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Hospital mergers and the public interest: recent developments in The Netherlands

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Abstract

This paper examines the recent experience concerning hospital mergers in The Netherlands. A topic that is likely to be of broader relevance as healthcare reform in The Netherlands is relatively advanced. In particular we look at issues concerning market definition, vertical integration and the efficiency defense. The findings are that there appears to be a case for stricter, possibly sector specific, forms of merger control in a liberalisation context. Also there is a need for flanking measures – such as facilitating market entry. Finally public interest standards in healthcare such as quality, affordability and accessibility should be developed further to enable them to play a more meaningful role in merger control.

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Introduction

Healthcare mergers generally, and hospital mergers in particular, tend to give rise to political debate. They are politically salient because consumers see them as a threat to the "human scale" of care (trusted providers at the bedside). Economists meanwhile are weary of the consequences of market power. In the US, following a series of misadventures by the antitrust authorities, hospital mergers are also the subject of academic debate as economists strain to develop new methods especially for geographic market definition.¹ In this contribution we will discuss the Dutch experience. We believe this to be as illustrative as that of the US because the Netherlands has one of the most liberal healthcare systems in Europe where both hospitals and health insurers are private and exposed to competition. Hence the Dutch experience may presage what is to come elsewhere in the EU.

We address three issues that are significant for hospital mergers:

- geographical market definition
- the efficiency defence
- vertical integration between health insurers and hospitals

In addition we will sketch the Dutch policy context, especially the role played by the general Competition Authority (NMa) and two sector-specific authorities: the Inspectorate for healthcare (IGZ), which is responsible for (minimum) quality, and the Dutch Healthcare Authority (NZA) the sector-specific regulator for healthcare charged with promoting the consumer interest (in particular accessibility, affordability and quality). The latter two bodies play an advisory role in relation to the Competition Authority in merger cases.

We will identify possible solutions both to the technical problems relating to market definition efficiency, quality and vertical integration as well as to the institutional problems involved.

Background

Health Insurance

The Dutch healthcare system was reformed in 2006.² The basis of the new system is formed by competition between private health insurers who operate within a framework of public service obligations, notably standard coverage and universal service requirements and prohibitions on premium differentiation and risk selection. Healthcare insurance is both universal and mandatory. Around 50% of health insurance funding is based on insurance premiums paid directly by consumers and 50% on income related pay deductions distributed pro rata among the insurers. The insurers are compensated for above average ex-ante risk profiles of their insured population by means of a system of risk equalisation.³ There are currently around twenty such insurers, of which the largest four have a significant market share (jointly almost 90%).

Hospital care

Like health insurance, hospital care is provided by private undertakings in The Netherlands – although there are rules restricting the distribution of dividends. Today there are around 100 independent hospitals in The Netherlands. Traditionally hospital financing was budget-based and subject to strict price controls. At present efforts are made to introduce performance based pricing, and at the same time an increasing percentage of treatments is being liberalised. The liberalised area is now at around 35% (the objective of the current government is 50%). In the liberalised area an increasing number of smaller specialised treatment centres has emerged, initially typically focussing on high volume and low risk treatments such as cataract and knee surgery.

Regulatory supervision

Several regulators are active in healthcare in The Netherlands. The first is the Competition Authority, which is formally responsible for deciding merger cases. The sector specific Health Authority is competent e.g. with respect to dominance based significant market power (SMP)

¹ Improving Healthcare: A Dose of Competition. Report by the Federal Trade Commission and the Department of Justice, July 2004. http://www.usdoj.gov/atr/public/health_care/204694.htm

² See: Dutch Ministry of Health, The new care system in The Netherlands: durability, solidarity, choice, quality, efficiency, May 2006 <http://www.minvws.nl/en/folders/z/2006/the-new-health-insurance-system-in-three-languages.asp>; Dutch Health Authority, Contribution to EU consultation on cross-border health services, October 2006 http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/health_services_co201_nl.pdf

³ A similar system in Ireland was examined in detail in a state aid context in Case T-289/03 *British United Provident Association Ltd (BUPA) et al. v Commission (BUPA)* [2008] ECR II-81

cases, but in merger cases only provides advice to the Competition Authority, focusing on the effects on consumers in terms of affordability, quality and accessibility. The Health Inspectorate provides the Health Authority with advice on quality-related issues in mergers, notably with regard to minimum quality. The Health Authority incorporates this advice in the opinion that it renders to the Competition Authority.

Context

Liberalisation of Dutch hospital markets was a key aspect of the 2006 Healthcare reform. The reform was designed to counter widespread public dissatisfaction with the combination of lengthening waiting lists and spiralling costs that characterised the supply based and densely regulated preceding system. For competition among hospitals to succeed it is important that new forms of financing and ownership are enabled, as well as new forms of cooperation, mergers and takeovers.

However inappropriate outcomes from the present system of merger control appear to jeopardise this process. Until 2004 the Competition Authority held the view that the existing scope for competition was marginal and therefore no scrutiny was required – refusing, in effect to anticipate the regime change. Predictably many hospitals took advantage of this regulatory holiday. Since 2004 failed mergers and/or merges that were approved when they should have been blocked have threatened public and political support for competition in the hospital sector. Dominant positions that result after a merger can frustrate competition on a lasting basis. Yet so far each and every healthcare merger that was examined by the Competition Authority (i.e. over 100, of which nine hospital mergers) has been cleared.⁴ This article sets out some of the concerns raised by this worrying trend.

Liberalisation

Healthcare liberalisation is based on the expectation that competition will contribute to the public values of affordability, quality and accessibility. This is the reason why the Health Authority was provided with regulatory tools that aim to increase or promote competition – as opposed to merely protecting existing competition, which is the task of the Competition Authority. Examples are powers relating to transparency and accounting methods, intervening in the conditions of agreements and in the manner in which such agreements come about as well as imposing remedies on parties that enjoy significant market power (SMP), ranging from imposing transparency to imposing cost-based individual price regulation. However the problem is that in spite of these regulatory powers mergers can frustrate the liberalisation process.

This problem is first of all caused by the difference between promoting competition and merger control. The Competition Authority can only block a merger if it “appreciably impedes competition” in particular as the result of the creation or strengthening of a dominant position, which is a very different standard from “promoting competition”.⁵ The result is that mergers can be allowed which reduce (the scope for) competition while the opposite is desirable.

One possible solution could be imposing (behavioural) SMP remedies to address specific problems caused by the merged entity. However because SMP is based on dominance this will be difficult to do in the wake of a merger case where the Competition Authority has just concluded that dominance was not created or strengthened. Moreover prevention is the best cure. Liberalisation was not undertaken to reintroduce detailed regulation at the level of individual firms. Instead, structural problems require structural solutions – such as selling off parts of a dominant undertaking – which are not part of the current set of SMP remedies.

A second reason for the “red carpet” for hospital mergers lies in the difficulty for the Competition Authority to decide cases in transition markets. This is because the burden of proof demanded in court is difficult to meet in such cases, while the balance between the parties and the Competition Authority is also different in healthcare mergers than it generally is in the context of merger control: there is much less time pressure on hospitals as they are generally not subject to the demands of shareholders and external financing, which generally introduce strict time constraints. Moreover accountability and external and internal governance

⁴ Apparently in two of nine hospital cases since 2004 the parties withdrew, possibly due to the objections raised by the Competition Authority. One of these cases – concerning the Zeeuwse Ziekenhuizen, as discussed here – however led to a new and successful application.

⁵ See Articles 37(2) and 41(2) of the (Dutch) Competition Act (as revised in 2007) available in English at http://www.nmanet.nl/Images/Mededingingswet%20-%20geredigeerd_tcm16-125901.pdf

in healthcare tend to be weak, which limits the checks and balances to which the merging parties are subject.

Undoing mergers once they have been cleared and implemented is all but impossible: "you can't unscramble an omelette". Interested third parties do not dispose of the information necessary to successfully contest a merger decision and judges are not keen to experiment with such cases. Consequently there really is no judicial review of decisions to clear mergers (although perhaps sometimes of conditions imposed), or even of decisions that no clearance is necessary.

This general problem is exacerbated by the policy context. Blocking a merger is far more risky (in terms of successful appeals by the parties) for the Competition Authority: hence there is a bonus on approving them. After falling into each other's arms weak merged entities often keel over altogether and end up in dire financial straits. Because the current political climate makes it very difficult to allow hospitals to fail and close down (who would dare do so while banks are bailed out on a fantastic scale), the result is a call for state aid – with further negative consequences for performance, competitive conditions and market structure.

Market definition

The first important step in merger control is evidently defining the relevant geographical and product market. In a relevant market thus defined the creation or strengthening of dominance is tested. However there are some general methodological problems with defining the relevant market for hospital mergers.⁶ Moreover, the Competition Authority does not always use all available tools – for example the German Bundeskartellamt appears to apply a more detailed analysis.⁷ In some cases the Competition Authority did not even define the market at all even though a market definition was called for.

As a result of this methodological muddle and the limited approach of the Competition Authority doubts remain concerning the relevant market. Because the Competition Authority bears the burden of proof, the result is that the merging parties are often given the benefit of the doubt. This too promotes merger approval. According to our own analysis at least three out of the past nine hospital merger cases in The Netherlands were cleared for this reason. If continued this trend can lead to the clearance of further mergers that are not in the general interest.

A case that illustrates this point is the merger of the Gooische hospitals.⁸ Two hospitals that were close substitutes (in terms of services provided, proximity and number of beds) in the centrally located region "Het Gooi" wanted to merge. What happened next was predictable. Both the Competition Authority and the involved parties hired consultants to delineate the relevant market. Unsurprisingly the various consultants used a variety of methods (the Elzinga-Hogarty test based on actual patient flows, and alternatives based on willingness to travel). Equally unsurprisingly, these methods yielded different results. A method based on stated preference data yielded a large relevant market, while revealed preferences pointed at a small relevant market. In such cases the NMA is afraid that judges will give the merging parties the benefit of the doubt, leading to a bias towards large relevant markets. Such a bias is quasi automatic since there can always be doubt about the relevant market, in particular in a densely populated country like the Netherlands.

Nevertheless the Competition Authority and the Healthcare Authority have jointly invested in developing new quantitative methods of market definition (variations on time-elasticity, competitor share and option demand).⁹ In future it might be expected that the discussion on methods will yield less controversy and hopefully more robust results.

Limited returns to scale

⁶ M. Varkevisser, C.S. Capps, en F.T. Schut, "Defining hospital markets for antitrust enforcement: new approaches and their applicability to The Netherlands", (2008) *Health Economics Policy and Law* 7-29.

⁷ T. Lübbig and M. Klasse, *Kartellrecht im Pharma- und Gesundheitssektor* (Baden-Baden, 2007).

⁸ Case no 3897, Hospital Hilversum-Hospital Gooi Noord, Decision of 8 June 2005. Available in English at <http://www.nmanet.nl/engels/home/Index.asp>.

⁹ For a description see above, note 6, and M. Varkevisser, S.A. van der Geest and F.T. Schut (2009, forthcoming), "Assessing hospital competition when prices don't matter to patients: the use of time-elasticities", *International Journal of Health Care Finance and Economics*.

Dutch hospitals are relatively large compared to hospitals in other developed countries. The literature suggests that in The Netherlands the efficient scale for hospitals is generally exceeded. Above two hundred to three hundred beds there are no more positive returns to scale and instead negative returns to scale may dominate. The average scale of Dutch hospitals is far above this level (and well above the average EU level) at almost five hundred beds.¹⁰

This observation is sometimes countered with the argument that the highly developed system of primary care in The Netherlands has generated the emergence of more specialised hospitals that may still be associated with increased returns to scale. The absence of well-organised primary care could lead to a greater degree of decentralisation, such that care that would classify as primary care in The Netherlands is performed by hospitals elsewhere. This thesis has not yet been proven or fully researched. However experience so far suggests increasing scale – including as the result of mergers – does not lead to better performance. Moreover, in the light of liberalisation and specialisation, it is likely that hospitals in the future will be more limited in their focus.

Finally, the effects of scale are not unambiguous in relation to the three public interests that define the consumer interest for the Health Authority, i.e. quality, affordability and accessibility. Especially efforts to promote quality appear to favour increased scale. The literature shows that at least in the case of complex surgical treatment increasing the number of times a treatment is performed by a consultant or surgical team can improve quality.¹¹ In this case concentration is in fact a means of promoting more specialisation, or sub-specialisation in relation to the efficient scale for a quality perspective per consultant (which is likely to differ from that for the hospital as a whole). Concentration can also play a role in relation to promoting continuity (e.g. 24/7 availability of services), which is a dimension of accessibility, even while another dimension of accessibility – such as travelling distance – may decline by the same measure.

Because the effects of increasing scale in relation to the three public interests are not unequivocal and are likely to differ per specialisation it is a legitimate question whether a hospital merger is the appropriate means to achieve the relevant returns to scale. Instead other forms of cooperation that involve fewer market distortions may be more targeted and therefore preferable.¹²

The public interest dimension

The absence of a clear legal basis

Healthcare (like the media and the financial sector) appears to be characterised by public interests that are not easily caught by the competition policy framework. These public interests, accessibility, affordability and quality, are anchored in legislation in relation to the Health Authority but do not bind the Competition Authority. This gives rise to a risk that they may be invoked selectively, e.g. in response to political pressure, but not as a part of an objective framework of analysis. This risk is clearly illustrated by the 2009 *Zeeuwse Hospitals Case* discussed below.

Measurement and SGEI

The consumer surplus that is generally agreed must be promoted by competition policy means that consumers obtain the best possible price/quality ratio. In principle it is possible to interpret affordability simply as price, and accessibility and quality of care as two different dimensions of quality. This makes it possible to account for the three different dimensions of healthcare in a competition policy context. However this approach involves several complications.

Firstly, it is not yet possible to measure and compare the different aspects of quality accurately. How does one compare a decrease in accessibility with an improvement in quality of care? Even if this could be expressed in quality adjusted life years (QALYs)¹³ political

¹⁰ The Dutch average is 478 beds, figures for Sweden are 256 beds, for Germany 243 beds and for France 145 beds. Cf. OECD Health data 2008.

¹¹ Cf. E.A. Halm, C. Lee en M.R. Chassin, "Is volume related to outcome in health care? A systematic review and methodological critique of the literature", (2002) *Annals of Internal Medicine* 511-552.

¹² See also P. Bogetoft and K. Katona, *Efficiency gains from mergers in the healthcare sector*, NZa Research Paper No. 10 (2008).

¹³ Cf. D. Dranove, *What's your life worth? Health care rationing... Who lives? Who dies? And Who decides?* (FT Prentice Hall, New Saddle River NJ 2003).

preferences play a role in weighing such variables: this is not a job for a competition authority. And as long as the different variables cannot be measured and compared, outcomes are uncertain and to a certain extent arbitrary. Hence the challenge is to make the three public interest dimensions comparable and measurable.

It is also necessary to make transparent reference frameworks of the authorities involved so it is clear which standards are applied in a merger procedure.. As far as the Competition Authority is concerned the process is currently well-defined in the Competition Act, but the involvement of the Healthcare Authority and the Inspectorate is based on more non-binding inter-institutional agreements and protocols. Once it is clear who is in charge of which aspects of merger control and what standards are being applied by whom, trade-offs between different objectives may become more transparent.

Secondly, fuzzy notions are often introduced, like "systemic hospitals", which played a role recently in a state aid context in the 2009 *IJsselmeer Hospitals Case*.¹⁴ What is missing is a clear definition of public services: what is the minimum set of hospital services that must be universally available, who is responsible for this and how are they to be paid for? On a smaller scale the same issue arises with regard to emergency care.

In order to create a system that is sound from the perspective of EU law – which is not an unimportant consideration in the Dutch context where hospitals are private undertakings and hence state aid issues arise – it is recommended that services of general economic interest (SGEI) are defined.¹⁵ Defining the public service clearly (with only proportional restrictions of competition) requires a process of rationalisation that will no longer allow "public interests" to be invoked at will in order to justify political interference. An interesting consequence could be that introducing SGEI might lead to fewer mergers (instead of more, as anticipated by the Dutch Competition Act): guaranteeing continuity of care will no longer be synonymous with keeping afloat a failing hospital but can then be approached on a functional basis. Instead the least restrictive means will have to be chosen, such as financing continuity of emergency care, possibly supplied outside the context of the failing hospital as a whole. Finally exceptions for SGEIs are already provided as a matter of national law in the Competition Act.

Mergers in practice

Vertical mergers

The appearance of vertical mergers between entities at different levels of the supply chain is also part of a lively public debate in the Netherlands. A first example outside the hospital sector, the *Evean Case*, involving a merger between a housing corporation and a provider of long term intramural care, gave rise to the first dissenting opinion by the Healthcare Authority (and after Parliamentary protests following its clearance by the Competition Authority was ultimately blocked by the Minister for Housing under specific legislation).¹⁶ Another example is provided by the recently cleared takeover by the Hospital of the University of Amsterdam of all ambulance services in that city. Against the objections raised by the Healthcare Authority the Competition Authority held that there would be no appreciable effects on competition (a question of market definition), and that abuse of market power was controlled by (current and future) protocols that govern ambulance services.¹⁷

Meanwhile in the ongoing *Vlietland Case* the first vertical hospital merger involving not only a health insurance company but also a network of general practitioners has emerged.¹⁸ On the one hand vertical mergers are less problematic than mergers between direct competitors because it is often unclear whether there are competition concerns and because generally there are efficiency gains (e.g. due to the elimination of double marginalisation).¹⁹

¹⁴ Logically systemic hospitals do not exist in the same way that systemic banks do. In the former case there are no cross-holdings and supply of liquidity, nor is the hospital system fundamentally based on trust to a comparable degree that banks are. Hence the failure of a competing hospital first of all means more business, not a threat.

¹⁵ Cf. W. Sauter, "Services of general economic interest and universal service in EU law", (2008) *European Law Review* 167.

¹⁶ Case 6141, *Evean – Philadelphia – Woonzorg Nederland*, Decision of 1 April 2008. Available only in Dutch at <http://www.nmanet.nl/nederlands/home/index.asp>.

¹⁷ Case 6704 AMC-VZA, Decision of 24 July 2009 with English language press release. An English language version of the Decision will be made available at <http://www.nmanet.nl/engels/home/Index.asp>.

¹⁸ Case 6669, *Coöperatie Vlietland – Vlietland Zieken huis*, notified on May 6th 2009.

¹⁹ M.J. Bijlsma, A.G. Meijer en V. Shestalova, *Vertical relationships between health insurers and healthcare providers*, CPB Document 167, augustus 2008.

Coordination problems can also be reduced. On the other hand a strong position in the hospital market can lead to a risk of exclusion of other health insurers, and/or other hospitals. This risk is all the greater as in this particular case not only the largest health insurer in the region is involved (an issue likely to arise elsewhere too given high regional concentration ratios of health insurers generally) but also most of the general practitioners in the region (who are responsible for crucial referral decisions). Finally apart from access- and discrimination issues questions arise with respect to the confidentiality of patient and treatment data.

It is at present not clear whether the Vlietland hospital will manage to merge and/or to obtain aid or whether it will collapse financially instead. It general is likely that vertical mergers between hospitals and insurers will arise more frequently as more and more hospitals run into financial difficulties. Instead of being forced to bankroll aid awarded by the Healthcare Authority (which is the current practice now under review, although subsequently insurers are compensated from the health insurance fund) insurers may prefer to take an equity stake in key hospitals, which provides them with at least some control over the way the funding provided is spent.

Meanwhile political concerns that insurance companies would use vertical relations to frustrate competition on the insurance market led the Dutch Minister to install an independent expert Committee. The Committee's task was to analyze the possibilities for abusive behaviour by insurers in vertical relationships. It concluded that there was a priori no reason to believe insurers would abuse their vertical relationships, and that in case they did, sufficient instruments were available (as a matter of sector specific and general competition law) to counter such behaviour. Having discussed market definition and verticals in the context of hospital mergers, we will now look at the efficiency defence.

Mergers and efficiency defence: the Zeeland Hospitals case

This case between the only two general hospitals in central Zeeland, located on a peninsula between Antwerp and Rotterdam that is isolated from major population centres and hospital facilities (by Dutch standards), turned into an authentic merger saga. It took over three years between the first notification in September 2005 (which was withdrawn after the Competition Authority decided a formal second phase clearance would be required) and the final second phase decision (following a second notification) which cleared the merger subject to a number of conditions in March 2009.²⁰ The case was subject to extensive lobbying efforts, while the Healthcare Authority submitted four opinions and the Inspectorate submitted two. Eventually it was the argument of improved quality that turned out to be decisive in the context of an efficiency defence.

There was a nearly complete overlap between the offerings of the two merging parties with 345 and 365 beds respectively, except for a top-clinical treatment facility for AIDS/HIV in cooperation with the medical centre of the University of Rotterdam operated by one of them. As such this was a horizontal merger between the two nearest rivals: a travelling time analysis showed that the merging hospitals were first and second choice for over 75% of consumers. (The nearest general hospital was at 45 minutes travelling distance and the next nearest hospitals at between an hour and 90 minutes.) The product market in this case was defined as the markets for clinical general hospital care respectively for non-clinical general hospital care. The geographical market, based on an analysis of travelling time and consumer flows was defined as central Zeeland. In the case as it was finally decided the market definition was not contested.

The merger would create a near-monopolist with 84% of the market for clinical general hospital care and 88% of the market for non-clinical general hospital care. There were no alternative providers within the relevant market nor was there any threat of market entry. Moreover health insurers could not exert countervailing market power given their obligation to contract adequate levels of care and the lack of alternatives in the region. Hence it was clear that the merger would significantly impede effective competition, in particular as a result of the creation or strengthening of a dominant position.

²⁰ Case 6524, Walcheren Hospital – Oosterschelde Hospitals, Decision of 25 March 2009. Available in English at <http://www.nmanet.nl/engels/home/Index.asp>.

The hospitals raised an efficiency defence, claiming that individually their departments were too small to ensure 24/7 continuity of care (especially in paediatrics and gynaecology); that they were attracting too few cases to allow for sub-specialisation, or create a first aid treatment centre and an intensive care unit at higher levels that (according to the merging parties) were required given their regional function. As a result, they claimed, they were underperforming which could lead to a downward spiral where it would become impossible to attract consultants and consultants already present would desert the hospital, with a danger that intensive care as well as mother and child care would be closed down and disappear from the region. A merger on the other hand would lead to the needed quality improvements (as well as the cost efficiencies and enhanced leadership more generally claimed in mergers).

The relevance of this plea was underlined as it was supported by the Inspectorate. In fact the Inspectorate claimed that the downward spiral could lead to the disappearance of general hospital care from central Zeeland altogether and that only a complete merger between the two parties could save the day.

The Healthcare Authority on the other hand was much more sceptical and claimed that this monopoly merger would potentially have serious consequences for affordability, accessibility and quality (in the sense of price to quality ratio). Because it was required to follow the Inspectorate on quality issues, the Authority insisted that if the merger was to be cleared to safeguard minimum quality it should at least be subject to a complex of both structural and behavioural remedies.

The Competition Authority held, in the first place, that the conditions for a successful efficiency defence had not been met.²¹ It felt that it was not plausible that the benefits claimed would accrue to consumers and that they could not be verified. Crucially, the Competition Authority did however accept – on the authority of the Inspectorate – that the improvements were merger specific. It next solved the case as follows: the remedies would ensure that the conditions for the efficiency defence could be met after all, allowing clearance of the monopoly merger. Thus it:

- imposed a price cap (based on the national average) for the competitive sector,
- required commitments with relation to the quality improvements that had been claimed (e.g. the next level intensive care and first aid units),
- and demanded opening up of the collective agreement between the hospitals and their consultants enabling the latter to set up shop in competition with the merged entity.

All three of these remedies are of course behavioural. Structural remedies were not considered because they were considered too complicated to put in place. This contradicts the general rule among Competition Authorities in the EU that where possible structural remedies are preferred and potentially sets a precedent, because if structural remedies are not indicated as the remedy of first resort in a monopoly merger, when would they be?²² Nevertheless, the use by the Competition Authority of behavioural remedies to enable a successful efficiency defence work shows remarkable creativity.

This case also raises questions relating to the cooperation between the various authorities and especially to the role of the Inspectorate whose quality arguments seem to have dominated this case. Often however the quality standards used were not met by up to 50% of existing Dutch hospitals and usually they only repeated input measures favoured by professional organisations (e.g. a clinic should have no fewer than five full-time gynaecologists). Of broader relevance is the issue how to weigh claims of increased quality in an efficiency context.

Mergers and aid

Finally there is a somewhat perverse link between mergers and state aid. Several healthcare conglomerates created by unchecked mergers are teetering on the edge of bankruptcy. One of the hospitals involved in the *Zeeuwse Hospitals Case* is already being tagged as the weakest in financial terms in The Netherlands. The *Vlietland* hospital with vertical merger ambitions is on

²¹ Commission Guidelines on the assessment of horizontal mergers under the Council Regulation on the control of concentrations between undertakings, OJ 2004 C31/5 Paras 76-88.

²² Commission Notice on remedies acceptable under the Council Regulation (EC) No 139/2004 and under Commission Regulation (EC) No 802/2004, OJ 2008, C267/1, Para 17.

the brink of collapse. The *IJsselmeer* Hospitals, mentioned above, and likewise created by merger, required many millions in state aid to remain afloat. At present the framework for awarding aid in the healthcare sector is sketchy. In particular it is unclear what public interest in being served with aid, because in The Netherlands there are no explicit continuity requirements.²³ Because of the absence of such standards it is understandable that as an alternative it has become politically unacceptable for hospitals to be shut down or even particular hospital locations.

The *IJsselmeer* Hospitals Case shows that state aid might harm competing neighbouring hospitals that had been prepared to step up their services to meet the increase in demand. This is all the more harmful because a takeover in the event of a (threat of) bankruptcy is one of the few practical ways of entering the hospital market in The Netherlands. This leads to the following potential perverse effect: badly designed mergers and failing executives trigger state aid that is granted in the name of public interests without any coherent attempt at actually guaranteeing the latter based on a clear standard.

At the same time there is a self-fulfilling prophecy at work here: it is clear that if all mergers continue to be cleared eventually hospitals will be created at a scale that really would lead to serious problems of continuity and accessibility of care if they were to keel over or disappear. In this scenario there will not be any competitors left, or they will not be in a position to meet the additional demand for care. In this context "too big to fail means too big to exist".²⁴ This risk too should be examined in the context of merger control.

This point has been acknowledged by the Ministry of Health Care. Some recent steps have been undertaken to try to define continuity of health care and to determine conditions for state aid in this context. Also there are public statements that the *Vlietland* Hospital mentioned above will not be saved with public money.

Conclusions

The Dutch experience with hospital liberalisation first of all shows that opening up markets leads to an increase in merger activity. This is so because in most cases markets prior to liberalisation were not efficient. The opening up then creates opportunities to enhance efficiency. However the increased merger activity is not necessarily exclusively of even primarily efficiency enhancing. There can also be increased incentives for less benign mergers, because market power is likely to be better rewarded than before (either at the level of the hospital or at the level of its executives).

Therefore it is crucial to employ appropriate merger control.

The first lesson of the Netherlands is that such merger control should start prior to the actual opening up since firms anticipate the new regime. Indeed this is exactly what happened.

A second and more fundamental lesson is that – for a variety of reasons - regular merger control is unlikely to be sufficient to stop mergers that are not in the public interest. A first reason may be of a temporary nature. As long as it is not established what the appropriate methodology is for defining the relevant market there will be doubt whether the relevant market is larger or smaller. This leads to an automatic bias towards larger markets. A more fundamental reason for the bias in favour of clearing mergers is caused by the difference between promoting competition and merger control. The aim to promote competition can be at odds with the far more stringent standard of "appreciably impeding competition" in merger control.

A third lesson is that it is important to make the health goals accessibility, affordability and quality sufficiently operational for competition authorities to handle.

A final lesson is that merger control in healthcare should be seen in a broader context. Advantages and disadvantages stemming from mergers can be greatly influenced by public policy, for instance by easing entry possibilities, by counteracting the sometimes excessive power of medical specialists or by allowing failing hospitals to go bankrupt.

²³ The exception is the requirement of a maximum of 45 minutes driving distance from the nearest emergency care unit, without a clear addressee.

²⁴ Paraphrasing Vermont Senator Bernie Sanders, in the hearings on the US credit crisis. <http://sanders.senate.gov/news/record.cfm?id=303313>.

