The Impact of EU Competition Law on National Healthcare Systems

Competition Law in the Healthcare Sector
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Healthcare and EU competition law

European Commission actions:

- December 2011 adopted package on state aid and SGEI including block exemption for healthcare services
- July 2012 issues 14 SOs re antitrust infringements following pharmaceutical sector inquiry
- July 2012 requests Ireland to end unlimited guarantee for VHI in state aid probe into PMI

Healthcare and national competition law

- January 2012 Dutch NCA fines general practitioners branch organisation for foreclosure
- April 2012 in UK the OFT refers sector investigation private healthcare to Competition Commission
- May 2012 Bulgarian NCA fines doctors branch organisation for price fixing

Is the impact of competition law on the sector increasing?

Impact of competition law questions

- How is application of internal market and competition law to healthcare different?
- What is the scope and the impact of competition law in relation to healthcare?
- In particular
  - Does competition law leave room for national health policies?
  - What is the role of services of general economic interest SGEI?
  - What are the implications of multi-level enforcement?
    - EU level and national level EU rules
    - National general competition and sector specific rules

Comparing IM and competition law

- Internal market about market access and public rules
  - Focus on public authorities
  - Public policy justifications

- Competition law about market conduct by private parties
  - Focus on undertakings
  - Largely effects-based

→ Complements: avoid private resurrection of public barriers

- State aid: prohibition on conferring unfair public advantage on private parties

- Public procurement: competition for the market not on market
  - Complements competition rules: one or other applies

Example: French laboratories I

- Market context clinical laboratories – no EU regulation
  - Prices in France 2 to 3 times higher than in other MS
  - Profits more than 3 times higher than French industry average
  - 4000 labs in France v 200 in Germany, practitioners 3x EU average
  - Various barriers to use of non-French laboratories

- Case C-496/01 Commission v France (2004)
  - Place of business requirement in France
    - No infringement of establishment (no barrier)
    - But infringes (cross-border) services freedom
  - Ban on sickness funds reimbursing costs of analyses in other MS
    - Likewise infringes services freedom

French laboratories II

- Case C-89/09 Commission v France (2010)
  - 25% cap on share holdings in laboratories by non pharmacists
  - Freedom of establishment infringed?

- MS free to determine level of public health protection
  - Restrictive measure but non-discriminatory

  - Measure appropriate
    - Professional indepence guarantee of safety and cost control
    - Pursue goal in a consistent and systematic manner (rules on presence)

  - Measure proportionate as 25% outside investment is allowed
    - Restriction or generosity?

French laboratories III

- Case 39510 *ONP* (2010) Ordre national des pharmaciens
  - Branch organisation of French pharmacists
  - Charged with protecting the industry and public interest
  - Disciplinary powers, (de-)registration (operating licence)

- Anticompetitive practices with regard to laboratories
  - Maximum prices fixed by law
    - ONP imposes maximum 10% discount = minimum price
  - Obstructing the formation of larger groups
    - Imposing minimum capital holding requirements for pharmacists
    - Prohibiting transfers of ownership rights

French laboratories IV

- Alleged infringement of Art 101(1) TFEU
  - Decision by association of undertakings
- *Wouters* (2002) defence: “inherent restrictions”
  - ONP charged with public service mission and public powers
  - NB: yet possible to separate public interest and economic aspects
- Here maintaining high prices and blocking development of groups
  - These are not public objectives with which ONP was charged
  - Hence these ONP decisions attributable solely to ONP
  - Not real excercise of delegated public powers

→ ONP fined 5 million € - launched appeal T-90/11

French laboratories V

- In this case healthcare sector plagued by combination of public and private constraints: market access (IM) and market behaviour (competition rules)

- Public and private constraints addressed in tandem
  - Establishment freedom ineffective
    - Opening markets seen as a threat to national systems
    - Professional independence as guarantee of quality and affordability
  - Services freedom more effective: no need to challenge national system
    - Here 2011 Patients' Rights Directive on cross-border services (< 1% of costs)
    - At the same time Art 168(7) TFEU no support for EU policy on organisation and delivery
  - Commission approach to cartel prohibition
    - Separates public functions from private constraints
    - But yet to be tested in Court

- Competition more effective than IM? What impact? What scope public policy?

Healthcare: what systems?

- Beveridge type systems: tax financed, NHS
  - Mixed provision
- Bismarck type systems: insurance based
  - Private provision
- Common trend: rising costs (toward 10% GDP) due to
  - Rising life span
  - Increasing expectations
  - Technological developments

→ Attempts to control costs and reduce waiting lists
  - More reliance on market provision
  - Creates a need for competition policy

- Is there room left for the pursuit of public policy goals?

Policy goals, boundaries and exceptions

- Healthcare values
  - Economic (efficiency) values
    - Cost control
    - Consumer values: access, affordability, quality, choice
    - Market failures: information asymmetry: adverse selection: moral hazard
  - Non-economic (equity) values: universality, equity and solidarity
- Boundaries and exceptions
  - Boundaries: within v outside the framework
    - Concept of undertaking → functional definition → most providers caught
    - Compensation approach*
  - Exceptions: within the framework but exempted
    - Article 101(3) TFEU
    - Services of general economic interest (SGEI)*

Boundaries: compensation

- Reimbursement for public service obligations
  - Debate on compensation v state aid approach
  - Measure not caught v measure caught but released

- *Altmark* (2003) Quid pro quo → no advantage no aid
  4 conditions
  - Public service defined and assigned
  - Parameters for compensation
  - Cost + reasonable rate of return
  - Public procurement or costs of efficient undertaking

- *BUPA* case (2008) ex post risk equalisation PMI in Ireland
  - Cost verifiable after the fact suffices
  - Services for only part of population if open enrolment
  - = Relaxed aplication of conditions

Exceptions: SGEI

- Commission 2005, 2011 Altmark packages Art 106(3) TFEU clearance
  - For compensation cases where not all Altmark conditions are met: hence aid
- For healthcare 2011 Altmark package provides:
  - Block exemption based on Art 106(3) TFEU provision on SGEI
    - Entrustment
    - Parameters
    - Cost plus reasonable return
- Member States may freely identify SGEI: economic and equity objectives
  - Compensation compatible in exchange for good governance
  - Other restrictions proportional: limiting scope to what is appropriate and necessary
- Potential driver for reform?
  - Role of USO in e-communications: separating USO enables liberalisation
  - Albeit in healthcare no EU harmonisation/liberalisation context
  - More relaxed rules now applied more strictly?

National practice Germany

- Bismarck system with public and private (10%) insurers
- *Glöckner* Case (2001) ambulance services
  - at least potentially in competition → undertakings
- *AOK* Case (2004) sickness funds fixing maximum reimbursements
  - Rate competition 30%
  - Consumer switching 5%
  - Benefits fixed by state → no undertakings
- *Oymanns* Case (2009) public insurers
  - If not undertakings then contracting authorities → procurement rules
- Several hospital merger cases blocked
  - Problem with SSNIP → Geographic markets based on actual patient flows
  - Versus new methods based on willingness to pay and/or to travel

National practice United Kingdom

- NHS system with parallel private system
- *Napp* Case (2001) pharmaceuticals
  - Delayed release morphine
  - Predation in Hospital prices, recoupment in private market 6 times more 10 times other MS
- *Bettercare* Case (2002) Competition Commission Appeal Tribunal
  - NHS Trust (purchaser) also providing services → undertaking
  - Versus *FENIN* Case (2006)
    - No separation between activities in market and NHS duties
    - Nature of purchasing determined by subsequent use of good
- OFT (2012) refers private healthcare markets to Competition Commission
  - Information asymmetries, concentration ratio's, entry barriers
- Health and social care Bill (2012) Monitor
  - Concurrent powers + goal to pursue consumer benefits
  - Will UK takes lead on innovative Art 101 and 102 TFEU enforcement?

National practice Netherlands

- Bismarck system with 100% private insurers
- EU level: State aid clearance for risk equalisation (SGEI) 2004
- Healthcare policy priority for general NL competition since 2004
  - Difficult enforcement: effects-based judicial review
- Cartel cases
  - Price cartel psychotherapists (2006): price competition parameter?
  - Market sharing home care providers (2012): scope for competition?
  - Foreclosure general practitioners (2012): appreciability?
- 150+ Merger Cases;1 blocked (insurers 33-4); evidence of price increases
  - *Zeeuwse Ziekenhuizen* (2009) merger to monopoly + quality/efficiency defence
- No dominance cases – SMP competence of Healthcare Authority

National practice Netherlands

- National sector specific competition policy since 2006
  - Independent healthcare authority
  - Priority but follows general (and EU) concepts and norms
- Mergers: initially opinions in merger cases
  - Now sector specific merger review (procedural and prior to general merger control)
  - Advisory power on divestiture and on exceptions to a ban on vertical integration
- Agreements: intervention in conditions and conclusion
  - Access to electronic networks relating to care: 2010
  - Procurement auctions in long-term care: 2013?
- SMP (EU electronic communications concept): dominance, no abuse required
  - *Breskens Pharmacy* (2012) use of lowest price products
  - Referrals GPs-pharmacies boycott of Internet pharmacies
- State aid and designating SGEI (availability and continuity) → USO model?

Conclusions

- Absence of support for an EU regime on healthcare liberalisation
- Member States decide the scope for competition by
  - Opting for healthcare provision and/or purchasing by undertakings
  - Assigning public interest obligations to undertakings
- However
  - Competition rules, state aid, procurement form a default regulatory framework
  - Not based on eliminating private parties' contribution to healthcare objectives
  - But on rationalisation of public policy and increasing the scope for competition.
- Much of the impact of competition rules is indirect: via national laws
  - Not just competition law but sector specific rules
  - Convergent application of competition law at national level is likely
  - At level of norms and techniques: for example market definition

Conclusions

- Room for both economic and non-economic justifications

- SGEI = broadest exception for both economic and non-economic objectives
  - However exceptions require rationalisation of public policy
  - Compensation can be justified based on a procedural test
  - Otherwise a proportionality test of suitability, necessity and balancing

  → Use of SGEI may increase scope for further liberalisation – the utilities model
  → Perhaps stricter application of limited (more relaxed) set of rules

- First evidence that competition curbs healthcare costs (OECD, Gaynor)
  - This underscores the usefulness of commpetition policy

- Result of the above: impact of competition law on healthcare likely to increase

- This may over time promote consensus on liberalisation