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MARKET COMPETITION IN HEALTH CARE MARKETS IN THE NETHERLANDS: SOME LESSONS FOR ENGLAND?

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ABSTRACT

This article seeks to establish what lessons might be available to the English health care sector following enactment of the Health and Social Care Act 2012 from the Dutch experience of introducing market competition into health care via a mandatory health insurance scheme implemented by for-profit insurance companies. The existence of the Beveridge NHS model in England, and a Bismarckian insurance system in The Netherlands perhaps suggest that a comparison of the two countries is at best limited, and reinforced by the different Enthoven-inspired competitive models each has adopted. However, we contend that there are positive and negative issues arising from introducing competition into health care—, e.g. concerns about equity and benefits of efficiencies—which go beyond national boundaries and different systems and reflect the global paradigm shift towards the use of market forces in previously non-market areas such as health. The article examines the situation in England following the HSCA 2012 and The Netherlands following the 2006 reforms before analysing two areas of common ground: the focus in both countries on competition on quality (as opposed to price) and integrated care, which is assuming ever greater significance. We suggest that our combined insights (as a health lawyer and competition lawyer respectively) coupled with a comparative approach create a novel contribution to current calls for a wider public debate about the real role of markets in health care over and above simple characterisation as a force for good or bad.

KEYWORDS: English NHS, Health and Social Care Act 2012, Health Care Regulation, Health Insurance, Monitor, The Netherlands

I. INTRODUCTION

The introduction of the Health and Social Care Act 2012 (HSCA 2012) in England has proved controversial for officially applying the principles of competition law to the

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English NHS. As such, it not only formalises the development of market forces in the English NHS (in evidence since Enthoven's conception of 'internal markets' from the late 1980s), but also reflects a contentious global paradigm shift regarding the use of competition and market forces in health care which polarises opinion. On the one hand, competition is increasingly seen as a solution to the problems of rising costs and increasing demand. On the other hand, competition in health care (and other social services) is seen as fundamentally corrosive, undermining relationships between both patients and practitioners, and between citizens and the State, even striking at the heart of the basic human right to health care.

This belief in market forces is not restricted to England. Other countries have already experimented with market competition in health care. In 2006, the Dutch health care system shifted towards a universal basic health insurance scheme for the entire population. However, unlike most universal schemes, the Dutch system is implemented by multiple private health insurers. Although based on the principles of competition in that it allows providers and insurers to compete for consumers, it is also highly regulated to ensure the allocation of essential care according to need.

The Dutch system is now an interesting marriage of tensions because in moving to extend insurance to all citizens, it simultaneously introduced a much greater role for the private sector in terms of relying on competing private for-profit health insurers. Although liberalising and privatising health care may be justifiable for economic and financial reasons (such as cost reduction, efficiency improvements, and innovation), there are serious concerns about whether a system of regulated competition and emerging private health arrangements respects the basic human right of equal access to health care services. From a human rights perspective, combining competition and private initiatives on health care markets with restrictive measures inspired by social values (e.g. solidarity and equity) appears to be an extremely difficult exercise. For example, as we will discuss further below, several market-driven policies have undermined the right to equal access (e.g. preferential treatment arrangements, voluntary deductibles, and discounts for group insurance schemes).

At first glance, examining what England can learn from the Dutch experience is at best limited in view of their very different health care systems (i.e. the Beveridge national health service funded by general taxation and a Bismarckian model of health insurance, respectively) and different Enthoven-inspired competitive models ('internal markets' based on a purchaser/provider split in the English NHS, and 'managed competition' which emphasises consumers in The Netherlands).

However, the comparison is valid because both countries are confronted with similar challenges and threats of replacing non-market values in health care and the corrosive effects of markets on solidarity and equity in health care access.[1] The comparison therefore fits in with wider global considerations of the proper role of markets and where the limits lie.

More concrete lessons drawn from this comparison are limited to areas where there is common ground, for instance the enhancing of consumer choice by introducing competition on quality instead of price, and integrated care initiatives.

1 As highlighted by, eg, MJ Sandel, *What Money Can't Buy: The Moral Limits of Markets* (Allen Lane, UK 2012) 7.

This article draws on insights from a health lawyer who focuses on the right to health care and a competition lawyer concentrating on health care to examine health care competition in both The Netherlands and England. This approach reveals various constraints impeding the ability of health care systems to address health inequalities relevant to policy-makers when marketising health care.

II. HEALTH CARE COMPETITION IN ENGLAND AND THE HCSA 2012 REFORMS

This section provides an overview of the competitive mechanisms which have developed within the English NHS and how the HSCA 2012 builds on these. It also identifies some areas of concern, although more detailed consideration of the effects of the HSCA 2012 on specific groups and the overall effect of the Act are considered elsewhere in this issue.[2]

In England, controversy about competition in health care has effectively centred on the introduction of market practices to the NHS, as distinct from the market for private healthcare (PH) and supplementary private medical insurance (PMI). The use of market mechanisms within the NHS proves controversial for a variety of reasons, and the questions these raise about accountability and consideration of exclusively economic concerns are of most relevance here. With regard to accountability, different networks of relationships (and thus legal rights)— i.e. between citizens and government, as opposed to consumer and competition authority—are reinforced by the fact that PH and PMI are overseen by the Office of Fair Trading (OFT), whereas the NHS is overseen ultimately by the Secretary of State for Health and subordinate bodies.

However, the supplementary nature of PH and PMI in England (as opposed to the mandatory private health insurance in The Netherlands) arguably belies its significance in the connection between PH and the NHS which developed following the evolution of NHS 'internal markets' (Enthoven's conception of a purchaser/provider split[3]) introduced by the Conservative government in the early 1990s. Although New Labour initially distanced itself from this model, the changes it implemented (e.g. emphasising choice policies, introducing greater private sector involvement via Independent Sector Treatment Centres (ITSCs),[4] and establishing Foundation Trusts (FTs)[5]) led to well-embedded NHS managerialism becoming an effective means of harnessing and operationalising market ideology.[6] The combined Conservative and New Labour efforts established the four types of relationship which currently exist.[7] These range from exclusively state-funded provision (e.g. an NHS patient treated in an NHS facility), to

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2 See contributions by, eg, Newdick and Stirton.

3 A Enthoven, 'Internal Market Reform of the British National Health Service' (1991) 10 (3) Health Affairs 60–70.

4 ITSCs offer certain treatments to NHS patients.

5 NHS bodies with greater independence from government and financial and commercial responsibilities.

6 A Cribb, 'Organizational Reform and Health-care Goods: Concerns about Marketization in the UK NHS' (2008) J Med Philos 33: 221–240.

7 O Odudu, 'Competition Law and the National Health Service' (Competition Bulletin: Competition Law Views from Blackstone Chambers, 8 October 2012) <http://competitionbulletin.com/2012/10/08/competition-law-and-the-national-health-service/> accessed 28 March 2014.

exclusively private provision (e.g. a PMI patient treated in a PH facility).[8] In between these two extremes are private funding and public provision (e.g. contracts for leasing buildings and land)[9] and public funding and private provision (e.g. an NHS patient treated in a PH facility). Although such a typology may raise questions of whether and when competition law applies, these have been considered redundant[10] by virtue of the definitions of EU law[11] (and thus national competition law).

Part 3 of the HSCA 2012 establishes Monitor as the economic regulator for health care[12] and enshrines the application of the Competition Act 1998 (CA 98) by granting Monitor concurrent powers with the OFT[13] regarding anti-competitive agreements and abuse of dominance.[14] These concurrent powers extend to Market Investigations under the Enterprise Act 2002 (EA 02),[15] but not to the merger provisions as Monitor has an advisory role regarding NHS FT mergers.[16] Monitor's competition role extends beyond this to safeguarding choice and preventing anticompetitive behaviour which is not in patients' interests[17] and enforcing the licence condition prohibiting anti-competitive practices when assessing new FTs.[18] This formal recognition and application of CA 98, coupled with the commitment to 'competitive neutrality'[19] with a 'fair playing field' for public, private, and voluntary sector providers of NHS care[20] might therefore be understood as a logical—if not universally desirable—conclusion of the competition developments in the NHS to date.

A further controversial aspect of the HSCA 2012 is the development of Clinical Commissioning Groups (CCGs), which follow previous initiatives[21] in seeing GPs assuming commissioning functions. These raise concerns regarding potential conflict of interests[22] as the purchaser and provider functions are conflated. As CCGs are not

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8 Ibid.

9 Ibid.

10 O Odudu, 'Are State Owned Healthcare Providers that Are Funded by General Taxation Undertakings Subject to Competition Law?' (2011) 32 (5) ECLR 231–41.

11 This is explored by Szyszczak and Van de Gronden in this issue, so further discussion is beyond the scope of this article.

12 An extension of its previous role as independent regulator of NHS FTs.

13 Subject to exceptions, eg, the OFT has sole responsibility for making regulations and issuing guidance regarding the application of the Competition Act 1998 for the economy as a whole. Explanatory Notes to the Health and Social Care Act 2012, para 712.

14 For example the Chapter I and Chapter II prohibitions of CA 98. HSCA 2012, s 72.

15 EA 02, Pt 4. HSCA 2012, s 73.

16 HSCA 2012, s 79(5).

17 Ibid.

18 Monitor, 'About Monitor's Licensing Conditions' <http://www.monitor.gov.uk/regulating-health-care-providers-commissioners/licensing-providers/about-the-licence-conditions> accessed 28 March 2014.

19 O Odudu, above, n 10.

20 <http://www.monitor-nhsft.gov.uk/regulating-health-care-providers-commissioners/fair-playing-field-%E2%80%93-the-benefit-nhs-patients> accessed 27 March 2014.

21 For an overview of these, see, eg, R Mannion, 'General Practitioner-led Commissioning in the NHS: Progress, Prospects and Pitfalls' (2011) 97(1) Br Med Bull 7–15.

22 As already recognised by NHS England in the document NHS Commissioning Board, 'Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services' October 2012. <http://www.england.nhs.uk/wp-content/uploads/2012/09/c-of-c-conflicts-of-interest.pdf> accessed 25 August 2013.

explicitly included in the competition provisions of the HSCA 2012, these are beyond the scope of this article,[23] as is Monitor's role beyond its competition duties. However, it is worth noting that Monitor has explicit duties to enable integrated care, despite apparent contradictions between this and competition.

As acknowledged above, further concerns arising from the HSCA 2012 focus on accountability and equity of access.

First, reliance on the competition authority (OFT) and the health care regulator (Monitor) as independent bodies raises questions about the Secretary of State's accountability with regard to health care provision and the recourse available to patients (as citizens) as a result. It has been suggested that the Secretary of State's accountability is threatened by the HSCA 2012 reforms for three reasons: they make the relationship between the minister and the NHS more complex; they create opaque networks of non-statutory bodies which may influence NHS decision-making; and (especially in relation to competition) they 'juridify' policy changes as matters of law.[24] This process of 'juridification' can be understood in terms of traditional political policy decisions being increasingly determined by the courts.[25] Certainly, it has been suggested in assessments of recent patient and public involvement policies that the HSCA 2012 reforms represent a retrograde step in opportunities for patients and the public to hold accountable those who plan and deliver health services in England.[26] The recent successful challenge by local residents to the Secretary of State's plans to reduce services available at Lewisham Hospital in order to improve the performance of a failing NHS trust[27] may offer some comfort, but arguably cannot assuage these concerns comprehensively.

Secondly, much of the public controversy relating to the HSCA 2012 echoes Aneurin Bevan's explanation of abuse of the NHS as attempts to marry the incompatible principles of private acquisitiveness with a public service.[28] Although a detailed discussion of the difficulties of attempting to reconcile the two is beyond the scope of this article, it is worth noting here that empirical evidence of greater use of private providers is mixed and varies depending on the group in question. For example, the experience of clinicians relocating from the NHS to ITSCs suggests that although some improvements might legitimise the role of the private sector, doubts remain about the commercialisation of services, the motives of managers, and the impact of clinical roles and capabilities.[29] The benefits delivered by for-profit businesses which

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23 For a good overview, see ACL Davies, 'This Time, it's for Real: The Health and Social Care Act 2012' (2013) 76(3) MLR 564–88.

24 Ibid.

25 Ibid.

26 J Tritter and M Koivusalo, 'Undermining Patient and Public Engagement and Limiting Its Impact: The Consequences of the Health and Social Care Act 2012 on Collective Patient and Public Involvement' (2013) 16 Health Expectations 115–18.

27 *The Queen* (*on the application of London Borough of Lewisham, Save Lewisham Hospital Campaign Limited*) *v Secretary of State for Health, Trust Special Administrator Appointed to South London Hospitals NHS Trust* [2013] EWHC 2381 (Admin).

28 A Bevan, 'A Free Health Service', in A Bevan (ed) *In Place of Fear* (Quartet Books Limited, London 1976) 108.

29 J Waring and S Bishop, 'Going Private: Clinicians' Experience of Working in UK Independent Sector Treatment Centres' (2012) 104 Health Policy 172–178.

tender to provide NHS services appear less obvious. Instead, risks for nurses (e.g. job losses, changes to working terms and conditions, and reduced influence as consultants assume a dominant role in commissioning)[30] have been acknowledged[31] and ethical concerns have been identified in that, in operating as businesses, private companies' ability to provide consistent care is compromised.[32]

Thirdly, the inability of general competition and merger rules to explicitly consider anything other than economic issues is of concern, as is the acknowledged inability of markets to achieve an equitable provision of health care.[33] The apparent exclusion of what might be termed 'public interests' regarding equity in the provision of, and access to, health care is clear from the general merger regime of EA02.[34] The counter-balance to a finding of 'significant lessening of competition' is found in 'relevant customer benefits',[35] defined under section 30(1)(a) EA02 as lower prices, higher quality, or greater choice of goods or services. This category was intended to be interpreted strictly; however the Explanatory Notes to the HSCA 2012 appeared to suggest that Monitor may take a more relaxed approach and interpret 'relevant customer benefits' as 'likely costs and benefits to patients'[36] in reflection of terminology used by its predecessor (the NHS Cooperation and Competition Panel (NHS CCP)) which considered the costs and benefits to patients and taxpayers of proposed NHS mergers.

The proposed merger between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and the Poole Hospital NHS Foundation Trust (the 'Dorset FTs merger') was the first to be assessed under the EA02 regime following the HSCA 2012. It was blocked by the Competition Commission (CC) in October 2013[37] for a lack of relevant customer benefits to offset the restriction of patient choice which exists between the two hospitals, and the potential loss of incentive to compete to maintain or improve quality to attract patients. Although the merger parties had revised their proposed benefits after these were initially rejected by Monitor, the CC ultimately found that these were inadequate to counterbalance a significant lessening of competition which would result from the merger in nineteen elective inpatient services and thirty-six outpatient specialities. In contrast to the Explanatory Notes to the HSCA 2012, this decision suggests that relevant customer

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30 A Moore, 'In the Market for Change' (2012) 26 (33) Nursing Stand.

31 Ibid.

32 L Frith, 'The NHS and Market Forces in Healthcare: The Need for Organisational Ethics' (2013) 39 J Med E 17–21.

33 P Allen, 'An Economic Analysis of the Limits of Market Based Reforms in the English NHS' (2013) 13 (Suppl 1) BMC Health Serv Res S1.

34 EA 02, Pt 3.

35 A mechanism available to both the CC and the OFT. OFT, 'Merger Assessment Guidelines' September 2010. <http://www.oft.gov.uk/OFTwork/mergers/publications/lw_mergers/#.UzUyu1LW_Mw> accessed 28 March 2014.

36 Explanatory Notes to the Health and Social Care Act 2012, para 740.

37 Competition Commission, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/ Poole Hospital NHS Foundation Trust. A report on the anticipated merger of the The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust, 17 October 2013. <http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/131017_final_report.pdf > accessed 28 March 2014.

benefits are to be narrowly construed. The CC has arguably further raised this threshold by clarifying that 'customers' are ultimately patients, not commissioners (CCGs), or shareholders (in view of the status of FTs as public benefit corporations[38]).

The CC's decision in the Dorset FTs merger case appears significant for potentially allowing scope to consider equitable aspects and underscoring its cooperation with the OFT and Monitor in placing patient interests at the heart of the merger review process.[39] However, the effects of the changes heralded by the HSCA 2012 have yet to be fully understood, particularly with regard to applying the competition law provisions[40] to implement a 'fair playing field' between PH, NHS, and Voluntary Sector providers.[41] It is therefore useful to consider at this early stage the experience of introducing health care competition in The Netherlands to see if there are specific lessons for England.

III. HEALTH CARE MARKET REFORMS IN THE NETHERLANDS

Since 2006, confronted with increased health care costs and the need for more efficiency, Dutch government coalitions have introduced several steps towards more market competition in health care, starting with health insurance reforms, followed by liberalising the health care providers market and health care tariffs. Before discussing the outcomes of these reforms, a brief outline of this three-stage approach is included.

A. The Three-Stage Reforms

1. Competitive Social Health Insurance

A main element of the Dutch health care sector reforms is the Zorgverzekeringswet (Health Insurance Act) (hereafter Zvw),[42] which introduced elements of regulated competition into the health insurance scheme, and replaced the previous health insurance system governed by the Ziekenfondswet (Sickness Funds Act) (hereafter Zfw).[43] Traditionally, health insurance is based on the principles of equal access and solidarity. The Zvw introduced a compulsory health insurance scheme for the entire population, carried out by for-profit insurance companies. Health insurance agreements are private law contracts by nature (providing indemnity insurance), and are therefore based on principles such as freedom of contract. However, the legislation imposes certain restrictions to protect the principle of equal access to health care. The prohibition of risk selection by health insurers is one clear example of this.

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38 NHS Act 2006, s 43.

39 Office of Fair Trading, Competition Commission, Monitor, 'Ensuring Patients' Interests are at the Heart of Assessing Public Hospital Mergers. A Joint Statement from the Office of Fair Trading, Competition Commission and Monitor, 17 October 2013. <http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/131017_oft_cc_monitor_merger_statement_final.pdf> accessed 28 March 2014.

40 The HSCA 2012 provides that Monitor is to have concurrent powers with the OFT to apply the provisions of the Competition Act 1998 (CA 98) regarding anticompetitive agreements and abuse of dominance (the 'Chapter I' and 'Chapter II' prohibitions, respectively).

41 Monitor, 'A Fair Playing Field for the Benefit of NHS Patients: Monitor's Independent Review for the Secretary of State for Health', 26 March 2013. <http://www.monitor-nhsft.gov.uk/fpfr> accessed 28 March 2014.

42 The Zvw came into force on January 1, 2006 (Official Journal of the State 2005, 358).

43 The Zfw of 15 October 1964.

In addition, all health insurers must participate in a risk equalisation system, which ensures that insurers who cover individuals with higher risk profiles receive more funding. Such a levelling mechanism prevents direct and indirect risk selection of the so-called 'high' risk insured (i.e. the chronically ill). Entitlements or benefits covered by health insurers are defined by law, but contracting parties may agree who will deliver the insured health services, and where. In the interests of public health, freedom of contract is non-existent in cases of emergency care and highly specialised care; by law, health insurers are forced to cover both types of service. These, and other restrictions of the Zvw's free contracting principle, reflect the tension in promoting market competition while still attempting to ensure solidarity in accessing health care.

The Zvw provides coverage for essential curative care tested against the criteria of necessity, proven efficacy, cost effectiveness, and collective or individual responsibility.[44] Under the scheme provided by the Zvw, the insured party may opt for a benefits-in-kind or reimbursement model, or a combination of both. Although both models guarantee a standard insurance policy, under the reimbursement model the insured party has free choice of provider. Under the benefits-in-kind variant, the insured party is limited to the list of health providers who have entered into contracts of delivery with the chosen health insurer. In exceptional cases under this model, the insured party may opt for a non-contracted provider, for example, where there is a long waiting period. Overall, the concept of choice, i.e. individual choice of provider, insurer, and insurance policy, as well as the insurer's choice of provider (arising from selective contracting), therefore represents a crucial element of the health insurance market reforms, at least in theory.

2. *Deregulating the Health Care Provider Market*

The shift towards a competitive private health insurance market is closely linked with a more liberal hospital admission policy. Prior to 2007, hospital capacity planning was strictly regulated. The hospital planning process was criticised for its complexity and lack of flexibility. Major revision occurred in 2007, when the Wet Toelating Zorginstellingen (Law on Health Facilities Admission) (hereafter WTZi) came into force. The WTZi introduced a shift from central planning towards a decentralised demand-driven system in which the governmental role is restricted to setting preconditions which govern hospital planning. These conditions attempt to ensure public interests such as accessibility, quality, and efficiency of inpatient care. As such, the WTZi sets requirements for hospital admission, organisational structure and management, and health care governance. The rationale is that consumer demand and market competition on the health care providers market will determine the required hospital capacity. Withdrawal of governmental interference in capacity planning was replaced by promoting entrepreneurship.

This will be encouraged by the latest initiative: lifting the ban on for-profit hospitals. In case of *in*patient care, so far, a for-profit basis has been prohibited since it raises concerns about the distribution of dividends funded by public means, and

44 Based on the method for priority-setting by the Dunning Committee 'Choices in Health Care' (1991).

shareholders' influence on healthcare decision-making. According to the Minister of Health, this will be solved by making payments conditional on to a minimum solvency ratio, a 3-year waiting time, and shareholders will have limited powers as concerns strategic decision-making.[45] The underlying assumption is that private investments will strengthen efficiency, innovation, and quality in health care. Though one may question such a market approach, it remains to be seen whether private investors (e.g. pension funds, hedge funds, and private equity funds) are interested in investing in 'corporate' hospitals.

3. *Liberalising Health Care Tariffs*

The final stage of the health care sector reforms included a gradual shift towards freely negotiated prices. In competitive markets, price is based on the equilibrium between demand and supply. Since health care is for many reasons a unique market, price regulation was not removed entirely. Governmental supervision on health care price-setting is delegated to the Nederlandse Zorgautoriteit (Netherlands Health Care Authority) (hereafter NZa). The NZa supervises both health care providers and insurers, to ensure that they provide good and efficient health care to consumers. It also has statutory responsibilities under the Wet Marktordening Gezondheidszorg (Health Care (Market Regulation) Act) (hereafter Wmg) for tariff regulation, setting prices (maximum and bandwidth rates), and budgets.[46]

For several years, the goal of a free market was aspirational, since the NZa defined the tariffs of important inpatient health services. This tariff is calculated using 'hospital products', divided into 'diagnosis-treatment-combinations' (hereafter DTCs), which are based on all types of procedures used during hospital treatment. All DTCs are exhaustively assigned to one of two lists—List A or List B. List A DTCs have fixed national prices, whereas List B prices result from negotiations between health insurers and hospitals. Since insurers are not obliged to contract with all hospitals, price negotiation strengthened market competition for List B DTCs which gradually increased to seventy per cent in 2012.[47] Although the introduction of DTCs encouraged insurers to contract selectively with hospitals, in practice all hospitals have entered into contracts since insurers fear the loss of reputation if they restrict consumer choice, and consequently, the threat of switching customers.

B. Outcomes of Health Care Market Competition

Since the 2006 health care reforms, it has been a research subject for various disciplines. However, one may question the success thus far of the aims of cost containment, more efficiency and maintaining equal access to health care for the entire population. Despite the complexity of the reforms, some preliminary results from research studies will be discussed focusing on the effects on accessibility of health care and freedom of choice as core values in the reform process, as well as insurers and providers.

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45 Kamerstukken II (Parliamentary proceedings) 2012/13, 33168 nos 2 and 7.

46 The functions of the NZa correspond largely to those of Monitor's predecessor, the NHS CCP.

47 Hospital DTCs have now been replaced by a new classification known as 'DOTs'.

1. Health Insurance: Retreat From Equal Access

Although the Zvw makes a commitment to equality in health care, in reality the Netherlands has retreated from that principle since 2006, which has caused a change in the public's commitment to equitable access. Prior to 2006, policy proposals that restricted access had no or little chance of assent and, consequently, were never placed on the policy agenda. Yet in March 2006, the Diaconessenhuis hospital in Leiden announced that it had entered into an agreement with a health insurer, Zorg & Zekerheid, and that waiting times for a cataract operation for its policyholders would be shorter than for patients with other health insurers, and this development drew little attention.[48] Similarly, the Groene Hart hospital in Woerden launched a plan for a 'business club' giving preferential treatment to workers.[49] Previously, however, such preferential treatment in the provision of medically necessary care would have caused more of a furore.[50]

Another example of the retreat from equitable access to health services is an agreement between the Kennemer Gasthuis hospital in Haarlem and a mediation agency. It was agreed that patients/employees would receive necessary health care ahead of other patients in need. In its assessment, the NZa concluded that such commercial mediation is forbidden by law.[51] Its reasoning was merely based on technical legal arguments, i.e. that charging commercial tariffs infringes Dutch tariff regulations. On the merits, however, the NZa welcomes such initiatives for efficiency (better use of existing capacity) and quality reasons (reduced waiting times). The key problem of prohibiting risk selection by providers based on financial incentives instead of medical needs was not deemed to fall within the remit of the NZa. Unfortunately, the NZa ignored the fact that risk selection based on non-medical needs is inherent to commercial mediation. Otherwise, there is no incentive for health providers to treat specific patients first.

Advocates of preferential treatment schemes claim that an increase in supply will ultimately lead to an overall improvement in the fulfilment of health care needs. As the chair of the board of directors of Diaconessenhuis hospital stated, while it is true that the health insurer's clients would receive care more quickly, this would also benefit the patients on the standard waiting list for cataract surgery.[52]

The Rawlsian argument here is that the added profits from the contract with the Zorg & Zekerheid mean that the Diaconessenhuis hospital can expand its service capacity, making everyone better off.[53] Nevertheless, patients in a preferential treatment scheme, or included in commercial mediation, benefit more.

Apart from altering the allocation of health services, the Zvw scheme has caused a regressive shift in the distribution of premium costs for three reasons. First, the Zvw introduced a partially fixed premium instead of an income related premium system

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48 Daily newspaper *Trouw*, 25 March 2006.

49 Kamerstukken II (Parliamentary proceedings) 2010/11, nr 314.

50 M Buijsen and A den Exter, 'Equality and the Right to Health Care' in A den Exter (ed) *Human Rights and Biomedicine* (Maklu Press, Antwerpen 2010) 70.

51 Zorgbemiddeling, NZa, Letter to the Minister of Health on commercial mediation (in Dutch), 11 February 2009.

52 *Trouw*, above, n 48.

53 J Rawls, *A Theory of Justice* (Belknap Press of Harvard University Press, Cambridge 1971) 305.

under the Zfw prior to the 2006 reforms. Secondly, under the Zvw, health insurers may offer insurance policy options with a limited number of voluntary deductibles (up to €500). Insured persons receive a discount on their premium in return for accepting a level of financial risk. Thirdly, health insurers can enter into group insurance schemes with employers for employees and their dependents. The discount may exceed ten per cent of the premium base for each employee or dependent. As a consequence, healthy individuals may now reduce their premiums by accepting a high deductible in the unlikely event they require care.

It goes without saying that the new health insurance system is designed to see to the needs of those requiring healthcare (whether affluent or needy). However, the new scheme serves the wealthy more generously than the poor.

For example, a €350 personal risk (2013 rate) is unlikely to deter those who are relatively affluent and require healthcare. These individuals will presumably prefer and can afford a more expensive reimbursement policy. In addition, they will not only take out supplementary insurance coverage, but also are more likely to be members of their employer's group insurance plan and therefore entitled to the maximum premium discount. In contrast, those with limited financial means will be required to pay the compulsory health insurance contribution; claim a care allowance (i.e. a subsidy); accept a degree of out-of-pocket payments to reduce their annual premium; and opt for a benefits in-kind policy. Moreover, they will be unable to afford supplementary insurance coverage, and it is less likely that they can benefit from a large discount as part of group insurance.

Whereas prior to 2006, under the income-related Zfw, premium costs were determined according to the insured person's ability to pay, other factors now play a more decisive role. The waning support for the ability-to-pay principle is being replaced by the growing importance of factors such as freedom of choice and socio-economic status. When claims are made that the individual cost of premiums under the Zvw are more determined by individual choice, it is important to remember that income, health, and socio-economic circumstances of individuals determine the range of health insurance options available to them. Under the Zvw, unhealthy and more needy individuals enjoy less freedom of choice than their healthy and more affluent counterparts, regardless of how well-informed their health insurance decisions are. If any freedom of choice remains, their options are limited to choices that conflict with their health care interests. When discussing the right to health care as the right to access to effective care, the actual access for unhealthy and more needy residents of the Netherlands is now far more limited in financial terms than for their affluent neighbours.[54]

2. *Freedom of Choice: but not for the Elderly*

According to the latest report, consumer exit rates are more or less stable (about 7.2 per cent in 2013), which differs from the beginning (18 per cent in 2006). With the introduction of the Zvw in 2006, substantial differences in tariffs meant greater financial incentives for consumers to change insurer. Currently, the maximum insurance

54 Buijsen and den Exter, above, n 50, 82.

tariff range is €277.[55] Increased consumers' exit options have resulted in a small premium reduction of 36 million ('exit profit') in 2011.[56] Although exit reflects the idea of free choice, it should be noted that its focus is on the younger generation, not the elderly. Since most insurance companies provide both mandatory and voluntary health insurance schemes, the elderly are reluctant to change insurer due to entrance barriers on the voluntary insurance market.

3. *Choice of Provider* v *Cost Containment and Quality of Care*

Although individuals' freedom of choice of provider was one of the leading aims of the reforms, in 2011, the Ministry of Health concluded a non-binding agreement (hereafter 'the Agreement') with health care stakeholders which restricted choice to contain hospital costs. The Agreement aims to strengthen the insurers' purchasing role in allocating, limiting, and concentrating the volume of hospital care. The underlying premise is that quality of care is related to expertise. Specific interventions will be concentrated to a limited number of hospitals, since this will be more efficient and cost-effective and improve the quality of care provided (described as high-volume contracting). Initial steps have been taken by regional insurers making volume standards a contractual condition. As expected, hospitals which were not selected argued that the volume criterion cannot be a decisive factor in deciding not to enter into contracts since there is insufficient scientific evidence between high-volume contracting and morbidity rates. Despite the lack of consensus in the *CZ v Bethesda hospital* case, the court found that the criterion was lawful.[57]

Essential for the success of high-volume contracting is that competitors will follow. If not, the desired concentration will not be established since each of the insurers may apply different volume standards and/or interpret them differently resulting in different outcomes. This is an inherent weakness of the Agreement requiring cooperation between insurers, which may be considered anti-competitive, and therefore not allowed. The question remains of who should take the lead in this high-volume contracting process? Leaving it to hospitals will not solve the problem, since they will face the same problem as insurers.[58] Irrespective of the outcome, what remains is a trade-off between individual's freedom of choice and cost containment and quality of care. Since selective contracting has only just started, we can expect further restriction of choice.

4. *Risk Selection*

The Zvw introduced a highly complex risk equalisation system in order to compensate health insurers for the so-called high-risk insured. This mechanism is intended to prevent any prohibited risk selection. However, concerns remain about implicit risk selection by means of marketing strategies focussing on target groups (e.g. academics and students). This approach is generally considered a niche activity, but in essence it increases the likelihood of profit since the selected categories reflect healthy, young, and price-conscious consumers. In June 2012, the outcomes of an independent

55 Kamerstukken II (parliamentary Proceedings) 2012/13, 33683, no 3–4, p 17–8.

56 Ibid.

57 District Court Breda 23 November 2010, LNJ BO4755.

58 JJ Rijken, 'Concentratie van ziekenhuiszorg – iemand moet het doen, maar wie?' (2011) 7 TvGr 544–59.

inquiry concerning risk selection by health insurers confirmed low rate practices of risk selection, undermining the system's solidarity notion.[59] It also confirmed expectations that this problem will increase when limiting the scope of the basic insurance plan, which will emphasise the need for additional voluntary insurance plans for the high-risk insured. Since risk equalisation remains imperfect, the intended risk solidarity and quality of care for certain categories of insured parties will diminish. Unfortunately, the committee's recommendations may mitigate, but not solve the problem. This illustrates the trade-off in the system between solidarity and efficiency.

5. *Merging Insurers: The Big Four*

Since 2006, the health insurance market has changed substantially. Starting with about fifty health insurers, this number has decreased to twenty-six in 2012 divided over nine insurance companies, of which four dominate the market.[60] The high level of concentration is scrutinised by both the Autoriteit Consument en Markt (Authority for Consumers and Markets) (hereafter ACM)[61] and the NZa.

In 2013, the overall increase in annual insurance premium has decreased. This is a first confirmation of the presumption that merges may result in cheaper health care, despite the tendency of increased health care costs.[62]

IV. HEALTH CARE COMPETITION IN ENGLAND AND THE NETHERLANDS: SOME POSSIBLE LESSONS

The foregoing country-specific analyses illustrate significant differences between England and The Netherlands which make meaningful comparison difficult. Despite this, there are concerns common to both, e.g. regarding reductions in equal access. However, the significant differences between the Dutch and English health care systems mean these can arise for different reasons and be dealt with in different ways. For example, in England, access to care is increasingly subject to local variations, which appears likely to continue with the transfer of responsibility for health improvement to Local Authorities (with a limited role, but including a legal duty, for the NHS). Such a change perhaps demonstrates that the link between inequity and competition which has arisen under the Dutch system may be less clear-cut in England due to wider institutional changes to the NHS under the HSCA 2012. However, it has been considered that there is both little evidence of choice and competition acting as a driver of performance in areas including access and equity.[63]

For the purposes of comparison, there appears to be an interesting trend towards two specific policies in both England and The Netherlands which are examined

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59 Kamerstukken II (Parliamentary proceedings) 2011/12 29689, no 391.

60 NZa, 'Monitor Toetredingsdrempels Zorgverzekeringsmarkt'. April 2012 <http://www.nza.nl/104107/105773/475605/Monitor_Toetredingsdrempels_zorgverzekeringsmarkt.pdf> accessed 28 March 2014.

61 Which includes the former Nederlandse Mededingingsautoriteit (Dutch Competition Authority) (NMa).

62 An average decrease with 0.6% or €7 source: Zorgthermometer, Vektis April 2013, p 10 <http://www.vektis.nl/index.php/nieuws/onderzoeken/376-zorgthermometer-verzekerden-in-beweging-2013-verschenen> accessed 27 March 2014.

63 S Gregory, A Dixon and C Ham (eds), 'Health Policy under the Coalition Government: A Mid-Term Assessment', The King's Fund, 2012. <http://www.kingsfund.org.uk/publications/health-policy-under-coalition-government> accessed 28 March 2014.

below. First, apparent commitments to competition on quality. While this seems logical in England given a fixed NHS tariff, it is an interesting development in The Netherlands, where competition on price has also been evident. Secondly, both countries are developing integrated care policies in the context of healthcare reform. Despite the distinction between competition and integrated care, both elements arise from the underlying concept of consumer choice as applied in the Dutch context. For example, modes of competition may improve consumer choice, whereas integrated care initiatives may give consumers control over key decisions, allowing people to have control and autonomy over their own lives, and respecting the personal choices. This idea of 'the right to manage one's own risks', in particularly relevant for certain categories of patients such as, e.g., the chronically ill.

A. Consumer Choice and Competition on Quality versus Price

In other sectors, competing on price can produce clear benefits for consumers and generate efficiencies. However in health care, price competition is generally perceived as undesirable as pursuing profit is thought to lead to a reduction in access and/or quality, which is not in the public interest. For instance, the introduction of price competition in dental care in the Netherlands appeared to be a disaster. Initiated as a market experiment, free prices in dental care were introduced in January 2012. As expected, dissolving maximum prices increased consumers' freedom of choice, flexibility of treatment arrangements, and encouraged professional entrepreneurship,[64] according to similar experiences with liberalising physiotherapy prices in 2008. Alarming outcomes of preliminary assessments show a decrease in contracted dental care and increase in tariffs (on average six per cent), both threatening accessibility and affordability.[65] Originally intended as a three-year experiment, it was annulled in January 2013.[66]

But the annulment of free dental prices seems contrary to the success of price competition on the pharmaceutical market. Apart from liberalising pharmacies service fees (January 2013), the strongest effect on purchasing drug prices was the introduction of preferred drug formulas for the cheapest generic. Since pharmaceutical price regulations (e.g. lowering reimbursement limits, claw-back discount policies, and voluntary price reductions) have not prevented an increase of pharmaceutical costs, a tendering strategy was introduced. Preferred generics were selected by health insurers by issuing tenders for several generic drugs. The bidding strategy had a dramatic effect on the generic prices, leading to substantial savings, i.e. €348 million in 2008.[67] It seems, therefore, that health insurers have gradually developed their role as prudent buyer in the pharmaceutical market.

The opposite outcomes on the health providers market show that price competition might be successful on certain submarkets where there is a level playing field with transparent prices and comparative alternatives. This seems to be the case when purchasing medicines by using tendering procedures. In case of scarcity of supply (e.g. of dentists), price competition will fail.

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64 Stcrt (Official Journal) 2011, no 13947, 29 July 2011, p 4.

65 Kamerstukken II (Parliamentary proceedings) 2011/12, 32 620, nr 66. Annex, p 4.

66 Stcrt. (Official Journal) 2012, no 14943, 20 July 2012.

67 L Boonen and others, Pharmaceutical Policy in the Netherlands: From Price Regulation towards Managed Competition, *Advances in Health Economics and Health Services Research* 2010, vol 22, p 67.

Although market competition should trigger insurers to contract better quality of care, the outcome of competition on both quality *and* price is less clear. If quality is readily detectable, and depending on whether payers are more sensitive to service quality or price, either better or worse quality is theoretically possible.[68]

But what lessons are available from the new Dutch health insurance system? Are insurers effectively steering on quality? One of the underlying premises is that consumers are *capable* of valuing quality of care and services provided. This is true to a limited extent: they can value services such as mediation in case of waiting times, speed of reimbursement, and customer-friendly employees. However, valuing the quality of care provided remains a subjective affair as objective criteria like sector-wide outcome indicators are still missing or unreliable.[69] The aim of increasing transparency and contributing to consumers' informed choices has yet to be realised. The main problem seems to be the absence of adequate review mechanisms, an extremely difficult and time-consuming exercise. For that reason, blaming the market seems unfair. What is needed are sound and feasible indicators. Here, a newly launched 'Quality Institute' will play an important role. This Institute will be entrusted with new tasks regarding quality, safety, and efficiency of health care, such as the development of an overall quality framework based newly developed and existing professional standards, and developing quality indicators.[70] The absence of reliable output indicators means that purchasing hospital providers are largely influenced by less rational motives, e.g. the threat of consumer exit, therefore loss of market share. Effective health care purchasing is therefore in its infancy.

In England, the controversy surrounding the HSCA 2012 prompted the coalition government to re-affirm its commitment to competition on quality, not price.

On the one hand, competition on quality is not a new concept within the NHS, where price competition has been severely restricted by initiatives in the public interest. One such initiative is the Pharmaceutical Price Regulation Scheme (PPRS), which ensures prices of medicines supplied to the NHS are fair and reasonable. The PPRS has previously been criticised for indirectly controlling discounts to wholesalers,[71] but has recently been subject to reforms, including a commitment by NHS England seeking to end initiatives by NHS commissioners to arrange for rebates to be paid by manufacturers via the commissioning body to NHS service providers in primary or secondary care.[72] A further example is Payment by Results (PbR),[73] a hospital payment system designed

68 Office of Health Economics Commission , 'Competition In The NHS' (2012). <http://www.ohe.org/publications/article/report-of-the-ohe-commission-on-competition-in-the-nhs-108.cfm> accessed 28 March 2014.

69 Kamerstukken II (Parliamentary proceedings), 2012–2013, 33585 no 2.

70 Kamerstukken II (Parliamentary proceedings), 2011–2012, 33 243, nos 2 and 3.

71 See the OFT Market Study: The Pharmaceutical Price Regulation Scheme. July 2007. <http://www.oft.gov.uk/shared_oft/reports/comp_policy/oft885.pdf> accessed 28 March 2014.

72 Department of Health, ABPI, 'The Pharmaceutical Price Regulation Scheme 2014'. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/282523/Pharmaceutical_Price_Regulation.pdf> accessed 28 March 2014.

73 For a good overview, see J Appleby and others, 'Payment by Results: How can payment systems help to deliver better care?' November 2012. <http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf> accessed 28 March 2014.

to reward efficiency, support patient choice, and encourage stronger incentives for investment.

On the other hand, the HSCA 2012 reinforces the concept of competition on quality by devolving responsibility away from the Secretary of State for Health. This is demonstrated clearly in at least two ways.

First, the HSCA 2012 establishes the Health and Social Care Information Centre (HSCIC),[74] whose duties include collecting data about health and social care and establishing a library of indicators to measure the quality of health and care services provided to the public.[75] In addition, the HSCA 2012 provides that the remit of the National Institute for Health and Care Excellence (NICE)[76] is to be extended from producing quality standards regarding NHS services and public health services to include a new responsibility to develop quality standards and other guidance for social care in England.[77]

Secondly, it provides for a consultative relationship between Monitor and the Care Quality Commission (CQC),[78] in a manner reminiscent of—but less well-defined than—the consultative relationship between the Dutch healthcare and quality regulators (the NZa and the IGZ).[79] It is notable that the Secretary of State for Health has oversight of both the HSCIC and the CQC (considered an example of the human rights and social solidarity approach to regulation),[80] which contrasts with the independent status of the economic regulator and competition authority, both of whom include aspects of quality in their assessments, as noted previously. It has furthermore been noted that ministerial oversight of the CQC does not preclude mechanisms for direct user involvement,[81] something which appears to be on the increase with healthcare-specific lobby groups.[82]

The growing dependence on independent agencies to deliver initiatives to bolster competition on quality can also be seen with regard to pricing for healthcare which, following the HSCA 2012, becomes a shared responsibility for NHS England and Monitor. By NHS England specifying healthcare services to be subject to a national price,[83] and Monitor setting that price,[84] it is intended that a review of PbR is facilitated, as this has been considered insufficiently patient-focused.[85]

The combination of a body whose duties include the establishment of quality indicators (the HSCIC), the extension of NICE's remit regarding quality standards, and a statutory relationship between Monitor and the CQC appear to suggest that England

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74 HSCA 2012, ss 252–275.

75 HSCIC, 'Our role', <http://www.hscic.gov.uk/whoweare> accessed 28 March 2014.

76 Formerly the National Institute for Clinical Excellence (NICE).

77 NICE, 'NICE Quality Standards'. <http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp> accessed 28 March 2014.

78 HSCA 2012, ss 288–289.

79 The relationship between the NZa and the IGZ is clearly defined by statute (the Wmg), with the NZa bound to follow the advice of the IGZ.

80 T Prosser, 'The Care Quality Commission and its Predecessors' in T Prosser (ed) *The Regulatory Enterprise: Government, Regulation and Legitimacy* (OUP, Oxford 2010).

81 Ibid.

82 eg internet fora such as <iwantgreatcare.org>.

83 HSCA 2012, s 118(7).

84 HSCA 2012, s 116.

85 NHS England, 'NHS Payment System'. <http://www.england.nhs.uk/resources/pay-syst/> accessed 28 March 2014.

is taking a similar approach to The Netherlands in promoting competition on quality, if not learning directly from the Dutch experience.

B. Integrated Care

It has been considered that while health care reform can see pendulum swings between competition and integration, the distinction is not as polarised in political terms between left and right as previously.[86] In essence, whereas competition in health care frequently entails negative connotations of 'winners' and 'losers', integration can be interpreted as fundamentally good for patients as an effective mechanism for managing chronic conditions. Indeed, the change in focus over time by governments from acute to chronic conditions (the former perhaps more amenable to competitive solutions) appears to support the growing, if still fragile, understanding that competition and integration are not necessarily in conflict.[87] This can be seen both in The Netherlands, where bundled payments have been used to promote integrated care in various conditions since 2010, and England, by the explicit focus of the HSCA 2012 and Monitor on integrated care, particularly its dual functions of facilitating competition and promoting integrated care.[88]

In The Netherlands, a tendency towards integrating health providers includes multidisciplinary arrangements (known as 'zorggroepen/ketenzorg', or 'care groups') covering diagnostic services, pharmacy, primary, and secondary care and focusing on integrated care for conditions such as diabetics, obesity, and COPD. Aimed at providing more efficient and optimal care, these collaborative arrangements are being used by health insurers for specific programmes at a certain price. Integrated care contracts therefore may cover both the content (i.e. quality of care) and price. Their control over management issues, exchange of sensitive information, and anti-competitive foreclosure of competitors has raised some concerns. As a result, the ACM and NZa have developed rules to be respected when organising integrated care groups.[89] In general, these rules recognise the need for innovative care arrangements but, simultaneously, such arrangements may not hinder competition on the health provider and purchasing markets.

Contrary to the horizontal integrating of providers, the vertical integration between the health insurance and delivery functions, however, remains problematic. The government is considering reintroducing a ban on vertical integration in which a health insurer merges with, or participates in a hospital.[90] Mergers and acquisition leading to control or decisive influence of the hospital (e.g. in terms of composition, voting, or board decisions) will therefore be abolished since these US-style 'health maintenance organisation' (HMO)-based arrangements may give raise to less objective decision-making about purchasing, threatening doctors' professional autonomy.

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86 C Ham, 'Competition and Integration in Health Care Reform' (2012) Int J Integrated Care 12, 15 June 2012.

87 Ibid.

88 Frontier Economics, 'Enablers and Barriers to Integrated Care and Implications for Monitor. A Report Prepared for Monitor' May 2012. <http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-23> accessed 28 March 2014.

89 NMa en NZa, Richtsnoeren Zorggroepen 2010; NZa. Uitvoeringstoets Mededingingsanalyse zorggroepen. Samenwerken en concurreren in ketenzorg, juli 2010. <https://www.acm.nl/nl/publicaties/publicatie/10739/NMa-en-NZa-publiceren-Richtsnoeren-zorggroepen/> accessed 28 March 2014.

90 Kamerstukken II (Parliamentary proceedings) 2011/12 33362, no 2.

In England, the concept of integration features prominently in the HSCA 2012 at both national and regional levels: NHS England,[91] CCGs, Health and Wellbeing Boards[92] and Monitor all have duties[93] to promote integration (in provision of health care services or working practices) in order to improve the quality (i.e. outcomes or efficiency) of services or reduce inequalities of access or outcomes.[94] However, there appears to be a clear division of effort: commissioners work with local providers to develop and fund better and more integrated patterns of care, while Monitor will work with others (particularly commissioners) to remove barriers and enable integrated care provision where this is in the interests of patients.[95]

In England, the new national frameworks are still in evolution and likely to be influenced by future legislation,[96] although some lessons are already available from integrated care pilots launched in different parts of England,[97] so some lessons are already available. For example, while integrated care has been found beneficial for specific social groups (e.g. older people), caution is advised in applying integrated care to single diseases or conditions (e.g. diabetes or dementia) as there is a need to follow on from focusing on the whole population to avoid creating new silos.[98] Moreover, it has been suggested that mergers (a frequent consequence of introducing competition) run counter to the breaking down of barriers between services and clinicians, which generate the main benefits of integrated care.

Further recommendations by The King's Fund underline Monitor and the OFT's roles in supporting integrated care by avoiding inappropriate application of competition policy to health and social care,[99] and the role of appropriate financial incentives (which would necessitate a move away from existing mechanisms such as Payment By Results).[100]

In its research so far, Monitor has already looked to The Netherlands to see what lessons may be available from the Dutch experience of reimbursement and

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91 Formerly the NHS Commissioning Board.

92 Health and Wellbeing Boards are fora established by local authorities where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. <http://healthandcare.dh.gov.uk/hwb-guide/> accessed 28 March 2014.

93 In respect of NHS England's duty regarding integrated care, HSCA 2012, s 23 inserts ss 13N into the NHS Act 2006. In respect of CCGs' duty to promote integrated care, HSCA 2012, s 26 inserts s 14Z1(1) into the NHS Act 2006. HSCA 2012, s 195 sets out the duty on Health and Wellbeing Boards to promote integrated care. HSCA 2012, s 62(4) establishes Monitor's duty to enable provision of integrated care.

94 Monitor, 'Enabling integrated care' <http://www.monitor-nhsft.gov.uk/regulating-health-care-providers-commissioners/enabling-integrated-care> accessed 28 March 2014.

95 Ibid.

96 For example the Care Bill (HL Bill 1), <http://www.publications.parliament.uk/pa/bills/lbill/2013-2014/0001/lbill_2013-20140001_en_4.htm#pt1-pb6-l1g26> accessed 28 March 2014.

97 Some have been reviewed by The Nuffield Trust. C Ham and J Smith, 'Removing the Policy Barriers to Integrated Care in England' The Nuffield Trust Briefing, September 2010. <http://www.nuffieldtrust.org.uk/publications/removing-policy-barriers-integrated-care-england> accessed 28 March 2014.

98 C Ham and N Walsh, 'Making Integrated Care Happen At Scale and Pace' The King's Fund. Lessons From Experience, March 2013. <http://www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace> accessed 28 March 2014.

99 Ibid.

100 C Ham and J Smith, 'Removing the policy barriers to integrated care in England' The Nuffield Trust Briefing, September 2010. <http://www.nuffieldtrust.org.uk/publications/removing-policy-barriers-integrated-care-england> accessed 28 March 2014.

competition.[101] It has been suggested, for example, that while introducing bundled payments for diabetes care in The Netherlands has yielded improvements in both care delivery processes and transparency of delivered care, antitrust concerns have arisen in the form of limited choice for patients.[102] Additional lessons may be learned from aspects as diverse as closer cooperation between the ACM and NZa, as noted above.

V. CONCLUSION

Economic theories on market competition in health care emphasise potential successes in terms of increased choice, better quality cost containment, and more efficiency. The Dutch experiences so far, however, are ambivalent if not quite disappointing. Indeed, in the case of health insurance and pharmaceuticals, competition on prices has been successful in terms of increased choice and decreasing costs. At the same time, regulated competition on the health insurance market caused a retreat from equitable access, making it less effective and more complicated. This was due to a shift in health policy emphasising selective contracting instead of choice, ambivalence about price-setting, prohibiting HMO-style initiatives, all of which indicate governmental fear of the market in health care. In a sense, there is a real warning for England here as unwillingness to leave matters to the market triggers the question of whether there is a way back. However, the HSCA 2012 reforms might be seen merely as a logical conclusion to market developments in the NHS so far, and—given the combined efforts of successive Conservative and Labour governments since the early 1990s—there seems little mainstream political appetite in England for giving serious consideration to reversing the changes made.

There appear to be two essential lessons from The Netherlands: the need for a consistent health policy, and the benefit of competing on quality instead of price. In addition, there are valuable lessons regarding integrated care initiatives, particularly with regard to collaboration between different agencies, and competition as a means for safeguarding equal access to adequate health care services as a basic human right.

These lessons can both benefit from and contribute to a more fundamental discussion and public debate about where markets belong and where they do not—, i.e. rethinking 'the proper role of the market in health care'.[103] This has also been acknowledged by economists seeking to progress the debate beyond the binary options of more or less marketisation.[104] Ingredients of this public debate are the lessons drawn above, including focusing on competition on quality more than price, differentiating by submarkets, as well as examining the risks of replacing non-market values (e.g. health, solidarity, and equity) with market reasoning (by emphasising choice, profit, cost-effectiveness, and cash incentives). As argued by Sandel, such a debate enables us to decide about the limits—moral and otherwise—of the market.

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101 Frontier Economics, above, n 86.

102 JN Struijs and CA Baan, 'Integrating Care through Bundled Payments—Lessons from The Netherlands' (2011) 364 (11), 990 (2) NEJM.

103 MJ Sandel, above n 1, 11.

104 T Zuiderent-Jerak, K Grit, and T van der Grinten, 'Markets and Public Values in Healthcare' (2010) iMBG Working Paper W2010.01, <http://repub.eur.nl/res/pub/19781/Markets%20and%20Public%20Values%20in%20Healthcare%20.pdf> accessed 28 March 2014.

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