Submission by the Dutch Healthcare Authority (NZa) to the EU consultation regarding Community action on health services

1. Introduction

The NZa welcomes the opportunity to contribute to this timely and topical consultation by the European Commission. Apart from responding to the specific issues raised in the consultation document, the NZa will submit:

- a concise outline of the recent (and ongoing) **healthcare reform in The Netherlands**, which aims to deliver consumer benefits in terms of access, quality, and affordability by means of maximising the scope for demand-driven markets.

- a description of the **role of the NZa as independent regulator** in the context of this reform, including further detail on technical aspects of the Dutch system such as yardstick competition and regulation based on significant market power (SMP).

- a proposal for an **informal working group on efficiency-enhancing regulation** for the exchange of experience and best practice and to enable peer review.

In this manner the NZa wishes to provide a regulatory perspective on the liberalization of healthcare provision and funding. The reason to propose a working group is that identifying and spreading best practice by definition requires sharing ideas and experience across national borders.

This contribution does not contain confidential information and may be posted on the Commission's website in the context of this consultation. Reactions by interested parties are welcomed at the following e-mail address: euconsultation@nza.nl

2. Health services liberalisation in The Netherlands

The healthcare system in The Netherlands has recently (2005-2006) undergone a number of profound changes that are designed to foster demand-based competitive provision of services to the benefit of the consumer within a framework of basic public interest guarantees.[1] The main aspects of this system are highlighted here. Because reform efforts are still ongoing proposals for future changes are also covered.

2.1 Consumer choice

Consumer choice is key to the new system, as its principal objective is to ensure access, quality and affordability by means of introducing demand-led competition and market-based incentives where possible (with public intervention where necessary). This is reflected in the free choice of healthcare insurance company and of healthcare provider that is protected by consumer rights set out in more detail below. Serving the general consumer interest is also the primary statutory objective of the NZa as independent sector-specific regulator.

[1] For a critical analysis see Philip de Jong and Ilaria Mosca, *Changes and Challenges of the New Health Care Reform in The Netherlands: What should the Dutch be aware of*, TILEC Discussion paper October 2006. (Cf http://papers.ssrn.com/abstract=943429)

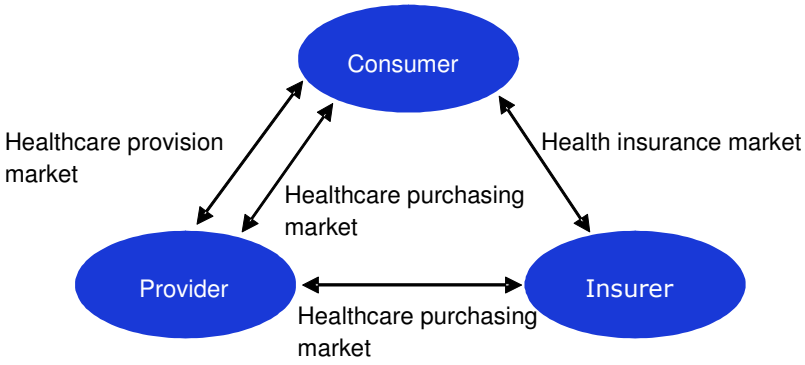
2.2 Healthcare markets

A proper market definition in healthcare, as in any other sector, requires the application of economic methods developed in general competition law, based on an analysis of demand- and supply-substitution. However, in general terms it is possible to define three broad categories of markets involving three types of market parties:

- the healthcare **provision** market (involving the interaction between consumers and providers)
- the healthcare **purchasing** market (involving interaction between, in most cases insurers and providers, and in some cases consumers and providers)
- and the health **insurance** market (involving the interaction between consumers and insurers).

This distinction is useful to illustrate the relationships between the different parties involved: consumers, providers and insurers.

Interrelationship between healthcare markets



The next paragraphs will provide further detail on healthcare insurance and provision in The Netherlands.

2.3 Privately funded insurance for curative care

One key aspect of the new Dutch healthcare system is mandatory universal private health insurance (i.e. a general legal obligation on all adult consumers to take out such insurance) for curative care. With regard to health insurance companies the main features are:

- an obligation to accept all consumers who apply
- a prohibition on risk selection and differentiation of insurance premiums[2]
- an extensive basic package of publicly defined coverage of healthcare services
- an obligation to ensure adequate availability of care (including contracting sufficient capacity)
- a risk adjustment system compensating insurers for an above average risk population, which ensures competition occurs on the merits, not on acquiring a low risk population (see point 4.3).

In addition, the private health insurance companies involved offer voluntary supplementary insurance for non-essential healthcare that is not included in the basic package, such as dentistry, physical therapy and cosmetic surgery.

This system of private insurance is funded directly by consumers by means of combination of (a) individually paid insurance premiums and

[2] A means-tested subsidy is available for those who cannot otherwise afford the standard premium.

(b) a percentage of gross income.[3] It covers around 50% of all healthcare expenditures in The Netherlands (i.e. 25 billion € out of total annual expenditures of 50 billion €), i.e. the part of healthcare that is defined as "cure" (broadly: curative healthcare that is delivered by GPs, medical specialists and/or in a hospital setting). Consumers contract with health insurance companies either individually or collectively (facilitated by employers, and/or patient groups or other affiliations, and subject to group discounts that are currently maximised by law at 10%[4]).

Health insurance companies that meet a subscription volume threshold (of 850.000 consumers) are obliged to provide a nationwide offer, and consumers have the right to switch between insurers at least once yearly.[5] Insurers may provide their services in cash (reimbursement), in kind (services contracted and/or paid directly between the insurance company and the provider), or as a mixture of both.

Insurers are allowed and in fact encouraged to conclude preferential agreements with particular providers of care and to direct their consumers toward these providers (there is no obligation for them to contract with all or with any particular providers). Such agreements are seen as an important way of ensuring the efficient provision of healthcare, including improved performance (price/quality ratio) – provided insurance markets themselves are effectively competitive and thereby guarantee that benefits achieved through preferential agreements are in fact passed on to consumers. However insurers freedom in this respect is balanced with the rights of consumers as follows:

- insurers have a legal duty to ensure that adequate care is available, i.e. is provided and/or reimbursed at levels that meet consumer demand
- consumers retain a statutory right to the final say in selecting the care provider of their choice substantiated by the right to reimbursement at a level that does not compromise the exercise of the right to freely choose a provider.[6]

The balance between free consumer choice of both insurer and healthcare provider and insurers' freedom contract selectively with providers also requires:

- meaningful choice at consumer level, hence availability of the quality (performance) data that is not yet supplied by the market
- as precondition for benefits of selective contracting being passed on to consumers: a competitive health insurance market.

2.4 Publicly funded insurance for long-term care

The system of individually funded private insurance described above is supplemented by a system of publicly funded insurance for long-term care (a publicly defined category comprising inter alia geriatric and psychiatric care, and care of the physically and mentally handicapped) based on a public ("social") insurance premium paid by all adults and set at around 4% of gross income (withheld at base). This covers the remaining 50% of healthcare expenditures in The Netherlands (i.e. like curative care, long-term care accounts for some 25 billion € of a total of 50 billion € in annual health expenditures). The "public funding"

[3] Around 6.5% of the first 30.000 € of gross income.
[4] Due to initial fears that collective discounts might be unfairly cross-subsidised by individual contracts, these discounts were capped at 10% of individual rates. However, because access to collective insurance is now widely available collective and individual contracts are readily substitutable. Consequently both are subject to the same (intense) degree of price competition and there is no room for significant cross-subsidization.
[5] Switching behaviour has been significant at 10 to 20% of consumers annually.
[6] This does not necessarily mean that reimbursement has to be identical to that for care provided within the preferential network. In particular a direct contribution by the consumer (co-payment) may be acceptable.

approach has been justified by a general view that while insuring this type of care was necessary to ensure affordability and adequate provision, taking out private insurance for this purpose was not deemed possible. To organise contracting and disbursements a system of regional purchasing monopolies (organised around regionally dominant health insurers) was established which contracted with care providers within publicly established budget constraints. Consumers are registered with their local monopoly.

At present proposals are being developed to liberalise this system by abolishing the regional purchasing monopolies and instead allocating the publicly collected funds to the private insurance companies that at present already provide the privately funded health insurance services. These insurance companies could then compete for the business of consumers and would bear a measure of purchasing risk (albeit most likely subject to a risk adjustment system as regards their consumer population). This model is being considered as it is expected to provide incentives for more efficient provision and improvements in performance.

2.5 Providers

Traditionally, healthcare providers have been tightly and extensively regulated, ranging from market entry to capacity, budgetary and detailed pricing constraints. As this has broadly failed to generate acceptable and future-proof results in terms of access, quality and affordability, the general objective now is to increase the scope for demand-led competition instead, reducing and phasing out regulation where possible.

Around 10% of the (privately funded) elective curative healthcare that is delivered by hospitals is already fully liberalised in the sense that prices are freely negotiable and no longer subject to regulatory approval.

The NZa is proposing to extend the scope of pricing liberalisation to 70% of all curative care (i.e. all elective curative care), subject only to a temporary general price cap based on **yardstick competition**[7] across all products that would not directly affect prices set for individual products. The policy decision whether or not to liberalise and the choice of a specific pricing constraint is obviously a political one, and therefore in the hands of the Health Minister. To support this decision making process the NZa provides technical expert advice on the scope and the modalities of liberalisation, notably the regulatory details of yardstick competition.

Yardstick competition caps the average price across all products delivered by a provider by the average price across all relevant products delivered by the sector (subject to case-mix compensation). It will either be based on costs and a reasonable rate of return, on historic prices, or on both in succession as steps to complete pricing freedom. As a result, providers that are not in the same geographic market or even in the same product market will still be competing with each other to increase overall efficiency across their product range in an effort to beat the average performance in the sector. Yardstick competition thus simulates competitive provision in circumstances where actual competition is not yet effective, leading to more efficient outcomes and less need for regulatory intervention.

This development requires clear definition of:

- standard diagnosis-treatment combinations within the segment covered by yardstick competition (i.e. elective curative care)
- the "universal service" elements of curative care where a free pricing regime may not be appropriate (e.g. concerning

[7] *Yardstick competition for multiproduct hospitals*, NZa research paper by Per Agrell, Peter Bogetoft, Rein Halbersma and Misja Mikkers of 23 November 2006 (see http://www.nza.nl).

emergency care, academic training facilities, and rare and expensive medication).

In addition the NZa is developing and proposing the introduction of an indicator of effective competition as the standard to be met as a trigger for rolling back regulation (by abolishing yardstick competition).[8]

Both regulated and liberalised provision of privately funded care is subject to regulatory supervision of significant market power (SMP) by the NZa (see point 3.4).

Long-term (publicly funded) care is presently subject to general budget controls. We are now in transition to a regime of maximum pricing per product, which in principle allows for a degree of price competition between providers. Further policy changes to the system of long-term care are being considered and the NZa will provide technical advice on the relative merits of the various options available. As mentioned, in future private insurers may come to receive public funding for long-term care proportionate to their subscriber base while being made responsible for contracting the required volumes of care. This would give them incentives to compete for consumers and to exercise pressure on providers to contain costs and improve performance for long-term care.

3. The role of the NZa

3.1 The NZa as sector-specific regulator

The NZa was created on 1 October 2006 as an independent sector-specific regulator for all three main types of healthcare markets: healthcare provision, healthcare purchasing and healthcare insurance.[9] This means that in The Netherlands healthcare **policy**, for which the Health Ministry remains responsible subject to Parliamentary scrutiny, has been separated from healthcare **regulation**, for which the NZa is responsible, subject to judicial review of its decisions. The NZa constitutes of a politically independent three-member board that is appointed by the Health Minister for a fixed four-year term that is once renewable. It is supported by a professional administrative staff. The Health Minister cannot intervene in, or overrule, individual decisions taken by the NZa, but may set general guidelines e.g. on the types of issue that he would like the NZa to tackle.

In the EU context, the model of introducing a sector-specific competition authority is familiar from other liberalised sectors such as telecommunications and energy. It is well suited to politically sensitive sectors of the economy such as healthcare that require a hybrid form of public policy based, on the one hand, on promoting competition, and on the other hand, on public interest guarantees such as universal service. It is also appropriate given the need for regulatory certainty and consistency that is particularly acute in a liberalisation setting and given the complex technical nature of the regulatory action concerned, which requires a combination of specialisation and norm-based independence.

In liberalised as well as regulated markets the NZa's primary statutary responsibility is protecting the general consumer interest in terms of access, quality and affordability. It is responsible for monitoring and supervising health markets and promoting the emergence of effective competition on these markets – including by means of regulating prices

[8] *How to phase out regulation*, NZa research paper by Jan Boone of 19 October 2006 (see http://www.nza.nl).
[9] *Strategy of the Dutch Healthcare Authority: Creating and monitoring properly functioning healthcare markets*, October 2006 (see http://www.nza.nl).

and conditions where necessary. The NZa also has a public advocacy role. Its main tasks are described in some more detail below.

3.2 Policing public interest guarantees

The NZa supervises both the public and the private healthcare insurance regime. This means ensuring that publicly mandated public interest guarantees, e.g. the obligation of insurers to abstain from risk selection and their obligation to ensure the availability of adequate levels of curative care, and the obligation of regional purchasing monopolies to contract adequate levels of long-term care, are met. The substantive content of the public interest guarantees concerned, e.g. the scope of the package of care that is subject to mandatory private insurance, is determined by the Health Ministry subject to the political process.

3.3 Moving from fixed to free prices, via yardstick competition

In part, the NZa still has traditional responsibilities in terms of setting (maximum, or sometimes fixed) prices in areas that are not yet subject to liberalization. It also has responsibility to formally approve prices agreed between insurers and providers where prices are not (yet) freely negotiated (e.g. where they are still subject to maximum prices). At the same time the NZa is developing new instruments, such as yardstick competition, to facilitate the transition to competitive markets (by creating incentives to compete and favouring efficiency) and ultimately, to phase out price controls altogether once effective competition takes hold. The NZa can also authorise price experiments for trial runs of various regulatory solutions – usually at the request of market parties.

3.4 Controlling Significant Market Power (SMP)

The NZa is responsible for ensuring a level playing field, i.e. effective competition in all types of healthcare markets in The Netherlands. An important instrument for this purpose is the authority to impose specific obligations on parties – both healthcare providers and insurers – that enjoy significant market power (SMP) on a particular relevant market. Based on the concept of economic dominance in general competition policy (and also used in the EU regulatory regime for the electronic communications sector), SMP equates to the power to behave independently from suppliers, competitors, and/or consumers. When the NZa makes a finding of SMP it can impose proportionate remedies on the particular market party concerned that range from transparency, to obligations to deal, and various forms of price regulation. SMP remedies are only imposed where general obligations (e.g. transparency requirements or a general price cap) do not suffice to remedy the market failures involved.

The purpose of controlling SMP – by imposing ex ante (in advance) conditions on parties with market power, in addition to the existing general competition rules that provide ex post (after the fact) checks on dominance abuse, is to speed up the transition from tightly regulated provision by regional monopolies and oligopolies to effective competition. The rationale for this sector-specific competition policy is therefore highly similar to that for electronic communications from which the SMP model has been derived. For the same reason the remedies that may be imposed in the case of SMP are more specific than general competition policy allows, such unbundling, and precise forms of access obligations and price setting. Important differences from electronic communications are that in healthcare there has never been a single nationwide legal monopoly, many more market parties and markets are involved, and the interrelationship between the healthcare purchasing, provision and insurance markets presents problems particular to this sector. Also, the application of SMP in the electronic communications sector is based on

EU rules and subject to coordination between national regulators and the European Commission, whereas a similar framework does not exist for healthcare.

In addressing SMP the NZa will give priority to **selling power** of providers of healthcare (not buying power of health insurance companies) and **exclusion** of competitors (not exploitation of consumers and providers).[10] This is because as long as insurance markets are effectively competitive any advantages derived from buying power will in any event be passed on to consumers, which is not the case for selling power. Exploitation can be addressed more fundamentally and permanently by barring exclusion to promote effective competition rather than by means of direct regulation of the undertaking that is practicing exploitation in order to simulate competitive outcomes. Moreover, in a liberalisation context, it is counterproductive to re-introduce direct regulation of exploitation that will be difficult to phase out because, once adopted, a dependency on regulation develops and the scope for competitive entry is reduced.

As sector-specific competition authority The NZa maintains a close working relationship with the general competition authority in The Netherlands (NMa). For example, the NZa advises the NMa in the latter's merger control cases in the healthcare sector, and the NZa and the NMa have jointly contracted leading international experts to provide advice on geographic market definition in healthcare.[11] In cases where both the general competition rules concerning dominance abuse and the SMP rules may apply, precedence is given to application of the sector-specific rules, unless the NZa and NMa agree that it would be more effective or efficient for the NMa to act, or for both authorities to act jointly.

3.5 Promoting quality-based competition

A fundamental concern of the NZa is that promoting competition should lead to efficiency in terms of the price/quality ratio, not solely in terms of constraining price: driving down prices and quality at the same rate is evidently pointless from the general consumer perspective embraced by the NZa. Instead value for money means that the price/quality ratio must improve. An important challenge will therefore be to identify and enforce the most important quality and performance parameters which healthcare providers must meter, make public, and share with consumers and insurers as well as third parties which are interested in aggregating and comparing healthcare quality indicators either on a commercial or on a non-profit basis.[12]

This is necessary to address information asymmetries in order to enable the informed consumer choice that is fundamental to demand-driven provision, to enable insurers to act as responsible intermediaries, and more fundamentally, to stimulate healthcare providers to monitor and improve quality where today even seemingly straightforward performance measures are not recorded, much less compared and

[10] *Significant market power in healthcare*, NZa consultation document of 11 December 2006 (see http://www.nza.nl).

[11] The most important distinctive features that are present in a unique combination and degree in markets for hospital care and long-term inpatient care include: the presence of third-party payers, differentiated products, uncertainty, asymmetric information, entry and exit barriers, and high search costs. In defining such markets, a balance has to be struck between the strong data requirements of direct implementations of the SSNIP-test (logit-competition index, option demand approach), and the use of less data-intensive implementations of the SSNIP-test (time-elasticity, competitor share, critical loss analysis) or even using only shipping data to define healthcare markets (Elzinga-Hogarty test). The preliminary papers on this subject that were presented at an NZa workshop on 10 January 2007 are available at http://www.nza.nl (reactions are welcomed).

[12] Cf Michael Porter and Elisabeth Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business School Press, 2006).

publicised. As far as quality is concerned, too often providers remain content to take a stab in the dark, instead of systematically working to improve their performance based on data and emulation of best practice.

3.6 Monitoring and Public advocacy

The NZa is responsible for ongoing monitoring and reporting efforts on the performance of all three types of healthcare markets. This is aimed to promote regulatory transparency and consistency, and to inform the NZa's efforts to promote effective competition.

In addition, the NZa has a public advocacy role supporting decision making on health issues by providing the Health Ministry (both on request and at its own initiative) with expert input on issues of present and future healthcare regulation and implementation aspects of general healthcare policy. Examples are advice on the timing and modalities of further liberalization of curative care (including yardstick competition) and on models for reforming long-term care.

3.7 Enforcement

Finally, the NZa disposes of a range of enforcement powers. More specifically it can hand down binding decisions (imposing specific performance), impose administrative fines, publicise breaches, apply police powers and impose periodic penalty payments. For SMP purposes the NZa can, where necessary, order interim measures. The exercise of all these powers is subject to judicial review by a specialised court for economic law and regulation (in two instances, for fining decisions).

4. Response to the issues raised in the public consultation

4.1 Shared values and principles for EU citizens

The NZa believes that the central objective for healthcare at EU level (as nationally) should be promoting the consumer interest in terms of access, quality and affordability, not catering to vested provider interests and bureaucracies. Centralised planning fails to control cost other than by rationing, whereas supply-based models entail the risk of exploding costs, and a mixture of oversupply and undersupply based on provider preferences rather than consumer demand and societal health needs. Hence the challenge is combining demand-led market-based reform with appropriate public interest guarantees

Providers and insurers must monitor and publicise performance quality data, and must compete to provide the most efficient services to consumers, whereas governments must define and guarantee universal service: including not only the basic package of care to be provided to all consumers, but also ensuring equitable access to health insurance coverage. This requires making universal health insurance mandatory and ensuring that health insurance providers do not engage in risk selection to lower their costs as a poor substitute for effective contracting with healthcare providers.

Defining universal service is key to balancing the promotion of competition that is necessary as an efficiency driver (quality improvement and cost containment) and other public interests related to equity and solidarity, such as accessibility of health care. It forms the first step toward identifying the regulatory solutions necessary to address the specific characteristics of health care markets, notably resulting from the triangular relationship between healthcare purchasing,

provision and insurance, which involves market failures such as adverse selection, moral hazard, market power, various externalities, and information asymmetry. A minimum (not a fully harmonised) standard of universal service should be agreed at EU level (see point 4.7).

In the view of the NZa, EU citizens seeking treatment abroad should have right to:

- the same provision of health services as the citizens of the host Member State at least concerning emergency care and care covered by the EU level minimum standard of universal service
- reimbursement up to at least the level provided for comparable treatment in their home Member State.

4.2 Practical issues to ensure cross-border provision

Experience in other economic sectors has demonstrated that not just competition between existing parties, but market entry, in particular also by parties from other Member States, is fundamental to engendering innovation, efficiency and growth. Open markets are key to effective competition. Hence entry barriers at the level of the "liberal" professions and e.g. prohibitions on the distribution of dividends by healthcare providers (effectively blocking providers from Member States where such rules do not apply) should be removed.

Cross-border provision of healthcare helps to increase the competitive pressure on national providers in the home Member State to improve their standards of performance. Provided proper reimbursement occurs it also rewards superior performance in the host Member State by directing additional consumers in its direction with benefits in terms of scale and scope for further specialisation and quality improvement, and positive employment spin-offs. National funding systems of host Member States should not discourage cross-border provision of health services, e.g. they should allow both "non-contracted" rates covering costs plus a reasonable rate of return for incidental provision of care (e.g. emergency care), and specifically contracted rates for planned provision of care. Equally, national rules should provide for proper reimbursement of medical expenses incurred in other Member States.

National decisions to ration healthcare provision, if made, should not discriminate against nationals from other Member States. Quality information should be made transparent and available to enable consumers to identify and choose providers – including abroad – on this basis (providing further encouragement for quality improvement).

By increasing the scope for effective cross-border competition and market entry the need for regulatory intervention in healthcare with its unavoidable distorsive consequences is reduced, to the benefit of consumers and providers alike. Hence liberalisation aiming to enhance efficiency at national level should benefit from promoting free movement at Community level.

4.3 Member States' scope to regulate and plan within the constraints of free movement

National systems should retain the freedom to apply risk adjustment mechanisms which allow health insurers to provide universal access to their services by compensating for differences in the risk profile of their population. Risk adjustment is a necessary condition to bar negative externalities of competitive provision of insurance. It ensures that providers of health insurance will compete positively on the merits, i.e. efficient performance and delivery of quality care, not merely negatively on risk selection to achieve a low-cost population and limit their financial exposure. Risk adjustment is thus pro-competitive and fundamental to an economically sound hybrid system that combines market forces with public guarantees of universal service and accessibility.

In this context, Member States moving toward more market-oriented means of health insurance and provision should not be penalised with respect to Member States that continue to support state-centred systems by indiscriminately imposing the competition, free movement and state aid rules on the former while wholly exempting the latter. If the European Court of Justice were to strike down the risk adjustment systems that are presently subject to judicial scrutiny, Community level legislation should be introduced to provide the requisite safeguards enabling such systems to continue functioning in accordance with EU law.

As mentioned above constraints on dividend distribution in the sector appear straightforward infringements of the free movement of capital rules – apart from restricting investment into the sector (as an inability to take funds back out again will effectively halt their moving into the sector in the first place) – and do not merit restraint.

Apart from a focus on free movement encouraging a more active application of the competition rules in the sector would appear to be appropriate (e.g. with respect to the "liberal" professions active in healthcare and their persistent efforts to foreclose and partition national markets to the detriment of consumers and free movement). Concerning SMP (significant market power), the NZa believes that at least in The Netherlands problems related to monopoly or oligopoly provision are currently likely to be more prevalent in more remote areas, which are frequently near national borders, where cross-border provision of healthcare would be one of the most effective remedies. Similar patterns may exist elsewhere in the EU.

4.4 Reconciling choice in exercising individual entitlements with overall financial sustainability of healthcare systems

Publicly constraining choice can only be an effective way to ensure financial sustainability if effectively denying healthcare to consumers is considered an acceptable consequence. It leads to a mismatch between demand and supply, to dampening of competition, inefficiency and rationing that will ultimately compromise the health of consumers only in order to protect substandard services and redundant working practices and technology. Demand-driven markets are the best guarantee of the consumer interest and require transparent information concerning price and quality to enable choice, including on a cross-border basis.

Solidarity at the funding level (e.g. compulsory health insurance without risk selection) is a better way to publicly ensure access and affordability (both at the personal and at the systemic level) than limiting choice and thereby reducing the provision of care.

Private constraints on choice (e.g. by means of incentivising the provision and consumption of care within a preferred provider network based on selective contracting) are acceptable provided there is effective competition in the health insurance market ensuring consumer choice between different insurance plans. In such cases selective contracting may provide incentives facilitating the emergence of more efficient and better care. Nevertheless to avoid second-guessing consumer preferences reasonable reimbursement (meaning co-payments may be required but not at a level not effectively foreclosing consumer choice) for care sought outside the preferred provider network, and equal reimbursement to that applicable nationally for care sought in other Member States, should be mandated.

4.5 Ensuring proper financial compensation of host health systems

As stated at various points above reimbursement of care received in another Member State should be based on, respectively:

- for **emergency care**: cost plus a reasonable rate of return as regulated by the host Member State on a non-discriminatory basis

- for **incidental care** (i.e. not contracted in advance between provider and insurer): the price for incidental care in the host Member State (which may in wholly or partly publicly funded systems also include a proportionate contribution to fixed costs), to be paid by the consumer with a guarantee of reimbursement up to the maximum for comparable care in the home Member State

- in the case of **care contracted in advance** between the insurance company and the provider: freely contracted rates (in wholly or partly publicly funded systems, a proportionate contribution to fixed costs may be mandated).

Although these principles themselves are readily imaginable, the main practical problem will evidently be accounting for fixed costs in systems where these are not incorporated as a standard component in (domestic) pricing of health services. Requiring consumers from other Member States to contribute disproportionately to such costs would evidently be an unjustifiable form of discrimination based on nationality. It may therefore be necessary to develop a standard methodology for defining a "proportionate contribution to fixed costs".

Evidently health insurance companies may wish to attract consumers by providing better terms of reimbursement for cross-border healthcare, e.g. for incidental care, thereby limiting out of pocket contributions by consumers, as a competitive feature of their plans. This can only be beneficial for proper financial compensation of host health systems.

4.6 Identifying, comparing and choosing between providers in other Member States

Broadening consumer choice to include providers in other Member States will provide further incentives for improving quality and efficiency in the home Member State (where providers will effectively be held to higher standards by having to meet cross-border competition) while rewarding excellent performance in host Member States. As one of the main drivers of quality appears to be specialisation it makes sense that this should not be limited by national borders (rare diseases being only the most obvious example).

The main requirement to enable meaningful consumer choice to include cross-border services is **transparency** concerning quality and pricing information.

The relevant parameters can be identified and developed further based on best practice by providers that are already measuring and comparing relevant performance data (including best practice outside the EU). Alternatively it may be appropriate to require sharing and publication of key data (e.g. risk-adjusted mortality rates, infection rates, re-hospitalization rates) for specific conditions.

In addition cross-border monitoring of treatment (for instance by the home GP and by insurance companies) should be enabled, for example

facilitated by IT solutions. Accordingly, appropriate patient rights may in due course be considered.

4.7 Link between healthcare and related services such as social services and long-term care

What is required primarily is a clear definition of universal service in healthcare (e.g. emergency care, and the standard package of basic care that should be available to all consumers) as this should impact rights of consumers from other Member States.

A completely uniform or fully harmonised definition of universal service across all Member States is not a prerequisite to provide a basis for market opening and cross-border provision of basic services. For example in the area of electronic communications it has been sufficient to establish a Community-wide **minimum standard of universal service** allowing for differences at national level (i.e. "topping up").

Care that is part of a Community-level minimum universal service standard should be available cross-border on an non-discriminatory basis, i.e. without limitations based on rationing constraints, provided adequate financial compensation along the lines set out above is available. In such cases all EU citizens should enjoy equal access rights.

In the view of the NZa this would provide the necessary minimum framework for developing a perspective on curative, respectively long-term care and social services.

5. Informal working group on efficiency-enhancing regulation

Existing cooperation within the EU (e.g. in the context of the High Level Group) does not appear to address regulation aiming to enhance efficiency as a distinct topic. This would involve addressing the questions of how to introduce incentives promoting effective competition, and, where this is not feasible, how to mimic the effects of competition by means of various proxies.

The NZa does not take a view on whether addressing such issues in more formal existing groups would be appropriate or feasible. However, there can be no doubt that interested healthcare regulators would benefit from sharing ideas and practical experience as a form of "peer review" that would allow the identification and diffusion of best practice in this field (e.g. identifying means of engendering quality-based competition).

Hence the NZa hereby proposes to provide an **informal forum for debate on efficiency-enhancing regulation** between those authorities that are presently interested in participating (a "coalition of the willing") by organising a workshop on this topic, in cooperation with the Dutch Health Ministry, in The Netherlands in Spring, 2007.

Further details will be provided at http://www.nza.nl, and suggestions are welcome at the e-mail address that was also provided in the introduction to this contribution: euconsultation@nza.nl

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