Approving or denying hospital mergers?

An assessment on the way the ACM assesses hospital merger requests in the Netherlands

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Executive summary

Introduction Managed competition was introduced in the Dutch healthcare industry in 2006. After this multiple healthcare institutions, including hospitals, started merging together to strengthen their economic position and improve their provided quality of care. The Authority Consument and Market (ACM) was appointed to assess hospital merger requests, while taking into account the Dutch Competition Law and the Law for Market Organisation in Healthcare. While the ACM has the assessment of competition as their legal mandate, they also are appointed to consider other factors, such as quality of care, where hospital mergers might bring negative consequences. In literature it was stated that the ACM has had questionable approvals of hospital mergers in the past. As a response to this, the ACM conducted a study and decided to change the emphasis in their assessment to be more patient centred. Considering the literature and the change in emphasis from the ACM, the research question arose: *How are hospital merger requests judged by the ACM when approving or denying hospital mergers in the Netherlands?* This question was answered through two sub-questions: *1. How are the Dutch criteria for the approval or denial of hospital mergers taken into account by the ACM when approving or denying hospital mergers in the Netherlands and what other criteria are considered to be important?* and *2. What is the difference to the way in which hospital mergers are judged before 2017 and after 2017 by the ACM?*

Methods: A study was conducted, which was made out of two components. The first one being an implementation study. In this implementation study, ACM reports regarding hospital merger requests are analysed according to the criteria that were found to be assessment criteria. These criteria are: A. The goals of the merger; B. The reasons for the merger; C. The structure of the organisations of the healthcare providers; D. The financial consequences of the merger for the

healthcare provider; E. The consequences of the merger for the provided healthcare to the patient; F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account; G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties; H. The way in which and the time frame wherein the merger will be realised; and I: Competition. The second component is qualitative with a semi-structured interview with an ACM spokesperson who has 9 years of experience in hospital merger assessments.

Results: Eventually 27 reports were coded and analysed, nineteen mergers were before 2017 and eleven after 2017. A total of three merger requests were denied, one before 2017 and two after 2017. It was found that the ACM considers the totality of the criteria to assess hospital merger requests, while competition is the most important factor. Furthermore, it was found that the ACM considered patients groups more thoroughly through their assessments after 2017 than before 2017 and denied more merger requests after 2017.

Conclusion: Thus, the totality of the criteria was considered to be important when assessing hospital merger requests. However, the assessment of competition remains ACM's legal mandate and the ACM has not much room to deviate from this even though after 2017 a shift has appeared in the emphasis put onto the previously addressed criteria. The emphasis was put onto the public interests together with an emphasis on risks to competition.

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1. Introduction

Managed competition was introduced to the Dutch healthcare sector in 2006 (Schut & Varkevisser, 2017). As a response to this, multiple healthcare institutions started merging. They aimed to strengthen their economic position and improve their provided quality of care. Hospitals were a part of these institutions that merged together.

These hospital mergers might bring a number of private and public benefits. First, Brekke et al. (2017) and Dafny et al. (2019) state that mergers have shown to be helpful in improving the economic position of hospitals. This is because mergers can help hospitals increase their resources and thus broaden their products and services. Moreover, Su (2017) found that mergers can help financially struggling hospitals to survive. Second, due to merging, specialised care can become concentrated at specific hospital locations, this would help these hospital locations to perform certain specialised interventions more often. This again could result in these locations becoming more experienced with these interventions and thus improving their quality of care (Schmid and Varkevisser 2016, Fulop et al. 2002).

While concentrating the specialised care and therefore improving the quality of care sounds desirable, it might bring negative consequences regarding economic competition (Stennek et al., 2001), the quality of care (de Kam et al. 2020) and also other negative consequences for other concerned parties such as patients and municipalities (Roos 2018, Bell 2020). For patients it might increase travel time as can be seen in the study of Sheiman & Shevsky (2019) in Russia, in the Netherlands there was a small increase in travel time for patients in the area of Utrecht (van der Schors et al., 2020). This increase is expected to be more in other areas of the country. Furthermore, concentrating healthcare at specific hospitals could also mean that multiple municipalities would be left without specialised hospitals in their area (Roos, 2018). Furthermore, without proper merger control hospital mergers could lead to

hospitals with a competitive advantage over unmerged hospitals, which could undermine market forces (Stennek et al., 2001) and lead to more negative consequences for patients (Loozen et al., 2014).

Within the Dutch Competition Law (Mededingingswet, 1997), concerned parties and economic competition are protected against negative consequences due to mergers. These laws state that hospitals that want to merge should take into account all involved parties and their views on the merger and hospitals should not gain competitive advantage due to merging. This is controlled by the Dutch authority for consumers and markets, the Autoriteit Consument en Markt (ACM) which is also responsible for approving or denying hospital merger requests. However, it is unclear whether this control is properly happening in practice, as there has been criticism on the ACM before (Varkevisser & Schut 2008, Loozen et al. 2014, Schut et al. 2014). Therefore, this study was conducted with the following research question:

How are hospital merger requests assessed by the ACM when approving or denying hospital mergers in the Netherlands?

To answer this question, several ACM hospital merger reports will be studied to find patterns within the approval of hospital mergers.

2. Theoretical framework

In this chapter, hospital mergers will be further examined by explaining in general what mergers are, what the drivers for general mergers are and what the drivers for hospital mergers are. Then, public interests regarding hospital mergers will be set out. To be able to answer the main question, it is necessary to find the Dutch criteria for analysing hospital merger requests. Therefore, these criteria will be described and the criticism on the previous approval of hospital mergers will be discussed. Eventually, sub-questions will be formulated according to the found criteria.

2.1 What are mergers

Mergers can be divided into mergers and acquisitions. They are transactions in which the ownership of companies, other business organisations, or their operating units are transmitted or united with other organisations (Stemler et al., 2013). From a legal perspective, a merger is a legal combination of two or more organisations into one. An acquisition here is when one organisation takes ownership of another organisation's stock, equity interests or assets. From an economic perspective, both types of transactions result in the combination of assets and liabilities under one organisation. Within this perspective the distinction between a "merger" and an "acquisition" is more ambiguous. However, this distinction is not important for the remainder of this study as the outcome of both mergers and acquisition is the same; multiple organisations become one organisation.

2.2 General drivers for mergers

Organisations and companies can be driven to merge for several reasons. To begin with, it was found by Stennek et al. (2001) that mergers and acquisitions can help strengthen the economic position of the merging parties as they can support each other financially and they can gain

competitive advantage over other unmerged organisations. It must be noted that there are several concerns here (Parisi, 2007). One of these concerns are unilateral effects, the other ones are non-unilateral effects. First, unilateral effects mean that a merged entity will become too powerful. This influences market forces (European Commission, 2004), as mergers reduce competition which can result in an increase of prices of products and services. Moreover, this reduced competition might again reduce the motivation of organisations to provide product diversity and to innovate. The second concern is the non-unilateral one, this means that the number of competitors in the market decreases, which could result in greater transparency and potential for anticompetitive coordination (European Commission, 2004). Then again, Stennek et al. (2001) also state that according to the Merger Regulation, a merger can be denied if it creates or strengthens a dominant position for the merging parties and negative consequences of competition can therefore be prevented.

Furthermore, mergers could help organisations improve their efficiency by pressuring managers to invest efforts and resources within these efficiencies (Sagers, 2021). Efficiencies may come in the form of economies of scale, improved quality, innovation or improved services. Competition resulting from mergers can have a positive effect on efficiencies too as organisations tend to improve their services and products when competing. In addition, mergers help organisations to increase their resources. Thus, organisations can broaden their products and services (OECD 2018, Stennek et al. 2001).

Finally, it was found by Bena and Li (2014) that an important driver for mergers and acquisitions are the synergies that are obtained from the combination of innovation capabilities, because these synergies lead to efficiency gains and a better market position for the merging parties, they can also prevent an organisation from bankruptcy.

2.3 Drivers for hospital mergers

There are multiple drivers for hospital mergers, the most important ones regard finances and quality of care (Schmid & Varkevisser, 2016). First, through merging, hospitals aim for a better economic position within the healthcare market (Brekke et al. 2017, Dafny et al. 2019), since mergers help hospitals to increase their resources and therefore broaden their products and services (OECD 2018, Stennek et al. 2001). Moreover, it was found by Su (2017) that mergers could help hospitals which are struggling financially to survive. Additionally, Fulop et al. (2002) found that hospitals might merge to make internal savings, which they can use to invest in their provided services and staff training.

Second, Schmid and Varkevisser (2016) found that hospitals have "ambitions to concentrate complex surgeries at fewer hospitals to improve quality." By merging, hospitals could concentrate certain healthcare interventions at specific hospitals, which would result in some hospitals performing this intervention more often than they are able to do right now and thus becoming more experienced with these interventions (Schmid and Varkevisser 2016, Fulop et al. 2002). According to Schmid and Varkevisser (2016) and Fulop et al. (2002) this would eventually increase the quality of care within the hospitals.

Third, competition within the healthcare market is a driver for hospital mergers (Schmid & Varkevisser, 2016) just as competition can be a general driver for organisations to merge (Stennek et al., 2001). This is related to the strengthening of the economic position and the increase in quality of care since hospitals are more able to compete on the healthcare market with a strong economic position and high quality of care. This even results in some small hospitals having to merge as without the financial aid of another hospital they cannot compete in the healthcare market.

2.4 Public interests within hospital mergers

Teulings et al. (2003) describe that hospital mergers are part of the public interests, as they can affect the general public in multiple ways. They can influence the market forces and together with this affect public health, concerning parties such as municipalities and individual patients.

A hospital merger could lead to changes in market forces and even market failure (Don, 2011) . The merger can give hospitals a dominant position in the healthcare market which can result in hospitals increasing prices of provided care or cancelling out other hospitals that provide the same care through competition which can lead to less access to healthcare in a certain area (Stennek et al. 2001). In this way hospital mergers affect public health.

Even more, without competition, the quality of care might decrease, affecting the individual patients (Stennek et al. 2001, Loozen et al. 2014). The interests of the market, which are related to competition, as well as the public health interests such as the accessibility to healthcare and the interests of the individual patients such as quality of care should therefore be considered when discussing hospital mergers.

Another important public party which is affected by hospital mergers, are the municipalities within the areas of merging hospitals. Concentration of care can affect the availability of specialised care within municipal boundaries (Roos, 2018). In addition, it was found that hospital mergers can affect municipal finances negatively (Bell, 2020). The ACM (2017) claims that as of 2017 there was allowed more room for these public interests within healthcare through emphasising views and recommendations of patients, personnel and other concerned parties in the approval or denial of hospital mergers.

The public interests are protected by the Law for Market Organisation in Healthcare (WMG, 2006). Here it is stated that concentration of care should not negatively affect the public

interests in means of public health, considering the economic interests and overall public interests as well. If this does not happen, the concentration should be denied.

2.5 Dutch criteria for the approval of hospital mergers

The Dutch criteria for hospital mergers can be found through the Law for Market Organisation in Healthcare (WMG, 2006) and the Dutch Competition Law (MW, 1997). This law is to a large extent determined by the EU Competition Law. This law secures the maintenance of competition within the European Single Market. In Chapter 5: Concentrations of the Dutch Competition Law the norms regarding mergers and acquisitions can be found.

The hospital merger requests are being assessed by the Dutch authority for consumers and markets, the Autoriteit Consument en Markt (ACM) and the Dutch healthcare authority, the Nederlandse zorgautoriteit (NZA). The ACM is responsible for enforcing the Competition Law (MW, 1997) and the NZA is responsible for enforcing the Law for Market Organisation in Healthcare. Hospital merger requests were previously controlled by the Dutch competition authority, the Nederlandse Mededingingsautoriteit (NMa). The Dutch Competition Law states that two or more hospitals with a joint turnover of €55.000.000 of which at least two of the concerned hospitals made €10.000.000 in the Netherlands decide to merge (Stb. 2007, 518), should submit a request to the ACM. These turnover levels are lower than the turnover levels for regular mergers, which are respectively €150.000.000 and €30.000.000. The Dutch Competition Law distinguishes two types of concentrations, which are mergers and acquisitions. The ACM will together with the NZA analyse the hospitals and the request, while taking into account patient groups. When assessing a merger request, the ACM will ask the NZA to give their opinion on the request and together decide whether to approve the request or not (ACM, 2015-II). It is therefore important that both authorities have a regular exchange of information.

Furthermore, while the ACM is mainly concerned with the Competition Law and the NZA with the Law for Market Organisation in Healthcare, they face some overlay. This means that both the authorities are responsible to enforce both the mentioned laws.

The ACM should decide within four weeks whether the merger is approved or denied or approved with conditions (Nma, 2009). The ACM has the possibility to approve a merger with conditions, such as a price ceiling. If a merger is unlikely to harm competition, the merger is approved. If at first glance a merger is likely to harm competition, a permit is required. With this permit the ACM has more time to investigate the request and is able to do a market test with the stakeholders. The ACM then invites consumers, suppliers and competitors to submit their observations. This invitation is published in the Staatscourant. The request should be denied if patients, personnel and other concerned parties are not taken into consideration by the merging hospitals. Also, the merger will not be accepted if these concerned parties were not carefully involved in the assessment process. These parties should be informed in time that they are allowed to express their views regarding the merger requests. Healthcare should not be put at risk through the merger. Besides, if the merger would give the merged hospitals a dominant economic position as opposed to other hospitals in that area, the merger will not be accepted (MW, 1997), which is in accordance with literature (Varkevisser & Schut 2008, Loozen et al. 2014, Schmid & Varkevisser 2016).

Sometimes mergers are still approved among parties with a strong economic position, as there can be other safeguards for competition (Loozen, 2015) or because it is important that the hospitals merge for the continuity of care. In these cases, the ACM can approve the merger with an authorisation requirement (WMG, 2006), a price ceiling for certain services or products.

2.6 Criteria for hospital mergers

For a hospital merger to be analysed, a specific report must be composed by the merging hospitals. This report consists of the following aspects:

A. The goals of the merger;
B. The reasons for the merger;
C. The structure of the organisations of the healthcare providers;
D. The financial consequences of the merger for the healthcare provider;
E. The consequences of the merger for the provided healthcare to the patient;
F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account;
G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties;
H. The way in which and the time frame wherein the merger will be realised.

Point A: Goals describes what type of merger the merging parties want to achieve. This can be an administrative merger, a holding foundation, a partial or total acquisition or a legal merger. Point B: Reasons regards the why-question of the merger, within this point it is possible for the merging parties to state their rationale for merging. Furthermore, C: Structure regards the structure of all hospitals which are involved with the merger. Here it is determined whether the hospitals offer only general care, or also top-clinical care. Likewise, private hospitals, hospitals which offer care for tropical diseases and hospitals that engage in scientific research are considered.

Point D: Financial consequences regards financial consequences to the merging parties which are connected to the process of the merger. Financial benefits are not considered here. Additionally, point E: Consequences to the patient considers how the patient can be affected through the merger, this is related to quality of care, which is mostly examined by the NZA. Moreover, the consequences consider the accessibility of care, which is related to the travel time, waiting times, healthcare options and the prices of healthcare. Point F: Risks on quality and accessibility however looks at the risks the merger could pose on these aspects and how this risk is taken into account by the merging parties. There could be risks to the continuity of care, the quality of care, accessibility of care, the availability of alternative hospitals and the safety of care.

Point G: Views of concerned parties are connected to all concerned parties and their views on the merger. Here mostly health insurers, patient organisations and other hospitals within the area of the merging hospitals provide their view on the merger. Since 2017, this point together with point E: Consequences to the patient is prioritised by the ACM when approving or denying hospital mergers (ACM, 2017-I) because the approval or denial of hospital mergers became more patient centred than it was before. Literature (Varkevisser & Schut 2008, Loozen et al. 2014, Schmid & Varkevisser 2016) however states that the emphasis should be put on robust competition policy, as the Netherlands tend to accept highly concentrated markets. The last point that is considered by the ACM, is the timeframe in which the merger will take place. Additionally, the ACM considers market competition overall through the reports, therefore this point is added as I: Competition. Competition and market forces are important, since the quality of care might decrease and prices of care might increase without competition (Stennek et al. 2001, Loozen et al. 2014).

2.7 Criticism on the previous approval of hospital mergers

Multiple Dutch studies (Varkevisser & Schut 2008, Loozen et al. 2014, Schut et al. 2014) claim that the ACM has had questionable approvals of hospital mergers in the past. Some cases of hospital mergers had high joint market shares, which led to unfair competition within the healthcare market. This gave certain hospitals a position of power and made other hospitals not able to survive within this market, which again led to higher prices of care and longer travel times for patients. Varkevisser and Schut (2009) highlight this by stating that 'hospital mergers may have serious anticompetitive effects and post-merger antitrust enforcement is not likely to offer an effective safety net'. Within these merger approvals, the emphasis was not put onto the patient and the other concerned parties while assessing the merger request (Loozen et al., 2014). Even more, it seems that the Dutch Competition Law was not taken sufficiently into account, ergo the unfair competition within the healthcare market. This has led to negative consequences for patients. Because of this, the ACM (2017-I) decided in 2017 to introduce a stricter emphasis on patients and other concerned parties when assessing requests for the approval of hospital mergers. The criteria for the assessment of hospital mergers were therefore not changed, however the way in which these criteria were applied should have shifted to be more patient and competition centred. However, Varkevisser and Schut (2008) argue that probable strict rules make the approval of hospital mergers very complex and time consuming, while Rosenboom (2018) explains the need for a proper assessment model of hospital mergers when continuing with the approval of mergers, again adding complexity to this approval. Whether the ACM has in fact put an emphasis on patients and other concerned parties within their views on hospital mergers, remains unclear.

2.8 Sub-questions

To answer the main research question: "*How are hospital merger requests judged by the ACM when approving or denying hospital mergers in the Netherlands?"* an implementation study was conducted. It was necessary to first find the criteria for the approval or denial of hospital mergers; these were found and selected through the Dutch Law for Market Organisation in Healthcare (WMG, 2006). After this, it remained unknown how the ACM took these criteria into account when approving or denying hospital mergers, it was unclear which criteria were emphasised and whether the ACM considered all the criteria in their assessment. It is however known that considering competition is within the legal mandate of the ACM, additionally literature considers competition policy to be highly important (Schmid & Varkevisser, 2016) when assessing hospital mergers. The ACM does not specifically consider competition within the found approval criteria. Therefore, the first sub-question is formulated as:

- *How are the Dutch criteria for the approval or denial of hospital mergers taken into account by the ACM when approving or denying hospital mergers in the Netherlands and what other criteria are considered to be important?*

Furthermore, it was found that the ACM changed its assessment policy in 2017 (ACM, 2017) and decided to put the emphasis on the consequences of hospital mergers on patients and other concerned parties and the views of these parties regarding hospital mergers. The concerned parties are not specified, but literature states the importance of consequences of hospital mergers on municipalities (Roos 2018, Bell 2020). To be able to find whether this change in assessment policy is put into practice after 2017, the following sub-question was formulated:

- *What is the difference to the way in which hospital mergers are judged before 2017 and after 2017 by the ACM?*

3. Methodology

This chapter will discuss the research aim, with the main research question and its sub-questions. The research design will be set out and the methods for data collection and data analysis will be described. Furthermore, the validity and reliability of this study will be discussed.

3.1 Research aim

The main aim of this study is to examine the way in which the ACM approves or denies requests of hospital mergers. Multiple criteria were found within the assessment of hospital merger requests, this study will try to find how these criteria are taken into consideration and which criteria weigh more heavily than others. In addition, the study aims to find if and in what way the assessment of hospital merger requests has changed before and after 2017. The two main laws, which are the Dutch Competition Law and the Dutch Law for Market Organisation in Healthcare and the views of concerned parties as well as an economic perspective were taken into account. The main research question is: *How are hospital merger requests assessed by the ACM when approving or denying hospital mergers in the Netherlands?*

This question is answered by answering several sub-questions. These are:

- *How are the individual points of criteria taken into account by the ACM when approving or denying hospital mergers in the Netherlands?*
- *What is the difference to the way in which hospital mergers are judged before 2017 and after 2017 by the ACM?*

In order to answer these questions, multiple ACM reports were studied through the years 2006, when managed competition was introduced in the healthcare market, up until 2021, the current year. Even more, complimentary to the study of these reports, the ACM was approached for interviews regarding decisions and discussions on hospital mergers.

3.2 Research design

The study is made up of two components. The first one is an implementation study. This is done by examining the ACM reports regarding the hospital merger approvals according to the law and finding out whether the criteria for approval of hospital mergers are considered properly. The second component is qualitative with a semi-structured interview with the ACM. A semi-structured interview was chosen to get as much information as possible from the ACM. The interview questions were focused on the different criteria that were found, and on the differences of assessment by the ACM before and after 2017. The exact questions can be found in point 3.4 Interview questions.

3.3 Data collection

The report data was collected through the ACM. This data can be found on the website of the ACM within their publications (ACM, 2021). A total of 36 hospital mergers have been found suitable for examination. Then, for the interviews, the ACM was approached. In the ideal situation, multiple spokespersons would be assigned by the ACM and multiple interviews would be conducted. This was however not possible, although one person, who is an economist with multiple years of experience in assessing hospital mergers, from 2013 up until 2022, was interviewed. The interviewee was able to oversee the process of assessing hospital merger requests before and after 2017.

The interview was conducted in Dutch and the transcript can be found in Appendix A: Interview Transcript. This data was used as complementary to the data found within the reports and the interview was thus conducted after the analysis of the reports.

3.4 Interview questions

The goal of the interview was to understand the data collected from the reports and to find whether it is in line with the data from the reports. To achieve this, 13 questions were conducted as can be found below. Below every question, an explanation can be found as to why this question was relevant.

1. *What do you consider to be the role of the ACM in the assessment of hospital merger requests?*

   It is clear that the ACM legally assesses hospital mergers through competition, however it is also important to know what the ACM itself sees as their role within this assessment and whether the ACM mostly considers competition or also finds the other criteria to be part of their assessment role.

2. *What are the criteria the ACM used when assessing a hospital merger request?*

   The criteria that were found were found in the Dutch Law for Market Organisation in Healthcare. These are important points that should be addressed within hospital merger requests by the merging parties. It is relevant to know if and which of these criteria are taken into account by the ACM in practice.

3. *Why are these criteria used?*

   The rationale behind the criteria can give more insight to what the ACM considers to be important within their assessment. Even more, it could show how the criteria are connected to each other.

4. *Which criteria are in practice the hardest to assess?*

   This question can show more about the way in which the hospital merger requests are assessed in practice and the considerations that are made by the ACM.

5. *While engaging in literature study I came across a set of criteria from the Dutch Law for Market Organisation in Healthcare. That is this set. (The set was sent). Could you tell me whether the ACM considers these criteria with the same weight?*
    a. *Why are some of these criteria considered to be more important than others?*

   This question elaborates again on the criteria from the Dutch Law for Market Organisation in Healthcare and the way in which these criteria are used in the assessments by the ACM. It gives more insight into what criteria are considered to be important and what criteria are not as important. Also, the rationale behind this is asked to understand why some criteria are weightier than others.
6. *What are the most important reasons to deny a hospital merger request?*
    a. *Why are these the most important reasons?*

   By asking this, insight is given into why the ACM would deny a hospital merger, this question tries to find the dealbreakers. Also, the rationale behind it is again sought to understand why a hospital merger request would be denied.
7. *The ACM stated that from 2017 the patient would be emphasised within the assessment of hospital merger requests, do you think this has really happened?*
    a. *If yes, is this visible in the assessments?*
    b. *If no, why do you think this has not happened?*

   The ACM (2017) brought out a report in 2017 where they mentioned the need to emphasise the patient while assessing hospital merger requests, it is relevant to find whether this has happened in practice. Within the report an answer to this is sought, but the interview can give extra information.

8. *Have there been any other changes in the assessment of hospital merger requests in the past years other than the patient interests?*

   With this question, the goal is to find out whether the way of assessing hospital merger requests has changed over the years and whether this was done knowingly or accidentally.

9. *How does the ACM make sure that quality of care does not decrease after a hospital merger?*

   The goal behind this question is to find how involved the ACM is with the quality of care and the evaluation of merged hospitals.

10. *Does the ACM track the developments of hospitals after the merger and does the ACM according to this evaluate its own decisions?*

    a. *If yes, are there reports available on this?*

   This question also tries to find out whether the ACM is evaluating hospital mergers regularly and what the ACM does with this information.

11. *Different concerned parties are asked to state their views on a hospital merger, are municipalities part of these parties?*

    a. *If yes, in which way?*

    b. *If no, why not?*

   Concerned parties are found to be important when assessing hospital mergers as they can be affected both positively and negatively. This question tries to find to what extent municipalities are concerned parties by the ACM and whether municipalities are considered.

12. *Are there any criteria in the legal framework that could be of interest in the assessment of hospital merger requests but are not considered by the ACM right now?*

    This question is important to find out what the ACM finds important in their assessments and what they focus on outside of their legal responsibilities. This could be connected to the findings from the reports to understand the rationale behind approving or denying merger requests better.

13. *Is there something you would like to change in the assessment of hospital merger requests?*

    a. *What is it?*

    b. *Why do you think that this should change?*

    Through this question, it can be found what the ACM wants to see within hospital mergers. Even though their legal role remains the assessment of competition within hospital merger requests, the ACM might have some criteria that they find more important and would want to focus on more than they are able to right now.

3.5 Data analysis

The report data was coded, the criteria as found in the Dutch Law for Market Organisation in Healthcare (WMG, 2006) were used as starting points for the codes with the additional code Competition. Thus, the codes were:

A. The goals of the merger;

B. The reasons for the merger;

C. The structure of the organisations of the healthcare providers;

D. The financial consequences of the merger for the healthcare provider;

E. The consequences of the merger for the provided healthcare to the patient;

F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account;
G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties;
H. The way in which and the time frame wherein the merger will be realised.
I. Competition

For A it was examined whether the goals of the merger are described by the hospitals that request the merger and patrons will be sought within these goals. Point B was studied in the same way, except reasons for the merger were considered instead of the goals of the merger.

For point C it was studied whether the structure of the organisations is described, thus also whether the hospitals are regular or specialised hospitals. Then, point D took into account the financial consequences of the merger, here the effects on the merging hospitals were examined as well as the effects on the market forces. Furthermore, within point E it was studied what the reports state as potential consequences to the quality of the healthcare provided for the patients due to the merger.

Furthermore, point F regards potential risks on quality and accessibility and the way these risks are considered by the merging parties. Therefore, the affected parties and the public interests must be taken into consideration by the ACM. The affected parties are mostly patients. The same thing was done regarding point G, but for the views and recommendations of patients, personnel and other concerned parties about the merger and the way this can be provided, as well as the way in which these views and recommendations are taken into account by the merging

parties. Here it was important again to consider the public interests, such as the financial consequences for municipalities (Bell, 2020) and the availability of specialised care within municipal boundaries (Roos, 2018). For point H it was studied whether the reports say something about the way that the merging parties want to realise the merger and the time frame wherein they would do this. Eventually, for point I the competitive pressure and risks to competition were considered.

Then, the interview was assessed, and the information was added to the analysis of the reports.

3.6 Validity and reliability

Within this study the content validity is important, as this study tries to describe which factors play a role in the assessment of hospital merger requests. Moreover, the study tries to describe how prominent these found factors are. Thus, all aspects of the concept must be considered. By using the original ACM reports provided by the ACM itself, the content validity is mostly secured. However, it might be the case that not everything is properly reported by the ACM and important aspects are missing within the reports. Therefore, the content validity might have limitations here. Furthermore, for the interviews the internal validity might be limited because there is a small number of participants. However, even though there are some limitations to the validity of this study, the study is valid enough to continue with it.

As for the reliability, this study uses reports provided by the ACM to find how the ACM takes the criteria (WMG, 2006) for the approval or denial of hospital mergers into account. To secure the reliability the reports will be coded twice by the same researcher, to prevent a difference in coding the data at the start of the analysis process and end of it. This makes this study reliable enough to proceed.

4. Results

Within this chapter the analysis of the reports and the ACM interview can be found. The chapter starts with a general analysis of the reports, this follows an in-depth analysis of all the individual criteria according to the first sub-question: *How are the individual points of criteria taken into account by the ACM when approving or denying hospital mergers in the Netherlands?* After this, the differences from before 2017 and after 2017 will be considered according to the second sub-question: *'What is the difference to the way in which hospital mergers are judged before 2017 and after 2017 by the ACM?*'

4.1 General analysis

A total of 33 hospital mergers were found eligible for analysis of which eventually 27 were analysed (ACM, 2021). Of these mergers, 21 were assessed before 2017 and eleven were assessed after 2017. Not all 21 mergers from before 2017 were available. Two merger requests, one from the Walcheren and Oosterschelde hospital and one from the Zaans Medisch Centrum and Westfries Gasthuis could not be found and were therefore not analysed. Eventually nineteen mergers from before 2017 were analysed. One merger request was denied, this was the merger of the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep (ACM, 2014-I: art. 194), the other eighteen mergers were approved.

Furthermore, three of the mergers from after 2017 were not available and were therefore not analysed. Two merger requests from after 2017 were denied, the merger of the Stichting Catharina hospital and the Sint Anna Zorggroep (ACM, 2017-III: art. 106) and the merger of Bergman Clinics and the Mauritskliniek (ACM, 2021: art. 93). It was stated that the hospitals need a permit to merge. The other six merger requests after 2017 were approved.

The codes that were used were: A. The goals of the merger; B. The reasons for the merger; C. The structure of the organisations of the healthcare providers; D. The financial consequences of the merger for the healthcare provider; E. The consequences of the merger for the provided healthcare to the patient; F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account; G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties; H. The way in which and the time frame wherein the merger will be realised; and I: Competition.

The codes that were mostly found during the analysis were C, F, G and I. Code D and H were not found at all within the reports from the ACM. Therefore, it could be concluded that the ACM did not find the financial consequences of the merger for the healthcare provider and the way in which and the time frame wherein the merger will be realised important when judging hospital mergers.

It was found that quality of care was deemed to be secured through multiple of these codes. Codes E: Consequences to the patient and F: Risks to the quality and accessibility are codes that directly take into account the effects of the merger on different aspects of the quality of care. Moreover, code G: Views of concerned parties considers the quality of care through multiple views of concerned parties. For example, in multiple reports it was found that the ACM asks health insurers about the geographical market the merging hospitals operate on. The effects of a concentration are highly correlated to the way in which insurers can negotiate with the merging hospitals. Thus, it is important to have different healthcare providers in this same geographical area, so the health insurers have alternatives. This is again connected to code I:

Competition. There should be enough alternative hospitals that are able to compete with the merging hospitals to prevent the merging hospitals from getting a dominant position in the healthcare market and therefore being able to lower their quality of care and increase their prices.

4.2 Individual criteria

A. The goals of the merger

The goals that are assessed are what kind of merger the merging parties want to achieve. In the interview with the ACM, it was elaborated that the ACM did not consider the goals themselves too much when assessing the merger requests (Interview 62, Appendix A). These goals were not deemed to be of big importance, however they were used to understand the entities of the merged parties. The possible goals that were found were administrative mergers, legal mergers, holding foundations and total or partial acquisitions. There was a total of ten administrative merger requests. An administrative merger means that the board of two or more hospitals, often referred to as the Board of Directors, will consist of the same persons. Out of these ten administrative mergers, nine (90%) were approved and one (10%) was denied by the ACM, this was the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep merger (ACM, 2014-I: art. 194). Out of all the approved mergers, 37.5% were administrative mergers and out of the denied mergers, 22.3% were administrative.

Furthermore, there were four requests for legal mergers, this means that two parties wish to continue together in a legal unit and thus decide to legally merge into one legal entity. This is possible because a new legal entity is established in which the two merging parties merge. It is also possible that there is a receiving legal entity in which the other legal entity is merged. The consequence of a legal merger is that all rights and obligations that are vested in the legal entities are transferred. Out of the four requested legal mergers, three (75%) were approved and one

(25%) was denied. The denied request was the one of the Stichting Catharina hospital and Stichting Sint Anna Zorggroep merger (ACM, 2017: art. 106). Out of all the approved mergers, 13% were legal mergers and out of the denied mergers, 33% were legal mergers making a higher percentage of legal mergers being denied. Additionally, six mergers aimed to create a holding foundation. A holding foundation structure means that one hospital holds all shares in another hospital. All of these requests were approved by the ACM, which is 100%. Out of the seven acquisitions, four were total acquisitions and three were partial acquisitions. An acquisition is a takeover of one entity by another. One (25%) request for a total acquisition was denied, this was the Bergman Clinics and Mauritskliniek request (ACM, 2021: art. 93). This percentage is the same as for the legal mergers. It was thus found that the three denied mergers did not aim for the same type of merger, as one aimed for an administrative merger, one for a legal merger and one for a total acquisition as can be seen in Table 1: The goals of the merger. Thus, it does not seem that the goals of the merger influenced the decisions made by the ACM which follows what was stated in the interview.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
A. The goals of the merger	Administrative merger	9 (90%)	1 (10%)
	Legal merger	3 (75%)	1 (25%)
	Holding foundation	6 (100%)	0 (0%)
	Total acquisition	3 (75%)	1 (25%)
	Partial acquisition	3 (100%)	0 (0%)
	Missing	0 (0%)	0 (0%)

Table 1: The goals of the merger

B. The reasons for the merger

It was found that reasons for mergers were not always specified, which could mean that the ACM did not deem it to be a weighty criterion within their assessment, this was confirmed by the ACM respondent in the interview even though the respondent mentioned it should be a weighty criterion (Interview 62-72, Appendix A). In the interview it was also stated that it was nice to know the rationale for merging and it can be beneficial for the assessment if there is a so-called good reason for merging. If there is a clear reason as to why the merger is needed, health insurers can be asked about their views more thoroughly.

For nine mergers the reason for the merger was given and sometimes several reasons were given. For eighteen mergers no reason was given for merging. It was found that in the cases where a reason was stated by the merging parties, whether approved or denied, the stated reason was survival of one or both merging hospitals. Survival of the hospitals means that the hospital must merge in order to be able to continue to offer healthcare (van Ineveld et al., 2018). Within this reason, there are again multiple reasons as to why a hospital would not be able to offer healthcare without merging. Six times a hospital was unable to meet legal requirements regarding capacity and volume norms. Volume norms are the national established standards that every hospital should meet. It means that every hospital must perform at least a certain amount of a specific type of surgery per year to be able to secure the process quality of this surgery. This inability made it impossible for these hospitals to survive without the help of another hospital. All hospital mergers that had this as a reason were approved. An example of a merger because of volume norms is the merger of the Ommelander Ziekenhuis Groep and the Universitair Medisch Centrum Groningen (ACM, 2015-I: art. 41). The Ommelander Ziekenhuis Groep would not be

able to meet the national volume norms without the help of the Universitair Medisch Centrum Groningen and therefore needed to merge.

Furthermore, it was found that twice the reason for merging was the threat of bankruptcy and hospitals needed to merge in order to survive. Both hospitals which almost went bankrupt were after 2017 and both these requests were approved. One is the merger of the Stichting Christelijk Algemeen Ziekenhuis Noordwest-Veluwe and the location Lelystad of the MC IJsselmeer hospitals B.V.. It was stated that on the 25th of October 2018 the MC IJsselmeer hospitals B.V. declared to be bankrupt, and the hospital was acquired by the Stichting Christelijk Algemeen Ziekenhuis Noordwest-Veluwe on the 23rd of November 2018 (ACM, 2019-I: art. 17). This was the only way in which the hospital in Lelystad would not vanish.

Once improvement of quality of care was given as a reason for merging together with the surviving of the hospital, this was the request of the Stichting Albert Schweitzer hospital and the Rivas Zorggroep (ACM, 2014-I: art. 31). This merger request was nevertheless denied, which makes improvement of quality 100% denied. This can be found in Table 2: The reasons for the merger.

In conclusion, the reason for merging was survival in each of the merger requests where the reason was mentioned. However, it was not a weighty criterion, but it helped the ACM understand the rationale for merging.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
B. The reasons for the merger	Survival	8 (89%)	1 (11%)
	Volume requirements	6 (100%)	0 (0%)
	Bankruptcy	2 (100%)	0 (0%)
	Improvement of quality	0 (0%)	1 (100%)
	Missing	16 (89%)	2 (11%)

Table 2: The reasons for the merger

C. The structure of the organisations

In every report the structure of the merging hospitals is mentioned separately for both merging parties. A total of 37 hospitals are general hospitals providing clinical and non-clinical care, 35 of these requests have been approved which is 95% and 2 have been denied, which is 5%. An example of a general hospital providing clinical and non-clinical care is the Stichting Waterland hospital (ACM, 2016-I: art. 7), here it is described that the Stichting Waterland hospital is a foundation under the Dutch law. It is a general hospital which is active within inpatient and outpatient general hospital care, supplemented with primary obstetrics. The Waterland hospital has its main location in Purmerend and an outpatient clinic in Volendam. Furthermore, there is a psychiatric department in Purmerend and a 24-hour pharmacy.

There are only nine hospitals that also offer top-clinical care, these are Stichting Sint Antonius hospital, Stichting TweeSteden hospital, Stichting Sint Elisabeth hospital, Universitair Medisch Centrum Groningen, Stichting Zorggroep Leveste Middenveld, Universitair Medisch Centrum Utrecht, Stichting Catharina hospital, Vrije Universiteit Medisch Centrum and Erasmus Medisch Centrum. The medical centres also engage in scientific research and so does the

Nederlands Kanker Instituut- Antoni van - Leeuwenhoek hospital which also specialises in oncological care. Out of these nine hospitals, eight requests have been approved by the ACM, which is 88.9%. One request has been denied, which is 11% of the hospitals offering top-clinical care. This is more than double as much as the 5% of the denied requests for general hospitals, which shows that hospital merger requests from top-clinical hospitals are more often rejected. This could be because hospitals offering top-clinical care are often bigger and already have a stronger market position than hospitals offering general care (van Ineveld et al., 2018), through merging these hospitals could endanger competition and are therefore more often denied of merging.

Two hospitals offer tropical care, next to general care. These are the Haven Hospital and Institute for Tropical diseases (ACM, 2017-II: art. 5) and the Amsterdam Medical Centre (ACM, 2017-IV: art. 13). Additionally, two hospitals operate as private hospitals, while offering elective care. These are Bergman Clinics and the Mauritskliniek (ACM, 2021: art. 14-15). The merger requests of these hospitals have been denied, which is a percentage of 100%.

While the structure of the organisations is mentioned, it is not directly taken into account when assessing hospital mergers. Even though, in the interview it is mentioned that structure has been important in the past to determine which patient groups went to the hospitals (Interview 93-97, Appendix A). Now however the structure of a certain hospital is not a hard criterion, instead the structure of the organisations is used as a tool to assess in which way other hospitals in the area are compatible to the merging hospitals. This does make the structure of the merging hospitals an important aspect within the assessment of hospital mergers.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
C. The structure of the organisations of the healthcare providers	Clinical and non-clinical care	35 (95%)	2 (5%)
	Clinical, non-clinical and top-clinical care	8 (89%)	1 (11%)
	Scientific research and clinical, non-clinical and top-clinical care	6 (100%)	0 (0%)
	General care and tropical care	2 (100%)	0 (0%)
	Private hospital	0 (0%)	2 (100%)
	Missing	0 (0%)	0 (0%)

Table 3: The structure of the organisations

E: Consequences to the patient

When looking at criterion E, increase of prices, extra travel time, shift in care provision, less care options for patients, longer waiting times and poor accessibility were found to be consequences on the provided healthcare for the patient. The ACM respondent stated that consequences to patients were considered when assessing hospital mergers, together with consequences to other insured people. (Interview 107-110, Appendix A). Furthermore, studies were conducted to find possible consequences to patients (Interview 83-84, Appendix A) and the view of the NZA was considered as well.

Out of the four requests where increased prices were mentioned, one (25%) was still approved and three (75%) were denied, making this a possible important reason for denial of the request. In the interview with the ACM this consequence was also mentioned to be an issue for approving a merger (Interview 129-135, Appendix A) however this could be prohibited with an authorisation requirement such as a price ceiling. This price ceiling can prohibit the chance of

prices exceeding a certain limit. Furthermore, in the interview it was stated that in order to prevent the increase of prices, the ACM wanted to become stricter within the assessments of hospital merger requests.

Furthermore, extra travel time was mentioned in three cases, however all three cases were still approved. For instance, in the merger of the Stichting Lievensberg hospital and the Stichting R.K. hospital Sint Franciscus it is stated that due to the concentration a group of patients would have to travel further for their treatment because this would not be provided anymore at their closest location (ACM, 2013-I: art. 71). According to these numbers, it does not seem that extra travel time is a reason to deny a merger request. Neither does the consequence 'less care options' seem to be a reason to deny a merger request. This consequence was found in two merger requests, one request was denied and the other one was approved.

For some mergers multiple consequences were specified while for some it was only stated that there were no consequences regarding for example travel time. Therefore, for 19 mergers possible consequences are missing. Nonetheless, for every denied merger the possible consequences were mentioned. Taking this into consideration however, it seems that possible consequences is a weighty criterion which is not always thoroughly examined per merger request.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
E. The consequences of the merger for the provided healthcare to the patient	Increase of prices	1 (25%)	3 (75%)
	Extra travel time	3 (100%)	0 (0%)
	Shift in care provision	1 (100%)	0 (0%)
	Less care options for patients	1 (50%)	1 (50%)
	Longer waiting times	1 (50%)	1 (50%)
	Poor accessibility	0 (0%)	1 (100%)
	Missing	19 (100%)	0 (0%)

Table 4: Consequences to the patient

F. Risks on quality and accessibility

Criterion F considers risks to the quality and accessibility of care. Risks that were found were risks to the continuity of care, the quality of care, the accessibility of care, the availability of alternative hospitals and the safety of care. For 18 hospitals no risks were stated, in these cases it was stated however that there would be no risks for specific issues such as quality of care, availability and accessibility.

In two cases a risk to accessibility of care was mentioned, both were denied. Additionally, risks to the quality of care were stated once (33%) in one of the denied merger requests, and twice (67%) in the approved merger requests. This is for the Stichting Waterland and Westfriesgasthuis merger and for the Bronovo and Medisch centrum Haaglanden merger. An example is the merger of the Stichting Lievensberg hospital and the Stichting R.K. hospital Sint Franciscus, it is found that as a consequence of the concentration a care option for patients would disappear and competition would become lower (ACM, 2013-I: art. 45). This could result in the

merging hospitals putting less effort in a high quality of care. However, the ACM found that without the merging of the hospitals, there would still be a possibility of the quality worsening and therefore the merger was still approved.

Poor availability of alternative hospitals was stated as a risk in 4 hospitals, which were all approved (100%). Therefore, when considering these percentages, it does not seem that this risk is a big issue when assessing hospital mergers.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account	Risks to the continuity of care	1 (50%)	1 (50%)
	Risks to the quality of care	2 (67%)	1 (33%)
	Risks to the accessibility of care	0 (0%)	2 (100%)
	Poor availability of alternative hospitals	4 (100%)	0 (0%)
	Risks to the safety of care	1 (100%)	0 (0%)
	Missing	17 (94%)	1 (6%)

Table 5: Risks on the quality and accessibility

G. Views of concerned parties

The views of concerned parties are considered comprehensively by the ACM. Patient organisations, other hospitals and health insurers are allowed to state their views about multiple issues regarding the mergers within all the reports. It was said in the interview that these views and recommendations are then taken into account (Interview 172-173, Appendix A). Sometimes the ACM asks certain parties to state their views about specific issues such as the health insurers' possibilities to negotiate with merging hospitals. Furthermore, other parties, such as

municipalities are also allowed to state their views, and these views would then be considered by the ACM when assessing merger requests. However, this does not happen according to the ACM respondent. Therefore, the views of municipalities cannot be taken into consideration by the ACM (Interview 172-183, Appendix A). The ACM respondent however mentioned that after the decision is published, municipalities tend to protest the merger as the effects of the merger become apparent and they do not agree with it (Interiew 187-118, Appendix A). But the ACM cannot intervene any longer with the merger, as it is out of their control after the decision is finalised.

It was found that concerned parties were sometimes positive about a merger and sometimes negative. For example, the denied merger of the Stichting Albert Schweitzer hospital and Rivas Zorggroep had positive recommendations from patient organisations (ACM, 2017-II: art. 120-123) but health insurers stated the merger was not necessary (ACM, 2017-II: art. 128-134). Patient organisations stated that they saw positive effects in the future, stating that the merger could help the hospitals provide a wide range of healthcare. However, health insurers were more sceptical about these benefits and mentioned that this could also be accomplished through collaboration. Overall, health insurers were once negative about a merger request. Patient organisations and other hospitals were also once negative about a merger, nonetheless these merger requests were approved by the ACM.

Enough options to discipline, enough competitive pressure and enough alternatives were also mentioned by the concerned parties. Three times it was judged that there were not enough options for the health insurers to discipline the merging parties due to the market power the hospitals would establish through the merger. This was found twice in approved merger requests, which was for the AMC and VUMC merger where multiple health insurers expressed their

concerns about the market power of the hospitals after merging (ACM, 2017-IV: art. 41-52). Not enough competitive pressure was also found three times, twice in approved merger requests and once in denied merger requests. Furthermore, concerned parties discussed whether there would remain enough alternative hospitals for patients to go to if they would not be satisfied by the merged hospitals. Once it was found that the concerned parties thought there would not be enough alternatives, this merger request was denied.

All in all, it seems that negative recommendations from concerned parties did indeed influence the decisions made by the ACM but the rationale behind the recommendations remains important as well.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
G. The judgment and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties	Negative health insurers	0 (0%)	1 (100%)
	Negative patient organisations	1 (100%)	0 (0%)
	Negative other hospitals	1 (100%)	0 (0%)
	Not enough options to discipline	2 (67%)	1 (33%)
	Not enough competitive pressure	2 (67%)	1 (33%)
	Not enough alternatives	0 (0%)	1 (100%)
	Missing	0 (0%)	0 (0%)

Table 6: Views of concerned parties

I: Competition

For the competition, the ACM put the emphasis on having enough competition available within the geographical area of the merging hospitals after the merger. As mentioned before, this

competition is important to prevent the merging hospitals from getting a dominant position in the healthcare market. A dominant position would enable merging hospitals to increase the prices of care and lower the quality of care. Within the interview with the ACM, it was again stated that competition is the most important criterion for them when assessing the requests for hospital mergers as it is their 'legal mandate' (Interview 7-10, Appendix A).

Mostly, approved mergers were found to be no threat to the competition in their geographical area. Mergers that were a threat were denied or approved with price ceilings which means that the prices of care within these hospitals may not exceed an annual indexation. The ACM judged in these cases that the care provision was more important than the risks posed onto the healthcare market. However, risks to competition were still more often found in the denied mergers, 60% as opposed to 40%. But this difference is not big. Not enough competitive pressure was found a total of 6 times, remarkably it was found more often in the approved mergers, as can be seen in Table 7: Competition. However, in all the denied merger requests risk to competition or not enough competitive pressure were found. This shows the importance of competition in the assessment of hospital mergers.

Criterion	Codes	Approved mergers (%)	Denied mergers (%)
I: Competition	Risks to competition	2 (40%)	3 (60%)
	Not enough competitive pressure	4 (67%)	2 (33%)
	Missing	0 (0%)	0 (0%)

Table 7: Competition

4.3 Differences in assessment before and after 2017

Regarding the goals of the mergers, there were some differences between before 2017 and after 2017 as there were mostly administrative mergers before 2017 and no hospitals that aimed for a holding foundation after 2017. Furthermore, before 2017 no hospitals aimed for a partial acquisition while after 2017, there were three requests that wanted a partial acquisition. It does however not seem this criterion was treated any differently by the ACM after 2017 than it was before 2017.

Additionally, reasons for merging were not a strict criterion before 2017 nor after 2017. It was however found that before 2017, hospitals were too small and could not reach certain volume norms or were financially unstable because of their size. This was found within all the hospitals that wanted to merge before 2017, but in none of the hospitals after 2017. Although after 2017, the reasons for merging were stated to be the threat of bankruptcy. Within the interview with the ACM, it was mentioned that it would be desirable to consider reasons for merging more often and to deny mergers rather than approve them unless the rationale is of great impact (Interview 207-215, Appendix A).

As stated before, the structure of the healthcare organisations was not a strict criterion either. Nevertheless, it was found that all the private hospital merger requests were after 2017 and were denied. In addition, it was mentioned in the interview with the ACM that before 2017 the structure of the merging healthcare organisations was analysed thoroughly, while after 2017 an emphasis was placed on patient groups (Interview 93-94, Appendix A). By emphasising patient groups, the underlying needs of patients are considered. More can be found within Table 8: Criterion E before and after 2017. It can be seen that after 2017 increase in prices becomes a dealbreaker. Before 2017, one hospital which had this consequence was denied and another one was approved. After 2017, both hospitals that had an increase in prices were denied.

Furthermore, less care options for patients and longer waiting times are both consequences in denied merger requests after 2017 and approved merger requests before 2017. These were both mentioned for the denied requests of Stichting Catharina hospital and Stichting Sint Anna Zorggroep (ACM, 2017-III: art. 69). According to these numbers, it could be said that consequences of merger were given more weight after 2017 than before 2017.

Criterion	Codes	Before 2017		After 2017	
E. The consequences of the merger for the provided healthcare to the patient		Approved	Denied	Approved	Denied
	Increase of prices	1 (50%)	1 (50%)	0 (0%)	2 (100%)
	Extra travel time	3 (100%)	0 (0%)	0 (0%)	0 (0%)
	Shift in care provision	1 (100%)	0 (0%)	0 (0%)	0 (0%)
	Less care options for patients	1 (100%)	0 (0%)	0 (0%)	1 (100%)
	Longer waiting times	1 (100%)	0 (0%)	0 (0%)	1 (100%)
	Poor accessibility	0 (0%)	0 (0%)	0 (0%)	1 (100%)
	Missing	12 (100%)	0 (0%)	7 (100%)	0 (0%)

Table 8: Criterion E before and after 2017

Table 9: Criterion F before and after 2017 shows that less risks were taken into consideration after 2017. Risks to the continuity, quality and safety of care were not considered after 2017 to be of risk. Furthermore, only one risk was mentioned after 2017 in a denied merger, this was a risk to the accessibility of care. This was for the Stichting Catharina hospital and the Stichting Sint Anna Zorggroep merger request (ACM, 2017-III: art. 104). Stil, where no risks

were mentioned, it was in every case stated that there would be no risks due to the merger. Considering these numbers, it seems that the ACM found less risks of mergers to quality and accessibility of care after 2017 than before 2017.

Criterion	Codes	Before 2017		After 2017	
F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account		Approved	Denied	Approved	Denied
	Risks to the continuity of care	1 (50%)	1 (50%)	0 (0%)	0 (0%)
	Risks to the quality of care	2 (67%)	1 (33%)	0 (0%)	0 (0%)
	Risks to the accessibility of care	0 (0%)	1 (100%)	0 (0%)	1 (100%)
	Poor availability of alternative hospitals	3 (100%)	0 (0%)	1 (100%)	0 (0%)
	Risks to the safety of care	1 (100%)	0 (0%)	0 (0%)	0 (0%)
	Missing	12 (100%)	0 (0%)	5 (83%)	1 (17%)

Table 9: Criterion F before and after 2017

Views and recommendations are considered by the ACM both before and after 2017. Most mergers with positive recommendations have been approved. Negative recommendations were not given often (Tab. 10). Negative health insurers led to denied mergers before as well as after 2017. Remarkably, one merger with negative other hospitals was approved, this was the case of the Nederlands Kanker Instituut- Antoni van - Leeuwenhoek hospital and the Universitair Medisch Centrum Utrecht merger (ACM, 2013-II: art. 86, 87). Two other hospitals in this geographical area were concerned that the merger would give the merging parties too much market power, but these hospitals also understood that the merger would bring advantages within science and education. Considering this, the merger request was approved.

Furthermore, before 2017 health insurers were not once concerned about their options to discipline merging hospitals in contrast to after 2017 where it was found that health insurers were twice concerned about their options to discipline. These concerns were for the Amsterdam Medisch Centrum and Vrije Universiteit Medisch Centrum merger (ACM, 2017-IV: art. 47-52) and for the Erasmus Medisch Centrum and Admiraal de Ruyter merger (ACM, 2017-V: art. 42, 44). It was however found that other concerned parties were positive regarding both of these mergers. Not enough competitive pressure was found a total of three times, once in an approved merger before 2017 and twice after 2017, once in an approved merger request and once in a denied one. Additionally, not enough alternatives was seen once, this was in a denied merger request after 2017.

Taking these numbers into account, it could be said that the ACM took views and recommendations of concerned parties more often into account after 2017 than before 2017 and also denied more mergers which had negative recommendations.

Criterion	Codes	Before 2017		After 2017	
G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties		Approved	Denied	Approved	Denied
	Negative health insurers	0 (0%)	1 (100%)	0 (0%)	1 (100%)
	Negative patient organisations	1 (100%)	0 (0%)	0 (0%)	0 (0%)
	Negative other hospitals	1 (100%)	0 (0%)	0 (0%)	0 (0%)
	Not enough options to discipline	0 (0%)	0 (0%)	2 (67%)	1 (33%)
	Not enough competitive pressure	1 (100%)	0 (0%)	1 (50%)	1 (50%)
	Not enough alternatives	0 (0%)	0 (0%)	0 (0%)	1 (100%)
	Missing	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Table 10: Criterion G before and after 2017

Table 11: Criterion I before and after 2017 shows that competition was an important factor in assessing hospital mergers before and after 2017. Risks to competition were found in two approved merger requests before 2017 but in none of the approved merger requests after 2017. Even more, not enough competitive pressure is found four times before 2017, 75% of which is in approved merger requests. After 2017 it is found twice, once (50%) in an approved request and once (50%) in a denied request. Therefore, according to these numbers it seems the ACM became stricter regarding this criterion within their assessments.

Criterion	Codes	Before 2017		After 2017	
I: Competition		Approved	Denied	Approved	Denied
	Risks to competition	2 (67%)	1 (33%)	0 (0%)	2 (100%)
	Not enough competitive pressure	3 (75%)	1 (25%)	1 (50%)	1 (50%)
	Missing	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Table 11: Criterion I before and after 2017

It was found that more merger requests were rejected after 2017 than before 2017, before 2017 5% of the hospital merger requests were rejected and after 2017 this was 18%.

As mentioned before, the ACM rejected the merger request of the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep. These hospitals wanted to merge to improve their quality of care and in order for the Rivas Zorggroep to survive and keep offering healthcare (ACM, 2014-I: art. 31). But the ACM judged that the benefits would not outweigh the consequences this merger would bring to the competition on the healthcare market (ACM, 2014-I: art. 33). The ACM concluded that both hospitals did not experience competition from other hospitals and health insurers added that the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep were each other's biggest competitors (ACM, 2014-I: art. 67). Furthermore, the NZA investigated whether there would be an increase in prices if these two hospitals were to merge and concluded that this would be the case. This information is taken into account by the ACM within their assessment (ACM, 2014-I: art. 79). Additionally, in this merger request case, multiple other hospitals, health insurers and patient organisations stated their views regarding the competition the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep have in relation

to each other (ACM, 2014-I: art. 83-92). Additionally, the possibilities of health insurers to negotiate with the hospitals and discipline them accordingly was thoroughly considered (ACM, 2014-I: art. 107-170). Afterwards, the ACM concluded that health insurers would not have enough options to discipline the hospitals and to negotiate about the healthcare prices because important alternative competitors would disappear due to the merger (ACM, 2014-I: art. 171, 172). Therefore, the ACM decided that the merger of the Stichting Albert Schweitzer Ziekenhuis and the Rivas Zorggroep would endanger competition and should be denied.

After 2017, the merger request of Stichting Catharina hospital and the Stichting Sint Anna Zorggroep was denied. In some cases, the ACM ruled that there would be no endangerment to competition as the hospitals were already only referring patients to each other, this concerns the nursing home care, geriatric rehabilitation care and home care (ACM, 2017-III: art. 25). Also, top clinical care is not considered because of the same reason (ACM, 2017-III: art. 22).

For general care the ACM decided to investigate to what extent a merger could influence the healthcare market in the geographical area of these two hospitals. Stichting Catharina hospital and the Stichting Sint Anna Zorggroep claim that the merger would not affect the competition within the healthcare market because the hospitals within their geographical area are rather close to them and therefore health insurers would be able to discipline them (ACM, 2017: art. 73). Health insurers have different opinions regarding the merger (ACM, 2017-III: art. 76-82), some are positive, and others are negative. Eventually, the ACM decides that the merger would worsen the negotiation position of health insurers (ACM, 2017-III: art. 103). Even more, the competitive pressure from other hospitals would not be enough to discipline these two hospitals if they were to merge (ACM, 2017-III: art. 104). According to this, the ACM ruled that

the Stichting Catharina hospital and the Stichting Sint Anna Zorggroep should request a permit if they want to merge as for now the merger request is denied.

The merger request of the Bergman Clinics and Mauritskliniek was denied as well. Bergman Clinics aimed to acquire 100% of the shares of the Mauritskliniek (ACM, 2021: art. 17). The ACM ruled that there would be no endangerment to competition within the skin and vascular healthcare market (ACM, 2021: art. 41).

Both hospitals claim that they are not each other's close competitor (ACM, 2017: art. 51). Also, the number of healthcare markets where the hospitals have a strong position, would not increase because of the merger thus hospitals claim that their merger would not change much to the healthcare competition (ACM, 2021: art. 51). To analyse this, the ACM took into account a previous merger from the Bergman Clinics with NL Healthcare clinics (ACM, 2021: art. 52). This merger led to significant price increases for the merged hospitals (ACM, 2021: art. 54). These price increases are reasons for the ACM to be critical about the Bergman Clinics and Mauritskliniek merger request (ACM, 2021: art. 55). In the interview it was mentioned that the merger of the Bergman Clinics and Mauritskliniek would not change the competition much since the hospitals are already having a dominant market position. When asking health insurers for their view regarding the merger, health insurers said that they were not able to negotiate with Bergman Clinics even before the merger and that this would not change after the merger. Still, the ACM claimed that the increase of prices would negatively affect patients. The merger therefore is not ideal, and the ACM wishes they would have more options to deny such merger requests. The interviewee said that the merger request was now denied but that this was a legally uncertain choice and the Bergman Clinics and Mauritskliniek have the option to go in appeal and still have their merger request approved (Interview 248-252, Appendix A).

Within the interview with the ACM, it was clear that there were certain options for hospitals to merge even though this would bring negative consequences (Interview 242-248, Appendix A). The ACM seem to have shifted their view to become more critical concerning hospital merger requests and not only consider competition. However, this remains their legal mandate and legally the ACM needs to consider competition when assessing hospital merger requests.

5. Discussion

This study aimed to understand the way in which the ACM assesses hospital merger requests and whether there has been a shift in the assessment of mergers after 2017. The main research question was: *How are hospital merger requests assessed by the ACM when approving or denying hospital mergers in the Netherlands?*

In addition to this, two sub-questions were formulated:

1. *How are the Dutch criteria for the approval or denial of hospital mergers taken into account by the ACM when approving or denying hospital mergers in the Netherlands and what other criteria are considered to be important?*
2. *What is the difference to the way in which hospital mergers are judged before 2017 and after 2017 by the ACM?*

An assessment was executed where 27 hospital merger reports were analysed and coded. Additionally, an interview was conducted with a spokesperson from the ACM. In this chapter the two sub-questions will be answered, then the previously mentioned criticism about the assessment of hospital mergers will be discussed according to the findings. After this, the strengths and limitations of this study will be discussed and recommendations for further study will be given together.

5.1 The Dutch criteria for the approval or denial of hospital mergers

In conclusion, it was found that the ACM considers the totality of the criteria to assess hospital merger requests, even though some criteria are not considered thoroughly at all such as D: The financial consequences of the merger for the healthcare provider, and H: The way in which and the time frame wherein the merger will be realised.

There were some differences between the approved and denied mergers, a remarkable difference is within the structure of the merging hospitals as all private hospital merging requests were denied. Additionally, within the denied merger requests a high percentage was found to have the possibility of an increase in prices. But the main emphasis in assessing hospital merger requests is put onto competition as this is the ACM's legal mandate. It is found that competition is an important factor which secures quality of healthcare and keeps prices of healthcare low. If a merger would endanger competition, the merger will be denied except if the merger is needed to secure continuity of care in for example the case of bankruptcy.

5.2 The difference to the way in which hospital mergers are judged before 2017 and after 2017

The ACM (2017-I) decided to change the way in which they assess hospital merger requests after 2017 as they had found that hospital mergers could lead to increases in prices and a decrease in quality (Batterink et al. 2016). It was mentioned that an emphasis would be put onto the public interests together with an emphasis on risks to competition (ACM, 2017-I). This was confirmed within the interview with the ACM where the importance of patient groups and their underlying needs was highlighted. It remained however unclear whether the ACM changed the way in which hospital merger requests were assessed as the criteria did not change.

In this assessment it was found that there were some differences between the hospital merger requests before and after 2017. First, it was found that after 2017 'volume requirements' were not once given as a reason for merging, but bankruptcy was which again was not mentioned before 2017. Because of the stricter competition criteria, it might be the case that merging to create a bigger hospital would result in a denied request, which could be why hospitals do not state this as a reason.

Second, consequences to patients were more frequently considered by the ACM after 2017 than before 2017, and mergers that could lead to consequences were also oftentimes denied after 2017. Risks to the quality and accessibility of healthcare were found more often before 2017 and were frequently found in denied mergers. After 2017, the ACM found less risks to the quality and accessibility of healthcare.

Third, the ACM became stricter regarding the risks to competition. Mergers that could bring risks were more steadily denied after 2017 than before 2017.

According to this it could be said that the ACM did in fact put an emphasis on consequences to the healthcare provided for patients and competition after 2017 when assessing hospital merger requests. The ACM was after 2017 more likely to deny mergers that could lead to bigger consequences to the provided healthcare and more risks to competition as can be seen in the denied merger requests of the Bergman Clinics and Mauritskliniek. In percentage terms, of the analysed merger requests more mergers were denied after 2017 than before 2017, 25% versus 5%. However, whether patients are considered more thoroughly is unclear when taking into account the reports. Patient groups are considered more often after 2017 which is confirmed in the interview.

5.3 Previous criticism

Previous criticism (Varkevisser & Schut 2008, Loozen et al. 2014, Schut et al. 2014) on the approval of hospital mergers underlined the anticompetitive nature of hospital mergers with the patient as the disadvantaged party. The ACM recognized the need to take measures to prevent this in the future (ACM, 2017). Even though, the ACM has the legal mandate to assess whether a hospital merger would affect competition as this is within their competences. The ACM needs good reasons to reject a merger request.

According to the results of this study it could be said the ACM is putting an emphasis on the consequences to the healthcare provided to the patient and the competitive risks due to the merger. It was however stated by the ACM respondent that some mergers might improve the market position of merging parties but still do not change competition much as the merging parties were already dominant, this increases the possibilities of these hospitals to negiotiate with health insurers (Interview 240-248, Appendix A). An example is the case of the Bergman Clinics and the Mauritskliniek merger request, as these hospitals already have such a strong position in the healthcare market, the merger would not lead to a loss in competitive pressure, but it would strengthen their market position even more which is nevertheless undesirable. The ACM denied this merger, but this case could go to court where the merger could still be approved. As a response to this case, the ACM respondent mentioned in the interview (Interview 212-223, Appendix A) it would be wise to change the way in which merger requests are handled altogether as for now the viewpoint is still that hospitals are required to merge unless they would threaten competition. This viewpoint should be that hospitals are not allowed to merge unless they have a good reason to merge, for example continuity of care. If a hospital wishes to improve quality of care or reach volume norms for certain procedures, a collaboration in the specific department where this is required is sufficient and there is no need to merge the entire hospitals.

5.4 Strengths and limitations

This study has had several strengths and limitations. To begin with, a strength of this study was the reliability of the data. The reports which were used were coded twice by the same researcher to prevent a difference in coding of the data at the start of the analysis process and the end of it. Additionally, the opportunity to interview someone from the ACM who is experienced with assessing hospital mergers adds to the reliability of the study. It also adds information from

practice to the analysis. Moreover, the study has been ethically safe as no personal data has been used throughout the study. Another strength of the study is that there were no extra costs connected to the study as it was conducted fully internally.

There were also several limitations within the study. First, even though the reports were coded twice it was still done by one researcher which could mean that some data was not coded properly. This could weaken the overall reliability of the study. Second, not all hospital merger reports were available for research, therefore not all information regarding the assessment of hospital mergers could be analysed. Third, there were only three denied merger requests which were denied. This small number made it difficult to compare the influence of the different criteria on the assessment of the ACM because there was a limited variation on the dependent variable.

5.5 Recommendations for further research

For further research it is recommended to have at least two researchers coding the reports. This way, the possibility of errors and information bias is smaller. In addition to this, the study should be conducted in at least five years from now so that there are more reports available to code and the probability of more denied merger requests is higher. Also, the reports that were not available online should be requested for a full analysis. If possible, multiple respondents from the ACM should be interviewed to also reduce the information bias and get more insight in the assessment process.

6. Conclusion

This study assessed the way in which the ACM approves or denies hospital merger requests. A number of criteria were found to be of importance: A. The goals of the merger; B. The reasons for the merger; C. The structure of the organisations of the healthcare providers; D. The financial consequences of the merger for the healthcare provider; E. The consequences of the merger for the provided healthcare to the patient; F. The risks of the merger on the quality and accessibility of healthcare and the manner in which these risks are taken into account; G. The views and recommendations of patients, personnel and other concerned parties about the merger and the manner in which this can be provided, as well as the way in which these views and recommendations are taken into account by the merging parties; H. The way in which and the time frame wherein the merger will be realised; and I: Competition.

Eventually, the ACM looked at the totality of these criteria to decide whether a merger would be approved or not. Nevertheless, the ACM is an authority that has the assessment of competition as their legal mandate and they do not have to possibility to deviate much from this.

Furthermore, this study tried to find the difference of the assessment of hospital mergers before and after 2017. All in all, there is a shift in the assessment of hospital merger requests where the ACM has become stricter in accepting mergers. An emphasis was put onto the public interests together with an emphasis on risks to competition.

This research adds to the knowledge that the ACM has competition assessment as their legal mandate. It also adds the point of view from the ACM, where there is understanding about possible negative consequences from hospital mergers but there is not much within their legal competence to act upon this when mergers do not lead to a shift in competition.

With the identification of this knowledge, this research provides new ideas and opportunities for hospitals to consider or rethink the intention to merge as they can reach quality purposes by collaboration instead of merging since merging can bring negative consequences.

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Appendix

Appendix A: Interview transcript

I: Dan zou ik graag willen beginnen met het interview zelf.

R: Is goed

I: Mijn eerste vraag is: wat ziet u als de rol van de ACM bij het beoordelen van ziekenhuisfusies?

R: Uhm nouja, we hebben in ieder geval een wettelijke taak. Dus we hebben een bepaalde rol. Want ervanuit gaande dat ziekenhuizen, als ze fuseren, dat ze boven de drempel gaan, betekent het dat ze dit moeten melden. En daarmee heeft de ACM dus een rol, dus uhm, de ACM moet dat beoordelen. Kijken of er mogelijke problemen ontstaan en als die ontstaan dan kunnen we geen vergunning geven om te mogen fuseren. Dus wat dat betreft is het vrij eenvoudig, we hebben gewoon een wettelijke taak.

I: Oke dankuwel. En wat zijn jullie criteria eigenlijk als jullie kijken naar het beoordelen van de ziekenhuisfusie?

R: Uhh ja we kijken met name of er problemen ontstaan in het geval van concurrentie en mededinging. En dan nog iets meer in het bijzonder of die problemen ontstaan door het ontstaan van een machtspositie of het versterken van de machtspositie. Dus dat is onze wettelijke, niet taak maar uhm opdracht. Daar moeten we naar kijken, dat is het wettelijk instrument waar we mee moeten werken.

I: Oke en hier zijn dan niet specifiek criteria voor zoals, nou ik had in de rapporten bijvoorbeeld gelezen over er moet genoeg concurrentiedruk blijven. Is dat dan ook een specifiek criterium waar naar gekeken wordt?

R: Dat is meer een uitwerking van wat ik net zei, het ontstaan of versterken van een machtspositie. En daar kun je bepaalde indicatoren voor gebruiken. Bijvoorbeeld marktaandeel wordt vaak naar gekeken. We kijken tegenwoordig ook meer naar de fusionratio's, dat is waar we zegmaar naartoe zouden gaan als er bijvoorbeeld 1 ziekenhuis niet zou zijn of zou sluiten. Wat de prijs hier.. Uhhh waar de meeste concurrentiedruk vanuit gaat, wat dan als alternatief wordt gezien. We kijken bijvoorbeeld ook van zijn er, omdat er toch, er moet onderhandeld worden met verschillende verzekeraars. Verzekeraars en ziekenhuizen moeten onderhandelen over prijzen en contracten en vanuit die onderhandelingspraktijk moeten we ook kijken naar wat voor alternatieven zijn er. Dus wat is de outside option. En dan kijken we bijvoorbeeld ook naar hoeveel verwachten we dat ziekenhuizen in de omgeving extra kunnen bijzetten mocht een verzekeraar bijvoorbeeld geen contract afsluiten. Dus op die manier heb je een aantal indicatoren die we gebruiken om handen en voeten te geven aan het mededingings.... We hebben bijvoorbeeld ook de counterfact van verzekeraars, dus hebben ze bepaalde instrumenten waardoor ze de ziekenhuizen kunnen disciplineren. Dat zijn een aantal van die aspecten waar we naar kijken.

I: Oke, en welke van deze aspecten vindt u in de praktijk het lastigst om te beoordelen?

R: Uhhm, ja… Dit is een lastige vraag. Want er wordt eigenlijk altijd gekeken naar totaliteit. Het is niet dat we 1 van de factoren moeilijk vinden of zo. Het is altijd het voordeel van het totaal wat we zien. En daar hebben we verschillende bronnen voor die we kunnen gebruiken, dat zijn locatiegegevens, waar gaat de patiënt daadwerkelijk naartoe? Dat zijn interviews bijvoorbeeld met verzekeraars, patiëntenverenigingen en we spreken ook altijd met concurrenten van die ziekenhuizen. Dus het is niet zo dat je kunt zeggen: deze factor vinden we het moeilijkst om te beoordelen. Ja soms is het net wat beter onderbouwd dan in een andere zaak. Ja, je gebruikt de best onderbouwde bronnen, die geef je wat meer gewicht. En in de ene zaak is dat het verhaal van de patiënten en in het andere is het het verhaal van de verzekeraar. Uhmm, en in een andere zaak is dat met name de patiëntstromen die we zien.

I: Ja, oke. Toen ik de beoordeling van de ziekenhuisfusies ging opzoeken, vind ik een aantal punten die ziekenhuizen moeten indienen in een verslag als verzoek om te mogen fuseren. Deze punten heb ik vervolgens als codes gebruikt bij het analyseren van de rappoten. Ik heb het hier over de doelen van de fusie, de redenen voor de fusie…. Dit rijtje kent u waarschijnlijk wel goed, ik vroeg me af of naar al deze punten gelijk wordt gekeken?

R: Uhhm, doelen en redenen wordt eigenlijk minder naar gekeken. We moeten wel de rationale weten, tenminste we vinden het wel prettig als we dat weten. Maar bij wijze van spreken als een ziekenhuis een kruisje er neerzet, dan zullen we zeggen van is dat nou echt nodig. Had dat niet beter kunnen worden ingevuld? Maar dat is nou niet het criterium waarop we kunnen zeggen van nou de reden dat er gefuseerd wordt is onduidelijk dus we verbieden hem. Dat is niet zo. Uhm, het helpt wel als er een goede reden is, hoe heet het? Deels ga je dan ook richting een soort

efficiency verweer. Als er een heel duidelijk en goed verhaal is waarom er gefuseerd moet worden, ja dan kan je dat ook directer vragen aan verzekeraars of dat nut heeft. Ja dan kan je dat ook bevestigen en zal je eerder zeggen van ja: daar hebben we niet zo veel problemen. Maar het is niet zo dat wij, ACM, de plannen van een fusie van ziekenhuizen beoordelen. Dat is niet onze taak.

I: Nee, duidelijk. Dankuwel. Uhm, dan gaan we door naar de volgende vraag: wat zijn de belangrijkste redenen voor het weigeren van een ziekenhuisfusie?

R: De belangrijkste reden is het ontstaan of het versterken van een machtspositie of onderhandelingspositie waarvan wij verwachten dat er nadelige effecten gaan optreden. En die effecten kunnen misschien wel op verschillende niveaus voorkomen, bijvoorbeeld op dat we verwachten dat er hogere prijzen gevraagd zullen worden. Dus extra hoge prijzen als gevolg van de fusie. Uhm, daar heb ik een aantal onderzoeken naar gedaan en ook literatuur die wel bewijst dat dat regelmatig gebeurt. Kwaliteit zou kunnen verslechteren. Dat is een iets theoretischer verhaal. Dat we niet echt verder vaak daarnaar gekeken hebben. We hebben hier wel onderzoek naar gedaan en dan zie je dat het iets verslechtert. Uhm dus dat zou iets kunnen zijn. Ook bijvoorbeeld dat wachttijden langer worden of dat er minder prikkel ontstaat om je uiterste best te doen en nieuwe methodes te introduceren en dat soort dingen. Uhm, dus dat zijn eigenlijk alle elementen waar een ziekenhuis op zou kunnen concurreren. Dus alle concurrentie-parameters zouden kunnen verslechteren als gevolg van de fusie.

I: Duidelijk. De ACM had vermeld dat vanaf 2017 de patiënt meer centraal gezet zou worden bij het beoordelen van een ziekenhuisfusie. Heeft u het gevoel dat dit daadwerkelijk is gebeurd?

R: Wat we in ieder geval wel vanaf die periode doen is dat we beter kijken naar patiëntgroepen. In het verleden keken we voornamelijk naar basiszorg, complexe zorg, klinisch, niet-klinisch. Uhm, ja als patiënt wil je naar een ziekenhuis toe omdat je bepaalde problemen hebt, en we hebben nu uit mijn hoofd 65 patiëntgroepen die wat meer geconcentreerd zijn op bepaalde ja gezondheidsproblemen. Dus op die manier kijken we beter naar de achterliggende behoeftes en behoeftes van de patiënt. Dus dat doen we. Het is niet zo dat we nu bijvoorbeeld extra vragen stellen aan patiëntenverenigingen en dat die zwaarder wegen. Dat denk ik niet. We vragen ze altijd wel wat ze van de fusie vinden, maar het is niet dat we daar nu extra gewicht aan toekennen ten opzichte van voor 2017.

I: Oke. Naar aanleiding van deze vraag, vroeg ik mij dus ook af of er in de afgelopen jaren veranderingen zijn geweest in de beoordeling van ziekenhuisfusies buiten dit patiëntenbelang om?

R: Uhm, ja weet ik niet. Hoe heet het? Uiteindelijk doen we die beoordeling ook voor de patiënt. De patiënt, maar ook voor de verzekerde. Het lastige in deze markt is altijd, de patiënt heeft veel belang bij de fusie want die is onder behandeling en zal er ook waarschijnlijk direct de voordelen van ondervinden. Of nadelen als het de verkeerde kant op gaat. Maar er zijn natuurlijk ook verzekerden, die nog geen zorg nodig hebben maar wel betalen om als ze zorg nodig hebben dat ze er gebruik van kunnen maken. Maar heel veel verzekerden zullen helemaal geen zorg nodig

hebben en die betalen wel verzekeringspremie. Dus je hebt eigenlijk twee groepen om op te letten als je… Want je hebt het nu sterk over patiënt-belang maar het is ook verzekerde-belang, want die moet uiteindelijk betalen. Dus dat aspect, die tweedeling heb je eigenlijk altijd wel. Uhm, en dat zie mogelijk ook een beetje terug in de antwoorden bijvoorbeeld van patiëntverenigingen, die letten meer op de patiënt dan op de verzekerde. De verzekeraars letten als het goed is op beide. Uhh, ziekenhuizen die letten natuurlijk ook iets meer op de patiënt, want ja dat is hun klant. Maar uiteindelijk doe je je toezicht voor beide groepen.

I: Ja.

R: En dat is… Voor 2017 was dat zo en dat is nog steeds zo. Dus daar is denk ik niet echt iets in veranderd.

I: Ja, interessant.

R: Ja waarschijnlijk met 2017 heb je met name gekeken naar de studie die wij uitgevoerd hebben, prijs-kostenstudie. Daar kwam natuurlijk naar voren dat de kwaliteit niet verbeterd werd en de prijs omhoog ging. En daarmee hebben we eigenlijk aangegeven: we willen wat kritischer worden, omdat we ziekenhuizen zeker in de publieke opinie zeggen ‘de fusie is goed dus alles wordt beter’. Maar dat hebben we niet gezien in onze studie. Wat we wel gezien hebben is dat gemiddeld genomen het iets duurder wordt en dat is niet goed. Dus vandaar dus dat we iets kritischer zijn geworden op fusies. Tenminste dat hebben we toen aangegeven dat we nog meer gaan kijken naar wat levert het nu echt op.

I: Oke, dat begrijp ik. Uhh, dus volgt de ACM verdere ontwikkelingen van ziekenhuizen na de fusies? En wordt hier dan geëvalueerd op deze… Hoe de fusies hebben uitgepakt? U zei namelijk als iets over dat onderzoek, maar ik vroeg me af of hier meer in wordt gedaan en hoe regelmatig?

R: Dat is niet onze primaire taak. Als wij eenmaal een fusie hebben goedgekeurd dan kunnen de ondernemingen binnen die fusie gewoon doorgaan als, ja, bedrijf. Uhmm, en hebben daarna geen relatie meer, ze krijgen geen extra toezicht meer van de ACM. Dat is binnen de zorg zo, dat is binnen alle sectoren in Nederland zo waar wij toezicht op houden. Omdat we wel veel zorgfusies hebben, ziekenhuisfusies, hebben we wel in 2016/2017 onderzoek gedaan om te kijken wat al die fusies hebben opgeleverd. Wij moeten het wel beoordelen, het zijn vaak best lastige beoordelingen. Maar wat levert het nu eigenlijk op? Wat hebben al die fusies opgeleverd? En wat betekent dat voor ons toezicht? Dus dat hebben we in 2016/2017 gedaan en daar hebben we dus ook bepaalde consequenties aan verbonden. Dus waar moeten we op letten? En dat soort zaken. Maar het is niet dat we dat regelmatig doen. Ik weet niet of je, ik neem aan van wel, de berichtgeving van de ACM in de gaten hebt gehouden? In ieder geval, voor de kerst hebben we een ZBC fusie verboden, ook op het gebied van ziekenhuizen, ziekenhuiszorg. En daar hebben we dus ook gekeken, dat zijn dus Bergman, die is eerder gefuseerd, in 2018, tenminste hebben we goedkeuring gegeven voor een overname van NL healthcare. Naar die zaak hebben we dus ook gekeken van wat heeft die fusie van NL healthcare met Bergman nu opgeleverd en is dat misschien een goede voorspeller van wat we mogen verwachten bij de nieuwe fusie? En daar zie je dus wel een hele duidelijke relatie tussen die twee fusies van wat heeft het opgeleverd. We

hebben dan ook heel gericht met de verzekeraars erover gesproken van ‘hey wat is jullie ervaring met die fusie?’. Dat hebben we dus ook weer nu in deze nieuwe beoordeling van deze nieuwe fusie meegenomen. En mede daarop dus ook de fusie verboden.

I: Duidelijk.

R: Maar dat is dus ook de eerste keer dat we zoiets hebben gedaan in een ziekenhuisfusie.

I: Oke, nou het is dus wel duidelijk dat patiëntenorganisaties en zorgverzekeraars worden meegenomen in de beoordeling van een ziekenhuisfusie, maar worden ook gemeenten waar de fuserende ziekenhuizen zich bevinden ook meegenomen buiten de, ja, de reistijdenanalyse om? Dus ook wat de gemeenten van de fusie vinden en hoe zij er tegenover staan?

R: Over het algemeen niet. Wij publiceren het natuurlijk als wij een fusie gaan beoordelen, dan kunnen belanghebbenden altijd hun visie naar voren brengen. Het gebeurt volgens mij niet, of ik kan me niet herinneren dat we op ons eigen initiatief bijvoorbeeld een gemeente hebben gevraagd van ‘goh wat vinden jullie van deze fusie?’. Volgens ons staan ze er toch iets te ver van af. Ze zijn in ieder geval niet belanghebbend, patiënten zijn natuurlijk wel belanghebbend. Verzekeraars zijn belanghebbend, maar een gemeente staat daar gewoon verder van af. Als je gewoon veel fusiebesluiten hebt gelezen, dan zal je waarschijnlijk niet vaak de gemeenten zijn tegengekomen van de gemeente zegt dit en de gemeente zegt dat. Dus dat is eigenlijk al het antwoord. Uhm, ja gemeenten nemen we eigenlijk niet vanuit ons eigen initiatief mee. Het moet echt vanuit de gemeente zelf komen als zij een visie of zienswijze inleveren, dan kijken we

ernaar, nemen we dit mee. Maar niet dat wij zelf actief naar gemeenten gaan om te vragen van ‘goh, wat denken jullie ervan?’.

I: En gemeenten zijn zich er ook wel bewust van dat ze zo’n zienswijze kunnen inleveren?

R: Uhh, weet ik niet. Wat je vaker ziet is dat gemeenten zich gaan roeren als er bijvoorbeeld zorg verplaatst gaat worden.

I: Ja.

R: Maar dat is natuurlijk beleid van het ziekenhuis zelf. Nadat ze gefuseerd zijn, mogen ze dat wat ons betreft prima doen. Maar dan zie je dat gemeenten zich gaan roeren omdat bijvoorbeeld ziekenhuizen worden uitgekleed waardoor ze uiteindelijk een soort sterfhuisconstructie krijgen en dat is voor ziekenhuizen misschien heel vervelend. Dat is eigenlijk meestal nadat wij onze goedkeuring hebben gegeven en daarmee valt het dus eigenlijk buiten wat wij doen.

I: Ja, oke. Uhm, zijn er criteria die ontbreken in het wettelijk kader dat gebruikt mag worden die toch van belang zouden kunnen zijn?

R: Zit jij zelf ergens aan te denken?

I: Nee, het is een hele open vraag.

R: Oke. Nou, uhm, ja misschien. Twee, drie jaar geleden speelde er, het speelt eigenlijk nog steeds, de eventuele overlevering van bepaalde taken van de NZa richting de NMa, de ACM sorry. We zijn alweer een aantal jaar verder. Uhm, en één van die taken is het AMM-instrument en we hebben aan VWS geadviseerd om dat ook eventueel mee te nemen binnen het fusie-toezicht. Dus dat… Er was, of is het gevoel dat soms fusies, zeker in ziekenhuizen, leiden tot hele grote organisaties, die misschien niet meer efficiënt zijn, niet patiënt-gericht en dat soort zaken. En dat zou je misschien kunnen voorkomen door te zeggen van, uhm… Nu is het 'ja, tenzij', dus je mag fuseren tenzij er grote problemen zijn. Dat zou je misschien voor bepaalde ondernemingen, aanbieders, moeten omdraaien. Dat het 'nee, tenzij' wordt. Dus als je een aanmerkelijke machtspositie hebt als ziekenhuis dan mag je niet fuseren tenzij je een heel goed verhaal hebt waarom het beter wordt. Dat is dus eigenlijk een beetje een soort omdraaien van de bewijslast en voor sommige fusies zou dat wel handig zijn als we dat zouden hebben. Waar we soms tegenaan lopen is dat er een, bijvoorbeeld twee ziekenhuizen die beiden nagenoeg een monopolie positie hebben, maar niet echt in hun eigen gebied, geen overlap hebben, in het werkgebied, dat die gaan fuseren en dat kunnen we eigenlijk niet tegenhouden. En soms, zou je willen dat je dat wel kunt tegenhouden en dat zou kunnen als je nu zegt van 'oke, als je een aanmerkelijke machtspositie hebt, aanmerkelijke macht hebt, dan mag je niet fuseren, tenzij je er echt een heel goed verhaal tegenover hebt met dat kwaliteit beter wordt en dat dat alleen maar gerealiseerd kan worden door een fusie. Dus dat zou mogelijk wel een goede aanvulling zijn.

I: Dan zou er dus een hele verandering komen in 'we kijken niet zo erg naar de reden voor de fusie' naar 'we kijken toch wel veel meer naar de reden dan we aanvankelijk deden'?

R: Ja, ja. Inderdaad, dat zou echt een verschuiving zijn dat je voor bepaalde fusies de reden wel gaat meenemen. Waarom is het goed dat je fuseert, wat levert het op? En nu is het zo dat we inderdaad in het begin, dat we daar helemaal niet naar kijken, van oke je bent gefuseerd en je mag doen en laten wat je wil. Met die omdraaiing zou dat het omgekeerde zijn, je mag niet fuseren, tenzij je, tenminste bepaalde aanbieders dan, tenzij je echt een heel goed verhaal hebt dat het beter wordt.

I: Oke, ja. Dan kom ik ook aan bij de laatste vraag die ik voor u heb en dat is: is er iets wat u anders zou willen zien in de beoordeling van ziekenhuisfusies?

R: Tja, wat ik net aangaf, dat heeft er wel een beetje mee te maken. Soms zie je dat een fusie wordt voorgesteld, uhm, en dat je eigenlijk het idee hebt van ‘goh dat moeten we niet toelaten’, maar dat je gewoon geen middelen hebt om dat te doen. Nou, bij Bergman zat het er een beetje tegen aan, die hebben een vrij sterke onderhandelingspositie, zijn vrij commercieel en gebruiken hun positie dus ook in onderhandelingen met verzekeraars. En wat dan altijd het probleem is bij zo’n fusiebeoordeling, dat je zowel naar de positie moet kijken als met name ook naar de delta, dus wat verandert er. En als we dan bijvoorbeeld met verzekeraars spreken, dan zeggen die van ‘ja, Bergman die is nu al heel dominant, ja en door de fusie verandert er eigenlijk niet heel veel. Ze zijn al dominant, we kunnen al niks en na de fusie zijn ze nog steeds dominant en kunnen we nog steeds niks’. Uhm, dus dan zie je of krijg je het idee dat de markt-uitkomst niet optimaal is, maar de fusie verandert daar niet zoveel aan. De delta van de fusie is heel beperkt. En daar zou je wel eigenlijk wat meer mogelijkheden mogen hebben om dat dan toch tegen te kunnen houden. En bij Bergman hebben we dat nu wel gedaan, maar het is wel opzich een juridisch onzekere

keuze geweest. Dus we zullen kijken of partijen in beroep gaan en als dat zo is dan zullen we bij de rechter kijken of onze keuze standhoudt.

I: Oke, dat is duidelijk, dat brengt wel lastige situaties inderdaad. Dat was mijn laatste vraag aan u, hebt u nog verdere vragen of opmerkingen voor mij om mee te nemen?

R: De zorg is wel, en zeker een ziekenhuis, is wel een erg interessant onderwerp, omdat er veel wordt samengewerkt en veel moet worden samengewerkt, soms mondt dat dan uit in een fusie. Maar af en toe heb ik wel het idee dat die fusie dan verder gaat dan noodzakelijk is om dan die voordelen van die samenwerking te realiseren. Het voordeel vanuit een ziekenhuis bekeken, als je nu eenmaal gefuseerd bent dan kan je doen en laten wat je wilt. Bij samenwerkingen moet je dat iedere keer weer aannemelijk maken dat het voordelen oplevert. Dus dat is af en toe dus misschien een beetje een oneerlijke positie. Samenwerkingen hebben misschien een iets lastigere positie dan de fusie. Bij de fusie moet je één keer door het hoepeltje springen en daarna ben je klaar en bij samenwerken moet je constant zorgen dat je door dat hoepeltje blijft springen en kan springen. Terwijl de oplossing, het beter maken van de zorg, waarschijnlijk bij beide prima kan. Dus dat is een beetje de afweging en de positie van samenwerken ten opzichte van fusies. Ik heb het idee dat fusies nu iets minder aantrekkelijk lijken of zijn dan zeg 5 of 6 jaar geleden en dat samenwerken eerder wordt gedaan nog of geprobeerd. Er zijn ook een aantal fusies die of fusieplannen die goedgekeurd zijn door de ACM, die zijn teruggetrokken of niet uitgevoerd. Ook aan het fuseren zitten mogelijke nadelen. We hadden het net kort even over gemeenten, volgens mij in de Achterhoek is er ook zo'n discussie geweest, moest er een nieuw ziekenhuis in de fusieplannen worden gerealiseerd en dan zie je gewoon dat ook de belangen die daar spelen

tussen de twee fuserende ziekenhuizen, dat die niet altijd duidelijk zijn en ja de ene groep specialisten was bang dat met verplaatsingen het ziekenhuis kleiner zou worden en het vertrouwen. Uiteindelijk gaat dan de fusie niet door. Dus dat is ook nog wel een punt. De laatste jaren is de algemene gedachte van ‘een fusie is fantastisch en moeten we zeker doen’ dat dat iets gekanteld is. Ook bijvoorbeeld in Delft/Zoetermeer/Den Haag, dus Reinier de Graaf, Langeland en Haga volgens mij, die is ook teruggedraaid. Dus de eventuele nadelen van fuseren worden nu ook wat meer erkend.

I: Het klinkt alsof u dat ziet als een positieve verandering?

R: Ja, ja. Wat je vaak ziet is dat als reden voor het fuseren wordt gezegd van ‘ja, we moeten meer behandelingen doen want dan gaat de kwaliteit omhoog’. Er zijn verschillende studies die dat aantonen, maar vaak gaat het over 1 behandeling. Kankerbehandelingen wordt heel veel onderzoek naar gedaan, naar het volume. Maar als dat voor die ene behandeling zo werkt, betekent dat niet dat het hele ziekenhuis hoeft te fuseren. Je kan er ook afspraken over maken. Dus als je de volumes van een bepaalde kankerbehandeling omhoog wilt krijgen, kan je fuseren maar dat betekent dat je voor alle andere behandelingen ook gefuseerd bent en vaak is dat helemaal niet nodig en daar lijkt wel een verandering in te komen. Dus dan wordt er eerder gezegd van ‘hey, kunnen we samenwerken om die volumes te realiseren en niet de hele te fuseren’, en ik denk dat dat goed is.

I: Ja mooi, nou dank u wel.