Health Policy 120 (2016) 16–25

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Review

Hospital merger control in Germany, the Netherlands and England: Experiences and challenges

Andreas Schmid [a], Marco Varkevisser [b,*]

[a] Health Management (MiG), University of Bayreuth, Germany
[b] Institute of Health Policy & Management (iBMG), Erasmus University Rotterdam, The Netherlands

ARTICLE INFO

Article history:
Received 28 July 2015
Received in revised form 30 October 2015
Accepted 2 November 2015

Keywords:
Hospital mergers
Competition policy
International comparison

ABSTRACT

Aiming at the efficiency enhancing and quality improving effects of competition, various steps have been undertaken to foster competition in hospital markets. For these mechanisms to work, robust competition policy needs to be enacted and enforced. We compare the hospital markets in Germany, the Netherlands and England regarding their experience with competition and put a special focus on merger control and the stringency of its implementation. Elaborating on the differences in merger control practice we find that despite very similar goals the respective agencies apply very different approaches and take fundamentally different routes when balancing proclaimed benefits of mergers with potential risks of consolidated markets. While the German competition authority has a strong focus on maintaining the preconditions for competition, in the Netherlands we find over the past decade a much stronger focus on hypothesized countervailing buyer power, accepting in turn highly concentrated markets. In England we find the currently most comprehensive analysis of proposed mergers in combination with a clearly positive assessment of the effects of patient choice and competition on prices and quality. All agencies are still reluctant to implement merger simulation models or similarly advanced econometric methods in their appraisal. One very likely reason is a lack of country specific empirical evidence on these matters.

1. Introduction

A growing number of countries have introduced or strengthened competition among health care providers, including hospitals, to improve the functioning of their health care systems. For hospital competition to be successful, the existence of a sufficient number of alternative hospitals for patients and payers to choose from is required. The empirical literature clearly shows that mergers between rivals in concentrated markets are likely to increase prices. The results for the effect on quality seem to depend on the price setting mechanism. In markets where prices are set by hospitals the empirical evidence is mixed, but competition between hospitals operating in markets with regulated prices has generally been found to have a positive effect on quality [1]. It is therefore argued that when the market mechanism is used for maximizing the public healthcare interests competition enforcement should be strict [2]. In the final opinion of the Expert Panel on effective ways of investing in Health (EXPH), it is recently concluded that the introduction of competition between providers of health care requires, among other conditions, the enforcement of competition rules to prevent the creation, strengthening and abuse of dominant

* Corresponding author.
E-mail address: varkevisser@bmg.eur.nl (M. Varkevisser).

http://dx.doi.org/10.1016/j.healthpol.2015.11.002
0168-8510/

positions [3]. However, hospital mergers may also benefit patients. For example, there is some evidence that reaching certain volume thresholds improves quality for specific complex hospital services [4]. Overall, the relevant question from the patient's perspective is whether the benefits of hospital consolidation outweigh the negative effects caused by reduced market competition.

Using a semi-structured narrative approach, this paper compares and discusses the experiences with and challenges for hospital merger control in three countries with competition among hospitals: Germany, the Netherlands, and England. In our country comparison, the focus is first on institutional differences related to hospital competition. This is the basis for the subsequent description of the respective approaches used for ex ante hospital merger control, as well as the comparative discussion of results achieved and challenges faced by the competition authorities. Table 1 provides some relevant key indicators for the three countries (i.e. including the United Kingdom rather than England because of the OECD statistics used here), highlighting already some of the structural differences and similarities.

Each of the countries included in the paper has experienced consolidation of the hospital industry. In Germany, in addition to a more "pro-market" attitude in health politics, hospital merger activity is predominantly fuelled by payment reforms and shrinking financial resources of municipalities owning public hospitals. The impact of those mergers on the hospital market structure is twofold [5]. First, the formation of multi-site hospital systems on a local level. Second, on a supra-regional level hospital chains arise that are active in various local hospital markets across the country. Consolidation in England has also been driven by financial pressure. However, whether a hospital is merged or not depends not just on (financial) performance but also on national politics related to the National Health Service (NHS). That is, to avoid unpopular closures merger activity between geographically co-located hospitals may also be initiated by the government [6]. In the Netherlands, the most important merger motives for hospitals – as well as other providers of health care – are quality improvements associated with the use of minimum volume thresholds for complex procedures and increased bargaining clout vis-à-vis payers followed by financial and efficiency considerations [7].

2. Hospital competition

2.1. Germany

Over the past 15 years, encouraged by official advisory bodies such as the German Advisory Council on the Assessment of Developments in the Health Care System [8–10] and the Monopoly Commission [11], policy makers have fostered the role of competition in the German hospital sector in multiple ways. For example by increasing transparency through mandatory quality reporting and allowing for some degree of selective contracting between sickness funds and providers. In this context, competition is always intended to achieve higher levels of efficiency and to increase quality of care [12]. The greatest impact on the cost side came from the introduction of the reimbursement system based on Diagnosis Related Groups (DRG) in 2003/4, which forced providers into cost oriented yardstick competition as the case-based lump sum payment is related to the average costs across hospitals. Acute care hospitals are now reimbursed on a case basis and the regulated price is calculated as an average of costs across a sample of hospitals. Cost structures have become significantly more transparent and large numbers of hospitals faced severe financial challenges. A relatively small number of hospitals went out of business and there were a considerable number of mergers, many of which were aimed at keeping all existing hospital sites open. This is partly due to political pressure especially at the local and state level, where (public) hospitals are considered to be important factors for the local economy (e.g. because they are important employers) [13,14].

There is considerable heterogeneity in the degree of hospital market concentration across the 16 German states [15]. Reasons for this heterogeneity include differences in geographic settlement structures, the states' different influence in hospital planning and the structural legacy differences between former East and West Germany. The average catchment area ranges from 108 km^2 in North Rhine-Westphalia over 224 km^2 in Bavaria to 703 km^2 in Mecklenburg–Vorpommern – the latter two states both having large rural areas. While an average hospital in Bavaria serves just about 40,000 people, other states have larger institutions that serve – as in Saxony – up to 55,000 people on average [16]. Generally speaking, there is excess capacity in metropolitan areas while it is challenging to ensure adequate access to care for patients in rural areas [16]. By 2007 about 40% of German hospitals operated in concentrated or highly concentrated regional hospital markets, with a Herfindahl–Hirschman-Index (HHI) of 0.18 or higher. Concentration is generally higher in rural states, but some more urban areas also have highly concentrated markets [14]. There is even more variation when concentration is analyzed for different procedures; i.e. in disaggregated product markets. While the average HHI for selected elective surgical procedures (e.g. hip or knee replacement) is as low as 0.19, markets for pneumonia or maternity units have an average HHI of more than 0.3 [5].

While the cost oriented incentives of the yardstick based DRG system are extremely strong, the quality component is still trailing behind. Considerable efforts have been undertaken to foster quality based competition, e.g. by the aforementioned mandatory quality reporting of hospitals and an increasing number of websites that provide quality related information. However, according to a recent study by Emmert et al., despite an overall positive trend, only about a third of their respondents were aware that such information existed in the first place [17].

Despite the low awareness of quality indicators, the role of patients is crucial as at the individual provider level increased patient volume leads to higher revenues in the long run. Physicians, including both general practitioners and independent medical specialists, are advised to include the two nearest suitable hospitals in their referral (§§ 39(2), 73(4) SGB V). If patients do not choose a hospital recommended in the referral they could be charged any