The Impact of EU Competition Law on National Healthcare Systems

Competition Law in the Healthcare Sector
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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

  - 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 exercise 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 application 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

  - 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

  - 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 competition policy

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

• This may over time promote consensus on liberalisation