

The Dutch Health Insurance Sector and EU Competition Law

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Paper prepared for delivery at the conference on ***European Integration and Health Care Systems: A Challenge for Social Policy***.
A conference organised during the Belgian Presidency of the European Union, 7-8 December 2001

INTRODUCTION

In this contribution, the effects of European competition Law on the system of health insurance in the Netherlands will be discussed. Attention will be paid mainly to the system of agreements that characterises the Dutch healthcare sector. It is in this area, in particular, that competition law has resulted in major changes. Before discussing these changes, a short description is given of the Dutch system of health insurance and the way European competition rules have affected this system.

THE DUTCH SYSTEM OF HEALTH INSURANCE

The Dutch system of health insurance is divided into three compartments. The first compartment relates to care financed in accordance with the Exceptional Medical Expenses Compensation Act [*Algemene Wet Bijzondere Ziektekosten*] and covers serious medical risks. This involves, in particular, long-term care in institutions, homecare and psychiatric care. The second compartment relates to 'normal' health risks, such as medical aid, hospital care of limited duration, medicines and medical aids. This compartment contains both health insurance, in accordance with the National Health Insurance Act [*Ziekenfondswet*], and private health insurance, including the Health Insurance (Access) Act [*Wet op de toegang tot de ziektekostenverzekeringen*]. The income level of the insured determines whether he is insured by a health insurance fund or privately. The health insurance funds are also the insurers for the Exceptional Medical Expenses Compensation Act. A third compartment relates to care that is not covered by the above-mentioned compartments. Policyholders may voluntarily decide to insure these risks by means of additional private insurance. Private and additional health insurance will not be discussed further in this contribution, since the effect of competition law relates mainly to the Exceptional Medical Expenses Compensation Act and the National Health Insurance Act.

The health insurance funds and insurance in accordance with the Exceptional Medical Expenses Compensation Act is insurance provided by law. This means that everyone who meets the conditions of the National Health Insurance Act or, alternatively, the Exceptional Medical Expenses Compensation Act is insured by law in accordance with the statutory schemes referred to above. Both the National Health Insurance Act and the Exceptional Medical Expenses Compensation Act are based on a system of insurance-in-kind. This means that the insured is not entitled to compensation for the costs he incurs, as in the case of private health insurance, but is only entitled to the provision of care-in-kind. The health insurance fund is required to ensure that the insured persons registered with it are able to exercise these rights and for this purpose enters into agreements with persons or institutions that can provide this care, the so-called cooperation agreements. An insured person who wishes to exercise his right to care is required to make use of the services of the person or institution with which the insured's health insurance fund has entered into an agreement.

Initially health insurance funds had little freedom to contract providers of care. Up until 1992, health insurance funds were subject to an obligation to enter into contracts and a region was allocated to every health insurance fund. This meant that they were obliged to enter into contracts with all providers of care in the region. In addition, the healthcare providers were only permitted to charge tariffs determined in accordance with the Healthcare Charges Act [*Wet Tarieven Gezondheidszorg*]. The system offered little flexibility.

In 1992, the National Health Insurance Act was amended. The aim of this amendment was to make the system of health insurance more market-oriented by introducing demand driven management of healthcare. This was implemented by giving health insurance the means and room to act and present themselves as active procurers of healthcare. Healthcare insurers are permitted to determine part of the premium and the composition of the healthcare package and were permitted to operate nationally. The insured were allowed to register with

the health insurance fund of their choice. With regard to independent professional practitioners, including general practitioners, speech therapists, pharmacists and physiotherapists, the obligation to enter into contracts was removed from the National Health Insurance Act and the Exceptional Medical Expenses Compensation Act and fixed tariffs were replaced by maximum tariffs. In addition, an incentive was introduced in the form of a partial financial risk to encourage insurers to actually make use of the above-mentioned opportunities. With regard to the institutions, the fixed tariffs and the obligation to enter into contracts continue to apply.

EFFECTS OF EUROPEAN COMPETITION RULES ON THE DUTCH SYSTEM OF HEALTH INSURANCE

The key feature of European competition law is the prohibition on the abuse of a dominant position, the prohibition on agreements or mutually coordinated *de facto* behaviour that restrain competition, and a system for regulating concentrations. This system is intended to ensure that dominant positions do not arise and are not strengthened by concentrations. The Dutch Competition Act contains similar provisions.

Direct Effect

The European competition rules, with the exception of European regulation of concentrations, may be applied by the NMa. The EC rules only apply if trade between states is affected appreciably. Situations are conceivable in which this is the case. In border regions, for instance, it may be beneficial to a healthcare insurer to enter into contracts with foreign providers of care. Inversely, foreign care providers may wish to provide care to Dutch patients, but may not be able to enter into contracts with an insurer. Up until now, the NMa has not dealt with any cases relating to the Dutch healthcare sector in which European competition rules have been applied. To date the European Commission has not taken any decisions with regard to the Dutch healthcare sector on the basis of European competition rules.

Indirect Effect

As was mentioned above, the Competition Act is strongly inspired by European competition Law and the Competition Act also includes a prohibition on agreements and mutually coordinated *de facto* behaviour that restrains competition, a prohibition on abusing a dominant position and a system of regulating concentrations. These prohibitions are (almost) substantially the same as the European prohibitions. In addition, the interpretation of these provisions is based on decisions taken under European law and European case law. A good example of this is the interpretation of the concept of a 'company'. In line with European case law and decisions, the NMa has decided, for instance, that individual healthcare providers and healthcare insurers are companies subject to the Competition Act, insofar as they implement the National Health Insurance Act. Healthcare providers carry out services subject to payment, which may be regarded as an economic activity. Healthcare insurers, which implement the National Health Insurance Act, have freedom to determine their own policy with regard to the most important parameters of competition, namely the pricing of health insurance provided by health insurance funds and the quality of the healthcare packages they offer. In addition, they are free to select the individual healthcare providers with whom they wish to enter into cooperation agreements.

EFFECTS OF COMPETITION LAW: AGREEMENT SYSTEM

In general terms, competition rules are aimed at promoting and maintaining healthy competition. A condition for applying competition rules is that there is (potential) room for companies to determine their own behaviour (in order to compete). This means that

competition rules are only relevant at the moment that the government withdraws. This room is not available everywhere within the Dutch system of healthcare insurance. This applies, for instance, to insurance under the Exceptional Medical Expenses Compensation Act, where the premiums and healthcare provision are fixed. This also applies to the procurement of care by healthcare insurers from institutions to which the obligation to enter into contracts and fixed tariffs apply. Since 1992, however, room has been created for differentiation in the provision of health insurance by health insurance funds and with regard to the procurement of care from individual healthcare providers (both in relation to the Exceptional Medical Expenses Compensation Act and within the framework of the National Health Insurance Act).

Although the amendments to the system in 1992 opened the way to greater operation of market forces in the healthcare sector, this room was hardly used either by healthcare insurers or by individual providers of healthcare. Both groups adhered to the former methods of contracting. Briefly this involves the following:

- the healthcare insurer, which was still regionally oriented, negotiated with a representative of the individual healthcare providers in the region in relation to the cooperation contracts to be entered into with each healthcare provider. This resulted in a single uniform contract (with a single tariff for all parties). Since the healthcare insurer continued to negotiate with a representative of the healthcare providers, it was not possible for the healthcare insurer to follow its own procurement policy. In addition, competition between the individual healthcare providers did not take place.

- On entering into group contracts with healthcare providers, the healthcare insurer acted in accordance with the policy of the professional association of healthcare providers with regard to the establishment of new practices. This policy with regard to the establishment of new practices meant that healthcare providers with an established practice decided whether there was room for new healthcare providers in the region (and, in doing so, they decided on the entry of additional competitors). If a healthcare provider had not established a practice in accordance with the rules of the professional group, he could not enter into a contract with the healthcare insurer.

The NMa has taken a number of important decisions with regard to the above-mentioned behaviour of healthcare insurers and healthcare providers. The NMa is not by definition opposed to collective negotiations. Insofar as collective negotiations relate to the quality of care to be provided or purely procedural or administrative aspects, they do not result in restraints on competition. Collective negotiations with regard to the parameters of competition, such as tariffs and the establishment of practices, are prohibited in accordance with the Competition Act, since these restrain competition between healthcare providers. Firstly, a uniform tariff does not take into account the differences in costs incurred by healthcare providers in practising their profession. Secondly, a uniform tariff is a restraint on paying more for better quality. The policy with regard to establishing practices, as described above, prevents healthcare providers, who have not established practices in accordance with the rules of the professional group, from practising their profession. After all, the majority of the population of the Netherlands is insured in accordance with the National Health Insurance Act and almost all healthcare insurers adhered to this policy in relation to the establishment of practices. This policy also had consequences for the provision of care in border regions. On the one hand, this policy meant that foreign healthcare providers did not have the opportunity to offer healthcare in the Netherlands. On the other hand, healthcare insurers, faced with a shortage of healthcare providers in a particular border region, were not able to enter into contracts with foreign healthcare providers. The NMa has rejected the policy with regard to the setting up of practices and, in doing so, has indirectly increased the opportunities for foreign care providers mentioned above. The likelihood that European competition rules will be applied in the future has therefore increased.

Now that collective negotiations with regard to the parameters of competition are no longer permitted, a situation has arisen where the healthcare insurer no longer negotiates with

representatives of healthcare providers in the region. This may mean that the healthcare insurer has a dominant position in the region in which it was originally established. A dominant position, in terms of the Competition Act, will only exist if the healthcare insurer is able to act independently of the healthcare providers. In addition to the market share of the healthcare insurer, this also depends on whether there is a shortage of healthcare providers in the region. A healthcare insurer, after all, has an obligation to provide care within the framework of the National Health Insurance Act and the Exceptional Medical Expenses Compensation Act. In order to fulfil this obligation to provide care, the healthcare insurer has to enter into cooperation contracts with individual healthcare providers. If there is a surplus of healthcare providers, an insurer will have no problems fulfilling its obligation to provide healthcare and a dominant position may exist. In this case, the NMa will have to ensure that the insurer does not abuse its position. For instance, a healthcare insurer with a dominant position may not treat healthcare providers differently or enter into contracts with healthcare providers subject to unreasonably low tariffs. Furthermore the insurer may not refuse to negotiate with individual healthcare providers and impose the same contracts on them. In the event of a shortage of healthcare providers, the power relations will be different and the healthcare insurer will not have a dominant position. In this case, the NMa will ensure that the healthcare providers that have a dominant position do not abuse this position.

CONCLUSION

The Dutch Competition Act is based on European competition rules and with regard to its interpretations is in line with European legal decisions and case law. Up until now European competition rules had only affected the Dutch healthcare system indirectly in this way. This effect has resulted in a major change in the way individual healthcare providers are contracted by healthcare insurers. In this way competition law has made an important contribution to the introduction of market forces in the healthcare sector, as was the government's intention. Both healthcare providers and healthcare insurers have had to change the way they behave. The providers of healthcare compete for the favours of healthcare insurers and healthcare insurers compete for the favours of the insured. The healthcare insurer may make use of foreign healthcare providers for this purpose.