Netherlands Competition Authority

DECISION

Decision of the Board of the Netherlands Competition Authority, within the meaning of Section 41 of the Competition Act.

Number 6424/427
Case: 6424/Walcheren Hospital - Oosterschelde Hospitals

CONTENTS

I. PROCEEDINGS

1. On 25 June 2008, the Board of the Netherlands Competition Authority (NMa) (referred to below as 'the Board') received notice of a proposed concentration, within the meaning of Section 34 of the Competition Act (referred to below as 'Mw'). This stated that Walcheren Hospital Foundation and the Oosterschelde Hospitals Foundation (jointly referred to below as 'the parties') intended to merge. On 23 July 2008, the Board adopted a decision that a licence was required for this concentration. This decision (referred to below as the first-phase decision) was announced in Government Gazette 141 of 24 July 2008.

2. On 22 August 2008, the Board received a licence application from the parties. The licence application was announced in Government Gazette 167 of 29 August 2008. In response to the announcement, opinions on the proposed concentration were submitted by various third parties. In the context of the present case, an opinion was also received from the Dutch Healthcare Authority (referred to below as the NZa). The latter opinion included a report by the Health Care Inspectorate (referred to below as IGZ). Officials also made enquiries to obtain certain information from various market parties. In addition, the NMa commissioned external research by Twynstra Gudde. The said opinions, market parties' responses and external research findings are set out in the body of this document insofar as they had a bearing upon the considerations upon which this decision is based.

3. On 29 August 2008, further information pertinent to the application was requested from the parties. On 16 October 2008, the requested information was received from the parties. On 24 November 2008, a supplementary request for further information pertinent to the application was made to the parties. The information in question was received on 20 February 2009. On 12 February 2009, a second supplementary request for further information pertinent to the application was made to the parties. The relevant information was received on 24 March 2009. In consequence, the period of thirteen weeks referred to in Section 44, subsection 1, of the Mw was postponed for a total of 166 days, as provided for in Section 4:15 of the General Administrative Law Act.

4. On 15 January 2009, the parties were orally informed of the NMa Competition Directorate's provisional findings following its assessment of the licence application under review, and in particular the so-called 'efficiency defence' made by the parties (see point 98).

5. On 24 March 2009, the NMa received a letter from the parties containing a definitive proposal regarding the conditions to be attached to the decision, on the basis of which a licence for the proposed concentration could be granted. The conditions themselves and the NMa's assessment of them are presented in points 151 and following of this decision.

II. THE PARTIES

6. The Walcheren Hospital Foundation (referred to below as Walcheren Hospital) is a foundation under Dutch law. Walcheren Hospital is a general hospital providing clinical and non-clinical general hospital care from its main site at Vlissingen. Walcheren Hospital also has a non-clinical site at Middelburg. Walcheren Hospital offers the following specialisms: internal medicine, cardiology, pulmonology, rheumatology, gastrointestinal and hepatic medicine, anaesthesiology, paediatric medicine, neurology, dermatology, urology, orthopaedic medicine, surgery, oral medicine and jaw surgery, plastic surgery, obstetrics and gynaecology, eye surgery and ear, nose and throat surgery. The hospital has a twenty-four-hour accident and emergency unit and intensive care/coronary care facilities. Walcheren Hospital is also licensed under the Exceptional Medical Procedures Act to perform specialist clinical procedures in the field of AIDS/HIV-treatment.[1]

7. The Oosterschelde Hospitals Foundation (referred to below as Oosterschelde Hospital) is a foundation under Dutch law. Oosterschelde Hospital is a general hospital providing clinical and non-clinical general hospital care from its main site at Goes and non-clinical general hospital care from its site at Zierikzee. Oosterschelde Hospital offers the following specialisms: internal medicine, cardiology, pulmonology, rheumatology, gastrointestinal and hepatic medicine, anaesthesiology, paediatric medicine, neurology, dermatology, urology, orthopaedic medicine, surgery, cardio-thoracic surgery, neurosurgery, oral medicine and jaw surgery, plastic surgery, obstetrics and gynaecology, eye surgery and ear, nose and throat surgery. The hospital has a twenty-four-hour accident and emergency unit and intensive care/coronary care facilities.

III. THE PROPOSED CONCENTRATION

8. The process under review involves the creation of a holding foundation to manage the two existing foundations. The parties have indicated that the merger will adhere to the principles laid down in the draft constitution dated 9 August 2005, as submitted by the parties during the proceedings in case 5196/Walcheren Hospital – Oosterschelde Hospital. Thus, the parties wish to effect the legal merger, in the sense of Article 2:309 of the Civil Code, of the holding foundation, the Walcheren Hospital Foundation and the Oosterschelde Hospitals Foundation. The notification submitted in this case included papers demonstrating that the management boards and supervisory boards of the two hospitals agree with the strategy adopted by the hospitals, as set out in other papers submitted with the notification (the *Statement of Principles regarding the Future of the Associated Zeeland Hospitals*, dated 12 June 2007, and the *General Strategy for the Future Zeeland Hospital*, dated 9 April 2008).

IV. APPLICABILITY OF CONCENTRATION REGULATION

[1] Walcheren Hospital and the Erasmus Medical Centre together operate an HIV Sub-treatment Centre.

9. The process under review is a concentration in the sense of Section 27, subsection 1(a), of the Mw. The outcome of the transaction referred to in point 8 will be the merger of two previously mutually independent undertakings.

10. The undertakings concerned are Walcheren Hospital and Oosterschelde Hospital.

11. From the turnover data supplied, the concentration under review falls within the scope of the regulation provisions of chapter 5 of the Mw.

V. THE RELEVANT MARKET

RELEVANT PRODUCT MARKET

12. Walcheren Hospital and Oosterschelde Hospital are both general hospitals. The parties are not active in the provision of tertiary specialist[2] and specialist clinical care[3], with the exception of the AIDS/HIV treatments (specialist clinical care) offered by Walcheren Hospital. The activities of the parties therefore overlap horizontally in the field of general hospital care.

Distinction between clinical and non-clinical care

13. In earlier decisions,[4] in light of considerations concerning supply and demand substitution and access threshold differences, it has been assumed that distinct relevant product markets exist for clinical and non-clinical care. Non-clinical care involves same-day treatment in an outpatient clinic or in the context of admission without an overnight stay. Clinical treatment involves hospitalisation for more than twenty-four hours.

General hospital care or specialisation

14. From the demand side – the patient's perspective – each medical specialism constitutes a distinct relevant market, which is not (or is barely) substitutable by another specialism.

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[2] Tertiary specialist care is highly specialised care. Tertiary specialist care is provided by university medical centres and, where certain provisions are concerned, by a small number of specialist teaching hospitals. The care is labelled tertiary because it involves referral by the secondary care sector (i.e. medical specialists) to recognised experts in the relevant fields. Tertiary specialist care embraces the function of what is sometimes called the '*hospital of last resort*'.

[3] Specialist care is highly specialised care whose provision requires not only a licence under the Exceptional Medical Procedures Act, but also in most cases relatively expensive specialised facilities.

[4] See, for example, the decision of 28 January 2004 in case 3524/ *Juliana Children's Hospital/Red Cross Hospital – Leyenburg Hospital,* points 45 to 48, the notification-phase decision of 15 July 2004 in case 3897/ *Hilversum Hospital – North Gooi Hospital*, points 14 and 15 and the more recent decision of 29 April 2008 in case 6284/ *St. Lucas – Delfzicht*, points 14 and 15.

However, previous decisions[5] have indicated that, because of possible supply substitution between various (clusters of) specialisms, markets can exist for general hospital care.

15. As indicated in the first-phase decision in this case, the Board currently sees no reason to depart from the market delineation described in point 14. Hence, in this decision the Board continues to assume the existence of distinct product markets for clinical general hospital care and non-clinical general hospital care. Any differences that may exist in the circumstances pertaining to certain specialisms within the general hospital care market will be taken into account where necessary in the assessment.

Opinion of the parties

16. The parties have indicated that, for the purpose of the licence application with which this case is concerned, they accept the product market delineation set out in the decision of 18 November 2005 in case 5196/Walcheren Hospital – Oosterschelde Hospital, implying the existence of a distinction between a market for clinical general hospital care and a market for non-clinical general hospital care.

Conclusion

17. In this case, the assessment will be based upon distinct relevant product markets for clinical general hospital care and non-clinical general hospital care.

RELEVANT GEOGRAPHICAL MARKET

18. In the decision in case 5196/Walcheren Hospital – Oosterschelde Hospital[6], the Board indicated that – in view of (i) research into the geographical and socio-cultural characteristics of the area, (ii) a travel time analysis and (iii) an analysis of patient flows – it could not be assumed that the parties were active in the provision of clinical general hospital care and non-clinical general hospital care in separate geographical regions. Nor did the Board believe that it could be assumed that the geographical market was larger than the area comprised of Walcheren, Schouwen-Duiveland, Noord-Beveland and Zuid-Beveland (referred to collectively below as 'Central Zeeland').

19. In the notification-phase investigation of the implications of the concentration under review, steps were taken to ascertain whether the earlier geographical market delineation was still

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[5] See, for example, the decision in case 3524/*Juliana Children's Hospital/Red Cross Hospital – Leyenburg Hospital*, as cited above, points 37 to 40, and the licence-phase decision of 8 June 2005 in case 3897/*Hilversum Hospital – North Gooi Hospital*, points 20 to 48.

[6] As previously cited, points 16 to 46.

supported by the current circumstances. It was found that no relevant material changes had taken place. Nor was any material change suggested by the Prismant report *Patient Flows and the Supply of Care in Zeeland* (a report on the travel habits of patients throughout the province of Zeeland, commissioned by the provincial government and published in November 2008). The travel patterns in the study region were not found to differ significantly from those previously observed. The Board therefore adheres to its previously expressed view concerning the size of the geographical market.

Opinion of the parties

20. In the notification and in connection with the licence application for the proposed concentration, the parties have indicated that, for the purposes of the notification and the licence application, they accept that the market is geographically limited to Central Zeeland.

Conclusion

21. In this case, the assessment will be based upon a relevant geographical market consisting of Central Zeeland.

VI. INVESTIGATION

OPINION OF THE PARTIES

Introduction

22. In support of their licence application, the parties submitted two documents of particular significance, namely the *General Strategy for the Future Zeeland Hospital*, dated 9 April 2008, and *Policy Considerations pertaining to the June 2008 Notification and Licensing Procedure*.

23. The parties are of the opinion that the various advantages of the proposed merger outweigh any possible adverse competition implications, particularly in view of the considerable improvements in care that the merger will bring about, the position of the hospitals in the long term, and the position and development of the health insurers, who will ensure that the benefits of the merger are felt by patients. If there is no merger, various interrelated problems will lead to a spiral of decline, adversely affecting the position of both Walcheren Hospital and Oosterschelde Hospital, which would have major implications for the availability of high-quality and affordable general clinical and non-clinical hospital care in Walcheren, Noord-Beveland, Zuid-Beveland and Schouwen-Duiveland.

Background

24. Both hospitals indicate that they have relatively small departments, thus creating vulnerabilities. The number of staff in certain departments could threaten the continuity of care and the ability to keep up with developments in the relevant discipline and to develop subspecialisations. The parties say that it is often difficult and sometimes impossible to fill vacancies. Consequently, patients requiring certain forms of care need to travel to hospitals outside the province. Filling vacancies has been particularly difficult in paediatric medicine and gynaecology. The parties argue that this has created a crisis necessitating the concentration of secondary obstetric care and the associated paediatric care. To support this contention, the parties cite a letter from the IGZ, dated 29 July 2008, confirming that this is the case (see point 41). Because of these problems, secondary obstetric care is available only at Goes.

25. Similarly, the parties indicate that, as individual hospitals, they are only able to operate on a small scale in the surgical disciplines. Where these disciplines are concerned, the parties report that it is particularly difficult for them to satisfy the quality requirements regarding procedure numbers. Where various procedures are concerned, such as in the field of carotid and AAA surgery, the numbers performed at each hospital are too small to enable them to comply with the volume standards. This leads to insufficient scope for subspecialisation, making the hospitals less attractive to specialists. This in turn threatens the continuity and availability of certain forms of (sub)specialist care. As a result, patients may in the future need to travel to hospitals outside the province for complex surgery, the parties argue.

26. On the subject of accident and emergency care (referred to below as A&E), the parties state that every year about five hundred patients require level-2 A&E care.[7] At present, roughly 90 per cent of these patients are treated in Zeeland, although neither hospital has a level-2 A&E unit. The rationale for this is that, because the nearest trauma centre is so far away, it is often better for the patient to be treated locally than taken to a facility of the appropriate kind. However, the parties consider it undesirable that they should continue to operate without a level-2 A&E unit, as required by the standards.

27. The parties report that a similar situation exists in relation to intensive care (referred to below as IC). The parties have a level-1 IC unit,[8] but patients sometimes remain in the unit longer than the standard permits for such facilities. Again, the parties say that this is preferable to transporting the patients in question large distances to more appropriate facilities[9] outside the province. Neither party can on its own create a level-2 IC unit. In consequence, patients either have to be treated in facilities where their health is at greater risk, or have to be exposed to the risk of relocation over large distances to appropriate facilities elsewhere. As indicated, the parties believe that, without a merger, it will not be possible to maintain and expand expertise in certain

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[7] The classification of A&E units is based on the level of expertise present in the hospital. An A&E unit with the highest level of expertise can admit and treat all patients. An A&E unit with the lowest level of expertise is, for the most part, able to provide only basic care. Source: Health Care Inspectorate, *Accident and Emergency Care: Standards Geographically Variable*, September 2004.

[8] In the Netherlands, the various IC care levels are defined as follows:

- A **level-1 IC unit** is a unit providing basic IC, as described in the CBO guidelines Organisation and Working Methods for Adult IC Units in the Netherlands. An IC unit of this level is intended for monitoring, nursing and treating patients suffering from or liable to develop a functional disorder of a vital organ, and possibly also requiring emergency ventilation, for a period that is not expected to last longer than two to three days.
- A **level-2 IC unit** is intended for patients with serious illnesses requiring the continuous availability and/or presence of specialised nurses and intensive care doctors. Such units do not need to be capable of treating particular patient groups with very complex conditions.
- A **level-3 IC unit** is a unit or section of a unit with an academic and/or supra-regional function, intended for patients with very complex and very serious conditions involving simultaneous disorders of several vital functions and requiring the continuous availability and/or presence of specialised nurses and intensive care doctors. In most cases, the units are set up to provide specific IC functions, such as IC associated with complex thoracic, neurological and transplant surgery, IC for trauma patients and IC for patients with (rare) complex conditions.

Source: Health Care Inspectorate, *Level-1 IC units: "towards responsible care"; a survey of the quality of level-1 intensive care units*, December 2008.

[9] For (acute) complex care, patients from Zeeland have to travel relatively great distances. The nearest hospital providing specialist clinical care is at Breda and the nearest centres offering academic (tertiary specialist) care are Rotterdam and Antwerp. Under the current regional arrangements, trauma patients requiring level-2 care have to go to Rotterdam.

forms of treatment, or to broaden the range of treatments available in Zeeland to include all those that a level-2 IC unit has to be able to provide.

28. The parties observe that – mainly as a result of population aging – the demand for care is both increasing and changing. More and more patients have chronic care needs (as associated with cardiovascular disease, diabetes, etc) and the growing number of older people is increasing the demand for complex treatments, the parties argue. Furthermore medical and technological advances are making it possible to do more. These developments, combined with the knowledge and experience requirements made by the relevant professions, are driving a trend towards greater subspecialisation and are making it more difficult to practise a discipline in the round. This is the case with oncology, gastrointestinal and hepatic medicine, endocrinology and infectious disease, for example. In the past, these were all fields within the discipline of internal medicine, but now they are almost separate specialisms each requiring a continuous care capability. The developments referred to also mean that the new generation of doctors are not seeking the same things as their predecessors. The parties suggest that young doctors want career paths that offer opportunities for subspecialisation and expertise development. They do not want to work on teams where they can only practise basic medicine; there has to be scope for in-depth work.

29. The parties additionally observe that the care that is provided is increasingly judged against standards set by professional organisations representing medical specialists and adopted by the IGZ and the Ministry of Health, Welfare and Sport (referred to below as the VWS). In this context, the parties point out that, at present, a (small) number of standards deal with quality defined in terms of experience and volume and that requirements are made regarding quality defined in terms of expertise and multidisciplinary treatment. The parties indicate that clear standards exist only for a small number of disciplines. The parties report, for example, that a minimum capacity of six to eight FTEs is required in the field of paediatric medicine, while in gynaecology the minimum capacity is five FTEs. No such standards are defined regarding the capacity required in other disciplines, according to the parties. The parties therefore assume that five FTEs are required in each of the other specialisms. Where IC is concerned, standards are defined regarding the numbers of ventilation days and the availability of specialist intensive care doctors. In addition, requirements are made regarding the minimum numbers of certain surgical procedures performed by each specialist.

30. The parties state that each separate hospital is too small (too few specialists per discipline) and has insufficient adherence to provide a sufficient range of treatments to allow for expertise to be built up. This has two mutually reinforcing effects. First, because the hospitals are unable, or liable to become unable, to meet standards relating to operational scale and volume, they will no longer be allowed to provide certain forms of treatment or specialisms. Second, because the hospitals have inappropriately small departments and provide an inappropriately

small number of procedures, it is not possible to support subspecialisation, which in practice means that the hospitals are less attractive to specialists. This in turn makes it even harder for the departments to meet the standards on operational scale. The result is a spiral of decline, which may ultimately mean that the quality of care and the capacity to provide care no longer meet the relevant standards.

31. The various specialisms and functions of a hospital cannot, the parties argue, be viewed separately, because many cannot exist without others. To support this argument, the parties identify a number of functions that they regard as closely interrelated. Gynaecology (obstetrics) and paediatric medicine cannot exist without each other, for example. There are areas of overlap between these two specialisms: obstetrics and neonatal care are overlapping functions, for instance. The parties fear that the inability to provide services such as paediatric medicine or gynaecology (obstetrics) could even lead to the loss of hospital status and consequently the withdrawal of twenty-four-hour care. Complex trauma care and complex surgical procedures such as carotid and AAA surgery cannot be provided at hospitals that do not have level-2 IC units, and hospitals that cannot provide such services are less attractive to surgeons as workplaces. It is also likely to become harder to find intensive care doctors who are prepared to work in level-1 IC units, making it necessary for other specialisms to provide personnel and threatening the continuity of the level-1 IC unit. This in turn has implications for other disciplines, such as internal medicine and cardiology, the parties say.

32. The combination of the internal and external circumstances described earlier and the cascade effect referred to in the previous point mean that, within three years, the parties will be obliged to contract the range of care services that they provide to the point where neither hospital is independently capable of responsibly providing basic care. The parties suggest that the insurer is unlikely to be willing to pay for mediocre or over-priced care and that the IGZ is liable to conclude that quality is no longer assured. Under such circumstances, it is reasonable to suppose that the IGZ would order the closure of some departments and withdraw its recognition, while it would become impossible to retain professional personnel. The parties say that the continuity of the IC unit and the mother-and-baby unit are already under serious threat.

Solution

33. In order to ensure that (i) both of the parties retain a staff that includes the minimum number of specialists and (ii) both parties' medical specialists perform the minimum numbers of procedures/treatments (see point 29), the parties need to merge. Furthermore, the merged entity needs to have the minimum scale required for adequate specialisation and differentiation. Scaling up would enable the parties to attract qualified medical specialists and nurses and to continue to function as a teaching hospital. Moreover, if the two hospitals were able to treat the areas that they respectively cover as a single area and to aggregate their patient numbers, they would meet

the criteria for a level-2 IC unit. Where a number of core specialisms (surgery, paediatric medicine, internal medicine and neurology) are concerned, such a unit is essential if patients are to be offered a wider spectrum of treatments within the province. The result would be more choice for patients, according to the parties.

34. According to the parties, scale and scope benefits would translate primarily into efficiencies, quality improvements (better medical care), cost reduction and enhanced recruitment prospects. However, the parties are not currently able to quantify the anticipated benefits of scale in terms of the number of additional procedures that the various specialisms would be able to perform as a result of the merger. To specify the *scope benefits*, the parties have indicated the additional subspecialisms that the hospitals would be able to support as a result of the proposed merger.[10] The parties have also indicated how the reallocation of fields of responsibility amongst the specialists working at the two hospitals would improve the cover per subspecialisation and thus enhance continuity and the availability of treatment. The parties additionally highlight the possibility of the two hospitals sharing the expertise that each of them has acquired.

35. The parties indicate that a merger would lead to reduced costs as a result of collective purchasing, joint medical investments (such as the acquisition of new MRI equipment), joint non-medical investments (such as the acquisition of new IT equipment) and the creation of unified service organisations (synergy benefits). The parties have not, however, been able to indicate what practical effect a merger would have on the cost of particular diagnosis-treatment combinations (referred to below as DTCs).

36. The parties believe that the *scale* and *scope* benefits attainable by a merger would be advantageous to patients, partly because of the position adopted by the health insurers and developments in the health insurance market.

37. If the hospitals do not merge, neither continuation of the present form of cooperation nor adoption of another form of cooperation would provide a real solution to the organisational, administrative and financial problems currently facing the two hospitals. In the particular situation that exists in Zeeland, a less comprehensive form of cooperation could not resolve the problems described. According to the parties, if all the cooperative initiatives necessary to continue to assure the quality of care were taken, the practical effect in terms of reduced competition would be the same as that of the proposed merger.

Summary

[10] Minimally invasive surgery, navigation/robot surgery, lumbar surgery, bone marrow transplantation, endoscopic laser treatments, PCI (percutaneous coronary interventions).

38. The hospitals will find it increasingly difficult to continue providing even basic care of adequate quality. There is perceived to be real risk of a collapse in the availability of care, and a risk that, in the long term, only one of the two hospitals in Central Zeeland will survive as a minor provider of basic hospital care. Only by merging will the hospitals be able to meet their qualitative objectives and thus to assure the continuity of care, the parties contend. In order to secure the future of the parties and of hospital care in Central Zeeland, a larger-scale operation is necessary, according to the parties.

OPINIONS OF THE IGZ AND NZA

Introduction

39. The NZa submitted an opinion regarding this case. Section 19 of the Healthcare Market Regulation Act requires the NZa to base its judgement of the quality of a care provider's activities on the judgement of the Public Health Supervisory Service, to which the IGZ belongs. The NZa accordingly put various questions to the IGZ regarding the proposed merger. As part of its own enquiries, the NMa also addressed a number of questions to the IGZ. The IGZ responded on 27 October 2008 by providing the NZa with a written advisory report regarding the proposed merger. Answers to the NMa's questions were appended to the latter report. In view of the importance of the IGZ's advice in this case, the report is discussed below before consideration is given to the NZa's opinion.

IGZ report

40. The IGZ says that, without a change in policy (by which the IGZ means without intensive generalised cooperation between the two hospitals), the continued availability of basic hospital functions[11] in the Central Zeeland region cannot be guaranteed. Both hospitals are extremely vulnerable, both in terms of human resource continuity and in terms of quality of care (little or no subspecialisation). Each hospital has an A&E unit that is below the standard required for the client population. Each hospital has a level-1 IC unit, where patients regularly stay for longer than

[11] By 'basic hospital care' the IGZ means the care provided by the following specialist medical functions, separately and on a cooperative basis, which under the WTZi must be available at every hospital: acute care (trauma care and acute care in connection with the below functions, as well as A&E care and IC), internal medicine, surgery/orthopaedic medicine, pulmonology, gynaecology/midwifery, paediatric medicine, ear, nose and throat medicine, eye surgery, neurology, cardiology, urology, dermatology, medical support, such as radiodiagnostics, anaesthesiology, clinical chemistry, pathology, etc. In order to responsibly provide basic hospital care, it is necessary that – in addition to the minimum staff complement needed for the perpetual continuity of care (in paid employment situations five FTEs, according to the IGZ) – it is necessary to have sufficient personnel to allow for the subdivision of specialisms, in combination with perpetual service availability where certain functions are concerned. Furthermore, additional criteria apply, such as a certain minimum patient volume for certain *high-tech* and *medium-tech* interventions.

is appropriate. In disciplines such as internal medicine and surgery/orthopaedic medicine, a full range of services cannot responsibly be provided, according to the IGZ. The IGZ fully expects that, within the foreseeable future – probably following a period of increasing problems in areas such as staffing, quality of care, diminishing care availability and deteriorating commercial performance – one of the two hospitals will cease to be able to (responsibly) provide its basic functions. The IGZ does not exclude the possibility that it will in due course have to advise the Minister of VWS to intervene on account of one or both of the hospitals no longer meeting (or being able to meet) the minimum quality requirements. In practical terms, this could ultimately result in only one of the hospitals surviving, and that hospital being in a very poor position from which to move forwards, according to the IGZ.

41. As previously indicated, the IGZ says that the departments in both hospitals are relatively small; indeed, in some cases they are smaller than required by the relevant standards. On 29 July 2008, the IGZ wrote to the parties informing them that, in view of the present shortage of gynaecologists, the concentration of secondary obstetric services and the associated clinical paediatric services at one site appears unavoidable. Such a move is required in order that the quality of gynaecological and obstetric care remains assured. The IGZ assumes that, in the event of the concentration of secondary gynaecological and obstetric services and the associated clinical paediatric services at Goes, gynaecological, obstetric and paediatric outpatient care will remain available at Vlissingen.

42. The IGZ also points out that such concentrations often lead to a cascade of other concentrations, which are necessary because a hospital's various basic functions are closely interrelated and therefore highly interdependent. So, for example, the concentration of secondary obstetrics at a single location is liable to necessitate the concentration of clinical paediatric services at the same location. The hospital that loses its secondary obstetrics and clinical paediatric functions will no longer be capable of responsibly providing the full spectrum of care services normally associated with the basic functions. The reason being that the loss of one basic function has implications for the remaining basic functions. The absence of secondary obstetric and clinical paediatric functions makes it difficult to provide adequate training for nurses, for example, because such training has to cover obstetric and paediatric nursing. Nor will the hospital be able to train gynaecologists or paediatricians. Furthermore, gynaecology is closely related to surgery and urology and interdependencies exist between paediatric medicine and, for example, ear, nose and throat medicine (adenotonsillectomy), neurology (children with convulsions), surgery (traumatology), and internal medicine (adolescents with diabetes mellitus), the IGZ indicates.

43. It is also worth noting that, according to the IGZ, cooperation in specialist fields always leads to the lateralisation of the fields in question at one hospital. The reason for this is that specialisms can be responsibly practised only if concentrated at one of the two locations, where

dedicated support functions, specialist staff, special equipment and departments (such as IC, operating facilities and dedicated endoscopic capability) are immediately available. Furthermore, such support functions need to be available for several specialisms. This implies a concentration of such functions at one of the two hospitals (lateralisation of the functions at one site), the IGZ reports.

44. Neither of the two hospitals has sufficient personnel to enable the necessary subspecialisation. As a result, departments will have to decide which forms of care can still responsibly be made available and which cannot. The non-availability of some forms of care will inevitably lead to a decline in patient numbers. Indeed, the number of 'lost' patients may exceed the number requiring the unavailable forms of treatment, since a patient who has to go elsewhere for one form of treatment may also obtain other treatments from the alternative provider. Such an outflow of patients is liable to threaten the quality of the care that remains available, insofar as that care entails procedures for which a minimum level of provision is necessary for the attainment or maintenance of quality standards. An outflow of patients may also have adverse financial effects, thus establishing a spiral of decline.

45. The IGZ believes that, where the merger of hospitals is concerned, Zeeland should be regarded as a unique region within the Netherlands. Each of the hospitals is in an isolated position, significantly removed from the nearest specialist clinical centre or university hospital. If such a facility were located closer to hand, it would be possible to make arrangements to reduce the staffing vulnerability and compensate for the limited level of care. Without a nearby specialist clinical centre or university hospital, Zeeland requires a basic hospital that can provide a full range of functions and supplementary care, of the kind normally provided by a general hospital of similar size and with a similar catchment area. According to the IGZ, that implies provision of at least the following facilities:

- All gatekeeping specialisms and the associated medical and other facilities and application of the specialisms required in such a hospital
- Facilities for acute intervention in life-threatening situations, such as use of Dotter's technique, aortic surgery and complex traumatology; and
- IC/CCU facilities with prolonged ventilation capability (a level-2 IC unit).

46. The IGZ believes that the continued availability of basic hospital care (including the necessary subspecialisation with sufficient staff cover) in the Central Zeeland region is possible only if Walcheren Hospital and Oosterschelde Hospital become a single legal-administrative and financial entity.[12] The potential client population in Central Zeeland is, in the IGZ's view, too small to sustain the provision of hospital care of the kind referred to in the previous point at two separate hospitals. A merger would allow the management to create a hospital with a sound basis in terms of catchment size, staffing, functions and specialisms. Hence, the move would ensure the continued availability of basic hospital care in the region. This applies in relation to acute care, elective care and chronic care, according to the IGZ.

47. The IGZ states that, if the two hospitals are given permission to merge, it will ensure that a number of conditions are met. In order to secure the full benefit of the merger, all departments need to merge. The geographical accessibility of acute care needs to be guaranteed. The hospitals need to address the obstetric care situation in the short term. The above-mentioned matters are considered by the IGZ to fall partly outside the competence of the hospital board. The active involvement of health insurers and the government is therefore required, according to the IGZ. Furthermore, the success of the merger depends upon optimal external consultation with primary care partners and health insurers. However, the IGZ considers it highly probable that the benefits of a merger identified by the parties will be secured.

48. The IGZ believes that the continued availability of basic hospital care in the Central Zeeland region can be ensured only by a merger. It would not be possible, for example, to resolve the problem by recruiting more specialists; each individual hospital's client population is too small and requires insufficient care (too few procedures) to support a larger department with a larger staff. Where many care procedures are concerned, it is known that a minimum number should be performed in order to ensure that appropriate quality standards are maintained. The two hospitals' potential client population is too small for the qualitatively or quantitatively sustainable operation of two fully equipped basic hospitals north of the Westerschelde. Cooperation between the hospitals is necessary in numerous fields, in particular acute care, surgery/orthopaedic medicine, internal medicine, mother and baby care and cardiology (see point 41). In combination with the cascade-effect and the lateralisation of functions and departments on one location, as described in points 42 and 43, this situation makes a general merger inevitable, also from an administrative viewpoint.

[12] This would constitute a concentration in the sense of Section 27 of the Mw.

Summary

49. To sum up, the IGZ cannot exclude the possibility that in due course one or both of the hospitals will no longer be able to meet the minimum quality requirements. Furthermore, the IGZ believes that, without a merger, it will not be possible to retain all basic hospital functions (including the necessary subspecialisation with adequate staff cover) in Central Zeeland. Moreover, in view of the particular situation in Zeeland, supplementary care capacity is required, covering at least all gatekeeping specialisms and the associated medical and other support facilities and application of subspecialisms, facilities for acute intervention in life-threatening situations, such as use of Dotter's technique, aortic surgery and complex traumatology, and IC/CCU facilities with prolonged ventilation capability (a level-2 IC unit). In the IGZ's opinion, the potential client population in Central Zeeland is too small to sustain the provision of such hospital care at two separate hospitals.

Opinion of the NZa

50. The NZa submitted an opinion regarding this case on 22 December 2008. In its submission, the NZa comments on the likely implications of the proposed concentration for the quality, affordability and accessibility of care. On the subject of quality, the NZa was advised by the IGZ. The content of the IGZ's advisory report is summarised above in points 40 to 49.

51. The NZa concludes that the proposed merger would result in the merged hospital occupying a monopoly position within Central Zeeland. Patients in Central Zeeland would have less freedom of choice: general hospital care would not be available from any provider other than the merged hospital. The NZa considers it likely that – because of the disappearance of direct competitive pressure within the relevant product and geographical market, the absence of potential competitive pressure from new market entrants and the increased negotiating power of the merged parties relative to the health insurers – the proposed concentration would have a negative effect on certain important public interests, namely affordability and geographical accessibility. In theory, the disappearance of direct competitive pressure could also have an adverse impact on the quality of the care provided by the merged hospital. However, the parties argue that the proposed concentration would in fact bring quality benefits outweighing the competition-restricting effects of the merger, the NZa states.

52. In its submission, the NZa states that it is apparent from the IGZ's advisory report and from information provided by the IGZ in discussions with the NZa that the IGZ firmly believes that, if the proposed merger does not take place, the quality of the care provided by the two hospitals will fall below the necessary minimum level, thus threatening the continuity of basic hospital care in Central Zeeland. This is mainly due to the unique geographical location of both hospitals, significantly removed from all specialist clinical centres and university hospitals. The NZa accordingly believes that the quality benefit of the proposed merger lies in the prevention of unacceptable deterioration in the quality of care. The NZa considers the assurance of minimum quality standards to be very important and indicates that it is therefore obliged, in accordance with the qualitative opinion of the IGZ, to advise the NMa to rule in favour of the principle of the licence application under review.

53. The NZa considers that, as well as benefitting the consumer by helping to assure minimum quality standards, the proposed merger would have clear disadvantages for the consumer. These disadvantages concern the affordability of care, its accessibility and the extent to which its quality exceeds the minimum level. To offset these disadvantages, the NZa believes that appropriate measures, conditions and rules of conduct should be imposed on the parties by the NMa in its merger decision. The NZa indicates that it cannot anticipate the process that would lead to the definition of what it would regard as a sensible package of measures to accompany the merger. The NZa recognises that the two hospitals themselves have considerable responsibility in this regard. If the parties are not (sufficiently) willing to cooperate with the definition of measures to safeguard the public/consumer interests, the NZa recommends rejection of the licence application.

54. The NZa advises the NMa to make approval for the merger subject to a combination of: a number of structural conditions relating to the hiving off or privatization of organisational units; two supporting rules of conduct and various quality-related conditions.

55. The NZa believes that the following structural conditions should be considered:

- All specialisms with more than 30 per cent turnover in the B segment should be hived off.
- There should be no integration of any team that would not benefit from scaling up. The NZa believes that integration is necessary only for A&E, IC, paediatric medicine, obstetric and diagnostic departments, such as radiology and the laboratories.
- All independent treatment centres should be hived off or their affiliation to the hospitals ended.

The NZa believes that the application of structural conditions can promote real competition (amongst certain units). The units in question should provide sufficient critical production to generate effective and sustainable competition in the short term.

56. Where the rules of conduct are concerned, the NZa proposes a pricing directive for the free B sector and revision of the admission agreement with medical specialists. The aim of a pricing directive would be to prevent the hospitals from charging unreasonable prices in the free B sector. The NZa believes that the best approach would be to impose ceilings based on national average contract prices and national average increases over the next three years for all DTCs in the B sector.[13] The price ceiling could also take account of relevant differences in the *case mix*.[14] In addition, the NZa advises amendment of the merged hospitals' admission agreement to allow medical specialists to undertake activities within the region that compete with those of the hospital, such as setting up independent treatment centres or working for other care providers. Revision along these lines would facilitate the entry of new market players in Central Zeeland, according to the NZa.

57. The NZa also considers it very important that conditions are imposed to ensure that minimum quality standards are met by the merged hospital. In the NZa's opinion, it cannot simply be assumed that the quality improvements proposed by the parties and regarded as necessary by the IGZ will be realised following the merger. Hence, the NZa considers it necessary to require the merged hospital to satisfy certain conditions relating to the said quality improvements. The NZa believes that approval for the merger should be made conditional upon satisfaction of the conditions for appropriate care defined by the IGZ, in particular the following:

- A level-2 IC unit must be realised within three years.
- The minimum volume requirements set by the IGZ must be met.
- Each basic hospital care specialism must have a specialist medical staff of at least five FTEs.

[13] In its submission, the NZa states that detailed analysis of contract prices agreed for 2008 on the basis of information provided by the health insurers has revealed that the contract prices agreed with the care insurers by the two parties do not differ significantly from the national average. Furthermore, the information provided to the NZa indicates that developments in the parties' contract prices over the period 2005 to 2008 have been closely in step with the national pattern.

[14] Differences in the *case mix* are attributable to differences in the product mix and the care weighting, with the product mix reflecting a given DTC's share of the overall DTC volume in a given year. The product mix can be ascertained for an individual hospital or for all hospitals nationally. By weighting the average prices in line with the hospital's DTC delivery numbers, it is possible to correct for price differences that are attributable to differences in the merged hospital's product mix, the NZa reports.

Summary

58. In view of the particular circumstances in Central Zeeland and the need to ensure that the care provided is of the necessary minimum quality, the NZa believes that the merger of Walcheren Hospital and Oosterschelde Hospital is ultimately in the best interests of care consumers in Central Zeeland, subject to the express proviso that approval for the merger is made conditional upon the satisfaction of certain conditions identified by the NZa.

OTHER OPINIONS

Clients' councils and patients' platform

59. The NMa made enquiries with the clients' councils of the two hospitals and with the Zeeland Klaverblad Foundation (a patients' platform). The two clients' councils and the patients' platform all favoured the merger of the two hospitals.

60. The Oosterschelde Hospital clients' council takes the view that merger is the only way of assuring the quality of patient care. Without a merger, the clients' council contends, there may be an increased outflow of patients due to deteriorating quality of care. The clients' council believes that a merger could be a long-term solution to the hospitals' financial problems and the difficulties they have had recruiting medical specialists. The clients' council does identify reduced geographical accessibility for certain patient groups as a possible disadvantage of the merger. However, it considers geographical accessibility to be less important than the quality of care. The council would accordingly like to see more emphasis placed on improving public transport. Wide-ranging cooperation between the two hospitals is expected by the Oosterschelde Hospital clients' council to be a less effective way of assuring the quality of care than a full merger.

61. The Walcheren Hospital clients' council states that, without a merger, it will be very difficult to maintain or improve the quality of the care available to clients in the two hospitals' catchment area in the immediate or longer-term future. The population of Zeeland is forecast to decline in the future. As well as having immediate implications for the running of the hospitals, this may also be expected to affect the number of specialists that can be deployed. Furthermore, the hospitals are financially weak. If there is no merger and the quality of care is consequently undermined, more patients will opt to receive treatment elsewhere, thus threatening the hospitals' continued existence. The Walcheren Hospital clients' council therefore believes that the two institutions need to pool their strength. In the council's view, wide-ranging cooperation between the two hospitals would not assure the quality of patient care as well as a merger.

62. The Walcheren Hospital clients' council says that the merger of the hospitals and the reorganisation of care in the Province of Zeeland can provide a basis for the realisation of a *high-level* IC unit. At present, because the province does not have such a unit, patients with multiple traumas always have to be moved further afield, increasing the risk that they will die before they can be treated. According to the Walcheren Hospital clients' council, it is also important that Zeeland remains an attractive place for specialists to work. The council is very concerned that the loss of specialists has increased in recent years and that vacancies have proved difficult to fill. If a department has unfilled vacancies, the remaining staff members are overworked and patients are placed at greater risk. If the number of non-routine specialist surgical and other procedures falls below a critical level, specialists may lose or be unable to enhance their skills in certain fields. As a result, more patients will be referred to university hospitals or other such centres outside the province, the clients' council suggests.

63. The Walcheren Hospital clients' council takes the view that, for some of the people of Zeeland, the disadvantage of reduced geographical accessibility can be offset by improved quality of care. If quality does indeed improve, clients will be more willing to travel to Goes, the council says. Nevertheless, the issue of geographical accessibility is felt to warrant attention. According to the clients' council, the existence of good access arrangements should be a condition for implementation of the merger plans. This implies that careful thought must be given to the way that the two sites are organised. Each site requires a proper outpatients' clinic and an A&E unit. The site chosen for acute and complex care must be reachable by ambulance within the applicable standard times. The surrounding infrastructure needs to be organised so as to make this possible – as do the ambulance service and ambulance stations. One issue that requires attention in this context, the clients' council suggests, is obstetric care and the opportunity to give birth at home. The clients' council indicates that a provincial steering committee has been set up to look into the question of the geographical accessibility of curative care north of the Westerschelde. The clients' council is confident that the merger will not adversely affect the geographical accessibility of care, certainly not if the operational excellence initiative – recently established with a view to improving internal processes through construction projects and service reorganisation – bears fruit following the merger.

64. Finally, both clients' councils highlight the importance of good communication by the administrators and of speedy implementation of the merger in order to remove the uncertainty and unease currently felt by clients, specialists and other staff.

65. The Zeeland Klaverblad Foundation patients' platform takes the view that, in the present circumstances, the residents of Central Zeeland have insufficient choice in terms of where to go locally to obtain more complex forms of hospital care and treatment. The volume of work is not enough to enable medical specialists to hone their skills in the performance of more complex interventions. By increasing the volume of work, the merger may be expected to raise the standard of hospital care in Zeeland, thus enabling more procedures to be undertaken in Zeeland, which currently take place outside the province. Hence, in the new situation, choice will not be restricted, but the quality of choice will improve, according to the foundation. The Zeeland Cloverleaf Foundation also takes the view that the quality of the care is more important than geographical accessibility.

Health insurers

66. The two biggest health insurers in the Central Zeeland area are CZ, which has a market share of approximately 60 per cent, and UVIT, whose market share is approximately 15 per cent. The NMa enquired after both health insurers' views on the proposed merger and established that both favour the plan.

67. According to both CZ and UVIT, it is likely that the merger will enhance the quality of the care provided by the hospitals. First, the concentration of care services will ensure availability and therefore continuity, which is a precondition for the realisation of minimum quality targets. Furthermore, the merger will open the way for subspecialisation. The merger will increase service volumes and it may be expected that capacity problems of the kind seen in the past in paediatric medicine, gynaecology, cardiology and IC/A&E will not recur. The possible development of the IC unit into a level-2 facility would mean that patients could be treated in Zeeland, who currently should (according to the protocol) be moved to IC units elsewhere, CZ suggests.

68. If the merger does not go ahead, the problems already facing the hospitals will be exacerbated, CZ contends. Even now, the hospitals are barely able to provide appropriate care, particularly in fields such as paediatric medicine, gynaecology and secondary obstetric care. A full merger of the hospitals would, CZ and UVIT believe, create greater scope for achieving the desired effects, making decisions and preventing or expediting prolonged (internal) debate than less wide-ranging cooperative arrangements.

69. CZ is confident that the proposed merger will result in a better price-quality ratio. The price/cost of the available care is more likely to fall following the merger than to rise, according to CZ. This belief is based on the assumption that a merged hospital would have more purchasing power, would be able to rationalise supporting and facilitative services, could spread its fixed costs over a larger volume of work and would be in a position to organise care processes more efficiently. Moreover, countervailing measures designed to ensure availability would cease to be necessary following a merger.

70. CZ additionally assumes that the threat of insurers exercising control measures will be sufficient to ensure that the hospitals pursue responsible policies on price and quality. If the merged hospital cannot deliver appropriate quality, or if the delivery of such quality cannot be demonstrated, CZ will cease to enter into contracts with the hospital. UVIT also indicated that it believes it can influence the pricing policy of the hospitals. If prices were to rise sharply (e.g. by 10 per cent), UVIT would switch to obtaining hospital care mainly from Terneuzen and Bergen op Zoom. In that event, the company might have to start meeting the travel costs of clients who have to go to these more distant hospitals. UVIT reported that it had already found it necessary to threaten to take such action in another part of the country, and had succeeded in regulating the behaviour of hospitals in this way.

71. Another means of exercising control is to attach conditions to the merger bonus, which under the FB system[15] is linked to scaling up. In the context of previous mergers, CZ and UVIT have (partially) sanctioned this bonus on the condition that (certain) teams are merged. More generally, CZ is investigating the possibility of exercising control by waiving the insurance excess payable by clients who opt to receive a particular treatment at a hospital recommended by CZ. The extent to which insured people can be encouraged through their GPs to make certain decisions is also under investigation. Finally, CZ will be able to monitor the site profiles developed by the merged hospital and any issues that arise can be discussed in the context of (administrative) consultation meetings.

72. CZ indicates that it will make use of the above-mentioned mechanisms for influencing price-quality ratio of the care provided by the merged hospital.

73. UVIT indicates that it is somewhat concerned about the implications of the proposed merger for its clients' freedom of choice. However, most of UVIT's clients in the Central Zeeland region live on Tholen and traditionally gravitate towards Bergen op Zoom. On balance, taking both quality and freedom of choice into account, UVIT favours the merger of the two hospitals.

74. According to both CZ and UVIT, the merger of the hospitals does not guarantee quality, but is a precondition for quality. UVIT does not perceive there to be any major obstacles to quality improvement, although the financial position of the hospitals could be an inhibiting factor.

Specialists

75. The NMa has held discussions with specialists on the two hospitals' surgery-orthopaedic medicine, gynaecology, paediatric medicine, internal medicine, anaesthesiology and cardiology

[15] FB stands for Functional Budgeting: a system used for A-sector hospital care. Under this system, the hospital is allocated a budget on the basis of numeric budget parameters agreed with the health insurers and the tariffs set by the NZa.

teams. Opinions were also obtained from a number of (former) specialists. The specialist teams all favour the merger of the hospitals, but a number of individual specialists departed from their teams' general views. The dissenting specialists are concerned mainly about site selection under the merger plan. One specialist takes the view that the merger plans generally lack a sound basis, in particular a sound financial basis.

76. The specialist teams state that it is currently very difficult to fill vacancies. They fear that specialists will leave in increasing numbers if the merger does not go ahead, because they feel unable to practise their profession to the desired level and/or because they find the workload excessive. The specialist teams believe that a merged hospital with level-2 IC unit will make working in Central Zeeland more attractive to new specialists. In addition, a larger hospital will draw in more patients, giving the (merged) hospitals a more solid financial basis.

77. Furthermore, the specialist teams state that it is already difficult to meet the applicable quality standards. The standards are becoming stricter and, within the foreseeable future (the next five years), the two hospitals will no longer be able to meet them. The challenges are particularly acute where the major surgical specialisms are concerned; although these specialisms may currently be practised at the hospitals, their continuation is threatened by stricter volume requirements. On its own, each hospital is too small to provide the facilities required for certain treatments. So, for example, neither has a level-2 IC unit, a *dedicated* operating theatre for breast reconstruction surgery using radiosurgical techniques or for emergency Caesarean sections, a reception area for trauma patients, twenty-four-hour specialist availability in certain fields, X-ray facilities, a laparoscopic centre, MRI facilities, CT scanning equipment or (training for) specialist nurses.

78. The specialist teams say that the level of the IC facilities at the hospitals is currently just high enough to be acceptable, but that the IGZ is likely to take a stricter approach to the enforcement of IC standards in the near future. When that happens, the two hospitals – and, indeed, many other small hospitals in the Netherlands – will no longer be able to comply with the standards. However, unlike other small hospitals, the Central Zeeland hospitals will not be able to resolve their IC problems by entering into cooperative agreements with other centres, because there is no larger hospital nearby whose facilities could be used.

79. Cooperation in specific fields only is not an option, according to the specialist teams, first because the various specialisms are too closely interrelated and second because the financial/administrative implications are too complex.

Walcheren municipalities and Province of Zeeland

80. The Walcheren municipalities (i.e. the municipalities of Veere, Middelburg and Vlissingen) submitted a joint opinion and each of them also submitted a separate opinion. The essence of these opinions is that the Walcheren municipalities are very concerned about the hospitals' intention to concentrate acute care at Goes as far as possible. They stress that, for

women in a large part of Walcheren, home birth will no longer be possible, because they will not be close enough to the hospital in Goes, where the acute obstetric care will be concentrated, to allow for emergency transfer. Moreover, the municipalities point out, the main hospital will not be centrally located within the area it serves. Approximately 90 per cent of the population of Central Zeeland live to the west of the hospital at Goes, which is also very difficult to reach because the only nearby junction on the A58 motorway is restricted, according to the municipalities.

81. In response to the Walcheren public's disquiet concerning the parties' merger proposal, the Zeeland Provincial Executive commissioned a study by TNO's Construction and Care Centre. The central question addressed by the study was whether the hospital boards had been able to arrive at a reasonable choice of location on the basis of the data available to them and collected by them. The Construction and Care Centre concluded that this was indeed the case. Nevertheless, the boards were advised to strive for greater transparency in their decision-making, with a view to securing greater support. Through its member Mr. Van Heukelom, the Zeeland Provincial Executive informed the Board that it backed the merger plans.

General practitioners (GPs)

82. The Zeeland General Practitioners' Association, a branch of the National General Practitioners' Association, also submitted an opinion. The Zeeland GPs indicate that they support the hospitals' merger plan and that they wish to work with the specialists to design a good secondary care system for Zeeland.

Primary obstetricians

83. A group of primary obstetricians from Walcheren submitted an opinion expressing great concern about the implications of the proposed merger for the quality of obstetric care on Walcheren. The obstetricians fear that home births on the peninsula will no longer be possible following the merger, because of the hospital boards' decision to concentrate acute care at Goes. The distance between some parts of Walcheren and Goes is too great to responsibly allow women living in the relevant areas to give birth at home, because, in the event of complications, a woman could not be transferred to the hospital quickly enough. The obstetricians therefore call for the implementation of a number of measures if the merger goes ahead. These include the creation of a fully equipped primary obstetric centre on Walcheren with the use of a twenty-four-hour ambulance station, the provision of good physical access to the hospital at Goes for patients and obstetricians from Walcheren, the award of adequate availability funding for the Walcheren obstetricians and the establishment of a platform for consultation amongst obstetricians, gynaecologists and paediatricians in Central Zeeland.

Others

84. The other opinions submitted to the NMa contained essentially the same arguments for and against the merger as those described above. Almost all parties who submitted opinions were in principle in favour of the merger of the two hospitals in Central Zeeland. Most of the criticism was of the hospital boards' choice of location, in view of the geographic and demographic characteristics of the area and the traffic problems during the tourist season.

VII. ASSESSMENT

IMPLICATIONS OF THE MERGER FOR THE MARKET STRUCTURE

85. The parties are the only providers of clinical general hospital care and non-clinical general hospital care in the Central Zeeland region. Consequently, if the proposed merger goes ahead, only one hospital organisation will be locally active on the relevant market for clinical general hospital care and non-clinical general hospital care, and patients in Central Zeeland will not have access to any major alternative service provider.

86. In previous decisions concerning the hospital sector,[16] the joint share of the markets for clinical general hospital care and non-clinical general hospital care has sometimes been expressed as the percentage of the total number of patients in the region who have received hospital care within the region (the so-called 'LIFO score' in the Elzinga-Hogarty test).[17] Expressed in this manner, the merged hospital's share of the market for clinical general hospital care is expected to be approximately 84 per cent and its share of the market for non-clinical general hospital care is forecast to be approximately 88 per cent.

87. Since January 2007, the Zeeland Medical Wellness Centre (referred to below as MWCZ) has been operating in Goes. The MWCZ is a centre for specialist medical care that has to date provided only schedulable clinical and non-clinical care. Its services consist mainly of jaw surgery, cosmetic dental surgery, plastic surgery and radiology.[18] The MWCZ employs specialists, nurses and support staff, some of whom also work at Walcheren Hospital and/or Oosterschelde Hospital. For the provision of its services, the MWCZ makes use of locations and facilities at Walcheren Hospital, Oosterschelde Hospital and the Zeeland-Flanders Hospital.

88. Furthermore, since April 2008, the Goes Cardio Centre has been active in the provision of schedulable non-clinical cardiological care. The Cardio Centre employs four cardiologists, all of whom also work at Oosterschelde Hospital. The Cardio Centre supplements the supply of cardiological hospital care in the region mainly by providing cardiological diagnostic services on GP referral.

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[16] See, for example, the decision in case 3524/ *Juliana Children's Hospital/Red Cross Hospital – Leyenburg Hospital*, as previously cited, points 59 to 63, and the notification-phase decision in case 3897/ *Hilversum Hospital – North Gooi Hospital*, as previously cited, points 30 to 38.

[17] Expressed in terms of patient numbers, the joint market share is lower than when expressed in a more conventional way, because account is taken of the portion of the (care) demand that is served by providers outside the defined geographical market. In this case, the turnover-based joint market share of (nearly) 100 per cent works out lower because patients, particularly those living near the periphery of the area, sometimes obtain care from other hospitals.

[18] The MWCZ has an MRI scanner for the so-called 'small extremities': the ankles, wrists and knees.

89. Both of the care providers referred to in the last two points are small and their activities barely overlap, if at all, with those of Walcheren Hospital and Oosterschelde Hospital.

90. From the foregoing, it follows that, if the merger goes ahead there will be (almost) no alternative care supply on the relevant market and that the merged hospital will occupy a very strong market position – indeed, a near-monopoly position. Consequently, the consumer benefits associated with the existence of real competition will in principle be lost.

Qualifying factors

91. In jurisprudence, such a high market share is in its own right normally deemed sufficient evidence of the existence of a dominant market position.[19] However, a dominant position need not be deemed to exist if qualifying factors are present. For example, the threat of new market entrants may have a regulating effect. Also, buyer power may have a countervailing effect.

92. It is possible for a high market share to be mitigated by a real prospect of new players entering market. While the licence application has been under review, two private investors, DaVaci and Orange Cure, have made it known that they are interested in entering the Central Zeeland general hospital care market. However, enquiries made by the NMa indicate that material plans are not yet in place. The markets for clinical and non-clinical general hospital care have high thresholds, and market entry would require very substantial investment. New players are therefore unlikely to enter the market in the short term.

93. The existence of powerful buyers capable of regulating the activities of the merger parties (countervailing buyer power) could also form a qualifying factor. In its Guidelines on the Assessment of Horizontal Mergers[20] (referred to below as the EC Guidelines), the European Commission defines countervailing buyer power as *"the bargaining power that the buyer has vis-à-vis the seller in commercial negotiations due to its size, its commercial significance to the seller and its ability to switch to alternative suppliers."*[21]

94. The parties have to deal with various health insurers that purchase care services. Although health insurers must be regarded as large, professional buyers, that does not necessarily mean that the market is characterised by the presence of countervailing buyer power. Such a situation implies that the buyer has a real opportunity to switch to an alternative provider. In the case under review, there are no alternative providers of general hospital care within the relevant geographical market.

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[19] Guidelines on the Assessment of Horizontal Mergers under the Council Regulation on the Control of Concentrations between Undertakings, PbEG 2004, C31, point 17.

[20] Guidelines on the Assessment of Horizontal Mergers, as previously cited.

[21] Guidelines on the Assessment of Horizontal Mergers, as previously cited, point 64.

95. The two largest health insurers in Central Zeeland have stated that they expect to wield sufficient influence in negotiations with the merged hospital, because they can threaten to send patients to hospitals outside the relevant geographical market. However, the Board does not believe that this statement is adequately supported by the facts. The insurers have a statutory duty of care[22], which implies (amongst other things) that they are obliged to contract sufficient care providers to ensure that appropriate care is available to insured clients promptly and at a reasonable distance.[23] Also, the insurers are open to influence by clients, insofar as they are exposed to the potential commercial risk associated with clients switching to other insurers. These circumstances mean that health insurers cannot be assumed to have complete freedom of action in their dealings with the care providers. It is more plausible to assume that the market will be characterised by mutual dependence.[24]

96. In view of the foregoing, the Board does not consider that, in the case under review, factors are present that would tend to qualify or countervail the very strong market position that the parties would enjoy if the proposed merger went ahead.

Conclusion regarding the implications for the market structure

97. On the basis of the considerations set out above, it may be concluded that the proposed concentration will significantly impede competition on the market for general clinical and general non-clinical hospital care in Central Zeeland, in particular by creating or strengthening a dominant position. Nevertheless, the parties have put forward an efficiency defence, which is considered below.

EFFICIENCY DEFENCE

98. The arguments made by the parties in support of their efficiency defence may be summarised as follows. By combining the catchment areas of the two hospitals, it will be possible to provide treatments and services which neither hospital could provide on the basis of its separate catchment area, such as level-2 IC, a level-2 A&E service and certain forms of acute intervention. A level-2 IC unit would be particularly important, as it would mean that a wider range of treatment options would be available to patients within the province. In consequence, patient choice in Central Zeeland would, according to the parties, increase. They also contend that the merger would enable them to provide a higher standard of medical care than is presently available, by making it easier for specialists to meet the volume requirements for procedures and

[22] Section 11 of the Health Insurance Act.

[23] See, for example, the Explanatory Memorandum accompanying the Health Insurance Act, Proceedings of the Lower House of the Dutch Parliament 2003-2004, 29 763, no. 3, pp. 28-34 and Memorandum of Reply to the Health Insurance Act, Proceedings of the Lower House of the Dutch Parliament 2004-2005, 29 763, E, p. 14 and pp. 46-52.

[24] See also the NZa's Hospital Care Monitoring Report 2008.

by creating greater scope for subspecialisation. The parties additionally suggest that the merger will lead to efficiencies and cost savings (increased purchasing power, joint investments and the merger of supporting services) and would make them more attractive employers. According to the parties, it is only by merging that the hospitals can realise their qualitative targets and thus ensure the continuity of care. The benefits of the merger will be felt by patients in Central Zeeland, the parties contend.[25]

Basis of assessment of the efficiency defence

99. The Explanatory Memorandum accompanying the amendment to the Mw introduced following its evaluation states that efficiencies such as those claimed by the parties may be taken into account when assessing technical and economic developments, insofar as such developments are beneficial to the consumer and the concentration does not significantly impede competition.[26] Assessment on this basis is consistent with the EC Merger Regulation,[27] in particular Article 2, clause 1(b) and paragraph 29 of the preamble.[28]

100. The Explanatory Memorandum makes reference to the EC Guidelines[29]: efficiencies brought about by the concentration may counteract the effects on competition that the concentration might otherwise have. The EC Guidelines state that the European Commission must be persuaded that the efficiencies generated by the concentration are likely to enhance the ability of and incentive for the merged entity to act pro-competitively for the benefit of consumers, thereby counteracting the adverse effects on competition which the merger might otherwise have. In the EC Guidelines, the European Commission goes on to say that, to be taken into account in the assessment of a concentration, an efficiency must benefit consumers, be merger-specific and be verifiable. Hence:

a) The efficiencies must be of significant benefit to consumers on those relevant markets where competition problems would otherwise be liable to arise.

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[25] For the opinions of the parties, see also points 22 to 38.

[26] Proceedings of the Lower House of the Dutch Parliament 2004-2005, 30 071, no. 3, p. 21.

[27] Regulation (EC) no. 139/2004 of the Council of 20 January 2004 concerning the control of concentrations between undertakings (Official Journal of 29-1-2004, L 24/1).

[28] Preamble, paragraph 29: "*In order to determine the impact of a concentration on competition in the common market, it is appropriate to take account of any substantiated and likely efficiencies put forward by the undertakings concerned. It is possible that the efficiencies brought about by the concentration counteract the effects on competition, and in particular the potential harm to consumers, that it might otherwise have and that, as a consequence, the concentration would not significantly impede effective competition, in the common market or in a substantial part of it [..].*"

[29] Guidelines on the Assessment of Horizontal Mergers, as previously cited.

b) The efficiencies must result directly from the merger under review and not be equally attainable by less competition-restricting means.
c) It must be satisfactorily demonstrated that the efficiencies will be realised in practice. Furthermore, they must be substantial and realisable in the short term. Finally, they must be adequately documented and, where possible, quantified.

The conditions set out above are cumulative.

101. Paragraph 84 of the EC Guidelines[30] states: "The greater the possible negative effects on competition, the more the Commission has to be sure that the claimed efficiencies are substantial, likely to be realised, and to be passed on, to a sufficient degree, to the consumer."[31]

Assessment of the efficiency defence

(i) The efficiencies must benefit consumers

102. In order to establish whether efficiencies may be expected to benefit consumers, it is first necessary to determine whether there are likely to be efficiencies in the sense of the Explanatory Memorandum[32] and the EC Guidelines.[33] To this end, the Board has considered various matters, including the following.

103. Real competition obliges (health care) providers to align their (health care) provision as closely as possible with the wishes of consumers. The (health care) provision may be shaped by various competition parameters that may reasonably be assumed to influence consumer decision-making regarding a particular (health care) product. Various aspects of the (health care) provision influence a consumer's appreciation of it. Quality is one of the more important aspects, but not the only one. Geographical accessibility and price are also important. The interrelationships between these aspects determine the consumer's appreciation of a given (health care) service. An effect of a merger should therefore be regarded as an efficiency only if it is reasonable to assume that consumers are likely to regard the sum of changes to the relevant service as positive. Consequently, it is possible to determine whether a change may be regarded as an efficiency only if all the relevant characteristics of the service are known and taken into account in the assessment.[34] Hence, a positive effect on quality is not necessarily an efficiency

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[30] Guidelines on the Assessment of Horizontal Mergers, as previously cited.

[31] See also the decision of the European Commission COMP/M.4439 – Ryanair / Air Lingus of 27 June 2007, point 1103.

[32] Explanatory Memorandum accompanying the amendment to the Mw introduced following its evaluation, Proceedings of the Lower House of the Dutch Parliament 2004-2005, 30 071, no. 3.

[33] Strictly speaking, this also applies to the other criteria of merger specificity (see point 115) and verifiability.

[34] Röller et al state: "*In practice horizontal mergers may also generate product (quality) improvements. In this case, consumers may benefit from a merger even without price decreases, provided that quality increases sufficiently. The discussion [..] must thus*

within the meaning of the EC Guidelines.

104. What the parties describe as efficiencies in the documentation submitted to the NMa are in fact more correctly described as improvements to the quality of health care. The parties do not attempt to weigh up these – claimed – quality improvements against other aspects of the health care provision that are important to consumers, such as geographical accessibility and price. Therefore, where the parties refer to efficiencies, this document refers below to quality improvements, in order to distinguish them from efficiencies as defined in points 102 and 103.

Anticipated effects of the merger on quality, geographical accessibility and price

105. In order to make the necessary assessment of how consumers' appreciation of (health care) provision is likely to change, the Board has considered the following matters.

106. In its report, the NZa indicates that it anticipates that the merger will have negative effects on certain important public interests, namely affordability, geographical accessibility and, in principle, the extent to which its quality exceeds the minimum level.[35]

107. Opponents of the merger highlight the fact that many people in Central Zeeland, particularly those from Walcheren, would have to travel long distances for certain forms of health care, particularly acute care, following a merger. On the other hand, the parties claim that, at present, many people in Central Zeeland cannot obtain certain treatments in their own region at all, but would be able to do so following a merger.

108. In the policy document *Acute Care*[36] and the written statement *Opting for Geographical Accessibility and the Quality of Care*[37] and the associated background document, the Minister of VWS identifies a number of dilemmas in the care sector that further define these issues and thus the concept of competition. In this context, the Minister highlights the tension between the geographical accessibility of care and the (minimum) quality of care. In the written statement *Opting for Geographical Accessibility and the Quality of Care*, the Minister states: "*…in some sparsely populated areas, relatively small care providers find it difficult to meet certain care safety*

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be rephrased in terms of "quality-adjusted" price effects of horizontal mergers (e.g. Rosen, 1974). The spirit of the various results will therefore also apply to mergers with product (quality) improvements"; 'Efficiency gains from Mergers', in: 'European merger control: do we need an efficiency defence?', Edward Elgar, 2006, p. 21.

[35] The NZa does, however, believe that realisation of the merger is very important for the prevention of an unacceptable deterioration in quality to below the minimum level; see also point 52.

[36] Proceedings of the Lower House of the Dutch Parliament 2007-2008, 29 247, no. 75.

[37] Written statement to the Lower House of the Dutch Parliament, 27 June 2008 *Opting for Geographical Accessibility and the Quality of Care*; Ministry of Health, Welfare and Sport.

standards because they have insufficient opportunity to build up experience with complex, less common care requirements. Their scale also restricts their ability to efficiently provide a complete package of care services. Understandably, therefore, they explore the scope for intensive cooperation, based for example on referral agreements. This can have the consequence of changing the nature of (parts of) a region's familiar hospital or even leading to closure and to some people having to travel further for assistance than was previously the case."[38] In this written statement, the Minister adds: "*If the minimum quality standards lead to certain forms of care being available at a relatively small number of centres in the Netherlands, resulting in tension between the quality of care and the geographical accessibility of that care, then we give priority to quality ahead of accessibility.*"[39] If quality is found to be below a certain minimum level to be defined by the Minister, the Minister and the IGZ will intervene. The Minister writes: "*We shall define clear minimum levels.*"[40]

109. By that statement, the Minister of VWS indicates that the minimum standards still need to be defined. According to the Minister, primary responsibility for developing quality standards lies with the sector itself. It will then be the IGZ's task to enforce those standards. However, if the sector fails to define appropriate standards, the Minister will lay down standards on the basis of advice from the IGZ. In the VWS's *Policy Agenda 2009*, the Minister describes the position as follows: "*The future Quality and Safety Regulatory Body will ensure that the development, improvement and the application of guidelines is stimulated throughout the care sector [...]. The Inspectorate will further intensify enforcement of the generally binding standards defined by the professions. Where the professions do not themselves define standards, the Inspectorate will initially exert further pressure with a view to bringing about the guideline development and standardisation sought by the Ministry. If this does not have the desired effect, the Inspectorate will itself put forward standards and guidelines.*"[41]

110. According to the Minister, the definition of stricter standards on geographical accessibility and quality of care, combined with increasing transparency, offers a clear starting point for merger proposal assessment by the NMa. He accordingly considers it very important that the IGZ defines a clear assessment framework based on recognisable standards and principles. The Minister writes: "*By laying down essential (safety) requirements in (statutory) regulations, a clearer assessment framework will be created; then, if the satisfaction of quality requirements demands increased concentration, that principle will be clear to the NMa.*"[42]

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[38] Written statement to the Lower House of the Dutch Parliament, 27 June 2008, as previously cited, p. 1.

[39] Written statement to the Lower House of the Dutch Parliament, 27 June 2008, as previously cited, p. 4.

[40] Written statement to the Lower House of the Dutch Parliament, 27 June 2008, as previously cited, p. 3.

[41] *Policy Agenda 2009*; Ministry of Health, Welfare and Sport, pp. 24 and 25.

[42] Written statement to the Lower House of the Dutch Parliament, 27 June 2008, as previously cited, p. 10.

111. In its report to the NZa, the IGZ weighs up the conflicting interests of geographical accessibility and quality of care. The IGZ also makes explicit reference to the Minister's above-mentioned written statement *Opting for Geographical Accessibility and the Quality of Care*[43] (see point 108). Against this background, the IGZ argues that, if the parties do not merge, the quality of basic hospital care in Central Zeeland is liable to fall below the minimum standard within the foreseeable future. The IGZ does not exclude the possibility that, under such circumstances, it would feel obliged to advise the Minister of VWS to close one of the two hospitals.

112. Where pricing is concerned, the following considerations apply. The creation of a (near) monopoly by the proposed merger could lead to the merged hospital putting up prices. If the price rises are out of proportion to the improvement in the quality of the care provision, the merger will not have brought about efficiencies beneficial to consumers. An improvement that comes at a disproportionately high price will not on balance generally be perceived by consumers to be an efficiency.

Conclusion regarding (i) the efficiencies must benefit consumers

113. In light of the considerations set out above in points 102 to 112 regarding the possible effects of a merger on the various aspects of care provision, in particular the pricing considerations described in point 112, the Board does not believe that it may yet be assumed that a merger would lead to real (net) efficiencies that are of benefit to consumers.

114. However, the parties have proposed certain measures intended to remove the above-mentioned objections and persuade the Board that the merger will indeed lead to efficiencies that are of benefit to buyers (see point 152 and points 154 to 157, below.

(ii) The efficiencies must be merger-specific

115. The EC Guidelines require that the claimed efficiencies are *merger-specific*.[44] If the same efficiencies can be achieved by means that restrict competition less, the efficiencies are not merger-specific and the efficiency defence is invalid.

116. In essence, the parties argue in this context that each of the two hospitals is too small and has too small a client population to provide certain treatments and facilities. The claimed quality improvements are achievable, according to the parties, only by a general merger of the two hospital organisations.

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[43] Written statement to the Lower House of the Dutch Parliament, 27 June 2008, as previously cited, p. 4.

[44] Guidelines on the Assessment of Horizontal Mergers, as previously cited, point 85.

117. The NMa asked the IGZ to indicate whether all the treatments and facilities referred to by the parties are among those that a basic hospital is required to provide. In response, the IGZ indicated that not every hospital has to be able to provide all the treatments and facilities referred to by the parties. Nevertheless, the IGZ considers it necessary that some of the treatments and facilities are available from some source within any given region. The availability of such treatments and facilities can also be assured in certain regions by several smaller hospitals working with larger university or other centres for specialist medical care and making use of their facilities for certain cases. However, the geographical locations of the two hospitals in the case under review preclude such an arrangement, making the concentration of care in Central Zeeland desirable, according to the IGZ.

Survey of problems and solutions at other comparable hospitals

118. In an effort to gain better insight into the necessity for a merger as called for by the parties, the NMa conducted an independent investigation into the degree to which comparable hospitals in the Netherlands experience the same bottlenecks. The investigation also looked into how the hospitals dealt with these bottlenecks and whether a merger provided a suitable solution.

119. Since the root of the problem highlighted by the parties is the relatively small client population and staff that each hospital has, the two selection criteria used by the NMa in the context of its survey of similar hospitals were client population size and staff size. A hospital was deemed to be (objectively/quantitatively) comparable if both its average client population (average of the clinical and outpatient client populations) and its specialist medical staff were within 10 per cent of the corresponding figures for Oosterschelde Hospital and Walcheren Hospital. Of the hospitals identified in this way, a number were excluded from further consideration on the grounds that they were already known to be located close to a university medical centre or in a highly urbanised area. Thus, twenty hospitals were ultimately selected for inclusion in the NMa survey. The selected hospitals were comparable with those at the centre of this case, in terms of size and in numeric terms. Naturally, every hospital has its own unique characteristics and external circumstances, such as proximity to competitors or historical specialisation, which make comparison more difficult.

120. Each of the selected hospitals was asked a number of questions under several topic headings (IC, A&E, mother-and-baby care and oncology), focusing in each case on the relationship between scale (expressed as procedure volume and specialist personnel capacity) and quality, and on the way that the hospital managed that relationship. This approach was adopted with a view to obtaining examples of possible alternatives to merger. Questions were also posed regarding the circumstances under which the hospital operated, such as its location relative to other hospitals, its geographical accessibility and its existing scale. These questions were intended to elicit more information concerning the hospital's comparability to those at the centre of this case. The feedback received from the surveyed hospitals indicated that their (external) circumstances were comparable with those of Oosterschelde Hospital and Walcheren Hospital in all respects bar one: their distance from the nearest specialist clinical centre or university hospital.

121. The information provided by the surveyed hospitals indicates that all of them to some extent face the challenge of operating on a relative small scale and yet meeting certain binding or voluntary quality standards. The hospitals identify various strategies that they have adopted in order to meet this challenge. Many hospitals report that they need to make extra investments because their limited scale makes the cost of for example IC, A&E and obstetric capability relatively high. The availability of such functions comes at a price, which is high in relation to the volume of care provided by these smaller-scale institutions. The surveyed hospitals also give numerous examples of cooperation between hospitals or departments intended to address scale-related problems. In this context, reference is made to better division of duties (specialisation), service sharing (continuity) and the concentration of low-volume activities.

122. Under each of the topic headings (IC, A&E, mother-and-baby care and oncology), the survey produced various examples of hospitals that had experienced problems similar to those facing the parties, but had found workable solutions that had less effect on competition than a general merger. However, the survey responses suggested that none of the hospitals in question had experienced problems or implemented solutions across a *range* of activities as wide as that referred to by the parties in their description of their difficulties.

123. From the considerations outlined above, it may be concluded that many hospitals of a size comparable to that of the hospitals at the centre of this case have to go to extra trouble and/or invest more in order to make certain treatments and facilities available.

Merger-specificity study by Twynstra Gudde

124. To supplement its own enquiries, as described above, the NMa commissioned the Twynstra Gudde consultancy to investigate the issue of *merger-specificity*. The central question that Twynstra Gudde was asked to address was: what other, less competition-restricting, means could be used to resolve the problems apparently facing the parties? To answer this question, Twynstra Gudde made use of theoretical principles, public sources, the knowledge and experience of their own consultants and interviews with experts in the field of mergers, cooperation, organisational models and such like.

125. According to Twynstra Gudde, it is appropriate to opt for forms of cooperation in fields where the problems are limited in their scope and the strategic importance of the cooperation modest. The wider the pallet of cooperation, the more appropriate it is to adopt a lower-transaction-cost and more manageable model, such as a merged organisation.

126. On the basis of its research, Twynstra Gudde concludes that there is an alternative way of tackling each of the problems identified by the parties on its own. All the alternatives in question are already in use in various practical settings in the Netherlands. Twynstra Gudde also observes that there are hospitals in the Netherlands with comparable catchment areas, which are apparently able to provide good secondary basic care.

127. Nevertheless, Twynstra Gudde acknowledges that, if the two hospitals were particularly vulnerable in relation to all basic functions, the alternative to a general merger would be a comprehensive form of cooperation and specialisation, resulting in the creation of two specialist hospitals that were no longer in competition with each other because their services complemented one another rather than overlapped. If all the departments are too small (in terms of their medical staff), the corresponding departments at the two hospitals should cooperate closely or merge. If the per-doctor or per-department volume of most interventions is too small, each hospital could specialise in certain fields and thus develop a service offering that is distinct from the other's. However, either strategy would remove the patient's freedom of choice and create a situation characterised by the presence of a single monopoly provider of each service.

Opinion of the parties

128. In summary, the parties' written response to the report indicated that, in the situation that exists in this case, the total number of cooperative arrangements that would be needed to continue to assure the quality of care would be so large as to have the same practical impact on competition as the proposed merger.

Opinion of the IGZ

129. In response to the question of whether the quality improvements anticipated by the parties could also be obtained through alternative, less competition-restricting, forms of

cooperation, the IGZ indicated that the two hospitals' client population is too small for the qualitatively or quantitatively sustainable operation of two fully equipped basic hospitals north of the Westerschelde. According to the IGZ, any intensive cooperation in certain care functions (acute care, obstetrics, paediatric medicine and certain specialisms within surgery, gynaecology, cardiology and other such departments) would require that the medical specialists concerned had no competitive interests. This would necessitate making financial arrangements to address any undesirable income displacements. In practice, this would almost always imply the merger of the relevant departments, according to the IGZ.

130. The cascade effect referred to earlier (see points 31 and 32) would also mean that, in the case under review, cooperation in individual fields did not represent an adequate solution to the identified problems. Furthermore, close cooperation in specialist fields would, the IGZ asserts, always lead to the lateralisation of these specialisms at one of the two hospitals. The reason being that specialisms can responsibly be practised only if concentrated at one of the two locations, where dedicated support functions, specialist staff, special equipment and departments (such as IC, theatre facilities and dedicated endoscopic capability) are immediately available. Furthermore, such support functions need to be available for several specialisms. This implies a concentration of such functions at one of the two hospitals (lateralisation of the functions at one site). The result of these processes, the IGZ argues, is the creation of two independent but unequal hospitals, which are no longer capable of competing with each other on the basis of equality.

131. Finally, the IGZ states that, for the establishment of these forms of cooperation (which it regards as essential), clear leadership is needed, both at the board level and at the medical staff level, in the context of which the common interest prevails over competitive interests.

132. In conclusion, the IGZ believes that, in the light of the considerations outlined above, it is not possible to establish the forms of cooperation needed to assure the quality and continuity of care without a merger.

Conclusion regarding (ii) the efficiencies must be merger-specific

133. In view of the foregoing, the Board concludes that the degree of cooperation between the parties necessary for the continuation of basic hospital care in Central Zeeland is such that a general merger is appropriate. The IGZ emphasises that Central Zeeland cannot accommodate more than one basic hospital. Taking into account the cascade effect identified by the parties and acknowledged by the IGZ and the interrelated nature of the various supporting functions and facilities (IC, theatre facilities etc), the Board therefore concludes that there is no realistic less competition-restricting way of securing the efficiencies.

134. The Board accordingly concludes that the efficiencies claimed by the parties can be achieved only by a general merger of the two hospitals.

(iii) Verifiability

135. Finally, it is necessary to consider whether it has been verifiably demonstrated that the merger will lead to substantial efficiencies. The more precisely and convincingly the efficiencies are defined, the better the claimed improvements can be assessed. If reasonably possible, the efficiencies and the resulting benefit for consumers should be quantified. Furthermore, the further into the future the efficiencies are expected to manifest themselves, the less probable it is that they will be realised.[45]

136. In support of their quality improvement claims,[46] the parties submitted two documents of particular significance, namely the *General Strategy for the Future Zeeland Hospital*, dated 9 April 2008, and *Policy Considerations pertaining to the June 2008 Notification and Licensing Procedure*[47] (both previously cited).

137. The Board takes the view that the documentation submitted by the parties is not sufficiently precise or persuasive to permit assessment of the claimed quality improvements. Both documents are primarily visionary. The parties assert that certain improvements will be achieved and explain the rationale for these assertions, but they do not make it verifiably clear how likely it is that the improvements will be achieved. Certain aspects of the parties' assertions were not elaborated upon by the parties at the time of the case's consideration by the NMa. For example, there were no (merger) plans for the various departments. Nor was the NMa able to find any objective evidence to support most of the parties' claims concerning the requirements pertaining to team sizes and procedure volumes. Furthermore, the documentation submitted by the parties does not make it sufficiently clear which quality improvements should be regarded as desirable and which as necessary. Neither in the notification nor in the licence application did the parties provide any evidence from objective and independent experts to support their claims regarding (the probability of) the claimed quality improvements.[48]

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[45] Guidelines on the Assessment of Horizontal Mergers, as previously cited, point 86.

[46] In the submitted documentation, the parties use the term 'efficiencies'. However, the changes in question may more correctly be referred to as improvements to the quality of the care provided. See also points 102 to 104.

[47] For details of the contents of these documents, see points 22 to 38.

[48] According to point 88 of the EC Guidelines, evidence that may be used in the assessment of efficiencies include: *"internal documents that were used by the management to decide on the merger, statements from the management to the owners and financial markets about the expected efficiencies, historical examples of efficiencies and consumer benefit, and pre-merger external experts' studies on the type and size of efficiency gains, and on the extent to which consumers are likely to benefit."* In the decision of the European Commission in the previously cited case COMP/M.4439 – Ryanair / Air Lingus,

138. The EC Guidelines also state that, if possible, the claimed efficiencies and the benefits to consumers should be quantified. If the data necessary for an accurate quantitative analysis are not available, clearly demonstrable – not merely marginal – positive effects for consumers must be expected.[49] In the case under review, the claimed quality improvements have not been quantified by the parties. Where quantification is not possible, the Guidelines allow for the claimed efficiencies and the associated consumer benefits to be confirmed by other means. However, the arguments presented by the parties contain no other objective evidence that the claimed quality improvements will be substantial.

139. Finally, the claimed efficiencies must be sufficiently certain, which implies that they will be realised within the foreseeable future. The longer the interval before the efficiencies are expected to materialise, the less the European Commission is generally inclined to accept that they will materialise at all.[50] The parties submitted no documentation containing sound evidence as to when realisation of the claimed quality improvements may be expected.

140. Hence, the documentation submitted by the parties in support of the notification and the licence application provide insufficient objective evidence to support a confident expectation that the claimed quality improvements will actually materialise and will be substantial.[51] Based solely on the parties' arguments, the Board is therefore unable to assess the significance of the quality improvements as claimed and to weigh them up against the competition-restricting implications of the merger.

141. In light of the considerations set out above, the Board is unable, on the exclusive basis of vision and standpoints of the parties presented in the said documents, to conclude that the proposed merger will lead to verifiable efficiencies that outweigh the anticipated competition-restricting effects. The submissions do not provide sufficient objective evidence that the claimed improvements will be substantial, that they will be realised promptly or that their realisation is reasonably certain.

Objectification of and need for the claimed quality improvements

142. The Board considers the IGZ's report to the NZa very important for the objectification and the concretisation of the quality improvements claimed by the parties, and for determining

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point 1133, the European Commission states: "*There appear not to exist business documents, dated pre-merger, which objectively and independently assess the scope for efficiency gains [...]*".

[49] Guidelines on the Assessment of Horizontal Mergers, as previously cited, point 89.

[50] Guidelines on the Assessment of Horizontal Mergers, as previously cited, point 86.

[51] Such evidence is contained, however, in the IGZ report considered in points 40 to 49; see also points 142 to 144, below.

whether those improvements may be deemed substantial. The IGZ strongly advises the NZa to enable the merger, as detailed in the two hospitals' licence application. As discussed in points 40 to 49, the essence of the IGZ report is that, in order to assure the quality of the care provision in certain respects, it is necessary that in the future a larger care provider is active in the Central Zeeland region. The IGZ asserts that, without this necessary scaling-up, there is a very real danger that the quality of care in Central Zeeland will fall below the minimum standard. The NZa accordingly advises the NMa to approve in principle the merger for which a licence application has been made.

143. Due to its (governmental) role,[52] the IGZ is regarded by the Board as a body with objective expertise in the determination of necessary care levels. Hence, the IGZ's report to the NZa is a sufficiently objective source of evidence for (the necessity of) certain quality improvements. It follows that, if certain quality improvements are considered to be necessary by the IGZ, they must be very substantial. The IGZ's assertion that the quality of care in this region will fall below the minimum standard without a merger, is also a significant consideration in this regard. The prevention of this scenario by means of a merger is itself regarded by the Board as a further substantial quality improvement.[53] In light of the foregoing considerations, the Board concludes that the body of potential quality improvements at the centre of this case is substantial.

144. In its report to the NZa, the IGZ points out that, for the claimed quality improvements to be realised, a number of conditions must be met (see point 47). According to the IGZ, all departments need to merge, the geographical accessibility of acute care needs to be guaranteed and the hospitals need to address the obstetric care situation in the short term. The above-mentioned matters are considered by the IGZ to fall partly outside the competence of the hospital board. The active involvement of health insurers and the government is therefore required, according to the IGZ. Furthermore, the success of the merger depends upon optimal external consultation with primary care partners and health insurers.

Conclusion regarding (iii) verifiability

145. On the basis of the arguments put forward by the parties and the IGZ, the Board concludes that the quality improvements claimed by the parties have been objectively

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[52] The IGZ's role is to promote public health by effectively monitoring the quality of care, prevention and medical products. The IGZ's website states: "*The Inspectorate advises the ministers and advises, encourages, presses and compels care providers as necessary with a view to ensuring the provision of appropriate care. The Inspectorate performs investigations and makes judgements impartially, expertly and carefully, without political bias and regardless of the care system in force.*"

[53] When assessing a proposed merger, it is necessary to take account of future (market) conditions that may reasonably be foreseen and that would have prevailed without the merger. See also point 9 of the EC Guidelines.

demonstrated and are substantial. However, no sound basis has yet been provided for assuming that the claimed quality improvements will actually be realised in full and within a reasonable time frame. With these considerations in mind, the Board concludes that the claimed quality improvements are as yet insufficiently verifiable.

146. The parties have proposed certain measures intended to remove the above-mentioned objections; see points 154 to 157, below.

Conclusion regarding the efficiency defence

147. The Board considers it likely that the quality benefits claimed by the parties will, if realised, be passed on to patients in Central Zeeland. Nevertheless, because of the possible negative effects on prices, the Board does not consider that it has yet been adequately demonstrated that the merger will lead to efficiencies that will be passed on to consumers to a sufficient extent (see points 113 and 114).

148. In light of the IGZ's report to the NZa and the report made by Twynstra Gudde, the Board concludes that the quality improvements claimed by the parties, if actually and promptly realised, will be specific and directly attributable to the proposed merger and that similar improvements cannot be secured by less competition-restricting means than a general merger (see points 133 and 134).

149. On the basis of the arguments put forward by the parties and the IGZ, the Board concludes that the quality improvements claimed by the parties have been objectively demonstrated and are substantial. However, no sound basis has yet been provided for assuming that the claimed quality improvements will actually be realised in full and within a reasonable time frame. With these considerations in mind, the Board concludes that the claimed quality improvements are as yet insufficiently verifiable (see points 145 and 146).

150. In view of the foregoing, the Board provisionally concludes the criteria for acceptance of an efficiency defence, as outlined in points 99 to 101 have not been met.

COMMITMENTS PROPOSED BY THE PARTIES

Introduction

151. In the course of the consideration of this case, the parties, in consultation with the NMa, made certain proposals with a view to removing the Board's objections relating to competition on the markets for clinical general hospital care and non-clinical general hospital care (see point 97) and with a view to ensuring realisation of the efficiencies that they claim the proposed merger would bring. The definitive wording for the conditions to which it is proposed that the decision should be subject is appended to this document. In essence, it is proposed that, following the concentration, the merged hospital should be obliged to keep its prices for DTCs in the B sector below a ceiling, to realise certain quality improvements and to simplify market entry by existing and future providers of specialist medical care.

Price ceiling

152. The price ceiling applies to DTCs in the B sector and is based on the national average price for such DTCs. This national average will be corrected to reflect the product mix of the merged hospital (see footnote 14), so that the merged hospital is neither advantaged nor disadvantaged by any over- or under-representation of particularly costly or particularly cheap DTCs. In principle, the price ceiling will apply indefinitely.[54]

Assessment of the price ceiling

153. The price ceiling prevents the merged hospital, in the absence of competitive pressures, from charging excessive prices for DTCs on the free B-sector market. By basing the ceiling on a weighted average of the prices charged by other hospitals in the Netherlands, the Board believes that a competitive market situation can be simulated. Application of the price ceiling will have the additional effect of preventing price rises that are out of proportion to the improvements in the quality of freely tradable B-sector care services. Hence, the price ceiling should ensure that the quality improvements lead to real (net) efficiencies that are passed on to the consumer to a sufficient extent. Not all aspects of the system described in the appendix to this decision have yet been worked out in detail. The relevant details will be worked out by the NMa – if and insofar as this is necessary in order to fix and enforce the price ceiling – in a manner that is reasonable and consistent with the purpose of the price ceiling.

Commitments regarding quality improvements

[54] If market conditions should change, the parties may submit a reasoned request to the NMa for the revision of this decision.

154. The merged hospital undertakes to ensure that, within three years of the date of this decision, it is able to provide all the gatekeeping specialisms – supported by the appropriate medical facilities and the practice of subspecialisms – that a full-capability basic hospital is expected to provide. Furthermore, the merged hospital undertakes to realise a level-2 IC unit and A&E facilities of a corresponding standard within the same time. The merged hospital also undertakes to realise operational facilities for acute intervention in life-threatening situations, such as facilities for Dotter's treatment, aortic surgery and complex traumatology, as well as to add laparoscopic colon surgery to the care services it is able to provide, and to do so within three years.

155. In addition, the merged hospital undertakes to ensure that, as soon as possible and certainly within six months of the date of this decision, it is in compliance with the standards on minimum department sizes, on minimum specialist team sizes within departments and on minimum procedure numbers per specialist.

156. The time periods specified for fulfilment of the parties' commitments are legally binding, except in the event of *force majeure*. Only circumstances entirely outside the control of the merged hospital may be deemed to constitute a *force majeure*.

157. The merged hospital shall moreover endeavour to bring about the merger of all departments within six months of the date of this decision and to assure the physical accessibility of acute care at all times. The merged hospital shall, with a particular view to maximising the physical accessibility of care, also endeavour to assure effective cooperation and coordination with all relevant primary care providers in Central Zeeland, including GPs and primary obstetricians.

Assessment of the commitments on quality improvements

158. The quality-related commitments set out above are geared to the realisation of facilities and conditions that, in the circumstances that prevail in Zeeland, are vital for the provision of basic hospital care. The facilities and conditions in question will make it possible to broaden, deepen and enhance the range of care services that are available. They will allow for the performance of more complex operations and for patients with complex conditions to be cared for within their own region. The facilities and conditions concerned are interrelated. So, for example, the presence of level-2 IC facilities will make more complex operations possible, so that fewer patients have to go outside the region for care. The presence of these patients will open the way for subspecialisation and will mean that the volume and nature of the care provided in Central Zeeland makes working in the region a more attractive option for medical staff. In consequence, it should become easier to recruit and retain personnel, and so on.

159. The parties' commitments regarding the realisation of quality improvements should ensure that, following the merger, the quality improvements necessary in Zeeland are indeed realised and realised promptly. The price ceiling referred to in point 152 will ensure that the price of the realised quality improvements is not excessive. The parties' commitments make it reasonable to assume that the efficiencies that the parties claim will result from the proposed concentration do indeed materialise, and within a reasonable time span. Hence, the Board concludes that the efficiencies are sufficiently verifiable.

Measures intended to facilitate market entry

160. The merged hospital undertakes to make its facilities available to all parties that wish to offer specialist medical care, including established and future providers of such care. The merged hospital will apply normal charges for the use of its facilities, in line with national market norms.

161. Furthermore, the merged hospital will allow medical specialists to privately offer extramural care in their specialist fields, if and insofar as this does not threaten the continuity of the care available from the merged hospital.

Assessment of the measures intended to facilitate market entry

162. The Board takes the view that the measures described in points 160 and 161 will facilitate market entry. Moreover, the Board believes that the measures are sufficiently material and, in combination with the reporting obligation referred to below in point 164 and the dispute referral arrangements referred to in point 165, sufficiently enforceable.

Monitoring, reporting obligation, dispute resolution and sanctions

163. The NMa will work closely with the NZa on implementation of the price ceiling, since the latter organisation has access to relevant data and mathematic models.[55] In addition, the NMa will, where appropriate, seek the IGZ's opinion as to whether the merged hospital is satisfying the applicable quality requirements, because the IGZ has responsibility for assessing whether care providers in the Netherlands are in compliance with quality requirements and has the authority to impose quality standards.

164. On 1 May of year *t+2*, the merged hospital shall submit to the NMa a definitive financial report demonstrating whether the price ceiling was adhered to. This report shall be accompanied

[55] Cooperation between the NMa and the NZa will be based on Article 13 of the protocol that the two organisations agreed on 10 October 2006, regulating cooperation on matters of mutual interest, as well as on the working arrangements that the organisations agreed in February 2008 for the handling of concentration cases (Government Gazette 5 March 2008, no. 46, p. 11).

by an unqualified audit opinion. Because a definitive report can be compiled only once all the relevant data become available, no report can be made until year *t+2*. Furthermore, every three months, the merged hospital must submit a progress report on realisation of the quality improvements; at a similar interval, the merged hospital must report on the requests that it has received from medical specialists who wish to privately offer extramural care or who wish to use the merged hospital's facilities, and on the associated responses. The merged hospital will submit copies of its reports on realisation of the quality improvements to the IGZ. Thus, the latter organisation will be aware of what the merged hospital has reported to the NMa, which may be significant in the context of the IGZ's oversight activities.

165. Any dispute that arises between the merged hospital and a medical specialist regarding the hospital's response to a request to privately offer extramural care or to use the merged hospital's facilities shall be referred to the Health Care Arbitration Board.

166. If the merged hospital does not comply with the conditions attaching to this decision, the Board may, as provided for in Section 75 of the Mw, order the hospital to comply, on pain of financial penalty. Such an order may or may not be accompanied by a fine. Furthermore, a fine may be imposed separately from the imposition of an order on pain of financial penalty.

Market assessment

167. The NMa gave the insurers CZ and UVIT, as well as the NZa and the IGZ, the opportunity to express their opinions on the likely effectiveness and practicality of the commitments offered by the parties. On the basis of their observations, a number of minor editorial changes have been made to the wording of the commitments.

Reasoned departure from the opinion of the NZa

168. In the statement of its opinion submitted to the NMa, the NZa recommended that approval for a merger should be subject to the satisfaction of a number of structural conditions (the hiving off or privatization of organisational units), compliance with two related rules of conduct and the satisfaction of a number of quality-related conditions (see points 54 to 57). However, the parties' proposed commitments do not include compliance with the structural conditions proposed by the NZa. Furthermore, the proposed commitments do not include a promise to meet one of the quality-related conditions proposed by the NZa, namely the maintenance of a specialist medical staff of at least five FTEs for each specialism that forms a part of basic hospital care[56].

[56] This standard is referred to by the IGZ in its report to the NZa; see also footnote 11. Furthermore, in its report, the IGZ states that, where the professional associations have defined no applicable standards, the IGZ assumes the applicability of

169. Because it has not been adequately demonstrated that the maintenance of a specialist medical staff of at least five FTEs for each specialism is necessary for the assurance of minimum basic hospital care quality standards in Central Zeeland[57], the Board sees insufficient reason to make its decision conditional upon the maintenance of such staffing levels.

170. The structural conditions proposed by the NZa would oblige the parties to:
- hive off all specialisms with more than 30 per cent turnover in the B sector;
- refrain from integrating any team that would not benefit from scaling up (the NZa believes that integration is necessary only for A&E, IC, paediatric medicine, obstetrics and diagnostic departments, such as radiology and the laboratories);
- Hive off all independent treatment centres or end their affiliation to the hospitals.
The NZa believes that consideration should be given not only to hiving off one of the existing locations, but also to hiving off certain activities within the existing locations (so-called '*carve-outs*'). According to the NZa, it should be left to the parties themselves to indicate the extent to which hiving off the above-mentioned activities is outside their sphere of influence.

171. The Board considers the imposition of the above structural conditions undesirable for the following reasons.[58] The parties believe that the quality levels that these basic hospitals must meet are realisable only by means of across-the-board cooperation, making a general merger the only practicable solution. This view is confirmed by the IGZ. In its submission, the IGZ pointed out that the various basic functions of a hospital are closely interrelated and therefore highly interdependent (see points 42 and 43). Partially or completely hiving off certain specialisms is, in the Board's opinion, at odds with the defined solution and could therefore compromise efforts to achieve the necessary quality standards. Furthermore, the Board considers the structural remedies proposed by the NZa impractical, since medical specialists cannot be obliged to start a practice in competition with the hospitals. Consequently, conditions to the effect described would

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the standard that applies in paid employment situations, namely that a complement of five FTEs is necessary to ensure that one person is available at all times.

[57] In its submission, the NZa says: *"The NZa is unable to support the IGZ's contention that a minimum staff of five FTEs is required for every specialism within basic hospital care, particularly in view of the fact that this standard applies only to personnel in paid employment, since independent specialists are generally willing to work longer hours. Moreover, this standard is not consistent with accepted practice in hospitals, many of which (particularly the smaller ones) do not maintain such staffing levels. The figure of five FTEs is based on a mathematical formula, and it is debatable whether it is generally valid for all specialisms within basic hospital care."* The NZa is nevertheless of the opinion that, in the absence of output conditions for the quality of care, this standard should be included in the conditions attached to approval of the merger as an approximation of output quality (see also point 57).

[58] The NMa has informed the NZa accordingly, orally and in writing.

not be enforceable and are regarded by the Board as inappropriate. The Board believes that the proposal made by the parties, involving the imposition of a price ceiling, combined with various commitments regarding quality improvements and the facilitation of market entry, constitutes an appropriate solution. The outlined strategy will mitigate the competition problem described in point 97 to a sufficient extent, while also ensuring that the quality improvements referred to by the parties and considered necessary by the IGZ (see point 45) are realised.

Conclusion

172. The proposal made by the parties – as outlined above and appended to this decision – provides sufficient grounds to assume that the proposed concentration will indeed lead promptly to (necessary) quality improvements, without the parties' very strong position leading to disproportionate rises in the prices charged for DTCs in the B sector (the sector of the market in which free trade is practised). Furthermore, the entry of new care providers to the market for clinical general hospital care and non-clinical general hospital care in Central Zeeland will be facilitated. Hence, the parties' proposal offers a solution to the problem that might otherwise affect competition on the markets for clinical general hospital care and non-clinical general hospital care in Central Zeeland.

173. In consideration of the parties' commitments, as referred to in points 151 to 166, the Board is persuaded that the efficiencies claimed by the parties will benefit consumers, are merger-specific and are verifiable and therefore counterbalance the effects on competition that the merger would otherwise have.

VIII. CONCLUSION

174. On the basis of the foregoing, the NMa Board concludes that the proposed concentration falls within the scope of the regulation provisions of chapter 5 of the Mw.

175. The NMa Board concludes that, if no conditions were attached to the licence, the proposed concentration would significantly restrict effective competition on the markets for clinical general hospital care and non-clinical general hospital care in Central Zeeland, in particular by creating or strengthening a dominant position.

176. In view of the parties' commitments, as described in points 151 to 166 and contained in the appendix that forms an integral part of this decision, the NMa Board concludes that, provided the commitments are properly fulfilled, the proposed concentration will not significantly restrict effective competition on the Dutch market or any part of it, in particular by creating or strengthening a dominant position.

177. In view of the foregoing, the NMa Board announces that a licence is granted for the concentration to which the licence application relates.

178. The licence is granted subject to the following conditions:
a. The parties shall, following the concentration, submit to a price ceiling for B-sector DTCs.
b. The parties shall, following the concentration, realise certain quality improvements, within the periods specified in the appendix to this decision.

c. The parties shall facilitate entry to the market for existing and future providers of specialist medical care.
d. The conditions specified in clauses a, b and c shall be fulfilled as provided for in the appendix to this decision, which appendix forms an integral part of this decision.

Date: 25 March 2009

Signed on behalf of the Board of the Netherlands Competition Authority and in accordance with the decision of that Board,

[signature]

René Jansen
Board member

Any party with a direct interest in this decision may file a reasoned objection to it within six weeks of the decision's publication, at the District Court in Rotterdam, Administrative Law Division, P.O. Box 20951, 3007 BM, Rotterdam, the Netherlands.

Memorandum

Netherlands Competition Authority

Meester TM Snoep and Meester S Chamalaun
Date 24 March 2009
Our ref. M6032831/1/20327730/SC

Subject: Proposed remedy for case 6424 Walcheren Hospital – Oosterschelde Hospital

(1) In this document, on behalf of Walcheren Hospital and Oosterschelde Hospital (following implementation of the concentration referred to in this context as 'the United Hospital'), we put forward a proposal for various remedies to the objections made by the NMa on the grounds of potential competition problems. This document deals with the following matters: A. the price ceiling, B. the anticipated quality improvements, and C. measures to simplify entry to the relevant market.

A. Price ceiling

(2) The United Hospital will be obliged to submit a price ceiling defining a maximum average charge for a B-sector DTC. This maximum charge will be calculated from the national average price for a DTC, corrected for the product mix of the United Hospital.

(3) In the context of the price ceiling, the following definitions will apply:
The **national average price** is the weighted national average price for a DTC.

The **average price of the United Hospital** is the weighted average price for a DTC provided by the United Hospital.

The **product mix figure** reflects a given DTC's share of the total DTC volume in a given year. (For example: in a given year, a total of 1000 DTCs are opened, of which 100 are Hip DTCs. The product mix figure for the Hip DTC is therefore 10 per cent.) The grand total of the product mix figures for all the DTCs must always be 100.

The **national product mix weighting** is a figure reflecting the ratio between the weight of the price of a DTC and that of the national average price. A figure greater than 1 implies that the price of the DTC in question is higher than the national average price, while a figure smaller than 1 implies a price lower than the national average price.

The **United Hospital product mix index** is a DTC-specific factor for correction of the national average price to reflect the particular product mix of the United Hospital.

(4) In order to define in advance a provisional price ceiling for the United Hospital for year t, certain national figures must be calculated as follows:

(i) *Calculation of the total national turnover per DTC*
The total national turnover is the sum of the turnovers for the various B-sector DTCs. The turnover per DTC is calculated by multiplying the total number of DTCs of a given kind opened in the Netherlands in year t-2 (and closed in year t-2 or t-1) by the national average price of that DTC. The national average price is the price for year t-1, as collated by the NZa and corrected for wage and price inflation, and as published in October of year t-1. The total number of DTCs of a given kind opened in the Netherlands in year t-2 (and closed in year t-2 or t-1) is also collated by the NZa.

(ii) *Calculation of the national average price*
The national average price is calculated by dividing the total national turnover by the total number of DTCs opened in year t-2. The national average price is therefore a weighted average of the prices for the various DTCs.

(iii) *Calculation of the national product mix weighting*
For each DTC, the national product mix weighting is calculated by dividing the national average price of that DTC for year t-1 by the national average price for year t-1.

(5) The national data are corrected for the product mix of the United Hospital in order to define the provisional price ceiling. To this end, the following data are calculated:

(iv) *Calculation of the product mix of the United Hospital*
The product mix of the United Hospital is calculated by dividing the number of DTCs of a given kind opened in year t-2 (and closed in year t-2 or t-1) by the total number of DTCs opened in year t-2 (and closed in year 1-2 or t-1).

(v) *Calculation of the United Hospital product mix index*

The product mix index of the United Hospital is calculated by multiplying the product mix figure for each DTC by the national product mix weighting for that DTC. The correction factor applied to the national average price for a DTC is obtained by calculating the sum of the product mix indices for all the United Hospital's DTCs.

(vi) *Fixing the maximum charge*

The price ceiling for year t is calculated by multiplying the national average price by the sum of the product mix indices for the United Hospital. The resulting figure is the maximum average price for a DTC provided by the United Hospital.

(6) On the basis of the calculations described above, a provisional price ceiling is fixed for the United Hospital for year t. In year t, the United Hospital cannot yet determine the definitive price ceiling for that year. In year t, therefore, the United Hospital will monitor the actual product mix to ascertain whether it is consistent with the forecast product mix and the prices. To monitor compliance with the price ceiling in year t, the United Hospital will use the model developed by the NZa.

(7) At the start of year t+2, the United Hospital will calculate the definitive price ceiling using the national prices for year t, as collated by the NZa and the actual volumes from year t, again as collated by the NZa. On the basis of these data, the United Hospital will calculate the definitive maximum average price for a DTC.

(8) To subsequently determine whether the price ceiling has been exceeded in year t, the United Hospital will calculate its average price for a DTC by dividing its total B-sector turnover for year t by the number of DTCs opened in year t. The average price thus calculated for a DTC must not exceed the maximum charge.

(9) If new DTCs are added to the B-sector list, it will not be possible to calculate the provisional price ceiling from the national average price of the new DTCs. Under such circumstances, the United Hospital will use the rates published by the NZa for the new DTCs.

(10) On 1 May of year t+2, the United Hospital will submit to the NMa a definitive financial report accompanied by an unqualified audit opinion.

Notes

The purpose of adopting a price ceiling is to prevent the United Hospital, in the absence of competitive pressures, from charging excessive prices for DTCs

on the free B-sector market. The ceiling is based on a weighted average of the prices charged by all other hospitals in the Netherlands for similar DTCs, and therefore reflects competitive prices.

On the basis of national data from previous years collated by the NZa, a provisional price ceiling will be calculated. By reference to its historical product mix and the national average price, the United Hospital will work out a forecast maximum charge for a DTC. This forecast price ceiling will be taken into account by the United Hospital when agreeing prices for B-sector DTCs with insurers. Retrospective checks will be performed to ascertain whether the United Hospital has adhered to the price ceiling. These checks can be performed at the start of year t+2, once all the definitive data on year t are known. At that point, a definitive report will be submitted to the NMa. Hence, attachment of the conditions set out above would address any price-related objections.

B. Anticipated quality improvements

(11) Within three years of the date of a licence being granted, the United Hospital will extend the range of care services that it provides as follows:

I All the gatekeeping specialisms that a full-capability basic hospital is expected to provide are to be made available, supported by the appropriate medical facilities and the practice of subspecialisms.

II A level-2 IC facility conforming to the applicable standards will be realised.

III An A&E facility (regional trauma centre) conforming to the applicable standards and complementing the level-2 IC facility will be realised.

IV Operational facilities conforming to the applicable standards will be realised for acute intervention in life-threatening situations, such as facilities for Dotter's treatment, aortic surgery and complex traumatology.

V Laparoscopic colon surgery conforming to the applicable standards will be added to the United Hospital's care service capability.

(12) In addition, the United Hospital will ensure that, as soon as possible and certainly within six months of the date of a licence being granted:

VI the United Hospital is in compliance with the standards on minimum department sizes and on minimum specialist team sizes within departments; and

VII the United Hospital is in compliance with the standards on minimum procedure numbers per specialist.

(13) The time periods specified above in clauses I to VII will be legally binding, except in the event of *force majeure*. The onus will be on the United Hospital to demonstrate that prevailing circumstances do constitute a *force majeure*. As soon as it becomes aware of circumstances that it believes to constitute a *force majeure*, the United Hospital will inform the NMa accordingly. It will then be up to the NMa to determine whether the circumstances do indeed constitute a *force majeure* and what the implications of those circumstances are. Only circumstances entirely outside the control of the United Hospital may be deemed to constitute a *force majeure*.

(14) The United Hospital will moreover endeavour to:

VIII bring about the merger of all departments within six months of the date of a licence being granted, possibly making use of Article 24, clause 1(e), of the Admission Agreement;

IX assure the physical accessibility of acute care at all times;

X assure effective cooperation and coordination with all relevant primary care providers in Central Zeeland, including GPs and primary obstetricians, with a particular view to maximising the physical accessibility of care.

(15) Starting with the first quarter after the date of a licence being granted and thereafter at least once a quarter, no later than the first day of each new quarter, the United Hospital will submit a written progress report to the NMa on fulfilment of its quality obligations. In these reports, the United Hospital will at least comment on the status quo, the forecast realisation dates, the identified risks and the implemented solutions.

(16) In each of its reports, the United Hospital will refer to the content of the reports published in the preceding quarter on the United Hospital by the IGZ. The United Hospital will send a copy of each of its reports to the IGZ.

Notes

Application of the conditions set out above would, following the concentration, oblige the United Hospital to ensure realisation of the quality improvements that justify the possible restriction of competition by the concentration. The United Hospital will be given three years from the date of a licence being granted to realise the quality improvements listed in clauses I to V.

Naturally, the United Hospital's ability to realise the quality improvements depends on a variety of factors. Some of these factors are outside the United Hospital's sphere of influence. Only if the United Hospital is prevented from fulfilling its obligations by such factors and has reported the matter to the NMa may the NMa excuse the United Hospital on the grounds of force majeure*. Thus, the United Hospital is obliged to do everything in its power to realise the quality improvements.*

Since the United Hospital is required to submit a quarterly report to the NMa, the latter organisation will be able to monitor progress towards realisation of the quality improvements. In addition, the United Hospital will forward the IGZ's reports on the United Hospital to the NMa, so that the NMa is also aware of the IGZ's views on relevant matters.

Attachment of the conditions set out above would address any objections concerning the possibility that the United Hospital might decide not to realise, or might use its influence to prevent the realisation of the quality improvements, e.g. with a view to controlling costs.

C. Simplifying entry to the relevant market

(17) The United Hospital will make its facilities available to all parties that wish to offer specialist medical care, including established and future providers of such care. The United Hospital will apply normal charges for the use of its facilities, in line with national market norms.

(18) The Board of the United Hospital will allow medical specialists to privately offer extramural care in their specialist fields, if and insofar as this does not threaten the continuity of the care available from the United Hospital.

(19) Any dispute that arises in connection with application of the measures to simplify entry to the market, as described above, shall be referred to the Health Care Arbitration Board, in accordance with the regulations of that body.

Notes

By taking the measures described above, the United Hospital can facilitate entry to the relevant market. Any existing or new provider of specialist medical care is assured use of the facilities of the United Hospital. Furthermore, any such provider of specialist medical care can be sure that use of the United Hospital's facilities will be at a competitive price. The measures described also ensure that medical specialists attached to the United Hospital can additionally practise their specialisms outside the setting of the United Hospital, provided that this does not threaten the continuity of the care available from the hospital. Thus, entry to the relevant market by other providers of specialist medical care will be facilitated further.

(20) Starting with the first quarter after the date of a licence being granted and thereafter at least once a quarter, no later than the first day of each new quarter, the United Hospital will submit a written report to the NMa on entry to the relevant market. In its reports, the United Hospital will specify the number of requests received from parties wishing to provide specialist medical care, and will indicate how it responded to these requests. The United Hospital will also specify the number of requests that its board received from medical specialists wishing to privately provide extramural care, and will indicate how its board responded to these requests.

(21) The Walcheren Hospital Foundation and the Oosterschelde Hospitals Foundation each commits itself to requiring any legal successor to undertake to satisfy the conditions set out in this document.