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Working Party No. 2 on Competition and Regulation

COMPETITION IN HOSPITAL SERVICES

-- Norway --

13 February 2012

The attached document is submitted to Working Party No.2 of the Competition Committee FOR DISCUSSION under item III of the agenda at its forthcoming meeting on 13 February 2012.

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1. Introduction

1. In the letter asking for contributions to the WP2 Roundtable on competition in hospital services, the Chairman states that the OECD Competition Committee seeks to consider whether competition can deliver improvements in health and hospital services.

2. In Norway, the state has the overall responsibility for the financing and provision of key social welfare tasks such as health, care and education. The health enterprise model, with four regional health enterprises, is the cornerstone of the Norwegian system for providing hospital and other specialist health services. The activities within the regional health enterprises are financed through a combination of basic grants and activity based funding. The overall state governance of the four regional health enterprises imply that most of the health services are provided within what the Norwegian Competition Authority (the NCA) in a decision in 2005 concluded was one enterprise. Moreover, even though there has been a substantial growth in the last 20 years, the private providers' share of the activity in the national health care system is still very limited.

3. These features combined with the policy of the current government which explicitly leaves a limited role for commercial actors within the health care system, obviously give limited space for competition as well as enforcement of the competition law in relation to the health care system in general and hospital services in particular.

4. There are nevertheless important tasks for the Competition Authority in relation to this sector, both with respect to enforcement as well as pointing out restrictive effects on competition of public measures. Thus, competition law and its enforcement can be an important contribution to efficient use of resources, i.e. more health for a given budget, in this area.

5. Before substantiating how, a description of the Norwegian health care system will be presented, as well as the current government's policy towards competition in the health care system. As part of the discussion on the scope and role of competition law and enforcement in relation to hospital services in Norway, we will also present some of the competition issues related to the health care system encountered by the NCA.

2. The political framework

2.1. Policy on competition in general

6. The Competition Policy of the present government is described ia. in the 2012 Budget proposition. Here it is stated that an active competition policy is instrumental in stimulating an effective use of resources in the society, and that markets with well-functioning competition contribute to the State using no more resources than necessary.

7. Furthermore, the government states that competition contributes to an innovative and adaptive industry structure that produces goods and services in an efficient manner. This will strengthen Norway's competitiveness internationally. To the consumers, competition ensures a wide range of goods and services with good quality at the right price. Consequently, the Government states that it will have a policy stimulating competition.

2.2. Current policy on competition in the health care system

8. The political platform for the current majority government (*The Soria Moria Declariation*) is very clear on the public sector's responsibility and role in the provision and financing of key social welfare

tasks such as health, care and education. The government is also explicit in that it will oppose the commercialization of these areas. More explicitly, it is a stated goal to ensure that the scope of agreements between regional health enterprises and private commercial hospitals shall be limited. Available capacity in the public hospitals shall be utilised, and agreements between health enterprises and private commercial hospitals shall not have a scope that undermines the catchment populations for the small local hospitals.

9. In the political platform, it is also stated that it is important to safeguard that "hospitals owned and operated by non-governmental organisations shall be ensured good terms through agreements with the public authorities".

10. Moreover, the Government Policy Declaration on "Competition policy, public support and public procurement" at the Ministry website also includes a commitment to community solutions and public control instead of compulsory competitive tendering in important welfare fields like education, health and care services[1], reflecting the political platform presented in the "Soria Moria Declaration".

3. Structural framework for health services[2]

11. A health system can be defined as all organizations, institutions and resources that are devoted to producing health actions – the latter being defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health. The health care system comprises a wide range of different services. Here we will mainly focus on specialist health care services.

3.1. The Norwegian health care system - specialist health services.

12. Norway has a national health care system. Hospital services are mainly financed by the government, and the right to receive hospital services is regulated by law.

13. From 1975 until the state took over the hospitals, the county authorities had the responsibility for running hospitals. As of 2002, the hospitals have been organized as state-owned health enterprises. The purpose of the reform was to entail a comprehensive reform of organization and responsibilities, with a clear division of remits and roles to permit continued political control. Equally, the aim was to create conditions conducive to the autonomy of the operating enterprises.

14. The enterprises are separate legal entities, which do not form a part of the central public administration. The State has no authority or responsibility for the day-today operation of the enterprises.

15. However, as owner the State lays down the articles of association and other framework conditions and objectives, and selects the board members. Through special regulatory documents issued annually by the Ministry of Health and Care Services to the regional health authorities, and meetings with the authorities, health-policy steering notices, grants and conditions applicable to allocations are communicated.

16. The Ministry of Health and Care Services may also, in the general meeting, lay down instructions for the boards of the regional enterprises. All decisions of considerable importance must be presented at the general meeting. It is clear from the preparatory works to the Health Enterprises Act that the State as owner

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1 See http://www.regjeringen.no/en/dep/fad/Selected-topics/competition-policy.html?id=1363

2 This description is based on http://www.helsedirektoratet.no/english/publications/health-creates-welfare--the-role-of-the-health-system-in-norwegian-society/Sider/default.aspx as well as a previous submission to the OECD WP2 roundtable on competition in health services, in 2005.

is entitled to make decisions of strategic, financial or other vital nature. It was also an explicit premise that the reform should lead to a centralized management of the health enterprises.

17. The ownership division of the Ministry of Health and Care Services exercises corporate governance, while the Minister of Health and Care Services constitutes the annual general meeting. Both the four regional health enterprises and the local health enterprises have the status of their own legal entity, with their own boards. These boards have comprehensive and supreme responsibility as supervisory, strategy-laying and decision-making bodies.

18. The public-sector specialist health service is currently organized into 23 health enterprises (HF) in 4 health regions under the respective regional health enterprises (RHF), i.e. north, middle, west, and south-eastern part of Norway.

3.2. Responsibilities

19. The State is responsible for providing specialist health services to the public, according to the Patients' Rights Act. This act states that the patient is entitled to receive necessary health care from the specialist health service. The specialist health service shall also set a time limit within which the patient shall receive necessary health care. If the patient does not receive such care within the time limit, the patient has a right to receive necessary health care immediately – if necessary from a private service provider or from a service provider outside Norway.

20. The RHFs are directed to fulfil this responsibility of providing hospital services for the population in their own region. The RHFs have two possible ways of doing this. Their own subsidiaries (the health enterprises) can produce the services, or the RHFs can buy the services from other suppliers – private or public.

21. Each RHF and each HF is responsible for its own economic result. The enterprises are obliged to be in economic balance over time, within the framework conditions set by the State. The Norwegian Accounting Act applies for the public health enterprises as well as for private enterprises. There is, however, an exception made for the estimation of the capital value in the opening balance at the time of foundation. Health enterprises also differ from other enterprises because they can not be taken under bankruptcy proceedings. The state has instructed the RHFs to coordinate the activities of the subsidiaries when required. Based on the ownership the RHFs can request the health enterprises to cooperate.

3.3. Private provision of health services

22. Hospital services are supplied mainly by government-owned institutions, but also to some extent by non-profit private institutions in addition to some commercial private providers of hospital services.

23. The non-profit institutions have a similar role to public health enterprises (HFs). They are financed in a similar way, and their agreements with the RHFs resemble the agreements between a RHF and its HFs. Non-profit institutions may provide a broad range of specialist health services, including emergency help. After the Health reform in 2002 some of these non-profit institutions became public health enterprises.

24. The extent of commercial private providers of hospital services has grown significantly the last 20 years. The private providers' share of the activity in the national health care system is, however, still very limited. They also play a different role than non-profit institutions in the health system

25. The figures in the table below encompass 21 private institutions with a contract with one of the regional health enterprises. These private providers have specialized in scheduled treatment, especially outpatient surgeries.

Table 1. Number of patients with at least one day-and-night stay, one day treatment or one polyclinic consultation (out-patient treatment) in public hospital or publicly financed at private hospital with a contract with the regional health enterprise, 2nd tertiary 2001[3]

	Public hospital	Private hospital
Day-and-night stay	406 379	5596
Day treatment	138 478	12 542
Polyclinic consultation (out-patient treatment)	1 221 823	21 200

26. The NCA stated in its contribution to the OECD roundtable on Competition in the provision of hospital services that the private commercial providers constituted a competitive benchmark and contributed to innovation. In addition, they had also played an important role in reducing waiting time and shortening the queue of patients waiting for outpatient surgeries or diagnostics by radiology or laboratory testing.

27. Private specialists outside hospitals also provide specialist health services. Their activities range from basic surgery to complex nursing and care services. They are all subject to the authorities' supervision. For some specialties they provide a substantial part of the total services. In 2009, the so called Contract specialists (*Avtalespesialister*) took care of one third of total out-patient treatment in the somatic areas, as well as psychic health care for adults.[4]

3.4. Financing of the health enterprises

28. In general, the Norwegian health system is funded primarily through taxes and transfers from the state. There is no earmarked health tax. The national insurance scheme guarantees the population the right to health, care and nursing services. Treatment at public sector hospitals is free, including medicines. There is partial fee-for-service payable for consultations with GPs and specialists, for outpatient care and for certain medications, along with transportation. In principle, patients have to pay the full cost of treatment from private-sector service providers, unless the private provider has a contract with one of the RHF's, and the patient has a referral to treatment.

29. The financing model for the regional health enterprises in Norway is a mixed model, combining a fixed budget appropriation and an output-based reimbursement. The main features of this model were implemented in 1997, when a system of activity based financing for general hospitals was introduced on a comprehensive basis.[5]

30. Prospective payment is often adjusted based on performance of median or best practice hospitals. Many countries are introducing prospective payment systems in order to encourage hospitals to improve their outputs for the funds they receive. Thus, the primary purpose of the reform was to increase activity so

3 http://www.helsedirektoratet.no/tall-analyse/aktivitetstall/somatikk/Documents/Aktivitetsdata-somatikk-tertial2-2011.pdf

4 http://www.helsedirektoratet.no/tall-analyse/aktivitetstall/avtalespesialister/Sider/default.aspx

5 http://www.helsedirektoratet.no/publikasjoner/regelverk-innsatsstyrt-finansiering-2012/Publikasjoner/regelverk-innsatsstyrt-finansiering-2012.pdf

that more patients could receive treatment more quickly without reducing the quality of care. Thus, the regional health authorities are basically financed by a combination of basic grants and activity-based funding.

31. The activity based financing system (*Innsatsstyrt finansiering*, ISF) is a DRG-based[6] reimbursement system, which applies to most of the hospitalised treatment. This percentage has varied from year to year. In 1997, when the system was implemented, the percentage was 30 per cent. In 2003 it was 60 per cent, then reduced to 40 per cent in 2004 and again increased to 60 per cent in 2005. The RHFs currently receive 40 per cent of the calculated DRG-price (equivalent to the average operating cost for each DRG). The basic grant constitutes approximately the remaining 60 per cent. The size of the basic grant depends on the number of inhabitants in the region, as well as the demographic properties with respect toe.g. age distribution, and is independent with respect to the actual production of health services. In addition to the activity based financing and the basic grant comes grants to the specialists with contract with the RHF's as well as private laboratory and radiology services

32. For outpatient treatment, radiology and laboratory services there is another output-based reimbursement system which is based on fixed payments for each type of consultation. The patients themselves also pay a small amount for each consultation (there are some exceptions to this).

33. Private providers of hospital services must have an agreement with one of the regional health enterprises to obtain state reimbursement. If the provider has no agreement with a RHF the patient will be responsible for paying for the treatment.

4. Contracting and competition mechanisms

4.1. Entry for new providers

34. Private hospitals or private health care service providers must be authorized by the Ministry of Health and Care Services. The Ministry focuses on whether the services in question are beneficial from both a social and economic point of view. It is also emphasized whether there is an actual need for the services, and if the intended use of health care personnel is considered to be reasonable. Lastly, it is also taken into consideration whether the services are sound from a professional viewpoint.

35. A patient with a right to necessary scheduled treatment has a statutory right to choose the hospital or other institution in which the treatment shall be carried out. It is a condition that the institution is owned by a regional health enterprise, or has an agreement with a regional health enterprise that entitles the patient to make such a choice.

36. Private laboratory and radiology service providers need a professional authorization to be allowed to supply their services, according to the specific regulations for this kind of services.[7] Moreover, an agreement with a regional health enterprise is a condition to be entitled to public reimbursement. Thus, the RHFs have a key role regarding the entry of new providers.

4.2. Benchmark competition

37. ISF-payment is a prospective payment system which implies a form of benchmark competition for hospital services. The hospitals have incentives to be more efficient, and they have incentives to shut

6 Diagnosis-related group /DRG) is a system of classification for hospital cases.

7 See http://www.lovdata.no/for/sf/ho/xo-20001201-1276.html (in Norwegian)

down inefficient units. In its contribution to the OECD roundtable on this issue in 2005,[8] the NCA noted that since ISF was introduced, two kinds of restructuring had been observed. First, an increasing part of the treatment were performed as day treatment (the patient is leaving the hospital the same day as he arrives). The NCA proposed various explanations for this; arguing that economic reasons were the most likely among them.

38. Second, the length of stay (LOS) were significantly reduced since the prospective payment systems were introduced. For most DRGs the decrease in LOS had been between 10 % and 20 % from 2000 to 2004. This was partly due to the increase in day treatment for conditions that earlier demanded several days of hospitalization. However, the length of stay was also significantly reduced for treatment where the patients stayed for more than 24 hours.

39. The NCA proposed that more efficient procedures could be one of the explanations for this, and found reasons to believe that the potential of benchmark competition were far from exhausted.

40. It can be added that a recent study shows that hospitals that have implemented ISF on a department level has managed to increase productivity without increasing costs.[9]

41. In its submission in 2005, the NCA also argued that the change in political signals with regard to the role of private providers in the health care system conditions had made it difficult for the enterprises to make rational decisions about investments or closing down of units.

42. The NCA also found it possible that the requirement for private enterprises to have an agreement with the RHFs represented an entry barrier, and thus reduced the number of competitors.

4.3. Outsourcing of services

43. The RHFs are responsible for providing hospital services to the population in their region. They can produce the services in their own HFs, or they can buy the services from other providers; private as well as HFs in the other regions.

44. Services like surgery, other kinds of scheduled treatment, radiology, laboratory services and ambulance services are to some extent tendered, thus introducing competition among private providers of these services. The RHFs are free to bargain prices and other conditions with the private providers. The per unit payment can be considered as a two part tariff with a fixed refund determined centrally and a part determined through the tender.

45. One potential issue of concern from a competition point of view is the dual role of the RHFs. The RHF is responsible for the provision of the relevant health services, and also a dominant producer of the same services.

46. In the OECD Competition assessment toolkit (version 2.0), it is pointed out that a number of rules and regulations can have the effect of limiting the actual number or the type of suppliers of goods and services in the marketplace, thus a concern from a competition point of view. The rationale for the concern is e.g. that entry by new businesses plays a crucial role in preserving the vitality of markets by offering competition to the incumbent firms and fostering innovation and growth in the longer-run.

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8 Norwegian submission to Roundtable on Competition to Promote Efficiency in the Provision of Hospital Services, held by the Working Party n°2 of the Competition Committee in October 2005

9 One of the essays in a recently submitted Phd thesss by Afsaneh Bjorvatn with the title ”Four Essays on Health Care Reforms in Norway”at the Univerity of Bergen (January 2012).

47. The NCA recognize that it is the responsibility of the RHF to determine if services shall be produced in-house or bought in the market. The make-or-buy decision depends on several factors like transactions costs, what is considered as core-activities and so on. It is, however important that the regulatory framework and the assessment and allocation of relevant costs within the RHF is designed so that make-or-buy decision can be based on actual costs of providing the services.

48. In its submission in 2005, the NCA argued that it should be possible to increase both scope and scale of outsourcing, maybe also by paving the ground for competition on equal terms among private and public hospitals.

4.4. Free choice of hospitals.[10]

49. Patients' rights are described in The Patients' Rights Act. The objective of this Act is to give the population equal access to high quality health care by granting patients' rights in their relations with the health service.

50. Since 2001, patients are according to the law free to choose a hospital for scheduled treatment (and specialist consultations/diagnostic services). Free hospital choice means that a patient who is referred to further investigations and/or treatment has the right to choose the hospital. The patient's travelling costs, and costs for food/accommodation, are reimbursed by the RHF. The patient only pays a limited amount.

51. The system is based on a gatekeeper model. All citizens are entitled to a personal general practitioner (GP). The GP sees the patient for initial diagnosis, and then decides whether the patient should be referred to the specialist health service. The specialist health service will then decide whether the diagnosis give the patient a right to treatment.

52. To facilitate patients' rights to choose where to receive treatment, the Norwegian Ministry of Health in 2003 launched an information service on the Internet; "Free Hospital Choice".

53. The service offers patients, next of kin and clinical personnel up to date quality information concerning patient's rights, waiting times and quality information about the different hospitals, as well as other relevant information.

54. This enables patients to make better informed decisions as to which hospital/institution to choose for different types of treatment. The patients may ask their GP to help them to choose, book treatment themselves by using a web site constructed specially for this purpose, or call a toll-free telephone number. In addition to the internet service, an existing telephone service was improved to support the peoples' right of free choice of hospital.

55. The information covers all public and private hospitals that have an agreement with the RHFs to perform selected treatments. One purpose of this service is to contribute to a better utilization of the capacity of treatment within the Norwegian healthcare services, and to increase competition among state-run hospitals.

56. In general, promoting consumer ability to choose is important for making markets work well. Thus, when patients according to the law are free to choose a hospital for scheduled treatment, this is from a competition point of view applaudable.

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10 Based on http://www.frittsykehusvalg.no/english.

57. In its OECD submission in 2005, the NCA referred to studies that confirm that the freedom of choice reduces the waiting time for each patient that uses this right. A recent report from the Office of the Auditor General's, submitted to the Norwegian Parliament on 20 October 2011, confirms that patients who make use of the free choice of hospital scheme experience shorter waiting times.[11] Moreover, a recently submitted PhD dissertation at the University of Bergen, Norway also presents evidence that free choice of hospital has increased patient mobility.[12]

58. In the NCA's view, it is important that patients have good, reliable, comparable and easily accessible information on relevant aspects of the different options. However, last year "The Norwegian Board of Technology"[13] presented a report to the Norwegian Parliament on free patient choice. One conclusion was that the information available to patients was highly inadequate. This is confirmed by the Office of the Auditor General's investigation, which states that in order to give patients a better basis for making decisions concerning choice of hospital, the scheme's website – www.frittsykehusvalg.no – needs to be improved with more reliable, up-to-date, relevant and realistic information.

59. The investigation of the Office of the Auditor General's also shows that the primary reason why patients exercise their right to free choice of hospital is that their GP has informed them about the system. Nearly half the patients were not given this information by their GPs. The investigation also shows that the patients receive inadequate information from hospitals about the possibility of shortening waiting times by changing hospitals – despite the fact that many hospitals have long waiting times for many types of treatment. The system is used most by patients with high incomes and higher education who are in employment

60. The Office of the Auditor General's recommend that the Ministry of Health and Care Services ensure that GPs and hospitals make more active use of the free choice of hospital system in order to achieve health policy goals. Better guidance can contribute to the provisions of the Patients' Rights Act concerning free hospital choice combining the goals of increased patient participation in decision-making and equal access to health services. At the same time, increased utilization of the free choice of hospital system can help to improve utilization of the specialist health service's capacity.

4.5. Exit/restructuring

61. Exit of non-efficient units is in an essential feature of a market based economy to realize efficiency improvements. The board of a HF can in principle decide to shut down hospitals. In practice there are severe obstacles to this.

62. Firstly, the political platform of the current government, i.e. the Soria Moria declariation, states that "No local hospital shall be closed down". Secondly, according to the Health enterprises act (section 30), matters with substantial effects on the society shall be submitted to the Ministry of Health and Care Services as owner, by the board of the regional health enterprise. Thus, both the board of the RHF and the Ministry as owner can reverse such decisions in the general meeting. In such situations, it is up to the HF to find other ways to improve efficiency to be able to meet the budget constraints.

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11 Document 3:3 (2011-2012) "The Office of the Auditor General's investigation into the free choice of hospital system".An English resume can be found at http://www.riksrevisjonen.no/en/Formedia/PressReleases/Pages/freechoice.aspx.

12 One of the essays in a recently submitted Phd thesss by Afsaneh Bjorvatn with the title "Four Essays on Health Care Reforms in Norway"at the Univerity of Bergen (January 2012).

13 The Norwegian Board of Technology is an independent body for technology assessment established by the Norwegian Government in 1999, following an initiative by the Norwegian Parliament (Stortinget)

63. If the HFs or RHFs choose to close down hospitals to increase efficiency, the protection of vulnerable consumers is ensured partly through the standards defined in the Patients' Rights Act, partly through the right to choose hospital. In this respect there are important differences between scheduled treatment and emergency care. When closing down hospitals, the health enterprise can choose to supply scheduled treatment from other institutions in the enterprise, or reduce its total supply. In any case, the patients are guaranteed to get the services they have legal right to. The combination of free choice of hospital, and waiting list guarantee, ensures this. Concerning emergency care it is the RHFs' responsibility to ensure this in all parts of its region, according to the standards defined in the Patients' Rights Act.

5. Competition law and enforcement

64. The NCA has only limited experience with applying competition law in this area. We will in the following describe the legal framework as well as some relevant cases.

5.1. The Norwegian competition law

65. The current Competition Act entered into force on 1 May 2004[14] when it replaced the Act relating to competition in commercial activity (Competition Act 1993).[15] The purpose of the Act is stated as to "further competition and thereby contribute to the efficient utilisation of society's resources". When applying the Act, special consideration shall be given to the interests of consumers.

66. The NCA's main task is to enforce the competition law. The NCA shall according to the law supervise competition in the various markets (section 9), among other things by ensuring adherence to the prohibitions and orders of the competition law and intervene where necessary against concentrations in addition to calling attention to any restrictive effects on competition of public measures

67. The prohibition in Section 10 and 11 in the Competition Act is harmonized with Article 101 and 102 TFEU and Articles 53 and 54 of the EEA Agreement.

68. Finally, note that according to Section 3, certain markets or industries may by regulation be exempt from all or part of this. Of particular relevance in this context is the exemption from the competition law for cooperation etc. for certain groups of doctors with private practice, psychologists and physiotherapists (regulations 2009.06.19 no 0674).[16]

5.2. The scope of the competition law in relation to the health care system

69. All undertakings operating in Norway are obliged to comply with the Norwegian Competition Act.[17]

70. An undertaking is defined as any *private or public entity* that carries out commercial activities (Section 2). Thus, the Norwegian Competition Act applies fully to public corporations and state-owned enterprises in the health care sector in the same way as to private corporations to the extent they are

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14 Act on competition between undertakings and control of concentrations of 5th March 2004 No. 12 (Competition Act 2004).

15 Act relating to competition in commercial activity of 11th June 1993 No. 65 (Competition Act 1993).

16 There is also a temporary exemption from the competition law for an agreement on clinical veterinary call duty (2010.12.17 no. 1660).

17 The prohibitions in the Norwegian Competition Act are aligned with Article 101 and 102 TFEU, and Articles 53 and 54 of the EEA Agreement.

involved in commercial activities. Thus, a public body in the health care system can be considered as an undertaking in the context of competition law for certain parts of its activity, even though other parts fall outside of the scope of the law.

71. According to Norwegian Competition Act, the Competition Authority shall also call attention to any restrictive effects on competition of public measures and, where appropriate, submit proposals aimed at furthering competition and facilitating market access by new competitors (Section 9e). If the Competition Authority so requires, a response from the public body responsible for the measure must be made within the deadline specified by the Competition Authority. The response must include inter alia a discussion of how the competition concerns will be dealt with.

72. Consequently, even though the public sector's responsibility and role in the provision and financing of key social welfare tasks such as health, care and education is an important feature of the current government's policy, and the policy explicitly leaves limited scope for commercial actors, there are nevertheless still important tasks for the competition authority relating to this sector, both relating to enforcement as well as pointing out restrictive effects of public measures.

5.3. Case 1: Are the regional health entreprises undertakings with respect to competition law?

73. As described above, a core part of the Norwegian health care system is the regional health enterprises. To what extent the regional health enterprises could be considered as undertakings in the context of competition law was considered by the NCA in a decision in 2005 (Decision A2005-21) as well as a guidance note in August 2005. Here the authority concluded that the five regional health enterprises (now four) should be considered as one economic entity. Thus, cooperation between the different regional health cooperation's would not be considered as a restriction of competition violating section 10 of the competition law.

74. The case was a complaint from the Private Hospital Association. The Association argued that the government’s regional health organizations were in breach of section 10 of the Act due to collusive pricing.

75. As alluded to above, the RHFs are responsible for providing hospital services to the population in their region. The RHFs are organized as separate legal entities, but the Ministry of Health and Care Services is ultimately responsible for both financing and management of the service. Private companies offer to some extent specialist health services. The private service providers generally have agreements with the RHFs regarding payment for rendered services.

76. As the RHFs use of private institutions to help reduce medical waiting lists has increased, the private healthcare providers had agreements with more than one RHF.

77. The RHFs therefore demanded that the lowest price offered by the private institution for rendering a specific service to one RHF should be applicable to all RHFs. The Private Hospital Association asked for an evaluation of this practice.

78. In this case the NCA had two basic questions to answer. First, whether the RHFs are enterprises under the Competition Act i.e. carries on an “economic activity”. Secondly, whether the RHFs were to be considered as different economic entities, since section 10 of the Act only applies to agreements between two or more independent enterprises.

79. The NCA did not give a specific answer to the first question. They gave a general description of the concept "economic activity" in accordance with EU case law, and concluded that it was not possible to give a general answer as to when the a RHF is engaged in economic activity. RHFs would in some

circumstances be considered as enterprises and not in others. This will, according to case law, depend especially on whether the activities concerned have an economic nature and what role the principle of solidarity plays. The NCA therefore stated that it is essential that a case by case assessment is made.

80. Regarding the second question the NCA concluded that the five RHFs are considered to be one economic entity. It was important for the conclusion that the RHFs where 100 % state owned, hereunder that the state was in charge of financing and strategic decisions. Furthermore it was emphasised that the Ministry of Health and Care Services is formally and actually in control of the RHFs and their activities, (by law).

81. The question of the application of competition law will be accentuated where there is a provision of health services in parallel from public and private entities. In these cases, an assessment of the characteristics of the actual health services supplied must be undertaken. To what extent there exists a commercial market for that service independent of the public procurement of the service. It cannot in general be determined whether the regional health enterprises shall be considered as undertakings. This must be assessed on a case by case basis.

5.4. Case 2: Competition between private and public hospitals

82. The second case handled by the NCA relating to hospitals were in some ways similar to the first one. A private hospital asked the NCA to examine the competition situation between public and private hospitals in general. As mentioned above, the first question to be answered in these cases is whether public specialist healthcare providers are considered to be enterprises. It is not possible to give a general answer to this question because one must do a case by case assessment. The Competition Authorities therefore gave a description of the principles laid down by the ECJ in their practice, but a more explicit conclusion was not reached.

5.5. Case 3: Laboratory services

83. In a case concerning laboratory services, the NCA made a concrete assessment of whether a public health provider is engaging in "economic activity", and whether section 11 of the Competition Act is applicable (abuse of dominance). The case concerned a private laboratory which has made a complaint against one of the HF's laboratories. The latter gave rebates to customers (doctors) that requisitioned more than 5.000 laboratory samples a year.

84. First, the NCA had to address the question whether the HF offering laboratory services is engaging in "economic activity". Second, the NCA had to consider whether the rebate system in question amounted to an abuse of a dominant position.

85. However, when the HF decided cessation of the arrangement, the authority in 2006 decided not to give priority to dealing with the case.

5.6. Case 4: Collusion between two health centers in RHF tender

86. An example of collusion is found in the Competition Authority's decision V2008-1, where two health centers in Bergen were instructed by the NCA to end their co-operation with regards to pricing of medical services during tender competitions.

87. The illegal cooperation occurred during submission of tenders in the market for ear, nose and throat surgery. The independent undertakings quoted the same prices in their separate and individual bids. The undertakings admitted co-operation with regards to pricing, citing the use of the same building, same equipment and same personnel as the reason for the collusion.

5.7. Case 5 and 6: Collusion in tender for patient transport.

88. About NOK[18] 2 billion is spent annually on patient transport in Norway. Most of this is related to taxi journeys. The Regional Health Authorities (RHF) are responsible for the procurement of patient transport. The health authorities use competitive tendering procedures to procure public transport in order to stimulate competition and thus reduce their expenditure on patient transport. Lower expenditure on public transport will make more money available for the treatment of patients.

89. Both the licensing authorities (the county administrations) and the purchasers (RHF) are able to influence the degree of competition in tenders for patient transport. The county administrations may, for example, increase competition by allowing more taxi central dispatchers in an area and by increasing the number of taxi licences. The health authorities can influence the competitive situation through how they formulate the call for tender and by acting as vigilant purchasers who keep an eye out for signs of illegal collusive tendering. In March 2009 the Competition Authority sent a letter to the county administrations and the Regional Health Authorities informing them about various methods for increasing competition.

90. Where there is competition, illegal cooperation among competing taxi businesses can weaken or eliminate competition, and increase the costs of providing health services. Case 5 and 6 presented below illustrate this clearly.

91. Case 5. In September 2006 Taxi Midt-Norge AS – a countywide dispatch service that organises taxi licence holders in the county of Nord-Trøndelag – submitted a tender on behalf of all the taxi dispatchers and taxi licence holders in a competitive tendering procedure advertised by the Central Norway Regional Health Authority for the purchase of patient transport for Nord-Trøndelag. The bid thus involved collusive tendering (bid-rigging) among all the taxi licence holders in Nord-Trøndelag.

92. The Central Norway Regional Health Authority submitted a complaint about this collusive tendering to the Competition Authority. After considering all the information relating to the case, the Competition Authority decided that the bid submitted by Taxi Midt-Norge AS in the competitive tendering procedure constituted illegal collusive tendering in breach of Section 10 of the Competition Act. Notification of a fine for breach of the law was issued in December 2008, and the final decision was made in March 2009. Taxi Midt-Norge was fined NOK 300,000 for violation of the Competition Act. The Central Norway Regional Health Authority conducted a round of tenders in 2008 with a view to entering into new contracts and having new suppliers from 1 January 2009. However, the round was cancelled because the bids submitted would have resulted in considerably higher costs than budgeted for patient transport in Nord-Trøndelag. The Central Norway Regional Health Authority therefore engaged in direct negotiations with several potential providers in the market.

93. This resulted in three providers receiving contracts for patient transport in various parts of Nord-Trøndelag during the period 1 January 2009 to 31 December 2011, with the option for a 1-year extension. According to the Nord-Trøndelag Health Trust the savings achieved by having competing bids for patient transport amount to approximately NOK 2 million per year. The health authority has stated that the Competition Authority's notification of its intervention against Taxi Midt-Norge played an important part in gaining acceptance for the outcome of their negotiations with the various providers.

94. One important point in the Competition Authority's assessment of the cooperation via Taxi-Midt Norge was the question of whether the various taxi businesses were actual or potential competitors in the tender. The call for tender stipulated no requirements that bidders be able themselves to offer services to one or more municipalities, and each of the central dispatchers and licence holders could in principle

[18] 1 Euro = 7,66 NOK (January 2012).

submit bids for just parts of the tender. The Competition Authority therefore based its decision on the licence holders associated with the main county service being largely actual or potential competitors.

95. In a similar case in the county of Nordland, the health authority made greater demands with respect to capacity. In much of the county, there were no grounds for submitting more than one bid in the competition. In these areas the health authority would not have received more than one offer, even without cooperation through the countywide taxi business. The Competition Authority therefore decided that there was no reason to intervene in the case in Nordland.

96. **Case 6.** The second case relating to illegal collusion in a tender for patient transport is from 2010. The tender was advertised by the Oslo University Hospital. Two competing taxi dispatchers, Follo Taxisentral and Ski Taxi, collaborated through a jointly-owned company, Ski Follo Taxidrift AS, on submitting bids during two competitive tendering rounds during the autumn of 2010. These competitive tendering rounds applied to the transport of patients for the Oslo University Hospital, valued respectively at up to NOK 20 million and NOK 30 million.

97. The Competition Authority learnt about this illegal collusive tendering from the Oslo University Hospital HF when the Hospital expressed its concern about the lack of competition in respect of patient transport in the Follo region. During the first round of competitive tendering, the collaboration between the taxi ranks resulted in the Oslo University Hospital only receiving one tender. The Oslo University Hospital decided to cancel the competition due to a lack of competition. When the second round of tenders was advertised the taxi ranks also submitted common bids. There were two other tenderers in this tendering round.

98. Follo Taxisentral and Ski Taxi were competitors in the taxi market in Follo, and these two companies could have submitted independent bids in both tendering rounds. The basic tendering material provided by the Oslo University Hospital contained nothing to prevent these companies from submitting individual bids. When instead they decided to collaborate, they violated Section 10 of the Competition Act which bans collaboration between competitors designed to limit competition.

99. In 2011 the NCA decided a fine of NOK 2.2 million for Ski Follo Taxidrift. Follo Taxisentral had to pay a fine of NOK 400,000 and Ski Taxi a fine of NOK 250,000. All three fines imposed for breaches of Section 10 of the Competition Act which bans collaboration between competitors designed to limit competition.[19]

100. These examples relating to tenders for patient transport illustrate well how important it is to create a good basis for competition through formulating the call for tenders, vigilantly carrying out competitive tendering procedures, and actively enforcing the Competition Act.

101. If little attention is paid to the effects on competition, then county administrations and the Regional Health Authorities must be prepared for transport services to be more expensive. If no arrangements are made for competition then the competition rules will not normally have a decisive impact either. If only one taxi company or one combination of such companies is able to submit a bid because of the terms of the call for tender, there will be no illegal collusive tendering to intervene against.

[19] The firms involved have decided to try this case before the court.

5.8. Calling attention to any restrictive effects on competition of public measures

102. As mentioned above, one of the important questions in the cases the NCA has dealt with is whether the public hospital service in question is engaging in "economic activity", is to be considered as an undertaking in the legal sense.

103. Moreover, a public body is not considered as an undertaking in its exercise public authority, or if the public service is part of a solidary arrangement with a social purpose.

104. However, if the public measure has restrictive effects on competition the NCA can, according to Section 9 e referred to above, call attention to this, and where appropriate, submit proposals aimed at furthering competition and facilitating market access.

105. In 2009, the NCA used this tool; sending a letter to the Ministry of Health and Care Services calling attention to concerns regarding the public operating grants to private practice physiotherapists, arguing that the arrangement implied a substantial risk for lowering the quality of services. Although the concerns were directed toward the agreements with the private practice physiotherapists, the concerns would in principle also apply to the agreements with psychologists and specialist doctors (*avtalespesialister*). The NCA proposed changes in the agreements that would alleviate the problems. In its reply the Ministry said that the financing system for the physiotherapists was in the process of being reconsidered, that the concerns of the NCA would be part of this assessment. The Ministry said that after this assessment it would come back to the issue with the NCA. This is still pending.

6. Public procurement

106. The Norwegian Complaints Board for Public Procurement's (KOFA), primary task is to safeguard that public bodies adhere to public procurement rules. The public sector in Norway procures goods and services for vast sums every year. The objective of the public procurement regulation is to ensure equal treatment for all suppliers. In a similar vein, the public procurement rules ensure that the procurement processes are transparent, predictable and can be effectively reviewed. Last, but not the least, the regulations are to ensure that effective competition is maintained in public procurement processes.

107. KOFA handles complaints of violation of the procurement rules. The board's secretariat is placed, administratively, under the Norwegian Competition Authority (NCA). A substantial number of the cases involve non-compliance with the procurement rules. Cases where public authorities have failed to announce publicly public procurements also feature prominently on the secretariat's activities.

108. Several of the cases KOFA has handled over the last years has involved the RHF's. Focusing on the period 2005-2007, KOFA assessed 28 complaints related to the procurement of specialist health care services by the RHF's or HF's. The services encompass somatic elective care, laboratory services, ambulance services, x-ray/radiotherapy and substance abuse treatment. In 19 of these cases, a violation of the procurement rules was concluded.

7. The role of competition policy and enforcement in health care

109. In Norway, the health care services are to a large extent publicly financed and publicly provided. The policy of the current government is that it will oppose the commercialization of key social welfare tasks such as health, care and education. Moreover, the Government Policy Declaration includes a commitment to community solutions and public control instead of compulsory competitive tendering in these important welfare fields. In the last budget proposition, it is stated that the government will take action to further the interaction between the public sector and non-profit organizations as providers of health and social services.

110. Nevertheless, different parts of the health care system is to varying degrees also operated by private for-profit as well as private not-for-profit (e.g. non-governmental organization). The health care system is in other words a structure that in the various parts of its interconnections has undertakings operating in a market, thus subject to competition law, or where various public measures in the health care system may have restrictive effects on competition. In addition, the various providers of health care services within the health care system also often rely upon a competitive bidding process to achieve better value for money. Competitive prices and/or better services and products are obviously desirable because it results in resources being saved or freed up for use on more health care, or better health care. The competitive process can contribute to this only when the companies genuinely compete.

111. Consequently, the health care system is a concern of the competition authorities. This follows from the tasks the NCA are obliged to take care of by law. The competition issues the NCA have dealt with related to the health care system illustrate the importance if these tasks.

112. This suggests that there are at least two important areas where competition policy and enforcement can contribute in relation to the health care system:

- Efficient borderlines for competition between public and private providers in the health care system

- Healthy competition in tenders for goods and services to the health care system by deterring collusion and abuse of dominance