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# **The role of competition rules in the context of healthcare reform in the Netherlands**

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The Netherlands is an early mover in healthcare liberalisation. It has a dual policy towards competition enforcement in the sector: not only the general competition rules (the prohibitions on cartels and the abuse of dominance, and merger control) but also rules of sector specific competition policy apply. Consequently the general Competition Authority and the Healthcare Authority have concurrent powers in this field. This paper examines both the basis for intervention (generally related to market failure and market power), the balance between general rules and specific cases, some of the technical problems involved (such as geographic market definition), and the institutional setting. In this context the new competition powers of the Healthcare Authority based on findings of significant market power by individual undertakings, respectively of structural problems involving entire categories of providers, are also reviewed. A number of case summaries are presented by way of example.

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## 1. Introduction

This paper is concerned with the role played by various types of competition rules in the context of the recent and ongoing drive toward healthcare liberalisation in The Netherlands. It focuses more specifically upon the relationship between the general competition rules applied by the National Competition Authority (NMa) and the sector specific competition policy that is applied by the Dutch Healthcare Authority (NZa). This is also a comparison between an EU inspired regime that will be familiar to most readers, based on the distinction between anticompetitive agreements, dominance abuse and mergers on the one hand and the more novel sectoral regime that has few parallels elsewhere (with the notable exception of the dominance-based concept of significant market power that is derived from the harmonisation context of electronic communications) on the other hand.

EU competition policy involvement in the healthcare sector in The Netherlands is so far limited to a crucial state aid decision in 2005. Meanwhile a noteworthy policy vis-à-vis state aid is emerging at national level which will be discussed briefly.

The structure of this paper is as set out above: first the main elements of healthcare liberalisation in The Netherlands are discussed, followed by a comparison between the two competition regimes at systemic level and then by discussing some individual cases by way of example. Next state aid is touched upon, followed by conclusions on the role of the twin tracks of competition policy in healthcare, and on their interaction.

## 2. Healthcare liberalisation

### *The drivers behind liberalisation*

The Dutch healthcare system is essentially market driven.<sup>1</sup> Thus it relies both on exclusively private health insurers as well as exclusively private healthcare providers, albeit within a regulatory framework. At the same time the system is consumer oriented: e.g. the Healthcare Authority has to adopt the general consumer interest as its first priority guiding all its actions, as set out in the Healthcare Market Regulation Act of 2006.<sup>2</sup> Consumer choice is seen as providing the impetus behind a system that relies on competition feeding through different markets and/or market segments. The most important (groups of) markets are pictured below.

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<sup>1</sup> Cf Dutch Ministry of Health, The new care system in The Netherlands: durability, solidarity, choice, quality, efficiency, May 2006 <http://www.minvws.nl/en/folders/z/2006/the-new-health-insurance-system-in-three-languages.asp>; Dutch Health Authority, Contribution to EU consultation on cross-border health services, October 2006 [http://ec.europa.eu/health/ph\\_overview/co\\_operation/healthcare/docs/health\\_services\\_co201\\_nl.pdf](http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/health_services_co201_nl.pdf).

<sup>2</sup> W. Sauter, "Is the general consumer interest a source of legitimacy for healthcare regulation? An analysis of the Dutch experience", (2009) *European Journal of Consumer Law/Revue Européenne de Droit de la Consommation* 419.

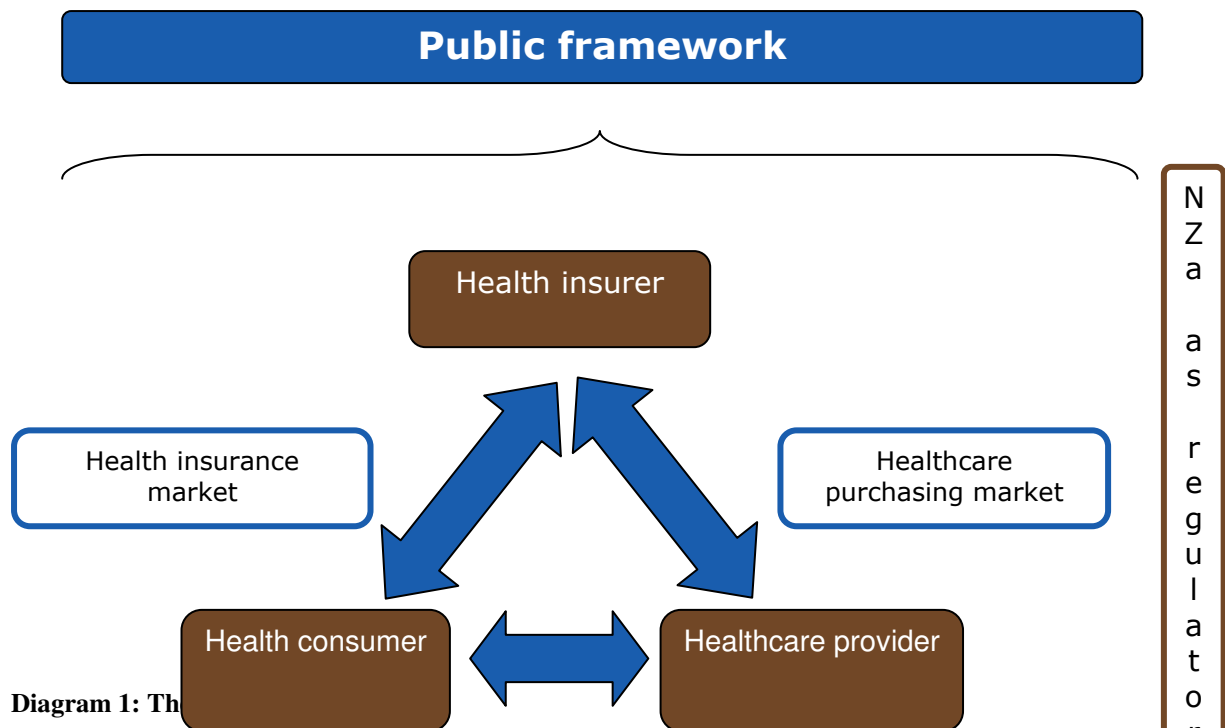


Diagram 1: The

Free consumer choice between insurers that is guaranteed by the regulatory framework intended to work as an incentive for competitive insurance markets. If such competitive insurance markets emerge such as next expected to filter through competitive markets for healthcare provision, consumers will try to gain competitive advantage by obtaining the best deal possible from healthcare providers. This eventually leads to provider combinations such as hospitals putting pressure on their consultants (doctors) to provide competitive high quality services as well.

Crucial to the success of this model is that insurers both have incentives and are able to direct their consumers to particular providers, and to selectively contract providers.<sup>3</sup> In this manner insurers can reward good, or preferred, providers of healthcare and punish poor ones, by directing more consumers to the former and/or cutting down the numbers destined for the latter (or sending them none). A further precondition are good quality indicators. So far these incentives and their results do not appear to be functioning adequately in practice. For instance the current system of ex post risk equalisation may fatally reduce the incentives involved, and market power of providers in combination with consumers' expectations to be able to see any doctor of their choosing may frustrate selective purchasing. For the purposes of the paper however we will stick to the system as it was designed, not its critique.

In a pattern familiar from the liberalisation of other industries (e.g. the utilities), healthcare liberalisation has not meant fewer rules, but instead an increase in the number of rules. This is because decisions that used to be taken centrally within firms or by government must now be negotiated between different market parties with conflicting interests. At the same time public interest objectives must be secured. Both to reduce transaction costs and to ensure that socially desirable outcomes are reached regulation is required. Because it is not possible to devise all detailed rules needed in advance, and because their application must be supervised,

<sup>3</sup> Ideally all parties would have incentives to contract mutually based on the pressures of (potential) competition. However it appears that to reach this stage selective contracting must first be possible. Cf. C.Capps, D. Dranove and M. Satterthwaite, "Competition and market power in option demand markets", (2003) 34 *Rand Journal of Economics* 737.

there is a need for an independent “regulator” on top of the need for “regulation”.<sup>4</sup> In this manner a measure of flexibility is introduced.

#### *Health insurance reform and price liberalisation*

The first step of the 2005/2006 healthcare reform was the introduction of a legal framework that provides for mandatory health insurance for all Dutch citizens and a tax subsidy for those on the lowest incomes. All health insurers are under an obligation to provide services to all consumers without risk selection or premium differentiation. This is to avoid insurers competing not on the merits (i.e. on quality and price of services) but on obtaining a healthy (or low risk) insured population that does not require treatment. The funding regime is in two parts:

- 50% of the premium is a nominal premium (that is differentiated per insurer not per consumer) and collected directly by the insurers (there is a low variation between insurers in the pricing of this basic insurance package);
- and 50% of the premium is income dependent and collected by the state (this part of the premium is redistributed to insurers based on a risk adjustment system)

This risk adjustment system is to avoid adverse selection and moral hazard and promote competition on the merits. It comprises both ex ante (the true “risk” adjustment) and ex post (reimbursement of costs with no risk component) elements, whereas the ambition is, over time, to eliminate ex post adjustment as much as possible. Risk equalisation is discussed further below in the section on State aid.

The next important development is the progressive (“step by step”) liberalisation of prices of curative healthcare. Fully liberalised prices now account for now 35% of the number of treatments, and this is likely to be 50% by 2011 (subject to a temporary price cap). Long term care on the other hand remains dominated by regional monopsony purchasers facing private providers with little competition so far. However it is believed there may be scope here to introduce at least competition “for” (if not “in”) the market by means of auctions and improved public procurement procedures. Also personal care budgets managed by the individual consume play an important role in increasing consumer choice and thereby provider responsiveness.

#### *The need for regulation*

Just a few more specific remarks about the general need for healthcare regulation in The Netherlands are made here. Rising costs led to widespread rationing and therefore waiting lists that became politically unsustainable. Apart from rising costs (due to ageing populations, increasing possibilities for treatment due to technological innovation, and rising expectations), healthcare markets are also burdened by a range of market failures. Of these just three important aspects are mentioned here.

- First the effects of the *third party pays principle* – which means that patients are not sensitive to costs whereas providers have obvious incentives to sell more care (supply induced demand) or to sell at higher prices. There is therefore a problem of moral hazard at the expense of insurers and/or the government as payor of last resort.

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<sup>4</sup> For additional arguments for regulation see E. Maskin and J. Tirole, “The Politician and the Judge: Accountability in Government”, (2004) 94 *The American Economic Review* 1034.

- Second is the problem of *adverse selection* which means that insurers would all like to insure exclusively healthy patients who never need care whereas healthy patients have no incentive to take out insurance. This can lead to a race to the bottom with insurers both weeding out costly consumers and barring them at the gate.
- Third is the strong position of healthcare providers both in terms of *information asymmetry* and in the form of *market power*: there is reason to believe that market power of healthcare providers is pervasive in many markets.

All three problems of these are serious ones that, if market based solutions (as a first choice)<sup>5</sup> are unavailable, regulation must address. Most importantly, in healthcare, as a market in transition, problems of market power call for a vigorous application of competition policy.

#### *The various regulators*

Finally in October 2006 the Healthcare Authority has been introduced as an independent regulator as well as sector-specific competition authority, an innovation that (with the recent exception of the UK) appears largely unique in the EU today.<sup>6</sup> Apart from the NZa there are a number of other authorities that are involved in healthcare regulation in The Netherlands. For instance there is an agency, CVZ, that is responsible for advising on whether specific forms of care should be covered by basic insurance or not and that is also responsible for the administration of the risk adjustment system. The healthcare inspectorate IGZ is in charge of the quality of healthcare provision and of developing and/or approving health quality standards. Apart from these healthcare specific agencies there are a number of regulators that are responsible for the entire economy and therefore also cover healthcare. These include the General Competition Authority NMa as well as the general regulators for behavioural and solvency aspects of financial supervision, the Central Bank DNB and the Securities Authority AFM. Of this panoply of regulators, only the Competition Authority and the Healthcare Authority will be discussed.

The next section examines the two parallel regimes of sector specific and general competition policy in healthcare.

### **3. Applying competition policy to healthcare**

#### *The relevance of competition policy in healthcare*

Because it is almost entirely composed of vulnerable transition markets the healthcare sector requires special scrutiny under competition policy. Examples are market structure (concerning especially mergers but with implications for aid) and entrenched positions of market power; leveraging and other cross-over effects, especially between liberalised and non-liberalised sectors. As was mentioned above providers' selling power is thought to be pervasive. Moreover a successful competition policy in this field is likely to be of central importance to the success of and/or support for liberalisation. This is because if due to a lack of competition the reforms fail to produce results i.e. improved healthcare performance in terms of quality, access and affordability, the overall support for reform is likely to erode.

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<sup>5</sup> The locus classicus is K.J. Arrow, "Uncertainty and the welfare economics of medical care", (1963) 80 *The American Economic Review* 941.

<sup>6</sup> Since 1 January 2009 the Cooperation and Competition Panel (CCP) in the UK performs similar functions especially as a sector-specific competition authority for the NHS. Cf <http://www.ccpanel.org.uk/>.

In The Netherlands there are two applicable competition policy regimes that are implemented by two separate authorities with concurrent powers.

- In the first place general competition policy, implemented by the Competition Authority. This is a system that was created in 1998 in spontaneous harmonisation with the EU system of competition law and that accordingly is based on prohibitions and ex post controls (except mergers which are screened ex ante).
- Second, in 2006 a system of sector-specific competition policy was introduced by the Healthcare Market Regulation Act. This policy is carried out by the Healthcare Authority and forms a prevention based system using ex ante controls.

Both systems will be discussed in detail below. In addition the EU regime for state aid control is relevant to the liberalisation context and will be touched upon briefly.

#### *General versus specific competition policy*

The two competition policy regimes for healthcare in The Netherlands that were mentioned above show a number of important similarities, differences and common problems.

The most important similarities are their common focus on market power, on horizontal instead of on vertical issues, and on hardcore restrictions like price fixing and foreclosure. Also, effects are considered more important than formal (or: “per se”) restrictions.<sup>7</sup> Finally, the authorities involved are in both cases independent from political control, at least where decisions in individual cases are involved.

The number of differences is larger. The general competition policy covers the entire economy, is prohibition based, and is about policing functioning markets. It derives part of its powers and most of its principles from the EU level (in addition the Competition Authority is empowered to apply Articles 101 and 102 TFEU where there is an effect on trade between the Member States).<sup>8</sup> The system of control is ex post, and infringements of the prohibitions of anticompetitive agreements (“cartels”) and dominance abuse are sanctioned by fines as well as, in some cases, not only behavioural but structural remedies – breaking up undertakings.

The sector specific regime is purely based on national law and regulation and as such more subject to political pressures. Instead of policing existing markets it is more concerned with creating markets where there were none before. For this reason, control is exercised ex ante: it is sufficient to prove the existence of opportunities and incentives to restrain competition in order to impose remedies (i.e. effects do not have to be demonstrated). So far remedies are behavioural – e.g. price constraints.

The common problems include market definition (especially geographic markets, about which more will be said below), and the especially exacting standards of judicial review that Dutch authorities appear to face compared to their EU counterparts.

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<sup>7</sup> The effects based approach is especially important regarding Article 102 TFEU. Cf Guidance on the Commission's enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings, COM(2009) 864 final . However some per se restrictions remain important, especially in the context of Article 101 TFEU. Cf Case C-8/08 *T-Mobile et al.*, Judgment of the Court of 4 June 2009, nyr.

<sup>8</sup> Council Regulation (EC) No 1/2003 of 16 December 2002 on the implementation of the rules on competition laid down in Articles 81 and 82 of the Treaty, OJ 2003 L1/1, Article 5 (“The competition authorities of the Member States shall have the power to apply Articles 81 and 82 of the Treaty in individual cases”).

### *Managing concurrent powers*

As was already mentioned the Competition Authority is an independent authority with the entire economy within its scope. It refers to the Ministry of Economic Affairs. The powers of the Competition Authority are enforcing the cartel prohibition, the abuse of dominance prohibition, and the monopoly on merger control (for mergers below the EU thresholds). To manage concurrence, it has precedence over the Healthcare Authority concerning the interpretation of competition concepts (such as “dominance”, or “foreclosure”) based on the Healthcare Markets Regulation Act. In addition there is cooperation between the two authorities on the contentious issues of geographical market definition, and collaboration governed by a mutual protocol (or inter-institutional agreement) which provides for regular mutual consultation at all levels.

The Healthcare Authority is an independent authority under the Ministry of Health the scope of which is limited to the healthcare sector. Its competition powers are the ability to determine contract terms and the contracting process, to control significant market power (SMP), and to provide advice on merger control. Apart from the cooperation and collaboration already mentioned, concurrence is managed by the fact that the Healthcare Market Regulation Act provides for the priority of the sector-specific over the general competition rules. So far this is especially important in the case of market dominance, where SMP is considered more effective and less burdensome to prove than is dominance abuse under the general competition rules. In future the ability to determine contracting terms may also become more important – for instance as will be seen below it was recently used to impose access to electronic networks related to healthcare, such as related to the exchange of patient records and referrals by general practitioners.

The next sections will provide more detail on each of the two authorities.

## **4. The national competition authority (NMa)**

We will briefly discuss the experience of the Competition Authority regarding the three branches of its competence in the healthcare sector: mergers, dominance abuse and cartels.

### *Merger review*

Until 2004 the Competition Authority elected not to exercise merger review in the healthcare sector due to what it perceived as the limited scope for competition at that time. In other words it did not take into account potential competition or the relevance of the market structure to future competition, i.e. adopting a static rather than a dynamic approach. This is illustrative of divergence with the Healthcare Authority’s view which is generally more prospective. The result of the Competition Authority’s approach was a merger wave in anticipation of regime change that may have significantly biased the market structure by creating numerous local and regional incumbencies that are resistant to entry and change.

Although since 2004 over 100 healthcare mergers have been reviewed by the Competition Authority, none were blocked, and only a handful was cleared with conditions. Again the Competition Authority has often used the argument that since little competition remained (following past mergers not vetted) there was not much competition left that could be restricted, thereby favouring further clearances.<sup>9</sup> Recently there has been a controversy

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<sup>9</sup> For a critical view see M. Canoy and W. Sauter, “Hospital mergers in the Netherlands and the public interest: What standard for merger control?”, (2010) *European Competition Law Review* (forthcoming).



concerning an ex post analysis by the Competition Authority itself that showed in at least one case significant price increases implemented by recently merged hospitals.<sup>10</sup>

A further complication in merger cases has been market definition. Product market definition has been relatively unproblematic although it may differ based on the level of analysis adopted: for consumers there is little to no substitution between diagnoses (e.g. hip treatment is not a useful substitute for heart surgery), although there are 900 different diagnoses for hospital treatment alone; at the provider level however a limited degree of supply substitution is possible (i.e. an orthopaedic surgeon can operate on knees and shoulders alike), so the market can be defined by specialisation or major diagnostic category (there are about 25 of these); and finally it is possible to define the market more abstractly as access to market groups, such as clinical (inpatient) versus non-clinical (outpatient) hospital care. Geographic market definition on the other hand is problematic – not just in The Netherlands but e.g. in the US experience as well.<sup>11</sup>

This problem occurs because the standard hypothetical monopolist or SSNIP test (based on the effects of a small but significant non-transitory increase in price of 5 or 10%) fails due to the prevalence of the “third party pays” system: because consumers rarely have to meet their hospital bills directly (the insurers do) they are not sensitive to price changes. Initially the Elzinga Hogarty test was used as an alternative, based on the LIFO/LOFI (little in from outside/little out from inside) test looking at travel patterns of patients to and from a particular area. The Elzinga Hogarty test was initially developed for measuring commodity movements (such as coal and corn) and used in healthcare due to its relative straightforward application. This test (as Elzinga himself testified in US proceedings) however is unreliable in healthcare because it measures actual travel patterns and not willingness to travel in response to a merger. For similar reasons the Critical Loss method (based on contestable ZIP codes) fails.

Meanwhile, the Competition Authority and Healthcare Authority have developed two alternatives based on actual consumer preferences. These are the LOCI (logit competition index) based on willingness to travel and the Option Demand method, based on willingness to pay.<sup>12</sup> So far the Competition Authority has not applied these methods to decide actual mergers, although the Healthcare Authority has begun using them in the opinions that it provides to the Competition Authority in such cases.

The most high profile merger case in healthcare to date was that of *Zeeuwse Ziekenhuizen*<sup>13</sup> in March 2009. This decision was the outcome of a true merger saga that lasted almost four years, starting in September 2005 across two notifications and intensive lobbying at all levels.

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<sup>10</sup> Based on the work of R. Kemp and A. Severijnen, ‘Ex post analysis of the actual effects of a Dutch hospital merger on prices: a case study’, in: *Proceedings of the Conference Ex-post evaluation of competition policy, Mannheim, Germany, 3-4 June 2009*. (Mannheim, 2009). The authors focused on hip replacement surgery and demonstrated that one set of merged hospitals (in “het Gooi”) significantly increased their prices, whereas another set of merged hospitals (in Rotterdam) did not.

<sup>11</sup> I am grateful to Rein Halbersma for his comments on the issue of market definition (see also further below). The usual disclaimer applies. Cf M. Varkevisser, C.S. Capps and F.T. Schut, “Defining hospital markets for antitrust enforcement: new approaches and their applicability to The Netherlands”, (2008) *Health Economics Policy and Law* 7. On the US experience see *Improving Healthcare: A Dose of Competition. Report by the Federal Trade Commission and the Department of Justice*, July 2004. [http://www.usdoj.gov/atr/public/health\\_care/204694.htm](http://www.usdoj.gov/atr/public/health_care/204694.htm)

<sup>12</sup> An additional method under consideration is the time elasticity approach based on the willingness to travel. Cf more generally M. Varkevisser, *Patient choice, competition and antitrust enforcement in Dutch hospital markets* (Optima, Rotterdam 2009).

<sup>13</sup> Decision of 25 March 2009, Case 6424 *Ziekenhuis Walcheren – Oosterscheldeziekenhuizen*.

At issue was a monopoly merger between the only two direct competitors in an isolated estuary region in the South West of The Netherlands which resulted in a market share of well over 80% for clinical and non-clinical hospital care. The parties mounted an efficiency defence that was initially rejected because neither the efficiencies claimed nor the passing on to consumers of the resultant benefits were held to be guaranteed.

A key role in the case was then played by the Healthcare Inspectorate (IGZ) which argued that the merger was necessary to guarantee minimum quality levels and indeed eventually hospital survival in this region. As a result the case was cleared based on behavioural remedies, notably the imposition of a price cap at the level of the national average for hospital prices, and with guarantees for securing the claimed quality improvements. The Competition Authority found these remedies ensured the requirements for the efficiency defence would be met and cleared the merger conditionally on that basis. Remarkably given the structural problems of this merger between closest rivals, structural remedies (such as hiving off services that were not key to quality improvements and hospital survival) were not considered.

#### *Dominance*

So far no dominance cases involving healthcare have been brought under the general competition rules. Based on the abovementioned statutory priority rule dominance issues are left for the Healthcare Authority to deal with under SMP.

#### *Anticompetitive agreements*

The Competition Authority has been more active with regard to anticompetitive agreements.

- In the *Thuiszorg 't Gooi* case it fined parties active in various forms of long term care for carving up markets between closest competitors.<sup>14</sup> The specialisation block exemption was found not to be applicable as the purpose of the contested market sharing agreement was the allocation of customers and territories.<sup>15</sup> An efficiency defence based on the notion that “integrated care” was at issue was rejected because the primary relations concerned were horizontal, not vertical.
- In *Dienstapothek Assen* local pharmacists were found guilty inter alia of excluding entrants from local/regional information systems with patient and medication records and denying them access to back-up schedules.<sup>16</sup> It is worth noting that because in subsequent years it turned out that this precedent had hardly any effect on similar exclusionary practices elsewhere, the Healthcare Authority has recently adopted a general regulation on access to electronic networks in healthcare (see further below).
- In *Brancheverenigingen van psychologen en psychotherapeuten*, the branch organisations of psychologists and psychotherapists were found guilty of price coordination by means of price recommendations.<sup>17</sup> Remarkably this decision was overturned on appeal by the Rotterdam District Court which held that the Competition Authority could not treat this as

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<sup>14</sup> Decision of 19 September 2008, Case 5851 *Thuiszorg 't Gooi*.

<sup>15</sup> Commission Regulation (EC) No 2658/2000 of 29 November 2000 on the application of Article 81(3) of the Treaty to categories of specialisation agreements, OJ 2000, L304/3.

<sup>16</sup> Decision of 16 November 2004, Case 2501 *Dienstapothek Assen*.

<sup>17</sup> Decision of 20 April 2005, Case 3309 *Brancheverenigingen van psychologen en psychotherapeuten*.

a per se (hardcore) infringement, but should instead have investigated more fully whether in this sector price was a relevant competition parameter.<sup>18</sup>

In addition the Competition Authority issued extensive guidelines focusing on horizontal agreements in 2007 and will provide revised guidance in 2010. A live issue at present is the relationship between insurers and liberalised professions (e.g. physical therapists, psychotherapists), with the latter accusing the former of exercising abusive buying power because insurers typically refuse to negotiate with individual practitioners, working instead with standard contracts on a “take it or leave it” basis. Another topical issue is integrated care, i.e. vertical chains of treatment for chronic diseases, which tend to involve large horizontal groups of general practitioners as well. In this case the insurers are faced with selling power and few or no regional and local alternatives. Hence, the 2010 guidelines are likely to focus on the issues of buying power, and of selling power in the context of vertical agreements. In any event healthcare will continue to be one of the main areas of focus of the Competition Authority.

We now move on to a discussion of the Healthcare Authority

## **5. The Dutch Healthcare Authority (NZa)**

In this section we will look at the tasks of the Healthcare Authority, at its approach to SMP, and its power to intervene in contract terms and contracting processes.

### *The Healthcare Authority’s regulatory tasks*

The Healthcare Authority is responsible for market supervision as well as market development relating to the three types of markets set out in the diagram earlier in this paper (the “healthcare triangle”): i.e. health insurance markets; healthcare provision markets; and healthcare contracting markets. It is also charged with the more traditional tasks of a rate regulator such as tariff and performance regulation; setting prices (including maximum and minimum rates as well as bandwidth rates, various forms of price caps and/or unregulated prices) and budgets; and defining standard product categories.

Furthermore the Healthcare Authority supervises the application of the 2006 Health Insurance Act, notably the key elements of the system, i.e. the duty of care; open enrolment; and community rating.<sup>19</sup> Similarly relating to long term care (e.g. nursing homes and care for the handicapped) the Healthcare Authority is charged with supervising the lawful and effective execution of the Act on Long Term Care. Finally the Healthcare Authority is responsible for advising the Health Minister both on request and ex officio. This latter role tends to take the form of competition advocacy.

### *Sector-specific competition policy for healthcare*

Of primary interest for the purposes of this paper are two types of relevant powers enjoyed by the Healthcare Authority:

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<sup>18</sup> Decision of 17 July 2006, LJN: AY4928. The subsequent appeal by the Competition Authority to the Administrative High Court for Trade and Industry was turned down as unfounded. Decision of 8 October 2008, LJN: BF8820.

<sup>19</sup> This branch of its activities and indeed the legal basis for the obligations involved is thought to be covered by the exception in Article 54 of the Third Non-life Insurance Directive 92/49/EEC, OJ 1992, L228/1. This reading was confirmed by a letter to the Dutch Health Minister from the then Commissioner for the Internal Market, Frits Bolkestein, dated October 8<sup>th</sup> 2003.

- The power to impose specific obligations on individual parties with SMP. This power is based on EU principles developed in the context of electronic communications, and may for that reason perhaps be more relevant outside The Netherlands.
- The power to impose general obligations on all market parties by intervening in contract terms and the contracting process, which is discussed last. This power so far appears to be unique to The Netherlands as an instrument of sector-specific competition policy.

These two powers will now be discussed in more detail.

### *Significant market power (SMP)*

A finding of SMP empowers the Healthcare Authority to impose specific obligations on the party or parties with SMP in order to promote effective competition. As mentioned above, the concept of SMP was borrowed from electronic communications. It is applicable across the entire healthcare sector (hence both to the regulated and the liberalised segments), and is applied to individual undertakings based on an in-depth (and time-consuming) analysis. The key criterion for a finding of existence of significant market power is dominance.

There are three steps to determining SMP:

- First, the definition of the relevant (product and geographical) market, on case by case basis, as in the case of merger analysis. The product market is less contested – as mentioned above from the perspective of the patient different treatments are unlikely to be in the same market, whereas from the perspective of the provider they may be grouped together by specialisation or even more abstractly as clinical versus non-clinical care: the results do not so far lead to significant problems or discussion – whereas the geographical market is highly problematic due to the third party pays principle. The same new methods devised for mergers that were mentioned above will be used here as well.
- The second element is dominance analysis. The question here is whether the party (or parties, in the case of collective dominance) concerned has the ability to determine its behaviour independent from other market participants, i.e. customers, suppliers and competitors. The necessary analysis is based on a combination of market share (with a presumption of dominance at shares that are over 55%),<sup>20</sup> market structure, and effects. Unlike dominance abuse in general competition law, proof of abuse is not necessary for an SMP finding. Nevertheless, based on national electronic communications case law with regard to SMP where showing 100% market share was not considered sufficient, the existence of “opportunities” and “incentives” to restrict competition must be shown.<sup>21</sup>
- Third a proportionate remedy (obligations) must be imposed. These remedies will be dealt with in more detail in the next paragraph.

### *SMP remedies*

A finding of SMP triggers proportional ex ante obligations. These are intended to be preventive, and not punitive. Unlike dominance abuse, which involves a legal transgression that is met with sanctions, a finding of SMP does not mean any legal rule has been breached.

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<sup>20</sup> This is an unexplained (if minor) deviation from the 50% market share familiar from general competition law. Cf Case C-62/86 *AKZO Chemie BV v Commission* [1991] ECR I-03359.

<sup>21</sup> CBB, AWB 05/903 and 05/921 to 05/931, Judgment of 29 August 2006 (“Mobile terminating rates”).

On the other hand if SMP obligations are not met or respected a breach will occur, and sanctions can be meted out accordingly.

The possible remedies are the following: transparency; non-discrimination; the obligation to deal; providing a reference offer; the obligation to provide unbundled services; apply cost accounting principles; accounting separation; and individual price regulation (in case of a risk of excessive or predatory pricing). In each case the maximum term of an obligation (prior to renewed examination of its continued justification) is three years. The Health Minister can add new categories of obligations, one of which, structural separation, is regularly debated as a possible supplement to the current toolbox. From a perspective of effectiveness and least intrusive intervention it might make more sense to provide the Healthcare Authority with more powers regarding mergers, i.e. ex ante to avoid competition issues arising, rather than with draconian divestiture powers ex post.

SMP remedies must always be tailored to the specificities of the case at hand. The proportionality of the remedy to the competition problem involved is one key to judicial review, the “opportunities and incentives” for anticompetitive behaviour that were mentioned above are the other. Finally, it is possible for the Healthcare Authority to impose interim measures in those cases where there is an irredeemable risk of harm as a result of a presumptive SMP position. In this case it is the former rather than the latter dimension that is likely to be strictly scrutinised.

#### *Significant market power (SMP): policy context*

The policy priorities of the Healthcare Authority toward SMP are exclusion and selling power. Where possible it would combat exclusion of competitors as a first order effect rather than the exploitation of consumers which is a second order effect. That is to say it considers promoting competition a more effective way of fighting exploitation than regulation which is likely to create dependency, is likely to throw up entry barriers and perpetuates itself. Likewise the Healthcare Authority intends to concentrate on selling power and not buying power especially where the benefits of buying power are eventually passed on to consumers. This would appear to be the case as long as health insurance markets are competitive.

The Healthcare Authority would tend to concentrate on horizontal instead of on vertical restraints of competition, and on leveraging of market power (for instance leveraging of SMP from the regulated into the liberalised sector). In the event of horizontal and vertical integration it would focus on foreclosure. The Healthcare Authority would address issues like low prices and discrimination only in presence of clear-cut foreclosure effects. This approach is broadly in line with the general competition policy priorities as expounded by the European Commission, albeit applied to the healthcare context. It is worth noting however that these are so far largely points of principle rather than examples of actual practice, which is slow in emerging. This also means that many pending issues have not yet been subjected to judicial scrutiny – an important caveat given the harsh reputation of Dutch administrative law courts when dealing with market authorities.

#### *Practical experience of SMP so far*

The practical application of its SMP powers by the Healthcare Authority has seen a slow start. Since Spring 2007 about 30 cases have been registered and screened, resulting in five formal decisions (of which three in the curative sector, and two in long-term care). The Healthcare Authority has taken two further decisions on administrative (internal) review. In none of these

cases were SMP positions found to exist. Most recently however it has taken a preliminary measure based on a presumption of SMP in the pharmacy section – about which more below.

Some examples of cases that were examined are the following:

- *Espria*: in this case, concerning a prospective merger between a grouping specialised in long term care and a large housing cooperative, the Healthcare Authority investigated the risk of exclusion of competitors from the market for housing long term care facilities. However because the probable SMP position was located outside healthcare sector (i.e. in the housing market) the Healthcare Authority was not competent to act.<sup>22</sup>
- *VieCurie*: this case concerned vertical cooperation between a general practitioners' collective and a general hospital in the market for primary care diagnostics. Both parties enjoyed high local market shares of above 50%, hence meeting the threshold for a presumption of SMP.<sup>23</sup> Because it appeared that there was nevertheless no possibility for independent behaviour by the hospital this case was not pursued further.
- *Ozis*: this concerns several cases of collaborating pharmacists excluding entrants from their systems with electronic medication and patient records (the “Ozis” system). This system was also at issue in the Competition Authority Case *Dienstapothek Assen* described above. Because this problem was found to be widespread and as the earlier intervention by the Competition Authority had not helped it was decided not to address this problem by using SMP in another individual case but based on a horizontal measure that will be discussed in the next section.
- *Apotheek Breskens*: this recent case concerns a pharmacy in an isolated border region of The Netherlands that boycotts insurers' preference schemes for cheaper generic drugs by refusing to contract with them, forcing consumers to pay for their drugs directly and claim (whole or partial) restitution from their insurers.<sup>24</sup> Here the Healthcare Authority has used not its interim measures powers with respect to SMP for the first time by imposing an obligation to deal pending further investigations.

Finally vertical chains of integrated treatment for chronic diseases (including horizontal groupings) are being scrutinised at present. The measures under consideration do not just involve SMP but also (potentially) intervening in contract terms and the contracting process. The latter instrument will be discussed further below after a short diversion into the Community law implications of SMP in healthcare.

#### *Compatibility with EU competition law?*

As has been seen above the priorities of and general approach to SMP as identified by the Healthcare Authority are in line with general competition law. Nevertheless there is a question whether the SMP instrument as such breaches EU competition rules which provide that national rules are not allowed to be more strict than the EU regime. (The issue did not arise in relation to SMP in electronic communications because this is based on a harmonised EU regime, unlike the purely national SMP regime for healthcare in The Netherlands.) However there is an exception to this rule in relation to unilateral conduct which is thought to

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<sup>22</sup> Although this merger was indeed cleared by the Competition Authority it was nevertheless subsequently blocked by the Housing Minister who has special powers regarding mergers involving housing cooperatives.

<sup>23</sup> Decision of 18 June 2007, *AMM VieCurie Ziekenhuis*.

<sup>24</sup> Decision of 18 November 2009, *Menzis-Apotheek J.D. van Dalen*.

apply here.<sup>25</sup> This makes sense because the ability to act independently is at the heart of any finding of SMP, and it is the ability to abuse this independence which the proportional obligations imposed are intended to forestall.

#### *Intervening in contract terms and/or the contracting process*

This power of the Healthcare Authority does not appear to have any precedents elsewhere. It can only be used in order to promote competition and/or in order to promote transparency of healthcare markets. In the pursuit of these objectives the NZa may either intervene directly in contracts – that is to say by setting and/or adjusting or striking out contract terms and conditions – or it may intervene in the contracting process, e.g. by imposing an obligation to negotiate, to follow certain procurement rules, or to auction care. In addition to the objectives of promoting competition and/or transparency the main condition for the use of these powers is that structural problems are involved, although it is not yet if this means nationwide problems or only in particular markets.

The applications so far have been a regulation to increase contracting transparency in long term care and a regulation introducing access obligations for electronic networks concerning the provision of healthcare (although literally “facilitating” rather than “imposing” access). The latter enables access to electronic networks under reasonable, objective and non-discriminatory conditions for the purposes of exchanging patient records and medication records, facilitating electronic prescriptions as well as for the use of referral networks including access to information on waiting lists. This is intended to solve a nationwide problem of which two examples are pharmacists excluding entrants from the exchange of patient and medication records (which raised issues of patient safety as well as market entry), and hospitals excluding new entrants (specialised clinics) from referral networks used by general practitioners.

Although applying the power to intervene in contract terms and the contracting process in this way is clearly highly useful to facilitate entry in transition markets the interpretation used by the Healthcare Authority to underpin the electronic networks regulation has not yet been tested in court. If it stands up in court (and there are good arguments to think that it should), other access issues may also come to the fore.

## **6. State aid**

In the interest of providing a full picture of the relationship between competition policy of healthcare liberalisation in The Netherlands the state aid dimension will be covered briefly.

#### *EU involvement*

A crucial state aid decision taken by the European Commission in 2005 in the context of risk equalisation is one of the pillars of the Dutch system.<sup>26</sup> As was mentioned above The Netherlands have introduced mandatory universal health insurance that is provided by exclusively private health insurers. These insurers have a set of obligations, notably to provide a legally defined minimum set of services, the duty to contract sufficient care and most importantly they are prohibited from applying risk selection to their consumers and, in line with this prohibition on risk selection, premium differentiation for the basic set of services is likewise prohibited.

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<sup>25</sup> Regulation 1/2003, above note 8, Article 3 sub 3.

<sup>26</sup> Decision of 3 May 2005 relating to State aid N 541/2004 and N 542/2004 – The Netherlands – Risk equalisation scheme and retention of reserves.

To underpin this system The Netherlands has introduced a system of risk equalisation in order to avoid overt and/or covert risk selection and to promote competition on the merits (e.g. efficiency and quality) instead. By compensating for an above average risk profile and doing so ex ante insurers are encouraged to improve their performance instead of refusing all other than healthy consumers (who, being healthy, would in a process of adverse selection not be interested in taking out insurance). In practice however there is an important element of ex post compensation as well, which is less ideal from a theoretical point of view as it constitutes a refund of costs actually incurred instead of risks engaged in, and hence compromises the incentive structure of the scheme – and thereby its purpose.<sup>27</sup>

As mentioned above, the funding for health insurance in The Netherlands is based on individual insurance premiums (50%) on the one hand, and based on income related premiums withheld at base, includes the funding based on risk equalisation through a public fund (the remaining 50%).

This system was duly notified as a potential state aid and subjected to Commission scrutiny based on the four *Altmark* criteria.<sup>28</sup> It failed on the fourth condition, which requires the beneficiary undertaking to have an efficiency that is at least equivalent to that of a well run operator. Consequently the Commission next considered the scheme based on the Article 86(2) EC (now Article 106(2) TFEU) exception for services of general economic interest. In the absence of an express designation of a service of general economic interest it was prepared to accept that the investiture could be derived from the general legal context in The Netherlands,<sup>29</sup> emphasizing the minimum set of services and the fact that premium differentiation was prohibited. Following the necessity and proportionality test (and in spite of the ex post equalisation also involved) the system was accepted as falling within the scope of the exemption.

By way of evaluation it would seem that The Netherlands took a huge gamble by proceeding in this way as 50% of Dutch hospital financing was at risk in the Commission's decision. Possibly this is one explanation for the Commission's circumspect approach. A much sounder approach in Community law would have been designating a proportional service of general economic interest explicitly, and a much sounder approach on the merits would have been to eliminate the ex post compensation as much as possible. The latter is currently under consideration by the Dutch Ministry of Health and would appear to be a good idea from both perspectives.

#### *Aid: recent developments at national level*

Perhaps surprisingly, the Healthcare Authority, although a sector-specific competition authority, is itself in the business of doling out state aid. This has not been widely recognised and in fact so far state aid in healthcare in The Netherlands is usually not notified. The reason why the Healthcare Authority is involved is because it is still responsible for fixing the budgets of hospitals for the 65% of healthcare services that are not yet liberalised. To provide aid to struggling hospitals it fixes the budget at a higher level, accordingly imposing higher

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<sup>27</sup> Cf Ministry of Health, Welfare and Sport, Risk Insurance under the Health Insurance Act in The Netherlands, Summary of 7 July 2008 (original report August 2007).

<sup>28</sup> Case C-280/00 *Altmark Trans GmbH and Regierungspräsidium Magdeburg v. Nahverkehrsgesellschaft Altmark GmbH*, and *Oberbundesanwalt beim Bundesverwaltungsgericht (Altmark)* [2003] ECR I-7747.

<sup>29</sup> Case C-393/92, *Municipality of Almelo et al. v. NV Energiebedrijf Ijsselmij* [1994] ECR I-1477. Cf Case T-289/03, *British United Provident Association Ltd (BUPA), BUPA Insurance Ltd, BUPA Ireland Ltd v. Commission of the European Communities*, Judgment of 12 February 2008 (nyr). Annotated by W. Sauter in (2009) 46 *Common Market Law Review* 269.



financial outlays on the insurers involved who are then compensated ex post from the risk equalisation fund. Because (as was just discussed) the latter is financed by income based (collective) premiums state aid would in most cases appear to be involved.

Increasing awareness of this problem has led to several developments. In the first place there is discussion about formally defining services of general economic interest (i.e. by law), which would notably include defining the dimension of “continuity” of care. Safeguarding continuity is generally the argument invoked to justify providing aid but objective criteria do not exist yet – which leads to ad hoc solutions under political pressure. Most likely elements of ambulance services and emergency services will be defined as key from a continuity perspective, but not all hospitals services, as is de facto the case at present.

Further ambitions include the introduction of an early warning system – i.e. monitoring which healthcare providers are in dire straits financially so intervention may be possible before they collapse under the weight of their debts – and introducing modalities of intervention that combine the provision of continuity with competitive incentives – e.g. auctioning of care or of capacity. Reasons to be concerned about state aid in a liberalisation context are obviously the resulting barriers to entry, and the distortions of competition involved: poor performance is rewarded, and thereby well-performing competitors are penalised, all at the ultimate expense of the consumer/taxpayer. It is therefore crucial that policy in this field is improved.

## **7. Conclusions**

The arguments in favour of a regulatory framework to facilitate competition in healthcare markets are strong, given the existence of pervasive market failures, the fact that liberalisation is taking place step by step, so we are dealing not just with a transition market but with a drawn out transition process, and given the serious risk of anticompetitive effects between the liberalised and non-liberalised sections. These are among the reasons why The Netherlands has adopted a dual system of competition policy in the healthcare sector, i.e. both general and sector-specific competition policy. Given the need for a coherent application of sector-specific competition policy with other regulatory duties in the sector this task has been attributed to the Healthcare Authority, which enjoys an independent status as regards its decisions in individual cases – a degree of independence comparable to the general Competition Authority.

Concurrence between the two regimes is managed by intensive inter-institutional cooperation, by a priority rule favouring the Competition Authority on the interpretation of competition concepts – thereby safeguarding the coherence with EU competition thinking – and a second priority rule favouring the Healthcare Authority where enforcement is concerned – thereby safeguarding the coherence of sectoral policy for healthcare as a whole.

Because sector-specific competition policy is largely about promoting entry and competition, there is a focus on exclusion not exploitation, selling power not buying power, and horizontal not vertical restraints. This is in line with general competition policy trends. A difference is that the Healthcare Authority attributes more importance to even a minor degree of competition remaining in a market (as a possible stepping-stone for entry), to potential competition, and to a dynamic view of the market more generally. The Healthcare Authority also appears more sensitive than the Competition Authority is to the effects on market structure as a result of merger activity. This is a logical consequence of the former’s broad powers and responsibilities for the healthcare sector that require a holistic perspective.

The interaction between competition and regulation is complex but so far appears to favour application of horizontal regulation instead of pursuing individual competition cases. This is also because at least initially the focus is most likely to be on competition problems that are widespread – and hence require horizontal solutions such as regulation of contract conditions and contracting processes – than more individualised and incidental (unless they are of particular and exemplary gravity). However there should be more scope for individual cases now that new methods for market definition have been developed. In any event, for the time being it will remain an open question whether the “Dutch model” of twin tracks of general and sector-specific competition policy in the healthcare sector will be successful. Much would appear to depend on the scope that the administrative courts in The Netherlands will be prepared to accord to the Healthcare Authority in the first cases on SMP and intervention in contract terms and the contracting process.