



# Competition policy for health care provision in the Netherlands



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## ABSTRACT

In the Netherlands in 2006 a major health care reform was introduced, aimed at reinforcing regulated competition in the health care sector. Health insurers were provided with strong incentives to compete and more room to negotiate and selectively contract with health care providers. Nevertheless, the bargaining position of health insurers vis-à-vis both GPs and hospitals is still relatively weak. GPs are very well organized in a powerful national interest association (LHV) and effectively exploit the long-standing trust relationship with their patients. They have been very successful in mobilizing public support against unfavorable contracting practices of health insurers and enforcement of the competition act. The rapid establishment of multidisciplinary care groups to coordinate care for patients with chronic diseases further strengthened their position. Due to ongoing horizontal consolidation, hospital markets in the Netherlands have become highly concentrated. Only recently the Dutch competition authority prohibited the first hospital merger. Despite the highly concentrated health insurance market, it is unclear whether insurers will have sufficient countervailing buyer power vis-à-vis GPs and hospitals to effectively fulfill their role as prudent buyer of care, as envisioned in the reform. To prevent further consolidation and anticompetitive coordination, strict enforcement of competition policy is crucially important for safeguarding the potential for effective insurer–provider negotiations about quality and price.

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## 1. Introduction

After decades of top-down health care rationing policies, the Netherlands has opted for a system of regulated (or managed) competition with wide-ranging reforms implemented since the mid-2000s to strengthen the role of market mechanisms [1]. In 2006, competition among health insurers was reinforced with the introduction of the Health Insurance Act (HIA) making competing pri-

vate health insurers responsible for providing affordable mandatory health insurance for every Dutch citizen. The basic idea was to give risk-bearing health insurers appropriate incentives and tools to act as prudent buyers of health services on behalf of their customers. To that end, consumers are annually free to choose among all basic health plans offered by insurers. Health insurers have to offer a standardized basic benefits package that is determined by the government. About half of the expenses are paid by income-related contributions which are centrally collected by the tax office and then redistributed as risk-adjusted capitation payments to health insurers. The other half has to be covered by out-of-pocket premiums set by health insurers themselves and the mandatory deductible

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set by the government (children under 18 years of age are exempted from paying both out-of-pocket premiums and the mandatory deductible; the deductible does not apply to GP consultations and maternity care). Health insurers can compete on price, but it is not allowed to differentiate out-of-pocket premiums across consumers of the same basic health plan (i.e. health plan premiums have to be community-rated). Since 2006, health insurers are increasingly offered more room to negotiate with health care providers about the price, volume and quality of care. They are allowed to contract selectively and use financial incentives for channeling patients to preferred providers. Due to horizontal consolidation, in 2016 the four largest health insurers have acquired a joint market share of 88.5% [2], giving them a potentially strong bargaining position vis-à-vis providers.

In addition to the fundamental reform of the health insurance system, a gradual deregulation of health care provision markets took place. In this paper, we focus on the introduction and/or strengthening of competition among GPs and hospitals. Competition policy is supposed to play an important role in safeguarding the room for competition among GPs and hospitals that has been created over the last decade [3]. In the health care sector, competition policy in the Netherlands is enforced by two independent authorities: (i) the Authority for Consumers & Markets (ACM), since 1998 responsible for enforcement of the Competition Act (Mw), and (ii) the Dutch Healthcare Authority (NZa), since 2006 responsible for enforcement of the Healthcare Market Organisation Act (Wmg). ACM is the general competition authority, charged with prohibiting anti-competitive agreements (cartels), abuse of dominant positions and merger control in health care sectors where the government created room for competition. The NZa is specifically designated to monitor and improve the general performance of liberalized health care markets as well as regulating non-liberalized markets. Furthermore, the NZa may also take action against parties with significant market power (SMP). In addition to both competition authorities, the Health Care Inspectorate (IGZ) is responsible for monitoring health care quality by ensuring health care providers' compliance with legislation, (professional) standards and guidelines. The National Health Care Institute (Zorginstituut Nederland) also plays an important role because it is responsible for improving health care quality in the Netherlands through the provision of public information about quality. If stakeholders cannot reach an agreement on how quality should be measured, this institute has the legal power to decide on a mandatory set of quality indicators that have to be reported. By the end of 2015 the quality institute used this power for the first time to impose quality indicators for six emergency care diagnoses (hip fracture, aneurysm, acute myocardial infarction, CVA, multi-trauma, and childbirth complications).

## 2. Institutional set-up

### 2.1. GPs

Traditionally, GPs fulfill an important role as gatekeeper in the Dutch health care system. Dutch citizens are required

to register with a single GP and – except for emergency care – they need a referral from their GP to consult a medical specialist. Licensed GPs are free to establish a practice if they guarantee 24/7 care (i.e. arrange available substitutes). In 2012 there were about 7900 self-employed and 1000 salaried GPs, serving on average 2400 people per fte [4]. Salaried GPs are either employed by primary health centers or by self-employed GPs. Most GPs are working in small private practices: 26% in single, 38% in duo, and 36% in group practices.

Since the introduction of the HIA (2006), GPs receive a capitation payment for each registered person and a fee-for-service payment for each practice visit. Although health insurers are allowed to selectively contract with GPs, they hardly did and also faced little incentives to do so since prices were highly regulated [5]. Moreover, almost all people are registered with a single GP, and most have a long-standing trust relationship with that GP. A survey showed that 98% of the respondents were registered with a single GP (practice). More than 60% of these people were registered with the same GP for more than ten years, whereas only 9% had a relationship of less than two years [5]. GPs are free (not) to accept people that want to register. Patients' long-standing and often high-valued relationship with a single GP makes selective contracting of GPs hardly feasible in practice, since this would imply that people could be forced to terminate this relationship.

After local experiments with bundled payments for diabetes (type II), which were started in 2007, in 2010 bundled payments were introduced nationwide for patients with diabetes (type II), COPD and vascular risks. Bundled payments were introduced to support a better coordination among primary care providers in treating patients and to prevent expensive outpatient-specialist care and hospitalizations. Prices of bundled payments have to be negotiated between a "care group" and health insurers. Care groups are legal entities that act as main contractor, employing or subcontracting providers to offer coordinated outpatient care. Since 2010 about a hundred care groups have been established by GPs, and within a few years' time about 80% of all GPs joined one of these care groups. The median number of GPs per care group is about 50, but varies widely, with an interquartile range from 25 to 107 GPs [6]. Early results from a formal evaluation of bundled payments for diabetes showed an improvement in the organization and coordination of care, and a better adherence to care protocols. However, also observed were an increasing administrative burden and higher overhead costs, as well as large price variations among care groups that could be only partially explained by differences in the volume of care provided [7]. A recent paper claims that during the first four years after the introduction of bundled payments for diabetes care, patient mortality rates and medical costs have dropped significantly [8].

The rapid clustering of GPs and other primary care providers in a limited number of care groups may have important implications for the room for competition. On average, there are five care groups per relevant geographic market (GGD region). The variation however is substantial, ranging from one (i.e. a regional monopoly) to thirteen care groups [6]. People do not actively choose for a par-

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