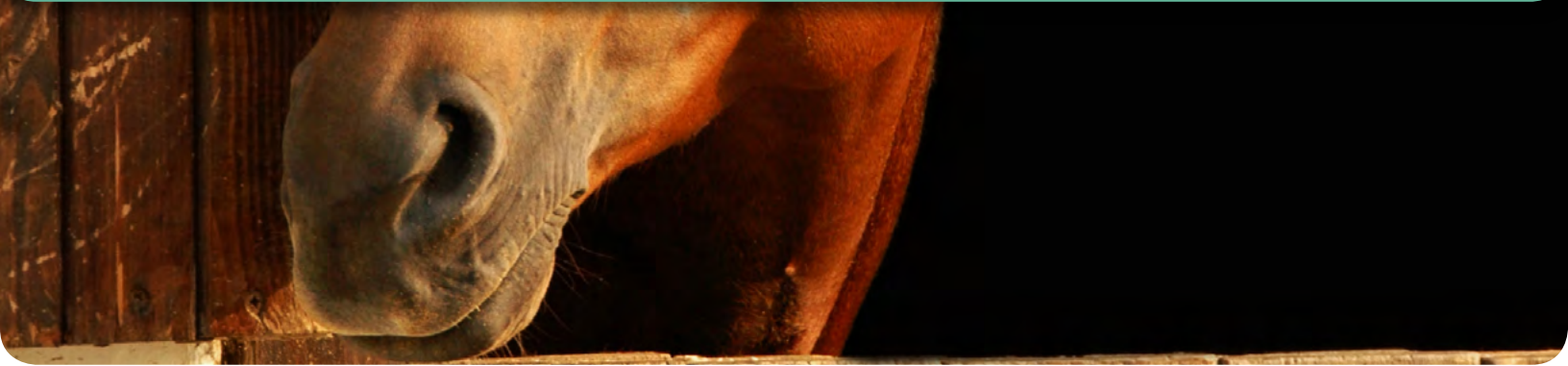


# HOSPITAL MERGER CONTROL IN THE NETHERLANDS: WAS THE BARN CLOSED IN TIME OR HAS THE HORSE ALREADY BOLTED?



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## I. INTRODUCTION

After decades of top-down health care rationing policies, the Netherlands has opted for a system of regulated (or managed) competition with wide-ranging reforms implemented since the mid-2000s to strengthen the role of market mechanisms. In 2006, introduction of the Health Insurance Act reinforced competition among health insurers by making competing private health insurers responsible for providing affordable mandatory health insurance for every Dutch citizen. With this reform, the government gave insurers more room to negotiate with health care providers about the price, volume and quality of care. Because of the market-oriented reforms, competition policy has become crucially important in Dutch health care. In this article, we discuss the track record of the Netherlands Authority for Consumers and Markets (“ACM”) in hospital merger control.<sup>3</sup>

## II. RELEVANT REGULATORY FRAMEWORK

In the Netherlands, the general rules of the Competition Act (“Mw”), introduced in 1998 and modelled after the competition rules in the EC Treaty and subsequent legislation, provide the relevant regulatory framework for competition policy. It includes a prohibition on cartels, a prohibition on the abuse of a dominant position and a preventive merger control regime. As an independent administrative body, ACM is responsible for applying the Mw in any market with competition, including all health care markets.

Under the Mw, mergers are subject to notification and prior approval by ACM. This requirement applies to all mergers between firms whose combined turnover has exceeded €113 million in the preceding calendar year, with at least €30 million realized in the Netherlands by at least two of the firms involved. For the health care industry lower thresholds apply (€55 million and €10 million respectively), because geographic markets for health care are typically small and competition is still

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<sup>3</sup> See also Schmid & Varkevisser (2016), Hospital merger control in Germany, the Netherlands and England: past experiences and future challenges, *Health Policy*, 120(1): 16-25 and Schut & Varkevisser (2017), Competition policy for health care provision in the Netherlands, *Health Policy*, 121(2): 126-133.

emerging and thus fragile.<sup>4</sup>

When hospitals notify ACM about their plan to merge, the competition authority starts a general review. If the merger is not likely to be anticompetitive, ACM directly clears the merger. Otherwise, it decides that a license is required. When the merging hospitals then apply for this license, a more substantial assessment of the proposed merger takes place. According to Section 41.2 of the Mw, ACM will eventually prohibit the merger “if, as a result of the proposed concentration, effective competition on the Dutch market or a part thereof would be appreciably impeded, specifically as a result of the creation or strengthening of a dominant economic position.” Based on supranational European guidelines, a dominant position is defined as “a position of one or more undertakings that enables them to prevent effective competition being maintained on the Dutch market or a part thereof, by giving them the power to behave to an appreciable extent independently of their competitors, their suppliers, their customers or end-users” (Mw, Section 1.i). When assessing the likely competitive effects of proposed hospital mergers, ACM takes into account the non-binding opinion of the Dutch Healthcare Authority (“NZA”).<sup>5</sup>

### III. WAS THE BARN CLOSED IN TIME...

From the start of preventive merger control in hospitals markets in 2004 until the summer of 2015,<sup>6</sup> ACM cleared all twenty-six merger cases after an initial or more substantial investigation. These decisions were frequently criticized for being too permissive. In some cases, ACM permitted hospital mergers on very questionable grounds and without a proper definition of the relevant geographic market. Most often the exact size of the geographical market was not defined at all. In those cases the competition authority argued that current patient flows were not indicative for patients’ willingness to travel in the future because quality differences across hospitals were expected to become more transparent. The approval of the merger between two hospitals in the city of Tilburg was a clear example of failing hospital merger control in the Netherlands.<sup>7</sup> ACM cleared this merger in November 2012 while based on patient flow data the post-merger market share was around 70 percent. The competition authority, however, based its decision on insurers’ speculative claims about patient willingness to travel and their future countervailing buyer power without properly examining their validity.

Things seem to have changed now. In recent years, the Dutch health insurers started expressing their concerns about the increased concentration in regional hospital markets. Following this change of opinion, in July 2015, ACM for the first time prohibited a proposed hospital merger. This merger involved two hospital groups – Albert Schweitzer Ziekenhuis (“ASz”) and Rivas Zorggroep (“Rivas”) – in the southwestern part of the Netherlands, near the cities of Dordrecht and Gorinchem. In contrast to previous cases, ACM now made a thorough analysis of the likely competitive effects, including in-depth analyses of patient travel times and research among the GPs who refer patients to the merging hospitals and their (potential) competitors. In its investigation, ACM concluded the following:<sup>8</sup>

- for both hospitals the relevant patient outflow<sup>9</sup> from their catchment area to other hospitals is 23 percent (inpatient care) and 27 percent (outpatient care) at most;
- the GPs located in the catchment area of ASz refer 80-90 percent of their patients to ASz;

<sup>4</sup> A third threshold is present to prevent these thresholds from applying to mergers involving firms whose health care services are only a small part of their business. This requires that, for at least two of the firms, revenues from health care services alone must exceed €5.5 million.

<sup>5</sup> Dutch hospitals also require formal permission from the NZa for their merger plans. This requirement, however, focuses on the merger process and the accessibility of some essential hospital services (24/7 emergency care) and does not involve an assessment of the likely competitive effects.

<sup>6</sup> Prior to 2004, the competition authority argued that the supply and price regulation at the time prevented hospitals from competing.

<sup>7</sup> Loozen, Varkevisser & Schut (2014), Dutch Authority for Consumers & Markets fails to meet the standard of proof in recent hospital merger decisions, *European Competition Law Review*, 35 (1), 17-23.

<sup>8</sup> ACM (2015), *Besluit in zaak 14.0982.24/Stichting Albert Schweitzer Ziekenhuis – Stichting Rivas Zorggroep*, ACM/DM/2015/203943\_OV, The Hague.

<sup>9</sup> That is, the patient outflow after taking into account the travelling of patients with specific complex care needs.

- the GPs located in the catchment area of Rivas refer 70-80 percent of their patients to Rivas;
- based on both current patient flows and the opinion of the GPs, ASz is the most important alternative for Rivas;
- the post-merger combined market share in the relevant geographic market equals 70-80 percent;<sup>10</sup>
- ASz and Rivas are important competitors according to patients' organizations as well as health insurers.

Based on the findings summarized above, ACM concluded that the merging hospitals were strong competitors. As a result, the competition authority argued, health insurers would have insufficient alternatives to negotiate good prices and quality with the merged hospital.<sup>11</sup> "This means that there is a potential risk that the merger hospitals would, for example, raise prices or reduce quality by investing less in innovation, customer-friendliness or hygiene. That would harm patients and the insured." The merging hospitals appealed against this decision stating that, among other things, ACM previously allowed other hospital mergers that resulted in similar or even higher combined market shares. In September 2016, the court ruled in favor of ACM. In its ruling, the court concluded that ACM based its merger prohibition on careful research. The judges therefore argued that ACM was correct when deeming this hospital merger anticompetitive. Finally, the court refuted the merging hospitals' argument that ACM was much more permissive in previous cases by accepting the explanation of enhanced insights. Most importantly, based on practical experiences, Dutch health insurers – as well as ACM – have become much less optimistic about their bargaining power when negotiating contracts with hospitals because (i) consumers are very reluctant to accept restricted hospital networks; (ii) courts have ruled that based on the current legislation, it is only allowed to limit the reimbursement of non-contracted care to such an extent that it is still affordable for patients to visit any provider they want.

The prohibition decision discussed above may mark the beginning of a more stringent approach to hospital mergers in the Netherlands. Additionally, the Dutch government has announced new measures to strengthen competition policy in health care. These measures include the transfer of regulatory tools from the Dutch Healthcare Authority to ACM. Additionally, the government funded the formation of a health care specific taskforce at ACM. The basic idea underlying these measures is that making ACM responsible for all competition policy in health care will help make it more effective.

## IV. ...OR HAS THE HORSE ALREADY BOLTED?

Due to the permissive hospital merger control that can be observed for more than a decade, the number of general hospitals has steadily declined from 90 in 2004 to 71 in 2016.<sup>12</sup> As a result, the average Dutch hospital has a market share of almost 60 percent in its catchment area.<sup>13</sup> Taking into account existing merger plans, local and regional hospital markets are likely to become even more concentrated. An important question is whether patients' willingness to travel – currently Dutch patients on average travel about twenty minutes for non-emergency hospital care – will increase in the future if quality differences across hospitals become more transparent. If not, insurers may have limited bargaining power *vis-à-vis* merged hospitals.

The jury is still out but preliminary empirical evidence from the Netherlands suggests that mergers may result in higher prices without improving quality of care. Kemp et al. have studied the price effects of six hospital mergers.<sup>14</sup> They investigated whether hospitals raised their prices for hip surgery after the merger. Additionally, they analyzed how patients reacted to higher prices. The results were mixed: for seven of the twelve hospitals a statistically significant price increase for hip surgery

<sup>10</sup> Because of confidentiality reasons the precise figure is not revealed.

<sup>11</sup> ACM (2015), *ACM prohibits proposed merger between two Dutch hospital groups*, press release July 15, 2015, The Hague.

<sup>12</sup> There are also eight university medical centers in the Netherlands, of which the two located in Amsterdam (AMC and VUmc) have now asked permission to merge.

<sup>13</sup> NZa (2017), *Marktscan medisch-specialistische zorg 2016*, Utrecht.

<sup>14</sup> Kemp, Kersten & Severijnen (2012), Price effects of Dutch hospital mergers: an ex-post assessment of hip surgery, *De Economist*, 160(3): 237-255.

was found.<sup>15</sup> A clear relationship between price changes of hip surgery and post-merger changes in travelling behavior of patients was not observed. In a more recent study, Roos et al. used a “difference-in-difference” model for comparing a merged hospital’s price changes to price changes at comparison hospitals.<sup>16</sup> This study found evidence of heterogeneous price effects across health insurers, hospital products and hospital locations. First, significant post-merger price increases were observed for hip replacements, but not for knee replacements and cataract surgery. Second, the merged hospital significantly raised its price for hip replacements at the more geographically isolated one of its two locations. Third, when disaggregating the post-merger price increase, it was found that the merger’s price effect varied between health insurers from -12 to 16 percentage points relative to the control group. In addition to the price effects presented above, ACM recently commissioned a study into the quality effects of fourteen hospital mergers in the period of 2007-2013.<sup>17</sup> Using almost a hundred quality indicators, the study compared the development of the quality of merged hospitals and non-merged hospitals. It was found that hospital mergers do not demonstrably improve health care quality.<sup>18</sup>

## V. CONCLUSION

Due to horizontal consolidation, hospital markets in the Netherlands have become highly concentrated. It is doubtful whether insurers have sufficient countervailing buyer power to prevent hospitals from charging too high prices and to effectively encourage them to improve quality. The future will tell whether ACM has seriously erred in clearing all but one hospital mergers since 2004. The ongoing hospital consolidation, however, has at least put the potential for effective insurer-hospital negotiations about quality and price at risk. While the first prohibition of a hospital merger in the summer of 2015 definitely was a step in the right direction, it may turn out that the barn was closed after the horse has bolted. This is particularly worrying since once markets have consolidated it is extremely difficult, if not impossible, to restructure these markets to prevent the abuse of market power. By being very permissive in the past, the competition authority has not only complicated hospital competition in the present but also restricted the scope for effective hospital competition in the future.

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<sup>15</sup> For three hospitals a significant price decrease was found.

<sup>16</sup> Roos, Croes, Shestalova, Varkevisser & Schut (2017), *Price effects of a hospital merger: heterogeneity across health insurers, hospital products and hospital locations*, iBMG Working Paper, Erasmus University Rotterdam.

<sup>17</sup> ACM (2016), *ACM: hospital mergers do not demonstrably improve health care quality*, press release September 7, 2016, The Hague.

<sup>18</sup> ACM is currently also studying the price effects of hospital mergers. The results of this study are expected to be released later this year.