System-wide health-care shocks and regulatory interventions in the face of the emergency: are there some lessons to be learned from the COVID-19 crisis?

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We all know that competition benefits consumers because it helps contain costs, improve quality, and encourage innovation. However, this statement is true only if some hypotheses are satisfied: consumers should be able to knowingly choose between alternatives, prices should be good indicators of relative quality, and suppliers that systematically do not cover their costs leave the market (or at least are forced to restructure). Furthermore, new entry has to be easy and suppliers should face an incentive to innovate, including organizational innovation. Finally competition is the right mechanism when the quantity supplied responds to prices and only indirectly to needs.

The problem with health care is that most of these characteristics are absent: consumers often lack the necessary information to choose, especially for the most expensive and infrequent services, relatively higher prices are not necessarily a signal of better care, market participants are often funded by government and their presence in the market is seldom related to relative performance. Furthermore, in health care, new entry is often not an economic decision but it is based on perceived needs.

For all these reasons health care markets have been traditionally isolated from the discipline that competition provides. Only recently, competition has become a positive force for achieving productive and allocative efficiencies in health care.

There are many areas where competition has proved to be beneficial in health care, and in the OECD Working Group on Competition and Regulation we have

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discussed these issues a number of times in recent years.\(^1\) The main conclusion that can be drawn from these discussions is that the benefits of competition are the highest when the income of health care providers, including hospitals, depends at least in part on consumers’ choices and their relative performance. Many health care systems around the world are increasingly organized around this principle.

Unfortunately one question, even though it was posed, always remained unanswered in the OECD discussions. The problem I wanted to address was that a market mechanism does not endogenously provide an infrastructure capacity able to satisfy peak demand. For example, if for next Christmas I want to go to Cortina, a fancy Italian ski resort (let us hope we will be able to do so), I have to book way in advance because the level of hotel capacity is not adjustable to peak demand and is defined by the average demand expected during a year. Public policy does not address the issue of peak demand for hotels in ski resorts because it is not of public interest if I have to remain home next Christmas. However, if there is a major accident in a country, public policy should make sure that there is enough hospital capacity to treat all the wounded and that people do not die for lack of assistance.

I. HOSPITAL CAPACITY AND PEAK DEMAND

If capacity is left to market forces, including hospital capacity, it will certainly not be sufficient in all locations for all possible needs. In general, helicopters and easy transportation across localities strongly enlarge the local market sometimes even beyond national borders. So peak demand for hospital services (and it is pretty much the same for ski resorts) is satisfied by creating the necessary flexibility through open borders, both within a country and across countries. But now where the same virus has hit every location and every country, the territorial flexibility that allowed the system to smoothly operate in normal conditions is no longer sufficient.

These are the same developments that led in 2007–08 to the financial crisis (even though of course the financial crisis was not a health issue and was not life threatening). Local housing markets were considered independent one from the other and as a result pooling the mortgages of all locations together reduced the overall risk an investor would face. The problem was that there are systemic phenomena, like monetary policy or the business cycle, that affects all borrowers independently of their location and as a result the aggregate asset was not as safe as expected.

The regulatory structure in place is the major difference between health care and financial markets. Financial markets had institutions dedicated to identifying the ways by which systemic risk should be reduced, the problem in 2007–08 being that the risk of a sub-prime mortgages crisis had not been properly identified. In health care there is usually no regulatory structure in charge of avoiding systemic risks and as a result they have been largely ignored, with a few exceptions. Germany, Japan, Korea, and Austria are some of the few OECD countries that had set up a capacity of hospital beds and of intensive care units more in line with the needs of a pandemic

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\(^1\) Roundtable discussion on ‘Competition in Hospital Services’ (2012) Contributions and transcripts available at: \(<\text{http://www.oecd.org/da/f/competition/50527122.pdf}>\); Roundtable discussion on ‘Designing Publicly Funded Health Care Markets’ (2018). Contributions and transcripts available at: \(<\text{http://www.oecd.org/da/competition/designing-publicly-funded-healthcare-markets.htm}>\) accessed 26 April 2020.
type emergency, an example of forward-looking health care systems that every other country should have followed (Table 1).

Indeed a pandemic emergency could have been anticipated, even more than the sub-prime mortgage crisis. The World Health Organization had warned countries a number of times of such a possibility, but only international organizations and a few countries took those warnings seriously. To my knowledge only the UK launched a pandemic simulation exercise back in 2016 to see what should be done in the UK to deal with peak demand (the report on the simulation was not published and nothing was done after the exercise was completed). Now that a pandemic is no longer a vague possibility but a certainty, every country should set up a regulatory structure up to the task to create emergency hospital capacity and emergency health-care supplies ready to be used. It is a high cost, but worthwhile to be paid. Health care would not be exceptional in this respect. In electricity markets, for example, where peak demand needs to be accommodated at a risk of a black out, in all the countries idle generators are being paid just to be ready to start producing electricity in case of a peak. The problem is to identify the proper price for idle capacity. The same could be done for hospitals and health-care supplies.

Such emergency capacity could be set up both in a privately run system and in one run by the State. Of course it would be easier in a State-run system because its financing would directly come from the State. However, even though in many countries hospitals are State-run, the issue of building up a capacity that could be used in case of a system-wide emergency was very seldom considered and in these rare instances often given up because of high costs. Now is the time to plan for the future. But in order to be effective, the regulatory structure has to be profoundly changed, for example, by giving a greater role to central governments as opposed to regions or localities in the planning and the financing of the health-care infrastructure.

Table 1. Hospital beds and intensive care units in selected OECD countries

| Selected OECD countries | Hospital beds per head (2018) | Intensive care units per head (2018) |
|-------------------------|-------------------------------|-------------------------------------|
| Austria                 | 7.37                          | 5.45                                |
| Canada                  | 2.5                           | 1.96                                |
| France                  | 5.98                          | 3.09                                |
| Germany                 | 8                             | 6.02                                |
| Italy                   | 3.18                          | 2.62                                |
| Japan                   | 13.05                         | 7.79                                |
| Korea                   | 12.27                         | 7.14                                |
| The Netherlands         | 3.32                          | 2.92                                |
| Spain                   | 2.97                          | 2.43                                |
| UK                      | 2.54                          | 2.11                                |
| USA                     | 2.77                          | 2.44                                |

Source: OECD health-care statistics.
II. ACTIVITIES TO BE SHUT DOWN IN THE CASE OF A LOCKDOWN

And now I come to the closures that many governments have undertaken to implement the lockdowns. In principle, the closures were decided to avoid large gatherings of people, like those that take place at sports events, concerts, bars, restaurants, shopping malls, etc. In many countries the closures were also extended to the manufacturing sector. Only the manufacturing of essentials (food and drugs) and the provision of public utility services were allowed. This is not easy to do (if the closures last for more than a few weeks) because not only the plants producing essentials have to remain open but also those plants producing inputs for the production of essentials and those producing inputs to those producing inputs, and so on. The identification of all these plants is practically impossible and the risk is that if the closures continue for some time, bottlenecks will emerge, making it impossible even for the essentials to reach consumers.

It would have been sufficient to identify the activities in final demand that needed to be stopped and then leave the productive system free to adjust. Unnecessary activities would be closed or reduced in size (since final demand for many products would have vanished) without the need of a prior incomplete and insufficient process of identification of what should be allowed and what closed down. This is the more important, considering that in a worldwide emergency many import flows, even imports of intermediate inputs, may suddenly stop and domestic industry should be left free to adjust and substitute them with domestic production.

Guaranteeing the safety of workers within a plant should be left to sanctions and deterrence and should not worry us too much, considering that it would be in the interest of the affected workers to denounce unsafe working conditions.