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**English - Or. English**

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## Working Party No. 2 on Competition and Regulation

**COMPETITION IN HOSPITAL SERVICES**

**-- Germany --**

**13 February 2012**

*The attached document is submitted to Working Party No.2 of the Competition Committee FOR DISCUSSION under item III of the agenda at its forthcoming meeting on 13 February 2012.*

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## 1. Introduction

1. Ensuring equal access to health services, including hospital services, for all citizens while at the same time guaranteeing a high quality standard of health care provision is considered to be of paramount political importance in many countries. Over the last years, health care expenditure has been steadily increasing worldwide, due to demographic and technological changes. In 2009, Germany spent EUR 278 billion, equaling over 11% of GDP, on health care, of which EUR 71 billion were expenditures for hospital services.[1] Against this background, it is therefore important to strengthen competition within the health system to ensure choice and at the same time cost effectiveness.

2. This also applies to hospital services. A number of hospital mergers examined by the *Bundeskartellamt* in Germany in recent years have prompted a discussion about the potential role of competition in the market(s) for the provision of hospital services in light of these developments.[2] Competition on hospital markets improves the quality of services, reduces expenditures on health care services and thus increases the efficiency of the provision of health care services.

3. This paper describes the legal framework relevant to competition in the market for hospital services in Germany. It presents recent regulatory reforms and developments intended to promote competition in these markets. However, as the provisions establishing the legal framework for hospitals in Germany are manifold and found in a number of different statutes, a detailed description of the regulatory system would be beyond this paper's scope. Therefore only a broad picture of the most relevant features will be presented here.[3]

## 2. Specific features of the markets for hospital services

4. In most services markets, competition between service providers takes place with regard to all parameters of competition, such as price or quality[4]. However, when it comes to hospital services, a number of special features and difficulties relating to the functioning of the market are discussed in health care economics as well as in the political discourse.

5. One of the difficulties and a reason for potential market failure are information asymmetries between the service provider (hospital) and the consumer (patient). Hospital services are considered "credence goods", i.e. goods, whose quality or the extent to which they are needed cannot (or only under very high costs) be adequately assessed by the consumer, both before and even after the purchase.[5] With

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1 German Federal Statistical Office (Destatis): http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2011/04/PD11__135__23611,templateId=renderPrint.psml

2 The term 'hospital services' will hereafter be used as referring mainly to stationary treatment provided by hospitals, in particular diagnosis and treatment.

3 For more details on the legal and economic framework of the German hospital markets see Bundeskartellamt, B10-123/04 *Rhön-Klinikum/Landkreis Rhön-Grabfeld*, Prohibition Decision of 10 March 2005; Press Release in English on www.bundeskartellamt.de. The decision was confirmed by the Higher Regional Court in Düsseldorf on 11 April 2007 and by the Federal Supreme Court on 16 January 2008 (Press Release of 17 January 2008 in English on www.bundeskartellamt.de.

4 Quality of hospital services can, in addition to successful treatment, also include the quality of the technical equipment, waiting periods, room quality, customer-orientedness of the hospital staff, or the quality of the food.

5 Compare i.a. Winand Emons, Credence goods and fraudulent experts, RAND Journal of Economics Vol. 28, No. 1, Spring 1997, pp. 107–119. Available at: http://staff.vwi.unibe.ch/emons/

regard to hospital services, this can refer to the necessity, the extent as well as the quality of the medical treatment provided. In many cases the consumer's (patient's) decision which hospital to choose for stationary treatment will also be based on the advice of his general practitioner or relatives/close friends who have had experience with the hospital in question.

6. In this context a further cause for potential market failure may arise from the moral hazard problem posed by (full) insurance coverage. Since 2009, health insurance has been mandatory for all citizens in Germany. A large majority of the population is insured with a statutory health insurance fund (also called sickness fund) and a minority, roughly 10 % of the population, has a private health insurance. In both cases the recipient of the service demanded (the patient) is not identical with the entity which ultimately has to bear the costs for the services (health insurance funds or the private health insurances). This division can have adverse effects on the demand side of the market for hospital services, as the patient may not take the costs of different options of treatment offered to him adequately into account.

7. Impediments to an optimal market outcome may also arise on the suppliers' side. There may be incentives for over- or under-provision of treatment by hospitals, arising from the fact that patients find it difficult to assess the need for and quality of the treatment offered to them. Such potential over- or under-provision of services may concern both, the quantity and the quality of treatment. However, the extent to which this becomes an issue will depend *inter alia* on the specific remuneration scheme for providers of hospital services.

8. Due to these and other causes of potential market failure, public intervention in the market for hospital services may be required.[6] Such intervention would also respond to concerns of society that unregulated competition could lead to an insufficient level of quality of hospital services. Such intervention may also ensure that the goal of ubiquitous provision of and equal access to hospital services is met, which in Germany as in many other countries are considered primary concerns of the society, may not be achieved solely by means of a competitive market outcome.

## 3. General framework for the hospital services market in Germany

9. The German hospital market is highly regulated by various codes and acts, such as the Social Code (*Sozialgesetzbuch*), the Hospital Financing Act (*Krankenhausfinanzierungsgesetz*), the Hospital Remuneration Act (*Krankenhausentgeltgesetz*) and the Hospital Codes of the federal states (*Krankenhausgesetze der Länder*) as well as the Trade Code (*Gewerbeordnung*).

10. Providers of hospital services can be distinguished according to ownership structure. In 2010, roughly 30 % of the hospitals in Germany were public hospitals, owned by municipalities, regional districts or federal states. Around 37 % were charitable hospitals, run by non-profit organizations (in particular the churches). The remaining 33 % were privately owned hospitals, whose number has increased in recent years.[7] However, in terms of accommodation capacity, the picture is quite different. Public hospitals account for around 49 % of accommodation capacity, charitable hospitals for around 34 % and private hospitals for the remaining 17%.[8]

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6 Naturally, that could only be the case for planned, elective hospital care and not for emergency care, where the decisive factor is getting initial treatment as quickly as possible.

7 Private hospitals may further be distinguished according to whether or not they are listed in the Hospital Plan and therefore allowed to provide services to patients with a statutory health insurance.

8 German Federal Statistical Office (Destatis), see above.

### *3.1. Regulation on remuneration of hospitals forming part of the German Hospital Plan*

11. The remuneration of all public and most private hospitals depends on two streams of revenue: a) the financing of investments (building, expanding and modifying of hospitals, also including investment in equipment) is provided or supported by investment subsidies paid by the federal states (*Länder*), b) the remuneration of operating costs is provided through payments by the health insurance funds and private health insurance companies for services rendered and, to a lower extend, by the patients themselves.

#### *3.1.1. Funding for capital investment*

12. In order to be entitled to receive investment subsidies, hospitals need to be listed in their federal state's "Hospital Plan" (*Krankenhausplan*). This plan is a capacity plan established on a yearly basis by each federal state in cooperation with the hospitals and health insurers active in the relevant federal state. The plan is to provide capacity in hospitals needed in order to meet the expected demand for stationary treatment. The regional needs are estimated on the basis of a number of indicators, such as population, average length of stay and capacity utilisation. Based on the Hospital Plan, each federal state determines the investments needed and sets up an investment programme on the basis of which hospitals can apply for subsidies.[9]

#### *3.1.2. Funding for operating costs*

13. In view of the ever rising costs of hospital and health services the German government considered different approaches to set optimal incentives for hospitals to balance quality and efficiency.

14. In 2003, Germany introduced the Diagnosis Related Groups (G-DRG) system to calculate hospital remuneration and prices for treatments. Similar systems have been installed in other OECD countries. A „DRG" describes an in-patient case and sums up all hospital resources devoted to that case from the beginning of hospitalization until discharge. The system classifies all hospital cases into different groups, depending on the main diagnosis, different treatment procedures, complications, length of stay, discharge reason, etc. The introduction of this system in Germany represented a change from a merely cost-based remuneration scheme for hospitals, which was seen as providing unwanted incentives for hospitals to over-admit patients, to a more generalized, case related one.

15. Roughly, the system is designed as follows. At federal level each of the 1200 G-DRGs[10] is given a specific cost weight with regard to a general per-diagnosis-value, which is determined on the basis of the average costs of all cases in the relevant federal state. More costly G-DRGs (for example those encompassing more expensive treatment procedures) receive a weight above the average costs, i.e. the basis, and less costly G-DRGs (for example those with minimum cost treatment) receive a lower weight. The weights for individual G-DRGs are defined annually for the whole of Germany on the basis of cost-samples taken from a number of hospitals.

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9 With the last amendment to the Hospital Financing Act at the end of 2011, a possibility for federal states was introduced to deviate from this form of investment subsidies. Beginning 2012 they may switch to an investment-surcharge instead, which is related to Diagnosis Related Groups (see below).

10 If the cost range within a certain G-DRG is too wide, the G-DRG is split up into several G-DRGs, which has led to an increase in the number of G-DRGs. The large number of G-DRGs, incorporating actual cost differences between hospitals, has been criticised as resembling a cost-based reimbursement scheme and thereby reducing the advantages the G-DRG system could bring about. See Monopolkommission (2008), 17. Hauptgutachten, http://dip21.bundestag.de/dip21/btd/16/101/1610140.pdf

16. At federal state level, the health insurance funds negotiate with the regional hospital association in the state a certain base rate. This base rate is calculated on the basis of the average costs of all in-patient cases in that state. The amount of money a hospital situated in the respective federal state receives for a specific treatment is calculated by multiplying the relevant DRG's with the base rate.

17. Moreover, each hospital negotiates with the health insurance funds the amount of services to be rendered according to the assignment in the Hospital Plan. This figure enables the partners to calculate the hospital's annual budget (*Erlösbudget*). Hospitals therefore are not remunerated solely on the basis of the actual services they have provided. If, at the end of the year, the hospital provided more services than agreed upon, it does not receive full remuneration for the extra services provided.[11] If, on the other hand, it did not render as many services as agreed upon, it still receives a part of remuneration for services it did not perform.[12]

### *3.2. Other Regulations*

18. A number of regulations are concerned with ensuring a minimum quality in hospital services provided. These can be distinguished according to whether they relate to structural, process or outcome quality. Structural quality is to be maintained by legally requiring minimum training standards for hospital staff, as well as a minimum amount of standard treatments performed in hospitals.[13] Quality of process is to be guaranteed by guidelines regarding examination and treatment procedures in hospital, which are devised and published collectively by the joint self-government of doctors, dentists, psycho-therapists, hospitals and health insurers.[14] Outcome quality is to be secured by requiring hospitals to publish reports every two years in which they report the number and form of services rendered, whether they fulfilled legal quality requirements, as well as measures undertaken with regard to internal quality management.

19. Special rules also apply to public advertising for hospital services which is restricted by the Act on Advertising in the Health Care Sector (*Heilmittelwerbegesetz*) and the Medical Association's professional code of conduct (*Berufsordnung der Ärzte*).

## 4. Competition in the German hospital market

### *4.1. Impact of the G-DRG system*

20. The introduction of the G-DRG system, which in effect acts as a price cap, led to increased pressure on hospitals, especially on less efficient ones, to reduce costs and to become more efficient. The G-DRG system also prevents hospitals with market power from using their position to raise prices beyond the cap. Incentives for keeping patients too long or discharging them too early are reduced.[15] The reason is

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11 In fact, hospitals at first receive payment by the health insurance funds on behalf of the patients, however, if they rendered extra services, they have to pay back parts of these payments in the final annual settlement.

12 The reason for that is that in the agreed budget also fixed costs (not investment costs) are incorporated, while the remuneration of additional services rendered only covers variable costs. Also, only the fixed costs of services not rendered are paid.

13 If a hospital does not perform the minimum amount of treatments established, it will no longer be allowed to offer these services (SGB V § 137). It may be possible, however, to provide convincing arguments why it would be able to do so for the next planning and contracting period.

14 See The Federal Joint Committee (G-BA): http://www.g-ba.de/institution/themenschwerpunkte/qualitaetssicherung/ergebnisqualitaet/

15 "Too long/too early" as compared to the established average length of stay, not compared to the actual length of stay necessary from a medical point of view.

that G-DRGs are connected to an average length-of-stay range, providing hospitals with reduced payments when this range is undercut or exceeded. The regulations on minimum requirements regarding hospital staff, quality management and hospital reports have drawn the attention of government, service providers and patients to the quality assessment of hospital services. After the reform, hospitals increasingly recognized the necessity to become more efficient as well as the need to compete with other hospitals. Some commentators have therefore reported an improvement in efficiency and competition on the German market for hospital services.[16]

### *4.2. Remaining impediments to competition*

21. Although a case-oriented remuneration scheme establishing specific payments for specific treatments is generally regarded to be more efficient than a reimbursement system based purely on the actual costs incurred, and the possibilities for hospitals to abuse market power in setting prices have been largely excluded, there may still be room for improvement. The actual design of the German remuneration system may create some impediments to competition, including competition on quality. These may however partly be justified as unavoidable trade-offs between different goals.

22. The strong emphasis on planning quantities and investments has some drawbacks as it requires an adequate prediction of demand by the central planning agencies, including estimations for the types and amount of services needed, accommodation capacity and technical equipment. Moreover, as long as the number of beds forms a basis for central planning issues, hospitals will only reduce overcapacity if the costs of maintaining the overcapacity are larger than the expected benefits resulting from a larger capacity in the central planning negotiations.

23. Restrictions on investment decisions arise from the central planning process that could make the specialization of hospitals on certain types of services more difficult.[17] In particular, new technologies or procedures for diagnosis or treatment need to be approved ex ante upon application by the hospital, which, after approval, may negotiate remuneration with the health insurers. The possibilities to establish new medical departments in hospitals are also reduced due to the necessity to be incorporated into the Hospital Plan. These difficulties are exacerbated by the fact that investment payments to hospitals have been continuously reduced in the last decade, leading to an often discussed investment lag (*Investitionsstau*).[18]

24. Incentives and realisation possibilities for specialisation efforts, which could be considered beneficial for competition on quality, can be diminished further by ex-ante planned budgets for the hospitals and the related services to be rendered. Hospitals can deviate from these plans and provide more or less than the agreed amounts of services and still receive some remuneration, but when hospitals over-perform, the remuneration for the additional services will be less than for the planned amount. While this may counteract potential incentives for hospitals to admit more patients and to perform more treatments than actually needed, it also reduces incentives to engage in specialisation efforts that have not been incorporated ex ante into the Hospital Plan and the contract between hospitals and health insurance funds.

25. The G-DRG system exerts pressure on hospitals to reduce costs. However, once organisational inefficiencies are taken care of, hospitals have limited possibilities to reduce costs any further and therefore

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16 See for example J. Debatin, Krankenhäuser – Mehr Qualität und Effizienz durch Wettbewerb, in: Medizin zwischen Humanität und Wettbewerb: Probleme, Trends und Perspektiven, Konrad-Adenauer-Stiftung e.V (Ed.), Herder, 2008, p.392.

17 The effects of the recent changes in the law as described above remain to be seen.

18 Monopolkommission 2008, see above.

there may be incentives for hospitals to save costs by reducing quality wherever it is less observable.[19] Hospitals may be tempted to discourage patients with complex needs or classify patients strategically into more profitable G-DRGs whenever this is possible. They could also discharge patients too early, making follow-up treatment necessary. Such "revolving door effects" have sometimes even led to bilateral "kick-back agreements" with referring physicians, who would provide follow-up care against payment from the hospital.[20] Such agreements can distort the decision of the physician as to which hospitals patients should be referred to and consequently hinder competition.

26. And finally, competition on quality is still inhibited by the lack of transparency and information in laymen's terms regarding the quality of hospital services, which could form the basis for an informed consumer's choice.[21] This difficulty is even more important as hospital services and medical services in general have a much greater impact on the quality of life of individuals than any other need or purchase.

27. Because of these and other additional considerations, different proposals have been discussed as to how competition on the German markets for hospital services could be fostered further. The German Monopolies Commission proposed a system of "monistic" financing of hospitals instead of a dualistic system.[22] The proposal, which can only be summarized here, includes the possibility for health insurance funds to contract selectively with hospitals where elective hospital treatment is concerned, options for health insurance funds to restrict the freedom of choice of hospital for the insured, and an investment premium on remuneration for hospital services. To insure the socially desired all-encompassing provision of hospital services, additional hospital services should be publicly provided through auctions similar to public procurement procedures. However, this solution could be criticised as focusing on cost-efficiency elements, potentially to the detriment of quality competition, and ignoring equity concerns, as paying more for an additional health insurance in order to maintain some freedom of hospital choice may not be a realistic option for all members of society.[23]

## 5. Competition law enforcement on hospital market in Germany

28. Given the regulatory framework described there is little room for price competition on the German market for hospital services. The aim of competition law enforcement therefore is to protect the remaining competition in the market, in particular concerning competition on quality. This is primarily achieved by merger control; however, the abuse of a dominant position can also be pursued, since the Act against Restraints of Competition is generally applicable to hospitals.

29. As internal growth, potentially necessary for the realization of economies of scale, is only possible within the boundaries set by regulation, and also because budgets of public local authorities have been declining in recent years, mergers have played an increasingly important role in the markets for hospital services. In the last eight years, the Bundeskartellamt reviewed around 150 hospital merger cases.

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19 Empirical studies seem to corroborate this assessment, finding increasing observable quality and diminished unobservable quality, see Coenen/Haucap/Herr: Regionalität- Wettbewerbliche Überlegungen zum Krankenhausmarkt,Ordnungspolitische Perspektiven, Juni 2011.

20 Monopolkommission 2008, see above. Such agreements can be illegal, Decision of the Higher Regional Court (OLG) Düsseldorf of 01.09.2009 (I-20U 121/08).

21 Monopolkommission 2008, see above. J. Debatin 2008, see above.

22 Monopolkommission 2008, see above.

23 See for example response of the German Hospital Federation (DKG) to Monopolkommission (2008): www.dkgev.de/media/file/8238.RS286-10_Anlage1.pdf

A large majority of these cases were cleared within the first phase proceedings and only four were prohibited.[24]

30. Substantive issues in merger control primarily concern the definition of the relevant product market.[25] The Federal Court of Justice (*BGH*) confirmed in 2008 that the relevant market is one for regular hospital services, including all in-patient medical services provided by hospitals.[26] The market is not to be divided according to specialization in specific medical disciplines.

31. The relevant geographic market is generally established by analysing patient flow data, taking into account only patients that are travelling to the hospitals of the merging parties and not, as may be done elsewhere, aggregate patient inflows to all hospitals in the hypothetical geographic market. All case-specific characteristics as well as the specificities of the health care sector are analysed and taken into account.[27]

32. A merger will be prohibited if it is expected to lead to the creation or strengthening of a dominant position. Competition in the market for hospital services, within the regulatory framework, is thus protected. So far no hospital merger has been blocked which led to market shares of the merging parties of less than 50%.

## 6. Conclusions

33. In order to reduce unnecessary costs borne by society as well as provide incentives for quality competition and innovation in the hospital services market, it is a very important task for competition authorities to protect competition on the hospital market at least as far as it exists within the current legal framework.

34. At the same time, the regulatory framework concerning the market for hospital services in Germany leaves little scope for price competition. The regulations aim to ensure access to health providers for all citizens, insuring high quality concerning the services provided as well as decreasing inefficiencies in the market due to rising expenditure on health care. These goals may not always be mutually compatible and consequently lead to unavoidable trade-offs. However, it will be an ongoing effort to consider ways of improving the existing regulatory framework in order to further reduce impediments to competition.

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24 One of these subsequently succeeded in obtaining a ministerial authorization on grounds of overriding public interests.

25 Except for gynaecology, obstetrics and ophthalmology services, which could each be considered as independent markets, see BGH, Decision of 16.1.2008, KVR 26/07 - Kreiskrankenhaus Bad Neustadt. .

26 BGH, Decision of 16.1.2008, KVR 26/07 - Kreiskrankenhaus Bad Neustadt.

27 Bundeskartellamt, B10-109/04 Rhön-Klinikum/Krankenhaus Eisenhüttenstadt, Prohibition Decision of 23 March 2005; Press Release in English on www.bundeskartellamt.de. Bundeskartellamt, B3-125/08 Gesundheit Nordhessen/Werra-Meißner, Prohibition Decision of 18 Juni 2009; Press Release in English on www.bundeskartellamt.de