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EDITORIAL

Competition and collaboration in health care: reconciling the irreconcilable? Lessons from The Netherlands

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Introduction

In health systems based on the principles of regulated (or managed) competition, effective competition regulation to prevent anticompetitive mergers and cartels as well as the abuse of dominant positions is a crucial precondition that must be fulfilled to safeguard public health care interests [9, 10, 12]. However, from the perspective of health system sustainability and resilience, integration and collaboration become increasingly important. This results in an important challenge for the authorities responsible for enforcing competition law in health care (e.g. [8]). Integration and collaboration may reduce coordination problems and facilitate better integrated health care. However, in a setting where (regulated) competition is used as an instrument for improving health system outcomes, both may also reduce incentives for efficiency, increase market power and restrict consumer choice. We here discuss how the Netherlands Authority for Consumers and Markets (ACM) deals with this challenge when applying the cartel prohibition in health care, both in normal times and during the COVID-19 pandemic.[1]

Competition policy in the Dutch health system

Cartel prohibition

In the Netherlands, ACM is the competition authority that is responsible for enforcing the general Competition Act in health care sectors where the government has created room for competition [11]. As part of the cartel prohibition in the Competition Act, agreements "which have the intention to or will result in hindrance, impediment or distortion of competition on the Dutch market or on a part thereof" are prohibited. However, an exception can be made for agreements "which do not (a) impose any restrictions on the undertakings concerned, ones that are not indispensable to the attainment of these objectives, or (b) afford such undertakings the possibility of eliminating competition in respect of a substantial part of the products and services in question."

Formal decisions

In 2004, anticipating market-based health system reforms, ACM started to enforce cartel prohibition in health care. Initially, this resulted in eight cases in which (representative associations of) health care providers were fined for anticompetitive practices such as market sharing (home health care), price fixing (mental health care) and entry deterrence (GP care). However, as a result of court rulings following appeals against the ACM's decisions, most of these fines were reversed. From these cases, it can be concluded that when applying the cartel prohibition in health care, the competition authority failed to meet the burden of proof required by the court [13]. This was particularly true regarding the justification of whether (1) there was room for competition in the specific sectors and (2) the alleged conduct restricted competition in practice and, thus, constituted an infringement of competition law. In three cases, the court explicitly

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[1] This discussion was included as a case study in our recent report [17], produced as part of the Partnership for Health System Sustainability and Resilience (PHSSR), providing a comprehensive overview of the Dutch health system's most important strengths and weaknesses across seven domains: health system governance, health system financing, workforce, medicines and technology, health service delivery, population health, and environmental sustainability.

ordered that additional research regarding the legal and economic context was required, which ACM deemed unfeasible due to staff shortages and the time elapsed between the start of the investigation and the court decision.

Informal guidance

Since the last cartel case in health care in 2012, ACM seems to have shifted policy from formal punitive enforcement to providing *ex ante* informal guidance [15]. This has resulted in a series of publications from which the following can be concluded [13]. First, informal guidance was sometimes issued at ACM's own initiative but most often at the request of health care organisations. The guidance then involved a preliminary assessment of the efficiency claims brought forward by the collaborating parties. An interesting example of the latter is the informal opinion concluding that three competing hospitals were allowed to collaborate in providing high-complexity low-volume cancer surgery because the benefits of meeting the minimum volume standards were expected to exceed the anticompetitive effects, such as reduced freedom of choice for patients and potential price increases [16]. Second, most of ACM's guidance focused on the application of the cartel prohibition in health care purchasing by insurers. Third, competition law does not seem to be unnecessarily restrictive. While it was frequently emphasised that some conduct was clearly anticompetitive and, thus, illegal (e.g. exchanging information on negotiated prices), for most types of collaboration, it was informally concluded that the cartel prohibition was either irrelevant or not being violated. Fourth, over time, the focus has shifted from horizontal collaborations (e.g. between hospitals only) towards novel forms of non-horizontal collaborations (e.g. provider–purchaser agreements, mixed agreements with health care providers from different sectors, cross-market agreements between organisations that are not regional competitors, or cooperative associations with a linking function between health care purchasers and providers, mainly for joint purchasing).

As an example, in 2019, the competition authority published its policy regarding collaborations as part of the government supported stakeholders' initiative The Right Care in the Right Place, aimed at (1) preventing the need for more expensive forms of health care, (2) providing health care closer to people's homes and (3) replacing some traditional forms of health care with other newer forms, such as e-Health. In its policy, ACM [1] explained that when arrangements *ex ante* meet each of the following five criteria, it will not impose any fines in case the arrangements *ex post* nevertheless turn out to violate the cartel prohibition:

1. The arrangements are based on a factual and public analysis of regional health care needs;
2. Health care providers, health care purchasers and patients (or their representatives) are fully involved;
3. The arrangements' objectives are concrete, measurable and verifiable, and they are phrased in terms of quality, accessibility and affordability of health care;
4. Market participants substantiate why the arrangements, if they restrict competition, are necessary for achieving the stated objectives; and
5. The objectives, the arrangements and the substantiation of the necessity are made public.

In a recent publication, ACM [7] also explained that competition law offers "plenty of room" for collaboration between health care organisations to deal with health care staff shortages, for example, by creating an online platform to facilitate employer–employee matching. However, agreements that harm the positions of health care workers (e.g. when collectively defining terms of employment other than agreements about the collective terms of employment negotiated between employers and employees) are not allowed.

Cartel enforcement during the COVID-19 pandemic

During the COVID-19 pandemic, competition law was relaxed for both health care providers and health insurers to facilitate the collaborations needed to deal with those extraordinary circumstances. Shortly after the COVID-19 outbreak in the Netherlands, health insurers were allowed to make collective agreements (including cost pooling) to provide financial support to health care providers [2]. This involved the set-up of so-called continuity contributions to compensate health care providers for the loss of revenue due to the cancellation or postponement of care because of nationwide measures taken to control the spread of the virus. ACM concluded that, because providers get their revenues from different payers, cooperation among insurers was needed to guarantee the continuity of health care during and after the pandemic. At the same time, hospitals, hospital pharmacies and pharmaceutical companies were allowed to collaborate closely to prevent, or reduce, any shortages of essential medicines [3]. It was concluded that the set-up of a National Coordination Centre for Prescription Drugs (LCG) to assess the supply and demand for 14 essential medicines and to coordinate their allocation and distribution among hospitals did not pose anticompetitive risks. Like the LCG, a National Coordination Centre for Patient Distribution (LCPS) was also set-up. Other than the LCG, the LCPS did not ask ACM about the anticompetitive risks of this collaboration, but the ACM did not take action against it. In the second year of the pandemic, Dutch health insurers were allowed to continue their pooling of the "exceptional additional costs" related to the COVID-19 crisis to "ensure the continuity of health care and to avoid significant

disruptions to the health system" [4]. However, following ACM's request, financial risks for individual health insurers were set substantially higher in 2021 than in 2020. Additionally, both insurers and health care providers expressed their intention to return to regular individual contracting. This was confirmed in the main principles of the new arrangements for 2022. These new arrangements were considerably less far-reaching and, thus, ACM [5] again had no objections. However, due to the extraordinary and unexpected severity of the Omicron variant of COVID-19 virus, joint arrangements were added to the bilateral contracts in the first months of 2022. The need for these joint arrangements was recognised by ACM [6], but it was also concluded that after April 2022, arrangements regarding the reimbursement of production losses caused by COVID-19 should be made part of regular bilateral provider-insurer contracting. According to ACM, new joint arrangements "can only be made in special, new circumstances in which the impact of COVID-19 hits the hospital landscape in such a way that a disruption to our health system becomes a looming threat."

Shift in health policy

Although the government does not want to fundamentally reform the current system based on regulated (or managed) competition, the focus in Dutch health policy is clearly shifting from competition to collaboration. For this reason, the Ministry of Health has stated that ACM will be requested to create as much room as possible within the current legislation to facilitate the necessary coordination for these transformations, referring to the existing rules and guidelines to enable collaborative agreements about Right Care in the Right Place. In recent years, the informal guidance published by ACM shows that collaboration and competition are not irreconcilable. The fact that collaboration is already widespread within the market-based Dutch Health System (see, for example, [14]), illustrates this as well. In addition to this structural challenge, the COVID-19 pandemic has put competition enforcement in Dutch health care to the test. As discussed above, ACM seems to have succeeded in temporarily offering both health care providers and health insurers the extra room for collaborations that were needed to deal with these extraordinary circumstances.

Conclusion

It can be concluded that, both in normal and extraordinary circumstances, the cartel prohibition offers ample opportunities for collaboration in health care. As the informal guidance issued by ACM clearly shows, competition and collaboration are certainly not irreconcilable in a competitive health system like in the Netherlands, thus contributing to its sustainability. Additionally, during the COVID-19 pandemic, enforcement of the cartel prohibition proved to be sufficiently flexible to deal with the need for increased collaboration among health care providers and insurers. This flexibility is important for the resilience of the health system.

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