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Public healthcare interests require strict competition enforcement

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ABSTRACT

Context: Several countries have introduced competition in their health systems in order to maintain the supply of high quality health care in a cost-effective manner. The introduction of competition triggers competition enforcement. Since healthcare is characterized by specific market failures, many favor healthcare-specific competition enforcement in order not only to account for the competition interest, but also for the healthcare interests. The question is whether healthcare systems based on competition can succeed when competition enforcement deviates from standard practice.

Methods: This paper analyzes whether healthcare-specific competition enforcement is theoretically sound and practically effective. This is exemplified by the Dutch system that is based on regulated competition and thus crucially depends on getting competition enforcement right.

Findings: Governments are responsible for correcting market failures. Markets are responsible for maximizing the public healthcare interests. By securing sufficient competitive pressure, competition enforcement makes sure they do. When interpreted according to welfare-economics, competition law takes into account both costs and benefits specific market behavior may have for healthcare. Competition agencies and judiciary are not legitimized to deviate from standard evidentiary requirements. Dutch case law shows that healthcare-specific enforcement favors the healthcare undertakings concerned, but to the detriment of public health care.

Conclusion: Healthcare-specific competition enforcement is conceptually flawed and counterproductive. In order for healthcare systems based on competition to succeed, competition enforcement should be strict.

1. Introduction

Healthcare is costly and expenditures are expected to continue to further increase due to demographic and technological developments [1]. In order to maintain the supply of high quality health care in a cost-effective manner, several countries have introduced competition in their health systems. The introduction of competition triggers the application of competition law. However, it is unclear how general competition rules should be applied in a semi-public sector like healthcare [2,3]. Basically, the question is whether competition enforcement in healthcare should be similar to enforcement in other sectors (i.e., standard and strict [4–6]), or different from enforcement in other sectors (i.e. healthcare-specific [7–9]). Many perceive a standard application of general competition rules as 'unfair' since healthcare services are considered to be 'special goods' to which normal economic principles would not necessarily

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apply. So, in order to further the public healthcare interests – high quality health care that is affordable and accessible for all, it is held that enforcement of general competition rules should be healthcare-specific. This paper analyzes whether that perception holds true or whether it is conceptually flawed and counterproductive. The analysis consists of two parts. The first part is conceptual and will verify whether the assumptions underlying the need for healthcare-specific competition enforcement are correct. The second part is more practical and will examine whether the public healthcare interests actually benefit from healthcare-specific competition enforcement. All of this will be exemplified by the Dutch healthcare system that is most advanced when it comes to introducing competition and thus crucially depends on getting competition enforcement right in order for the system to succeed.

2. The Dutch healthcare system

The Dutch healthcare system exemplifies a Bismarckian system that provides for social health insurance with private insurers. In 2006, Dutch healthcare policy took a major step in the gradual transition from supply-side government regulation towards regulated competition. In that year, the Health Insurance Act (HIA) was enacted that introduced a system in which competing health insurers are expected to become prudent buyers of health care on behalf of their enrollees [10]. In addition, the Healthcare Facilities Admission Act (HFAA) and the Healthcare Market Regulation Act (HMRA) were enacted in order to liberalize provider markets [11,12].

When distinguished by type of insurance, the current Dutch system knows three segments of healthcare: basic care, long-term care and supplementary care. Basic care is funded through the HIA. This act provides for a private insurance scheme that is both mandatory and universal [13,14]. 'Mandatory', since all Dutch citizens are legally obliged to buy individual health insurance. 'Universal', since all health insurers are legally obliged to accept each applicant for basic insurance coverage at a community-rated premium (as opposed to a risk-rated premium) and open enrollment (without exclusion of coverage because of pre-existing conditions that prevents insurers from contracting healthy people only). Premium subsidies make basic health insurance affordable for everyone and a risk-equalization system compensates insurers for enrollees with predictably high medical expenses. Basic care includes primary care (such as GP and midwife services), specialist care, hospital care, medicines and devices, medical rehabilitation and patient transport. Dutch citizens have an annual choice among insurers and may opt for a benefit-in-kind policy, a reimbursement policy or a combination of both. Long-term care is funded through public insurance based on the Long-term Care Act (LCA) [15]. One of the reasons long-term care is not covered under the HIA is that risk-equalization is less feasible. The difference between public insurance under the LCA and private insurance under the HIA is that citizens do not have to contract an insurer in order to claim long-term care; their right to nursing and stay in a nursing home or institute for disabled is automatically established under the LCA. All the same, health insurers are responsible for the implementation of the LCA. Insurers have mandated the provision of long-term care to so-called health offices that coordinate said provision for all insurers active in a certain area. Since most Dutch citizens appreciate more extensive healthcare coverage than offered under the HIA and LCA, health insurers offer supplementary insurance policies covering for example dental care (for adults) and physiotherapy. The difference between basic and supplementary care is that enrollment is voluntary, while insurers are not under an obligation to accept each applicant and may cover different risks or cover risks differently. It follows that the current Dutch healthcare system contains three kinds of markets. *Healthcare provision markets* where healthcare providers offer all sorts of (basic, long-term or supplementary) health care to patients. *Health insurance markets* where health insurers offer basic or supplementary health insurance to insured. And *healthcare purchasing markets* where health insurers purchase all sorts of care on behalf of their insured. Such extensive use of the market instrument begs the question what competition enforcement serves the public healthcare interests best: Standard or healthcare-specific competition enforcement?

3. Healthcare-specific competition enforcement is conceptually flawed

Healthcare markets are unlike most other markets. In 1963, Arrow pointed out that the healthcare sector is characterized by special features and specific market failures [16]. This has led to a number of intertwined (explicit or implicit) assumptions. First, it is assumed that the rationale underlying strict competition enforcement, i.e. that markets only maximize welfare as long as competition is secured, would not apply to healthcare [7–9]. Second, that the furtherance of the public healthcare interests would fall short if competition enforcement in healthcare is standard [7,17]. Third, that imperfect regulation of healthcare markets would call for healthcare-specific competition enforcement [9,18]. The relevant question though is whether those assumptions are correct.

3.1. Also healthcare markets only maximize welfare as long as competition is secured

Arrow was right (of course). The unconditional use of the price mechanism would yield both socially undesirable and inefficient outcomes in the healthcare sector. However, this does not imply that healthcare markets would only maximize welfare when competition enforcement is less vigorous. Point in case being that markets are not the only institution responsible for the realization of the public healthcare interests in healthcare systems based on regulated competition. While the market is responsible for maximizing those interests, the government is responsible for defining the minimum conditions of quality, affordability and accessibility to be met and for regulating the market in order for it to achieve the public goals [14]. For example, unconditional operation of supply and demand would endanger access to care, because people with low incomes would not be able to buy good quality care as the