Reaction of the European Forum for Primary Care to the EXPH – Opinion Competition among health care providers in the European Union.

Counting 95 institutional members and 50 individual members

This reaction to the draft opinion of the EXPH contains the views of the European Forum for Primary Care. It therefore focuses on issues related to primary care. In our view the EXPH has given a well-balanced opinion on competition in the provision of health care. We appreciate the EXPH’s emphasis on the importance of empirical research in this area, especially within and comparing European countries. Much of the (often inconclusive) evidence is now based on only few health care systems, the most important of which (that of the USA) is difficult to compare with European health care systems, especially as far as primary care is concerned.

We endorse the importance of context in evaluating the value of competition in health care. We would like to add that this does not only relate to context differences between countries or health care systems, but also within countries. The context of competition differs between rural and remote areas on the one hand and urban areas on the other. And it is not only the health care context that is important, but also the context of societal values that might differ between countries, e.g. the importance that people attach to values of equity and solidarity. Research, published about impact of social determinants, gives us a complex picture of multiple factors, which affects health outcomes – the picture is much broader than triangle of patients, payers and providers. Equity, equality, solidarity are those ethical characteristics of health care systems, which are defining specific approaches – they differ from the usual characteristics of market system.

European health care systems differ in numerous respects. From the point of view of primary care in relation to competition, especially the organization of the relationship and interface between primary care and specialist and hospital care is important. Patient choice and some extent of competition within primary care might have positive effects, as long as the guide and gatekeeper role of primary care to specialist and hospital care is guaranteed. Easy entry, easy exit of providers and so-called fast tracks of care might be unsafe and even dangerous in some circumstances: in a case of rare diseases and in the case of changing morbidity pattern (i.e. some forms of cancers). In particularly mental health problems might be underestimated in competitive systems. By increasing patient choice and controlling of costs and resources it is necessary to analyze the likelihood of unexpected medical errors. Patients safety should be well balanced with the pressure of costs reduction.

We want to point out a specific aspect of primary care where professional views of quality and (short term) patient preferences might be at odds. An important aspect of primary care is watchful waiting and restrained treatment policies. However, this might be under pressure in health care systems with competition between primary care providers. An example is prescribing of antibiotics in case of self-limiting disease. In a competitive system patients might shop around and providers might feel pressed to agree to patient preferences that have negative consequences in the longer term. From a professional point of view not prescribing antibiotics would constitute good quality care, but patients might expect and prefer a prescription.

The provision of good quality health care increasingly requires cooperation between health care providers (and social care). It also requires continuity in the course of a disease pattern. This is related to the changing patterns of morbidity in modern society, where multimorbidity is becoming the rule rather than an exception. In the treatment and support of people with multimorbidity often several different health and social care providers should be involved. In a competitive system, the danger exist that the information exchange in (inter)professional cooperation gets framed as strategic business
information that should be kept. This change in morbidity also increasingly asks for special skills that some primary care providers may have acquired and that are available on a consultation basis for patients that are normally treated by another primary care provider. For example patients with multimorbidity may have over 10 different drugs, prescribed by different specialists from the secondary and tertiary level. A community pharmacist closely connected to a GP could provide the support to handle this poly-pharmacy issue for the patient and the other care providers. In a competitive environment this may be less attractive to primary care providers, due to the risk of losing a patient altogether. There is a big value in exchanging information and using each other’s special skills and interests to provide patient-centered care. This is not to say that competition would have negative consequences in this respect under all conditions; it is, however, something to take into account.

In some countries, especially in the former communist countries, competition among primary care providers has been introduced without a level playing field between public and private providers of primary care. In our view, the public or private character of providers is not relevant; the quality of their care and accessibility to patients are. However, the system should be organized in a way that fair competition is possible. In a completely free competitive environment within health care provision the risk is high that industry (pharmaceutical, electronic, real estate, etc) will gain influence which will increase the total cost of health care provision. The current EC focus on the introduction for more innovations with e-health provision is a good example as many of these e-health innovations fails an effective implementation plan. The industry lacks a self-regulation within this highly competitive environment to pay sufficient attention to this aspect of implementation and effective output. We want to warn that no market is perfect, not just because of ineffective competition, but also because of different lobbies (pharmaceutical industry, information technologies, production of expensive devices, overproduction of “healthy” food, etc).

Cost-sharing is one of the market elements introduced in many health care systems. Of course this is – just like patient choice – different from competition, but it could be part of competition among health care providers, when out-of-pocket payments are part of their revenues or when they are able to grant exemptions to them. We think it would be wise to mention this issue of cost-sharing in the EXPH opinion, especially in relation to equity goals and in relation to informal payments that have a strong influence on the transparency of any competitive policy.

Paragraph 12: This paragraph states the goals of health systems. We think that health systems goals should first and foremost include: improving population health. We would also like to add the long-term sustainability of the health system.

In the document we did not find any plans to provide health care of specific sub-groups, e.g.: migrants and persons with disabilities. This important part of human society is not able to compete in today’s world. We wonder what their place will be in the promotion of competition. We believe that it is the ethical imperative to look at vulnerable subgroups of the population.