

*A l'exclusion des optométristes qui affichent une publicité en devanture

Qualité

Nombre de professionnels feraient valoir qu'une simple comparaison des prix ne peut pas rendre compte des différences de qualité, et que l'hypothèse d'une qualité égale entre les villes encadrant le plus strictement la publicité et les villes l'encadrant le moins n'est pas valide. En particulier, des observateurs pourraient estimer que la publicité conduit les professionnels à abaisser la qualité du service offert et que, par réaction, les professionnels ne pratiquant aucune publicité sont enclins à suivre leur exemple. Pour mesurer la qualité, les enquêteurs ont donc rempli un formulaire après chaque visite et répondu à des questions relatives au détail de l'examen. Les lunettes achetées ont été collectées afin d'en apprécier la qualité. De surcroît, chaque enquêteur a été examiné par des membres de deux écoles d'optométrie de façon à déterminer quelle était la prescription appropriée et à pouvoir comparer avec la prescription effectivement délivrée. L'étude a évalué quatre mesures de la qualité : 1) la rigueur de l'examen visuel, 2) la conformité de la prescription, 3) la qualité de la fabrication des lunettes délivrées, et 4) l'ampleur des prescriptions injustifiées.

Rigueur de l'examen visuel

Les estimations relatives à ce critère de qualité ont montré 1) que la rigueur des examens pratiqués par les optométristes dans les villes plus ou moins restrictives, en moyenne, étaient comparables, 2) que les examens pratiqués dans des magasins appartenant à de grandes chaînes d'optique ou par des optométristes faisant une publicité, en moyenne, étaient moins rigoureux que ceux pratiqués par les optométristes ne faisant pas de publicité dans les villes non restrictives, et 3) que les examens pratiqués par les optométristes ne faisant pas de publicité dans les villes non restrictives étaient, en moyenne, plus rigoureux que ceux pratiqués par les optométristes ne faisant pas de publicité dans les villes restrictives." Le tableau 2 propose une synthèse de ces résultats.

Tableau 2. Estimations de la rigueur de l'examen visuel (Indice FTC sur 100)

	Villes restrictives	Villes non restrictives
Ensemble des optométristes*	58.5	61.6
Ne pratiquant aucune publicité	58.8	70.0
Pratiquant une publicité	Néant	47.4
Magasins appartenant à une chaîne	Néant	51.6

* A l'exclusion des optométristes qui affichent une publicité en devanture.

Les résultats peuvent sembler ambigus. Le point le plus intéressant est que les variations observées pour ce qui est de la rigueur de l'examen sont en fait assez amples dans les villes restrictives (et du même ordre que dans les villes non restrictives). Par conséquent, la rigueur moyenne et les variations de la rigueur des examens pratiqués sont en fait assez semblables dans les deux catégories de villes, mais dans les villes non restrictives, les consommateurs sont mieux à même de prévoir quels sont les praticiens qui offriront le produit de la meilleure qualité (la meilleure qualité se trouvant chez les praticiens ne faisant pas de publicité).

Les optométristes pratiquant les examens les plus rigoureux n'ont pas pour autant été exclus du marché dans les villes où la publicité est autorisée. Environ 55 % des optométristes dans les villes non restrictives ne faisaient aucune publicité.

Bien-fondé de la prescription

Les prescriptions délivrées aux enquêteurs ont été transmises à deux écoles d'optométrie, sans aucune indication quant au nom, au lieu d'installation et à l'affiliation de l'optométriste auteur de la prescription. Il leur a été demandé de juger du bien-fondé de chaque prescription à l'aide d'un système d'évaluation acceptable/inacceptable. Les résultats donnent à penser que les praticiens faisant de la publicité et les magasins appartenant à une chaîne ont établi des prescriptions également ou plus satisfaisantes que celles délivrées par les optométristes des villes restreignant la publicité.

Tableau 3. Estimations du pourcentage de prescriptions jugées adéquates par une école ou par les deux

	Villes restrictives	Villes non restrictives
Ensemble des optométristes*	82	88
Ne pratiquant aucune publicité	82	88
Pratiquant une publicité	Néant	90
Magasins appartenant à une chaîne	Néant	86

* A l'exclusion des optométristes qui affichent une publicité en devanture.

Précision et qualité de fabrication des lunettes

La qualité de la fabrication des lunettes livrées a été évaluée en fonction des normes de l'American National Standards Institute (ANSI), normes techniques très exigeantes, d'où le taux élevé de lunettes jugées non satisfaisantes. Les lunettes fabriquées dans les villes restrictives ne semblaient pas être de meilleure qualité que celles fabriquées dans les villes non restrictives.

Tableau 4. Estimations du pourcentage de lunettes jugées satisfaisantes selon les normes ANSI

	Villes restrictives	Villes non restrictives
Ensemble des optométristes *	50	64
Ne pratiquant aucune publicité	50	64
Pratiquant une publicité	Néant	70
Magasins appartenant à une chaîne	Néant	52

* A l'exclusion des optométristes qui affichent une publicité en devanture.

Ampleur des prescriptions injustifiées

Une préoccupation récurrente portait sur les organisations à visée purement commerciale (telles que les magasins appartenant à des chaînes d'optique), que l'on jugeait plus enclines à prescrire des verres correcteurs qui n'étaient pas véritablement nécessaires que les organisations à visée non commerciale. C'est un des arguments invoqués pour justifier la limitation du droit des organisations commerciales à employer des professionnels tels que les optométristes. Pour déterminer si cette crainte était fondée, un scénario spécial a été établi : 123 examens ont été pratiqués sur 5 enquêteurs qui portaient des lunettes que l'optométriste consultant de la FTC jugeait adaptées à leur vue. Il a été demandé aux enquêteurs de dire aux optométristes qu'ils ne voulaient de nouvelles lunettes que si elles leur apportaient une réelle amélioration visuelle. D'après les résultats, il ne semble pas que les magasins de chaînes aient été plus enclins à recommander des lunettes non adaptées. A tout prendre, ils suggèrent peut-être que les prescriptions injustifiées sont plus fréquentes dans les villes restrictives, mais on ne dispose pas de suffisamment d'observations pour l'affirmer avec certitude.

Tableau 5. Estimations du pourcentage d'optométristes auteurs de prescriptions injustifiées

	Villes restrictives	Villes non restrictives
Ensemble des optométristes*	32	12
Ne pratiquant aucune publicité	32	9
Pratiquant une publicité	Néant	18
Magasins appartenant à une chaîne	Néant	14

* A l'exclusion des optométristes qui affichent une publicité en devanture.

Source : Bond et al. (1980)

Les limitations à la publicité peuvent parfois autoriser la publicité sur les prix mais empêcher certaines formes de publicité comme la publicité comparative. Dans l'étude Indecon (2002), les auteurs examinent les restrictions à la publicité comparative en Irlande pour les opticiens/optométristes. « Leur sentiment est que les restrictions auxquelles sont soumis les optométristes/opticiens en matière de publicité sont de nature à nuire à la concurrence. En particulier, les restrictions au recours à la publicité comparative sont de nature à nuire à un comportement normal de concurrence sur le marché. » (page 479)

Approche possible pour réduire les problèmes de concurrence :

Une approche possible pour améliorer le marché des services des professions de santé, en rapport avec la publicité, consisterait en ceci :

- Autoriser une publicité honnête de la part des professionnels de santé et des compagnies.

4.2.2 Fixation des honoraires

Les représentants d'une profession peuvent faire des suggestions concernant les honoraires que leurs membres peuvent pratiquer. La fixation des honoraires peut se faire directement, par la publication d'un barème de prix, ou indirectement, par des mécanismes interdisant les rabais. Ce type de pratique introduit de la clarté pour le consommateur et lui évite de devoir payer trop cher les services qui lui sont fournis. Cependant, la fixation de tarifs communs peut être un vrai problème dans le secteur de la santé.

Des cas de fixation de tarifs communs pour certaines professions de santé existent dans de nombreux pays, ainsi qu'en témoignent plusieurs procédures antitrust.

- En octobre 2003, l'autorité de la concurrence, aux Pays-Bas, a fait état de ses premières conclusions dans une enquête sur les services des psychologues. Elle a constaté que quatre associations régionales de psychologues et psychothérapeutes recommandaient à leurs adhérents de pratiquer certains tarifs. Ces associations représentaient 60 pour cent du marché et leurs recommandations étaient suivies, ce qui se traduisait par des prix plus élevés pour les services en

question. Leurs recommandations, estime-t-on, avaient un impact du fait qu'elles rendaient prévisibles les prix pratiqués par un concurrent et qu'elles réduisaient la probabilité d'une baisse des prix. (NMa (2003, 2004))

- Au Brésil, il a été constaté que l'association des anesthésistes de l'Etat de Goiás appliquait les mêmes tarifs pour leurs services. (OCDE (2002))

- En décembre 2001, la Cour fédérale, en Australie, a sanctionné l'antenne d'Australie-Occidentale de l'association médicale en lui imposant une amende de 285 000 dollars pour entente sur les prix et infraction à la loi sur les pratiques commerciales (Trade Practices Act).

Les mesures visant les tarifs ne consistent pas toujours à annoncer un objectif tarifaire mais peuvent consister à interdire les rabais. On peut s'appuyer, pour ce faire, sur des règles dites « d'éthique » ou même sur les modalités de location des locaux. Le recours à des règles « d'éthique » a été mis en évidence par la Federal Trade Commission, aux Etats-Unis, dans l'affaire de l'American Medical Association (1979). La Commission a estimé que l'American Medical Association avait illégalement restreint la concurrence en instituant notamment des principes « d'éthique » interdisant aux médecins de pratiquer des prix notablement inférieurs aux prix habituels pour le même type de service dans leur zone géographique.[40] En ce qui concerne les entraves à la concurrence liées aux modalités de location des locaux, un cas a été mis en évidence en Australie, en mars 2003 : une cour fédérale a estimé qu'un médecin avait organisé un boycottage des formules de tiers payant et empêché la prestation de services en dehors des heures habituelles en spécifiant dans la convention de location des locaux que les généralistes n'avaient pas le droit de pratiquer le tiers payant, sauf pour une catégorie particulière de patients, et n'avaient pas le droit de dispenser des services médicaux aux patients après 20 heures, du lundi au samedi, ou après 13 heures, le dimanche.

Une formule pour améliorer l'efficience de la négociation des tarifs des médecins avec des assureurs multiples consiste à autoriser les médecins à faire appel à un même négociateur, qui ne communique pas les tarifs proposés par un praticien à ses confrères mais sert simplement de « messager ».[41] Lorsque les tarifs sont ainsi fixés par l'entremise d'un intermédiaire, on peut néanmoins craindre que l'intermédiaire ne se comporte pas en arbitre neutre mais plutôt en négociateur solidaire.[42] La mise en évidence d'une pratique illégale de tarification collective peut alors reposer sur la règle de raison et pas sur un principe d'illicéité automatique. La tarification collective est légale dans certaines juridictions, tant que la forme d'organisation proposée favorise l'efficience (grâce, par exemple, à une mutualisation des risques) et que la tarification commune est réputée nécessaire pour réaliser des gains d'efficience.

Les consommateurs non avertis peuvent parfois se sentir rassurés par des barèmes tarifaires standard, car ils craignent moins, alors, de se voir appliquer des tarifs trop élevés. Un tarif standard peut contribuer à protéger le client non averti qui ne sait pas quel est le juste prix pour un service donné.[43]

Approche possible pour réduire les problèmes de concurrence :

Certaines approches possibles pour améliorer le marché des services des professions de santé, en rapport avec les pratiques de tarification et de rabais, consisteraient en ceci :

- Ne pas autoriser les professionnels de santé travaillant pour des entités différentes à fixer des barèmes tarifaires communs ou à recommander un tarif maximum commun (en l'absence d'accord de la part des personnes ou organisations représentant le consommateur et l'organisme payeur), sauf si cela se justifie du point de vue de l'efficience.

- Ne pas autoriser les associations professionnelles à interdire les rabais sur les tarifs pratiqués par d'autres professionnels.

5. Mesures délibérées en faveur d'un renforcement d'une concurrence bénéfique

On a vu, dans la précédente section, diverses solutions de nature à résoudre les problèmes de concurrence dans le secteur de la santé. On peut aussi envisager certaines politiques plus générales :

- Améliorer l'information du consommateur ;
- Instaurer des mécanismes contractuels qui encouragent la concurrence ; et,
- Mise en application du droit de la concurrence.

5.1 Information du consommateur

L'un des problèmes fondamentaux, dans le secteur de la santé, est que l'information sur la qualité des praticiens est difficile à obtenir. De ce fait, le choix des consommateurs n'a souvent rien d'objectif : ils vont chez le praticien qui leur a été indiqué ; ils s'en remettent aux recommandations de leurs proches ; ils se fient à la réputation de l'établissement ; ou bien encore, ils choisissent au hasard. Le patient peut être dirigé vers un bon praticien, mais tous les praticiens n'ont pas un bon réseau de correspondants. En améliorant l'information des consommateurs, on leur permettrait de faire des choix mieux éclairés et d'identifier les praticiens médiocres. C'est particulièrement important en présence d'une maladie qui met la vie en jeu ou lorsque la procédure médicale en question comporte un risque important – chirurgie à cœur ouvert, par exemple. C'est pourquoi il y a eu plusieurs tentatives, auxquelles, souvent, les professionnels de santé se sont opposés, pour fournir une information précise sur les praticiens aux consommateurs potentiels. L'idée est qu'en améliorant l'information du consommateur on élargira la part de marché des prestataires de qualité et on amènera les prestataires médiocres à faire un effort de qualité.

Il est difficile de donner une information objective sur le niveau de qualification. L'indicateur qui paraît le plus évident serait de considérer les résultats pour le patient. Cependant, la complexité initiale de l'état du patient influe sur les probabilités de réussite du traitement et cette complexité initiale est difficile à apprécier de façon systématique. Pour certains actes, par exemple la chirurgie cardiaque, les résultats pour le patient peuvent être mesurés avec une grande précision (fréquence des décès dans un certain délai, par exemple). Mais si les meilleurs praticiens ont à traiter les cas les plus complexes, la fréquence des décès sera sans doute, au moins en théorie, plus élevée.

Les systèmes de suivi (« report cards ») peuvent avoir notamment pour effet d'inciter les professionnels les moins qualifiés à essayer de diriger les patients les plus gravement atteints vers d'autres confrères. Par suite, il sera plus difficile de repérer les professionnels les moins qualifiés, encore que le système puisse aussi permettre une meilleure répartition des patients, les professionnels les moins qualifiés étant amenés à voir un moins grand nombre de patients gravement atteints. Il se peut aussi que les professionnels les mieux qualifiés ne souhaitent pas traiter les cas les plus graves, car cela risque d'avoir un impact sur la façon dont ils seront évalués, et les cas les plus graves risquent alors de ne pas être pris en charge.

Une étude récente a soigneusement examiné l'impact à court terme des systèmes de suivi de l'activité des médecins et conclut à des résultats décevants. Des comptes rendus de suivi ont été établis pour des chirurgiens cardiaques pratiquant des pontages veineux aorto-coronariens (PVAC) dans deux Etats, aux Etats-Unis, l'Etat de New York et la Pennsylvanie. Sont indiqués, pour chaque chirurgien, le taux de mortalité des patients et le taux de mortalité ajusté en fonction du risque. Le risque est apprécié sur la base

d'informations cliniques qui vont au-delà des données de sortie. Dranove et al. (2003) font les observations suivantes:

- Les cas complexes sont plus souvent traités dans les hôpitaux universitaires ;
- Au total, un moins grand nombre de cas complexes bénéficient d'un PVAC ;
- Le délai écoulé entre la survenue d'une crise cardiaque et une intervention chirurgicale s'allonge notablement, tant pour les cas complexes que pour les cas plus simples ; et
- Un plus grand nombre de cas simples bénéficient d'un PVAC.[44]

Par conséquent, si l'on observe un certain déplacement des patients vers les meilleurs professionnels, l'un des grands effets des comptes rendus de suivi est la réduction du nombre de cas complexes faisant l'objet d'un PVAC.[45] Ces résultats corroborent les données d'enquête qui montrent que 59 pour cent des cardiologues déclarent que les comptes rendus de suivi font qu'il est plus difficile de faire admettre les malades gravement atteints candidats à un PVAC. (Schneider et Epstein (1996))

L'information sur les prix peut souvent être améliorée sans qu'il y ait à craindre d'effets négatifs. Par exemple, de nombreux praticiens ne communiquent pas d'informations sur les prix, même pas une estimation révisable, avant de dispenser les soins. Il est donc difficile pour le consommateur de chercher un prestataire moins cher car il ne saura qu'après coup ce qu'il aura à payer. Au Royaume-Uni, les dentistes sont, depuis peu, tenus de communiquer à l'avance à l'organisme payeur l'information sur le prix des soins (sauf en cas d'urgence).[46]

Demander un second avis peut être un autre moyen d'améliorer l'information. Lorsqu'une intervention coûteuse est recommandée par un spécialiste, il peut être intéressant d'encourager le patient à solliciter un second avis. Un second avis est intéressant car le praticien qui est sollicité n'a aucun intérêt financier à recommander une intervention coûteuse plutôt qu'une autre formule meilleur marché.

5.2 Contrats qui encouragent la concurrence

Dans les professions de santé, les mécanismes contractuels entre fournisseurs et payeurs déterminent les incitations financières des professionnels à fournir des services appropriés. Même dans les systèmes financés sur fonds publics, il est possible de mettre en place des dispositifs contractuels qui constituent de bonnes incitations pour les fournisseurs de services à assurer ces services à moindre coût ou plus rapidement. Par exemple, on peut attribuer aux omnipraticiens une « enveloppe budgétaire » à dépenser pour leurs patients, comme décrit dans l'encadré 4 sur le système des enveloppes budgétaires. Cette approche est envisageable dans les systèmes avec filtrage de l'accès aux soins primaires, comme au Danemark, en Italie, aux Pays-Bas, en Norvège, en Espagne et au Royaume-Uni.

Encadré 4. Système des enveloppes budgétaires

Le National Health Service du Royaume-Uni a institué en 1991, à titre d'option, un système d'enveloppes budgétaires pour les omnipraticiens. Cela consiste à attribuer aux généralistes une enveloppe pour payer les services utilisés par leurs patients. Le volume de l'enveloppe est déterminé en fonction du nombre de patients inscrits au cabinet du patricien, des caractéristiques démographiques des patients, et des dépenses effectuées préalablement à l'adoption par le praticien du système des enveloppes. Les généralistes orientaient leurs patients vers des fournisseurs de services particuliers, et des paiements étaient effectués à ces fournisseurs au moyen de l'enveloppe. Les éventuels fonds excédentaires pouvaient être utilisés pour améliorer les services fournis par le généraliste aux patients, par exemple amélioration des locaux du praticien. SI ces paiements ne constituent pas des revenus directs, ils peuvent être convertis en capital lors de la vente d'un cabinet médical. Les fonds étaient destinés à permettre aux généralistes d'acheter la même panoplie de services que celle qu'ils avaient acquise avant la mise en place du système du budget.

Le budget avait deux effets principaux. Le premier était de permettre aux généralistes d'orienter les patients vers les spécialistes et les hôpitaux qui pourraient, d'une manière ou d'une autre, offrir un meilleur rapport qualité-prix. Le second était que les généralistes intégraient expressément la notion de rationnement dans leurs décisions concernant les modalités de répartition des fonds entre les patients, l'idée étant que les généralistes étaient mieux placés que quiconque pour déterminer la nécessité des traitements pour les patients. Tous les généralistes n'ont pas adhéré au système du budget et tous les actes médicaux n'ont pas été financés au moyen des enveloppes budgétaires, mais une part importante des dépenses consacrées aux patients des généralistes était prise en charge. En 1997, plus de 50 pour cent de la population était inscrite auprès d'un cabinet médical détenteur d'une enveloppe et les dépenses financées par les enveloppes représentaient 15 pour cent des dépenses du National Health Service consacrées aux soins secondaires. (Dusheiko et divers collaborateurs (2004a), p. 3) Il convient de noter que les détenteurs d'enveloppes ne payaient pas pour tous les soins secondaires, en particulier les actes les plus coûteux.

Le système présentait un grave inconvénient. Les hôpitaux qui recevaient des fonds des détenteurs d'enveloppes ne risquaient pas de faire faillite s'ils ne couvraient pas leurs coûts, du fait des filets de sécurité mis en place par le gouvernement, et ils n'avaient pas la possibilité de conserver les gains découlant du système du budget, parce que les gestionnaires du NHS à l'échelon central réduisaient les « fonds excédentaires » des hôpitaux quelle qu'en soit l'origine. Par conséquent, alors que les généralistes avaient de bonnes raisons de rechercher des soins de meilleure qualité pour les patients, les hôpitaux n'étaient pas incités à le faire. (LeGrand (1999))

Le système des enveloppes budgétaires a été supprimé en 1999. Cela a permis aux chercheurs d'examiner à l'échelon national comment les cabinets médicaux précédemment titulaires d'enveloppes se sont comportés lorsque la contrainte de l'enveloppe a été supprimée. Après 1999, les admissions non urgentes dans les catégories couvertes par le système ont augmenté de 3.9 pour cent pour les cabinets médicaux anciennement détenteurs d'une enveloppe. D'une manière générale, les recherches ont fait apparaître que :

- « Les résultats semblent indiquer que les enveloppes ont eu un effet limité mais réel sur les taux d'admission des cabinets médicaux qui ont choisi de devenir détenteurs d'une enveloppe ». (Dusheiko et divers collaborateurs (2004a) p. 1)
- Les temps d'attente ont été réduits pour les patients des médecins détenteurs d'enveloppes (Dowling (1997))
- La satisfaction des patients semble avoir quelque peu diminué à la suite de la mise en place du système des enveloppes. Dusheiko et divers collaborateurs (2004b)

Le système initial des enveloppes budgétaires a été supprimé et remplacé par un système modifié qui intègre tous les cabinets de généralistes dans de grands groupes de soins primaires, dénommés Primary Care Trusts.

5.3 Mise en application du droit de la concurrence

Les professions peuvent chercher à accroître leur pouvoir sur le marché et leurs revenus de diverses manières, notamment les fusions, les accords sur les prix et la syndicalisation. Il est très difficile de déceler

et de lutter contre les abus de pouvoir de marché par les professions de santé. Cela tient notamment au fait que les fusions de groupes de médecins sont rarement signalées aux autorités chargées de la concurrence et qu'elles sont souvent d'une ampleur trop limitée pour justifier une analyse par l'organisme chargé de la politique de concurrence à un niveau individuel. Néanmoins, de nombreuses autorités appliquent rigoureusement les lois sur la concurrence (1) aux règles des associations professionnelles qui ont pour premier effet d'entraver la concurrence et (2) aux professionnels qui cherchent à acquérir une emprise sur le marché afin de fixer les prix ou de coordonner des actions de boycottage.

Les membres des professions médicales font valoir parfois qu'il n'y a pas lieu de les soumettre au droit de la concurrence et que le droit de la concurrence est incompatible avec les obligations éthiques des médecins envers leurs patients. Toutefois, comme l'a souligné le Commissaire responsable de l'autorité de la concurrence en Australie au sujet des professions de santé australiennes « tous les secteurs de l'économie australienne, et notamment les contribuables, ont un intérêt légitime à ce que les professionnels de santé se fassent une concurrence loyale afin de disposer de services de meilleure qualité à des prix compétitifs. » (Bhojani (2002))

L'application des lois sur la concurrence aux professions de santé peut avoir des effets bénéfiques pour les consommateurs. En conséquence, dans certains pays, les exemptions des dispositions antitrust pour les professions de santé ont été supprimées, comme cela a été le cas en Australie en 1995, lorsque les professions de santé ont été placées sous le régime de la Loi sur les pratiques commerciales de 1974. En revanche, dans d'autres pays, des tentatives ont été faites pour instaurer des exemptions qui n'existaient pas précédemment. Par exemple, aux Etats-Unis, une série de lois visant à instituer des exemptions des dispositions antitrust pour les médecins ont été proposées au niveau fédéral, mais aucune d'entre elles n'a été adoptée.[47]

Les questions qui ont donné lieu à des procédures judiciaires de la part des organismes chargés de la politique de la concurrence comprennent notamment : accords de non-concurrence, accords sur des clauses de prix ou des clauses liées aux prix, accords pour faire obstacle aux formes novatrices de prestation ou de financement des soins de santé, restrictions en matière de publicité, notamment les restrictions frappant les associations privées, restrictions frappant les organismes de réglementation professionnelle, ventes liées illicites et restrictions à l'accès aux hôpitaux et aux équipements médicaux. Les Etats-Unis sont le pays le plus actif dans la mise en oeuvre du droit de la concurrence, en raison de la taille importante du secteur privé dans le domaine des soins de santé et de l'environnement concurrentiel dans lequel opèrent les professionnels de santé dans ce pays. Les défendeurs dans les procès intentés par les autorités publiques comprennent de nombreux praticiens, notamment des anesthésistes, des chiropracteurs, des dentistes, des personnels médicaux hospitaliers, des associations médicales, des obstétriciens, des optométristes, des ostéopathes, des associations de pharmaciens, des réseaux de pharmacies, des médecins, des réseaux contractuels de médecins, des podologues, des psychologues, des radiologues et des chirurgiens. (Federal Trade Commission (2004))

L'application du droit de la concurrence et la transparence des politiques peuvent être extrêmement importantes et efficaces dans les professions de santé. La transparence est importante parce que les praticiens des soins de santé souvent ne savent pas quels sont les comportements illégaux. Les organismes chargés de la politique de la concurrence peuvent mettre en place des programmes pour informer les professions de santé des activités qui sont problématiques tant de la part d'autres acteurs économiques que de la profession elle-même. Par exemple, la Commission australienne de la concurrence et des consommateurs a récemment publié à l'intention des professions médicales un dossier d'information. (ACCC (2004a, 2004b, 2004c, 2004d, 2004e, 2004f, 2004g)) Ce dossier a été élaboré en consultation avec le Comité consultatif des services de santé de la Commission qui comprend des représentants des professions médicales et des professions de santé ainsi que des consommateurs de soins de santé. Le dossier contient des dépliants sur des sujets comme : types de comportements inopportuns envers les

médecins de la part d'autres organismes chargés de fixer les honoraires, mise en place d'activités communes entre des médecins indépendants (en particulier listes de médecins), et entretiens avec les patients au sujet des coûts prévisibles. Une autre forme de transparence se traduit par la publication de lettres d'orientation en réponse à des questions précises posées par des professionnels de la santé ou par leurs conseillers juridiques. Les organismes des Etats-Unis traitent de longue date les questions relatives aux soins de santé dans leurs lettres consultatives sur les problèmes d'actualité qui apportent une réponse aux questions du secteur privé.[48]

Les actions de mise en œuvre du droit de la concurrence peuvent être centrées sur la fourniture de conseils aux associations professionnelles, aux législateurs et à ceux qui sont chargés d'élaborer des règles lorsque l'activité envisagée ou déjà entreprise auraient des effets préjudiciables à la concurrence. En réponse aux efforts récents pour créer des unités de négociations centrales pour les médecins aux Etats-Unis, la Federal Trade Commission a déposé devant le Congrès pour faire valoir qu'avec des négociations centrales, « il faut s'attendre à ce que les prix des services de santé augmentent substantiellement ». (Pitofsky, 1999) La FTC a également adressé des lettres aux Parlements d'au moins quatre Etats qui envisageaient d'adopter des lois qui autoriseraient des négociations collectives par les médecins. De nombreux organismes n'ont à connaître que depuis peu des professions de santé et ne se préoccupent pas de l'application du droit de la concurrence, en particulier du fait que de nombreuses professions de santé sont déjà supervisées par les autorités publiques. L'importance des actions visant à faire appliquer le droit de la concurrence, comme les lettres et les dossiers d'information à l'intention des législateurs et des responsables de l'élaboration de règles concernés, ne doit pas être sous-estimée. Dans le processus d'élaboration des règles et des réglementations, les intérêts des consommateurs et des autorités de la concurrence sont souvent peu représentés.

Outre les actions antitrust du gouvernement et la mise en œuvre du droit de la concurrence, les actions antitrust privées engagées par les associations professionnelles, lorsqu'elles sont autorisées, peuvent avoir des effets bénéfiques importants pour la concurrence parallèlement aux actions publiques. Les professions établies peuvent engager des actions qui limitent la possibilité pour les professions connexes de pratiquer, en particulier les paraprofessionels ou les professions parallèles comme la chiropractie. Voir encadré 5 pour des informations sur les actions qu'une action professionnelle médicale a engagé à l'encontre d'une autre profession et la décision rendue par un tribunal au sujet des violations présumées.

Encadré 5. Wilk et consorts contre American Medical Association (AMA)

L'affaire Wilk et consorts contre AMA est une action antitrust privée engagée en 1976 et définitivement réglée en 1987. Les plaignants soutenaient que les défendeurs (représentants des professions médicales établies aux Etats-Unis) avaient agi pour limiter les droits de leurs membres de s'associer avec des chiropracteurs en vue de restreindre et de supprimer la profession de chiropracteur. Les défendeurs étaient l'AMA, l'American Hospital Association (AHA), l'American College of Surgeons, the American College of Radiology, the American Academy of Orthopaedic Surgeons, and the Joint Committee on Accreditation of Hospitals. Les cinq plaignants étaient des chiropracteurs d'Etats où la chiropractie était une profession de santé autorisée et où il n'y avait pas de loi interdisant aux chiropracteurs de pratiquer dans un cadre hospitalier ou de loi interdisant aux hôpitaux de fournir des services de radiologie et de laboratoire aux chiropracteurs ou de communiquer les rapports et les radiographies aux chiropracteurs. L'affaire a donné lieu à un procès devant jury en 1980 et à un appel en 1983. La cour d'appel a défini les critères d'une « défense fondée sur les soins aux patients » que les défendeurs devraient respecter en cas de nouveau procès.

Si un plaignant établit l'existence d'une entente à d'autres égards illicite constituant une restriction au commerce, les défendeurs seraient excusés et exonérés de toute responsabilité s'ils peuvent démontrer que :

- Dans leur opposition à la chiropractie, ils avaient pour véritable souci l'utilisation de méthodes scientifiques appropriées pour le traitement des patients ;
- Ce souci était raisonnable ;

- Ce souci était la motivation principale de leur comportement potentiellement problématique ; et

- Il n'était pas possible de répondre à cette préoccupation d'une manière ayant des effets moins restrictifs sur la concurrence.

Dans sa constatation des questions de fait, la cour a indiqué qu'en septembre 1963, l'AMA s'était fixé pour objectif « l'élimination complète de la chiropractie ». (p. 10) A cette fin, l'AMA a créé un Comité sur le charlatanisme.[50] Au cours du procès, le directeur du Comité a déclaré que l'objectif de celui-ci n'était pas l'élimination de la chiropractie en tant que telle mais de la chiropractie comme pratique dangereuse pour la santé. Toutefois, la cour a jugé que le Comité s'était employé à dissuader les collèges, universités et membres des facultés de coopérer avec les écoles de chiropractie et avait mis en place un cadre éthique propre à décourager et empêcher toute association professionnelle entre les professions médicales et les chiropracteurs. Les règles applicables aux membres de l'AMA : (1) rendaient contraire à l'éthique pour un médecin de collaborer avec un praticien non scientifique, (2) la Chambre des délégués de l'AMA a adopté une résolution qui considérait la chiropractie comme un « culte non scientifique » et (3) le Conseil judiciaire de l'AMA a formulé un avis selon lequel il était contraire à l'éthique pour un médecin de collaborer professionnellement avec un chiropracteur. « Collaborer professionnellement » recouvrait notamment le fait de diriger des patients ou d'accepter des patients recommandés, la fourniture de services (comme des radiographies ou des dossiers médicaux de patients), la pratique conjointe sous quelque forme que ce soit, et la participation à des programmes de formation avec des chiropracteurs.

Il a été ensuite établi que l'AMA a collaboré avec d'autres professions pour mettre en place des obstacles analogues à la coopération professionnelle et au cours des années 70, le Comité conjoint sur l'accréditation des hôpitaux a répondu aux hôpitaux sollicitant des informations sur le rôle des chiropracteurs dans les hôpitaux que « la Commission retirerait et refuserait l'accréditation à un hôpital qui accorde des privilèges aux chiropracteurs ».

Le jugement de 1987 a considéré que l'AMA n'avait pas respecté les critères (b) ou (d) de la défense fondée sur les soins aux patients. En conséquence, l'AMA s'est vue interdire de « restreindre, réglementer ou entraver… la liberté de tout membre de l'AMA, toute institution ou tout hôpital de prendre une décision individuelle quant à une collaboration professionnelle entre ce membre de l'AMA, cette institution ou cet hôpital et des chiropracteurs, étudiants en chiropractie ou établissements de chiropractie ».

Avant que le jugement de 1987 ne soit rendu, l'AHA a trouvé un accord avec les chiropracteurs et adopté une déclaration de principe indiquant que les différents hôpitaux étaient libres de déterminer leur propre politique à l'égard des services de chiropractie dans un cadre hospitalier.

6. Conclusion

Les professionnels de santé fournissent des services de grande valeur à la société, mais les règles qui régissent leurs professions et l'octroi de licences ont parfois des effets anticoncurrentiels, notamment :

- hausse des prix pour les organismes payeurs, en particulier hors du cadre d'un système d'assurance ;

- limitation des informations dont disposent les consommateurs pour opérer des choix ;

- limitation des arbitrages qualité/prix que peuvent opérer les organismes payeurs ;

- réduction de la concurrence entre les fournisseurs au sein d'une profession ; et

- création d'obstacles qui empêchent d'autres professions d'accomplir leurs tâches de manière indépendante.

Dans de nombreux pays Membres de l'OCDE, les mesures prises par les pouvoirs publics à l'égard des professions de santé répondent à des objectifs d'intérêt public mais renforcent indûment le pouvoir de marché et accroissent les obstacles à l'entrée. Les pouvoirs publics devraient faire preuve d'une grande

prudence lorsqu'ils accordent à certaines professions le droit exclusif d'accomplir certains types de procédures, et lorsqu'ils empêchent des professionnels d'établir des bureaux indépendants ou de s'implanter dans de nouveaux endroits. Si les responsables de l'organisme chargé de la concurrence ne sont généralement pas qualifiés pour examiner dans le cas des professions de santé, tous les aspects touchant la santé qui peuvent limiter la concurrence bénéfique, il faut probablement empêcher les professions elles-mêmes de contrôler tous les aspects concernant les structures et les comportements.

Pour réduire les pratiques préjudiciables des professions, on peut notamment recourir aux mécanismes suivants :

- Veiller à ce que les représentants des consommateurs, les pouvoirs publics et les organismes payeurs aient un droit de regard dans les décisions concernant l'octroi de licences ;

- Réexaminer les lois ou réglementations qui donnent de jure ou de facto l'exclusivité pour accomplir certaines procédures à une seule profession et, s'il y a lieu, les modifier ;

- Empêcher les praticiens de fixer conjointement les honoraires, par le biais d'associations professionnelles ou d'autres moyens, lorsque le barème des honoraires n'est pas soumis au contrôle des organismes payeurs ;

- Améliorer les informations comparatives dont disposent les consommateurs ;

- Réduire ou supprimer l'obligation pour les professionnels de santé associés d'assurer l'adaptation et la délivrance aux consommateurs de produits de santé ;

- Améliorer l'accès aux installations et aux dossiers médicaux par les patients et les praticiens choisis par eux ;

- Attribuer aux médecins jouant un rôle de filtrage une enveloppe limitée à dépenser pour les soins fournis à leurs patients ;

- Supprimer les restrictions à la publicité honnête.

Ces solutions possibles ne constituent pas des recommandations universelles. Du fait de la grande diversité des systèmes de financement et des valeurs collectives inhérentes aux systèmes de santé des pays Membres de l'OCDE, il existe un ensemble complexe d'intérêts et d'impacts sur la santé qui peuvent découler d'une recommandation déterminée dans une profession ou un pays particulier. Le présent document contient donc une liste de base, non exhaustive, d'approches qui pourraient être envisagées pouvant accroître la concurrence. Pour les décisions concernant la mise en œuvre de ces approches, il conviendra d'apprécier les effets sur la santé, les coûts des réglementations gouvernementales, les coûts du respect de la réglementation par l'industrie, les prix élevés imputables aux restrictions de la concurrence, la réduction des variations souhaitables de la qualité, l'accroissement des coûts de recherche, les pertes d'efficience dues aux différents types de réglementations, les effets sur les relations entre patients et fournisseurs de soins et les incidences sur les grands objectifs sociaux. Un point est clair : les décisions au sujet des réglementations des soins de santé sont complexes et impliquent nécessairement des arbitrages entre qualité, dépenses et résultats. Les solutions simples sont rares, si tant est qu'il en existe.

Néanmoins, s'il est peu probable qu'il existe des solutions simples, un impératif économique fondamental s'impose : Il est d'une importance primordiale d'améliorer l'efficacité productive des professions de santé à mesure que les pays Membres seront confrontés à une population vieillissante qui aura besoin de davantage de soins de santé qu'aucun Membre n'a actuellement la capacité financière ou

professionnelle de fournir. Compte tenu de l'importance que revêt l'accroissement de l'efficacité productive dans l'avenir, quatre points ressortent clairement :

- Les professions paramédicales méritent de jouer des rôles accrus ;
- La reconnaissance mutuelle plus large des qualifications par delà les frontières internationales est importante, en particulier pour faire face aux pénuries de professionnels prévisibles dans l'avenir ;
- L'élargissement du choix des consommateurs pour ce qui est de la qualité des services reçus contribue à réduire le coût et l'intensité des services et des produits achetés au secteur privé ; et
- L'allégement des réglementations professionnelles régissant la publicité, les rabais et le régime de propriété, peut souvent avoir des effets bénéfiques pour les services non assurés.

NOTES

1 Il faut noter que les règles, règlements et autres normes déontologiques ne sont pas les seuls facteurs qui déterminent si le marché d'une profession de santé fonctionne bien. Le respect des textes et des bonnes pratiques a également son importance. Ces règles peuvent être assez restrictives et donner l'impression de limiter la concurrence alors que celle-ci est en fait plus vigoureuse que dans des juridictions soumises à des règles moins restrictives.

2 Voir les Perspectives économiques de l'OCDE (1998). Ces chiffres partent de l'hypothèse que les taux de participation masculine et féminine resteront à leur niveau de 1995.

3 L'analyse de l'efficacité des différents fournisseurs de soins, tels que les chiropracteurs et les sages-femmes, n'entre pas dans le champ du présent article.

4 Les dépenses totales de santé des pays de l'OCDE s'élevaient en 2001 aux alentours de 2.83 mille milliards USD (sur la base des parités de pouvoir d'achat). Il faut noter que les chiffres cités ci-dessus correspondent à un pourcentage bien supérieur à 0.1 %, mais ne prennent pas en compte les seules professions médicales.

5 Hammer et Sage font valoir qu'il conviendrait de s'intéresser de plus près aux problèmes de monopsone qui prévalent sur les marchés des soins de santé (Hammer et Sage (2004)). Leur hypothèse de départ, selon laquelle le faible niveau de rémunération des médecins résultant d'une situation de monopsone induirait une réduction de l'offre dommageable pour la collectivité, n'est toutefois peut-être pas correcte car les médecins sont une profession particulière dans laquelle les aspects "non financiers" de l'activité, comme le prestige, garantissent que le nombre de bons candidats à la formation dépassera presque toujours le nombre de médecins à former au cours d'une année donnée pour couvrir les besoins. (C'est là une justification des restrictions quantitatives). S'agissant des infirmières, dont la profession est moins prestigieuse et qui sont plus nombreuses que les médecins, le niveau de rémunération doit être plus élevé de façon à pouvoir concurrencer d'autres possibilités d'emploi et attirer suffisamment de candidats en formation. En résumé, pour certaines professions de santé "prestigieuses", comme les médecins, les pouvoirs publics peuvent réduire les salaires au-dessous du "niveau du marché" sans réduire la qualité des professionnels concernés. Ce qui donne aux pouvoirs publics la possibilité de ne pas donner suite aux revendications de certaines professions réclamant un relèvement des salaires. Il faut cependant noter que les professionnels concernés peuvent travailler plus et de façon plus efficace dans le cadre de systèmes de rémunération autres que ceux qui résultent d'une situation de monopsone. Autrement dit, la production par médecin peut être supérieure dans un régime non monopsonistique. (Pour une analyse des arguments montrant les aspects dommageables d'une situation de monopsone, voir Danzon (1992)).

6 Ces statistiques doivent être interprétées avec prudence. Les dépenses médicales ne sont qu'un des multiples facteurs qui influent sur l'espérance de vie, aux côtés d'autres facteurs importants comme le style de vie (exercice, régime alimentaire, tabagisme, etc.).

7 On entend par contributions privées la part non publique des paiements. Elles comprennent donc les sommes versées par les employeurs ou d'autres entités, en sus du consommateur lui-même.

8 Le code éthique du médecin est incarné par le serment d'Hippocrate actualisé, qui proscrit les traitements inutiles.

9 Ce résultat part de l'hypothèse qu'il est plus facile et moins coûteux de fournir des services de moindre qualité.

10 Au Japon, les médecins prescrivaient à un moment donné plus de médicaments que leurs confrères d'autres pays, peut-être du fait qu'ils étaient propriétaires des pharmacies installées dans les mêmes locaux que leur cabinet et que la vente de médicaments étaient pour eux une source importante de revenu. (Voir OCDE (1999) p.18.).

11 A l'évidence, les problèmes dentaires seront toujours douloureux, même si les conséquences sur le plan financier sont minimes. La crainte de la douleur peut réduire les comportements à risque. Cela étant, même pour les consommateurs prudents, le fait d'être moins exposés à des déboires financiers en cas de problème du fait de la couverture par l'assurance interfère généralement sur l'arbitrage opéré entre l'effort nécessaire pour éviter le risque et les conséquences financières d'un comportement moins prudent.

12 Se reporter à Goldman et Lightwood (2002) pour une analyse récente du niveau de traitement adéquat pour les personnes souffrant de tuberculose et de la façon dont il peut varier en fonction de la gravité de l'atteinte des différents groupes.

13 L'action en justice ou la garantie de résultat d'une part, et la certification d'autre part, sont des méthodes ne faisant pas appel à la réglementation qui permettent d'assurer la qualité. Ainsi, un professionnel incompétent s'expose à une action en justice ou offre une garantie de résultat étant entendu que si le résultat n'est pas conforme à ce qui était prévu, le patient ne paiera pas ce qu'il doit ou devra être indemnisé. Ces mécanismes ne relevant pas de la réglementation ne suffisent pas toujours à garantir la qualité des soins dispensés, du fait notamment que ce sont les mêmes raisons qui rendent difficile l'évaluation de la qualité d'un praticien qui rendent également difficile de juger de son incompétence. De surcroît, de tels mécanismes ex post peuvent parfois se solder par des dommages irréparables. La certification est une option qui permet de conférer l'exclusivité d'un titre (cas des psychothérapeutes, par exemple) à des praticiens qui obéissent à un ensemble de normes, mais qui n'empêche pas d'autres personnes de proposer les mêmes services tant qu'ils ne prétendent pas indûment à cette certification.

14 Ces obstacles à l'entrée dans une profession peuvent en fait renforcer la concurrence en incitant les consommateurs à rechercher les prix les plus bas. "Cela peut même conduire à ce que le marché fonctionne de façon plus concurrentielle du fait que la garantie de "qualité minimum" que procure l'octroi d'une autorisation d'exercer peut inciter les consommateurs à rechercher les prix les plus bas." (Phelps (1977), p. 243.)

15 Voir Shaked et Sutton (1981), qui estiment que ce sont les critères "qualitatifs" qui déterminent le nombre de praticiens dans une profession donnée. Il faut noter par ailleurs qu'une qualité excessive peut impliquer des pratiques qui conduisent les professionnels concernés à multiplier des examens et tests dont l'intérêt est limité mais qui prennent beaucoup de temps et qui restreignent de fait l'offre.

16 Le présent document ne se prononce pas sur la nature des professions entrant dans cette catégorie compte tenu des connaissances spécialisées du point de vue médical ou de la santé nécessaires pour ce faire.

17 A l'évidence, il est difficile pour le non-spécialiste d'avoir une opinion sur ce qui constitue une exigence de qualification excessive.

18 Voir Federal Trade Commission et Department of Justice (2004), chapitre 2, p. 27 pour la citation, et Kleiner (2003) ainsi que Cox et Foster (1990) pour les analyses.

19 Le caractère restrictif est mesuré en fonction des taux de réussite aux examens qui valident le droit d'exercer, après correction pour tenir compte de la qualité initiale de la population d'étudiants en dentaire.

20 Voir Federal Trade Commission et Department of Justice (2004), chapitre 2, p. 26 pour cette affirmation concernant les États-Unis, et Indecon (2002) pour l'analyse des professions de santé (médecins, dentistes et optométristes) en Irlande.

21 Indecon (2002) explique que "si la représentation de la profession au Conseil est nécessaire pour qu'il soit possible de mener une politique éclairée par l'expérience et les connaissances des praticiens, il faut garantir une représentation explicite suffisante des consommateurs au Conseil". (p. 480)

22 Ce type d'approche a récemment été préconisé par les organismes de la concurrence, aux Etats-Unis, dans Federal Trade Commission et Department of Justice (2004).

23 Par exemple, l'implantation et le nombre de pharmacies sont encadrés dans certains pays.

24 La Commission européenne (2004) signale que c'est l'un des arguments avancés par les partisans des mesures de limitation quantitatives mais elle n'y souscrit pas.

25 L'argument est différent de celui qui fait obligation à un monopole d'assurer un service universel. Dans la logique de l'obligation de service universel, le monopole bénéficie d'une rente excessive dans une zone pour être en mesure de subventionner des activités non rentables dans d'autres zones. En revanche, les mesures de limitation quantitatives visent à limiter le nombre de concurrents afin qu'il soit rentable d'exercer en zone rurale. Il n'y a pas d'idée de subventionnement croisé entre zones rentables et zones non rentables.

26 Par exemple, de nombreux systèmes de santé nationaux et de nombreuses compagnies d'assurance ont des directeurs médicaux qui supervisent la détermination des titres jugés satisfaisants pour prester certains services. En règle générale, ces directeurs sont des médecins. Il n'est pas question ici de dire que les directeurs médicaux ne devraient pas être des médecins, mais on peut penser que leur qualité de médecin les amène à privilégier les médecins plutôt que d'autres praticiens potentiels.

27 Le chiffre serait vraisemblablement plus élevé si l'achat était moins coûteux ou subventionné. Aux Etats-Unis, le système public d'assurance maladie en faveur des personnes âgées, Medicare, ne couvre pas les prothèses auditives, et la plupart des plans d'assurance privés non plus.

28 La proposition se trouve dans Killion (2003) et le refus de la FDA dans Rothstein (2004) – US FDA Docket 2003P-0362.

29 Des mécanismes existent qui doivent limiter le risque de vente agressive, par exemple le fait d'exiger que le client bénéficie d'un droit à remboursement pendant 30 jours.

30 Par exemple, l'American Medical Association aurait, dans le passé, restreint l'accès des praticiens « non scientifiques » aux équipements de radiologie en décourageant les médecins et les hôpitaux de s'associer avec ces praticiens.

31 Les prescripteurs peuvent contourner l'obligation de vérification en refusant de répondre à une demande de vérification. La loi Fairness to Contact Lens Consumers Act traite ce problème en indiquant que l'absence de réaction à une demande de vérification de la part d'un vendeur dans un délai de 8 heures, un jour ouvrable, constitue vérification.

32 Voir Pharmacy Guild of Australia (2004).

33 L'étude n'a pas pris en compte les pharmacies par Internet.

34 Le prix moyen était de 412 USD dans un magasin en ligne ; de 416 USD dans un point de vente de masse ; de 464 USD dans un supermarché ; de 470 USD chez un indépendant ; et de 481 USD dans une chaîne de drugstore.

35 D'après Eco-Santé OCDE (2004), on recensait 623 217 médecins en activité, aux Etats-Unis, en 2000.

36 US Department of Health and Social Services (2002). Les autres facteurs de coûts sont les coûts d'assurance responsabilité pour les programmes fédéraux (3.91 milliards de dollars) ; les coûts d'assurance responsabilité intégrés dans les prestations santé au profit des salariés et des retraités (246 millions de dollars) ; et le manque à gagner fiscal lié aux primes d'assurance maladie acquittées par les travailleurs indépendants et les employeurs (778 millions de dollars).

37 Beggs et Klemperer (1992) montrent que les transferts de coûts se traduisent par une augmentation des prix (et des profits) en situation de duopole.

38 On notera que ces résultats ont été observés à partir de secteurs dans lesquels l'assurance ne joue pas un très grand rôle. La publicité dans les secteurs pleinement couverts par les assurances pourrait plus aisément entraîner une amélioration de la qualité et une hausse des coûts.

39 L'étude s'est déroulée sous la direction du Dr. Kenneth Myers, Ph.D., O.D., Directeur du Service d'optométrie du Département de médecine et de chirurgie de la Veterans Administration aux États-Unis. Celui-ci a élaboré un indice permettant de pondérer les différents éléments constitutifs de l'examen, en collaboration avec le College of Optometry de l'Université de l'État de New York et le Pennsylvania College of Optometry. Des associations professionnelles d'optométristes ont été invitées à soumettre leurs propres pondérations, mais seules l'association d'opticiens à visée commerciale et l'association d'optométristes y ont accédé, les autres associations l'ayant déclinée.

40 American Medical Association, 94 F.T.C. (701 (1979), affidavit tel que modifié, 638 F.2D 443 (2ème circuit 1980), affidavit accordé avec partage des voix, 455 U.S. 676 (1982) (ordonnance modifiée 99 F.T.C. 440 (1982), 100 F.T.C. 572 (1982) et 114 F.T.C. 575 (1991))

41 On parle du modèle dit « du messager ». Voir les Lignes directrices en matière de soins de santé de l'US Department of Justice et de la Federal Trade Commission (1996).

42 Des actions ont été intentées contre des praticiens qui avaient recours à des ententes sur les prix et qui, en outre, refusaient de traiter. C'est ainsi, par exemple, qu'un règlement à l'amiable a été conclu, le 4 mai 1999, dans une affaire concernant un réseau de soins, dans le Comté de Mesa (Colorado). « La Federal Trade Commission avait reformulée une plainte et rendu une décision finale à l'encontre du réseau de soins de médecins du Comté de Mesa, réseau qui regroupait 85 pour cent de l'ensemble des médecins et 90 pour cent des médecins de soins primaires du Comté de Mesa (Colorado). La FTC reprochait au réseau des ententes sur les prix et autres pratiques anti-concurrentielles à l'égard des organismes payeurs, les médecins du réseau refusant collectivement de traiter avec des organismes payeurs tiers, entravant de ce fait le développement d'autres modes de financement et de prestation des soins dans le Comté de Mesa. Il était reproché au réseau de soins d'avoir, de par son alliance avec la HMO Rocky Mountain, créé un obstacle sérieux à d'autres organismes payeurs pour contracter avec un groupe de médecins du Comté de Mesa. Il était aussi reproché au réseau de soins d'avoir négocié collectivement les tarifs auprès de plusieurs organismes payeurs tiers pour le compte de ses membres en appliquant des directives et un barème tarifaire approuvé au niveau de son Conseil, et il lui était reproché d'avoir eu le même comportement, sous la forme d'une autre structure, après que le règlement à l'amiable avait été proposé, en 1998. » (voir Federal Trade Commission (2004b))

43 En revanche, lorsque les payeurs – organismes publics ou assureurs – sont généralement bien informés sur les tarifs normaux pour un service donné, l'avantage qu'il peut y avoir à indiquer des tarifs recommandés peut ne pas être très important.

44 On ne tient pas compte de l'effet qu'il peut y avoir, à long terme, à élever la qualité des services prestés par des prestataires moins qualifiés.

45 De précédentes études ont semblé indiquer que les comptes rendus de suivi se traduisaient par de meilleurs résultats en cas de PVAC (ce qui se traduit par des taux de mortalité moindres), mais cela pourrait s'expliquer par le fait que l'existence des comptes rendus de suivi aurait entraîné une augmentation du

nombre de PVAC pratiqués sur des patients relativement en bonne santé tout en réduisant les interventions (avec, par conséquent, une hausse de la mortalité) sur les patients plus gravement malades. Cette explication cadre avec les résultats présentés dans Dranove et al. (2003).

46 Cette obligation résulte de l'étude réalisée par l'OFT sur les services dentaires (Office of Fair Trading (2002)).

47 Ces projets comprenaient notamment le Quality Health-Care Coalition Act de 2000 (Loi de coalition pour des soins de santé de qualité), HR 1304.

48 L'une des faiblesses de ce système de lettres d'opinion est que, lorsqu'une réponse négative est probable, la demande d'avis est souvent retirée et aucune lettre officielle n'est publiée.

50 En 1964, un membre de ce Comité a déclaré que « il serait bien de faire comprendre que le docteur en chiropractie vole l'argent du docteur en médecine ».

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DENMARK

None of the professions mentioned are fully funded by the public (the National Health Insurance or the social authorities).

Profession	Change in regulation (Year)	Effect on competition and efficiency
Chiropractors	• Deregulation of advertising rules (2003).	• No data available.
Dental hygienists	• Possible to be authorised and open own clinic independent of a dentists clinic (1996). Fees are not reimbursable. • Deregulation of advertising rules (2003).	• Only very few dental hygienists have yet open own clinic. The main reason is that the fees are not reimbursable. • A tendency towards more price-conscious users is seen.
Dental technicians	• Deregulation of specific advertising rules (2003).	• A tendency towards more price-conscious users is seen.
Dentists	• Deregulation of specific advertising rules (2003). • Enhanced transparency concerning prices on ordinary as well as more complicated treatments (2004).	• A tendency towards more price-conscious users is seen. • No data available.
Pharmacists	• Larger range of non-prescription drugs that can be sold by others than pharmacists, if the shop is approved by the authorities (2001). • Rules regarding pharmacists' choice of the cheapest generic form of a prescribed drug (1991).	• Prices on the specific drugs - now sold in e.g. supermarkets - have decreased by 5-15 %. • Undoubtedly resulted in lower prices, but no data available.

Specific competition issues within the health professions

Dentistry:

- Contrary to most other professions mentioned in this paper the number of dentists by whom the patient can receive treatment partly reimbursed by the National Health Insurance is not limited.

- An independent body (Patientklagenævnet) review users' complaints against dentists and dental hygienists as well as other professionals in the health sector.

- Until the rules on advertising changed in 2003 dentists were in ads only allowed to state their profession, the name and address of their clinic, opening hours and their possible affiliation to the reimbursement agreements. It was not legal to mention quality, special services/qualifications or prices in advertisements for their services. After the change advertisements for health services are subject only to rules very much like the general rules on fair and correct marketing and advertisement.

- In Denmark many of the services provided by dentists are partly subsidized by the National Health Insurance. These services are subject to fixed prices meaning that also the users'/patients' self-payment is fixed. The services which are not subsidized are not subject to restrictions concerning prices. And the health authorities do not publish indicative fees. Still, there is not much competition on price on these services, but there is a tendency towards more price-conscious and less loyal users/patients. In order to further competition among dentists certain steps are taken to ensure more transparency. On April 1, 2004 new rules have entered into force. If the cost of a dental service is assumed to exceed Dkr. 2.500 (approximately 335 €) the dentists are obliged to make a written offer in advance to the consumer. Also, dentists are obliged to make available a price list for the users/patients. It is recommended that the price list is accessible on the Internet. That is, however, not a requirement. Also, it is the intention to change the fixed prices on certain services to maximum prices.

- In 1996 it was made possible for dental hygienists to be authorised and open own clinic independent of a dentists clinic. However, reimbursement from the National Health Insurance apply only to treatments carried out by dental hygienists working in a dentist's clinic – not to independent dental hygienists. This means that the incentive to open up one's own practice as a dental hygienist is not that strong.

Pharmacists:

- The number and geographical placing of pharmacies in Denmark is fixed by the health authorities primarily with regard to the individual pharmacy's potential customer base (profitability) and to the even distribution of prescription drugs throughout the country.

- Only appointed pharmacists can own a pharmacy.

- Only authorised undertakings – including pharmacies – can handle, pack and distribute prescription drugs.

- Pharmacists with foreign exams equivalent to the Danish pharmacological exam can on the same conditions as Danish nationals apply for licence as a pharmacist.

- Producers and importers of prescription drugs are free to set their own prices. However the retail prices in pharmacies are fixed by the health authorities. This excludes any form of competition on prices at the end-user level and makes it impossible to let end-users profit from efficiency gains.

- As a result of the regulation opening part of the pharmacists' monopoly on selling drugs in 2001, supermarkets and other ordinary shops approved by the health authorities have taken 20-25 % of the market for these products (on certain products like anti-smoking-remedies the percentage is near 40), and the prices have gone down with approximately 5-15 %.

- A couple of Danish pharmacies are already using the Internet in the distribution of prescription drugs and more pharmacies are expected to follow. Though, due to the regulation on fixed retail prices, the use of the Internet cannot result in cheaper products for the users. The main advantage of the Internet is still in the area of providing information about pharmaceutical products for doctors and pharmacists. Also the handling of prescriptions from the doctors to the pharmacies has been facilitated by the use of the Internet.

Opticians (eyeglasses and contact lenses):

- The market for optician services is only regulated in regard to the professional's qualifications (education etc.) and professional behaviour. The fitting of custom eyeglasses and contact lenses can only be made by authorised opticians. The examination of the eyes has in these cases to be made by either an optometrist or an optician.

- However, eyeglasses with simple standard corrections can be bought in e.g. supermarkets, bookshops and at newsagents.

- Only users with severe visual handicaps can get their costs reimbursed by the social authorities. Normally the users (or in some cases their private health insurances) pay the entire costs themselves. The setting of prices is free and authorisations are not limited to a certain number. However, competition is weak also because of tradition and inertia among the users.

Audiologists (Fitting and selling of hearing aids)

- After being examined by a specialist the user/patient is given the choice between the public audiologic clinics (usually placed in hospitals) and the private clinics to have a hearing aid delivered and fitted.

- In the public clinics the fitting and the hearing aids are free.

- In the private clinics the patient must pay for the fitting and the aids themselves. However, the social authorities reimburse costs up to 5000 DKr. (approximately 670 €) per hearing aid. Waiting lists for the public clinics, geographical and other preferences are the main reasons why users/patients choose a private clinic.

General challenges in improving the efficiency and upholding the quality of the services

Health services are for many reasons highly regulated. Besides basic regulation securing the safety and health of the users, regulation often aims to control costs and facilitate even distribution throughout the country. Some reasons, though, are more or less based on tradition and may not necessarily have any positive effects on safety, health, public spending etc. In these cases it should be possible to improve efficiency and promote development within the services without lowering the quality.

Often a part of the price that the users pay for the treatment is fixed by agreements between the National Health Insurance and the professional organisations independent of the actual costs, quality, extra services etc. Thus, the immediate demand side of the market (the users) has no impact on the setting of prices. No or only scarce incentive from the supply side of the market (the professions) to compete on price or quality is present as far as treatments partly or entirely reimbursed by the National Health Insurance are concerned. At the same time prices fixed by agreements can blur the actual cost structures and thereby making it difficult to asses and adjust the structures towards higher efficiency in a focused way.

In most health professions – except pharmacists – in Denmark the professionals are free to practice in accordance to the basic regulation securing the safety and health of the users. However, to control costs the health authorities have in many cases limited the number of professionals (the supply side) who can deliver treatments which are reimbursable for the users. This constitutes an indirect barrier for the professionals who wish to practice and freezes the supply-demand equilibrium in a position that over time can turn out to be inefficient from a macro economic perspective.

Public demand within health services (the users' expectations of the health system) is still increasing due to new and better treatments as well as the ageing of the population. With a partly public financed health sector limitations and/or relocation of supply is necessary from an economic point of view. This can lead to waiting lists/unmet demands.

Insuring safety for the patients, quality and value for money is especially challenging when it comes to new or alternative treatments. Reviewing older forms of treatment and assessing new forms is in itself costly and can eventually result in growing public demand. Cost/benefit analyses are difficult to make in this area because the benefits of treatments are often uncertain, not quantifiable and only to be seen on the long term. However, an effort has been made to give the authorities better basis for decision. In 1999 the Institute for Rational Pharmacotherapy (www.irf.dk) was founded as a partly independent institute under the Danish Medicines Agency. The institute was established in order to ensure the population the most rational use of the range of medicinal products available. The evaluation of medicinal products is made on the basis of both effectual and financial points of view.

The liability regime in Denmark is in general a "light" one. Damages and compensations awarded by the Danish courts are relatively low compared with the amounts awarded in other legal systems. Furthermore most users of authorised health professions are automatically covered by the public malpractice insurance.

The Danish Competition Act basically applies to any business activity with effect on the Danish market, including the health professions. Though, the prohibitions of the Act and the means of enforcement do not apply to anticompetitive practices which are direct or necessary consequences of public regulation. This means that e.g. the agreements between the National Health Insurance and the professions on reimbursement amounts and numbers are out of the scope of the Competition Act.

In 2003 the rules on advertising for health services were liberalized. Until the change most health professionals were in ads only allowed to state their profession, the name and address of their clinic, opening hours and their possible affiliation to the reimbursement agreements. It was not legal to mention quality, special services/qualifications or prices in advertisements for their services. After the change advertisements for health services are subject only to rules very much like the general rules on fair and correct marketing and advertisement.

Education and appointments

In Denmark most educations within the health services area are publicly financed and free. No tuition fee is paid. On the other hand, the number of students is limited by quotas.

When educated the professional is in most areas free to open up a clinic, but normally only a limited number of professionals are appointed the right to practice with reimbursements from the National Health Insurance – The Supplier Number System. This has resulted in waiting lists in some areas. Foreign graduates can after assessment of their education and skills along with a course in Danish apply for the right to practice on the same terms as Danish graduates. However, most foreign graduates find jobs in the public health sector (hospitals). The Supplier Number System does make it easier for the health authorities to control costs and supply, but does also hinder mobility among the employed professionals and constitutes a barrier to entrance for new independent professionals.

Free choice

In the light of limited financial resources the Danish Government has tried to create more competition among certain health professions by giving the users the free choice of supplier. Especially in the area of personal care (e.g. of elderly or handicapped citizens), where the contractors (the local social authorities) have until now primarily used their own staff, competition is foreseen both on quality and – where the full fee is not reimbursed – on price. Different models of free choice are currently being tested. At this point, it looks as if that models built on tendering promote competition on price, whereas models built on endorsement promote quality competition.

The process of deregulation

In 2003, the Danish Government started a project with the aim of repealing regulation which restricts competition unnecessarily. It was decided to make analyses of various areas of regulation in order to propose policy initiatives i.e. new regulation which both take into account competition and other general society interests e.g. environment, health etc. The Danish Competition Authority has played an active role in this process.

A result of this process is e.g. the mentioned improvement of transparency in regard to dentists' prices.

GERMANY

1. Introduction

The scoping paper suggests that if responses were provided for every health profession, the submissions could result in a huge amount of information. This submission therefore focuses as suggested on one single health profession. The pharmacist profession as a key player in the pharmaceutical distribution process is chosen because this is an area which is less regulated when compared to other health professions and thus the scope for antitrust enforcement may be broader than in other health professions.

2. Structure of pharmaceutical distribution

Before finished medicinal products may be marketed in Germany, they must undergo an authorisation process under the German Drug Law ("Arzneimittelgesetz"). In the course of the licensing procedures the efficacy, safety and adequate pharmaceutical quality of the finished medicinal products are reviewed. The vast majority of medicines can only be sold in a pharmacy or by a pharmacy through mail-order (Sections 43-45 Drug Law, "pharmacy-only medicines"). Many medicines may only be sold under prescription by a physician (Sections 48-49 Drug Law, "prescription-only medicines"). By 2002, about 48.700 medicinal products were cleared for marketing in Germany, which is estimated to be by far the highest number worldwide.

Pharmaceuticals are largely distributed in three stages: Pharmaceutical industry – pharmaceutical wholesalers – pharmacies – end customer. As in most countries, the pharmaceutical wholesale business is highly concentrated. The top three companies share more than two thirds of the total German pharmaceutical wholesale turnover and dominant market positions exist in several regions. In contrast, the pharmaceutical retail sector is highly fragmented due to the so-called "prohibition of ownership of multiple pharmacies" which was codified in the Law on Pharmacies ("Apothekenwesengesetz", LoP) and was slightly relaxed as of 1 January 2004. Even under the new LoP, pharmacies may not be run by limited liability companies (Section 8 LoP) but each pharmacist may now own up to four pharmacies (Sections 1 and 2 LoP). In 2001 there were about 21.590 pharmacies which were not affiliated to a hospital (so-called 'public' pharmacies). This number reflects a very high density of pharmacies with approximately one pharmacy per 3800 residents. In 2001 roughly 86% of medicines were sold through public pharmacies and the remaining 14% through hospital pharmacies. The public pharmacies' turnover in medicines amounted to approx. 31.8 bn Euro, of which 23.5 bn Euro were prescription-only medicines, 7.8 bn Euro non-prescription but pharmacy-only medicines and 0.5 bn Euro freely available medicines. According to a study undertaken by the Austrian Health Institute in 2001, the German gross distribution margins are very high when compared to other European countries which could indicate a relative inefficiency of the German distribution system.

3. German health insurance system and insurants' co-payments for medicines

A distinctive feature of the German health insurance system is the duality of private health insurance (PHI) and so-called statutory health insurance (SHI), which is a compulsory public health insurance. Basically all German residents have either a PHI or an SHI. Up to a certain income level (currently 3.862,50 Euro per month) all employees have to be a member of one of the more than 320 SHI funds. Only freelancers, civil servants or employees with an income above the threshold quoted above may quit the SHI and select a PHI. Currently, about 89% of German residents are members of the SHI funds and 9% are with a PHI. Employees and employers each pay 50% of the SHI contributions. The level of contributions

differs significantly according to SHI fund and in January 2004 amounted on average to 14,3% of gross salaried income. In recent years, competition for insurants has developed between the SHI funds because since 1996 insurants can chose into which fund they want to pay. Family members of the insurant who are not gainfully employed do not pay additional contributions, they are covered by the SHI fund of the insurant. When compared to the PHI, the result of this contribution structure in the SHI is a redistribution effect between all insurants. The beneficiaries are families and low-income households as well as the aged and sick.

Whether PHI patients have to pay for their medicines depends largely on their respective contract. In most PHI contracts, the insurants receive full (100%) reimbursement of the costs for all medicaments which they have purchased with a prescription from a doctor, even if those medicines could also be purchased without prescription. As a general rule, medicines purchased without prescription are not refunded by the PHI.

The SHI pays solely for prescription-only medicaments (some exceptions apply). For some groups of medicines, reference prices are set for therapeutic applications. The SHI pays only up to this reference price. Where the medicament price exceeds this limit, the insurants have to pay the difference. Irrespective of the reference price system, the insurant co-payments for SHI patients amount to 10% of the medicament's price, but at least 5 Euro and not more than 10 Euro per medicament. Persons under the age of 18 do not have to make any co-payments. The maximum limit of insurant co-payments is 2% of the yearly (gross) income and 1% for chronically ill patients.

4. Entry barriers for pharmacists and pharmacies

The conditions for operating a pharmacy are set out in the Law on Pharmacies (LoP). Anyone whishing to run a pharmacy needs a permit from the local health authority (Section 1 LoP). Only pharmacists who have a state-approved pharmaceutical diploma are entitled to a permit to run a pharmacy (Section 2 LoP). Apart from the German pharmaceutical diploma, the equivalent diplomas of the other EU and EEA member countries are also accepted without the need for specific accreditation. If the applicant holds the required diploma and meets the other requirements of Section 2 LoP, the local authority must grant the permit. Unlike in many other countries, no "demand" or "market" aspect is examined before granting the permit, hence there are no administrative restrictions as regards the specific location of new pharmacies or the total number of pharmacies.

The most important entry barrier is the restrictions on ownership of pharmacies. Pharmacies may not be run by limited liability companies (Section 8 LoP), with the exception of hospital pharmacies (Section 14 LoP). As a consequence, pharmacists who intend to open a new pharmacy have limited options to raise the required capital: They cannot raise equity from third parties like other entrepreneurs and must rely exclusively on bank loans. A pharmacist may own up to four pharmacies, all of which need to be located in the same district or in neighbouring districts (Sections 1 and 2 LoP). Where a pharmacist operates more than one pharmacy, he or she needs to nominate responsible pharmacists as managers for each of the additional pharmacies. These provisions prevent pharmacy chains (with more than four pharmacies) as well vertical integration between pharmacies and wholesalers or medicine suppliers.

5. Regulation on pharmaceutical prices and selection

In principle, pharmaceutical companies are not subject to restrictions as regards the setting of prices. In a situation where end users receive (full) reimbursement from their health insurance, the suppliers do not need to consider them when setting their prices. However, the suppliers' pricing strategies are constrained by several price and selection regulations for the SHI which are incorporated in the Fifth Book of the Code

of Social Law (CSL V). It is important to note that these regulations apply only to the medicines paid for by the SHI.

The most important constraint are the so-called reference prices for therapeutic applications which were introduced in 1989. Various organisations within the SHI system form the so-called Joint Federal Committee (JFC, Section 91 CSL V). The JFC classifies different medicines which contain the same or similarly active ingredients under one reference price group (Section 35 CSL V). In the next step, the SHI funds' associations set a uniform reference price for those groups. For medicines included in one of the reference price groups, the SHI funds pay only up to the reference price assigned to this group (Section 31 (2) CSL V). Where the price of the medicine exceeds this limit, the insurants have to pay the difference. This creates a strong incentive for pharmaceutical companies not to set their prices above the reference price. The incentive is reinforced by an obligation on the part of doctors to inform their patients about the additional payments when prescribing a medicine priced above the reference price and by an obligation on the part of the pharmacies to provide the patient with low-priced medicines. However, the reference price system is susceptible to strategies of the pharmaceutical industry to avoid having their medicines categorised in a reference price group, e.g. by filing so-called "pseudo patents" or "iterative patents". While in 1997 reference prices applied to approx. 60% of the medicines paid for by the SHI, in 2002 this proportion had dropped to 37%. With the recent SHI reform, this figure is expected to rise significantly during 2004.

Another (however much weaker) constraint on pharmaceutical suppliers are the general antitrust rules against excessive pricing. Article 82 EC-Treaty and Section 19 of the Act against Restraints of Competition (ARC) ban excessive pricing by market dominant undertakings.

The pharmaceutical wholesale margins and the pharmacy margins are regulated by the Pharmaceutical Price Ordinance (Arzneimittelpreisverordnung, PPO). The PPO sets fixed upper limits for the gross margins of prescription-only medicines sold in pharmacies. The PPO has resulted in uniform prices of prescription-only medicines at retail level.

6. Mail-order distribution of medicines

The extent to which the mail-order distribution of medicines was allowed or not under national and European law was controversially discussed in a series of legal disputes. Also due to the legal uncertainty, mail-order had not become a significant distribution channel in Germany, as opposed to other countries. After a decision of the European Court of Justice (ECJ) and the recent amendment to the LoP as of 1 January 2004, it has now been clarified that nearly all medicines can be distributed by mail order.

The LoP sets the conditions under which medicines can be ordered by mail. According to Section 11a LoP only pharmacies with a stationary outlet may distribute by mail-order. When delivering via mail pharmacies must set up a quality assurance system which includes inter alia safeguards ensuring that the medicines are well packaged and delivered on time to the ordering person. Pharmacies which deliver by mail must also offer their patients advisory services via phone. During the past months more mail-order pharmacies have entered the market. As compared to stationary pharmacies they offer price discounts of up to 30% on non-prescription medicines.

The discussions on the exact limits of the legality of mail-order distribution continue. In a recent case, in June 2004, a German drugstore chain started a test cooperation with a Dutch pharmacy delivering medicines to consumers. Under this model the drugstore collected prescriptions for medicines and forwarded the prescriptions to the Dutch mail-order pharmacy. Within 48 hours the medicines ordered could be picked up by the ordering person at the drugstore. In August 2004 the local health authority enjoined the drugstore chain from collecting prescriptions and from handing out pharmacy-only medicines

to patients. The local health authority held that the practice of the drugstore circumvented the distribution process as regulated by the LoP which only allowed distribution in pharmacies or by pharmacies via mail. In the meantime the drugstore chain has filed an appeal against the local health authority's decision.

7. Competition law exemption area

Neither the European nor the German competition law establishes a general exemption area for the health sector. However, the general competition law is not applicable to various practices and regulations of the SHI and its institutions.

In a recent judgement of March 2004 the ECJ held that the SHI funds are involved in the management of the social security system and in this regard fulfil an exclusively social function. Thus their activity had to be regarded as non-economic in nature and therefore SHI funds did not constitute undertakings within the meaning of Articles 81 and 82 of the EC Treaty. The result of this judgement is that the EC competition rules only apply to the SHI funds and other SHI institutions if they engage in operations whose purpose is not social but economic in nature.

In accordance with national law, the norms of the CSL V create a similar exemption area from the ARC for the SHI funds. Section 69 CSL V classifies the legal relationships covered by the CSL V, also those in relation to third parties, as belonging to the sector of social, thus public law. The provision thus creates a substantive exemption from the application of German competition law. However, in the Bundeskartellamt's opinion the application of German competition law is still possible in cases where statutory health insurance funds choose to take forms of action vis-à-vis their service providers (also including pharmacies) which are not provided for under the CSL V.

The introduction of further competitive elements to the SHI system is currently being discussed by the government and parliament. One of the consequences of introducing more competition into the health sector is that the scope of the exemption area is narrowed.

8. Competition law enforcement - case examples

Reference price setting by SHI funds' associations

In the past years several civil proceedings have been brought against the SHI funds before the German civil courts. These proceedings were initiated by pharmaceutical undertakings which were affected by the SHI reference price system. As explained above, the SHI funds' associations set a uniform reference price for certain groups of medicines. For medicines included in one of the reference price groups the SHI funds will not pay more than the reference price assigned to this group. The pharmaceutical undertakings held that in setting the reference prices the SHI funds' associations violated Article 81 EC Treaty. They requested an injunction prohibiting the application of the reference prices, and a compensation for the losses resulting from the setting of these amounts. The Federal Supreme Court as well as the Higher Regional Court Düsseldorf referred the question of the applicability of Article 81 EC Treaty to the ECJ for a preliminary ruling.

In March 2004 the ECJ decided that the SHI funds did not constitute undertakings within the meaning of Articles 81 and 82 EC Treaty. Furthermore, the ECJ held that, in determining the reference prices, the funds' associations did not pursue a specific interest separable from the exclusively social objective of the SHI funds. On the contrary, in making such a determination, the funds' associations in fact performed an obligation which was imposed on them by the CSL V and which was integrally connected with the activity of the sickness funds within the framework of the German statutory health insurance scheme. Thus Article 81 EC Treaty did not apply to the setting of reference prices by SHI funds' associations.

Proposed merger between pharmaceutical wholesalers

In September 2001 the Bundeskartellamt prohibited the concentration plans of Sanacorp e.G. Pharmazeutische Grosshandlung (turnover in Germany approximately 2 billion Euro) which planned to acquire a majority holding in Andreae-Noris Zahn AG (turnover in Germany approximately 2.5 billion Euro).

The Bundeskartellamt held that the concentration would have led to dominant positions gained by the firms involved on certain markets in the pharmaceutical wholesale sector in southern Germany and Mecklenburg-Western Pomerania. The German pharmaceutical wholesale sector was already characterised by a very tight market structure with only four firms operating nationally or cross-regionally. If the third and fourth-largest pharmaceutical wholesalers had joined forces to become the German market leader, the level of concentration would also have increased further at national level. The undertakings held large market shares in almost all the regional markets in Germany. In large parts of southern Germany and in Mecklenburg-Western Pomerania their market shares consistently added up to more than 40 per cent, with much higher percentages in some regional markets. The clear distance to the market share of the next largest competitors had remained stable in the last few years. The Bundeskartellamt assumed that as regards the firms' established distribution structures, the situation was unlikely to change fundamentally in the future.

The proposed merger is still pending as the Higher Regional Court Düsseldorf overturned the Bundeskartellamt's decision but was consequently overruled by the Federal Supreme Court.

9. Competition advocacy

In Germany, competition advocacy is entrusted to the independent Monopolies Commission and the Bundeskartellamt. Every second year the Monopolies Commission reviews recent antitrust policy issues (Section 42 ARC). At the request of the Federal Government as well as at its own initiative it delivers further expert opinions. The Monopolies Commission has repeatedly argued in favour of abolishing or limiting sector-specific exemptions from competition law and has advocated market liberalisation efforts. It most prominently proposed further liberalization in the health sector in its report of July 1998.

Contrary to the majority of competition authorities in OECD countries the Bundeskartellamt does not have any formalised rights or duties to comment on the general legislative process. However, the Bundeskartellamt frequently comments on general competition policy issues as part of its public relations work. In individual cases the Federal Ministry of Economics and Labour also now and then informally asks the Bundeskartellamt to comment on competition law aspects of legislative processes outside competition law. Sometimes the Bundeskartellamt is also asked to do so by other ministries or parliament. In the discussion paper on the meeting of the Working Group on Competition Law in September 2003 the Bundeskartellamt advocated reduction and/or abolishment of the several competition law exemption areas including the SHI funds' activities. The Bundeskartellamt also welcomes the ongoing liberalization efforts by the government in the health sector.

HUNGARY

Structural approaches

- **Quality standards and entry**

In Hungary the government establishes through the responsible ministries the standards and the number of training places, such as the possible number of the applicants for the university education, or the authorised training places for each medical practitioner. In our view this entry control does not keep up with the real demand of the market and sometimes certain professions exceed the indicated numbers. However, beyond the obligate educational qualifications, in the case of medical service providers there are not any quantitative limits on the number of practitioners who may enter the profession in a given time period. The eligibility of foreign graduates depends on the diploma and the citizenship of the graduate. If he/she is an European Economic Area (EEA) citizen, having an EEA diploma/certificate falling under the scope of a sectoral directive of the European Council, the diploma/certificate will be recognised without any condition. The diplomas falling under the scope of the general directives are also recognised with the reservation of fulfilling some requirements (exam, adaptation period or additional training). Other than the above-mentioned diplomas are envisaged thoroughly and the holder either has to fulfil certain requirements such as exam, adaptation period or additional training or the diploma is recognised without any further prescription.

- **Exclusive rights**

Generally, in the case of medical services there is a de jure exclusivity where the government establishes the requirements of licenses or allowances to practice certain medical procedures, in accordance with the type of treatments or services.

In the case of pharmaceutical service providers the only regulation of the access to profession is obtaining a qualification as pharmacist in accordance with the European Council Directive 85/432/EEC coordinating national laws in the field of pharmacy activities. In accordance with the above-mentioned Council Directive (Article 1 .2), pharmacists have access to a set of activities, among which, the "storage; preservation and distribution of medicinal products in pharmacies open to the public". In line with the principle expressed in the same Directive, the Hungarian authorities have reserved such activities to pharmacists. Finally, the legislation allows some exceptions to the exclusive rights of distribution of medicines for pharmacists in order to meet specific public health needs (veterinarians can dispense veterinary medicines, and in certain cases, when there are no pharmacies in the proximity doctors can dispense medicines).

In the area of the pharmaceutical services some changes relevant to entry to the profession have been implemented in Hungarian law as a consequence of the accession to the European Union. This is mainly to ensure that the way the profession is organised is in line with the European Council Directives 85/432/EEC and 85/433/EEC (concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in pharmacy including measures to facilitate the effective exercise of the right of establishment). These changes for example the introduction of new provisions to achieve a balance between practical training and courses in the curricula; or the removing of the obligation that once existed

to have practiced a certain number of year before been eligible to open and being responsible for a pharmacy.

- **Organizational structure**

In Hungary the professional associations don't have any right to limit the organization of their members in the pharmaceutical retailing, however there are considerable limitations both on the structure of pharmaceutical retail industry and on the organizational structure of individual pharmacies through government regulations. The opening of new pharmacies is restricted through the Act LIV of 1994 On the Establishment of Pharmacies and on the rules of their operation. According to this law there are restrictions both on population numbers and geographical distance, resulting in an effective legal barrier to entry to the pharmaceutical retail sector. There are also rules on the corporate form that can be adopted by the pharmacists, and on the number of outlets that can be owned by a pharmacist. Ironically, the pharmacist, who has a personal right to operate in one pharmacy, cannot operate in another at the same time, but the regulations allow business entities to own multiple pharmacies (pharmacy chains).

There are no such limitations regarding other health professions.

- **Consumer redress**

In Hungary regarding the liability regime a mid-level one is adopted, although there are some aspects that may have relations with the low liability regimes. Since 1989 according to a Directive of the Ministry of Health no private health provider can start it's activity without the appropriate insurance. In addition in accordance with the Act CLIV of 1997 (Health Act) the national health authority, the National Public Health and Chief Medical Officer's Service refuses to give a permission to perform health service for any providers without insurance.

Regarding the legislation all physicians must gain a Hungarian Medical Chamber membership in Hungary. Without it, performing any medical services is forbidden. If the possibility of medical errors occurs the Chamber starts an ethical investigation, which - in case of proved malpractice – may lead into revoking the membership. In case of malpractice lawsuits medical experts starts a detailed examination according to Civil Law.

As the patients are not well informed or qualified considering their rights and the necessary steps in case of malpractices, there are professionally trained experts who helps consumers for free of charge. These experts have offices inside the hospitals so they are close when in need.

In Hungary the medical services are mainly performed as public services. Speaking about the question of the behaviour of professionals it means physicians don't fear of malpractice suits as in those countries that have a high liability regime. This derives from the fact that if any medical malpractice occurs during performing a public service, the liability appears on the level of institute.

- **Market power limitations and competition agencies**

In our view, the competition law is applicable to the health services. The Hungarian Competition Authority (Gazdasági Versenyhivatal, hereinafter the GVH) investigated mainly the anticompetitive restrictions of the professional organisations so far.

On the one hand, the GVH launched a proceeding[1] against the Hungarian Medical Chamber in 1999 to reveal whether some points of its Code of Conduct were not against the Competition Act. The GVH found that one clause of the Code of Conduct (stating that setting lower price than the recommended price

of the Ethical Code qualifies as ethical harm under the Ethical Code) violated the prohibition of restrictive agreement. The GVH again investigated the restrictive conditions of the Code of Conduct of the Hungarian Medical Chamber[2] in 2001-2002 because the Code prohibited the advertisement of medical services and threatened its members with sanctions for the violation of this provision. The GVH found that the general ban on advertisement might have restricted competition among undertakings and also limited the consumers' access to information. The GVH pointed out that these rules of the Code of Conduct were against the general prohibition of agreements and were capable of restricting competition.

On the other hand, in the case of the Hungarian Chamber of Pharmacists[3] the Office investigated those points of their Code of Conduct, which defined that their members may not apply lower prices than the minimal prices (set in the Code of Conduct) are. As a result of the investigation they changed the mandatory prices to recommended prices, so that establishing a voluntary compliance, the GVH terminated the proceeding against them. Following this decision, the GVH tried to help them in the preparation of the new Code of Conduct through competition advocacy, however this process was not sufficient, and currently there is an investigation concerning the exemption from the prohibiton of restrictive agreements. (For further details please see the answers for competition advocacy.)

Behavioral approaches

- **Conduct rules**

In accordance with EU Directive 83/2001/EC, advertising directly to the public for prescription only medicines and therapeutic aids is forbidden and advertising of non prescription medicines is allowed but subject to certain conditions defined in legislation to address public health concerns. But, the advertising of those products, what the state regulation does not qualify as a therapeutic aim (such as eyeglasses or contact lenses) is allowed.

- **Fee setting, Contractual Mechanisms**

In general, the state system of medical payment mechanisms is performance based and determined of the type of services. The National Health Insurance Fund (NHIF) introduces the per capita system for family doctors, a fee-for-service system for out-patient health care services. Hospitals are financed through Diagnosis Related Groups (DRG). Both the NHIF and the Information Centre for Health manage the procedure. In case of chronic in-patient care the number of days spent in hospital is the underlying basis for payments.

The benefits in kind for health services provided by the suppliers financed by NHIF and the benefits in cash provided by the NHIF are as follows:

- **Health services** provided free of charge according to the "in natura" (in kind) principle, like preventive medical examinations, medical care by family physicians (primary health care services), dental care, out-patient care, in-patient care, delivery care, medical rehabilitation, patient transportation, accident health supply.

- **Cost allowances** to health care services, like drug cost allowance, medical aids cost allowances, travel cost reimbursement, international medical cost reimbursement.

- **Co-payment is charged** in the following instances: orthodontic treatment under the age of 18, tooth keeping and replacement above the age of 18, extra meal and accommodation for in-patients, sanatorium treatment.

- **Benefits in cash** delivered by the Fund are the sick pay, the pregnancy and confinement benefit, the childcare fee, the disability benefits, the accident benefits and the accident pension.

Significant **co-payment** by patients is required for certain dental treatments, services rendered without referrals, and services in addition to those ordered by specialists and extra hotel/accommodation costs. Co-payments are also paid for chronic care and treatment in sanatoriums. Medical services covered neither by the NHIF nor by the State are classified as out-of-pocket expenses. Some out-of-pocket payments are on medicines and medical aids. Finally, informal gratitude payments constitute another category of out-of-pocket expenditure.

The NHIF finances the recurrent costs in the framework of **contracts** with health care providers. The investment and development costs of the health care institutions do not burden the budget of the Health Insurance Fund. Accordingly, their costs are covered by the owners of the institutions or by the state. The **Ministry of Health has no longer direct responsibility** concerning financing health care services, except high-cost diagnostic procedures, organ transplants and blood supplies. The Ministry of Finance bears responsibility for fiscal policy and budget planning as well as for the macro-economic implications of health care financing.

In the **medical services** the professional chamber is binding concrete prices for all kinds of services in the public sector and recommended prices ("indicative fees") in the private on the basis of state authorisation. In the pharmaceutical services generally the state establishes the margins and fees, where pharmacists are remunerated by the government under a system regulating prices and reimbursement for medicines and prescription fees. However, some pharmacists' services (not the medicines) are free of charge to the patients.

In the case of **medicines**, there exist uniform retail prices in a sense, that for the same drugs there is a same price in every pharmacy. It means, that there is no competition between pharmacies (in other words, there is no intrabrand competition), but there is some competition between drugs of different producers in the same product market ("interbrand competition").

The reason for uniform prices is a combination of margins and government regulations. There is a maximised wholesale margin and a maximised retail margin (based on the wholesale price) for every drug. (There is generally no regulation concerning the producer's prices.) In addition there is a ministerial regulation, stating that the Hungarian Chamber of Pharmacists quarterly announces the referential retail prices for every drug. This regulation (along with another provision of the Pharmacy Act) is interpreted and operated in such a way, that it leads to the uniform retail prices in Hungary.

In accordance with our obligation to harmonize legislation, it has become necessary to transpose European Council Directive 89/105/EEC relating to the transparency of measures regulating the pricing of medicinal products for human use and their inclusion in the scope of national health insurance systems (hereinafter: Transparency Directive).

Prior to its accession to the EU, Hungary used a completely different reimbursement scheme. The competent authority to decide on including medicinal products in the list of products covered by social insurance was the Government until 2002, and subsequently the Minister. In other words, the price of medicinal products agreed as the basis for public financing and the size or amount of reimbursement were set in the frames of a normative decision-making mechanism.

Before taking such decisions, price negotiations took place, which were announced and conducted in accordance with the provisions of legislation, and the outcome of the decisions were also published in a

piece of legislation. Therefore no individual legal remedy was available. The application for reimbursement of the individual pharmaceutical manufacturer was published annually, as the outcome of price negotiations, in the relevant pieces of legislation. Anything that was not published in the list had to be construed automatically as rejection.

Consequently, the normative decision-making system used previously had to be transformed into individual decisions.

In keeping with the aforementioned, legislation was amended in both 2002 and 2003, while the comprehensive harmonisation of the drug reimbursement scheme in keeping with the Transparency Directive, with regard to the detailed definition of the rules of procedures to be followed in decisions on including a medicinal product in the scope of the social insurance system as well as the criteria of including a medicinal product in the list of products covered by the Health Insurance Fund, was accomplished as of May 1, 2004.

Finally, In the case of the **medical devices and therapeutic aims** in general, also the state establishes the type and extent of the subsidised product, also the area of those patients who can get them without paying. In addition, the distribution of the medical devices and therapeutic aims are allowed to those retailers who make a contract with the National Health Insurance Fund and fulfil the quality requirements of the related regulation. Custom-made devices are only subsidised if the manufacturer obtains a certification awarded by the competent authority (Office for Authorisation and Administrative Procedures) attesting that he fulfils the requirements set by law. Nevertheless previously the manufacturer has to fulfil to these obligations anyhow (regardless subsidy) otherwise he is not entitled to make such devices for the market.

Examples

Dentistry:

- *Whether hygienists are able to perform and set up their own practice to perform basic teeth cleaning, such as scaling and polishing:* No, they are not able.

- *Whether there is a independent body for reviewing complaints by patient-consumers:* No, there isn't a special body for the dental services, but according to the general rules the patients can appeal to the Chamber or to the General Inspectorate of Consumer Protection.

- *Whether dentists/hygienists must provide clear guidance on their prices in advance of performing treatment:* Yes, they must.

- *Whether dentists/hygienists can advertise, including prices:* No, they can not.

- *Whether dentists/hygienists have any obligation to tell their patients about publicly paid services that they or others provide:* Yes, they have.

- *Whether there are "indicative" fees published by that government or another body and adhered to by the profession:* There are proposed minimum prices by the professional Chamber, but this practice is under revision upon considerations of the competition law.

For pharmacists, please state:

- *The responsibilities of the pharmaceutical professional association:* f.i. consultancy right in the case of establishment of pharmacies; indicative fees; to allow licensing for practicing; to allow the personal right (ad personam). (There's a compulsory membership for all pharmacists performing professional services.)

- *What restrictions may exist to the movement of pharmacists across borders*: The Chamber can measure the allowance of the personal right for the citizens of the EEA, but there is a (mutual) recognition system for the diplomas of the foreigners.

- *Whether there are limitations on the locations of new pharmacies:* In Hungary establishing of a new pharmacy is allowed per 5000 inhabitant and in a distance of 250 metres from each other.

- *Whether pharmacies must be owned by a pharmacist:* Yes, in special circumstances they must be owned by a pharmacist. In limited partnership companies the general partner should be a pharmacist.

- *Whether medicines can be packaged by non-pharmacists:* The magistral products can be compiled only by pharmacists, but can be packaged by non-pharmacists (pharmaceutical assistants) too, in the pharmacy. In the mass production according to the EU-law a qualified person's responsible for the packaging. The qualified person need not be a pharmacist, but must be high educated as a biologist, chemist, doctor, etc.

- *The extent to which Internet delivery of medicines may serve as a substitute to local pharmacist services:* Because of the low penetration of Internet services in Hungary, Internet delivery wouldn't be an effective substitute to local pharmacist services in Hungary, especially in the rural areas. Beside this there is a major resistance from the professional chambers regarding Internet delivery (and other services, such as home delivery, non-stop pharmacies, etc.), and so far their lobbying activity against the introduction of these services was successful.

Medical device delivery linked to professional qualification

In the area of vision care, please state whether:

- *Eyeglasses with pre-prepared corrections can be purchased outside of an eyeglass store*: Yes, they can be.

- *Custom eyeglasses can only be prepared after a review by an optometrist. If so, are there time limits on when the review must have occurred?* No, there is not any obligation for reviewing. It is a basic personal condition for every enterprise dealing piece-produced optical medical aids in Hungary to employ an optician (or an optometrist for eye-diagnosis with computer or selling contact lenses).

- *Indicative prices are provided by the state for certain frames or other services*? There aren't any indicative prices, but there are subsidised products (subsidies can be only given after diagnosis and indication by a doctor).

- *If indicative prices are provided for certain frames, do some stores display only the "uglier" frames in order to increase sales of private unregulated frames?* We do not have any information about such a practice.

In the area of hearing aids, please state whether:

- *Hearing aids can be purchased over the counter*: No, it can not be. Similarly to the optical aids, hearing aids can be sold only in stores employing an audiologist or other qualified staff (acoustic specialist or physiologist).

- *Hearing aids must be fitted with the help of an audiologist*: Not required.

- *Hearing aids are approved for distribution by a government authority and, if so, whether the approval is contingent upon delivery by audiologists*: All hearing aids which are medical devices must be approved according to the rules of EU-law.

- *There are proven risks of installing modern hearing aids without an audiologist, particularly those designed for self-installation*: We do not have any information about this practice.

Competition advocacy

In the course of the regulation of health professional services the competition advocacy activity of the Hungarian Competition Authority proved to be a fairly effective instrument. In the framework of our competition advocacy activity, we usually pronounce against market entry barriers. However, it often happens that those practitioners who work in service sectors where intense competition exists make an effort to put pressure on the government in order to make the market entry more difficult by administrative provisions (like qualification prescriptions, etc.). The GVH is not able to intervene effectively in these new regulations; it has only the possibility to gain information on the regulation practice of health services.

The competition advocacy activity of the GVH is generally connected to the liberal professions as a whole, so the GVH tries to intervene on a broader level. The results achieved by the authority are mainly from the pharmaceutical sector, but we used them as a starting point in other areas of the health sector.

The general experience of the GVH is that special remedies may be – in the framework of advocacy – to hold discussions with professional bodies, consumer organisations or national regulatory authorities responsible for health professions. For instance, the GVH has contacted the Hungarian Medical Chamber bilaterally. The GVH investigated the restrictive conditions of the Ethical Code of the Chamber[4] in 2001-2002 because the Code prohibited the advertisement of medical services and threatened its members with sanctions for the violation of this provision. The GVH found that the general ban on advertisement might have restricted competition among undertakings and also limited the consumers' access to information. The GVH pointed out that these rules of the Ethical Code were against the general prohibition of agreements and were capable of restricting competition. As a result, the Chamber has to modify its ethical rules; therefore we initiated a discussion in order to help them in the preparation of the regulation of advertising. The aim of this dialogue is that during this consultation process some of the most severe anticompetitive provisions disappear from the proposal. We hope that through this advocacy we will be able to prevent future enforcement proceedings, which nevertheless still stays an option if the Code remains disproportionately anticompetitive.

It is also worth mentioning in this context that the GVH has contacted the Hungarian Chamber of Pharmacist, as they are just about to renew their ethical rules, also in order to help them in the preparation of the new Code of Conduct. However, this consultation process was not successful, because the

unproportionally anticompetitive provisions have not changed, nevertheless the ex-officio investigation still serves as an option.

Another potential item on the GVH's agenda for the near future is to organise a bilateral discussion with the regulators of the health services to justify those types of competition restrictions, which are set up by state regulation and are not proportionate instrument to ensure the quality of services.

Finally, the GVH published a booklet on the competition issues in the pharmaceutical sector. This booklet – among other issues – deals extensively with the pharmacies and their regulation, proposes to set up a more pro-competitive regulatory framework in pharmaceutical retailing, and includes some kind of general economic analysis and broad conclusions about the possible benefits of competition.

NOTES

1 Case no Vj-137/1999

2 Case no Vj-45/2001

3 Case no Vj-134/1999

4 Case no Vj-45/2001

IRELAND

1. Introduction

To give the context for regulation and competition in the health professions in Ireland, the first part of this contribution briefly sketches the Irish healthcare sector, both public and private. It then describes, in both general and specific terms, the regulatory environment applicable to the health professions and identifies the competition issues which tend to arise.

2. The Public Healthcare Sector in Ireland

Public healthcare funding and governance in Ireland is currently undergoing profound change. The performance of the public health service has been strongly criticised over the last number of years, mainly on the grounds that it is not delivering value for money. Since 1997, public spending on health care has increased by about 125%, yet the popular perception is that the quantity and quality of medical services provided has not improved. Certainly, public waiting lists are still long – very long in many cases. A number of official reports over the last three years have pointed to organisational issues and inflexibility as the chief cause of failure within the system.[1] The consensus is that radical overhaul is required, with emphasis on the need for greater financial accountability, and on the need to rationalise the existing array of multiple agencies, with the creation of a single executive body with responsibility for managing the system as a unitary service.

3. The Irish Private Healthcare Sector

Alongside the public health sector, a sizeable private health sector has developed in Ireland. 31% of the population is fully covered by the State for medical expenses. For the remaining 69% not fully covered by the public service[2], GP medical services must be privately financed either out-of-pocket or through private health insurance. Such consumers must also pay for certain hospital services; they must also make a co-payment for prescription drugs above a financial threshold of €78 per month.

Private markets also exist where State health agencies and boards out-source certain services to private operators.

In addition to their entitlement under the public system, 47% of the population have invested in private health insurance coverage. At present, there are only two mainstream providers of health insurance, the (State-owned) Voluntary Health Insurance Board ("VHI") with 87% market share and BUPA Ireland with the remainder.

There is a universal entitlement to public hospital care for a significant part of the population. However, those holding private insurance often choose to avail of the service of private health care providers to avoid the queues of the public health care system. Private health care is offered by a small number of private hospitals. Private care is also offered in most public hospitals – in these cases, the same personnel often deliver services to both public and private patients. For this reason, the private and public sector health systems are considered to be intertwined at almost every level.[3]

4. The Regulatory Environment for Health Professionals

4.1 General regulatory structure

In Ireland, as elsewhere, traditional medical and para-medical professions are heavily regulated by the State.[4] While the degree of regulation, and the precise regulatory structures applicable, naturally vary profession by profession, it is possible to paint some general pictures.

At the top level, all mainstream medical and para-medical professionals are subject, in principle, to overall statutory oversight by the Government Department of Health & Children.

At the next level, several pieces of legislation delegate responsibility for the day-to-day regulation of particular professions to independent statutory bodies. The Medical Council is responsible for regulating medical practitioners, the Dental Council regulates dentists and other dental professions, and so on. In each case, the legislation sets out the constitution, functions and membership of the body involved. The functions of these regulatory bodies normally include specifying educational requirements for entry to the profession, organising registration systems, and sometimes conducting processes concerning fitness to practise. The composition of the governing councils of the regulatory bodies varies: the relevant legislation may require a number of members not to be members of the profession or to represent the interest of the general public. For instance, legislation requires that the Minister for Heath and Children appoints three non-medical practitioners out of the four members representing the interests of the general public on the Medical Council; on the other hand, the pharmacists' governing body (Pharmaceutical Society of Ireland) is composed exclusively of pharmacists.

In addition, the professional and commercial interests of individual health professionals are usually represented by at least one professional organisation. Most health professions have their own representative bodies in this way, e.g. the Irish Medical Organisation and the Irish Hospital Consultants Association for doctors, the Irish Dental Association for dentists, the Irish Pharmaceutical Union for pharmacists, and so on.

The Minister for Health and Children currently proposes to extend the current regulatory approach to many more types of health professional. First, there is a legislative proposal to provide for statutory oversight, regulatory and registration bodies etc. for another twelve health professions[5], while there are also outline plans to legislate similarly for a wide range of alternative medicine practitioners, e.g. chiropractors, reflexologists.

4.2 Structural Approach

<u>Quality standards and entry</u>

The Government plays a key role in relation to the number of training places available and, through the independent statutory bodies, it also regulates entry standards. There are considerable restrictions on entry to the state-regulated health professions. Direct restrictions include a limited list of qualifying courses for a profession approved by the statutory body, and (sometimes burdensome) requirements on foreign-trained professionals. Indirect restrictions also arise, due to a shortfall in State funding for training. This has led to considerable waiting lists for certain types of (specialist) treatment, such as orthodontic treatment and speech and language therapy. In the pharmacy area, a derogation from an EU directive provides that pharmacists trained in other EU countries cannot operate a pharmacy that is less than three years old. This has inhibited the opening of new pharmacies in Ireland.

Exclusive Rights

All State-regulated professions enjoy the protection of reservation of title, the principle being enshrined in the relevant legislation. This principle is also being applied in the proposed State-regulation of further health professions. Reservation of function is also enjoyed by most of the health professions currently subject to State-regulation. For example, the Opticians Board regulates optometrists and dispensing opticians and defines their respective functions. The Dental Council regulates dentists, dental specialists and dental hygienists but precludes dental hygienists from operating outside the supervision of a dentist. The Council has not, as the 1985 legislation envisaged, created a register for denturists/dental technicians. Not being registered limits the activity of denturists/dental technicians, who cannot supply and fit dentures directly to members of the public but must, instead, act through a dentist.

It is not proposed to apply the principle of reservation of function to of any the professions being considered for the next wave of statutory regulation, in recognition of the restrictive effect on other professions or emerging professions that such a provision would have.

Restrictions on Organisational Structure

In Ireland the approach to this issue, and the Government's hand in it, varies across the professions. Dental practitioners are not permitted to practise through limited liability corporations, as a matter of law, nor as multidisciplinary practices, under the rules of the Dental Council. Medical practitioners are not forbidden from entering into such arrangements but as a matter of convention do not operate through limited liability corporations nor as part of multidisciplinary practices. Pharmacies can and do operate as limited corporate bodies but have declined to enter into multidisciplinary practices. The issue of multi-disciplinary practices is a topical one in Ireland as one report on primary health care recommended the introduction of one-stop primary health care centres, encompassing general medical practitioners, pharmacists etc.

Consumer Redress

The Medical and Dental Councils have investigative/disciplinary functions in relation to complaints by members of the public. The new legislation proposing regulation of a further twelve health professions also proposes a similar system of complaints investigation and disciplinary actions, subject to approval by the Irish High Court.

4.3 Behavioural Approach

Conduct re Advertising

Each statutory body currently regulating a health profession has (and the next wave of such bodies will also have) codes of conduct and ethics which registered practitioners must abide by. Most of these codes contain limitations on the amount of advertising practitioners can undertake. Health professionals are generally prohibited from undertaking comparative advertising and from making any unsolicited approaches to consumers or potential users of their services. They are also prohibited from advertising specialist expertise knowledge. Furthermore, press advertisements are subject to size restrictions, and sometimes restrictions on frequency. For example, a new dental practice is allowed to advertise itself in the print media only, and up to a maximum of six times in any one year. On-site advertising is restricted to a brass plate of stipulated size.

Fee Setting and Contractual Mechanisms

None of the statutory regulatory bodies has any involvement in relation to fee setting for services offered to private patients. Non-statutory professional representative bodies like the Irish Medical Organisation and the Irish Dental Association are involved in negotiating with the Exchequer (through various government departments) for fees for treatment to medical cardholders (patients entitled to free care). Such representative bodies have, as part of their negotiating strategy, occasionally threatened to boycott the provision of services under government medical services programmes.

5. Views of the Competition Authority

5.1 General views on the regulation of the health professions

The Competition Authority regularly expresses its concerns about the effects of over-regulation on competition. The Authority's general view has been articulated as follows – generally when whenever new legislative proposals are made to regulate (or re-regulate) a particular profession -

- Any system of professional regulation – particularly one underpinned by statutory authority, and direct or indirect State control, oversight or funding – should not be controlled by members of the profession involved; in particular, there should be strong consumer representation on any oversight body – perhaps even a majority.

- Members of a profession should not be in a position to control entry to the profession by dictating entry standards or controlling initial education provision, to avoid placing them in a position whereby, by controlling entry to a registration system, they can restrict entry to the profession itself.

- The level of regulation should be proportionate to the need identified, and should not be such as to allow anti-competitive conduct to masquerade as the maintenance of standards. In particular, it is unwise to allow members of a profession an unlimited potential to define for itself terms such as '*professional misconduct'*, or '*bringing the profession into disrepute*', and to allow it to sanction individuals for breaches of such open-ended terms. For example, some professionals may regard advertising (however limited that may be) as '*bringing a profession into disrepute'*. The Authority, allowing for some exceptions, takes a radically different view, namely that advertising should be *generally permitted*, rather than *generally banned.*

- There is an obvious need, when framing regulatory regimes for professionals, to guard against the risk of regulatory capture – in particular allowing the profession itself a disproportionate say in the design of its own oversight system.

The Authority's view on these matters has been particularly bolstered by critical comments by the OECD about the bias towards producer interests rather than consumer interests inherent in Irish regulation.[6]

5.2 Public restrictions on competition means more advocacy

Enforcement of competition law in respect of the health professions is complicated by the fact that many of the restrictions on competition are bound up in public regulation and therefore risk being beyond the scope of direct enforcement.

The clear result is that there is a strong role for competition advocacy in the area. The Competition Authority has become more vocal in this respect in recent years, in publicly highlighting the restrictive nature of many public restrictions on competition in the health sector; for example, its views on competition in the pharmacy profession, and in the retail pharmacy sector generally, are particularly well developed and widely-recognised.

5.3 The Competition Authority's Study of Competition in the Professions

The Competition Authority has, more widely, taken a strong interest in competition in the professions generally, and commissioned a wide-ranging consultancy report on competition in eight professions, including three in the medical field – medical practitioners, optometrists and dentists. This report was published in March 2003[7], and the Authority is currently working its way through the competition issues presented in relation to each profession, in turn. The Consultants'[8] preliminary findings indicate three basic classes of restriction on competition across many of the professions studied:

- Restrictions on entry;
- Restrictions on behaviour; and
- Restrictions on organisational form.

As the Authority works through each professional sector dealt with in the report, it publishes draft recommendations for public comment.[9] At the end of the process in each case, the Authority may do one or several of the following:

- Seek changes to existing practices, present recommendations and where appropriate issue best practice guidelines to Government, relevant regulators, professional bodies and others with a view to the removal of unnecessary impediments to competition;
- Publish information about markets or practices that improves knowledge and understanding of, or stimulates and improves competition generally in some or all of these sectors;
- Make recommendations for regulatory reform;
- Offer a clean bill of health.

The key factor informing the Authority's perspective is the principle of proportionality. That is, only those restrictions or regulations that achieve their objective in the most efficient and non-distortionary fashion should be retained. Where more effective and non-distortionary alternatives are available, these should be implemented.

6. The Regulation of selected Health Professions in Ireland

This section describes the main features of the regulatory regime applying to the provision of dentistry, optometry, general practice medical services (GP services) and pharmacy services in Ireland. The provision of GP services is included, as all patients except medical cardholders (i.e. patients eligible for free medical care) pay for such services. By contrast, the provision of services by specialist medical practitioners is excluded, as patients' fees tend to be paid by either social or private insurance.

6.1. The Dental Profession

Dentists are involved in the prevention, diagnosis and treatment of problems of the teeth, jaws, mouth and associated tissues and may offer more specialised services such as orthodontics and oral surgery. Dentists in private general practice treat two types of patient: medical cardholders (i.e. patients entitled to free medical care) and private patients, some of whom are entitled to a partial discount on their fee through their social insurance.[10] Other dentists, whether they are general dental practitioners or specialists, work for regional health boards and university dental hospitals where they treat public patients and a limited number of private patients. Two other categories of professionals are involved in dental care:

- Dental hygienists - who carry out scaling, polishing and cleaning of teeth, apply prophylactic materials to the teeth or gums and give advice in relation to oral health;

- Dental technicians and denturists - who specialise in the manufacture of dentures and other dental prosthetics.

The Dental Council has responsibility for the regulation of the dental professions. The Council was established under the Dentists Act, 1985, and has a membership of 19 persons, 2 of whom represent consumer interests. The Irish Dental Association is the professional representative association for dentists.

Entry Requirements

Under the Dentists Act, 1985 and rules set by the Dental Council, those who want to practise as dentists, dental specialists or dental hygienists and assume the relevant title, have to register with the Council. To be accepted on the register, the candidates must fulfil certain requirements. The main requirement is to hold a recognised Irish Degree in Dentistry, or be an EU national with an approved dental qualification. Non-EU Nationals have to pass the Dental Council's special examination.

Currently, no register exists for those who want to practise as dental technicians and denturists. The absence of statutory registration for such professionals under the Dentists Act, 1985 has a number of implications:

- Dental technicians and denturists cannot supply and fit dentures to members of the public;

- There is no protection of the title of denturist or dental technician.

In its report, The Competition Authority's Consultants considered that the absence of registration status for suitably qualified denturists and dental technicians was likely to result in a barrier to entry to the profession and therefore was adversely affecting potential competition in the market. This situation may be reversed in the future, as the Dental Council recently lodged a proposal with the Minister of Health and Children to create, under the Dentists Act 1985, a new class of auxiliary dental worker who would sell and fit dentures to members of the public. It should be noted, however, that on foot of a previous (1982) Report of Enquiry in this area, the then Minister for Health also directed the Dental Council to create such a register. 20 years later, there is still no scheme for registered denturists in place.

The Consultants also identified two other barriers to entry in the supply of dental services:

- The limitation on the number of places available for study at the school of dentistry; and

- The educational requirements applying to non-EU nationals wishing to practise in Ireland.

Exclusive Rights (Demarcation)

The Dental Council prescribes that registered dental hygienists cannot practise independently of a registered dentist and must operate under the latter's supervision. The Consultants considered that this restriction reduced the supply of dental services and adversely affected competition and consumer interests.

Organisation Structure

The Dentists Act, 1985 prohibits corporate bodies from engaging in the practice of dentistry. The Consultants considered that this prohibition was likely to constrain the growth of dental practices and the entry of new and possibly more efficient dental practices into the market.

Advertising Rules

The Dental Council prohibits advertising and canvassing going beyond its Guidelines on Public Relations and Communications (1990). The Guidelines lay down specific requirements in relation to the size and content of professional wall nameplates and telephone directory entries, as well as the frequency and content of press notices for dentists commencing practice. The legislation does not explicitly prohibit the advertising of fees and charges, but tradition within the profession seems to preclude price advertising. The Consultants considered that these rules were likely to constrain normal competitive behaviour among dental practices.

Fee Setting

Neither the Dental Council nor the Irish Dental Association have any statutory role in relation to fee-setting for private patients. However, the Irish Dental Association is involved in negotiating the Exchequer's contribution to fees for patients under the dental schemes funded by the Department of Social, Community and Family Affairs and the Department of Health and Children.

6.2. The Optometry Profession

In Ireland, the following professionals are involved in the prescription and sale of spectacles:

- Medical practitioners (ophthalmologists or ophthalmic surgeons) who prescribe spectacles and can sell them.
- Optometrists (formerly known as ophthalmic opticians) who can prescribe spectacles.
- Dispensing opticians who sell spectacles.

The Opticians Board is the regulatory body for both branches of the profession, under the Opticians Act, 1956. The Board comprises 11 members, with 6 members elected by the profession (5 optometrists and 1 dispensing optician) and the Minister for Health and Children appointing the remaining 5 members (4 of whom must be medical practitioners). The relevant professional representative associations are The Association of Optometrists of Ireland and The Irish Association of Dispensing Opticians.

Entry Requirements

Those who want to practise as optometrists and dispensing opticians and assume the relevant titles have to fulfil a number of requirements under the Opticians Act, 1956, and rules set by the Opticians Board. The main requirements relate to their education and training. They are described in the table below.

Main Requirements to Register as an Optometrist or Dispensing Optician under the Opticians Act, 1956	
Registration	**Educational and training**
Optometrist	Recognised qualification (optometry course offered by the Dublin Institute of Technology) Pass the clinical examination of the Association of Optometrists of Ireland Specific rules apply for those who qualified outside Ireland.
Dispensing optician	Recognised qualification (3 year distance learning course offered by the Association of British Dispensing Opticians) Specific rules apply for those who qualified outside Ireland.

The Opticians Board recognises the only optometry course offered in Ireland. The Dublin Institute of Technology course offers 25 places. The Competition Authority's Consultants considered that the very limited number of places on the optometry degree course may act as a barrier to entry to the profession of optometrist.

There is no qualifying course to become a dispensing optician in Ireland. To enter the Opticians Board's Register of Dispensing Opticians, one needs to graduate from the 3-year distance-learning course offered by the Association of British Dispensing Opticians.

Exclusive Rights (Demarcation)

The Opticians Act, 1956 and the rules of the Opticians Board specify the scope of each profession: optometrists specialise in the clinical side of the profession, while dispensing opticians specialise in the commercial side. In addition, the Board prohibits registered dispensing opticians from being involved in any clinical aspect of the profession. They cannot perform the following tasks:

- Treat any disease of the eye or prescribe or administer any drug or other medical preparation for the purpose,
- Prescribe or administer any drug for the purpose of paralysing the accommodation of the eye; and
- Suggest or make a medical diagnosis of a disease of the eye.

The Consultants did not believe that this demarcation of the opticians professions raised any competition issue *per se*. They considered that, so long as entry into either branch of the profession was not restricted, practitioners should be free to choose their preferred mode of specialisation. They noted that consumers should be free to choose their dispensing optician and that any practices that restrict the consumer to purchasing spectacles or other visual aids from a given optician could be regarded as anti-competitive.

It is worth noting that one particular public restriction on competition was removed in 2003, namely a prohibition on the sale of "ready-made reading spectacles" by anyone other than a registered optician or a

registered medical practitioner. Following an amendment to the Opticians Act, the sale of ready-made spectacles is now unrestricted. This is undoubtedly a welcome boost to competition and consumer welfare.

Organisation Structure

There are no legal restrictions in operation within the opticians' professions concerning permissible organisational forms.

Advertising Rules

The Opticians Board prohibits false or misleading advertising and advertising that is in "bad taste". The Board also prohibits canvassing (touting or soliciting for business by way of direct personalised approach) and using comparisons with other optical practices in the advertising. The Authority's Consultants considered that such prohibitions were restrictive of competition in the market and that these rules were likely to constrain normal competitive behaviour.

Fee Setting

Individual practitioners in both branches of the profession are free to set their own fees. The representative body for Optometrists (the Association of Optometrists of Ireland), states in its Code of Ethics and Practice that practitioners should indicate any charges that may be due for the consultation and the costs associated with the dispensing function.

6.3. The Medical Profession

General medical practitioners (GPs) treat two categories of patients: (a) patients paying for the services they receive, and (b) medical cardholders i.e. patients entitled to free medical care under the State's General Medical Services Scheme. Doctors offering services under the State Scheme have a contract with the Health Board of their region.

The Medical Council regulates the provision of medical care by general practitioners, non-consultant hospital doctors and hospital consultants. The Council was established as a statutory regulatory body by the Medical Practitioners Act, 1978 (this Act is about to be replaced). The Council's functions revolve around the protection of the public and the support of medical professionals, with the publication of guidance on professional standards within medicine. The Council consists of 25 members, appointed by the Irish medical schools, registered medical practitioners, and the Minister for Health and Children, respectively. Three of the nine members appointed by the Minister for Health and Children represent the interest of the general public. The professional representative role in relation to doctors is fulfilled mainly by the Irish Medical Organisation, the Irish College of General Practitioners, and the Irish Hospital Consultants Association.

Entry Requirements

The Medical Practitioners Act, 1978 and the Medical Council specify the requirements to be satisfied to practise medicine in Ireland. Registration with the Medical Council is necessary to practise. To enter the Register, applicants must have a "registrable" qualification or transfer their registration from abroad. Irish medical degree-holders, as well as those with recognised qualifications from EU member states, Australia, New Zealand and South Africa can register in Ireland. Medical practitioners already fully registered in another EU country can transfer easily to the Irish Register. Other applicants for registration are required to pass a clinical examination and a language examination and have their medical qualification authenticated by the Council. The Consultants considered that the transfer procedure for doctors from non-EU countries constituted a barrier to entry to the provision of general medical services in Ireland. The consultants also

considered that the limitation on the number of study places available at the Irish schools of medicine acted as a serious constraint on entry to the medical profession in Ireland and that it is therefore likely to limit potential competition in the market place.

Organisation Structure

The Medical Council's Guide to Ethical Conduct and Behaviour contains no legal or explicit restrictions on the legal status of medical practices. However, the Consultants found that there was a tradition within the medical profession that precluded general practitioners from practising within limited liability structures. The consultants considered that such a tradition constrained the growth of GP practices and the entry of new and possibly more efficient practices into the market.

Consumer Redress

Under the Medical Practitioners Act, the Medical Council deals with complaints from patients about doctors' professional standards of medical care, or indeed any other aspect of professional behaviour. If found guilty of professional misconduct or found unfit to practise, a practitioner may appeal the decision to the High Court who will conduct a full re-hearing of the inquiry. The Consultants concluded that the Medical Council's procedures were appropriately designed to protect consumer interests and to maintain high standards in the profession.

Advertising Rules

The Medical Council's Guide to Ethical Conduct and Behaviour contains detailed guidelines on the advertisement and publicity of services by medical practitioners. The guidelines specify how to announce a new practice, and the format and frequency of advertisements. In addition, they prohibit practitioners from advertising their fees or from making any comments about their personal qualifications or expertise. The Consultants considered that these advertising restrictions limited the availability of information to patients and could restrict competition between practitioners.

Professional Fees

The Medical Council plays no role in relation to fees. The Irish Medical Organisation is a registered trade union and negotiates, among other things, the terms and conditions of GPs' contracts with State for the treatment of medical card holders.

6.4 The Pharmacy Profession

There have been competition-related problems with this sector for many years. Pharmacies are considerably more valuable assets than other forms of retail outlet, reflecting the restrictive regulatory environment in which they operate, and the ensuing rents to be earned by incumbents. The pharmacy sector is currently under review in Ireland and new legislation is expected in the near future (the basic legislation governing the practice of pharmacy is still the Pharmacy Act (Ireland), 1875, and is completely outdated).

The Pharmaceutical Society of Ireland (established by the 1875 Act) is the statutory regulatory body responsible for overseeing the registration and supervision of community pharmacists. The Society –

- Regulates the qualification of *pharmaceutical chemist* which entitles one to practise pharmacy in Ireland,

- Regulates the operation of pharmacies for the dispensing of medical prescriptions and sale of medicines,

- Ensures that medicines are supplied in accordance with the regulations governing such supply.

The Society's Governing Council comprises 21 Members; all elected by members of the Society, i.e. there are no lay or other external members.

Requirements for Pharmacy Opening

Under the legislation, an outlet dispensing or compounding medical prescriptions must be operated and personally supervised by a pharmacist who satisfies two requirements:

- Be registered with the Pharmaceutical Society,

- Have at least three years post-qualification experience working in a community pharmacy.

In addition, the Act stipulates that when the pharmacy is owned by a body corporate, the shop (and the dispensing of prescriptions) has to be personally supervised by such a person registered with the Society.

Until the last few years, Trinity College, Dublin had a monopoly on the provision of pharmacy degree courses in Ireland, and provided only a small (70) number of degree places. The limited number of places led to a situation of significant (a) unmet demand from students, and (b) under-supply of pharmacists in the State, and many Irish students had no alternative but to qualify in other countries (mainly the UK). While the recent approval by the Pharmaceutical Society of two new schools of pharmacy will reduce the shortfall of qualified pharmacists in the future, it will still fall far short of meeting demand.

Currently, pharmacists with qualifications from other EU Member States, Australia and New Zealand can transfer to Ireland to work as a pharmacist. However, regulations have been in place since 1987 which effectively prevent overseas-trained pharmacists (including even those who had to seek education outside Ireland as described above) from actually opening their own pharmacy. The stated objective was to maintain a "level playing field" with EU countries with similar restrictions.

The Irish Competition Authority has consistently stated that these regulations are overt and protectionist restrictions on competition, benefiting only existing pharmacists operating existing pharmacies. This view was endorsed by the OECD, in its 2001 Report *Regulatory Reform in Ireland*.

Restrictions on the Location of New Pharmacies

Previous restrictions on the location of new pharmacies (dating from 1996) were removed in 2002 following a High Court challenge to their legal validity. The restrictions had been based on various criteria including population/distance criteria, and the impact of new pharmacies on the viability of existing ones. The Competition Authority had consistently maintained that the Regulations involved were anti-competitive, primarily on the grounds that, in effect, they created a new barrier to entry to the sector. New pharmacies incurred a cost not faced by existing pharmacies in terms of restricted opportunities to obtain a State contract. With limited threat of entry, existing pharmacies faced limited incentives to keep their cost and price down. The same conclusions were reached by the OECD in its 2001 Report *Regulatory Reform in Ireland*.

A Government Review of the sector, following the removal of the restrictions found that the capital value of contracted pharmacies increased greatly under the Regulations, giving a commodity value to the contract, and an increase in the value of contracted businesses, that was never intended.

NOTES

1 See for example Deloitte & Touche in conjunction with The York Health Economics Consortium (2001), "Value for Money Audit of the Irish Health System", Brennan Commission (2003), "Report of the Commission on Financial Management and Control Systems in the Health Service", commissioned by the Department of Finance, Ireland. Available for download from – www.doh.ie/publications/hsreform.html.

2 The public health system gives universal entitlement to basic hospital care, plus limited partial coverage for all citizens in respect of primary medical services.

3 Wiley, Miriam M. (2001), "Reform and Renewal of the Irish Health Care System: Policy and Practice", Budget Perspectives Conference Proceedings of October 9, 2001, Economic and Social Research Institute.

4 Doctors, nurses, dentists, pharmacists and optometrists have been subject to statutory regulation for many generations.

5 Clinical biochemists, chiropodists/ podiatrists, dieticians, orthoptists, physiotherapists, radiographers, speech and language therapists, occupational therapists, social workers, medical scientists, social care workers.

6 Report on Regulatory Reform in Ireland (OECD: 2001).

7 The Report can be downloaded from – www.tca.ie.

8 Indecon International Economic Consultants/London Economics

9 More information on the Professions Study can be downloaded from - www.tca.ie/professions.html .

10 Employees (and their spouses) who have paid the necessary amount of PRSI (Pay Related Social Insurance) contributions are entitled to a discount on their fees for certain services. The discount granted to the patient is reimbursed by the Department of Social and Community Affairs to the dentist (or the Department of Health and Children in the case of children).

ITALY

Competition in the Health Professions

Health-care services are textbook examples for credence goods and the risk from having such services provided by unqualified professionals is very high. This is why health-care professions are strictly regulated everywhere: entry is subject to control on professional qualifications and conduct is also subject to quality standards as well as to a number of ethical requirements. Sometimes, however, regulatory restrictions go much farther: in Italy, for example, for most recognised health professions, advertising is prohibited and vigorous competition among professionals is hindered by binding and statutorily sanctioned minimum tariffs.

Entry in the medical profession

In Italy, physicians (basic and specialists), dentists and pharmacists are obliged to join their respective professional boards in order to practice. However, up until very recently there have been no restrictions as to the possibility of becoming a physician, a dentist or a pharmacist (quantitative restrictions only existed for post-graduate specialised training). Only a few years ago universities started to introduce some quantitative constraints on the number of students attending medical schools, however the policy is much too recent for it to have had any appreciable effect. In any case, such quantitative ceilings do not appear to be particularly strict and seem to rather exclude only students that would not have been able to attain the degree anyway. After graduation, joining the professional board requires passing an exam that, until now, has not been selective.

As a result, the number of doctors in Italy relative to the population is the highest among OECD countries: over 4,4 practising physicians per 1000 inhabitants, compared to the standard 3,3 of the European area (source 2002 OECD Health Data).

With respect to the possibility of becoming a specialized doctor, the number of training places available every year in each school is fixed every three years by the government (Ministry of Health, Ministry of University and Research, Ministry of the Treasury), based upon the health-care needs of the population and the employment opportunities in each local area. Entry can be very selective for specialisations that require a long practice into a hospital structure (different branches of surgery, orthopaedics, cardiology, obstetrics, etc.).

After the entry into force of the community directive on mutual recognition of diplomas[1], professionals qualified to practice in other member States can also practice in Italy, provided they have obtained the administrative recognition of their degree from the Health Ministry and the Ministry of University (for professions with licence obligation). As for the recognition of training periods completed in other member States, professionals may submit an application to the Health Ministry for the recognition of such training. Once training has been recognized as valid, the enrolment in the professional board is automatic. For non-EU citizens the procedure is more thorough and includes an evaluation of the completed studies and a control on the professional experience acquired by the candidate.

Professional boards are responsible for controlling compliance with the rules of the professional ethical code as well as for dealing with complaints over the quality of services. They can suspend a member for malpractice or for non-compliance with the ethical codes. Appeals against the professional board's decisions are dealt by a special commission within the Health Ministry. Each professional board is usually organized through local branches (at a provincial level) entrusted with the control over members operating in the relevant local area and reporting to a national association.

Exclusive rights

The prevention, diagnosis and treatment of any disease are reserved to medical specialists. Traditionally the scope of such exclusive rights has been subject to a very strict interpretation: the practice of each type of therapy or treatment by health professionals needed a specific prescription by the medical specialist.

Further to the 1996 reform of the medical profession, however, a number of new three-year university diplomas were established for the recognition of the so-called primary health professions[2]. The recognition as primary health profession is still pending for chiropractice, already recognized in a number of other EU member States. The 1996 reform changed the regulatory approach for such professions. For these professions, there are no professional boards, nor requirements for additional exams beyond the university diploma. Furthermore all these professionals can set up their own practice. Also dental hygienists can provide services on their own, but need an indication by a dentist. Optometrists are allowed to prescribe the required visual correction for patients (they cannot however treat any disease of the eye). Audiologists can provide non-invasive audio-exams and hearing aids application without medical prescription. Dispensing opticians need a technical degree and so do dental specialists and denture technicians. The sale of ready-made reading spectacles is unrestricted. Denture technicians are allowed to serve the public directly, but the mould has to be made by a dentist.

Pharmacists' exclusive rights include the preparation, testing, storage, and supply of drugs as well as the sale of prescription drugs, non-prescription drugs and of some other health products over the counter. Also, the packaging of drugs must be done under the direct control by the pharmacists.

Organizational structure

Doctors in public healthcare organisations are still free to practice on a private basis provided they have chosen a part-time option. On the other hand, the law limits the adoption of a corporate form for the provision of professional services: for example, clinics and healthcare centersmust always have a doctor ultimately responsible for the medical care provided. Some changes have been introduced in recent years by the professional associations: for example, medical services can be provided by single professionals or associations of professionals, under a corporate or a partnership form. In the case of corporations, the majority of members must be healthcare professionals and the form of corporation must be approved by the competent local professional board. In any case, medical doctors cannot engage in any activity (either commercial or industrial) that could adversely impact on their professional independence.

The situation is different for pharmacies. Pharmacies, with the partial exception of those owned by a municipality, are owned by single professionals (one outlet per pharmacist). In case of death of the responsible pharmacist, there is a period of ten years before the licence is to be returned for a new allocation. When service by private sources is lacking, municipalities can establish their own pharmacies. Each municipal pharmacy must be under the responsibility of a single pharmacist (employed by the municipality).

Privatization of municipally-owned pharmacies

In the last decade some Italian municipalities decided to privatize their pharmacies. In Milan, a shareholding company was created for this purpose and the majority of its capital was sold to a multinational wholesale distributor of drugs. Such privatization was opposed by the National Federation of Private Pharmacies (so called Federfarma), which appealed the local government's decision up to the Constitutional Court. In its judgement (24 July 2003) the Court underlined that the privatisation of municipal pharmacies is constrained by a public health standard. In particular, the Court ruled that having a single operator both at the wholesale and retail level could create problems in the provision of drugs and could undermine the protection of public interests in the field of healthcare services.

Advertising

Advertising of services provided by healthcare professionals is restricted by law (law n. 175/92): advertising is only allowed through wall signs on the building where the practitioner operates and through adverts on telephone directories (white and yellow pages), lists of professionals, specialised press and general press, indicating only name, address, telephone, visiting hours and professional qualification; wall signs must be verified by the competent professional board and authorised by the local public authority.

Advertising must be limited to the qualification of the professional and the description of the techniques adopted, without any mention of the provider's experience or applicable prices. Local professional associations are in charge to verify members' compliance with the restrictions on advertising, along the rules specified in the code of conduct.

Even if advertising on the Internet is not specified by the law, the national association of physicians and dentists has recently adopted rules whereby Internet advertising must be authorised by the professional board and placed on sites registered under the name of the professional (or the authorised healthcare organisation); the rules restrict any advertising on prices as well as the inclusion of any adverts concerning pharmaceutical products. Advertising on other products, such as eyeglasses or hearing aids, is not restricted.

Fee setting

A fee schedule for physicians' services is fixed by law at a national level: it is a set of minimum fees, which can be revised by the Ministry of Health every two years and must be updated every five years upon advice by the national professional board. Such fees are identified as the minimum compatible with the professional dignity of the provider. Fees for specialists are automatically fixed by percentage increases on the minimum fee. Discounts on minimum fees are restricted by law and the professional board monitors its members' compliance with such rules.

Prices for prescription and non-prescription drugs are subject to authorization (based upon the average prices applicable in different countries) and are identical all over the national territory. The law establishes all the relevant mark-ups (wholesale and retail) along the vertical chain. The pharmacist's margin is fixed at 25.5% of non-reimbursable drugs and 22.5% on drugs reimbursed by the national health system.

Regulation of pharmacies

While the number of pharmacists is quite high, since there are no limitations on access to university education and entry into the profession is not appreciably constrained by selective mechanisms, the number of pharmacies is regulated. In mid '90s the number of outlets in Italy was about 16.000, whereas the pharmacists'professional board included almost 60.000 members.

The law regulates the number of pharmacies: every two years municipalities fix both the number and the location of pharmacies (one outlet per 5.000 residents for small towns –under 12.500 residents- and one outlet per 4.000 residents for larger cities). The distance between outlets must be greater than 200 metres.

Selection procedures and contractual mechanisms for family doctors

In Italy the selection of family doctors is regulated by an agreement (called Convention) between the main professional associations and the regional governments: in order to be included in the lists of family doctors, qualified physicians must apply to the local health service. The number of physicians that in each Region can be included in the lists depends on the number of residents (over 14 year old): the so-called "optimal ratio" between basic doctors and inhabitants is 1/1000 and is fixed by the Convention, but each Region has the possibility to reduce such ratio to a minimum of 1/1500, depending on the population density in the area. The lists of selected applicants are prepared every year by the Regions on the basis of the professional experience of the candidates. The doctors included in the lists must guarantee a daily service in their premises and visits at home for more serious illness; each doctor can have a maximum of 1500 patients and receives an average annual compensation for each patient. Such compensation can be increased if the physician provides additional services to patients. Patients can change their family doctor, but given the existing close correspondence between the maximum number of patients a physician is allowed to have (1500) and the family doctors/inhabitants "optimal ratio", such switching opportunities have a very limited disciplining effect on physicians' income.

Antitrust enforcement in healthcare professions

Italian competition law applies to all liberal professions, including healthcare professions: following the consolidated approach of the European Court of Justice, physicians and healthcare professionals in general are considered to be undertakings, as long as they run their own economic activity, and their professional associations are expressly subject to competition rules as associations of undertakings.

In 2000, the Italian Competition Authority concluded an investigation on two decisions adopted by the national association of physicians and dentists (respectively in 1985 and in 1997). These decisions governed the terms on which doctors were to sign conventions with private healthcare agencies. Specifically, under the criteria laid down in the 1985 decision, doctors were to provide their services only to members of supplementary healthcare agencies that agreed: i) to give preference to direct economic relations between doctors and patients; ii) to adhere to the principle of open lists whereby the agencies were to admit to the public service convention all requesting doctors; iii) to follow the fee schedule set by the association. Subsequently, with the 1997 resolution, the first two of these points were confirmed; the other was replaced by two alternative provisions: namely, that the agencies could carry out checks on service quality, albeit only with the participation of the association, and that they were required to allow patients to freely choose their doctor.

The Authority concluded that these decisions were intended to restrict competition among doctors in their dealings with supplementary healthcare agencies. Essentially, the object and the effect of the decisions was an unjustified restriction of the choice by the healthcare agencies, eliminating all possible competition between doctors in the qualitative differentiation of their services and, at least until 1997, in the fees charged. The Authority further ascertained that these resolutions substantially restricted competition in each of the local markets for medical and dental services in Italy, in that they were capable of affecting the conduct of all healthcare professionals operating in those markets.

In 2002 the Authority concluded an investigation on a number of restrictive agreements by several national and regional associations of pharmacists with respect to the sale of pharmaceutical-related products by pharmacies. These products were not distributed exclusively through pharmacies, and included

sanitary articles, food integrators, special foods, articles for children and cosmetics. The price of these products was not regulated. The elements acquired during the investigation showed that the associations had entered into three types of restrictive agreements: *i)* imposing constraints on advertising by pharmacies; *ii)* limiting the scope for pharmacies to provide home-delivery services; and *iii)* soliciting uniform pricing behaviour.

In view of the special regulations governing pharmacies (regulated prices for drugs, controls on the number and location of outlets, limits on opening hours), the Authority concluded that pharmacies could only compete in the supply of these products and in the provision of additional services (such as home delivery). It thus held that the agreements on prices and advertising were to be seen as particularly serious infringements of competition rules. Accordingly, the Authority fined the associations for a total of around € 95,000.

The Authority's competition advocacy role

On many occasions the Italian competition Authority has played a strong role in advocating for a market-oriented reform of the sector. Some of these interventions concern the regulatory reform of the health professions and raise issues such as hospital health services reform, the fixing of fee schedules for dentists services, the institution of boards and registers for auxiliary professions and pharmacies' opening hours and service duties.

Opinion on the proposed reform of hospital services

In 1998, the Authority submitted to Parliament and to the Government an opinion concerning the potential distortion of competition arising from the behaviour of the National Health Service (NHS) as regards the selection of organisations eligible for the provision of healthcare services ultimately paid for by the NHS. The Authority observed that the objectives of creating a level playing field for healthcare providers and guaranteeing patients freedom of choice still appeared far from being achieved in a satisfactory manner. This was largely the result of choices made by the Regions, which in some cases had applied fully discretionary criteria in selecting healthcare providers. The Authority observed that the achievement of the objectives of free user choice and budgetary control was being hindered by Local Health Agencies (ASL) performing the dual functions of provider and purchaser-payer. The effect of any mixing of these two roles was to distort competition and the efficient allocation of public resources. The Authority underlined the need to separate the functions of (a) planning, (b) service provision, and (c) payment of health services, by allocating them to different "players". The planning function should fall within the competence of local governments; the service-provider function should be performed by the public or private health organisations formally approved by the Regions; the payment function, and the power to check and monitor the quality of the services provided by the eligible organisations should fall onto Local Health Agencies.

Opinion on a proposal to fix minimum fees for dental care services

In its opinion to Parliament and the Government, the Authority observed that the professional bodies' power to determine fees conflicted with the antitrust law. The Authority reaffirmed its view that, even in the healthcare sector, imposing mandatory minimum fees was not an effective way of ensuring quality and prevented users from benefiting from cheaper services. Furthermore, giving professional associations a decisive role in the determination of fees was seen likely, considering the clear conflict of interest, to lead to an increase in the general level of prices for individual services.

Of course there are significant information asymmetries in the markets for health care services. The dissemination of independently gathered information on prices was a better solution than fixing minimum fees.

Report on the regulation of pharmacies' opening hours and service duties

In 2000 the Authority sent a report to the Heads of Regional Governments on the market distortions resulting from the current laws and regulations concerning the arrangements for pharmacies, with particular reference to opening hours and service duties.

The Authority observed that guaranteeing a continuous and widely available service throughout the country could be attained by obliging pharmacies to respect minimum opening hours for night services and for holidays. Any other restriction would appear to be not only superfluous, but anti-competitive.

Far from protecting customers, the existence of limitations on the maximum hours a pharmacy can be open, the obligatory Sunday or holiday closures, minimum annual holidays, or the imposition at the regional or municipal level of requirements for uniform opening hours, appeared to be designed to stabilize the income of operators in the sector. In fact, such homogenizing rules reduce incentives for operators to improve service quality. For these reasons, the Authority recommended that regional regulations be revised, with the aim of eliminating any limits to and distortions of competition that are not justified by general interest considerations.

NOTES

1 COUNCIL DIRECTIVE 93/16/EEC, concerning the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications, together with directives 97/50/CE, 98/21/CE, 98/63/CE e 99/46/CE, was implemented in 1999 by legislative decree n. 368/99.

2 The most important diplomas established by the 1996 reform are: Dietician, Physiotherapist, Dental Hygienist, Nurse, Speech Pathologist, Orthopaedist, Midwifery, Podiatrist, Audiologist.

JAPAN

I. Introduction

Many regulations exist in the health professions due to the special nature of medical care, such as the characteristic that human life and health can be directly influenced. In addition to this specialty, a system to provide every patient with medical services equally and uniformly has been established based on the principle of medical insurance, whereby all people are part of the national insurance system and can use medical services freely. However, creative incentives in the business activities of medical institutions can be stimulated, as well as patient profits ensured, by promoting fair and free competition among medical institutions as entrepreneurs through the choices of patients as seekers of medical services among physicians and medical institutions that provide medical services in accordance with patient demands. And as a result, the quality of medical services can be enhanced. Furthermore, in the health professions, the Antimonopoly Act of Japan is applied to those areas in which competition functions, and so far, the Japan Fair Trade Commission (hereinafter the "JFTC") has shown its approach to this area and has taken measures to prohibit violations of the Antimonopoly Act.

The following describes the policy and the view about regulation of the medical field in Japan of the Ministry of Health, Labor and Welfare (hereinafter the "MHLW"), the JFTC's approach to health professions under the Antimonopoly Act, major cases related to health professions under the Act, and the JFTC's surveys and reports from the perspective of competition policy.

II. About the policy and the view about regulation of the medical field

In the following, an example is given and explained about the policy and the view about regulation of the medical field in Japan of the MHLW.

Structural approaches

In health professions, the Antimonopoly Act promotes free and fair competition, and becomes in effect when medical facilities are buyers in deals. On the other hand, the national government, to keep the quality of medical service, establishes the regulation on safety and sanitation of medical service to be provided. Besides, under the precondition that medical care should be provided for the public without seeking profit, the structural competition is being promoted. For example, the most of the fee for medical service is provided by the national government under the national health insurance, however, medical facilities are also granted to establish, by themselves, fees for medical services, which are not compensated by the national health insurance. Also, there are several professional licenses to provide medical services in addition to doctor and dentist.

In Medical Law, it is not permitted to establish the medical facilities for commercial gain, but The Law passed in May 2004 admits, as special case, joint-stock companies satisfying the condition to establish medical facilities which provide medical treatment with high technology not compensated by the national health insurance in the special zone, and this plan is scheduled to be put into practice in October 2004.

It is still more examined referring to the result of joint-stock companies' management of medical facilities, whether joint-stock companies satisfying the condition are admitted all over Japan to establish medical facilities which provide medical treatment with high technology not compensated by the national health insurance.

Behavioural approaches –Conduct rules

In the same way, as for behaviour of health professions, the government establishes the regulation on the advertising practiced by medical facilities and health professions to ensure that patients are not misled by the advertising unfairly, reflecting asymmetry of information between doctors and patients. Medical facilities are only allowed to use expressions, which are legally provided, in their advertisement, which would prevent patients from being confused by advertisement. Expressions, which medical facilities are legally allowed to use in advertisement, are restricted to only objective ones such as the fact being a doctor or a dentist, basic information of medical facilities including name, address and phone number, and so on. Moreover, the fee for medical service can not be advertised in advertisement, because, as mentioned above, the most of the fee for medical service is established by the national government under the national health insurance, and therefore, there is not margin of the fee.

Example –Dentistry

For example, in the case of dentistry, the competition is being promoted in both structural and behavioural approaches when the government establishes the regulation under the precondition that medical occupations and facilities have to provide good and adequate medical services. Dentistry is not monopolized by dentists and can be partially provided by other legal professions, such as dental hygienists who are allowed to remove, by mechanical means, adhesion and deposit on the exposed surface of tooth and the normal free sub-gingival part, under the indication of a dentist. Besides, a dentist is the only profession that is granted to practice dentistry independently. Dentists can only use expressions legally provided in their advertisement, and can not advertise the fee for medical services, as the most of the fee is established by the national government under the national health insurance. As mentioned above, it is common, not only in dentistry but in any other medical professions, that only the legal expressions can be used in the advertisement.

Example – Pharmacist

The responsibilities of the pharmaceutical professional association

If the question about responsibilities of the pharmaceutical professional association is the role of the pharmaceutical association, the purpose of the Japan pharmaceutical association is to increase ethical and scholarly levels of pharmacists and to promote progress and development of pharmaceutical science and pharmaceutical business for contributing to national welfare.

What restrictions may exist to the movement of pharmacists across borders

In Article 15(2) of Pharmacists Law, "Persons who have graduated from a pharmaceutical school overseas or who have received a pharmacist license overseas and have been confirmed by the Minister to have equivalent or better scholastic ability and technical skill than those specified in the previous item", the person corresponding to the requirement shall be able to receive the examination.

Whether there are limitations on the locations of new pharmacies

There is no located limitation on opening of a pharmacy. But at the point of the designation of a insurance pharmacy, the pharmacy must be independent from medical institution structurally, functionally and economically.

Whether pharmacies must be owned by a pharmacist

A person who is not a pharmacist is able to become a proprietor of pharmacy, but in that case, a proprietor shall designate a pharmacist, from among the pharmacists engaged in actual business related to pharmaceutical affairs in the pharmacy, as technical supervisor for the practical supervision thereof.

III. Major Cases in the Health Professions under the Antimonopoly Act

1. Approach to the Health Professions under the Antimonopoly Act

The Health Professions and the Antimonopoly Act

To secure fair and free competition, the Antimonopoly Act stipulates a number of provisions concerning the activities of entrepreneurs and entrepreneurs' associations. For the purposes of the Antimonopoly Act, an entrepreneur means "a person who engages in commerce, manufacturing, financial business or other businesses." The Antimonopoly Act considers whether an entrepreneur is an independent economic entity engaging in business or not, but doesn't consider whether an entrepreneur is generating profit. Accordingly, entrepreneurs engaging in the medical services business are not exceptions to this, and if the said entrepreneurs satisfy the above requirements, the Antimonopoly Act is applied to those engaging in the health professions.

For example, if a doctor is a simple researcher or an employed doctor, the doctor is not classed as an "entrepreneur" under the Antimonopoly Act. However, if the doctor engages in the medical services business as his or her business, the doctor is classified as an "entrepreneur" under the Act. Whether a doctor conducts medical activities as a business or not is decided based on whether the doctor engages in medical activities repeatedly and continuously as an operating body. "Entrepreneurs' associations" under the Antimonopoly Act mean associations that unite or combine two or more entrepreneurs, mainly aiming to increase their common profit as entrepreneurs. If an association of medical entrepreneurs satisfies this requirement, the said association of medical entrepreneurs comes under the definition of "entrepreneurs' association" and the Antimonopoly Act is applied.

Guidelines Concerning the Activities of Medical Associations Based on the Antimonopoly Act (August 7, 1981)

"Doctor" is one type of business associated with the health professions. As already noted, if a doctor satisfies certain requirements, the Antimonopoly Act is applied to the doctor as an entrepreneur. Medical associations that exist as professional bodies of doctors are not always invariable, and do not necessarily fall under the definition of entrepreneurs' associations based on the Antimonopoly Act. However, if a medical association satisfies certain requirements, the Antimonopoly Act is applied to the association as an entrepreneurs' association. If a medical association as an entrepreneurs' association commits an act to restrict competition, for example by limiting the number of present or future medical institutions in a certain business area on the pretext of proper placement of medical institutions, or if a medical association commits an act to unjustly restrict the function and activities of doctors who are members of the association, then such acts shall be regarded as violations of the Antimonopoly Act. Therefore, the JFTC published the "Guidelines Concerning the Activities of Medical Associations Based on the Antimonopoly Act" in 1981, based on the results of an investigation concerning the activities of medical associations and cases in which the activities were deemed to be violations of the Antimonopoly Act.

With respect to whether the Antimonopoly Act is applied to a medical association, the Guidelines stipulate that if a medical association is purely an academic association, the medical association is not regarded as an entrepreneurs' association based on the Antimonopoly Act. However, if a medical association is an association for the purpose of increasing common profits as an entrepreneur, the medical

association is regarded as an entrepreneurs' association based on the Antimonopoly Act and the Act is applied to it. The following acts conducted by medical associations deemed to be entrepreneurs' associations are classified as "acts in violation of the Antimonopoly Act in principle," "acts that may be in violation of the Antimonopoly Act" or "acts not in violation of the Antimonopoly Act in principle": (i) acts that restrict the opening of a new medical institution, (ii) acts that unjustly disrupt business activities, (iii) acts that prepare freely decided medical fee tables, etc., or (iv) acts concerning medical care hours and advertisements.

For example, if based on its code or the like, a medical association limits the number of medical institutions in a specified area, limits the distance between two medical institutions, or decides on optional medical services fees and document fees, then the association will be acting against the Antimonopoly Act in principle because these acts will unjustly restrict the business activities of the association's members, or may substantially restrict competition in the area. In contrast, if a medical association provides reasonable advice in response to an approach by a party wishing to establish a medical institution, encourages a member to show its fee table, or unifies the form of fee tables, then it will not be acting against the Antimonopoly Act in principle.

2. Major Cases Violating the Antimonopoly Act in the Medical Services Business

1998 (Decision) No. 26 - The case against Hamakita City Medical Association

To prevent medical institutions from acquiring patients through their advertising activities, Hamakita City Medical Association unjustly restricted the function and activities of its members by (i) restricting the media and timing of advertisements other than signboards, (ii) limiting the place and number of signboards, and (iii) requesting members who had already displayed a signboard restricted in (ii) above to remove it.

2004 (Decision) No. 18 - The case against Yokkaichi City Medical Association

- At a meeting of its board of directors held around October 15, 2002, Yokkaichi City Medical Association decided to set the fee for flu vaccination given by its members to persons aged less than 65 at 3,800 Japanese yen or more per vaccination in and after October 2002, which substantially restricted competition in the field of trade of flu vaccinations within the area of Yokkaichi City.

- The said medical association also restricted the opening of a medical institution by its members, any increase in the number of types of diagnosis and treatment, and any increase in the number of sickbeds based on an internal code of the consultation committee on the opening of medical institutions.

The above medical association thus unjustly restricted the function and activities of its members.

IV. Examinations and Reports from the Perspective of Competition Policy for the Medical Services Business (Proposals)

The JFTC has conducted examinations on the actual competitive situation in the medical services area. For example, in 1997, when the Japanese yen became stronger and price differences for goods and services were observed inside and outside Japan, the JFTC examined the status of distribution and trade practices for certain medical equipment with such differences. In addition, the JFTC conducted an examination into the situation concerning restrictions on advertising and new shop or store openings by pharmacies and drug stores in 1998.

Furthermore, regulatory reforms have recently been promoted in Japan. Even in areas where new market entries, withdrawals, volumes, prices, and other factors are directly regulated and controlled with the purpose of ensuring health, hygiene and safety, preventing environmental pollution, and preserving the environment, many problems have been cited in terms of the diversity and efficiency of services given changing public awareness and the new economic environment. Entrepreneurs are therefore required to improve efficiency by displaying originality and innovation. Also, reform of the systems by which services can be provided to meet diversified needs has become an issue.

From the above perspective, the JFTC examined the state of regulations in the medical services area and approaches from the viewpoint of competition policy in 2002. Presented below is the result of the study and proposals by a study group held by the JFTC consisting of experts (which are not the views of the MHLW that supervises the medical field).

"State of regulation in the medical services business and approach from the viewpoint of competition policy"

The JFTC convened the Study Group on Government Regulations and Competition Policy and published the report titled "State of regulation in the medical services business and approach from the viewpoint of competition policy" prepared by the Study Group in November 2002.

This report is based on the viewpoint that (i) in order to realize medical services for patients as consumers a system is essential whereby patients can choose medical institutions according to their needs and medical institutions compete with each other, (ii) while at the same time, it is important to enhance the negotiation power of patients and insurers to review regulations at both the supply and demand side in order to promote competition in this area and bring benefits to them. Based on this viewpoint, the report points out the following:

- Promotion of competition among medical institutions
  - Review of restrictions on opening hospitals
  - Regulations on the total amount of beds should be reviewed through preparing a system of promoting competition among medical institutions.
  - Review of restrictions on opening medical institutions and management
  - Regulations on the entry of joint-stock companies, etc., based on the Medical Law should be reviewed to enable current legally incorporated medical institutions to change their status to stock companies or stock companies to open and run medical institutions.
  - (Note) in the special zone of structural reform, regulations on opening hospitals or medical offices (or clinics) by stock companies were removed, offering advanced medical services not compensated by the national health insurance and after October 2004 (revised Structural Reform Special Zones Act, promulgated in May 2004) (see II Structural approaches).
  - Review of the medical fees system
  - Shifting the system of medical fees to one in which improvements in the quality of medical services are reflected directly on the management of medical institutions should be considered.

- Review of mixed medical services
- Approving mixed medical services should be considered by making the standard of listing insured items and the scope of application of public insurance clear. In this case, it is assumed that patients are required to judge the rationality of mixed medical services, so medical institutions should be obliged to disclose proper information to patients.
- Securing the number of doctors
- In order to realize the proper arrangement of doctors and improve the quality of medical services through competition among doctors, such measures should be taken as improving the clinical training system and introducing a renewal system for medical licensing, without cutting down the number of new doctors under conditions of doctor shortage.

- Choice of medical institutions by patients and the insurer
  - Review of regulations on advertisements
  - In order to ensure the interests of choosing medical institutions by patients and promote competition among medical institutions, advertising by medical institutions should be made less restrictive on the condition that measures are strengthened to secure the truth (or authenticity) of advertisements and eliminate inappropriate ones.
  - Choice of medical institutions by the insurer

    (a) Implementing contracts between the insurer and medical institutions

    The option of designating medical institutions, which is currently made by the central government, should be left to the choice of the insurer and approving direct contracts between the insurer and medical institutions should be considered.

    （notes）For the direct contact between insurer and medical institution, Health Insurance Bureau released the notice on 20th May,2003 after paying attention to ensuring of free access.

    (b) Implementing discount contracts

    In addition to approving direct contracts between the insurer and medical institutions, making it possible to make discount contracts between them should be considered.

The role of the JFTC

As the review of regulations in the health professions progresses, it is becoming more important to exclude the anti-competitive practices of entrepreneurs through enforcement of the Antimonopoly Act, as well as promote more active competition among entrepreneurs in health professions. The JFTC needs to watch whether entrepreneurs and trade associations, or administrative guidance, restrict competition, whether they exclude new entry and whether they conduct cartels in the liberalized industry. If the acts above do take place, the JFTC must take measures to strictly prohibit violation of the Antimonopoly Act. The JFTC also needs to make proposals on regulatory reform and follow the current situation of reform, conduct surveys and publish their results after deregulation.

V. Conclusion

The JFTC has strictly applied the Antimonopoly Act to areas in the health professions in case of anti-competitive practices and endeavors to make entrepreneurs conduct fair trade by demanding industry associations to enlighten their members about the contents of JFTC guidelines if they are suspected of conducting anti-competitive acts.

Many regulations exist in the health professions, however, patients as seekers can have more choices in medical services by promoting regulatory reform, which leads to enhancing services among competitors. The JFTC thinks that it is important to take strict measures to prohibit violations of the Antimonopoly Act so as not to damage the fruits of regulatory reform.

And, according to the MHLW, in health professions, competition has been being promoted in various ways, such as deregulating legal expressions in advertisement, promoting evaluation of function of medical facilities executed by neutral organizations, and so on. These measures for promoting competition are practiced, from a point of view that it is important that the government steadily carries out policies, which help patients choose medical facilities and promote competition, while the government establishes and maintains necessary regulations to provide people with good and adequate medical services.

KOREA

I. Introduction

The health professions in Korea have a long history. Since the 10th Century, the government organized examinations to issue licence to doctors. From the late 19th Century, there came the influx of western medicine. Currently, both Korean and Western medicine are recognized as official health profession.

Although the history of health profession is long and extensive, the medical service market is about to go through a major change. For the last few decades, having a licence to be a physician was very much appreciated. This was because there were not many doctors in the past. However, with increasing number of doctors and intense competition, many doctors and hospitals are going bankrupt, except for certain areas such as cosmetic surgery and ophthalmology.

With increased competition, the health profession and hospitals will seek new ways of business for sheer survival. There may be business combinations and joint ventures. Also, there may be even more false and misleading advertisements. This will increase the role of competition authority, which already has authority to enforce the Monopoly Regulation and Fair Trade Act to the health sector.

This submission will examine the current regulations surrounding the health professions and actions take by the Korea Fair Trade Commission, the competition authority of Korea.

II. Market Regulations in the Health Professions

1. Structural Regulations

a) Trend in number of physicians in Korea

To become a doctor in Korea, a person must have an appropriate BSc degree. The same is true to become a pharmacist.

There is not much migration of doctors in Korea. A physician from overseas cannot directly practice medicine in Korea. However, a physician will be given an opportunity to take a licence examination, without having to take a pre-licence examination, which must be taken by medical students in Korea. As for pharmacist, a student or an overseas pharmacist who studied relevant subject abroad can take the national examination to become a pharmacist.

While this is the case for Western medicine, which is rather universal, a doctor of oriental medicine from abroad cannot take the licence examination for oriental medicine in Korea. For instance, a student who studied Chinese medicine is not recognized as a suitable candidate to take the examination.

The number of physicians is determined by the number of medical students in universities as only the graduates of medicine can take the licence examination. This number is determined after close consultation between the Ministry of Health and Welfare and the Ministry of Education and Human Resources.

Restriction imposed on foreign licence holders and control in number medical students may result in shortage of physicians. However, the opposite is the case.

The number of doctors steadily grew from the 1980s. In 1980, there were only just over 20,000 doctors, which meant that a doctor was responsible for over 1,600 people. The number of doctors have increased to nearly 80,000 in 2003. Now, a doctor is responsible for only 606 people, which is almost a third of the figure for 1980.

Table 4. Number of Doctors and Population per Doctor

	Number of Doctors	Population per Doctor
1980	22,564	1,609
2003	78,609	606

* Excludes dentists

This figure is also comparable to other more developed countries. According to the Human Development Index published by the UNDP in 2004, Korea has 180 doctors per population of 100,000. The figures for Japan and Britain are 202 and 164, which are not too different.

b) Exclusive Rights of Healthcare Professionals

The health profession are endowed with exclusive rights. According to the "Medical Service Act", there are 5 different medical profession. They are doctors, doctors of Korean medicine, dentists, nurses, and midwives. By law, they are the "Medical Service Professionals."

To assist these professionals, there are also "Medical Technicians." Good examples are dental hygienist and physiotherapist. These technicians cannot practice by themselves nor can they operate a clinic by themselves. The technicians can only practice under supervision by a doctor or dentist.

There are also professions that practice expertise that are similar to medical service professions. The Articles 60 and 61 stipulates the existence and limitations of these professions. They are chiropodists, moxa cautery experts, acupuncture experts and massagers. These professionals are prohibited from calling their practice "hospitals" and they cannot call themselves "medical service professional." Instead, they are referred to as "clinics" and "practitioners".

c) Restrictions on Establishment of Medical Facilities

There are restrictions on establishment of hospitals. According to Article 3 of the Medical Service Act, 9 types of medical facilities. They are general hospital, hospital, dental hospital, Korean medicine hospital, recuperation hospital, private clinic, private dental clinic, private Korean medicine clinic, and maternity hospital.

Table 5. Characteristics of Medical Facilities

Facility	Characteristic
General Hospital	Over 100 beds, over 9 treatment areas
Hospital	Over 30 beds
Dental Hospital	"
Korean Medicine Hospital	"
Recuperation Hospital	Over 30 beds for recuperating patients
Private Clinic	Treats out-patients
Private Dental Clinic	"
Private Korean Medicine Clinic	"
Maternity Hospital	Midwifery, healthcare of mother and newborn

Maternity hospital is the only medical facility that can be established by a person who is not a doctor. Nevertheless, a maternity hospital is required to have a supervising doctor.

As it is stipulated in Article 30-2 of the Medical Service Act, Only the following can establish a medical facility. They are, medical professionals, central or local government, healthcare company, non-profit company, and National Veterans Welfare Corporation. As for the medical service professionals, one professional can only have one facility.

There are also restrictions on establishment of pharmacies. A western pharmacist or Korean medicine pharmacist can only own and run one pharmacy. The pharmacy must be operated and managed by the owner. As it is stipulated in Article 41 of the Pharmaceutical Affairs Act, drugs can only be sold at a registered pharmacy. This prevents drugs being sold on the internet and post. A violator can face up to either 3 years imprisonment or fine of 10,000 Won(Approximately 8,600 US Dollars). However, supplements such as vitamins and squalene oil can be sold off the pharmacies.

d) Consumer Redress Issues

As the patients have gained greater knowledge of medicine through various sources, the number of medical disputes have increased. In 1995 there were only 115 cases of medical disputes, but by 2003, the number has increase to 755.

To resolve such disputes, the Ministry of Health and Welfare has been operating "Medical Review and Coordination Committee" at both central and local government level. However, not many cases are settled here. For instance there was only 11 cases filed to the committee in 2003.

The Consumer Protection Board has a "Medical Dispute Coordination Committee". This committee has been more active and has issued recommendation for compensation for 424 cases in the same period. Unfortunately, the Board has no power to see to it that the hospitals compensate to their patients.

Nevertheless, the increase in disputes reflect that the powers of the patients have increased. Often the compensation in very high. This can have a noticeable effect on the way doctors treat their patients. For instance, the doctors in fear of possible dispute, will become risk-averse and will opt for the safest treatment. This is even more so when the government through government subsidizes part of treatment cost. Such risk-averseness of doctors will in effect, raise costs for the patients.

2. Behavioral Regulations

a) The Professional Associations

The professional associations exit in accordance with Article 26 of the Medical Service Act. Their purpose is to enhance professional ethics and to promote their rights.

Although there has been no case concerning fee setting, sometimes these associations take actions which is against the Monopoly Regulation and Fair Trade Act. The most significance case was when the Physician Association refused treatment against government decision to take away physicians rights to compound medicine.

b) Restrictions on Advertisements

Advertisements are not restricted by agreement among members of the association, but by Chapter 4 of the Medical Service Act and its enforcement rules(Enforcement Rule Article 33).

According to the Enforcement Rule, hospitals and physicians are not permitted to advertise on television or radio. For daily newspapers, they can only have two advertisements per month. Because of such restrictions, hospitals and physicians are utilizing the internet, as most of Koreans have access to the internet.

In Korea medical advertisement can only carry the following information.

- Name, gender and qualification of physician
- Area of practice
- Name, address, contact, and website
- Business days and hours
- Availability of emergency room
- Reservation hours
- Availability of Weekend and holiday treatment
- Availability of parking space

Strict regulation on advertisement have caused some impracticalities. The rule prohibits a hospital from using words that mean a type of diseases or a word that may confuse a patient in finding the right area of practice. For example, a hospital that specializes in piles and hemorrhoids cannot use a name such as "The Anus Clinic." To dodge such regulations, hospitals would use words that rhymes with "Anus."

III. Competition Law Enforcement in the Health Sector

As it was explained earlier, the Korean competition law is a comprehensive act, which is also applied to the health sector. However, the health industry is still in its early stage of development and competition law violations are found and corrected in only certain areas.

a) Violation of Article 26 of MRFTA

In 2000, the Ministry of Health and Welfare changed to a system where the National Health Insurance will only compensate the doctors for drugs according to actual price, not according to the price set by the government to promote transparency. Also, doctors role has been limited to prescribing drugs whereas they were able to dispense drugs in the past.

Against such decision by the government, the Korean Medical Association(KMA) formed 'Medical Rights Protection Committee' and held meetings to reach an agreement where they would stop treating patients. The Committee had also sent letters asking the Korean Hospital Association(KHA) to stop taking out-patients. The KHA has also urged participation of hospitals by circulating its newsletter.

The KMA and the KHA are business associations as defined in Article 26 of the MRFTA. These association have substantial power over its members. Not abiding by the agreement would have deprived its member of the membership and in more extreme case, impose financial sanction on its non-complying members. As a result, the KFTC decided to prosecute 102 individuals who were core members of the KMA and KHA and the two associations concerned.

b) Violation of Fair Label and Advertisement Act

Plastic surgery clinic is one of most profitable clinic in Korea. Therefore, the competition is quite intense. The 'Korean Cosmetic Surgery Specialist Association' has made an advertisement in one of Korea's leading women's magazine, which read 'Cosmetic Surgery by Quack Doctors Result in After-effects.'

In Korea, plastic surgery can be practiced by not only the clinics specializing in cosmetic surgery, but also by doctors who specialized in internal medicine and ophthalmology. The KFTC decided that this case is a false advertisement as stipulated in the Article 3-1 of the Fair Labeling and Advertisement Act, because the public might be misled to believe that the qualified doctors who are not members of the 'Korean Cosmetic Surgery Specialist Association' are quack doctors who are not qualified to practice plastic surgery. The KFTC gave a correctional order and ordered the association to publicize in a national press that it had violated the Fair Labeling and Advertisement Act.

c) Violation of Adhesion Contract Act

Many general hospitals and hospitals have funeral service because the service is quite profitable. In 2001, the KFTC investigated 40 funeral service providers as part of 'Clean Market Project(CMP)', which was a targeted investigation. Among the 40 funeral service providers, 13 were found to have adhesion contracts that are unfair.

The provisions of the adhesion contracts that were seen as being unfair were as following :

- The customer shall bear responsibility for all accidents occurring in the premise, irrespective of circumstances
- Upon termination of contract, the customer must return the premise to the provider within 3 hours and pay the rent despite termination
- In case of dispute, only the interpretation by the provider will be valid

The KFTC decided that in the adhesion contract, there should be no immunity provision(Article 7 of the Adhesion Contract Act), there should be no undue burden on customer upon termination of contract(Article 9-3), and that the contract should not go against the principle of good faith(Article 6-1).

In November 2001, the KFTC drafted a 'Standard Adhesion Contract' for funeral service providers. The service providers that adopted KFTC's standard adhesion contract can promote themselves of using the contract, and it is expected that the consumers will be able to choose the providers that use the standard adhesion contract.

d) Violation of Article 23

Article 23 of the MRFTA concerns regulation of unfair business practices. One form of unfair business practice is 'tying in sale.' The above-mentioned funeral services provided by hospitals have violated this regulation in the past. Often the funeral service provider will bundle-up different services and coerce the customer to use the bundled service. Most common types of 'tying in sale' are:

- Coercion to use funeral car provided by the service provider
- Coercion to use its own catering service

- Coercion to use shroud provided by the service provider
- Coercion to use casket provided by the service provider
- Coercion to use funeral service helpers

In 2001, the KFTC ran a series of investigation on funeral service providers and gave corrective orders to the providers that violated the Article 23 of the MRFTA.

IV. Conclusion

As it can be seen, there has not been many cases that are related to traditional competition issues such as mergers and cartels. Most cases were regarding false advertising in fairly competitive plastic surgery and ophthalmology practices.

However, the market is going through a change. Many hospitals and private clinics are beginning to go bankrupt with increasingly intense competition. It is expected that the hospitals and clinic will seek new business models such as diversifying to geriatrics clinics with elderly housing and franchise. This means that the possibility of MRFTA violation might increase. The KFTC which is the enforcer of the MRFTA, a comprehensive competition law, will keep its eyes on the health market and promote competition culture by way of proactive advocacy in the sector.

MEXICO

1. Introduction

This paper focuses on the medical services sector, but also covers issues that apply to professional services in general. In Mexico, the competitive environment for this sector is markedly different from that of other OECD countries. Institutional purchasers (insurance companies) are relatively small in size, so that professional medical services are either directly provided by the government and purchased by those enrolled in the social security network, or are provided by individuals or associations of individual practitioners and paid directly as out-of-pocket expenses by the patient.[1] In this sense, and contrary to other countries, Mexican consumers, especially those that purchase services in the private sector, are particularly sensitive to price.

Another important difference between Mexico and other economies, is the degree of informational asymmetry between doctor and patient that characterizes the relationship. To the extent that information is not public or compulsory, a patient lacks information about the doctor's experience (including negligent behaviour), certification, etc. Furthermore, data such as prices, for example, have not yet been systematically collected, making oversight particularly difficult. In this context, self regulation for professional health services in Mexico becomes even more important.

Although competition law is fully enforceable in the sector, the competition agency has so far only reviewed mergers among hospitals. Nevertheless, competition advocacy, in the sense of reviewing existing legislation and rules, seems to be an important way in which the Federal Competition Commission (FCC or the Commission) can promote a more appropriate balance between the different objectives pursued by numerous sectoral regulations, and the need to ensure competition in the health professions.

2. Legal Framework

In Mexico, professional services are subject to a number of regulations that can be broadly classified into two categories: i) regulations relating to the necessary qualifications required to practice the profession under standards of professional competence and ii) regulations affecting competitive conditions within the profession, such as restrictions on price, entry, advertising and forms of organisation. According to Article 5 of the Mexican Constitution, no person can be impeded from exercising a profession, however, the legislation of each state determines the professional activities that require a title and the means of obtaining such a title. In general, the obligation to hold a title to practice a profession is widespread.

Although most states have their own Law of Professions these are not the only determinants of professional activities subject to regulation. In addition to state laws aimed specifically at regulating professions, there are numerous laws and regulations, both at the federal and the state level, that regulate the practice of certain professions.

The Law of Professions in the Federal District (LPDF) not only applies to the capital city, but covers matters of a federal nature and contains some provisions that regulate the boundaries of applicability, entry into the professions, professional associations, etc.[2] Article 78 of the General Law of Health (LGS) establishes that health professions, technical and auxiliary activities and specialties are subject to the

following regulations: i) the LPDF, ii) coordination between education and sanitary authorities; iii) provisions of the LGS and other applicable legal rules and iv) laws issued by state governments.

For the medical services sector, the public sector regulates indirectly by overseeing the market, by providing fiscal subsidies and, more importantly, by directly competing with the private sector in the provision of medical services.

3. Structural regulations

The LPDF establishes that the Federal Executive, through the General Directorate of Professions (DGP) of the Ministry of Public Education, defines the fields of action for each profession as well as its boundaries after hearing from the professional associations and their technical committees. Since the 1994 amendments to the LPDF, there have been no requirements relating to either nationality or professional titles obtained abroad. Any professional can register, under certain conditions, before the DGP to obtain a license.[3] The LPDF also establishes that the registry of foreign titles be carried out according to guidelines established in international treaties where Mexico is a signatory, or on the basis of reciprocity. In the absence of such treaties, the principle of reciprocity implies that foreigners applying for a license in Mexico must demonstrate that their home countries also grant licenses to title holders from Mexico. In all cases foreigners must comply with a social service requirement.[4]

Government regulation establishes basic, standard procedures and sanitary specifications that a professional must follow when providing his or her services. For example, a physician must have a professional certificate which guarantees that the service provider has minimum academic credentials and practical knowledge. This certificate, however, does not indicate the extent of the physician's length of practice or whether his knowledge is up-to-date.

Mexican Official Standards (*Normas Oficiales Mexicanas*, or NOM's) are an additional compulsory instrument aimed at guaranteeing the quality of medical services and at protecting users against health risks and negligence. At present there are 100 NOM's in force relating to the provision of health services. Most NOM's include two types of dispositions: i) those aimed at preventing, detecting, diagnosing, treating and/or controlling a specific medical condition; and ii) those aimed at indicating the correct use and handling of equipment, substances and other hazardous and non hazardous materials involved in the provision of medical care. Additional NOM's regulate medical practice in areas such as anaesthesia and outpatient surgery, as well as in specific medical services such as mental hospitals, emergency attention and clinical laboratories.

Self regulation in the sector also exists through councils of medical specialties which grant specialty certificates to those professionals that undergo and pass an exam. However the value of these certificates as a means of passing information onto the user about the quality of the medical service received is limited, as there are no requirements to post them either in private offices or publicly. Moreover, while the specialty certificate ensures that the doctor has passed a first time quality screen within a medical specialty, they do not provide information on whether the specialty physician has sufficient or adequate practical experience.

3.1 Organisational structure

There are no legal restrictions on the type of organisational structure that professional associations in the medical services sector must follow. In principle, professionals may freely associate themselves with other professionals or even with non-professionals. Liability and responsibilities are not limited, but remain individual (Article 40 of the LPDF). In fact, according to the LPDF professionals may form a practice within their profession, in accordance with the relevant legislation, but still remain individually liable.

The LPDF does not establish a membership obligation in order to practice, and this determination has been ratified by the Supreme Court, which ruled that the principle of free association established under Article 9 of the Mexican Constitution excludes the possibility to make membership mandatory. Thus, both members and non-members can practice a medical profession.

There are 47 medical specialty councils in Mexico, coordinated by the National Medical Academy through the Conacem (National Normative Committee of Medical Specialties). These councils are: anatomopathology; anaesthesiology; angiology and vascular surgery; audiology, phoniatry, and human communication; cardiology; thorax surgery; general surgery; facial-maxillary surgery; neurological surgery; pediatric surgery; aesthetic, plastic, and reconstructive surgery; dermatology; colon and rectal diseases; endocrinology; gastroenterology; genetics; geriatrics; gynaecology and obstetrics; haematology; infectology; clinic immunology and allergies; aerospatial medicine; critical medicine and intensive care; sports medicine; family medicine; internal medicine; rehabilitation medicine; legal and forensic medicine; employment medicine; emergency medicine; nuclear medicine; pneumology; nephrology; clinical neurophysiology; neurology; ophthalmology; oncology; orthopaedics and traumatology; head surgery and ears, nose and throat; clinical pathology; paediatrics; psychiatrics; radiology; radiotherapy; rheumatology; public health; and urology.

Medical specialty councils are civil associations created by specialists to regulate their actions based on certain educational foundation requisites and practical training in each field of the medical profession, as well as on the proof of abilities through certification examinations. Each of these councils is responsible for the granting of specialty certificates to physicians who request one and have different modes of certification and participation. A medical doctor of any of the above specialties should be certified by its council.

In general, each council gives written and oral exams to candidates who must prove that they have the adequate education required to be a specialist medical doctor. Certification must be renewed every 5 years, implying that councils also evaluate whether specialists have kept up-to-date by reinstating examinations that require approval for the reissue of new certification for the next 5-year period. Not passing the exam does not cancel membership or revoke a medical license.

According to the Article 2 of the Conacem's ruling code, it is responsible for:

- Establishing the requisites that the Medical Specialty Councils must satisfy in order to reach a level of adequacy.
- Receiving, studying and considering initial requests for adequacy by Medical Specialty Councils.
- Bestowing acknowledgement of adequacy to one and only one council for each medical specialty and granting the corresponding document.
- Studying and providing advice about the creation of sections or subspecialty areas within each council.
- Authenticating the acknowledgment of adequacy of the councils every five years and granting the corresponding documentation.
- Receiving, studying and answering the reports that Medical Specialty Councils must render to the Conacem.

- Receiving, investigating, considering and solving complaints and controversies arising from actions by Medical Specialty Councils.

- Requesting information from Medical Specialty Councils on: a) requisites to accept candidates for certification, b) examination systems for candidates seeking certification, c) results of the process of certification, d) evaluation methods aimed at maintaining a valid certification, e) complete results of the prior certification process.

- Requesting information from Medical Specialty Councils about their internal mechanisms to verify that their requirements, statutes, and rules are in force.

- Reviewing and updating, if necessary, requirements, statutes, rules and reports of Medical Specialty Councils.

- Registering certification diplomas.

- Periodically meeting with the presidents or boards of directors of Medical Specialty Councils.

- Informing Medical Specialty Councils of any agreements and decisions that may affect them.

- Summoning, at least once a year, presidents of Medical Specialty Councils to receive a report on their activities.

- Registering and filing all official documentation sent by Medical Specialty Councils.

- Registering and filing agreements and decisions made by Conacem that would serve for consultation, reference, and precedent for future decisions.

- Administering its budget.

- Every two years, reviewing and modifying its constitutive document and rules, if necessary.

- Periodically elaborating a directory of certified and re-certified specialists for each council, acknowledging its adequacy and validity, and determining and verifying its correct distribution.

- Through the boards of directors of the Academies, submitting to the legislative and executive powers any proposed modifications to laws and regulations aimed at endorsing the responsibilities of councils and continuing education of specialists.

Members certified by councils have the advantage of proving a degree of knowledge in their field that signals trustworthiness to the patient. Certification also protects patients from informational asymmetries, assuring patients that their doctor knows the latest trends, within a five-year span, in the discipline.

It is noteworthy that neither the certificate nor its renewal are compulsory, and do not represent a license to practice the specialty. So the possibility remains that a specialist doctor practices without being certified by a council. The effectiveness of certification largely depends on the availability of this information both to consumers, who ultimately have the choice in selecting their practitioner, and to doctors themselves whose standing and reputation is aided by certification.[5]

3.2 Negligence and civil liability

Medical malpractice is fought through preventive and corrective mechanisms which include conciliation, arbitration and the judicial system. In general, Mexico's liability regime could be characterised as "light" in the sense that consumers may not have substantial protections, and that incentives for the behaviour of health professionals are not dramatically impacted by the regime.

The object of the government's preventive participation is to compensate the consumer for informational disadvantages and to guarantee the reliability of medical services providers. This participation includes oversight of certification mechanisms for physicians and hospitals, as well as the establishment of standards and therapeutic guidelines for specific medical treatments and procedures. The executive branch has also established conciliation and arbitration mechanisms aimed at solving controversies arising from medical practice before these reach the judiciary.[6]

The judicial branch, based on current laws on civil liability, implements corrective measures including compensation of damages caused by a practicing medical professional.[7] In Mexico the law recognises two types of compensation for damages arising from physician negligence: material and moral. Article 1915 of the Federal Civil Code (CCF) establishes that the injured party may choose whether compensations can be provided by restoring the prior situation whenever possible, or through a monetary payment covering damages.

Material damages

Mexico has no jury system therefore determination of indemnity is subject to a judge's assessment. Elements such as the existence of an appropriate care standard, experts' participation, and compensation estimating rules, are used to diminish subjectivity when determining material damage. Material damage determination takes into account but-for future incomes lost due to disability or death. The calculation of wages or incomes lost by patients as a result of temporal or irreparable disability or even death is based on: i) a fixed amount of 4 minimum wages established by the CCF and ii) the number of days that will be paid, which is established according the Federal Labour Law (LFT).[8] Thus, compensation would be overestimated if the expected income of the patient were lower than four minimum wages and underestimated if the expected income were higher.

Damage for temporal disability (partial or total) must take into account days when the patient could not effectively perform his activities, but is limited to 1,095 days in the case of total irreparable disability. Partial irreparable disability is calculated on the basis of a fraction of recognised days for total irreparable disability. This fraction varies according to the type of partial disability. Based on future income damage resulting from death is limited to only 730 days (Article 502 of the LFT).[9] In addition to damages based on future income, directly or indirectly affected persons (relatives, in case of death) may sue and claim additional compensation for material damages such as funeral, hospital and other similar expenses. However, some of these damages are also capped: legislation establishes that compensation for funeral expenses should be 60 disability days at a rate of 4 minimum wages per day (US$15.70 per day).

Moral damages

In the case of moral damages, article 1916 of the CCF establishes that indemnity will be determined by a judge taking into account injured rights, level of liability, economic status of the liable person and that of the affected person, as well as other case circumstances. Hence, legislation does not limit the compensation for moral damage. However, even though there is no information available, it is generally thought that the costs of trial are considerable relative to the indemnity amounts determined at trial.

Since codes of conduct imposed by professional associations are not binding, as professionals have the option to decline or resign as members of the association without losing their license to practice, self-regulation can do little to discipline negligent physicians. Furthermore, since malpractice insurance is not common in the medical sector the cost of insurance does not serve as an instrument that checks medical behaviour.[10]

3.3 Competition law and policy in the sector

Health professions are not exempt from the Federal Law of Economic Competition (FLEC). Therefore, monopolistic practices and conduct, for example, price fixing agreements that professional medical associations could potentially promote can be challenged as absolute monopolistic practices. Likewise, attempts to unduly displace competitors from the market or to impede their access may fall under the category of relative monopolistic practices prohibited by the Law. To date, no cases dealing with monopolistic practices in the medical professions have arisen and the Commission has only investigated mergers among medical services providers (hospitals) that meet or pass thresholds established under the law and are therefore subject to notification.[11]

4. Behavioural regulations

4.1 Conduct rules

There are no legal impediments to advertise professional services in Mexico. The only restrictions are laid out in the Codes of Ethics of professional associations, where membership is not compulsory. The DGP, in co-operation with 19 professional associations, wrote a Code of Ethics for professional associations that contained some provisions relating to advertising. Article 10 establishes that a professional should offer services in accordance with his or her scientific and technical capabilities, and that this behaviour should be observed in the publicity used to promote said services. In light of the non-compulsory character of these recommendations, it is not surprising that a fair amount of publicity takes place in the professional services sectors in Mexico. Although not especially aggressive, it definitely goes beyond the mere announcement of names.

In terms of professional specialists, technical or auxiliary persons who practice health care activities, Article 83 of the LGS notes that they must show the institution that granted them their title, diploma or certification and, if that is the case, its professional license number. This information must also be provided in any documents and papers used when they are practicing and through any advertising they make. According to Article 300 of the LGS, the Ministry of Health is in charge of authorising advertising regarding health, disease treatment, rehabilitation and the practicing of health care professions. The Rulings of the LGS establish that advertising for medical or paramedical techniques and treatments must be authorised by the Ministry of Health, and that the Ministry will not authorise advertising that disregards regulation dealing with prevention and treatment, when it offers treatments that have no proved effectiveness, or when the technical capabilities of the service provider cannot be proved.

4.2 Fee setting

One of the principal problems encountered when making an assessment about the level of competition in the market for medical services in Mexico, is the lack of price data in both the private and public sectors. With this limitation in mind, this section lays out potential issues relating to fees and their setting in both the public and private sectors.

According to Article 43 of the LGS, social and private health care services are subject to tariffs set by the Ministry of the Economy, prior to consultations with the Ministry of Health, with the exception of

independent personal services.[12] Article 7 of the FLEC,[13] implicitly exempts fee setting for products and services deemed essential.

The LPDF establishes that one of the objectives of a professional association is to propose indicative fees, meant as a guideline for professionals without being enforceable. The Mexican Association of Pediatric Surgery, for example, mentions that it is in charge of establishing fair fees to be used by insurance companies' tabulators, but makes no mention that it will do so in the case of the general public. Another possibility is that fee setting could partially take place in the face of monopsonic power held by insurance companies, although this market is still relatively small in Mexico. In 2002, for example, only 3% Mexicans had private medical insurance.[14] Still there is a possibility that this information could serve as an instrument for tacit price coordination. In the Commission's experience, however, there are only few cases dealing with fee determination by professional associations; most notable are cases relating to notaries and customs agents.[15] Although the FLEC also applies to the health professions, to date, the Commission has not received a case alleging unlawful monopolistic practices (either vertical or horizontal) by physicians or other medical professionals.

In the private sector, there is no price regulation nor are there mechanisms that estimate costs of medical services for institutional purchasers or individual persons. Therefore, the repayments to hospitals by insurance companies are based on itemizing inputs, not on products or outcomes. Cost information for these inputs is proprietary. Nevertheless, studies exist illustrating how prevalent insurance-based payments are in the private sector. According to the results of a survey carried out by Rivero-Serrano, Tanimoto and Paredes among different certified specialist doctors,[16] 58.8% of specialists stated that they offered services to patients insured by several insurance companies, 17.6% offered services to patients insured by only one company, while 9.1% of these doctors said they did not accept payment through an insurance company. For those doctors accepting payment from insurance companies, 51.4% said that the payment they received from these companies was less than 25% of their normal fees, 36.5% claimed that they received a reasonable payment – over 50% of what they charged normally. Also, 52.9% of doctors considered that they had lost autonomy to the insurance companies when exercising their profession. Nevertheless, 68% of them said that they did not discriminate in their treatment of patients, regardless of their mode of payment.

Prices in the public sector consist of fees paid by users (and their employers) to the social security system, as well as non monetary factors (opportunity costs), such as waiting time to acquire the services. In the public sector, payments to physicians for surgeries are significantly lower than those in the private sector. The public sector allots a fixed wage to physicians, irrespective of the number or surgeries or operations they undertake. This economic disadvantage is partly offset by the significant learning-by-doing that takes place in the public sector, where the number and potential complexity of surgeries contributes towards the building of human capital and professional growth of medical providers.

4.3 Contractual mechanisms

Payments to health professionals in Mexico mainly flow from three different sources. First, as was mentioned above, out-of-pocket payments from ultimate users of health care account for roughly half of total expenditure on medical services. Therefore, a considerable share of physician's income is received directly from the uninsured patient at the point of service. Second, health professionals providing services at public hospitals receive payments from the government either directly or through their health institutions. Finally, health professionals providing services to privately insured patients receive payments from private insurers.

In Mexico there is no general public regulation governing pricing of medical services or payment delivery to providers. Moreover, institutional contractual arrangements differ significantly across institutional payors. Health professionals at public hospitals receive a salary for providing their services,

regardless of the number of patients they see or the services actually provided. There are no salary adjustments based on capitation or the complexity of delivered services. This system usually implies more control on health care costs at the expense of appropriate incentives for the professional to perform. The last implication being accentuated in Mexico since users of the public system are not allowed to freely choose their providers.

In contrast, private institutional purchasers of health care, mostly private insurers, pay health professionals on a fee-for-service basis, under a procedure-specific schedule of prices either mandated by the insurer or previously negotiated between the insurer and the hospital to which the health professional is affiliated. In case there is no previous agreement between the insurer and the provider, the professional has financial incentives to perform well but also an incentive to prescribe "excessive" treatment.

5. Concluding remarks

Health care services in Mexico are subject to sector specific law and regulations, a law of general character, and codes of conduct imposed by professional associations. While an academic title is required for practicing, there are no general nationality requirements and registering of foreign titles is done according to guidelines established under international treaties or on the basis of reciprocity. In addition, there are no legal restrictions on the type of organizational structure that professional associations in the medical services sector must follow.

Government regulation establishes basic, standard procedures and sanitary specifications aimed at ensuring that services be provided by qualified persons, guaranteeing the quality of medical services and allowing for patient in cases of health risk and negligence. Self regulation also exists through councils of medical specialties. In general, Mexico's liability regime could be characterized as "light" in the sense that consumers do not enjoy substantial protections. Indemnity is subject to a judge's assessment, with a likely overestimation or underestimation of the real damage and malpractice insurance is not common.

Competition law is applicable to the health care sector. The lack of price data in both the private and public health care sectors in Mexico is a problem for assessing potential antitrust issues. For certain medical services, fees are caped by insurance companies but given their small size and share in the sector, their bargaining position vis à vis that of doctors is still relatively weak. At present consumers are free to choose their own insurance plan, doctors and hospitals are free to adhere to any insurance plan, and the nascent health care insurance market is still sufficiently contestable. Nonetheless, there is still ample room for competition advocacy activities for the FCC.

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ANNEX

Merger between Grupo Empresarial Angeles (GEA) / Asociación de Gineco-obstetricia (AGO)[17]

In November 1998, the Federal Competition Commission (FCC or the Commission) received a notification for a proposed acquisition by GEA of AGO stock. GEA is an association engaged in a number of businesses, which include the ownership of three hospitals in Mexico City. AGO is an association that owns a hospital located in Mexico City, which was the object of the transaction. Both GEA and AGO provide health services through different health care facilities. The provision of these services is of a private nature and intended for people who do not make use of the State's health care facilities in Mexico City. This led the Commission to decide that the market was sufficiently competitive and that the effect of the acquisition would not be harmful to competition. The transaction was not objected or conditioned.

Corporate restructuring between Grupo Angeles Servicios de Salud, SA de CV (GASS) / Resonancia Magnética Angeles, SA de CV (RMA) / Hospital Angeles del Pedregal, SA de CV (HAP)[18]

In April 2002, the Commission was notified of a corporate restructuring between GASS, RMA and HAP. The notification was made according to Article 21 of the Rulings of the FLEC. On May 2002, the Commission acknowledged receipt of the notification.

Merger between Grupo Angeles Servicios de Salud, SA de CV (GASS) / Inovamed, SA de CV[19]

In August 2003, the Commission received a notification for a proposed acquisition by GASS of stock of Inovamed subsidiaries. GASS is a subsidiary of GEA. Both GASS and Inovamed provide health services through different health care facilities and the provision of their services is of a private nature. The transaction had effects on the medium-low income segment of private hospital services in Mexico City. Concentration indexes were found to be under the established limits set out by the Commission and there are no significant barriers to entry. The FCC decided that the effect of the acquisition would not be harmful to competition, therefore the transaction was not objected or conditioned.

NOTES

1 According to González Pier and Peña (2004) during 2001 the consumption of medical services in Mexico reached $235,304 million of Mexican pesos (US$20,413 millions). 49% was paid by the federal and state public sector, 48% was paid directly by the patient as out-of-pocket expenses, and the remaining 3% was paid through insurance companies.

2 The LPDF is enforced at the federal level where service provision is granted to federal authorities or where it relates to activities regulated by a federal law.

3 Conditions are: that studies covered by the foreign professional title are the same or similar to those acquired in institutions of the educational national system; when it is not possible to establish similarity between studies, a studies equivalence system is established and some tests and examinations are applied to interested persons in order to verify their knowledge.

4 Social service is defined as temporal work in the field that professionals must perform for a minimum period of half a year but no longer than two years, on behalf of society and the State (Articles 53 and 55 of the LPDF). In the case of health professionals, social service must be provided in regions with relatively lower economic and social development (Article 87 of the LGS).

5 González Pier and Peña (2004) note that Ruíz, Molina and Nigenda (2003) estimated that only 70% of specialist doctors held a valid certificate in 2001. The Conacem estimates, however, that approximately 79% (of a total of about 75,000) of specialist doctors in Mexico will be certified by their Medical Specialty Council in 2004.

6 In 1996 the National Commission of Medical Arbitration (Conamed) was created as an alternative mechanism to resolve controversies raised in providing health care services. In 2002, the Conamed reported 1,614 solved cases that is cases where specific commitment was reached between the parties either monetary (16%) or non monetary terms. The average amount of payment in these solved cases was: indemnity $99,137 Mexican pesos (US$8,600), repayment $22,694 Mexican pesos (US$1,969), and writing off debt $3,357 Mexican pesos (US$291).

7 If there is an assumption that a crime has been committed, then the person who caused damage would have to face criminal trial in addition to a civil trial.

8 The CCF establishes 4 minimum wages as indemnity per disability day without taking into account wage or income effectively received or the expected income of the individual during the disability period.

9 According to the CCF and the LFT with the minimum wage for Mexico City for 2004, the maximum indemnity for lost income is up to $132,101 Mexican pesos in case of death (US$11,459.24), and $198,151 Mexican pesos (US$17,188.82) in case of total irreparable disability.

10 Insurance for civil responsibility in the medical professions is available to doctors who work in the private sector. This insurance grants protection to the insured if a third party sues for damages as a result of an even that may cause death, injury or decline in health of the person (personal damages) or the deterioration or destruction of their goods (material damages). On the other hand, for those doctors who work in the public sector, insurance and other benefits are paid in equal parts by the doctor and the public institution where they work.

11 Refer to the Annex for a summary of these cases.

12 In fiscal terms “independent personal service” means those professionals who receive fee payments. The rulings of the LGS establish that the Ministry of the Economy, prior to consultations with the Ministry of

Health, will set maximum prices for pharmaceuticals and other medical inputs, without mentioning medical services

13 "ARTICLE 7. The following shall apply in order to set maximum prices for products and services that are essential for the Mexican economy or for mass consumption.

I. The Federal Executive shall be exclusively responsible for determining by decree, the goods and services that are subject to maximum prices; and

II. Without affecting other agencies' powers, the Ministry [of the Economy] shall set, through founded and motivated intent of resolution, the maximum prices of goods and services as determined by the preceding section, pursuant to criteria which shall prevent supply shortages.

Without interpreting the following as a violation of this law, the Ministry may agree or coordinate with producers or distributors the necessary actions in this matter, to minimise the effects on competition and free market participation…"

14 See González Pier and Peña (2004).

15 DE-14-95 / RA-03-98, IO-26-95 / RA-14-96, respectively.

16 See Rivero-Serrano, O., Tanimoto M. and R. Paredes (2003).

17 File CNT-146-98.

18 File AVI-CNT-22-2002.

19 File CNT-66-2003.

NETHERLANDS

1. Content

This paper contains the Dutch contribution for the OECD round table of the 11th of October 2004, on "competition in health professions." After a short introduction in which the general system of health care in the Netherlands is described, the paper focuses on regulation concerning market entry and market conduct for health professions. Following a short description of Dutch competition policy for the health sector is given. The paper ends with answers to some of the questions Asked by the OECD in the guide for country submissions. Under each subject examples are given of the medical profession that is the most interesting in this field. The professions used for these examples are dentists, General practitioners and medical specialists who work in hospitals.

2. General system of health care in the Netherlands

2.1 The current system

The quantity supply of medical professional activities in the Netherlands is not regulated as such, but tariffs are regulated and the government does influence supply via the funding of health care.

The funding situation is as follows. A statutory insurance scheme covers a sizable section of the Dutch population. Another section has private medical insurance that affords some risk groups an opportunity to take out a standard policy regulated by law for a range of defined services. The Netherlands finances long-term care by tax on income.

If certain care provided by health professionals is not part of the insured health care, patients will pay for this care privately.

Advantages of the present system include scope for private initiative, a relatively strong private sector basis, financial responsibilities for government regulated health funds and for private insurance companies and good accessibility to services. However the system also has some marketplace imperfections like:

- Regulatory costs caused by central control over the supply of services and pricing.
- Small interest among insured persons in consciously choosing an insurer
- An unlevel playing field for companies
- High entry barriers for some potential suppliers
- A lack of transparency
- The costs incurred in switching from one insurer to another.
- Monopolies and oligopolies in regional markets

Another shortcoming that has been mentioned is that although there is central regulation of supply, government cannot influence suppliers or insurers directly. These shortcomings have caused a lack of alignment between supply and demand; the system does not meet demands of patients and insurers sufficiently.

The mentioned problems can also arise for health professionals who can be influenced by the central control of supply and setting of tariffs.

The Netherlands needs a good performing healthcare system that encourages all concerned to make appropriate use of medical services in order to continue assuring people of affordable essential care. This is all the more important because of the expected increase in demand for medical care due to circumstances like the ageing population in the coming decades. The current system's imperfections obstruct achievement of the targeted situation. The current healthcare system could be made to perform considerably better by replacing central government control, where possible, by a decentralised system of regulated competition. Introducing more competition if possible can help to realise a higher level of welfare. Actors would have greater freedoms and responsibilities and be able to play their roles under equal conditions. This would apply to both care providers, including health professionals as insurers

2.2 A new regime in the Netherlands

The new system will be built on a single statutory insurance regime applicable throughout the Netherlands. Equal conditions will be created for market parties, like insurers, care providers and insured parties to compete amongst each other. Introducing regulated market mechanisms where it is possible to do so will give parties greater financial responsibilities, influence and freedom of choice in selecting their medical insurance and care products supplied by care providers. Care insurers will need to compete more actively with each other to secure the preference of their customers. Care providers will have to adopt more performance-driven working practices. Where possible the care insurers and care providers will negotiate prices with each other through open bargaining.

If more competition and responsibility for individual professionals is introduced, different regulation will be necessary to insure that good quality health is provided under fair circumstances so the increase in welfare can be realised for the patient/consumer. This means that under the new system regulation concerning the market structure for and conduct of health professionals will be changed to make the introducing of competition in certain areas possible.

The proposed system reforms will start on 1 January 2006. The exact contents of many of the changes are still under preparation. This paper describes a few distinct parts of the overall market considered interesting examples for the roundtable. The paper explains the overhaul from the baseline of the existing situation because many of the reforms have not yet been worked out in detail. Known new developments are described where relevant. The paper focuses chiefly on general practitioners, medical specialists.

3. Regulation for health professionals

The health professions provide an essential part of health care in the Netherlands. There are several elements of public interest involved, which the Dutch government wants to insure, such as:

- Desired level of quality
- Financial accessibility
- Physical accessibility.

The health professions are therefore heavily regulated by a wide range of public regulations combined with forms of self-regulation.

The government and the professional bodies use a variety of regulatory instruments to protect the public interests. Relevant instruments that can be used are described below. Like the European Commission the Dutch of Economic Affairs distinguishes between instruments that influence market entry and instruments that influence market conduct.

3.1 Regulation of Market entry

Regulation of market entry can be either quantitative or qualitative.

Quantitative instruments are:

- Capacity requirements
- Criteria governing geographic locations
- Licenses.

Qualitative instruments are:

- Qualification requirements
- Title protection
- Oath-taking
- Domain monopoly
- Requirements relating to personal preconditions.

Almost all these quantitative and qualitative instruments are used for the health professions as is described below in a couple of examples.

Regulation of capacity

Capacity is mainly regulated through regulation of number of training places.

For example in case of medical specialists and general practitioners the training program is as follows.

Medical students receive training in two stages in the Netherlands. They are first trained to MD level by means of a six-year master's course including an internship for two years.

The Ministry of Education, Culture and Science finances this part of the training. The Netherlands applies a *numerus fixus* (quota) system because of the limited number of training places. Not more than 2400 people can start medical training in the Netherlands each year. The quota significantly impedes admittance of medical training. A person who obtains the MD degree (junior doctor) is able to specialise in the second stage of training. This occurs through a specific training placement. The Ministry of Health, Welfare and Sport, the medical education training institution and the care insurers fund these placements.

In the past, the government set the number of training places for medical specialists. Today, this is left to market parties. The Training Quota Authority advises the Minister of Health, Welfare and Sport on the future need for general practitioners, medical specialists and dentists. The authority includes representatives of insurers, training institutions and professional bodies. The authority indicates the training placements necessary for the medical and dental professions in order to match supply and demand in the longer term. The Ministry of Health, Welfare and Sport provides funding based on these estimates. This means that there is in fact an open-ended financing for trainee specialists from a budgetary perspective. The training authority and care insurers determine the number of training places ultimately available. The professional bodies set the training requirements for each specialism (general practitioners, dentists and medical specialists). The requirements are submitted to the Minister of Health, Welfare and Sport and are regularly revised. The rules formulated in The Individual Health Care Professions Act (Wet BIG) lay down the study requirements for being registered as a medical practitioner.

The professional bodies play a key role in filling the number of training places and designing medical education in the Netherlands. This can thwart opportunities for would-be doctors to join the medical education system and impede introduction of new healthcare professions.

The Ministry of Health, Welfare and Sport wants to get a firmer grip on the design and a number of training places. For that purpose, the ministry recently established a steering committee called Modernisation of Education and Practice in the Healthcare System. This committee is positioned between the ministry and the field. The committee's remit is to work with all involved parties to set up within five years an entirely new structure for a cohesive system of professions and education in the care sector. The new structure is urgently needed to improve the coherence of medical education, create greater harmonisation between professional practice and education in a way that meets society's demands and prevent impending personnel shortages in the care sector. It is also necessary to increase opportunities for new professions. This will raise the efficiency of the care process. Amendments to the Individual Health Care Professions Act may be necessary to embed the reforms in law in a responsible manner in terms of quality.

Domain monopolies

In the Netherlands for health professionals in general the domain monopoly is formed by the law (wet BIG) in which the qualification requirements for different specialisms are described.

As far as is known the quality standards are not set higher then necessary, so this would not create an unnecessary entry barrier. For medical specialists an entry barrier could however be formed by the partnership in which specialists are organised.

Most specialists working in Dutch general hospitals are organised into partnerships. The partners decide who may join the partnership. Admittance is conditional on a financial investment in the partnership. It is mandatory for hospitals to conclude contracts with these partnerships. The general hospitals only marginally recruit payroll doctors independently. This organisational framework can create an entrance barrier. The information we have received to date shows that would-be doctors do not perceive this as a barrier. Dutch authorities require care providers to provide care 24 hours a day, 7 days a week. This can be another entrance barrier.

Title protection and oath taking

Both are used in the Netherlands and regulated by law (Wet BIG). The Individual Health Care Professions Act describes the providing of care by medical practitioners Only those that are entered in the

register are allowed to use the described title. The professional level of the registered practitioners is thereby visible for everyone

Exclusive rights(licensing)

The Individual Health Care Professions Act regulates the provision of care by practitioners. Titles protected by law may be used only by persons entered in the register established pursuant to the Act. Registration evidences the professional competence of practitioners.

The Act regulates treatments performable only by specific groups of practitioners. The exclusivity depends on the nature of treatment and expertise required to administer it. However, practitioners other than those declared competent under the Act may provide a reserved treatment under instruction or in pursuit of their distinct professional duties. The activities of the nurse practitioner for example fall within the responsibility of the medical practitioner registered in the BIG register and cannot be carried out independently.

The Act is regularly revised and amended to accommodate new healthcare professions.

Under the European Directive concerning recognition of qualifications, foreign practitioners may apply for registration in the Netherlands under the provisions of the Individual Health care Profession Act. A person from another EU member state may register on the strength of a certificate of conformity. The certificate is deemed evidence that the applicant's qualifications satisfy the minimum requirements defined in the European Directive. A practitioner from outside the EU may be eligible subject to acceptance of a certificate of professional competence submitted to the Minister of Health, Welfare and sport.

Organisational structure

The government lays down regulations under the Care Institutions (Quality) Act for the way institutions organise the provision of care in general. The regulations focus on quality of care. The Act is built on the principle that institutions must have scope to determine their own quality policy and, for that reason, it is their responsibility to assure the quality of care in the first instance. The use of a quality policy is mandatory. The Dutch Healthcare Inspectorate is charged with the supervision and monitoring of the quality of health care in the Netherlands. There is no separate regulation for health professionals concerning the organisational structure. The central regulation which requires that care can be provided 24 hours a day 7 days a week will however have consequences for the possible organisational structures.

3.2. Regulation on market conduct

Regulation on market conduct can be applied to costumers and providers. A costumer instrument is introducing tied costumers. Instruments focussing on professionals are tariff regulation, advertisement/marketing regulations, good professional practice, requirements governing commercial practice and requirements governing inter/intra professional co-operations.

Tied customers

For tied customers a program is being developed to increase transparency in health care product and providers.

Regulation concerning good professional practice/conduct rules and advertising regulations

Most professional bodies in the Netherlands have laid down their own professional standards and codes of conduct. One of these associations is the Royal Dutch Medical Association (KNMG). This is a

physicians' organisation established under private law. Physicians are not obliged to join. KNMG has a code of conduct for physicians. One of the rules is that physicians may not engage in advertising. Similarly, they are not allowed to compare services in public or individual advertising. They are prohibited from disclosing publicly any data traceable back to persons (which is also prohibited by the law of protection of personal information). However, physicians may engage in interdisciplinary co-operation. For example, a general practitioner may also run a dispensing pharmacy if desired.

The Individual Health Care professions Act gives the government the power to act against the favouring of practitioners.

A recent report published by the National Council for Public Health and Care showed that the Netherlands does not have a growing culture of legal action against medical practitioners. The number of claims awarded over the past 20 years has remained stable and in the same period there has been hardly any increase in the levels of compensation.

Tariff regulation

The Health Care charges Act regulates prices for healthcare in the Netherlands. The purpose of the Act is to promote a balanced system of tariffs.

Care institutions and individual practitioners may charge only prices approved by the Health Care Charges Board. The tariffs are established through negotiations between care providers and insurers. The board and the Ministry of Health, Welfare and Sport monitor observance of the law. The tariffs the board sets are usually in the form of the maximum prices that may be charged.

The Dutch care system is currently being overhauled. Insurers will get a more controlling role in the supply of services and quality of care. Numerous different developments are occurring as regards tariffs. One example is open bargaining in the setting of tariffs for physiotherapy. A two-year national experiment with bargained pricing in physiotherapy will start on 1 January 2005. The experiment will allow insurers and physiotherapists to negotiate freely on price levels. A care insurer will be able to agree different tariffs with physiotherapists who provide better service or quality.

Hospitals will be funded differently under the new system. Performance-related funding will be introduced wherever possible. Performance levels will be defined in 'Diagnosis Treatment Combinations' (DBCs). The new system will result in introduction of bargained pricing for approximately 10% of all services rendered by hospitals. For this 10% tariffs will be abandoned The care providers (hospitals) and insurers will negotiate prices of care in this part of the market. A widening of the 10% limit will be considered in the future.

4. Position of the competition authority on health issues

To strengthen the burgeoning market forces in the healthcare sector, it is of great importance, partly in the interests of consumers, that the operation of market forces is not frustrated by the formation of cartels. The healthcare sector was therefore an important focus of the Dutch Competition Authority (NMa) attention in recent years and will remain so in the coming years. In February 2003, the Minister of Health, Welfare and Sport issued instructions for the creation of a so-called 'market superintendent' as a chamber of NMa.

In October 2002, NMa drew guidelines for the healthcare sector. Through the publication of these, NMa wishes to make it simpler for providers and insurers of healthcare to assess forms of cooperation and practices themselves in the light of competition rules. In fact, the guidelines bring together the conclusions

of the assessments made by NMa in more than 390 cases in the healthcare sector dealt with by NMa. A consultation round preceded the adoption of the guidelines.

In its guidelines, NMa clarifies which agreements restrict competition and are, in principle, prohibited. These include, for instance, price and tariff agreements, agreements to divide markets and coordinated boycott campaigns. Agreements such as these reduce the range of healthcare on offer and detract from consumers' freedom of choice.

Professional practitioners, health insurers and other entrepreneurs in the healthcare sector can assess their forms of cooperation and practices against the Competition Act independently.

A healthcare insurer with a dominant position may not abuse this position by discriminating against healthcare providers or by refusing to enter into a contract with a healthcare provider without giving an objective justification for this. Health insurers with a dominant position are obliged to apply objective, transparent and non-discriminatory criteria in negotiating contracts with healthcare providers. The healthcare insurer, however, does not have to enter into a contract with everyone.

In its guidelines, NMa states that where cooperation increases efficiency or quality, agreements between entrepreneurs in the healthcare sector are to the benefit of consumers, provided competition is not restricted unnecessarily. This includes for instance, agreements which improve the level of quality, such as joint locum schemes and the joint creation of electronic customer databases. Such schemes may not be abused to exclude competitors.

Box 8. Example

Case 1994/prohibition of supplying third parties AstraZeneca On 9 July 2002, NMa decided that the prohibition of the supply of medicines outside the premises of the hospital imposed on hospitals and pharmacies by the pharmaceuticals manufacturer AstraZeneca was in conflict with the Competition Act. Exemption from the prohibition of cartels was therefore not granted for this prohibition. The hospitals, which purchase medicines from AstraZeneca, receive very high discounts on condition that they only use these medicines for patients who are admitted to hospital (hospital healthcare). The sale of these medicines, for instance to private individuals or pharmacies (community healthcare), is explicitly prohibited by AstraZeneca.

Considerations: By applying a prohibition, AstraZeneca maintains an artificial price difference between the hospital healthcare segment and community healthcare segment. This restricts potential competition and AstraZeneca denies hospitals the incentive to switch to competitive medicines which have the same effect. Without prohibitions on supplying third parties, different medicines may be chosen and the total costs may be lower than at present. It is the legislator's aim to enable hospitals to compete with pharmacies by giving hospitals the possibility of supplying medicines to patients who are not hospitalised, through polyclinic pharmacies at or near the hospital. This will give consumers more freedom of choice with regard to the purchase of medicines. In addition, pharmacies will be encouraged to approve their efficiency and quality and an incentive may be given to provide medicines that are cheaper than the present maximum prices. AstraZeneca's prohibition of supplying third parties impedes these effects intended by the legislator. For pharmaceuticals manufacturers it is of considerable importance to acquire a significant position in hospital healthcare. General practitioners often prescribe the same medicines to former hospital patients as those prescribed by the specialist in the hospital (the so-called knock-on effect). Due to the high discounts given by AstraZeneca, it is more difficult for manufacturers to acquire a position on the hospital healthcare market, because as a result of these high discounts hospitals will not be inclined to switch to a competing medicines. The criteria for the granting of an exemption from the prohibition of cartels were not met.

5. Answers to OECD specific questions. Regulation concerning certain liberal professions in health care in the Netherlands

In this section some answers are provided to the specific questions asked by the OECD concerning regulation on consumer redress, dentists and pharmacists

Consumer Redress

Failing practitioners can be held accountable under civil or criminal law in the Netherlands

The possibilities of legal redress in case of medical errors in the Netherlands are linked to:

- Rules governing the relationship between medical practitioners and patients as codified in the *Act of Parliament concerning the medical treatment agreement* as incorporated in the Dutch Civil Law Code (articles 7:446 BW etc.);
- Disciplinary rules governing the medical profession formulated and controlled by professional associations;
- The Dutch Penal Code.

Ad 1. Act of Parliament concerning the medical treatment agreement

The rules formulated in the Act concerning the medical treatment agreement are an addition to the general rules governing civil contracts. All acts by a medical practitioner outside such an agreement fall within the sphere of the general rules on tort. The general rules on contractual liability apply, but are mitigated by the specific rules formulated in the Act. These mitigated rules only apply if:

- An agreement is made between a medical practitioner acting within a medical practice and a patient;
- The agreement concerns a medical treatment recognised as such in the field of medicine;
- The treatment is specifically intended for the patient.

The possibilities of redress are linked to the agreement: if a medical practitioner breaches the agreement by not fulfilling the intended medical act or trough a medical error, he will be liable under the contractual liability rules of the Dutch Civil Code. The standard for a medical treatment is defined as the "care a good medical practitioner would apply in compliance with the responsibility conferred to him by the professional standards for medical practitioners" (art. 7:453 BW). This article therefore gives the threshold for liability in case of medical error.

The jurisprudence by the national courts indicates that the threshold for liability is not crossed as long as the given treatment corresponds to the average and usual medical treatment and this level of treatment is not unreasonably low. The question if a treatment fulfils these standards can be answered by looking at the standards formulated by the professional associations and by science (e.g. the views of the National Health Council). The Act itself gives further clues on the required level of professional standards", e.g. the obligation to maintain patient records (article 7:454 BW).

Liability in the case of intramural care or medical treatment is structured around a rule of "central liability:" From a legal point of view there are two medical treatment agreements when a patient is hospitalised for a medical treatment: the first agreement is with the medical practitioner (e.g. cardiologist), the second agreement with the hospital (for the nursing etc.). To prevent difficulties for patients when trying to determine liability in case of a medical fault, the Act contains the rule that the hospital is liable for all medical treatments within its walls even if the liability is governed by the medical treatment agreement between the patient and practitioner. The hospital can subsequently recover any damages from the practitioner, but this is a matter only between hospital and practitioner.

Contractual exoneration clauses which fully exclude any liability or even limit liability for medical faults are by law forbidden (article 7:463 BW).

Finally the judiciary can on the basis of general rules of contractual liability on limit or mitigate liabilities for practitioners due to the specific circumstances of the case, the financial capabilities of each party, the contractual relationship etc. (article 6:109 BW). Mutatis mutandis the judiciary, when applying the general rules on tort, can apply the same kind of mitigating circumstances (article 6:162 BW etc.).

Pharmacists:

The Royal Dutch Pharmaceutical Society (Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie, KNMP) represents 90 percent of all pharmacists. The KNMP represents pharmacists in discussions on policy matters with the ministry of Health, Welfare and Sport.

There are no direct restrictions on movement of pharmacists abroad, but there are some indirect restrictions since working abroad makes it more difficult to check prescriptions, and insurance companies will be unwilling to contract an pharmacist which is not easy to visit for their clients.

The legislation doesn't pose any constraints to the location of pharmacies, apart from regulation on quality. The purpose of The Individual Health Care Professions Act is to foster and monitor high standards of professional practice and to protect the patient against professional carelessness and incompetence. In addition to this Act, the KNMP issued guidelines to ensure a minimum level of quality.

In 1999 the government opened the ways for chains of pharmacies by making it possible for others than pharmacists to own a pharmacy. In April 2000 the law was changed to permit hospital pharmacies to provide pharmaceuticals to individuals outside the hospital. The government is planning to make it possible for one pharmacist to be responsible for more than one pharmacy.

Whether medicines can be packaged by non-pharmacists

This is possible, as long as there is a pharmacist to monitor these activities.

Internet delivery of medicines is possible at the moment, but recent initiatives did not succeed, partly because of opposition of the pharmacists.

Dentistry:

Hygienists are able to perform and set up their own practice to perform basic teeth cleaning. In order to be eligible for reimbursement out of the Sickness Fund, declaration has to be done by a dentist. For both dentists and hygienists, complaints are dealt with by their associations.

There are maximum fees that apply to treatment by a dentist. A dentist should mention the prices for treatment.

There is an ethical code or professional code of conduct, which limits advertising for both dentists and hygienists. Advertising is only possible when a change in practice takes place (such as change of address, job offers etc.).

Dentists and hygienists must tell their patients about publicly paid services. That is based on a law (Act of parliament concerning medical treatment agreement. A law that regulates the agreements of treatment between patient and professional) dentists and hygienists have to inform patients about treatments given and the options that they may have to treatment by a dentist or hygienist.

NORWAY

Introduction

This paper deals with several competition issues in relation to the liberal health professions. Based on OECDs invitation to submit papers, the most important issues connected to each profession are outlined successively. At the end of the paper, the explicit questions put forward by OECD will be answered question by question in order to provide a good basis for comparisons between the different papers.

Competition among dentists and dental hygienists is particularly interesting for Norway, because the majority pays for dental treatment themselves, with no reimbursement from the State. There is no regulation on prices for dentist services, and thus the conditions are there for competition.

Concerning General Practitioners (GPs), the fees are regulated (through negotiations), so any competition for patients is based another aspects than price. Quality is probably the most important parameter, but the real quality is difficult for the patient to establish, so one might suspect that perceived quality is the most important parameter. A new reform, where everyone is entitled to their own private GP, gives rise to incentives to the GPs. We will return to this in chapter 3.

1. Issues in health-market – A general overview

1.1 Recruitment

The number of training places for physicians, psychologists, dentists, pharmacists and optometrists are decided by the Parliament. These training places are expensive, and are paid by the State. Consequently, the number of places is decided during the annual budgetary discussions in the Parliament. Thus, budgetary constraints as well as health-politics have impact on the number of training places.

Professionals with education from other EEA/EU states can apply for authorisation to practice in Norway. The applications are treated in accordance with the appropriate Council directives regarding right of establishment and freedom to provide services - Sectoral application - Medical and para-medical activities.

The license of a General Practitioner is reviewed every five years. GPs are the only group of health professionals whose license is reviewed regularly.

The license to practice as a health professional can be revoked in cases of grave malpractice.

1.2 Exclusive rights

The value-added tax (VAT) causes some distortions of demand. All services are required to add VAT to their prices. However, VAT is not added to services performed by health-personnel. Health personnel are defined in a law concerning health personnel, and include nurses, physicians, dentist etc. with licenses. In addition selected health services are exempted from VAT, such as acupuncture, acupressure, and chiropractic.

Up until 2003, acupressure was previously not exempted from the VAT-rules. In 2002 the NCA pointed out the unfair competition between acupuncture and acupressure, which both rely on the same principle for treatment: the manipulation of certain points on the body. Acupuncture punctures the skin, whereas acupressure only applies pressure to the point. As a consequence, acupressure was exempted from the VAT rules in 2003.

Presently the NCA is investigating a case with similar problems. Norwegian courts occasionally use expert witnesses in trials. When the expert witness carries a licence to provide health services, no VAT is added to the fee paid by the courts to the expert witness. Conversely, if the witness is not licensed, VAT is added to the fee. Furthermore, the fee paid by the court is fixed by regulation. As a consequence, health personnel are cheaper to the courts than other expert witnesses, even though they can offer expert opinion in the same cases. For instance, a master of sociology working in child care can give the same expert opinion as a child psychologist in a case regarding parental rights for a child, but the price charged is different.

1.3 Conduct rules

In Norway all advertisement of products and services are regulated by law. Additionally, the health sector is subject to further restrictions, requiring all advertisements to be matter-of-factly.

1.4 Consumer redress

The compensation for malpractice has been increasing the last couple of years. There is more than one reason for this development. An organisation has been formed to help represent patients that have suffered maltreatment. This has mainly affected public hospitals. It is our opinion that the liability regime for health professions is rather “light”, and therefore does not seem to influence the behaviour of the providers.

1.5 Market power limitations and competition agencies

The question whether our Competition Act applies to health professions has not yet been settled. The Norwegian Competition Act has the same wording as the EU Competition Law. Our preliminary view is that the Competition Act is applicable to health professions.

1.6 Quality Standards and Entry

There are generally short waiting lists for any of the services supplied by the liberal health professions. This is also true for Psychologists, but therapeutic counselling by a psychologist is often a lengthy procedure, and not all can afford to pay all the costs of this treatment on their own. If a patient is referred from his GP, he is eligible for support from the National Insurance Scheme. These budgets are limited, which in turn leads to long waiting lists.

1.7 Fee setting

1.7.1 Private laboratories and X-ray treatment

Some rates are set by the State. This applies to services that are refundable in accordance with the National Insurance Scheme. The rates for private laboratories are set within a diagnose-based model. The rates for X-ray treatment is set based on a model of job-codes, where a certain X-ray job is represented by a code.

1.7.2 Psychologists and physiotherapists

Rates are negotiated between the respective association and the state.

1.7.3 Public hospitals and public health services

The rates are set by the state roughly based upon the costs of the services, within a diagnose-based model.

1.8 Contractual Mechanisms

1.8.1 Public sector

Fixed yearly salary with compensation for overtime, is the most common arrangement in public sector. When there is a long list of patients waiting for treatment, however, employees sometimes work in their spare time. When employees work overtime, their income is sometimes calculated as a part of the policlinics revenue.

1.8.2 Private sector

Each institution is free to set its own employees salary, and a salary based upon revenue (at least partly) is quite common.

2. Dentistry

2.1 Recruitment to the dentist profession

There has been a growing concern that there will be a shortage of dentists in Norway. Reacting to this, the Norwegian Public Employment Service (Aetat) has started to actively recruit dentists from other countries, especially Germany. To further help this situation, there has been an increase in the number of dental hygienists hired in the public dental care. An increased use of dental hygienists can take some of the workload off of dentists so that they can concentrate on the services they alone can provide (e.g. filling cavities).

In addition, the public scholarships for studying deontology abroad have been increased, leading to a lot of Norwegian students starting deontology programs in foreign universities.

2.2 Exclusive rights

Different from filling cavities, most other services delivered by dentist, are also available from dental hygienists, such as checking teeth for cavities, professional cleansing of the teeth etc.

There are private clinics where all employees are dental hygienists, but the majority of dental services in the private sector is delivered by dentists.

2.3 Competition through pricing

There are no regulations on the price-setting for dentists and dental hygienists.

Even though there are regulations on presentation of prices for services, and further regulation on presentation of prices for dentists, it is difficult for the customer to get a clear view of the total costs of dental services. The limited success of dental hygienists to enter the market for dental services might

suggest that price is not the first concern for the customer in this market. It has been shown that of all visits to private dentist, about 50 % of these consultations could have been performed by a dental hygienist. The other half of the customers needed services that only dentists could perform. This shows that for a large portion of the population, there is a possibility to save money by consulting dental hygienists instead of dentists.

There seems to be a potential for increased competition from dental hygienists in the market for dental services. One of the main obstacles for this competition seems to be the difficulty of the customer to get a clear picture of the costs associated with dental services.

As mentioned in chapter 7.1 below, there are special regulations on the presentation of prices from a dentist.

Cross border trade.

3. General practitioners

3.1 Contractual Mechanisms

In 2001 there was a reform of the Norwegian health sector. Every patient was entitled to his/her personal GP, which he/she could change twice a year.

The purpose of this arrangement was partly to increase the patients' choice, and partly to reduce the waiting-time for an appointment with a doctor. Based on a system where the GP's income is partly based on his number of patients, the arrangement sought to provide doctors with incentive to be more service-minded, and to keep patients on their lists.

As a side remark; this arrangement also gives the GP an incentive to have a majority of young males in his patient-population, because they rarely visit the doctor. At the outset, the GP has little influence on the mix of patients, but there have been examples where popular patient-populations have been sold for quite large sums of money.

3.2 Fee setting

The Norwegian medical Association and the Norwegian State negotiate the rates, which are roughly based on the costs of the services. The rate consists of two parts, one is the price the patient pays for the service, and the other is a sum which the state refunds by way of the National Insurance Scheme.

3.3 Excessive treatment

The total costs for reimbursements for laboratory tests, and especially X-ray services have increased in the latter years. Most of these services stem from referrals from the GPs. The Ministry of Health is currently proposing new rules for reimbursements, in order to limit the (excessive) use of laboratory and X-ray services. There are no incentives for the GPs to limit their use of referrals.

4. Pharmacies

4.1 Organizational structure

Earlier, the Ministry of Health issued licenses for pharmacies, and the licenses where limited in number. The rationale why the licenses were limited, was the assumption that free establishment would lead to too few pharmacies in rural areas. The limitation on pharmacies was lifted in 2001, and the number

of pharmacies has increased from 350 to over 500. There has been no shortage of pharmacies in rural areas after the liberalisation.

The professional associations have no right to limit organizational structure of their members.

4.2 Exclusive rights

4.2.1 Abolishment of agreements with exclusive rights for pharmacies

In 2003 new legislation liberalized the sale of a selection of non-prescription drugs. Remedies for head-ache and nasal spray could in principle be purchased from shops, petrol-stations etc. in November 2003. However, the important brands in these segments refused to deliver their goods to these alternative outlets.

Normally, the refusal to supply goods would pose no problem in regards to competition, since none of the active ingredients are protected by patents, and there are generic products available. In this case, however, the very same regulation that allowed sale of the selection of non-prescription drugs from alternative outlets, also made it clear that oral guidance as to the usage of these drugs was illegal outside of pharmacies. Furthermore, drugs sold from alternative outlets had to be stored in locked cabinets, unavailable to the customers. These conditions would make it very difficult for the alternative outlets to sell drugs if the customers did not know the name of the product.

The NCA gave notice that agreements giving pharmacies exclusive rights to sell the well-known brands would be abolished. At this point, all exclusive rights given to pharmacies were wavered, and the alternative outlets started to sell these drugs within a couple of months.

The abolishment of the agreements of exclusive rights was laid down in a decision made by the NCA in April 2004, although the agreements had already been terminated.

4.3 Fee setting

The prices for pharmaceuticals are set in different regimes.

4.3.1 Non-prescription drugs (OTC)

The pricing of OTC-drugs is not regulated. The pharmacies (and other outlets) can freely set prices for these products. Pricing was liberalized in 2001. Following the liberation the prices on OTC-drugs have risen. The pharmacies often explain this by saying that the regulation on prescription drugs is so strict, that they have to make up for the low profit/loss of selling these drugs by pricing OTC-drugs higher.

4.3.2 Prescription drugs

Prices for innovative prescription drugs are regulated in a regime where the prices of the drug in question are compared in 8 pre-selected European countries. The price is set as at the level of the average price of the three lowest prices.

Undertakings supplying generic drugs can apply to the Norwegian Medicines Agency (the regulator) for a price for the generic drug. The price must be lower than the original innovative drug. An incentive based scheme is in place, which aims at giving the pharmacies incentives to use generic substitution, and supply the patient/customer with the cheapest generic drug. This scheme has had limited success, and generic prices in Norway are often high, compared to the rest of Europe.

4.4 Conduct rules

There are different restrictions on advertisement for pharmaceuticals compared to advertisement for other health-services /-products. In addition to the requirement that advertising is to be matter-of-factly, it is also prohibited to advertise for pharmaceuticals on television. Furthermore, all advertisements have to warn consumers on the dangers of careless use of the pharmaceutical.

5. Assistive Technical Aids

5.1 Conduct rules

There are no restrictions on advertisements for prices on eyeglasses and hearing aids. It is, however, unusual to advertise prises on hearing aids, because hearing aids and other aids for impaired hearing are covered by the National Insurance Scheme.

5.2 Fee setting

This system is complicated, mainly due to the division of medical devices into several different groups. I will only refer to the most common ways of deciding these rates.

5.2.1 Technical devices

There are general rules for public procurement of products and services exceeding NOK 200 000 (24 000 €). All such purchases must be put out to tender. This also applies to technical devices purchased by the State. The State typically chooses more than one undertaking as a supplier. 19 local Assistive Technology Centres can then choose from the undertakings that won the tender. The result is that a low price is secured, and at the same time there is little risk of monopolizing the market. All expenses are covered by the National Insurance Scheme.

5.2.2 Orthopaedic devices

Sometimes orthopaedic devices are put out to tender. Most of the rates, however, are based on negotiations between the producer and the National Insurance Scheme, and most of the rates are hourly based. Hourly based rates imply that the price is the time of the production process multiplied with the hourly rate (which is negotiated).

All expenses are covered by the National Insurance Scheme, except for some devices that are only partly subsidised based upon the idea that the patient should be as well off as people who don't need medical devices, but not better.

5.2.3 Refundable prescriptions

This arrangement mainly applies to consumable medical devices.

The rates are negotiated between the importer or producer and the National Insurance Scheme.

The patient pays 36% of the price and the rest is refundable. When a patient has paid 1550 NOK (185 €), all exceeding expenses are paid by the state.

5.2.4 Indicative fees for health services not paid for by the state

There are no indicative fees for health services which are not refundable by the National Insurance Scheme. Each institution/undertaking is free to set its own rates.

6. Competition advocacy

6.1 The new pharmacy act

During the development of the new Pharmacy Act, the Norwegian Competition Authority strongly advocated against an upper limit to the number of pharmacies. At first, the Ministry of Health did not remove this limit for pharmacies. In the end the Parliament instructed the Ministry of Health to take our advocacy into consideration. The solution was that the NCA was to review all denials from the Ministry of Health to give a licence to a pharmacy. The NCA then rejected all denials from the Ministry of Health, and subsequently, the Ministry of Health stopped denying licenses to new pharmacies.

6.2 Sale of non-prescription drugs outside pharmacies

New legislation was aimed at allowing the sale of certain non-prescription drugs outside of pharmacies. The NCA was of the opinion that the proposed legislation was too restrictive. The NCA advocated several alleviations to the proposed act. The NCA advocated to remove the demand that the shops should carry a minimum selection of drugs. This was partly taken into account by including only the "best-sellers" where included in the minimum selection (headache remedies and nasal spray).

The NCA also argued that the proposed age-limit of 18 years should be removed, because there was no such regulation in pharmacies. This rule, however, was ratified.

7. Specific questions from OECD

7.1 Dentistry

Dental hygienists can offer some competition to dentists, as they are able to set up their own practices, and perform services like X-rays of teeth to diagnose cavities, teeth cleansing, scaling and polishing.

There are no particular regulations as to the presentation of prices for services provided by dental hygienists, only the general regulations for price-information on services apply. These general regulations demand that prices should be readily available for the customers.

The pricing of dentist-services is regulated by a special regulation, where certain services must be listed on a price-list. The price-list must be available in the waiting-room. Furthermore, if the dentist is about to start a set of services (treatments) where the total costs exceed 2000 NOK (240 €), a written cost-estimate must be given to the patient. This regulation was passed in 1996, and the benchmark has not been adjusted since then. Such an adjustment is probably needed.

Patients can complain about treatment from a dentist to a local body that stems from the local branch of the Dentists Association. All dentists that belong to the association must accept rulings from this body or appeal to a national body. The decision of the national body is binding for the dentist, and cannot be appealed. There is also a possibility to take the complaint to the local branch of the Norwegian Board of Health.

Patients of dental hygienists have to take complaints to the local branch of the Norwegian Board of Health.

Dental hygienists have not captured large parts of the market for dental health in the private market. In public dental care, provided *inter alia* to people younger than 16, the use of dental hygienists has been more extensive. The dental hygienists in public dental care normally work in offices next to dentists, allowing the dentists to focus on the tasks that only they can perform.

7.2 Pharmacists

The responsibilities of the Pharmaceutical Professional Organisation in Norway are:

1. To secure the salaries, the working conditions and the social rights of the members

2. To contribute to the development of pharmaceutical expertise

3. To contribute to high professional expertise and good work-ethics among the members

Previously the license for a pharmacy was limited to a certain geographical location. This was to ensure equal rights to pharmaceutical services all over the country. There were concerns that free establishment of pharmacies would weaken the pharmacist-services in the rural areas. The new Pharmaceutical Act entered into force in 2001. Due to changes in the legislation, there are now no limits to the establishment of new pharmacies. There has been no weakening of pharmacist-services in the rural areas, but the dispersion of pharmacies in the densely populated areas has increased.

The new Pharmaceutical Act also removed the requirement that a pharmacy had to be owned by a pharmacist.

Using internet to order medicines, and distribution either by mail or express delivery is an interesting option. It is considered to be a future solution, especially to serve the rural areas.

7.3 Vision care

Eyeglasses with pre-prepared corrections can be purchased outside of an eyeglass store. When preparing custom eyeglasses it is for the optician to deem whether a new review has to be made, or if the old review is sufficient. Before applying new contact lenses, there is always a new review of the eyesight. In addition new reviews are being made at least once a year, for a person using contact-lenses.

7.4 Hearing aids

Hearing aids has to be fitted by an audiologist. If hearing-loss is established, the National Insurance Scheme covers the cost of the hearing aid. Consequently there are few incentives for persons to buy hearing-aids over the counter.

SWITZERLAND

I. Introduction

Le système suisse d'assurance-maladie est divisé en un domaine réglementé et un domaine non réglementé.

Au niveau fédéral, la Loi sur l'assurance-maladie (LAMal) réglemente l'assurance-maladie de base et elle prévoit l'obligation de s'assurer pour toute personne domiciliée en Suisse. L'assurance de base prend en charge les coûts des prestations qui servent à diagnostiquer ou à traiter une maladie et ses séquelles. Concernant les professionnels de la santé (médecins, pharmaciens, chiropraticiens, sage-femmes etc.), la loi définit les critères qu'ils doivent remplir pour pouvoir exercer aux frais de cette assurance de base. La LAMal prévoit aussi des prix administrés pour les prestations. Les tarifs sont fixés en négociations entre fournisseurs de prestations et assureurs au niveau des associations ou par des conventions séparées. Il existe pour les assureurs une obligation de contracter avec tous les fournisseurs de prestations admis à exercer à la charge de l'assurance-maladie de base.

En sus des prestations fournies par l'assurance obligatoire, l'assurance-maladie dite complémentaire offre par exemple des prestations de médecine alternative, le remboursement de médicaments qui ne sont pas pris en charge par la LAMal facultative ou encore des prestations d'hôtellerie dans le domaine hospitalier (chambre privée ou semi-privée). Dans ce contexte non réglementé, les fournisseurs de prestations et les assureurs sont libres de se déterminer sur leur activité et leurs rémunérations. Néanmoins, pour les professionnels de la santé, les conditions-cadre concernant leur niveau de formation et les dispositions relatives à l'exercice de leur activité continuent de s'appliquer.

Au niveau cantonal, il existe pour chaque canton (26) une réglementation du domaine de la santé. En règle générale, cette réglementation prévoit notamment les règles relatives à la pratique des professions de la santé, la surveillance des activités, les possibilités de pratiquer en groupe, les règles relatives à la publicité, la possibilité pour le médecins de distribuer des médicaments etc. Ces règles diffèrent d'un canton à l'autre. Pour cette raison, il n'est pas possible de présenter un bilan complet de la situation relative aux professions de la santé en Suisse. Cette contribution portera donc sur les points suivants: une analyse dans le cadre de l'approche structurelle et de l'approche comportementale, ainsi que des considérations sur la promotion de la concurrence.

II. Approche structurelle

A. Standards de qualité et d'entrée

- Limitation du nombre de médecins

Afin de diminuer l'augmentation des coûts dans le domaine ambulatoire, la Suisse a introduit en 2002 une mesure visant à limiter le nombre de cabinets médicaux. Cette mesure est prévue pour une durée de trois ans. En effet, selon une statistique, chaque cabinet médical coûte en moyenne 500'000 CHF de plus par année à l'assurance obligatoire. Alors que le Conseil fédéral fixe les critères, les cantons délivrent les autorisations. Cette mesure a été prise en vue, d'une part, de l'acceptation des accords bilatéraux avec

l'Union européenne et, d'autre part, en tant que mesure extraordinaire pour un frein à l'augmentation des coûts dans le domaine ambulatoire. A moyen terme, il est prévu de remplacer cette mesure par l'introduction de la liberté de contracter.

D'un point de vue économique, cette limitation des autorisations est jugée de façon négative pour différents motifs.

La réglementation crée de fausses incitations : En 2002, respectivement avant l'introduction du gel de l'ouverture de nouveaux cabinets, il y a eu 3.5 fois plus de demandes d'autorisation de pratiquer qu'en 2001.

Les effets sur la densité des médecins sont discutables : La limitation des autorisations de pratiquer vise à influencer la densité des médecins. Toutefois, il n'y a pas de grands effets à attendre d'une réduction de la densité, dans la mesure où il n'existe entre les médecins quasiment aucune concurrence sur les prix, indépendamment de la densité. Les consommateurs n'ont en effet pas un grand intérêt à comparer les prix des médecins, puisqu'ils sont assurés et ne peuvent par ailleurs le faire en raison d'un déficit d'informations. Par ailleurs, pour des motifs connus, les médecins n'ont pas un grand intérêt à se concurrencer mutuellement. De ce fait, la limitation introduite n'est pas en mesure d'améliorer la relation prix – prestation dans le système de santé suisse, telle que la liberté de contracter pourrait le faire de façon plus efficace.

Barrières à l'entrée et protection des médecins nationaux déjà établis :La limitation des autorisations de pratiquer conduit notamment à protéger les médecins nationaux déjà établis des nouveaux, suisses et étrangers. Cette mesure peut avoir un impact en matière de coûts, mais elle est discutable d'un point de vue concurrentiel. Un nombre plus élevé de médecins ne devrait pas amener à plus de concurrence sur les prix, eu égard aux dispositions légales. Cependant, cela pourrait améliorer la relation prix – prestation en Suisse, si les médecins nouveaux ou étrangers devaient en offrir une meilleure en attirant ainsi la demande. Cette situation pourrait en théorie aussi plus profiter à des systèmes HMO ou managed care, ainsi qu'aux hôpitaux.

- Étude sur les effets de la limitation des autorisations

Les effets de la limitation des autorisations ont été analysés dans une étude[1] parue en juillet 2004. Cette étude met en évidence, entre autres, les limites de ce système en ce qui concerne une éventuelle pénurie dans certaines spécialités. De plus, elle a pu démontrer que cette mesure pourrait conduire à une meilleure allocation des ressources médicales vers les hôpitaux et les régions périphériques. Malheureusement, l'étude n'a pas pu mesurer l'impact de cette mesure sur les coûts. Les autorités de la concurrence sont de l'avis que seule la suppression de l'obligation de contracter peut conduire à un bilan plus positif dans le domaine des prestations ambulatoires de l'assurance obligatoire. L'obligation de contracter impose aux assureurs de rembourser les prestations de tous les fournisseurs admis à exercer à la charge de l'assurance-maladie de base. Les assureurs n'ont donc pas le choix des professionnels avec lesquels ils désirent travailler.

- Développements en Suisse

Après l'échec de la deuxième révision partielle de la LAMal, fin 2003, une nouvelle révision est actuellement en cours. Il est notamment prévu de supprimer l'obligation de contracter avant l'échéance de la mesure de limitation des autorisations. Cette suppression a connu cet été un premier report, de sorte que la limitation des autorisations risque d'être prolongée. L'importance du projet ne permet aucune conclusion quant à l'issue des débats parlementaires. Les points principaux seraient les suivants. Le Conseil fédéral fixerait les limites minimales et maximales du nombre nécessaire de fournisseurs de prestations de chaque

catégorie pour assurer une couverture des soins justifiée dans chaque canton. Les cantons choisiraient ensuite, dans cette fourchette, un nombre minimum de médecins avec lesquels chaque assureur doit conclure un contrat. Les assureurs présenteraient aux assurés une liste de médecins autorisés, laquelle demeurerait inchangée durant une année. Comme actuellement, les tarifs seraient convenus entre associations, de sorte qu'il ne devrait y avoir que peu de concurrence sur ce point.

Dans un système en concurrence, avec des conditions cadre, les prestations sont en général fournies de façon efficiente et en tenant compte des préférences des consommateurs. Cela peut amener à une diminution des coûts et des quantités, conformément aux désirs des consommateurs. Dans ce sens, les autorités de la concurrence soutiennent la suppression de l'obligation de contracter, qui implique aussi la mise en concurrence des prix des fournisseurs de prestations.[2]

B. Droits exclusifs

- Registre de Médecine Empirique

Il existe en Suisse un système privé d'enregistrement des thérapeutes, le Registre de Médecine Empirique (RME)[3]. Ce système initialisé, par des caisses-maladie, a pour objectif de vérifier la qualité des thérapeutes pour différentes méthodes de médecine complémentaire (relevant de l'assurance privée), telles que l'acupuncture, la kinésiologie, la médecine traditionnelle chinoise et la réflexologie. Une fois ces méthodes vérifiées et acceptées, les thérapeutes sont inscrits sur les listes RME. Des conditions étatiques comparables, permettant une preuve de la qualité des thérapeutes de la médecine complémentaire, n'existent pas pour le moment. C'est la raison pour laquelle les assureurs ont initialisé ce type d'enregistrement et ont créé une réglementation privée.

Une partie des assureurs font dépendre le remboursement des prestations des thérapeutes de l'enregistrement sur les listes RME. De ce fait, ce système est devenu très important pour l'exercice de ce type de médecine à la charge de l'assurance complémentaire. Plusieurs plaintes avaient été déposées auprès des autorités de la concurrence par des associations et par des thérapeutes. Elles portaient essentiellement sur les critères d'enregistrement.

Au cours de la procédure menée par les autorités suisses de la concurrence, les comportements qui auraient pu être problématiques d'un point de vue de la concurrence ont été corrigés par Eskamed SA, entreprise chargée de tenir le registre.

- Personnes prodiguant des soins sur prescription médicale selon la LAMal

Les physiothérapeutes, les ergothérapeutes, les infirmiers, les logopédistes et les diététiciens ne peuvent voir leurs prestations remboursées par l'assurance de base qu'à la condition que le patient ait au préalable consulté un médecin, lequel doit avoir prescrit les soins en question.

- Dentistes

Certain assureurs-maladie ne remboursent, dans le domaine de l'assurance complémentaire, que les dentistes affiliés à la Société Suisse d'Odontostomatologie (SSO). Aucune intervention n'a été faite dans ce domaine, dans la mesure où l'affiliation à cette association n'est pas soumise à des conditions et qu'il est donc aisé pour tout dentiste de pouvoir devenir membre et, partant, de voir ses prestations remboursées par l'assurance privée.

III. Approche comportementale

- Recommandations tarifaires

Comme préalablement mentionné, les fournisseurs de prestations sont remboursés, pour leurs soins à charge de l'assurance obligatoire, sur la base de conventions tarifaires. La structure tarifaire est établie au niveau suisse et elle se fonde sur l'attribution d'un point à chacune des prestations fournies. Une valeur de ce point est fixée dans chaque canton. Toutefois, pour les prestations fournies à charge de l'assurance sur-obligatoire, la rémunération est libre. Les autorités de la concurrence sont intervenues à deux reprises à l'encontre d'associations cantonales de médecins en raison de recommandations tarifaires qu'elles édictaient à l'intention de leurs membres.

Chaque intervention, dans chaque domaine de spécialité, se voyait attribuer un montant fixe ou une fourchette de prix. Les membres de ces associations étaient libres de respecter le tarif mais un mécanisme de contrôle avait été mis en place, dans un des cas, lorsque le tarif dépassait de plus de 20% le montant recommandé.

Une analyse du marché a démontré que la majorité des praticiens suivaient ces recommandations. Lorsque le tarif recommandé était fixe, cela avait pour conséquence que la majorité des prestations étaient fournies à un tarif unique. Lorsque le tarif recommandé l'était sous forme de fourchette, la conséquence était que les prix pratiqués étaient mieux distribués à l'intérieur des limites, mais tendaient néanmoins à s'approcher de la limite maximale.

Ces comportements ont donc été considérés comme contraires au droit de la concurrence, raison pour laquelle les parties les ont cessés.

- Mécanismes contractuels

Dans le domaine ambulatoire, les formes de remboursement prévues sont principalement des tarifs rétrospectifs à la prestation, basés sur un tarif valable au niveau suisse. Le tarif à la prestation est multiplié par une valeur de point, laquelle est fixée par chaque autorité cantonale.

Il est connu que ces tarifs à la prestation donnent aux fournisseurs de services une incitation à multiplier leurs soins (demande induite par l'offre, augmentation des quantités). Un fournisseur de prestations rémunéré à la prestation a moins d'incitation à mettre en œuvre un traitement effectif au niveau des coûts qu'un fournisseur de prestations rémunéré forfaitairement. En raison d'une structure tarifaire commune et d'un tarif unique au niveau cantonal, il n'existe pratiquement aucune concurrence sur les prix entre les médecins. Une modification de cette forme de remboursement n'est pas prévue en Suisse dans le domaine ambulatoire, bien que les autorités de la concurrence l'aient à plusieurs reprises demandé, dans le cadre de la suppression de l'obligation de contracter.

Malgré les points mentionnés ci-dessus, il apparaît que les tarifs à la prestation par cas n'aient pas que des désavantages. Cette forme de remboursement est par exemple nécessaire compte tenu de la forte différence de coûts qui peut exister dans les mêmes interventions (par exemple dans la médecine de pointe). Dans ces cas, un tarif forfaitaire ne serait pas adéquat.

IV. Promotion de la concurrence

Les autorités suisses de la concurrence sont compétentes pour assurer la promotion de la concurrence dans le domaine non réglementé à travers des procédures d'enquête visant à interdire des comportements illicites. A cet égard, comme mentionné ci-dessus, elles ont eu à intervenir pour interdire des

recommandations tarifaires entre médecins dans différents cantons, des accords entre médecins, cliniques et assureurs ainsi que des accords relatifs aux marges des pharmaciens. Elles se sont aussi intéressées aux honoraires des dentistes.

Dans le domaine réglementé, en revanche, elles peuvent adresser des recommandations aux autorités tant fédérales que cantonales afin que ces dernières modifient ou aménagent les réglementations amenant à des distorsions de la concurrence. A titre d'exemple, nous pouvons mentionner différentes recommandations adressées à des gouvernements cantonaux afin qu'ils modifient leur législation sur la santé pour ce qui concerne les règles touchant au droit de faire de la publicité. En effet, la publicité est un paramètre concurrentiel important. Elle peut aussi augmenter la transparence sur le marché en informant de l'existence d'un nouvel offreur et de ses prestations et services ainsi que du prix, de la qualité et de l'utilisation d'un produit.

Dans le domaine de la santé, la publicité contribue à augmenter les connaissances des patients (diminution de l'asymétrie de l'information). Elle leur permet de mieux comparer les offres et de choisir celles qui représentent le meilleur rapport prix - prestation. Du côté des prestataires, la publicité peut influencer positivement la concurrence dans la mesure où elle permet aux entreprises qui veulent entrer sur le marché de se faire plus facilement connaître. Pour ces motifs, la Commission de la concurrence avait recommandé à différents gouvernements cantonaux d'autoriser la publicité pour les professions de la santé. Ces recommandations ont été en partie suivies.

D'une façon générale, les autorités de la concurrence sont invitées lors de l'introduction de nouvelles lois, respectivement lors de la modification de lois existantes, à se prononcer sur les projets. A cette occasion, elles peuvent rendre attentives les autorités législatives à différents problèmes concurrentiels contenus dans la réglementation. Cette activité a été particulièrement importante ces dernières années dans le domaine de la santé compte tenu des différentes révisions du système qui se succèdent.

V. Conclusion

Dans le domaine de la santé, les activités des autorités suisses de la concurrence ont été particulièrement soutenues ces dernières années. Elles se sont adressées autant bien aux entreprises qu'à l'Etat. Elles ont consisté d'une part en enquêtes, pour ce qui concerne la partie assurance complémentaire (sur-obligatoire), et d'autre part en recommandations et prises de positions dans le cadre de modifications législatives.

D'une façon générale, le domaine de la santé est très réglementé. Il s'agit là d'une difficulté supplémentaire pour les autorités de la concurrence dans la mesure où leur marge de manœuvre se trouve réduite. La coexistence d'une part de la réglementation fédérale et d'autre part des réglementations complémentaires cantonales rend la tâche des autorités particulièrement difficile dans la mesure où elles doivent systématiquement analyser l'état de la réglementation afin de déterminer s'il est possible de mener une procédure d'enquête ou si l'intervention doit prendre la forme d'une recommandation à l'autorité législative.

NOTES

1 http://www.bsv.admin.ch/forschung/publikationen/3_04d_eBericht.pdf

2 Cf. www.bag.admin.ch/kv/projekte/d/3_Kontrahierungszwang.pdf

3 Cf. http://www.emr.ch

TURKEY

Health services are delivered by a range of different health practitioners, including doctors, dentists, pharmacists, nurses and related para-professionals such as dental auxiliaries (dental therapists and dental hygienists). One thing all these professions traditionally have in common is a high level of regulation. Turkey has also legislated to protect public health and safety by limiting who may practise as a health professional and how service providers may represent themselves.

Government regulation is the preferred method by many people and is the dominant market perspective today. In part due to the public's perception of healthcare as a right rather than a privilege, access to healthcare became a priority of all the governments. Government regulation is justified by several assumptions, which must be accepted before government regulation makes sense:

- The healthcare market is flawed and is not capable of responding to free market forces. Government regulation can compensate for the flaws in the system and improve market performance. These flaws include a lack of information by the consumer (asymetric information), dissociation between healthcare consumers and payers, and lack of equity in access.

- The healthcare market is fundamentally different from other economic institutions. The two primary differences are that the physician is both the provider of healthcare services and the consultant who decides what a patient needs for healthcare, and the dissociation of payer and consumer. Physicians not only influence the cost of individual treatment but also the services and assets of local hospitals, often without regard to cost. Third party payers insulate the patient from the cost of healthcare. Both of these factors may also be accepted as powerful inflationary forces.

- Another line of argument in favour of regulating health care professions takes into account externalities. This means that the health care services affect someone who is not involved in the buying or selling of the service itself. The price paid in the transaction therefore does not reflect all of its advantages or disadvantages.

Current Situation in Turkey

In Turkey health professions are self-regulated through professional bodies organised at national or even local level. This regulation can affect the number of entrants into the profession, the prices professionals may charge, the organisational structure of professional services undertakings, the exclusive rights they enjoy and their ability to advertise.

Most healthcare legislation in Turkey requires practitioners to hold certain qualifications before they can enter a profession, and to be licensed by a registration board while they continue to practise. Some legislation also reserves the right to practise in certain areas of health care exclusively for certain professions. In addition, health practitioner legislation often regulates the business conduct of registered professionals. The three main self-regulatory professional bodies are “Turkish Pharmacists’ Association” (TPA), “Turkish Medical Association” (TMA) and “Turkish Dental Association” (TDA).

Turkish Pharmacists' Association

Pharmacy regulation, in Turkey, is closely interlinked with the regulation of drugs, poisons and controlled substances. State regulation controls or influences virtually every aspect of pharmacy, including the prescription medicine prices, ownership restrictions (only pharmacists may own pharmacies), obligatory registration to professional bodies (Turkish Pharmacists' Association and its local subsidiaries) and license requirements. TPA is a professional body founded by Act No:6643, Turkish Pharmacists' Association Act. TPA has constitutional protection (like TDA and TMA) with legal personality and empowered with public powers such as generating regulations relevant to its members. Prescription medicine prices are determined (annually) by a committee which is under the supervision of Health Ministry.

TPA regulates the pharmacy business in similar ways to the regulation of other health professions i.e. requirement of appropriate qualifications and registration by a local pharmacy board. State legislation prohibits the handling and selling of pharmaceuticals in retail shops other than registered pharmacists. Pharmacy legislation also restricts the ownership of pharmacies. Non-pharmacists may be employed by pharmacists (i.e. medicines can be packed by non-pharmacists). New pharmacies can be founded without any location limitation.

Turkish Medical Association

TMA is a professional body with legal personality, empowered with public powers such as generating regulations relevant to its members. This licence stems from Article 124 of the Constitution. TMA was established by Act No:6023, Turkish Medical Association Act. TMA represents more than 70000 physicians (nearly % 80) all over Turkey which are organised under 54 sub-local branches.

Article 4 of the relevant Act defines the power and duties of TMA Board. Accordingly " *to promote its members financial welfare and status* " is a duty of the board. Article 7 enforces membership in order to practise medical activity, Article 28 bans any type of advertising for members. Finally Act No:6023 clearly articulated TMA's power to impose minimum service fees. (as a result of the Article 28 of Act No: 6023, which constitutes the legal basis of TMA's price regulations)

TMA has different regulations, one about principles of setting minimum prices and one about the discipline and punishment rules, which are applicable on all member physicians. According to the "Disciplinary Rules" practising in more than one private consultancy is banned and will be fined.

Turkish Dental Association

Turkish Dental Association (TDA) represents more than 16500 dentists all over Turkey. In order to practise privately a dentist should be a member to TDA. According to TDA's data approximately % 70 of all dentistry services in 2003 were conducted by private sector (mainly sole practices). This feature of dentistry differs from the general healtcare services. Many health professions in Turkey operate under public entities (i.e general hospitals) and/or public insurance organisations pays for these services. Accordingly consumers/patients of dentistry services face the cost of treatment directly and this leads to a more competitive environment between dentists.

Similar to "Medical Association" TDA, which was established by Act No:6023, "Turkish Dental Association Act", is a professional body with legal personality, empowered with public powers such as generating regulations relevant to its members. Article 11 of the relevant Act bans advertisement and Article 42 prohibits working in more than one clinic and/or private practise.

Article 40 of Act No: 3224 constitutes the legal basis of TDA's service price regulations. In this process TDA designs regulations which contains minimum service fees varying from city to city and Ministry of Health approves them with or without change.

As mentioned above most of the dental services in Turkey have traditionally been delivered through privately as sole practices or as partnerships of dentists. In some areas of health care, such as general medical services-hospitals, increasing number of entities are owned by non-professional, corporations. In dentistry some jurisdictions (Article 45 of TDA Act) prohibit employment of health professionals by non-professionals or ownership of related facilities.

It can be argued that ownership restrictions ensure the owners of a clinic are held accountable for the quality standards, thus protecting the consumers from inappropriate commercial behaviour. However, ownership restrictions potentially impose significant costs on the public by limiting health care businesses' access to capital, thus constraining innovation and growth. Accordingly these type of restrictions may increase the cost of relevant services and limit the variability for patients/customers. Moreover ownership restrictions also impose costs on dentists. They reduce employment options for dentists who prefer to concentrate on clinical care.

Act No:3575 is also crucial in order to examine the potential competition pressure on dentistry services. This Act is specifically designed to define the rules that dental para-professionals (dental prosthetists and dental technicians) should follow during their related practises. According to the Act No:3575 and "TDA" Act it is forbidden for all para-professionals (dental hygienists, therapists, prosthetists and technicians to practise) to practise any dental service apart from the ones that clearly mentioned in the related regulations. Within this framework hygienists are not able to perform basic teeth cleaning, such as scaling and polishing.

Like any other sector of the economy, health care sector overall and each individual profession, has its own distinctive characteristics. Health professional markets have a high degree of self-regulation and restrictions which affect competition. The following broad issues of concerns can be summarised across heath professionals in Turkey:

- Reservation of work/monopoly-reserving a field of activity to particular professionals,
- Entry restrictions—regulating entry into the market, including the imposition of educational and competency standards, licensing and certification requirements, and restricting entry by foreign professionals and para-professionals,
- Regulation of service prices, in particular via obligatory fee schedules,
- Prohibition of advertising and promotion,
- Restrictions on ownership and business structure for professional practice,
- Privately imposed restrictions, which may be provided for via self regulatory arrangements imposed by bodies such as professional associations. (i.e. obligatory membership requirements)

Restrictions imposed by legislation generally fall outside the reach of the Turkish Competition Act and competition issues in relation to those restrictions are overseen by the Turkish Competition Authority. Privately imposed restrictions with no legislative protection are very much within the reach of the Act.

Two "Inability" Cases: "Turkish Medical Association"[1] and "Turkish Dental Association"[2]

Within Turkish legislation cases against health professional bodies have been conducted (Cases: *Turkish Medical Associations and Turkish Dental Association, 13 Nov 2003).* Summary of the allegations of these two cases can be summarised as follows:

- Turkish Medical Association and Turkish Dental Association and their regional subsidiaries impose minimum service fees to their members..
- TMA and TDA required all its members country-wide obey the pre-defined minimum service fees.

The scope "Turkish Competition Act" (Act on the Protection of Competition No:4054) is defined in Article 2 as follows:

> "Agreements, decisions and practices which prevent, distort or restrict competition between the undertakings which operate in or affect goods and services markets in the territory of the Republic of Turkey and the abuse of dominant position by those undertakings which are dominant in the market and all kinds of operations and practices which are considered to be a merger or an acquisition by which competition in the market is significantly impeded, and all operations concerning the measures, decisions, regulation and supervision for the protection of competition are within the scope of this Act".

To answer the question of whether this scope covers professional bodies (TMA and TDA in relevant cases), it has to be examined the meaning of undertaking and association of undertakings which are defined in Article 3 as follows respectively:

> "any natural or legal person who produces, markets or sells goods and services, and who forms an economic whole, capable of acting independently in the market" and " any association whether with or without a legal personality, which is formed by enterprises to carry out certain objectives".

TMA and TDA members are professionals who produce and sell medical and dental services in the market. They are assessed as undertakings in means of Article 3 of Competition Act. Thus, TMA and TDA are associations of undertakings. The public powers enjoyed by these Bodies or their establishment by law makes no difference. The European Commission reached the same conclusions in cases COAPI and CNSD. The point is whether they have the power to effect the economical conducts of their members, which are undertakings.

Competition Board decided not to conduct investigations on both of these cases for the following reasons.

The Act on the Protection of Competition No:4054 (hereinafter, referred to as the Turkish Competition Act), which was passed by the Parliament on 13th December 1994, is accepted as a "general" law within Turkish legislation system. This means Competition Act aims to settle the competition rules nationwide and is applicable to any areas not covered by a "special" act. However as mentioned above TMA and TDA foundation laws clearly articulate these professional bodies to impose minimum service fees for their members. Accordingly as a result of the Article 28 of TMA and Article 40 of TDA Acts respectively, which constitute the legal basis of TMA and TDA's price regulations; decisions and actions of these two professional organisations' can not be accepted under the scope of Competition Act.

Together with its enforcement role, the Turkish Competition Authority (TCA) has a competition advocacy role with regard to specific measures which may distort competition. The TCA has attached great significance to following up these sorts of measures in order to eliminate them in a reasonable way. However, during the very first years of the TCA, the advocacy role was not understood well. It is thought that only the enforcement of competition rules would be sufficient. By the time the TCA has begun to perceive and understand that it must have an advocacy role in eliminating the distortions arising from foundation laws of professional bodies. Accordingly in November 2003, the TCA has taken initiatives, to review the foundation laws which give certain association of undertakings, namely Turkish Medical Association, Turkish Dental Association, Turkish Association of Bars, Turkish Union of Chambers of Accountants and Financial Consultants, the power of fixing minimum prices. In accordance with the Article 30 of Competition Act, Turkish Competition Authority sent its opinions to the Government about the needed remedies relevant to above TMA and TDA's foundation laws[3].

Case: Opticians Associations[4]

In a letter of complaint, following infringements were claimed to have been committed: Associations placed revenue sharing systems and price fixing provisions in their regulations, 17 optician associations arranged meetings at the beginning of each year, in which they generated two different mandatory fee scales; one for social security institutions' purchases, one for individual purchases, associations required all the optic shops country-wide obey the above mentioned price lists.

The parties are opticians associations, formed by opticians who produce and/or sell goods and services in the market. According to Article 3 of the CA which includes the definitions of "undertaking" and "association of undertakings", there is no doubt that opticians who act independently in the market should be assessed as undertakings. Again in Article 3 it is defined that

> "Any association whether with or without a legal personality, which is formed by undertakings to carry out certain objectives" are to be assessed as "association of undertakings."

Thus, the parties are associations of undertakings in means of the Competition Act. Article 4 of the CA says

> "Agreements and concerted practices of the undertakings and decisions and practices of association of undertakings, the object or effect or the possible impact of which is, directly or indirectly, to prevent, distort or restrict competition in a certain market for goods and services, are unlawful and prohibited."

And Article 4(a) describes one type of prohibited practices as follows:

> "To fix purchase or sales prices or factors which form the price (such as cost or profit) or all other trading conditions concerning purchase and sales of goods and services"

The parties infringed Article 4 in two ways: First, they accepted some rules in their regulations, which are contrary to the CA. The goal of these rules was to prevent price competition and attain a single and fixed price level among optic shops. The rules were considered as "decisions" of association of undertakings by the Authority. Second, due to the mentioned rules, associations generated mandatory fee scales and forced optic shops to obey these lists. These behaviours are obviously against Article 4, especially 4-a.

The approval of Ministry (one of the defence statements) is related to other administrative concerns and has got nothing to do with competition issues. When approving a regulation, Ministry is not obliged to check the regulation for competition concerns. This duty/licence is given solely to the Competition

Authority by the Competition Act. Price fixing action between competitors is per se illegal in all national competition laws.

The Authority concluded that the parties infringed Article 4 by the mentioned behaviours and thus, should be punished due to Article 16/2 of the CA. It also required the parties remove the restrictive rules off the regulations. However, because negotiations between the Authority and the parties ended positively and parties agreed to abolish the mentioned restrictions in the regulations, the Authority has decided to take this positive approach into account.

NOTES

1 Board Decision No:03-73/876 (c)-376 and Date: 13.11.2003

2 Board Decision No: 03-78/876 (b)-375 and Date: 13.11.2003

3 In addition, in November 2003, the TCA has taken initiatives, to review the foundation laws which give certain association of undertakings, Turkish Association of Bars, Turkish Union of Chambers of Accountants and Financial Consultants, the power of fixing minimum prices. Actually it is important to mention on the final decision of High Council of state-which is the appeal court- about the Competition Board's TAECA (Turkish Architects' and Engineers' Chambers Association) decision. In this particular case (No:02-04/40-21 and Date:22.01.2002) Competition Board decided that, TAECA's foundation law (Act No:6235) includes no delegation relevant to setting prices. It has general rules which say that TAECA is in charge of regulating the conducts of its members. However, there is no clearly articulated delegation of power to set minimum prices. So, TAECA has exceeded the limit of its powers by setting the prices and breached the Competition Act. Accordingly High Council of state's final decision will guide the future actions and policies about all professional bodies, including Medical, Dentists' and Pharmacists' associations.

4 Board Decision No: 01-42/424-103 and Date: 31.08.2001

UNITED STATES

Questions about the role of competition and market-oriented strategies in the health care sector are of vital importance as countries seek to meet the challenges of rising health care costs, promoting high-quality, affordable health care, and ensuring access to care. The United States competition enforcement agencies – the Federal Trade Commission and the Antitrust Division of the Department of Justice ("the Agencies") – have been actively involved in examining health care markets for nearly three decades. Our function is not to regulate these markets, but rather to eliminate barriers to competition that prevent markets from functioning as effectively as possible.

Our response to the issues raised in the Secretariat's paper concerning competition in the health professions begins with an overview of the perspective that underlies the Agencies' activities in the health care sector. We then discuss agency actions relating to some specific issues regarding health care professionals that are the focus of the Roundtable. Following the framework outlined in the Secretariat's paper, we address first some activities relating to "structural issues" (entry standards, scope of practice definitions, and regulation of the organizational structure of professional firms), and second the "behavioral issues" (advertising, fee setting, and contractual relationships with payers). As requested, we give special attention to those health care professions in which third party payment has played a less prominent role than in medical services, in particular dental and vision care services and products.

In addition, attachments to this report provide: (1) a list of Agency reports relating to health care; (2) a list of competition advocacy activities in health care; and (3) a guide to Agency materials concerning antitrust law in health care available at the Federal Trade Commission and Department of Justice web sites.

Overview

It has been almost 30 years since the beginning of active antitrust enforcement in U.S. health care markets. Nonetheless, there is still ongoing debate about whether and how competition policy applies to health care and its potential as a tool for improving the U.S. health care system. Thus, in various settings – whether litigation, competition advocacy, or guidance to the public – there continues to be a need to address fundamental issues about the role of competition and antitrust enforcement in health care. These are some recurring themes that the Agencies articulate:

- *Competition has an important role in health care notwithstanding the special characteristics of these markets*. Promoting competition does not mean ignoring the special characteristics of health care markets or assuming that the market, if left alone, will cure all problems. Factors such as information disparities, third party payment, the prevalence of regulation (including self-regulation), and the need to ensure access for the poor, present challenges to the use of competitive strategies. But governments and private parties can play an important role in creating conditions and incentives for effective competition.

- *There is no need for special antitrust rules for health care*. Antitrust law and analysis is sufficiently flexible to take into account the special characteristics of these markets.

- *Self-regulation has an important role to play in promoting competition*. Private professional association efforts to provide information to consumers and to prevent deceptive advertising or other abuses that distort the ability of market forces to reflect consumer preferences, can benefit competition.

- Competition is an important tool for stimulating innovative strategies to control costs, increase quality, and provide consumer choice. The difficult task of improving quality and ensuring cost-effective care requires creativity and experimentation by market participants. It is critically important to address government regulations and private arrangements that unnecessarily impede the incentive or ability of market participants to pursue such innovation.

- Antitrust enforcement plays a key role in ensuring that innovations by governments and private actors are able to compete for acceptance in the marketplace. Antitrust in the health care sector has helped assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. Although health care markets have changed dramatically over time, and continue to evolve, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing, remains a significant threat to consumers.

- *Antitrust does not pick winners and losers*. Many cases have focused on health care providers' efforts to obstruct new approaches to delivery, financing, or paying for care, but the Agencies do not favor any particular model of health care delivery, or type of provider, over another. The goal is simply to deter restraints that unduly limit the options available in the market or artificially raise prices, so that consumers will be free to choose the health care arrangements they prefer at competitive prices.

Many of the matters in the discussion that follows reflect these themes, in particular the use of antitrust to address competitors' efforts to resist innovations in delivering or paying for care, and the importance of distinguishing anticompetitive from procompetitive self-regulation.

Structural Issues – Entry, Scope of Practice, and Organizational Structures

In the United States, government regulation of health care professionals occurs primarily through state governments. State laws set standards for licensure, define the scope of practice of the profession, and regulate various types of business and professional behavior. These regulatory schemes are carried out through state licensing boards. The boards are typically composed predominantly of members of the regulated profession.

Principles of federalism limit the application of the federal antitrust laws to state-imposed restraints on competition. In essence, the "state action doctrine" means that states can decide to displace competition with regulation as long as the state legislature clearly expresses its intent to do so, and state officials actively supervise private conduct taken pursuant to state policy.

Actions by state professional licensing boards are sometimes, but not always, exempt from antitrust enforcement by virtue of the state action doctrine. A current Federal Trade Commission case involves restraints on practice by dental hygienists imposed by a state board of dentistry.[1] The nine-member South Carolina State Board of Dentistry includes seven dentists, six of whom are elected by the dentists in their local area.

The Federal Trade Commission complaint alleges that the Board illegally restricted the ability of dental hygienists to provide preventive dental services (cleanings, fluoride, and sealants) in school settings.

The state legislature in 2000 eliminated a statutory requirement that a dentist examine each child before a hygienist may perform preventive care in schools, in order to address concerns that many schoolchildren, particularly those in low income families, were receiving no preventive dental services. In 2001, the complaint states, the Board re-imposed the dentist examination requirement. The complaint charges that the Board's action unreasonably restrained competition in the provision of preventive dental care services, deprived thousands of economically disadvantaged schoolchildren of needed dental care, and that its harmful effects on competition and consumers could not be justified. The Board sought to have the complaint dismissed on the ground that its actions are exempt from the antitrust laws under the state action doctrine. The Commission denied the motion to dismiss, and the Board is seeking an interlocutory review of that ruling by a federal appellate court.

Concerns about the potential for overly restrictive regulation by state licensing boards composed of members with a stake in competitive conditions in the regulated market are longstanding. Years ago many states responded by adding a public member to such boards. As part of a recent series of hearings addressing a broad range of issues relating to competition and health care, the Agencies received testimony concerning restraints on allied health providers. In its report on the hearings, the Agencies recommend that states consider a proposal for restructuring licensing boards advocated by the Institute of Medicine (a private advisory body), which undertook an extensive, congressionally-mandated study of the role of allied health professionals.[2] This proposal would have at least half of the members of state licensing boards chosen from outside the regulated profession, and these individuals would include experts in fields such as health services research, economics, and consumer affairs.

The Federal Trade Commission has long had an active program of competition advocacy regarding regulations in the health professions. These activities have included recommendations concerning restrictions on practice by various allied health professionals, including dental hygienists, opticians, and nurse-midwives.[3]

Changes in technology have also raised new issues regarding the application of state licensure requirements. The Federal Trade Commission recently issued a staff report concerning competition from sales of replacement contact lenses over the Internet.[4] The staff recommended that states not require that an Internet seller have a professional license to sell replacement contact lenses, and, if further regulation is deemed necessary, states should consider adopting simple registration requirements. The use of contact lenses raises significant health issues, but the report concludes that requiring a professional license to sell replacement contact lenses over the Internet is likely to raise prices and reduce convenience to consumers, without substantially increasing health protections provided by existing prescription requirements and general consumer protection laws.

With respect to limits on the organizational structures that health professionals may adopt, such restraints have arisen both in state regulation and in private association codes of ethics. These include bans on: employment by a "lay"corporation; partnerships with allied health providers; use of branch offices or trade names; and salaried employment. The Federal Trade Commission has undertaken extensive study of such "commercial practice" restraints in optometry. After an empirical study comparing states with different regulatory schemes, it found that restrictions on the commercial practice of optometry increased prices but did not improve the quality of professional services available in the market.[5] In addition to advocating the relaxation of state-imposed restraints,[6] the Commission has taken enforcement action against private optometric association rules limiting organizational structures.[7]

Behavioral Issues

Advertising

The importance of advertising to competition is well-understood. Advertising can provide consumers with information about who is selling what, at what prices, and under what conditions. Both theory and empirical evidence link the presence of advertising in the health professions with lower prices. Advertising also can play a role in encouraging innovation and entry in health care markets.

Broad state-imposed bans on advertising by health care professionals have been essentially eliminated as a result of the evolution of constitutional protections accorded to "commercial speech." At the same time, antitrust law enforcement successfully attacked private professional association bans, beginning with the Federal Trade Commission's complaints against the American Dental Association and the American Medical Association in the mid-1970s.[8] The Federal Trade Commission also brought enforcement actions to eliminate various advertising restraints imposed by state licensing boards in the health professions. For example, the Commission challenged prohibitions imposed by state boards of dentistry and optometry on advertising discounted prices, as well as an optometry board's restraints on advertising of affiliations between optometrists and retail optical stores.[9]

With the success in eliminating broad advertising bans, the primary issues in the realm of advertising restraints now focus on distinguishing between appropriate regulation to prevent false or misleading advertising and unreasonably broad suppression of advertising cast in the form of rules against deception. Because deceptive advertising distorts the operation of market forces, it has long been recognized that regulation of deceptive advertising can serve to promote competition. The Commission's orders barring professional associations from restricting advertising consistently provide that the association may adopt and enforce reasonable rules to prevent advertising that is false or misleading.

But the risk remains that professional societies will take an overly broad view of what is deceptive. The Federal Trade Commission's case against the California Dental Association illustrates this concern and demonstrates the continuing challenges that enforcers can face in this area.[10] The case involved bans on various forms of price and non-price advertising. For example, while advertising of specific prices for particular services was permitted, the Association – in the name of preventing potential deception – required extensive disclosures in any offer of discounted prices. These requirements served to preclude offers of across-the-board fee discounts, such as the type of senior citizen discounts that are commonly used outside the professions. The Association also banned other types of representations about price, including statements such as "reasonable fees" or "ask about our low prices," statements that may be especially important when dentists advertise in telephone directories or other media where advertising of specific prices is not possible.

Although the court of appeals agreed with the Commission that the Association's suppression of various categories of price and non-price advertising was not justified on grounds of deception, a narrowly divided Supreme Court was unwilling to sustain the Commission's decision. In reaching its conclusion, the majority placed great emphasis on information disparities in professional services markets. As a result, it held that a more thorough inquiry into the effects of the Association's restraints was required before reaching a conclusion that those restraints were anticompetitive.

It is, of course, critically important to prevent deceptive advertising by health professionals. The Federal Trade Commission, under its consumer protection authority, plays a role in attacking deceptive advertising in the health professions. Its most recent cases concerned misleading claims about the results of laser eye surgery.[11]

Fee Setting

The antitrust laws' prohibitions on price fixing bar professional associations from adopting fee schedules, recommending fees, or negotiating fees on behalf of their members. The Agencies vigorously pursue price fixing violations, and in some circumstance such conduct by professionals has prompted criminal prosecution by the Department of Justice.[12] At the same time, legitimate concerns about the needs of providers, consumers, and payers for information can be addressed in ways that do not involve price fixing. With appropriate safeguards, professional associations can undertake various activities to provide information about prices to members, consumers, and third party payers, and can also take disciplinary actions against abusive behavior by their members.

Professional associations can conduct and disseminate fee surveys, subject to certain safeguards to avoid the risk of collusive pricing or collective bargaining. Statement 6 of the Agencies' *Statements of Antitrust Enforcement Policy in Health Care* describes conditions – for example, that the data be at least 3 months old and there be at least 5 providers reporting data – that the Agencies believe make it unlikely that the survey would facilitate collusion.[13] It also sets forth the analytical approach that the Agencies use in assessing fee surveys that do not meet these criteria, and cautions against providers' exchange of future price information. The Agencies have also issued advice letters analyzing specific fee survey proposals by health care professionals.[14]

The *Statements of Antitrust Enforcement Policy in Health Care* also contain guidance regarding the collective provision of fee-related information to purchasers. As Statement 5 explains, the Agencies seek to distinguish potentially procompetitive activities to provide information to payers, including current or prospective fee information, from conduct that may reflect or facilitate unlawful agreements on price or other terms of dealing with purchasers.

Professional associations can also set up informational programs to assist patients through advisory peer review of fees, provided they take precautions to guard against the risk of a fee review program becoming a vehicle for coordinating fees or other anticompetitive conduct. As has often been noted, patients frequently lack good information about the prices of health care services, as well as about the quality and necessity of the services they receive.[15] Advisory peer review can provide information about the basis for a fee and an informed opinion about its reasonableness, and help patients decide whether to pay a disputed bill or to continue to patronize a particular provider. In an advisory opinion to the American Medical Association, the Federal Trade Commission approved a proposed professional society peer review of physicians' fees in which local societies would render opinions on patients' complaints about fees.[16] The Commission explained that the program contained a variety of safeguards to protect against the risk that the program would amount to professional society sanctioning of fee levels or have other anticompetitive effects. For example, opinions about fees charged would be not be binding on the physicians, the societies would impose no form of penalty on physicians for failure to adhere to the committees' advice as to the fee; the committees would not develop a benchmark schedule of fees; proceedings would be confidential; and the committee's opinions on the reasonableness of fees would not be publicized.

The AMA proposal also sought to establish a program to discipline members for charging unusually high fees. In cases where the fee charged arose from fraud, misrepresentation, undue influence, or other abusive behavior by the provider, professional discipline may improve the functioning of the market by deterring such behavior. Thus, the Commission found no antitrust problem in discipline based on such abuses. But the Commission warned that professional society discipline based on fee levels alone without regard to abusive conduct would amount to competitor regulation of fee levels. As such, it would pose inherent dangers to consumers.

Contractual Arrangements Between Providers and Payers

It is widely recognized that third party payment in health care can distort the incentives of providers and consumers. Various attempts have been made to devise alternatives to address these concerns. One approach was capitation arrangements in which primary care providers receive a fixed payment per patient per month from a health plan to provide all needed services. As health care markets have evolved, use of capitation has declined. Substantial efforts are currently being made to develop new ways to structure payment systems to improve incentives for providers to deliver high quality, cost-effective care and likewise to enhance incentives and information for consumers to choose providers that offer such care. For example, some large employers are experimenting with what are sometimes referred to as "pay for performance" arrangements, in which providers receive bonuses for meeting specified quality measures.

Such approaches depend on the availability of good measures of quality. Much attention is being given to ways to develop information systems and quality measurements that would allow more informed decision-making about quality.

The Agencies have expressed strong support for experimentation by both public and private payers in redesigning payment methods to better align incentives for quality and cost-effectiveness. Antitrust law enforcement has an important role to play in ensuring that such innovation is not stifled through collective resistance by providers. The Agencies have a long history of challenging anticompetitive collective bargaining with health plans – both private and government payers – by groups of competing health professionals, and this continues to be an area of substantial enforcement activity.[17]

Some of the joint bargaining cases involve straightforward cartel behavior. In other situations, a group may offer some potential efficiencies. As in other industries, we look closely at whether the arrangement imposes anticompetitive restraints that go beyond what is necessary to produce those efficiencies. In addition, health care providers continue to raise arguments about disparities in bargaining power in contracting with health plans as a justification for agreements that create market power on the provider side. There is no reason, however, to expect that creating countervailing power would benefit consumers. Rather, our experience is that collective bargaining by providers raises prices without assuring quality. The Agencies instead emphasize effective antitrust enforcement regarding both buyers and sellers of health care services.

Another category of enforcement activity relating to contracts between providers and payers involves the use of "most favored nation" clauses. These provisions require the provider to give that payer at least the lowest price that it offers to any other customer. In some settings, such clauses can injure competition among providers and also among health plans. The Agencies have challenged the use of an MFN by provider-controlled health plans in dentistry and pharmacy, charging that they were mechanisms by which competing providers sought to discourage discounting and maintain prices.[18] In addition, the Department of Justice has brought cases against health plans that were not provider-controlled, alleging that they were used by entities with market power to limit competition from other health plans.[19]

Competition advocacy involving provider-payer contracting has also included opposition to "any willing provider" laws. Such laws require a health plan to include in its network any provider that is willing to accept the terms set by the plan for participation. The Federal Trade Commission staff has filed comments on legislative proposals to adopt any willing provider provisions, noting that such requirements can reduce incentives for providers to offer discounted fees to health plans, and also may impede efforts to design health plans that offer consumers varying degrees of choice among providers. The comments have also pointed to empirical evidence that any willing provider laws raise health care costs.[20]

Conclusion

Health care markets continue to undergo tremendous change. The Agencies seek to protect competition so that new ways of delivering and financing health care services can compete for acceptance. We tailor our analysis and our enforcement strategies to the changing realties of those markets. As always, our enforcement efforts are directed to stopping activities that harm consumers, while seeking to provide market participants with the understanding they need to avoid antitrust pitfalls as they respond to market challenges.

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- Testimony of FTC Staff before the Committee on Regulatory Reform, Florida House of Representatives, concerning the sunset review of the Florida Optometry Act (April 30, 1986)

- Response from FTC Staff to the Virginia State Board of Optometry, concerning proposed regulations (April 15, 1986)

- Response from FTC Staff to the Virginia State Board of Dentistry, concerning proposed regulations (April 3, 1986)

- Comments of FTC Staff to the Council of the District of Columbia, concerning regulation of expanded role nurses (November 22, 1985)

- Response from FTC Staff to the Florida Board of Dentistry concerning disclosure of financial interests by referring dentists (November 6, 1985)

- Comments from FTC Staff to the Arizona State Board of Optometry concerning the Board's proposed rules (October 17, 1985)

- Response from FTC Staff to the Attorney General of California concerning Assembly Bill 707, which would grant special treatment under the antitrust laws to health care providers, insurers, and purchasers for joint activities relating to contracts for the provision of health services (September 17, 1985)

- Response from FTC Staff to The Honorable Phillip Isenberg, California State Assembly, concerning Assembly Bill 1217, which would repeal existing restrictions on the number of branch offices that an optometrist or group of optometrists practicing in California may permissibly operate; remove existing restrictions on the ability of optometrists and opticians to develop and use brand names; and remove many of the existing restrictions on business relationships between optometrists and opticians (June 21, 1985)

- Response from FTC staff to the Legislative Council of Delaware, Sunset Review Committee, concerning review of the Delaware State Board of Optometric Examiners, including comments concerning regulations that prohibit certain business practices (May 31, 1985)

- Response from FTC Staff to the Honorable Ralph L. Axselle, Chairman of the Governor's Regulatory Reform Board of the Commonwealth of Virginia, concerning review of health professional regulatory boards by the Commonwealth of Virginia (May 22, 1985)

- Response from FTC Staff to the Honorable Strom Thurmond, Chairman of the Committee of the Judiciary, U.S. Senate, regarding Hon. Thurmond's request fo the FTC's views concerning S. 379, the "Health Care Cost Containment Act of 1985" (May, 21, 1985)

- Response from FTC Staff to the New Jersey State Board of Dentistry, commenting on the Board of Dentistry's proposed rules (March 19, 1985)

- Response from FTC Staff to the North Dakota State Board of Optometry, concerning proposed regulations (February 14, 1985)

- Comments from FTC Staff to the Minnesota Board of Dentistry concerning proposed amendments to rules of the Board (1985)

- Comments from FTC Staff to the Board of Registration in Medicine of the Commonwealth of Massachusetts, regarding the role of competition in the delivery of health care services (December 14, 1984)

- FTC Testimony before New Jersey Senate Labor, Industry, and Professions Committee concerning restrictions on contact lens fitting (October 17, 1984)

- Response from FTC Staff to the Legislative Research Office, Legislative Administration Committee, State of Oregon, concerning the sunset review of the Oregon State Boards of Optometry and Dentistry (August 22, 1984)

- Response from FTC Staff to the Department of Health Regulatory Boards, Commonwealth of Virginia, concerning the regulatory review of the Virginia State Boards of Dentistry and Medicine (August 21, 1984)

- Response from FTC Staff to the U.S. Department of Health and Human Services, concerning proposed regulations implementing Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982, requiring that Health Maintenance Organizations and Competitive Medical Plans must meet to enter into a Medicare contract with the Health Care Financing Administration and to qualify for Medicare reimbursement (July 9, 1984)

- Response from FTC Staff to the Honorable Art Agnos, California State Assembly, concerning Assembly Bill 3504, which repeals existing restrictions on the number of branch offices that an optometrist or group of optometrists practicing in California may permissibly operate (June 28, 1984)

- Statement of FTC Staff to the Committee on the Judiciary, United States Senate, concerning S. 2051, Health Care Cost Containment Act of 1984 (June 26, 1984)

- FTC Testimony before the Health Committee of the California State Assembly concerning the proposed repeal of California statutes that limit forms of commercial practice by optometrists (May 10, 1983)

- Comments from FTC Staff to the U.S. Department of Health and Human Services concerning proposed revisions to the Conditions of Participation for Hospitals in Medicare and Medicaid (March 7, 1983)

Comments from FTC Staff to the Board for Licensing Health Care Facilities of the State of Tennessee concerning competition among physicians and other health care providers licensed by the States, including nurse midwives, nurse practitioners, and nurse anaesthetists (1983)

NOTES

1 South Carolina State Board of Dentistry, FTC Docket No. 9311 (complaint issued September 17, 2003) (http://www.ftc.gov/os/adjpro/d9311/index.htm).

2 Improving Health Care: A Dose of Competition: A Report by the Federal Trade Commission and the Department of Justice (July 2004), Chapter 2 at 30

(http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf).

3 See, e.g., Federal Trade Commission Staff Comments to the South Carolina Legislative Audit Council (concerning dental hygienists and optometrists) (January 11, 1993); Statement from Federal Trade Commission Staff to the Joint Administrative Rule Review Committee of the Washington State Legislature (concerning opticians) (December 15, 1992); Federal Trade Commission Staff Comments to the California Board of Dental Examiners (concerning dental hygienists) (February 1988); Comments of Federal Trade Commission Staff to the Council of the District of Columbia (concerning expanded role nurses) (November 22, 1985).

4 Possible Anticompetitive Barriers to E-Commerce: Contact Lenses: A Report from the Staff of the Federal Trade Commission (2004) (http://www.ftc.gov/os/2004/03/040329clreportfinal.pdf). In 2003, the U.S. Congress enacted the Fairness to Contact Lens Consumers Act, 15 U.S.C. 7601-7610, which requires prescribers of contacts lenses to provide patients with a copy of their contact lens prescription upon completion of a contact lens fitting. The Federal Trade Commission Rule implementing the Act is set forth at 16 C.F.R. Part 315

(http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=3ad5b48a02eb1707974872e00175bbb5&rgn=div5&view=text&node=16:1.0.1.3.39&idno=16).

5 Bureau of Economics, Federal Trade Commission, Effects of Restrictions of Advertising and Commercial Practice in the Professions: The Case of Optometry (1980).

6 See, e.g., Comments by Federal Trade Commission to The Honorable Ward Crutchfield, Tennessee Senate Majority Leader (concerning Senate Bill 855, which would amend the portion of the Tennessee Code regulating the practice of Optometry) (April 29, 2003) (http://www.ftc.gov/be/v030009.htm); Comments of the Staff of the Federal Trade Commission to The Honorable Gary A. Merritt, Kansas House of Representatives (concerning a bill to clarify the conditions under which optometrists and non-optometrists could enter into lease agreements) (February 10, 1995) (http://www.ftc.gov/be/v950004.htm).

7 Oklahoma Optometric Ass'n, 106 F.T.C. 556 (1985) (consent order); Michigan Optometric Ass'n, 106 F.T.C. 342 (1985) (consent order).

8 American Dental Ass'n, 94 F.T.C. 403 (1979) (consent order), order modified, 100 F.T.C. 448 (1982) and 101 F.T.C. 34 (1983); American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982).

9 Louisiana State Board of Dentistry, 106 F.T.C. 65 (1985) (consent order); Massachusetts Board of Registration in Optometry, 110 F.T.C. 549 (1988).

10 California Dental Ass'n, 121 F.T.C. 190 (1996), aff'd, 128 F.3d 720 (9th Cir 1997), vacated and remanded, 526 U.S. 726 (1999), rev'd and remanded, 224 F.3d 922 (9th Cir. 2000).

11 The Laser Vision Institute, FTC Dkt. No. C-4084 (July 8, 2003) (consent order) (http://www.ftc.gov/os/caselist/0223053.htm); LCA-Vision, Inc, d/b/a/ LasikPlus, FTC Dkt. No. C-4083 (July 8, 2003)(consent order) (http://www.ftc.gov/os/caselist/0223098.htm).

12 See, e.g., United States v. Lake Country Optometric Society, W-95-CR-114 (W.D. Tex.1995) (agreement to raise prices for eye examinations) (http://www.usdoj.gov/atr/cases/f0600/0607.htm).

13 Statements of Antitrust Enforcement Policy in Health Care (1996) (http://www.ftc.gov/reports/hlth3s.htm). The Statements are intended to explain the Agencies' analysis of several common types of collaborative activity among health care providers. The Statements provide some clear rules of thumb, including "antitrust safety zones" for certain types of arrangements, as well as a description of how the Agencies analyze conduct that does not fall within a safety zone.

14 See, e.g., Letter from Jeffrey W. Brennan, Federal Trade Commission, to Greg Binford (re PriMed Physicians) (Feb. 6, 2003) (http://www.ftc.gov/bc/adops/030206dayton.htm); Letter from Charles A. James, Department of Justice, to Jerry B. Edmonds (re Washington State Medical Association) (Sept. 23, 2002) (http://www.usdoj.gov/atr/public/busreview/200260.htm).

15 Patients may receive care without any prior discussion with the provider of the price to be charged. Lack of information, the presence of third-party payment, and patients' reliance on their providers to act in the patient's best interests may all mean that patients often may not know what price will be charged until after the services are rendered. Consequently, patients may desire assistance in assessing the reasonableness of the price charged.

16 Letter from Donald Clark, Secretary, Federal Trade Commission, to Kirk B. Johnson, American Medical Association, (February 14, 1994) (http://www.ftc.gov/bc/adops/009.htm).

17 Descriptions of these enforcement actions can be found at http://www.ftc.gov/bc/healthindex.htm and http://www.usdoj.gov/atr/public/health_care/health_care.htm.

18 RxCare of Tennessee, Inc., 121 F.T.C. 762 (1996); United States v. Delta Dental Plan of Arizona, 1995-1 Trade Cas. (CCH) P 71,048 (D.Ariz. 1995).

19 United States v. Medical Mutual of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999); United States v. Delta Dental of Rhode Island, 943 F. Supp. 172 (D. R. I. 1996); United States v. Vision Service Plan, 1996-1 Trade Cas, (CCH) ¶ 71,404 (D.D.C. 1996); United States v. Oregon Dental Service, 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D. Cal. 1995).

20 See, e.g., Comments of the Staff of the Federal Trade Commission to The Honorable Patrick C. Lynch, Attorney General, and The Honorable Juan M. Pichardo, Deputy Majority Leader, Senate, State of Rhode Island and Providence Plantations (concerning the competitive effects of bills containing "freedom of choice" and "any willing provider" provisions) (April 8, 2004) (http://www.ftc.gov/os/2004/04/ribills.pdf).

21 Filings after 1993 are available at http://www.ftc.gov/be/advofile.htm

MATERIAL AVAILABLE AT FTC AND DOJ WEB SITES CONCERNING ANTITRUST LAW & HEALTH CARE

1. FTC and DOJ Guidelines

- "Statements of Antitrust Enforcement Policy in Health Care," issued by the Federal Trade Commission & U.S. Department of Justice, August 18, 1996.
- Available at: www.ftc.gov/reports/hlth3s.htm
- "Antitrust Guidelines for Collaborations Among Competitors," issued by the Federal Trade Commission & U.S. Department of Justice, April 2000.
- Available at: www.ftc.gov/bc/guidelin.htm
- "Horizontal Merger Guidelines of the Department of Justice and Federal Trade Commission," issued April 2, 1992, revised April 8, 1997.
- Available at: www.ftc.gov/bc/guidelin.htm
- "Antitrust Guidelines for the Licensing of Intellectual Property," issued by the U.S. Department of Justice & the Federal Trade Commission, April 6, 1995. Available at: www.ftc.gov/bc/guidelin.htm
- "Promoting Competition, Protecting Consumers: A Plain English Guide to Antitrust Laws."
- Available at: www.ftc.gov/bc/compguide/index.htm

2. Other Materials Concerning FTC Actions in Health Care

- "Improving Health Care: A Dose of Competition" – a report of the FTC and Department of Justice issued in July 2004.
- Available at: www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf
- "FTC Antitrust Actions in Health Care Services and Products" – summarizes all FTC enforcement actions, Commission advisory opinions, and amicus briefs in the health-care industry.
- Available at: www.ftc.gov/bc/atahcsvs.htm
- Commission Actions – full text of complaints and consent orders issued by the Commission since July 1996.
- Available at: www.ftc.gov/bc/CommissionActions/index.htm

- "Topic and Yearly Indices of Health Care Antitrust Advisory Opinions by Commission and Staff" – summarizes all Commission and FTC staff advisory opinions in the health-care industry.

- Available at: www.ftc.gov/bc/adops/indices.htm

- Advisory Opinions – full text of advisory opinions in the health-care industry issued by the Commission and FTC staff since 1993.

- Available at: www.ftc.gov/bc/advisory.htm

- Staff Letters to Other Governmental Bodies – letters to federal and state governmental bodies in response to requests for guidance on various aspects of competition policy in the health-care industry.

- Available at: www.ftc.gov/bc/hcpolicy.htm

- Speeches – speeches by Commission personnel concerning the health-care industry.

- Available at: www.ftc.gov/bc/speeches.htm

- FTC/DOJ Hearings on Health Care and Competition Law & Policy – lists all publicly available information about the hearings.

- Available at: www.ftc.gov/ogc/healthcarehearings/index.htm

3. Other Materials Concerning the U.S. Department of Justice, Antitrust Division, Actions in Health Care

The following materials are available at: www.usdoj.gov/atr/public/health_care/health_care.htm

- Health Care Task Force: Recent Enforcement Actions – summarizes some recent actions brought by DOJ in the health-care industry.

- Health Care Cases – summaries of DOJ antitrust civil, criminal, and merger actions in the health care industry since August 25, 1983. Full text of complaints and related materials available at http://www.usdoj.gov/atr/cases.html.

- Business Review Letters – summaries of DOJ business review letters in the health-care industry since 1993 issuance of the DOJ/FTC Health Care Antitrust Statements of Enforcement Policy. Full text of letters from 1993 to the present available at

  http://www.usdoj.gov/atr/public/busreview/letters.htm.

EUROPEAN COMMISSION

Role of the European Commission in dealing with Health related issues

Article 152 of the Treaty setting up the European Community requires that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities", and that "Community action … shall fully respect the responsibility of the Member States for the organisation and the delivery of health services and medical care". Therefore, in the area of health the main responsibility remains at national level. This is also consistent with the fact that the markets in which health professionals operate are probably local.

However, whenever this is possible DG Competition does take on an active role in promoting competition at the Community level. In relation to the healthcare market other Directorates General whose activities might affect that market are notably DG Internal Market, DG Health and Consumer Protection and DG Employment and Social Affairs. DG Competition can therefore primarily play a role in advocating competition issues in healthcare in our contacts with those services. The most recent example concerns the cooperation between services which led to the Commission White Paper on Services of General Interest[1].

In general, the application of competition to the health sector is considered relatively new; for this reason, advocacy of competition in this sector is extremely important. The same can be said for liberal professions in general.

The European Commission's initiative on professional services

Liberal professions are occupations requiring special training in the liberal arts or sciences, for example lawyers, notaries, engineers, architects, doctors and accountants. All the different kinds of medical professionals, such as doctors, dentists, obstetricians and even pharmacists are to be considered as liberal professionals. The sector is usually characterised by a high level of regulation, either imposed by national governments or self-regulation by the professional bodies. Such regulation clearly has the potential to affect competition and when it is decided by associations of undertakings it may therefore come within the scope of Article 81(1) of the EC Treaty. The Commission's policy is to fully apply the competition rules to this sector, whilst recognising its specificities, such as the asymmetry of information between customer and service provider.

On the basis of a stock taking exercise in 2003, on 9 February 2004 the Commission has adopted a Report on competition in professional services[2]. The main purpose of this Report is to set out the Commission's thinking on the scope to reform or modernise the rules applicable to certain liberal professions. This report covers pharmacists, but it explicitly does not cover other health professionals.

It emphasises the economic importance of professional services and the general arguments in favour of pro-competitive reforms in this sector. It then presents the Commission's analysis of the key restrictions to competition in the professions: namely, price regulation, advertising restrictions, entry requirements, reserved rights and rules governing business structure (including multi-disciplinary practices). It summarises the general arguments for and against restrictive regulations and considers the scope for reforming unnecessary or disproportionate rules. It then outlines the elements of the Community legal framework within which those restrictions have to be analysed. The report concludes by proposing a future

course of action. Professional bodies and regulatory authorities in the individual Member States are invited to revise existing restrictive regulation or to justify it.

In the Report, in particular, the Commission recognises that there might often be legitimate arguments in favour of certain regulations in the liberal professions. However, it also stresses that restrictive regulations such as fee scales, advertising restrictions and rules limiting inter-professional co-operation, should be established only where they provide an effective and proportionate means of protecting citizens. Unnecessary or excessive regulation is likely to lead to higher prices and poorer quality of the services themselves and damages to the EU economy overall.

Cases

At national level there is often a complex interplay of State intervention (public healthcare) and markets. As a consequence there are many State measures aimed at steering and controlling demand and supply, which are formally not covered by the competition rules.

The Commission has not dealt successfully with any case dealing with health professionals. We have received many informal complaints by health professionals which were rejected for various reasons: lack of community interest, the complaint was more properly to be addressed to DG Internal Market in the framework of mutual recognition, the complaint was directed towards some healthcare institution that could not be considered an 'undertaking' in the sense of competition law. In the latter case the rejections follow the reasoning used in the Poucet and Pistre judgment, and more recently in the Fenin[3] decision, now confirmed by the Court of First Instance.

Although the Commission has not dealt with any case dealing with health professionals, Member States have. Indeed, National Competition Authorities have challenged the anti-competitive practices mainly carried out by pharmacists (Belgium, Germany, Spain, France, Italy, Netherlands, Slovakia, Slovenia, Latvia), by dentists (Denmark, Spain, Italy, Sweden, Finland, UK, Cyprus), by veterinary surgeons (Denmark, Ireland, Netherlands, Belgium, Spain), and by doctors (Finland, Netherlands, Spain, UK).

DG Competition currently is looking at a formal complaint by oral hygienists against Finland. They are allowed to work as independents providing notably preventive dental care. However, under existing social security rules, no social security reimbursement is foreseen for treatment provided by oral hygienists working as independents, whereas if the very same treatment is provided by a dentist or an oral hygienist employed by (under the supervision of) a dentist, the treatment is reimbursed.

NOTES

1 White Paper on services of general interest, COM(2004) 374 final, Brussels, 12.5.2004

2 Report on Competition in professional services, COM (2004) 83 final, Brussels, 9 February 2004.

3 Joined Cases C-159/91 and C-160/91 Poucet and Pistre [1993] ECR I-637, and Case T-319/99, Fenin v. Commission. In Poucet and Pistre the Court concluded that the organisations managing the health funds in question in that case were not carrying on an economic activity and were not, therefore, undertakings for the purposes of Articles 81 EC and 82 EC. The Court relied on the fact that they were fulfilling an exclusively social function, that their activity was based on the principle of national solidarity and, lastly, that they were non-profit-making, the benefits paid out being statutory benefits that bore no relation to the level of contributions. In Fenin the Court ruled that if the activity for which an entity purchases goods is not an economic activity, it is also not acting as an undertaking for the purposes of Community competition law.

SUMMARY OF THE DISCUSSION

Introduction

The **Chairman**, Alberto Heimler, began by stating that it was the first time that the Competition Committee or its Working Party had addressed health care issues. The Round Table on competition in the health professions would address similar issues to those normally addressed in the professions, that is, structural impediments to entry and behaviour restraints. Because the health care sector is so peculiar, and because demand is always a derived demand, as doctors usually make decisions for patients and furthermore patients usually do not pay the full cost of the service they receive, he went on to suggest that it was necessary to start with a brief description of the key features of the healthcare system and of the role of competition and regulation. Healthcare services are textbook examples of credence goods, i.e. goods where the beneficiary cannot judge quality either before or after purchase. The risk of having services provided by unqualified professionals is very high so it is strictly regulated everywhere. Entry is subject to professional qualifications and conduct is subject to quality standards and very often to so-called ethical requirements. Advertising is prohibited in many countries, and vigorous competition among professionals is hindered by binding and statutorily sanctioned minimum tariffs. There are instances where the width of exclusivity assigned to a given profession is much larger than necessary. In many countries, for example, dental hygienists are not allowed to set up an activity independent of a dentist.

In most OECD countries, the majority of health services are almost fully financed by the government who also employs many healthcare professionals. Final consumers do not pay the full cost for health services received and tend to demand services for which they would not be willing to pay the full cost. Demand for health services is generally not expressed by patients but by an intermediary-the medical doctor. Doctors can be agents for the government and keep medical expenses low (taking some risks); or be agents for patients, doing what patients want and sometimes prescribe unnecessary tests.

The **Chairman** pointed out that in a system with insurance, consumers will demand excessive care unless constrained by rationing non-essential healthcare services. In many cases individuals who have a higher willingness to pay and do not want to wait can move to the private sector which will keep expenses down. More transparency can be introduced by giving a family doctor the responsibility to take decisions in the public interest. Considering they can work for the government with the public interest as their objective, work for patients or work for themselves, how can one ensure doctors will pursue the public interest? The chairman highlighted the importance of the UK's experience.

Professor Hugh Gravelle from the University of York began by stating that the health care sector has a number of characteristics which imply the possibility of both market failure and government failure. The sector operates in a second-best world. There are consumption and production externalities in health; information asymmetry amongst patients, providers, and funders (taxpayers or insurers); provider monopoly power arising from patient distance costs and economies of scale in production.

The UK's National Health Service (NHS) is tax financed and while there are some charges for patients, these only raise a small amount of money. Patients who enter hospital as emergency cases are admitted directly via Accident and Emergency departments. There is a gatekeeper system for non-emergency treatment since patients must be referred by a general practitioner (GP). There are no money

charges for patients for hospital care. Elective admissions are rationed by waiting time. The average wait for all types of elective admissions is over 100 days, and people can wait up to a year. The GPs are independent contractors, paid by a mixture of capitation (i.e., payments per patient on their list); by fee for service; and by lump sum payments. GPs operate as gatekeepers for non-emergency secondary care.

In 1990 the Government revised the national contract with GPs in order to improve quality. Direct financial incentives were linked to quality targets and the capitation fee was increased so that patients became more valuable, giving GPs a greater incentive to compete by providing better quality care. Another incentive for competition was that patients could now move from one GP to another without the permission of the current doctor. General practices were given the option to hold a budget to buy elective non-emergency care for patients. The budget was generous: it was based on the previous level of admissions and excluded expensive cases which were covered by the local health authority. If a general practice with a fund holding budget overspent, the costs were covered by the local health authority. Fundholding GPs also had budgets for prescribing. Any surplus was meant to be spent for the benefit of patients. This was interpreted to include investing in practice premises. Most GPs own their premises and so could capitalise surpluses invested in them, taking the money out when they retire. GPs thus had a personal incentive to reduce expenditure on elective admissions and prescribing, in addition to the incentive to benefit patients if they believed that the savings could be spent on other services which provided better care, such as chiropody. Emergency care was paid for by local health authorities. The non-fund holding practices had continued as before, with no budgets for care, and all hospital costs for patients paid by their local health authority. Fundholding was abolished in April 1999 by which time about 50 % of the UK population was covered by a fund holding practice.

A key element of the internal market reform of 1990 was the splitting of purchasers from providers. From 1949 until 1990, hospitals were owned and run by local health authorities who a fixed budget. In 1990, hospitals were split from health authorities to become non-profit trusts within the public sector. They were intended to earn a small rate of return on their capital. They contracted with purchasers, who were the local health authorities, and, for a proportion of elective care, with fund holders. The ambition was to encourage competition between providers and hospitals. The purchaser-provider split survived the abolition of fundholding.

There may not have been much competition for patients as about a third of patients choose the nearest practice and GPs are experience goods, in the sense that one must try them in order to learn about their quality. There are significant switching costs of moving from one GP to another. Each year only about 1-2.5 % of patients change their GP without changing their address. But around 13 % of patients change GP each year because of change of address. The evidence is limited but it does suggest that patients, in addition to distance, care about the quality of their GPs. Thus there is some potential for competition for patients in order to improve the quality of care.

Since fundholding was voluntary estimates of its effects on those practices which chose to become fundholders may be different from the effects of a compulsory scheme applied to all practices. Fundholders responded to the incentives in the system, sometimes in unintended ways. Since the budget for fund holders was based on their admissions in the year before they became a fund holder they increased their admissions in that year to boost their subsequent budgets. Also there is an increase in administrative costs. Cream skimming is another obvious unintended incentive; fund holders could drop expensive patients and select cheaper ones. The little evidence on the topic suggests that creamskimming did not happen on a large scale.

The intended effects of fund holding were reductions in costs; prescribing costs were reduced by 3-5 % for fund holders; there was a similar reduction in admissions and no sign of a substitution of emergency

for elective admissions. Providers competed for fundholding patients by offering lower waiting times (around 5% lower on average), leading to accusations of a two-tier system.

A crucial aspect of the internal market was the purchaser-provider split and encouragement of competition between providers. Some limited evidence suggests that providers did appear to compete both in terms of price and in waiting times. So competition did what was expected. However, some unintended consequences were suggested by a recent study by Carol Propper: providers may have diverted effort from emergency care. She has suggested that there may have been a small increase in mortality for heart attack patients.

The effects of the new internal market, which is currently developing, look more significant. There will be further deregulation of secondary care providers and greater competition in the secondary care market. NHS hospitals will have a change in status with less regulation; be allowed to spin off private companies and be able to borrow more easily. NHS purchasers will be encouraged to use private providers. Specialist treatment centres will be introduced, and the NHS will also use foreign hospitals, so that patients for hip replacement and cataracts for example will travel overseas for treatment, normally to other European countries. Changing the contracting system will accompany this. There were extremely fuzzy contracts between, health authorities and hospitals, with payments very loosely related to the number of patients treated. From 2008 onwards, all secondary care will be contracted at a uniform centrally regulated price per case, using Diagnosis Related Groups (DRG). The aim is that revenue will vary with quantity and, so that with fixed prices providers will compete on quality. This is backed up by the requirement that patients who are referred for elective secondary care must be offered a choice of four or five providers, and in order to inform their decisions there will be a wide range of quality and performance indicators.

There will be primary care deregulation together with an increasing range of alternative providers. Primary care trusts will be allowed to commission primary care from non-GP providers and wider roles for pharmacies are envisioned while removing controls on entry for pharmacy. A new (from April 2004) GP contract gives direct financial incentives for quality linked to 146 quality indicators. These are likely to have very powerful effects on the way GPs function since the additional rewards for quality will amount to around 20% of GP income. The Government announced a few days before this meeting that it is going to introduce something known as "practice based commissioning" from April, 2005. Practices will be allowed hold an indicative budget for secondary care, including emergency admissions. They will be able to keep 50 % of any budget surplus. Thus fundholding has been reintroduced.

The **Chairman** then asked if the number of GPs is fixed in the UK and if GPs have a fixed maximum number of patients.

Professor Gravelle explained that GPs in UK have no restrictions on the number of patients on their list. Past policy had tried, by controls on entry in areas with a high GP/patient ratio, to steer GPs who wanted to open a new practice into under-doctored areas. However the total number of GPs was regulated by the government by entry into medical schools.

The **Chairman** turned to an expert from the United States to discuss the regulatory solutions that have been identified in order to keep expenses down. In most markets, competition allows consumers to choose what they actually consume and this is another particularity of competition in healthcare: it is not clear what competition intends.

Professor David Hyman began by pointing out that the U.S. spends a lot more on healthcare than every other country on a per capita basis, 1.6 trillion dollars, nearly twice as much per capita as in the UK, and around 15 % of GDP. It is a mixed private and public system, on both the funding and the delivery side. The delivery system is predominantly private, with a small portion that is exclusively public. A

sizable 60 % of the population has health insurance through the employment of a family member, with categorical coverage of the elderly, the poor and the young. There is a complex relationship between State and Federal governments. The Federal government does regulate some aspects of health insurance, but most of it is left for the State. The U.S. relies much more heavily on competition on both the financing and delivery sides than many other countries. A report, which was launched in 2003, provides greater transparency for the enforcement agencies. The U.S. has an ongoing competition advocacy project to try to persuade states, as well as the Federal government, to be mindful of the implications of competition in the healthcare marketplace.

Broadly the report deals with healthcare financing and delivery in the United States, the movement from straight fee-for-service delivery of healthcare services, to capitation and to post-capitation arrangements. Also the study addresses quality, as it is salient in the context of medical malpractice assesses the extent to which more competition enhances quality or triggers the results that the UK delegate described. It points out the failure from the competition agencies in the area of hospital mergers because of difficulties in underlying cases, and in part because the judges before whom these cases are brought prefer not to think of hospitals as competitive actors but as non-market oriented actors. Insurance is primarily regulated at state level, with some modest Federal regulation which tends to be employment based

Professor Hyman discussed the development of consumer-driven healthcare, where individuals have complete control in choosing a doctor and at times face out-of-pocket expenses associated with these decisions, patients have funds that roll over and accumulate in order to pay. This has been a controversial issue, as there are concerns about monopsony power. The report deals with mandated benefits, as a good example of where government regulation can affect competition in ways that are unanticipated and have anticompetitive consequences. It deals with certificate of need arrangements that are government created barriers to entry.

This report led to six recommendations and eleven antitrust observations. The recommendations are directed at State and Federal governments, and also to providers and payers. They include giving incentives to providers, lowering costs and enhancing quality. States should decrease barriers to entry and provider markets, governments should consider the ways in which subsidies can distort competition - the more transparent subsidies are, the better off one is likely to be. The report finds that collective bargaining by independent providers is not recommended, even though it is often sought on pro-competition grounds. States should consider transparency issues, and the benefits of regulating them. Meanwhile, governments should consider whether current mandates are effective in serving the citizens' healthcare needs.

The **Chairman** then stated that the discussion would be organised around 3 major themes, structural regulation, behavioural regulation and enforcement issues. He then turned to expert Mark Botti to hear his views on standard setting in the health professions.

Structural regulation

Mr. Mark Botti presented his paper on Private standards setting in the United States. He went on to say that he would be focusing on purely private behaviour, that is, not sanctioned by the government and not enforced by the government.

Several organisations exist to set standards that assure health care quality. government licensing often sets minimum standards, however the private standard-setting in the United States often set higher levels of performance. They inform consumers and others as to who is competent to deliver services and who has special expertise so that people can make informed choices. However they can also impede competition in significant ways. Sometimes healthcare professionals have influence over important facilities to which new entrants need access in order to compete in our markets. These standard-setting organisations can create barriers to entry, which impedes competition.

He outlined two cases illustrating the effects of the private standard setting organisations. In the first case (Donald W. Kreuzer, MD v. American Academy of Periodontology (1984)) the court made clear, in the strongest possible terms, that the antitrust laws do not bar formation of association with memberships limited to a class of similarly situated persons and are dedicated to the joint pursuit of common interest. The court was concerned about over enforcement against professional standard setting, because it recognised that it had the potential to assure quality and to provide greater information.

The second case (Ronald A. Schacar v. American Academy of Ophthalmology) was essentially a competitor in the eyeglasses and contact lenses market, it being corrective eye surgery. This widespread practice was categorised by The National Advisory Eye Council as experimental. It had called on the profession to use restraint until more research was completed. The doctor who took the case against them believed that the dissemination of this information was impeding his market opportunities. The courts threw out his claim. They noted that ophthalmologists are just appealing to potential patients with information, they are telling them to use contact lenses and glasses until the surgical procedure is tested further, and that the remedy here is not antitrust enforcement but more information. The doctors and his colleagues who performed the surgery compete in the marketplace of ideas.

In conclusion, where there are robust markets that function aggressively, people compete strongly and standard-setting organisations are able to provide relevant information to the markets and to direct them away from anti-competitive behaviour. But where market competition is not robust, standard-setting organisations have the potential to impede the emergence of new competitors and there is a role for antitrust to guard against the adverse effects of standard-setting organisations. The **Chairman** then moved to Ireland and asked the delegate to comment on the case where The Competition Authority maintained that absence of legislation status for suitable qualified denturists or dental technicians was likely to result in a barrier to entry to the profession, and therefore was adversely affecting potential competition in the market

The delegate from **Ireland** clarified that the authority was not in existence to protect professionals but to protect consumers and society in general. However the definition of dentistry under Irish legislation was far from clear. The Dental Council, which is composed primarily of dentists and is the statutory oversight body, attempted in vain to prepare a separate regulatory scheme for the registration of dental auxiliaries, including technicians, in 1985. Failure meant that dental technicians still cannot offer independent services to the public and is a classic case of regulatory capture. The Dental Council has control over when, and how, dental auxiliaries practise. If it chooses not to make regulations, which is the current case, no regulation is worse than having regulation in the first place. This, the Irish delegate pressed, was a classic barrier to entry masked as consumer protection. The inference is that denturists are not capable of making false teeth and selling them, without dentists' supervision. This leads to higher costs and higher prices for the consumer. The danger of allowing health professionals to dominate oversight bodies demonstrates a number of key challenges to competition agencies and other competition advocates, as well as allowing health professionals the decisive say in demarcation issues. But the biggest challenge is to persuade government policymakers and the lawmakers of the vital principle of proportionality and that they should not be allowed to facilitate anticompetitive activity.

Over-extensive width of exclusivities for certain old professions exists, the **Chairman** pointed out, and a lack of entry for such new professions which could indeed compete with the old professions is quite common in many countries.

He went on to highlight that Mexico was an interesting case for structural regulation where healthcare professionals are required to get a quality certification every five years. This is a criticism that professional boards make in general: that requirements are considered only on entry to the profession and not

throughout their professional life. He asked the Mexican delegate, what, if any, was the point of the on-going examination of professionals if it is not ultimately a case for revoking a medical licence.

The **Mexican** delegate noted that insurance certification every five years is an effective quality signal but it did not have the formal effect of losing ones licence. 50 % of total healthcare expenses are paid by the patient in Mexico so symmetry is more important than self information. The certification is seen by hospitals, insurance companies and private patients as a quality assurance and also the insurance company will not reimburse expenses if the doctors are not certifying every five years. Doctors with the certification are being hired by the leading hospitals and their tariffs are higher.

The **Chairman** questioned whether the exams were selective or a formality, and if everyone receives certification.

The **Mexican** delegate responded that 70 % of doctors in different specialities have the certification.

The **Chairman** now moved to the United States to ask about the situation with dental hygienists in North Carolina where the FTC alleged that the Board of dentistry illegally restricted the ability of dental hygienists to provide preventative dental services in school settings. Because of the different institutional frameworks in each country he asked the U.S. delegate to clarify if the boards in question were public or private associations and to describe the difficulties of the case.

A delegate from the **United States** began by pointing out that national associations are sensitised to competition issues and apply antitrust laws to activities. The South Carolina State Dental Board, which is a licensure and regulatory board for dentistry, required that dental hygienists could not provide preventative dental hygiene services in schools without their first having been a timely prior examination by a dentist. The Board was composed of 8 members, 6 of whom were dentists elected by dentists throughout the State of South Carolina. There was one dental hygienist representative on the board, and one public member. The legal issue was whether this was the action of the State as a sovereign, or whether it was private anticompetitive activity on the part of the dentists on the board. As the chairman noted States are entitled, as part of that sovereignty, to substitute regulatory systems for a system of competition. However, there must be clearly articulated state policy to substitute regulation for competition. The Commission concluded that these really were private activities and therefore subject to antitrust laws. That decision however, is currently on appeal to the United States Court of Appeals Board. Clearly the state licensure board is a quasi governmental entity; it exists by virtue of the state legislature having passed legislation.

The **Chairman** then turned to the European Commission regarding Finland where the work of a dental hygienist would only be refunded by national health insurance if it had been supplied under a dentist's supervision in a dentist's practice, which is an overextension of regulation. Contrary to Ireland, in Finland, dental hygienists are allowed to operate independently. He went on to ask if it is a normal enforcement case, or whether it is a case which refers to violations of the European Treaty by the Government of Finland.

The delegate from the **European Commission** responded that it was being dealt with under general antitrust enforcement rules because under the current case law in the Court of Justice, Article 86 can be applied only when there are exclusive rights. There is no limit on the number of dentists that can operate in Finland, so, it would not be considered as a special right.

The **Chairman** then pointed out that regardless of how states or a government restricts entry, such as by legislation in Ireland; by State Boards in the U.S.; or by the national insurance system in Finland, it has the same effect of keeping independent dental hygienists out of the market and raising prices for the consumer. The other way of controlling the market in the case of Ireland and the United Kingdom is by

controlling access to university and is a further important element that should be taken into consideration when analysing competition in the professions.

The chairman then turned to Italy which, in general, does not have quantitative restraints for university access, neither for the medical professions nor the paramedical professions. However, recently some quantitative restraints have been introduced. The chairman asked the Italian delegate to provide a brief description of the regulatory system in place for access to the professions and universities

The delegate from **Italy** responded that until recently, there were no quantitative restrictions on access to university and the direct cost of education was not prohibitive. After obtaining the degree, the candidate must join a professional association to be recognised as an authorised practitioner. This process is not based on numbers of successful candidates and therefore does not constitute a real barrier to entry. Some universities have recently introduced quantitative restrictions on access to universities, but the effect cannot be judged as of yet. There are some restrictions for specialised training as the candidate needs to have a place at authorised training schools, and the number of these places is fixed every three years by the Government based upon the identified healthcare needs of the population and the employment opportunities in each local area. In Italy in order to practise as a general practitioner, there must be an agreement between the professional association and the regional governments. The number of physicians in each region depends on the number of residents. So there is an optimal ratio between family doctors and inhabitants. The doctors receive a fixed amount of compensation for each patient and they must guarantee a daily service in their premises and visits to homes for serious illness. As patients can change the family doctor there is competition in this respect, but given the optimal GP/inhabitant ratio, the incentives for physicians to be competitive appears to be rather limited.

To conclude the Italian delegate pointed out that new university diplomas have been introduced for health professions such as dieticians, physiotherapists, dental hygienists, and audiologists. The difference between these professions and the licensed professions is that there are no professional boards, there is no licensed regime because of this there have been cases of malpractice and major quality problems but they were not found to be either more serious or more frequent than the licensed professions.

The Chairman then turned to the issue of pharmacies and pharmacists, and the distinct difference when considering access to pharmacy ownership. In the case of Italy there are over 60,000 pharmacists, but only 16,000 pharmacies. Pharmacy ownership is highly regulated conversely to entry into the pharmacy sector. He then turned to Germany where entry to the pharmacy sector is completely free; given one is a pharmacist. The chairman asked if there were any limitations in opening a pharmacy and if the Government ever assures public provision of pharmacy services.

The **German** delegate responded that in short there were no major limitations except for needing a pharmacological diploma and the fact that no pharmaceutical wholesalers may own pharmacies nor are there any pharmacy chains in Germany. However this is relaxing and now one pharmacist may own up to four pharmacies but not more. The health professions sector is publicly financed, but delivery of professional services is purely private. Due to the high density of pharmacies in Germany the government has not had to intervene to guarantee this service; however, it does regulate opening hours, and pharmacies must provide a night service and weekend service.

The **Chairman** pointed out that the lack of corporate sponsorship or ownership could be viewed as a barrier to entry due to a possible lack of capital a pharmacist may require to open a business.

Also in Denmark and the United Kingdom, the market for non-prescription drugs has opened up to other entities, such as supermarkets. The Chairman then asked the Danish delegate what repercussions there had been from this recent decision to allow supermarkets to sell non-prescriptive medication; if they

were aggressively supplying those drugs; why this decision was made and what if any reaction was had from pharmacists.

The delegate from **Denmark** clarified that only selected non-prescription drugs can be sold in supermarkets. The monopoly power of pharmacies in Denmark had been in focus, both by the competition authorities and the public, and the reason behind the change was purely to enhance competition and efficiency in this area. Pharmacists were initially worried on behalf of the consumers, and of course concerned about their income. Some figures on the effects of the new scheme are already available from the Danish Medicines Agency, 20-25 % of the market of these products are now sold in supermarkets and other approved shops, and the prices have lowered by an average of 5-15 %.

The **Chairman** opened up the floor for comments and observations. The **European Commission** asked for clarification as to the price setting of services by the British Government in order to push competition on quality and the inconsistency with normal views on this subject.

Professor Gravelle explained that The Department of Health lays down a set of prices at which different treatments have to be bought and sold in the new internal market, and that these prices are national, except that there are some variations across areas to reflect what the Department thinks are justifiable differences in costs, otherwise these are the prices at which transactions have to take place, for both purchases from NHS hospitals and when the NHS buys these products from private sector hospitals.

The **Chairman** further probed if the government fixed the price for treatment as well, such as appendicitis, and if this did not lead to a reduction in quality.

Professor Gravelle clarified the position of the government that the argument is that since the providers can no longer compete on price GPs efforts are directed into searching for improved quality rather than into searching for lower priced providers.

The **European Commission** countered with the fact that this is normally the argument that professionals make to fix prices.

Professor Gravelle further explained that the UK was not starting from a situation of an unregulated market in which competition rules. In the past, block contracts between NHS purchasers and NHS hospitals were ill-defined; the purchasing health authority simply gave a sum of money to the hospital with an expectation that it would support a loosely defined number of cases.

The **Chairman** concurred and turned to Brazil.

The delegate from **Brazil** addressed a question to the delegation of the United States asking to comment on the countervailing power hypothesis of the collective bargaining problem and to enlighten the Working Party on the highly controversial discussion on this subject in the U.S.

The delegate from **United States** replied that the report from 2003 considers the countervailing power issue in some detail in the monopsony power issue. Physicians view disparity and bargaining power as sufficient for them to engage in what the FTC has alleged is collusive behaviour. It was not a targeted response to monopsony, it is a disparity in bargaining power alone that seems to be viewed by physicians as a sufficient basis on which to engage in such conduct, so the FTC alleges.

The FTC's and the Antitrust Division's position is that even if physicians face monopsony power, countervailing power is the last resort because consumer interest is not the first concern, but instead it is the monopsonist and the monopolist. If consumer interest is the concern rather than provider or payer

interest, the first step is to address the monopsony rather than rely on countervailing power, which is always subject to physicians serving their own interests.

The **Chairman** opened the floor to comments and questions and then turned to Australia

The **Australian** delegate returned to the subject of pharmacies to explain the recent failures in Australia. The aim was to regulate ownership of pharmacies so that they remain community based but the Pharmacy Guild is a very strong lobby the delegate explained and highlighted the need for very strong arguments when dealing with these kinds of associations.

The **Chairman** then gave the floor to Norway

The delegate from **Norway** asked if the regulation of entry into the professions or special training colleges was done by the professional association or the government.

The delegate from the **UK** responded that in recent years, the Government, since it pays for the doctors, is regulating the number of places available in the institutions, it had previously delegated control of entry to the Royal Colleges. It has also taken steps to loosen the power of the Royal Colleges.

Behavioural regulation

The **Chairman** introduced the topic of behavioural regulation, which concerns itself with advertising limitation and minimum price obligations. He called on the U.S. delegation to answer on what to do about limited consumer information, and whether the introduction of minimum prices was one way to address the asymmetry of information with consumers.

The delegate from the **United States** pointed out that The United States does not establish minimum prices. The Federal Medicare Program does establish a resource-based relative value schedule for services. Prices that are applied to that relative value schedule may vary from state to state, but those prices may be used as a benchmark by both healthcare providers and private health insurance. States rely largely on sources of information to consumers in order to be able to evaluate prices, as one aspect of their choice in selecting healthcare providers. The sources of information include price advertising, survey results and the provision of information on relative price levels to various payers, or on pure review of fees by professional associations. The antitrust enforcement agencies find these activities generally pro-competitive, as long as there are protections in place to assure that the information collection and provision are not used as a basis for price fixing by members of the professions. Private health insurers frequently contract with different providers of health services, establishing panels of providers who have indicated their willingness to accept certain levels of reimbursement for the provision of services relying largely on information sources. As long as they are not used to restrain trade this is considered beneficial to consumers.

The **Chairman** asked why the Supreme Court did not follow the FTC position in the California dental case.

The delegate from the **United States** replied that private associations in healthcare are viewed as an important source of expertise and information. The antitrust enforcement agencies are not in a position to substitute their judgment for that of the professions, except where activities appear to unreasonably restrain competition. In the California Dental Association case, the agencies' enforcement activities might not in fact be harming consumers, by restricting the ability of professions to appropriately self regulate. The report simply said that these types of restraints were not appropriate for summary condemnation by the agencies in that context

Further to that the **Chairman** addressed Denmark where advertising in the health professions was recently allowed.

The delegate from **Denmark** replied that due to this very new regulation, no data was available except to explain that there is tendency towards more price consciousness among consumers, especially in regard to expensive services, such as dentists' gold fillings and bridge work. For the moment, the rules are there to safeguard correct marketing and advertising procedures.

The **Chairman** asked if the restriction on advertising was eliminated for all professional services other than health professions.

The delegate from **Denmark** explained that special rules existed for advertising in the health professions and they were lifted. So the health professionals can advertise services in line with other professions.

Enforcement of competition rules in the health professions

The **Chairman** stated that many countries had actively intervened with anti-trust enforcement in healthcare and addressed the Japanese delegate, asking why the JFTC did not fine the Yokkaichi Medical Association for price fixing.

The delegate from **Japan** pointed out that there were two steps in the process; firstly to make a recommendation for a cease and desist order against the activities by the association, at which point the association consented to the proposal and recommendation and agreed, not repeat such activities again. The second phase was to calculate the amount, so the surcharge payment order follows and is in the process of being decided at the time of this meeting.

The **Chairman** turned to Turkey and asked why enforcement did not occur in the case of the Turkish Medical Association and the Turkish Dental Association, who were fixing minimum prices.

The delegate from **Turkey** replied that the professional organisations in this case have strong constitutional bases in Turkey. Therefore the Turkish Competition Authority expressed their opinions to the Prime Minister, for a change in its foundation laws, as professional bodies like the Turkish Bars' Association, the Turkish Chambers' Association and the Accountants' Association behave like trade unions in Turkey.

The Chairman asked then why they were able to intervene in the case of the opticians association.

The delegate from **Turkey** explained that opticians do not function under a specific professional law like doctors and dentists. Their secondary regulation for their members does not take its foundation from the law, so in that case, competition law is applicable.

The **Chairman** asked with respect to the opticians, if the authority found that the optician association violated the competition law.

The **Turkish** delegate replied that at this time in Turkey the professional bodies appear to be stronger than the competition authorities and the decision was yet unclear.

The **Chairman** then turned to Korea and asked the delegate to explain the case against the Korean Medical Association.

The delegate from **Korea** explained that in 2000, there was a change in the Korean healthcare system. The doctors were no longer allowed to dispense drugs, and the refund system for drugs also changed. In this case doctors who are members of the Korean Medical Association formed a committee where they decided to boycott patients. The committee also sent letters to the Korean Hospital Association ordering them not to take any outpatients. The Medical Association and the Hospital Association are business associations with strong internal regulations and if its members were not to follow the decision not to take patients, they would be deprived of their membership and termination of their licence would ensue. The KFTC made the decision to impose a forced correction order and a second cease and desist order to the Korean Medical Association and the Korean Hospital Association, resulting in the prosecution of 102 individuals.

The **Chairman** asked Hungary to comment on the case where the Association of Hungarian pharmacist's conduct was in question regarding a recommendation to their members that they should not apply lower than minimum prices, resulting in the Chamber of Pharmacists changing the mandatory prices to recommended prices

The delegate **from Hungary** replied that due to this case being in preliminary stages that no data was available. But because of the particular characteristics of the Hungarian pharmacist pricing system, where the prices of the drugs in the pharmacies are not regulated, but the margins on drugs are, it results in the prices being the same in every pharmacy. This regulation is interpreted and carried out by the Ministry of Healthcare and by the pharmacists. So from a competition policy standpoint there is no real concern.

The **Chairman** asked why there was a need for recommended prices and whether the national association of pharmacists and whether the chamber of pharmacists was a public or private body as it would strongly change the perception of the case.

The delegate from **Hungary** explained that it is a mixture of private and public body, which works as kind of self-organising body of the professionals to protect their interest on a very civil basis. But in the case of pharmacists, they do not have the legal power to fix prices, fortunately, unlike some other professional bodies. So in this case the competition authority can intervene.

The **Chairman** asked for clarification about non-prescription drugs

The **Hungarian** delegate replied that in Hungary there are subsidised and non-subsidised drugs and, the pharmacists receive a floppy disk with the prices, from the Ministry or the insurance fund. And this list is not only limited to prescription drugs but many others also. Nevertheless, there are some services which can be carried out by pharmacists, which are not really regulated so the issue has some relevance, but not in terms of prices.

The **Chairman** then moved to Netherlands, and in particular to the AstraZeneca case to ask the delegate to explain why hospitals received high discounts from AstraZeneca in the purchase of their products, but with the provision that they use these drugs just for patients in the hospital and not be sold outside. The chairman asked if it was an exclusionary practice, or an exploitative abuse.

The delegate from **The Netherlands** explained the rationale of the decision of the NMA, the Dutch competition authority, that it was an agreement that hospitals could not deliver medicines to pharmacies because it was prohibition of competition. The agreement was to prohibit competition between hospitals and pharmacies, because hospitals received large discounts and the pharmacies did not. The decision was made that the industries had to deliver straight to the pharmacies instead of the hospitals.

The **Chairman** asked if there were competitors to AstraZeneca that would have been excluded from the hospital market because of these discounts and if this was not an issue of pure discrimination.

The delegate from **The Netherlands** replied that patients received medicines from hospitals with discount, but when they were released from hospital they had of course to buy from the pharmacies at much higher in prices and that was in conflict with the competition act.

The **Chairman** then asked Switzerland to comment on the case against Eskamed which is a private body in charge of a register with a list of all drugs admitted to the market in Switzerland. The case was initiated by the competition authorities. The chairman asked if Eskamed's role was public or private, and if it was connected with excluding a competitor from the market.

The delegate from **Switzerland** replied that Eskamed is a company that is concerned with supplemental health insurance and had nothing to do with pharmaceuticals. This company controls admission of practitioners of complimentary medicine such as acupuncture, or traditional Chinese medicine, for example who would be covered by supplementary health insurance. These practitioners must fulfil certain conditions, which are set by the private company Eskamed. This company was taken on by a group of insurers to assure a quality standard of the practitioners who would then be put on the list. Different complaints were lodged with the Swiss Competition Authority (Commission de la Concurrences) on the basis that the conditions were too strict, such as minimum amount of hours as a practitioner before being allowed on the list. On analysing these the authority concurred with the petitioners that in fact the conditions laid out by the company were unjust for some, which lead to certain adjustments by the company and an amiable solution was found without enforcement.

The **Chairman** turned to Norway to discuss the issue of Value Added Tax (VAT), and the discriminatory effect of different rates of VAT. for different professional services, and further whether it was a case for advocacy.

The delegate from **Norway** explained that in Norway health services were exempt from VAT but other service orientated industries were not. However, there are situations where health personnel and other personnel could deliver exactly the same service and thus competition is distorted. There exists a section in Norwegian law giving the authority powers regarding advocacy. In the previous competition act the authority was allowed to point to distortions caused by regulations in competition through the Ministry of Work and Administration, which is the ministry responsible for competition policy. With the new competition act, however, the authority is allowed to send this letter directly to the ministry or the regulatory body in question, and they are by law, obliged to respond within a given deadline. In short the advocacy role of the competition authority in Norway is strengthened, and we can apply the competition act to all advocacy questions.

The **Chairman asked** if there were any recent examples of the force of these new powers.

The delegate from **Norway** replied that it was true that an advocacy power existed in the old competition act, but not to the same extent. With the new competition act they were confident that advocacy will have more effect, but it was in its infancy stages and no data is available.

The **Chairman** called on New Zealand to give their experience on enforcement in the health care professions.

The delegate from **New Zealand** began by pointing out that this year the authority were successful in taking High Court proceedings against the Ophthalmological Society in New Zealand where five of its individual ophthalmologists were found guilty of entering into an arrangement that blocked entry by Australian ophthalmologists into the market in New Zealand, which was found to result in a substantial lessening of competition. Fines, penalties and costs against the Society were levied on the individual doctors. The second case, of which the results are not yet known at the time of this meeting, involves a

group of ophthalmologists who, the authority alleges, colluded to no longer individually negotiate fees, but to set fees through one negotiator. In the third, a warning was issued to a group of cardiac anaesthetists who colluded to negotiate fees on their own behalf with the hospitals. They had believed they had formed a joint venture and therefore were subject to an exemption. The authority found that the exemption did not apply and they have since agreed to cease the joint negotiation of fees in that area. The fourth involves the Pharmacy Guild of New Zealand to whom a warning was issued because the guild was recommending price increases in their monthly publications, in breach of the commerce act representing a form of price fixing. They also have since agreed to cease recommending any increase but instead have undertaken to provide education to their members about the application of the commerce act in New Zealand. A warning has been issued to the New Zealand Dental Association as a result of price surveys that they undertook which was providing pricing information to their members that was believed to insinuate what prices should be charged. The Dental Association also agreed to cease undertaking a survey of pricing information representing a barometer of price indicators. The delegate went on to explain that the main positive outcome has been an increase in information provided to the health associations resulting in a significant change of behaviour by the professional bodies.

The **Chairman** then moved to Australia.

The delegate from **Australia** reinforced the importance of educating members of the medical profession. A recent parliamentary review looking at the application of Australia's competition law to the medical profession recognised that education of medical professionals was needed to ensure that they were aware of their rights and responsibilities under Australia's competition law. The HWC was given additional funding to undertake the role and produced an information kit for medical professionals covering a range of topics that medical professionals come across in their everyday dealings with patients; with each other; and with suppliers. Therefore the authority's hope is that more information will lead to less infringement of competition law.

The delegate from **Ireland** addressed the topic of the recent overhaul of legislation in New Zealand.

The delegate from **New Zealand** responded that changes have been undertaken by the health officials to address long waiting lists in the health area because of shortages in some of the professions. But despite the changes that had been made at a policy level there are still significant issues to be dealt with across the health profession. There is resistance to the notion that the Commerce Act should apply to health professions, and use patient safety as an argument for undertaking varying activities that are found to be in breach of the Commerce Act.

Conclusion

The **Chairman** then closed the discussion by summarising various points made by the delegations reiterating that no delegation thought that entry into the health professions should be completely free and that qualifications were necessary. He pointed out the difficulties between the old and new professions such as dentists and dental hygienists across countries which had very different types of institutional structures, but nonetheless the same outcome was of keeping dental hygienists out of the market as independent providers of services. He highlighted variations in the pharmaceutical sector, pharmacy and the pricing of drugs from country to country. He reminded the delegates of the morning session and especially the presentation from the United Kingdom that is so important for the rest of Europe, which is a slow but progressive process towards privatisation in the healthcare sector, where hospitals are slowly becoming enterprises which will lead to greater antitrust enforcement and competition issues to be addressed in the future.

COMPTE RENDU DE LA DISCUSSION

Introduction

Le **Président**, Alberto Heimler, commence par préciser que c'est la première fois que le Comité de la concurrence ou son Groupe de travail traite de questions de santé. La table ronde sur la concurrence dans les professions de santé portera sur des questions analogues à celles normalement examinées dans le cadre des autres professions, c'est-à-dire les obstacles structurels à l'accès et les restrictions en matière de comportement. Compte tenu de la spécificité du secteur de la santé et du fait que la demande est toujours une demande dérivée dans la mesure où les médecins prennent généralement les décisions pour les patients, qui ne s'acquittent d'ordinaire pas de la totalité du coût du service dont ils bénéficient, le Président juge nécessaire de commencer par décrire brièvement les principales caractéristiques du système de santé et le rôle de la concurrence et de la réglementation. Les services de santé sont des exemples parfaits de biens impliquant une relation de confiance, autrement dit de biens dont le bénéficiaire n'est pas en mesure de juger de la qualité, ni avant ni après l'achat. Le risque de voir des professionnels non qualifiés fournir des services est très élevé de sorte que l'excercice est rigoureusement réglementé dans tous les pays. L'accès est subordonné à des qualifications professionnelles et le comportement est assujetti à des normes de qualité, et très souvent à des exigences dites éthiques. La publicité est interdite, dans de nombreux pays, et on évite une concurrence effrénée entre professionnels en imposant des prix minimums légaux. Dans certains cas, le droit exclusif accordé à une profession donnée est beaucoup trop étendu. Dans de nombreux pays, par exemple, les hygiénistes dentaires ne sont pas autorisés à exercer indépendamment d'un dentiste.

Dans la plupart des pays de l'OCDE, la majorité des services de santé est presque entièrement financée par l'Etat, qui emploie aussi de nombreux professionnels de la santé. Le consommateur final ne s'acquitte pas de la totalité du coût des services de santé dont il bénéficie et tend à exiger des services dont il n'est pas prêt à régler le coût intégral. La demande de services de santé n'est généralement pas exprimée par les patients mais par un intermédiaire : le médecin. Les médecins peuvent agir pour l'Etat, en maintenant les dépenses médicales à un faible niveau (en prenant certains risques) ou pour les patients, en accédant à leurs souhaits et en prescrivant parfois des examens inutiles.

Le **Président** fait observer que, dans un système d'assurance, les consommateurs ont tendance à demander des soins superflus, sauf si les services de santé non essentiels sont rationnés. Bien souvent, les personnes qui sont prêtes à payer et qui ne veulent pas attendre peuvent s'adresser au secteur privé, ce qui ne fera pas augmenter les dépenses. Une plus grande transparence est possible lorsqu'un médecin de famille est chargé de prendre les décisions dans l'intérêt général. Etant donné que les médecins peuvent travailler pour la collectivité en ayant comme objectif l'intérêt général, qu'ils peuvent travailler pour les patients ou travailler pour eux-mêmes, comment veiller à ce qu'ils défendent l'intérêt général ? Le Président souligne l'importance de l'expérience du Royaume-Uni.

Le **Professeur Hugh Gravelle**, de l'Université de York, déclare tout d'abord que le secteur des soins de santé présente un certain nombre de caractéristiques qui impliquent la possibilité que le marché, et aussi l'Etat, soient défaillants. Ce secteur fonctionne dans un monde qui n'est pas parfait. La santé a des coûts externes au niveau de la consommation et de la production ; on observe une asymétrie de l'information parmi les patients, les prestataires et payeurs (contribuables ou assureurs) ; les prestataires ont un pouvoir monopolistique découlant des coûts de déplacement des patients et d'économies d'échelle dans la production.

Le Service National de Santé (NHS) du Royaume-Uni est financé par l'impôt et si les patients sont mis à contribution, ils ne règlent qu'un faible montant. Les malades hospitalisés en urgence sont admis directement au service des urgences. Il existe un système de filtrage pour les traitements non urgents dans la mesure où les patients doivent être envoyés par un généraliste. Les patients hospitalisés ne paient rien. Les admissions non urgentes sont peu nombreuses en raison des délais d'attente. L'attente moyenne pour toutes les admissions non urgentes, quel que soit leur type, est supérieure à 100 jours et peut même aller jusqu'à un an. Les généralistes sont indépendants, payés à la capitation (c'est-à-dire rémunération par malade inscrit sur leur liste) ; à l'acte ; ou forfaitairement. Ils sont les intermédiaires obligés pour les soins secondaires non urgents.

En 1990, le gouvernement a révisé le contrat conclu avec les généralistes au niveau national dans le souci d'améliorer la qualité. Des incitations financières directes ont été reliées à des objectifs de qualité et la rémunération par malade inscrit a été relevée de manière à rendre les patients plus intéressants et à davantage inciter les généralistes à se concurrencer en offrant des soins de meilleure qualité. Pour favoriser la concurrence, les patients ont été autorisés à changer de généraliste sans l'autorisation de leur médecin traitant. Les groupements de médecins généralistes ont eu la possibilité d'avoir un budget pour acheter des soins non vitaux pour les patients. Ce budget était généreux : il était calculé en fonction du nombre antérieur d'admissions et excluait les cas onéreux qui étaient pris en charge par l'autorité sanitaire locale. Si les dépenses d'un groupement médical étaient supérieures au montant de l'enveloppe budgétaire, les coûts étaient pris en charge par l'autorité sanitaire locale. Les généralistes utilisant le système des enveloppes budgétaires avaient aussi des budgets aux fins de prescription. Les éventuels fonds excédentaires devaient être dépensés pour améliorer les services fournis aux patients, ce qui a été interprété de manière à inclure les investissements dans les locaux. La plupart des généralistes sont propriétaires de leurs locaux et peuvent donc capitaliser les excédents qu'ils y ont investis et récupérer l'argent au moment de leur retraite. Les généralistes étaient donc personnellement incités à réduire les dépenses liées aux admissions non urgentes et aux prescriptions, outre l'incitation à en faire profiter les patients s'ils estimaient que les économies ainsi réalisées pouvaient servir à financer d'autres services assurant des soins de meilleure qualité, comme la pédicurie. Les services de santé locaux prenaient en charge les soins dispensés en urgence. Les groupements médicaux non titulaires d'enveloppes avaient poursuivi leurs activités comme avant, sans disposer de budgets pour les soins et tous les coûts d'hospitalisation des patients étaient à la charge de l'autorité sanitaire locale. Le système des enveloppes budgétaires a été supprimé en avril 1999, date à laquelle environ 50 % de la population du Royaume-Uni relevaient d'un groupement de médecins détenteur d'une enveloppe.

La séparation entre les acheteurs et les prestataires a été un élément essentiel de la réforme du marché interne opérée en 1990. De 1949 à 1990, les autorités sanitaires locales étaient propriétaires des hôpitaux qu'elles géraient en disposant d'un budget fixe. En 1990, les hôpitaux ont cessé de relever des autorités sanitaires pour devenir des sociétés de droit public à but non lucratif. Ils devaient obtenir un petit taux de rendement sur leur capital. Ils ont passé des contrats avec des acheteurs, à savoir les autorités sanitaires locales et, pour une partie des soins non urgents, avec des détenteurs de fonds. Le but était d'encourager la concurrence entre les prestataires et les hôpitaux. La séparation acheteurs/prestataires a survécu à la suppression du système des enveloppes budgétaires.

La concurrence ne s'est sans doute pas beaucoup exercée pour les patients, car un tiers d'entre eux choisissent le cabinet le plus proche et les généralistes sont des biens d'expérience dans la mesure où il faut les essayer pour savoir s'ils sont bons. Les coûts de transfert pour passer d'un généraliste à l'autre sont importants. Chaque année, 1 à 2.5 % seulement des patients changent de généraliste sans changer d'adresse. Cela étant, environ 13 % des patients changent chaque année de généraliste parce qu'ils déménagent. Les données sont limitées mais donnent à penser qu'en dehors du critère de distance, les patients sont soucieux d'avoir un bon généraliste, d'où certaines possibilités de concurrence pour les patients, afin d'améliorer la qualité des soins.

Comme le système des enveloppes budgétaires était facultatif, les estimations relatives aux effets qu'il a eus sur les groupements médicaux l'ayant choisi risquent d'être différentes de celles portant sur les effets d'un système obligatoire appliqué à l'ensemble des groupements. Les détenteurs d'enveloppes ont réagi aux incitations, parfois de manière involontaire. Comme le volume de l'enveloppe était calculé en fonction du nombre de patients qu'ils avaient enregistrés l'année précédant leur décision, les médecins qui choisissaient ce système ont gonflé ce nombre pour disposer de budgets supérieurs par la suite. Les coûts administratifs augmentent aussi. L'écrémage est une autre incitation évidente non intentionnelle; les médecins détenteurs d'une enveloppe pouvaient refuser les patients qui coûtaient cher pour choisir ceux qui coûtaient moins cher. Le peu d'éléments dont on dispose sur le sujet semble indiquer que l'écrémage ne s'est pas fait à grande échelle.

Le système des enveloppes budgétaires était destiné à abaisser les coûts ; les coûts de prescription ont été réduits de 3 à 5 % pour les détenteurs d'une enveloppe ; le nombre d'admissions a baissé d'autant ; les admissions non urgentes n'ont apparemment pas remplacé les admissions en urgence. Les médecins se sont fait concurrence pour avoir des patients relevant du système des enveloppes budgétaires en réduisant les temps d'attente (d'environ 5 % en moyenne), d'où des accusations de système à deux vitesses.

La séparation entre prestataires et acheteurs et l'incitation à la concurrence entre prestataires ont caractérisé le marché interne. D'après le peu de données disponibles, les prestataires se sont apparemment fait concurrence à la fois au niveau des prix et à celui des délais d'attente. La concurrence a donc eu les résultats attendus. Cela étant, certaines conséquences involontaires ont été mises en évidence par Carol Propper dans une étude récente : les prestataires auraient eu moins recours aux soins d'urgence. L'auteur semble indiquer que la mortalité par crise cardiaque aurait légèrement augmenté.

Les effets du nouveau marché interne qui se dessine actuellement semblent plus marqués. Les prestataires de soins secondaires seront soumis à une nouvelle déréglementation et la concurrence sur le marché de ces soins sera plus forte. Les hôpitaux du NHS verront leur statut modifié et seront moins réglementés ; ils pourront créer des sociétés privées et contracter plus facilement des emprunts. Les acheteurs du NHS seront incités à avoir recours à des prestataires privés. Des centres de traitement spécialisés seront mis en place et le NHS fera aussi appel aux hôpitaux étrangers, de sorte que les patients en attente d'une prothèse de la hanche ou d'une opération de la cataracte, par exemple, se rendront à l'étranger, normalement en Europe, pour se faire soigner. Le système de contrat sera aussi modifié. Les contrats entre les autorités de santé et les hôpitaux étaient extrêmement flous, les versements effectués n'avaient qu'un lien très vague avec le nombre de patients traités. A compter de 2008, tous les soins secondaires seront facturés à un taux uniforme, fixé au niveau central, en fonction des groupes homogènes de maladies (GHM). Le but est de faire en sorte que les recettes varient en fonction de la quantité, de sorte qu'en appliquant des prix fixes les prestataires se feront concurrence au niveau de la qualité. Ce choix s'explique par la nécessité de veiller à ce que les patients qui doivent bénéficier de soins secondaires non urgents aient le choix entre quatre ou cinq prestataires ; ils disposeront, par ailleurs, d'une vaste gamme d'indicateurs de qualité et de performance pour pouvoir décider en connaissance de cause.

Les soins primaires seront déréglementés et la gamme des prestataires sera élargie. Les « primary care trusts » (groupements de soins primaires) seront autorisés à se procurer des services auprès d'autres catégories de prestataires que des généralistes, les pharmacies devraient avoir un rôle plus large à jouer et les restrictions à l'entrée dans le secteur de la pharmacie devraient être supprimées. Un nouveau contrat avec les généralistes (mis en place en avril 2004) offre des incitations financières directes pour améliorer la qualité par rapport à 146 indicateurs de qualité. Ces derniers devraient profondément modifier la façon dont les généralistes fonctionnent, car la rémunération supplémentaire perçue au titre de la qualité représentera environ 20 % du revenu du généraliste. Le gouvernement a annoncé, quelques jours avant la présente réunion, qu'il avait décidé d'étendre la formule d'achat des soins à l'ensemble des praticiens à compter d'avril 2005. Les groupements médicaux seront autorisés à avoir un budget indicatif pour les soins secondaires, y compris pour les admissions en urgence. Ils pourront aussi conserver la moitié des éventuels excédents budgétaires. Le système des enveloppes budgétaires a donc été réintroduit.

Le **Président** demande ensuite si, au Royaume-Uni, le nombre de généralistes est fixe et si le nombre de patients par généraliste est plafonné.

Le **Professeur Gravelle** explique qu'au Royaume-Uni, les généralistes ne sont soumis à aucune restriction en ce qui concerne le nombre de patients inscrits sur leurs listes. Dans le passé, les pouvoirs publics ont essayé d'orienter les généralistes qui souhaitaient ouvrir un nouveau cabinet vers les zones mal desservies en limitant l'accès aux régions dans lesquelles le rapport généralistes/patients était élevé. Cela étant, le nombre total de généralistes a été réglementé par l'Etat par le biais de l'accès aux facultés de médecine.

Le **Président** se tourne vers un expert des Etats-Unis pour connaître les solutions réglementaires qui ont été trouvées pour maîtriser les dépenses. Sur la plupart des marchés, la concurrence permet aux consommateurs de choisir ce qu'ils consomment réellement ; et c'est là une autre particularité de la concurrence dans les soins de santé : on ne sait pas bien quelle est sa finalité.

Le **Professeur David Hyman** signale tout d'abord que les dépenses de santé par habitant, aux Etats-Unis, sont beaucoup plus élevées dans les autres pays ; elles s'élèvent à 1 600 milliards de dollars, soit près de deux fois plus qu'au Royaume-Uni, et représentent environ 15 % du PIB. Le système associe secteur privé et secteur public, que ce soit au niveau du financement ou à celui des prestations. Les prestations relèvent pour l'essentiel du secteur privé, une petite partie étant l'apanage du secteur public. Pas moins de 60 % de la population bénéficient de la couverture maladie d'un membre de la famille actif et une couverture particulière est offerte aux personnes âgées, aux couches défavorisées et aux jeunes. La relation entre les Etats et le gouvernement fédéral est complexe. Ce dernier réglemente certains aspects de l'assurance maladie mais l'essentiel relève de chaque Etat. Les Etats-Unis comptent bien plus que de nombreux autres pays sur la concurrence, que se soit en matière de financement ou de prestations. Grâce à la publication, en 2003, d'un rapport, les organismes chargés de la politique de la concurrence sont devenus plus transparents. Les Etats-Unis exécutent actuellement un programme de promotion de la concurrence pour essayer de persuader les Etats et le gouvernement fédéral d'être attentifs aux implications de la concurrence sur le marché des soins de santé.

Schématiquement, ce rapport traite du financement et de la fourniture des soins de santé aux Etats-Unis, de la prestation de services de santé rémunérés à l'acte à des dispositifs de capitation et de post-capitation. Il porte aussi sur les problèmes de qualité, mis en évidence par les erreurs médicales, et examine dans quelle mesure une concurrence accrue permet d'améliorer la qualité ou donne les résultats que le délégué du Royaume-Uni a décrits. Il fait ressortir les défaillances des organismes chargés de la politique de la concurrence dans le domaine de la fusion des hôpitaux en raison des difficultés inhérentes à l'opération et du fait que les juges saisis de ces affaires préfèrent ne pas considérer les hôpitaux comme des concurrents mais comme des acteurs non orientés vers le marché. L'assurance est essentiellement

réglementée au niveau des Etats bien qu'il existe, au niveau fédéral, certaines réglementations qui tendent à être fondées sur l'emploi.

Le Professeur Hyman examine l'évolution des soins de santé déterminés par le consommateur, qui a toute liberté pour choisir un médecin et doit donc parfois participer aux frais ; les patients disposent en conséquence de financements qui se reconstituent et s'accumulent afin de régler leurs dépenses. Cette question a soulevé une certaine controverse par crainte d'un pouvoir de monopsone. Le rapport traite des prestations obligatoires, qui illustrent bien les effets imprévus que les réglementations publiques peuvent avoir sur la concurrence et leurs conséquences anticoncurrentielles. Il traite aussi des systèmes d'encadrement de l'offre de services qui sont des obstacles à l'entrée créés par les pouvoirs publics.

Ce rapport débouche sur six recommandations et onze observations sur le droit de la concurrence. Les recommandations visent les Etats et le gouvernement fédéral mais aussi les prestataires et les organismes payeurs. Il est notamment recommandé de fournir des incitations aux prestataires, d'abaisser les coûts et d'améliorer la qualité. Les Etats devraient réduire le nombre de barrières à l'entrée et aux marchés de fournisseurs, les administrations devraient réfléchir à la manière dont les subventions peuvent fausser la concurrence – plus les subventions sont transparentes, plus la situation aura tendance à être favorable. Les négociations collectives par des prestataires indépendants ne sont pas recommandées même si le but est souvent de favoriser la concurrence. Les Etats devraient examiner les questions de transparence et l'intérêt que présente une réglementation. Dans l'immédiat, les pouvoirs publics devraient se demander si les dispositions actuelles répondent bien aux besoins de santé de la population.

Le **Président** déclare ensuite que les débats seront organisés autour de trois grands thèmes, à savoir les règles structurelles, les règles de comportement et les questions d'application du droit de la concurrence. Il se tourne ensuite vers Mark Botti, expert, qui va parler des activités normatives dans les professions de santé.

Règles structurelles

M. Mark Botti présente son document sur les activités normatives du secteur privé aux Etats-Unis. Il ajoute qu'il se concentrera sur les comportements purement privés, c'est-à-dire sur ceux qui ne sont pas imposés par l'Etat.

Plusieurs organisations fixent des normes pour assurer la qualité des soins de santé. L'administration établit souvent des normes minimales concernant le droit d'exercice mais le secteur privé, aux Etats-Unis, fixe souvent des normes plus rigoureuses. Grâce à ces normes, le consommateur notamment sait qui est compétent pour fournir les services et qui est spécialisé, ce qui lui permet de choisir en toute connaissance de cause. Cette activité peut aussi, toutefois, nuire à la concurrence. Il arrive que les professionnels de la santé aient une influence sur d'importants équipements auxquels les nouveaux entrants doivent avoir accès pour pouvoir être compétitifs sur nos marchés. Ces organisations normatives peuvent mettre en place des obstacles à l'accès, ce qui nuit à la concurrence.

M. Botti présente deux affaires illustrant les effets des organisations normatives privées. Dans la première (Donald W. Kreuzer, MD c. American Academy of Periodontology (1984)), le tribunal a affirmé de manière très catégorique que la législation antitrust n'empêche pas la formation d'associations regroupant des personnes oeuvrant dans le même domaine et recherchant conjointement l'intérêt commun. Il s'est intéressé à la mise en œuvre du droit de la concurrence par rapport à la fixation de normes professionnelles, y voyant un gage de qualité et une source d'information.

Dans la deuxième affaire (Ronald A. Schacar c. American Academy of Ophtalmology), la chirurgie corrective de l'oeil était considérée en substance comme une source de concurrence sur le marché des lunettes et des lentilles de contact. Le National Advisory Eye Council a qualifié cette pratique largement répandue d'expérimentale. Il avait demandé aux professionnels de faire preuve de retenue en attendant que des recherches complémentaires soient menées. Pour le médecin qui avait engagé les poursuites, la diffusion de cette information réduisait ses chances sur le marché. Les juges ont estimé que sa demande était dépourvue de fondement. Ils ont fait observer que les ophtalmologistes attirent simplement l'attention d'éventuels patients en leur donnant des informations et en leur préconisant le port de lentilles de contact ou de lunettes en attendant que la procédure chirurgicale soit soumise à des tests plus approfondis ; la solution, dans ce cas, ne résidait pas dans une législation antitrust mais dans plus d'information. Les médecins et les chirurgiens se font donc concurrence sur le marché des idées.

En conclusion, lorsque les marchés sont solides et fonctionnent de manière agressive, la concurrence est forte et les organisations normatives peuvent leur donner des informations utiles et les dissuader de tout comportement anticoncurrentiel. Cela étant, lorsque la concurrence sur les marchés est faible, les organisations normatives peuvent faire obstacle à l'apparition de nouveaux concurrents, d'où le rôle que la législation antitrust peut jouer pour éviter les effets fâcheux des organisations normatives. Le **Président** passe ensuite à l'Irlande et demande au délégué de ce pays de formuler des observations sur l'affaire dans laquelle l'autorité chargée de la politique de la concurrence a affirmé que l'absence de statut légal des prothésistes ou techniciens dentaires qualifiés risquait de faire obstacle à l'accès à la profession et nuisait en conséquence à la concurrence éventuelle sur le marché.

Le délégué de l'**Irlande** précise que cette autorité n'a pas pour mission de protéger les professionnels mais les consommateurs et la société en général. Toutefois, la définition de la médecine dentaire dans la législation irlandaise est loin d'être claire. Le Dental Council, qui compte essentiellement des dentistes et est l'organe de supervision officiel, a essayé en vain d'élaborer, en 1985, un système réglementaire distinct afin d'enregistrer les auxiliaires dentaires, dont les techniciens. Cette tentative avortée fait que les techniciens dentaires ne peuvent toujours pas offrir de services indépendants au public et c'est un exemple classique d'entrave réglementaire. Le Dental Council contrôle les modalités d'exercice des auxiliaires dentaires. Lorsqu'il choisit de ne pas élaborer de réglementation, comme c'est le cas actuellement, on observe que l'absence de réglementation est pire que tout. Pour le délégué irlandais, il s'agit là d'un obstacle classique à l'accès, déguisé en protection du consommateur. On en déduit donc que les prothésistes ne peuvent pas faire de prothèses et les vendre sans la supervision des dentistes, d'où des coûts supérieurs et des prix plus élevés pour le consommateur. Le danger qu'il y a à autoriser les professionnels de la santé à dominer les organes de supervision met en évidence un certain nombre de défis majeurs pour les organismes chargés de la politique de la concurrence et autres partisans du jeu de la concurrence, de même pour les risques qu'implique le fait de laisser le dernier mot aux professionnels de la santé dans la délimitation des périmètres d'intervention. Le principal défi consiste toutefois à persuader les décideurs et les parlementaires du caractère essentiel du principe de proportionnalité et du fait qu'ils ne devraient pas faciliter les pratiques anticoncurrentielles.

Le **Président** relève les très nombreuses exclusivités dont bénéficient certaines professions anciennes et note que, dans de nombreux pays, les nouvelles professions susceptibles, de fait, de faire concurrence aux anciennes, se voient refuser tout accès.

Le **Président** passe ensuite au Mexique qui est un cas intéressant de réglementation structurelle : les professionnels de la santé doivent obtenir un certificat de qualité tous les cinq ans. En règle générale, les associations professionnelles font la critique suivante : les conditions fixées ne s'appliquent qu'à l'accès à la profession et non tout au long de la vie professionnelle. Le Président demande au délégué mexicain quelle est l'utilité, si tant est qu'il y en ait une, de soumettre en permanence les professionnels à un examen si le but n'est pas, en dernier ressort, de ne plus les autoriser à exercer.

Le délégué **mexicain** fait observer que l'agrément quinquennal est une preuve de qualité mais n'a pas pour effet de retirer une autorisation d'exercer. Au Mexique, 50 % du total des dépenses de santé sont à la charge du patient de sorte que la symétrie est plus importante que l'auto-information. La certification est considérée par les hôpitaux, les compagnies d'assurance et les patients privés comme une garantie de qualité, et les compagnies d'assurance ne remboursent pas les frais si les médecins ne sont pas agréés tous les cinq ans. Les médecins agréés sont recrutés par les grands hôpitaux et leurs honoraires sont supérieurs.

Le **Président** se demande si l'examen est sélectif ou s'il ne s'agit que d'une formalité et si le taux de réussite est de 100%.

Le délégué **mexicain** répond que 70% des médecins, toutes spécialités confondues, le réussissent .

Le **Président** passe ensuite aux Etats-Unis pour savoir quelle est la situation des hygiénistes dentaires en Caroline du Nord où, d'après la FTC, le Board of dentistry a restreint illégalement la capacité des hygiénistes dentaires à dispenser des soins dentaires préventifs en milieu scolaire. En raison des différences de cadres institutionnels entre les pays, il demande au délégué des Etats-Unis de préciser si les boards en question sont publics ou s'il s'agit d'associations privées et de décrire les problèmes qui se posent.

Un délégué des **Etats-Unis** commence par préciser que les associations nationales sont sensibilisées aux problèmes de concurrence et appliquent le droit de la concurrence. Le Dental Board de l'Etat de Caroline du Sud, organe qui conditionne l'exercice de la profession de dentiste à une autorisation, exige des hygiénistes dentaires qu'ils ne dispensent pas de soins dentaires préventifs dans les établissements scolaires tant qu'un dentiste n'a pas procédé à un examen préalable. Le Board se compose de huit membres, dont six dentistes élus par d'autres dentistes dans tout l'Etat de Caroline du Sud. Il compte un représentant des hygiénistes dentaires et un particulier. La question juridique qui se pose est la suivante : est-ce l'Etat qui exerce son pouvoir souverain ou s'agit-il d'une activité anticoncurrentielle privée de la part des dentistes du Board ? Comme le Président le fait observer, les Etats ont la faculté, en vertu de leur pouvoir souverain, de remplacer les systèmes réglementaires par un système de concurrence. Cela étant, l'Etat qui souhaite remplacer la réglementation par la concurrence doit avoir une politique cohérente. La Commission a conclu que les activités en question étaient véritablement privées et donc soumises au droit de la concurrence. Cette décision a toutefois fait l'objet d'un recours devant le Court of Appeals Board des Etats-Unis. L'organisme qui délivre les autorisations d'exercer au niveau de l'Etat est manifestement une entité quasi publique qui existe en vertu d'une loi adoptée au niveau de l'Etat.

Le **Président** se tourne ensuite vers la Commission européenne en évoquant le cas de la Finlande où les travaux des hygiénistes dentaires ne sont remboursés par l'assurance maladie nationale que s'ils ont été effectués sous la supervision d'un dentiste, dans un cabinet dentaire, ce qui va au-delà de la réglementation. Contrairement à l'Irlande, la Finlande autorise les hygiénistes dentaires à exercer indépendamment. Le Président demande si c'est un cas normal d'application de la réglementation ou s'il y a violation de la législation européenne par le gouvernement finlandais.

Le délégué de la **Commission européenne** répond que l'affaire est traitée conformément aux règles générales du droit de la concurrence car, d'après la jurisprudence actuelle de la Cour de Justice, l'article 86 ne s'applique que si les droits sont exclusifs. Le nombre de dentistes pouvant exercer en Finlande n'est pas limité de sorte que l'on ne peut pas parler de droit spécial.

Le **Président** précise qu'indépendamment de la manière dont les Etats ou les pouvoirs publics limitent l'accès, que ce soit par la voie législative comme en Irlande, par l'intermédiaire des State Boards comme aux Etats-Unis ou par le système national d'assurance comme en Finlande, l'effet est le même, à savoir que les hygiénistes dentaires indépendants demeurent en dehors du marché, ce qui renchérit le prix

pour le consommateur. L'autre manière de contrôler le marché dans le cas de l'Irlande et du Royaume-Uni est de contrôler l'accès à l'université, autre élément important dont il conviendrait de tenir compte dans l'analyse de la concurrence dans les professions.

Le Président passe ensuite à l'Italie qui, en règle générale, ne limite pas quantitativement l'accès à l'université, ni pour les professions médicales, ni pour les professions paramédicales. Cela étant, certaines mesures d'encadrement quantitatives ont été prises récemment. Le Président demande au délégué italien de décrire brièvement le système réglementaire applicable à l'accès aux professions et aux universités.

Le délégué de l'**Italie** répond qu'il y a peu de temps encore, l'accès à l'université n'était pas limité et que le coût direct de l'éducation n'était pas prohibitif. Une fois diplômé, l'étudiant doit devenir membre d'une association professionnelle pour être reconnu en tant que praticien agréé. Cette procédure ne repose pas sur le nombre de candidats diplômés et ne constitue donc pas un véritable obstacle à l'accès. Récemment, certaines universités ont limité le nombre de places mais il est encore trop tôt pour pouvoir juger des effets. Certaines restrictions concernent les formations spécialisées, dans la mesure où le candidat doit avoir une place dans un institut de formation agréé ; le nombre de places est fixé tous les trois ans par les pouvoirs publics en fonction des besoins de santé recensés dans la population et des possibilités d'emploi locales. En Italie, pour pouvoir exercer en qualité d'omnipraticien, l'association professionnelle doit passer un accord avec les régions. Le nombre de médecins dans chaque région dépend du nombre de résidents. On optimise ainsi le rapport entre le nombre de médecins de famille et le nombre d'habitants. Les médecins reçoivent une indemnité fixe pour chacun de leurs patients et ils doivent garantir un service quotidien dans leurs locaux et des visites à domicile en cas de maladie grave. Les patients ayant la possibilité de changer de médecin de famille, la concurrence s'exerce mais, compte tenu du rapport optimal généralistes/habitants, les médecins ne sont guère incités à être compétitifs.

En conclusion, le délégué italien précise que de nouveaux diplômes universitaires ont été créés pour les professions de santé suivantes : diététiciens, physiothérapeutes, hygiénistes dentaires et audiologistes. Ces professions se distinguent des professions agréées par l'absence d'ordres professionnels, de système d'autorisation d'exercer, d'où des erreurs médicales et des problèmes de qualité qui n'ont toutefois pas été jugés plus graves ou plus fréquents que ceux observés parmi les professionnels soumis à autorisation.

Le Président évoque ensuite la question des pharmacies et des pharmaciens, et les différences relativement à la propriété d'une pharmacie. L'Italie compte plus de 60 000 pharmaciens mais seulement 16 000 pharmacies. Le droit de propriété d'une pharmacie est fortement réglementé contrairement à l'accès au secteur. Le Président passe ensuite à l'Allemagne où l'accès au secteur est entièrement libre, à condition d'être pharmacien. Il demande si l'ouverture d'une pharmacie est soumise à des restrictions et si l'Etat garantit l'offre publique des services.

Le délégué **allemand** répond qu'il n'existe pas de limitation majeure, à ceci près qu'il faut avoir un diplôme de pharmacologie, que les grossistes en produits pharmaceutiques ne peuvent pas acheter de pharmacie et qu'il n'y a pas non plus de chaînes de pharmacies, en Allemagne. Néanmoins, les règles s'assouplissent et, aujourd'hui, un pharmacien peut posséder jusqu'à quatre pharmacies. Le secteur des professions de santé est financé sur fonds publics mais la prestation des services professionnels est entièrement privée. Compte tenu de la forte densité de pharmacies en Allemagne, l'Etat n'a pas dû intervenir pour garantir ce service ; il réglemente, toutefois, les heures d'ouverture et les pharmacies doivent assurer un service de garde la nuit et le week-end.

Le **Président** souligne que le fait qu'il ne puisse y avoir participation ou détention par une société peut être considéré comme un obstacle à l'accès car un pharmacien ne dispose pas toujours du capital nécessaire pour ouvrir une pharmacie.

Au Danemark et au Royaume-Uni également, le marché des médicaments en vente libre s'est ouvert à d'autres entités, comme les supermarchés. Le Président demande ensuite au délégué danois quelles ont été les répercussions de cette décision récente d'autoriser les supermarchés à vendre des médicaments en vente libre ; si leur stratégie de commercialisation est agressive ; pourquoi cette décision a été prise ; et quelle a été la réaction des pharmaciens, si tant est qu'ils aient réagi.

Le délégué du **Danemark** précise que seuls certains médicaments en vente libre peuvent être vendus en supermarché. Le pouvoir de monopole des pharmacies, au Danemark, a fortement retenu l'attention, aussi bien des autorités chargées de la politique de la concurrence que du public, et le changement a été motivé par la volonté d'accroître la concurrence et l'efficience dans ce domaine. Au début, les pharmaciens s'inquiétaient pour les consommateurs et, naturellement, pour leurs revenus. L'Agence danoise des médicaments a déjà publié certains chiffres sur les effets du nouveau système : les supermarchés et autres magasins agréés représentent désormais 20 à 25% de ce marché et, en moyenne, les prix ont baissé de 5 à 15%.

Le **Président** sollicite des commentaires et des observations. La **Commission européenne** demande des précisions sur la politique de fixation des prix des services par le gouvernement britannique, pour intensifier la concurrence au niveau de la qualité, et s'interroge sur le décalage avec le point de vue habituel sur le sujet.

Le **Professeur Gravelle** explique que le ministère de la Santé fixe une série de prix auxquels les différents traitements doivent être achetés et vendus sur le nouveau marché interne, et que ces prix sont applicables à l'échelle nationale. Il existe, toutefois, certaines variations en fonction des régions pour tenir compte des différences de coûts que le Ministère juge justifiables. Dans les autres cas, les transactions doivent se faire au prix fixé, que ce soit pour les achats des hôpitaux relevant du NHS ou pour les produits que le NHS achète à des hôpitaux du secteur privé.

Le **Président** demande aussi si le gouvernement fixe le prix des traitements, par exemple pour une appendicite, et s'il n'en résulte pas une baisse de la qualité.

Le **Professeur Gravelle** précise la position du gouvernement. Etant donné que les prestataires ne peuvent plus se concurrencer sur les prix, les généralistes s'efforcent de trouver une meilleure qualité et non de rechercher des prestataires moins onéreux.

La **Commission européenne** réplique en affirmant que cet argument est d'ordinaire celui que les professionnels avancent pour fixer les prix.

Le **Professeur Gravelle** explique, en outre, que le Royaume-Uni ne part pas d'une situation de marché non réglementé laissant libre cours à la concurrence. Dans le passé, les contrats globaux entre acheteurs du NHS et hôpitaux du NHS étaient mal définis ; l'autorité sanitaire chargée des achats versait simplement des fonds à l'hôpital et s'attendait à ce qu'ils permettent de financer un nombre mal défini de cas.

Le **Président** souscrit à cette opinion et passe au Brésil.

Le délégué du **Brésil** pose une question à la délégation des Etats-Unis en lui demandant de faire des commentaires sur l'hypothèse du pouvoir compensateur de la négociation collective et de donner au Groupe de travail des informations sur les débats très controversés dont ce sujet fait l'objet aux Etats-Unis.

Le délégué des **Etats-Unis** répond que le rapport de 2003 examine en détail la question du pouvoir compensateur en situation de monopsone. Les médecins jugent la disparité et le pouvoir de négociation suffisants pour se livrer à des pratiques jugées collusoires par la FTC. Il ne s'agit pas d'une réaction ciblée

à la situation de monopsone mais d'une disparité du pouvoir de négociation que les médecins semblent juger suffisante pour avoir un tel comportement, d'après la FTC.

Pour la FTC et l'Antitrust Division, même si les médecins se trouvent face à un pouvoir de monopsone, le pouvoir compensateur est le dernier recours, car la préoccupation première n'est pas l'intérêt du consommateur mais l'intérêt du monopsone et du monopole. Si l'intérêt du consommateur prime sur celui du fournisseur ou de l'organisme payeur, la première mesure est d'agir sur le monopsone et non de compter sur le pouvoir compensateur, toujours subordonné au fait que les médecins sont avant tout soucieux de leurs propres intérêts.

Le **Président** invite les participants à formuler des observations et à poser des questions et passe ensuite à l'Australie.

Le délégué **australien** revient sur le sujet des pharmacies pour expliquer les récents échecs dans son pays. Le but était de réglementer l'acquisition des pharmacies de manière qu'elles demeurent implantées dans des structures de proximité mais la Pharmacy Guild est, d'après le délégué, un groupe de pression très puissant, d'où la nécessité d'avancer des arguments particulièrement solides lorsque l'on s'attaque à ce type d'association.

Le **Président** donne ensuite la parole au délégué de la Norvège.

Le délégué de la **Norvège** demande si la réglementation de l'accès aux professions ou aux instituts de formation spécialisés est le fait de l'association professionnelle ou des pouvoirs publics.

Le délégué du **Royaume-Uni** répond que, depuis quelques années, l'Etat réglemente le nombre de places disponibles dans les instituts puisqu'il rémunère les médecins alors que, dans le passé, il avait délégué cette tâche aux Royal Colleges. Il a aussi pris des mesures pour que ces Colleges aient moins de pouvoir .

Principes de comportement

Le **Président** présente le sujet des principes de comportement qui porte sur la limitation de la publicité et l'obligation de prix minimums. Il invite la délégation des Etats-Unis à intervenir sur les mesures à prendre face à une information limitée du consommateur et à répondre à la question de savoir si la mise en place de prix minimums est une façon de traiter le problème de l'asymétrie de l'information avec les consommateurs.

Le délégué des **Etats-Unis** précise que son pays ne fixe pas de prix minimums. Le Programme fédéral Medicare établit, certes, une grille des valeurs relatives constatées des services. Les tarifs pratiqués par rapport à ces valeurs relatives peuvent varier d'un Etat à l'autre mais ils peuvent servir de référence aux prestataires de soins de santé et aux compagnies d'assurance maladie privées. Les Etats ont, dans une large mesure, recours aux sources d'information des consommateurs pour pouvoir évaluer les prix, notamment pour sélectionner les prestataires de soins de santé. Ces sources d'information comprennent la publicité sur les prix, les résultats d'enquêtes et les informations sur le niveau relatif des prix données aux divers organismes payeurs ou sur le simple relevé des honoraires par les associations professionnelles. Les organismes chargés de la politique de la concurrence jugent ces activités favorables à la concurrence tant qu'il existe des protections pour que les professionnels ne se servent pas des informations collectées et fournies pour fixer les prix. Les compagnies d'assurance maladie privées passent fréquemment des contrats avec différents prestataires de services de santé et créent des groupes de prestataires prêts à accepter, pour les services à fournir, certains niveaux de rémunération fondés dans une large mesure sur les sources d'information. Tant que ces pratiques ne servent pas à limiter l'activité, elles sont jugées favorables aux consommateurs.

Le **Président** demande pourquoi la Cour suprême n'a pas suivi la FTC dans l'affaire des soins dentaires en Californie.

Le délégué des **Etats-Unis** répond que les associations privées spécialisées dans les soins de santé sont considérées comme une source importante d'expertise et d'informations. Les organismes chargés de la politique de la concurrence ne sont pas en mesure de juger à la place des professionnels sauf si les activités semblent limiter la concurrence sans raison valable. Dans l'affaire concernant l'Association dentaire de Californie, les activités de ces organismes ne risquent pas, de fait, d'être préjudiciables aux consommateurs en limitant la capacité des professions à s'autoréglementer comme il convient. Le rapport précise simplement que ces types de restrictions ne permettent pas aux organismes de prononcer des condamnations sur procédure sommaire dans ce contexte.

Le **Président** passe ensuite au Danemark qui a récemment autorisé la publicité dans les professions de santé.

Le délégué du **Danemark** répond qu'en raison de la nouveauté de cette réglementation aucune donnée n'est disponible, à ceci près que l'on observe une tendance parmi les consommateurs à être plus sensibles aux prix, notamment par rapport aux services onéreux, comme les travaux dentaires utilisant de l'or. Pour le moment, les règles servent à garantir de bonnes procédures de commercialisation et de publicité.

Le **Président** demande si les restrictions à la publicité ont été supprimées pour toutes les professions autres que les professions de santé.

Le délégué du **Danemark** explique que les règles spécifiques qui s'appliquaient à la publicité dans les professions de santé ont été supprimées. Les professionnels de la santé peuvent donc faire la publicité de leurs services comme les autres professions.

Application des règles de la concurrence dans les professions de santé

Le **Président** déclare que de nombreux pays sont intervenus activement pour faire appliquer le droit de la concurrence dans les soins de santé et il s'adresse au délégué japonais en lui demandant pourquoi la JFTC n'a pas condamné l'Association médicale Yokkaichi à une amende pour fixation des prix.

Le délégué du **Japon** répond que la procédure comporte deux étapes ; premièrement, il s'agit de recommander l'adoption d'une ordonnance de cessation des pratiques de l'association, laquelle a accepté la proposition et la recommandation et consenti à ne pas recommencer ; deuxièmement, il s'agit de calculer le montant, de manière qu'une ordonnance imposant une pénalité suive, et c'est là qu'on en est au moment où se tient cette réunion.

Le **Président** passe à la Turquie et demande pourquoi le droit de la concurrence n' a pas été appliqué dans le cas de l'Association médicale turque et de l'Association dentaire turque qui fixaient des prix minimums.

Le délégué de la **Turquie** répond que ces organisations professionnelles ont un fondement juridique solide dans son pays. L'Autorité turque de la concurrence a, en conséquence, recommandé au Premier Ministre une modification de ses statuts , les organismes professionnels comme le Barreau turc, l'Association turque des chambres de commerce et l'Association des comptables se comportant comme des syndicats.

Le **Président** demande alors pourquoi l'Autorité turque de la concurrence a pu intervenir dans le cas de l'Association des opticiens.

Le délégué de la **Turquie** explique que les opticiens ne relèvent pas d'un statut professionnel spécifique comme les médecins et les dentistes. Les règles qui s'appliquent à leurs membres ne sont pas d'origine législative, de sorte que le droit commun de la concurrence s s'applique.

Le **Président** demande, en ce qui concerne les opticiens, si l'Autorité de la concurrence estime que l'association des opticiens a enfreint le droit de la concurrence.

Le délégué **turc** répond qu'actuellement, en Turquie, les organismes professionnels semblent être plus puissants que ceux chargés de la politique de la concurrence et que la décision n'est pas encore claire.

Le **Président** passe ensuite à la Corée et demande au délégué de ce pays d'expliquer l'affaire contre l'Association médicale coréenne.

Le délégué de la **Corée** explique qu'en 2000, le système de santé coréen a été modifié. Les médecins ne sont plus autorisés à délivrer des médicaments et le système de remboursement de ces derniers a aussi changé. Dans cette affaire, les médecins membres de l'Association médicale coréenne ont décidé de se regrouper et de boycotter les patients. Ils ont aussi écrit à l'Association coréenne des hôpitaux pour que ces derniers n'acceptent pas de malades ambulatoires. L'Association des médecins et celle des hôpitaux sont des associations professionnelles dotées de règles de fonctionnement interne strictes et si leurs membres ne respectaient pas la décision de ne pas admettre de patients, ils seraient radiés et ne seraient plus autorisés à exercer. La KFTC a pris la décision d'imposer une ordonnance corrective et une deuxième ordonnance de cessation à l'Association médicale coréenne et à l'Association coréenne des hôpitaux, d'où des poursuites contre 102 personnes.

Le **Président** demande à la Hongrie de faire des commentaires sur l'affaire dans laquelle l'attitude de l'Association hongroise des pharmaciens a été mise en cause ; celle-ci avait recommandé à ses membres de ne pas descendre en dessous d'un prix minimum, l'Ordre des pharmaciens transformant donc les prix obligatoires en prix recommandés.

Le délégué de la **Hongrie** précise qu'aucune donnée n'est disponible, car l'affaire en est au stade préliminaire. En raison toutefois des caractéristiques particulières du système hongrois de fixation des prix pharmaceutiques, dans lequel le prix des médicaments en pharmacie n'est pas réglementé alors que ce sont les marges sur les médicaments qui le sont, les prix sont les mêmes dans toutes les pharmacies. Cette règle est interprétée et appliquée par le Ministère de la santé et par les pharmaciens. Du point de vue de la politique de la concurrence, il n'y a donc pas véritablement d'inquiétude à avoir.

Le **Président** demande pourquoi des prix recommandés sont nécessaires et si l'Association nationale des pharmaciens et l'Ordre des pharmaciens sont des organismes publics ou privés, car cela changerait sensiblement la façon de voir les choses.

Le délégué de la **Hongrie** explique que ces organismes associent des éléments privés et publics ; ce sont des instances autorégulées chargées de protéger l'intérêt des professionnels. Les pharmaciens ne sont toutefois pas habilités à fixer les prix, ce dont il faut se féliciter, contrairement à certaines autres professions. L'autorité chargée de la politique de la concurrence peut donc intervenir.

Le **Président** demande des précisions sur les médicaments en vente libre.

Le délégué **hongrois** répond que, dans son pays, certains médicaments sont subventionnés contrairement à d'autres et que les pharmaciens reçoivent du Ministère ou de la caisse d'assurance une disquette sur laquelle figurent les prix. Cette liste n'est pas limitée aux médicaments vendus sur ordonnance. Certains services peuvent toutefois être rendus par les pharmaciens, qui ne sont pas véritablement réglementés ; la question présente donc un certain intérêt mais pas en termes de prix.

Le **Président** passe ensuite aux Pays-Bas et, en particulier, à l'affaire AstraZeneca, pour demander au délégué d'expliquer pourquoi les hôpitaux ont bénéficié, de la part de cette société, d'importantes réductions sur les prix d'achat de ses produits, à condition toutefois de les utiliser uniquement pour les malades hospitalisés et de ne pas les vendre à l'extérieur. Le Président demande s'il s'agit d'une pratique d'exclusion ou d'un abus d'exploitation.

Le délégué des **Pays-Bas** explique comment la décision de la NMA, l'autorité néerlandaise de la concurrence, se justifie, à savoir qu'il y a entente avec les hôpitaux pour leur interdire de fournir des médicaments aux pharmacies. L'entente vise à interdire la concurrence entre les hôpitaux et les pharmacies, car les premiers bénéficient d'importantes réductions contrairement aux secondes. Il a été décidé que les fabricants devaient approvisionner directement les pharmacies et non les hôpitaux.

Le **Président** demande si des concurrents d'AstraZeneca auraient été exclus du marché hospitalier en raison de ces rabais et s'il ne s'agit pas là d'une question de pure discrimination.

Le délégué des **Pays-Bas** répond que les patients hospitalisés paient les médicaments moins cher mais doivent naturellement, lorsqu'ils sortent de l'hôpital, se les procurer dans les pharmacies à des prix beaucoup plus élevés, ce qui est contraire à la loi sur la concurrence.

Le **Président** demande ensuite à la Suisse de faire des commentaires sur l'affaire contre Eskamed, organisme privé chargé de tenir un registre recensant tous les médicaments autorisés sur le marché suisse. Les autorités de la concurrence sont à l'origine de l'affaire. Le Président demande si Eskamed a un rôle public ou privé et s'il s'agissait d'exclure un concurrent du marché.

Le délégué de la **Suisse** répond qu'Eskamed est une société spécialisée dans l'assurance maladie complémentaire qui n'a rien à voir avec les produits pharmaceutiques. Elle supervise l'admission des praticiens de médecine parallèle, comme les acupuncteurs ou les spécialistes de médecine chinoise, qui sont couverts par l'assurance maladie complémentaire. Ces praticiens doivent satisfaire à certaines conditions fixées par la société privée Eskamed. Celle-ci a été choisie par un groupe d'assureurs pour garantir la qualité des praticiens inscrits sur la liste. La Commission suisse de la concurrence a été saisie de différentes plaintes au motif que les conditions étaient trop rigoureuses ; il faut, par exemple, avoir exercé un nombre minimum d'heures avant de pouvoir être inscrit sur la liste. Après analyse, la Commission a partagé l'avis des requérants selon lequel les conditions fixées par la société étaient parfois injustes, ce qui a conduit à certains ajustements de la part de l'entreprise et une solution à l'amiable a été trouvée.

Le **Président** passe ensuite à la Norvège pour examiner la question de la taxe sur la valeur ajoutée (TVA) et l'effet discriminatoire des différents taux de TVA appliqués aux divers services professionnels. Il se demande, en outre, s'il s'agit d'une question qui touche au droit de la concurrence.

Le délégué de la **Norvège** explique que, dans son pays, les services de santé ne sont pas soumis à la TVA contrairement à d'autres activités de service. Il arrive, cependant, que le personnel de santé et d'autres catégories de personnel puissent fournir exactement le même service, ce qui fausse la concurrence. Il existe, dans la législation norvégienne, une section qui confère à l'autorité le pouvoir de promouvoir la concurrence. Avec la précédente loi sur la concurrence, l'autorité pouvait signaler les distorsions de concurrence dues à la réglementation par l'intermédiaire du Ministère du travail et de l'administration qui est le ministère chargé de la politique de la concurrence. Avec la nouvelle loi sur la concurrence, elle est autorisée à s'adresser directement au ministère ou à l'organe réglementaire visé qui est, de par la loi, obligé de répondre dans un délai donné. En résumé, le rôle de l'autorité a été renforcé et la loi sur la concurrence peut s'appliquer à toutes les questions de promotion de la concurrence.

Le **Président** demande s'il existe des exemples récents de mise en oeuvre de ces nouvelles compétences.

Le délégué de la **Norvège** répond qu'il est vrai que l'ancienne loi sur la concurrence reconnaissait un pouvoir de promotion de la concurrence mais pas dans la même mesure. La nouvelle loi devrait être plus efficace mais il est encore trop tôt pour disposer de données.

Le **Président** invite le délégué de la Nouvelle-Zélande à faire part de l'expérience de son pays en matière de mise en œuvre du droit de la concurrence dans les professions de santé.

Le délégué de la **Nouvelle-Zélande** commence par préciser que, cette année, l'autorité a engagé avec succès des poursuites devant la Haute Cour contre l'Association d'ophtalmologie de Nouvelle-Zélande dont cinq membres ont été reconnus coupables de s'être entendus pour bloquer l'accès d'ophtalmologues australiens au marché néo-zélandais, ce qui a eu pour effet de réduire considérablement la concurrence. Les médecins de l'association ont été condamnés à des amendes, des sanctions et des dépens. La deuxième affaire, dont on ne connaît pas encore l'issue, concerne un groupe d'ophtalmologues qui, d'après l'autorité, se sont entendus pour ne plus négocier individuellement leurs honoraires mais les fixer par l'intermédiaire d'un négociateur. Dans une troisième affaire, un groupe d'anesthésistes cardiaques qui s'étaient entendus pour négocier les honoraires en leur nom propre avec les hôpitaux a fait l'objet d'un avertissement. Ces anesthésistes avaient cru former une coentreprise et donc bénéficier d'une exemption. L'autorité a estimé que l'exemption ne s'appliquait pas et ils ont, depuis lors, accepté de ne plus négocier conjointement les honoraires dans ce domaine. La quatrième affaire concerne l'Association des pharmaciens de Nouvelle-Zélande qui a fait l'objet d'un avertissement parce qu'elle avait recommandé, dans ses publications mensuelles, d'augmenter les prix en violation de la loi sur le commerce, car cela revenait à une forme de fixation des prix. L'Association a aussi accepté, depuis lors, de cesser de recommander toute augmentation et s'est engagée à sensibiliser ses membres à l'application de la loi sur le commerce en Nouvelle-Zélande. L'Association dentaire de Nouvelle-Zélande a fait l'objet d'un avertissement à la suite d'enquêtes sur les prix qu'elle a menées et dans le cadre desquelles elle a donné à ses membres des informations sur les prix ; ces informations pouvaient apparaître comme indiquant les prix à pratiquer. L'Association a aussi accepté de renoncer à une enquête sur les prix, représentant un baromètre d'indicateurs de prix. Le délégué explique ensuite que le principal résultat positif a été la multiplication des informations communiquées aux associations de santé, ce qui a profondément modifié le comportement des organismes professionnels.

Le **Président** passe ensuite à'Australie

Le délégué de l'**Australie** insiste sur l'importance de sensibiliser les membres de la profession médicale. Une récente étude parlementaire sur l'application de la loi australienne sur la concurrence aux professions médicales a montré qu'il fallait sensibiliser ces professions aux droits et aux responsabilités qui sont les leurs en application de cette loi. Des fonds supplémentaires ont été accordés à la HWC à cette fin

et il lui a été demandé d'élaborer, à l'intention des professions médicales, un dossier d'information traitant des divers problèmes qui se posent quotidiennement dans les relations avec les patients, avec les autres professionnels de la santé et avec les fournisseurs. L'autorité espère qu'une meilleure information permettra de mieux faire respecter la loi sur la concurrence.

Le délégué de l'**Irlande** aborde le sujet de la refonte récente de la législation de la Nouvelle-Zélande.

Le délégué de la **Nouvelle-Zélande** répond que les responsables de la santé ont introduit des changements pour faire face au problème des longues listes d'attente dues à la pénurie de personnel dans certaines professions. Mais, malgré les changements apportés, d'importants problèmes demeurent. L'idée que la loi sur le commerce s'applique aux professions de santé suscite une certaine résistance et les professionnels mettent en avant l'argument de la sécurité des patients pour justifier diverses activités contraires à la loi.

Conclusion

Le **Président** clôt les débats en résumant les divers points soulevés par les délégations et en réaffirmant qu'aucune délégation ne pense que l'accès aux professions de santé doit être entièrement libre et que des qualifications sont indispensables. Il revient sur les difficultés rencontrées entre anciennes et nouvelles professions – dentistes et hygiénistes dentaires, par exemple – dans des pays aux structures institutionnelles très différentes. Mais le résultat est néanmoins le même, à savoir que les hygiénistes dentaires sont maintenus à l'écart du marché en tant que prestataires indépendants. Le Président souligne les variations observées d'un pays à l'autre dans le secteur pharmaceutique, qu'il s'agisse des pharmacies ou du prix des médicaments. Il rappelle aux délégués la séance du matin et notamment l'intervention du délégué du Royaume-Uni qui est très importante pour le reste de l'Europe, qui illustre un processus lent mais progressif de privatisation du secteur de la santé dans le cadre duquel les hôpitaux deviennent peu à peu des entreprises, ce qui donnera d'autant plus d'importance à l'application du droit de la concurrence et à la problématique de la concurrence, à l'avenir.