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COMPETITION IN THE PROVISION OF HOSPITAL SERVICES

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1. Introduction

The organisation of the German health care system is based on the principle of subsidiarity of state action. The state – in Germany the federal government as the central power and the *Länder* – should only take on those tasks which cannot be appropriately accomplished by other institutions. The implementation of the principle of subsidiarity in the German social security system therefore requires, to a large extent, the self-management of health insurance funds, hospitals and registered doctors. The state's sole task is to provide the necessary legal framework. On the basis of this regulatory framework co-operation between those responsible for self-management in the health care system takes place independently.

2.. The Structure of the German Hospital Sector

2.1. Regional structure of the hospital sector

In the German hospital sector the responsibility for capacities and the provision of health care services lies mainly with the 16 *Länder*. They have to ensure the provision of area-wide in-patient medical care for the population. In their respective hospital laws, the *Länder* have included the administrative districts and independent cities in the task of providing hospital care. Where no other suitable hospital operator can be found the local municipalities are obliged to build and run hospitals to ensure health care services for the population in their areas. However, so far such an emergency has never occurred.

2.2 The principle of hospital operator diversity: state hospitals, non-profit and private hospitals

German hospital law postulates the principle of operator diversity. Accordingly, the existence of non-profit and private hospitals has to be guaranteed. The principle prohibits that state hospitals or municipal hospitals be given priority over private and non-profit hospitals.

Health care services are provided as follows: 37 per cent by public hospitals (municipalities), 41 per cent by non-profit hospitals (operated by churches, foundations and other non-profit organisations) and 22 per cent by private hospitals; in addition, there are 34 *Länder*-supported university hospitals. In contrast to many other states the German hospital sector is therefore not dominated by state hospitals. It is to be expected that the number of public hospitals will fall while the number of private hospitals will increase, because more and more municipal hospitals are being purchased by private hospital chains. In addition, some hospitals are owned by a municipal authority but are run by a private operator on the basis of a management contract.

In principle, the patients, both those with private health insurance and those with statutory health insurance, can choose freely among the registered hospitals. The costs are borne by the health insurance funds; travel expenses for long journeys to distant hospitals which are not medically indicated are not covered, however.

Another important factor is that all hospitals, including the public hospitals, are independent in their structure and organisation. The recruitment of doctors or administrative staff is not subject to state

regulation. The outsourcing of certain areas, such as kitchen and laundry services, is allowed, as well as the external operation of dormitories, provided overall responsibility remains with the hospital.

3. Requirements Planning in the German Hospital Sector

Due to the regional structure of hospital care the federal *Länder* each prepares a hospital plan according to which the respective regional requirement planning is conducted. On the basis of these hospital plans, hospitals are categorised under three different health care levels.

- Basic and regular care: local health care of the population, comprising health care services in the fields of surgery, internal medicine and gynaecology.
- Central health care: various specialisations in addition to basic care.
- Maximum health care: the complete spectrum of in-patient health care services (university hospitals and several large municipal hospitals).

In general, the hospital plans are drafted on an annual basis. The basic conditions such as population numbers; population structure; morbidity; new and improved methods in diagnostics and therapy; new forms of health care service organisation or health care laws, are constantly changing.

In order to operate, a hospital does not have to be listed in the respective hospital plan of a *Land*. However, to be able to provide in-patient treatment covered by statutory health insurance funds, hospitals must either be listed in a Land hospital plan or have a provision contract with the health insurance fund associations. Being included in a hospital plan is also important with regard to investment assistance grants. Only those hospitals that are included in a hospital plan receive grants from the respective federal *Land* for the purchasing or replacement of equipment and other long-term investments. The regular payment for hospital services in the form of hospital allowances does not cover such investment costs (so-called "dual financing"). In accordance with the principle of diversity in the ownership of hospitals, apart from public hospitals about 80 per cent of the private hospitals in Germany are also included in the hospital plan of a *Land*. Each year the *Länder* raise just under 3 billion Euro for investments in the hospital sector.

Due to the fact that the granting of investment assistance and the accreditation for health care services covered by the statutory health insurance funds are conditional upon a hospital being listed in a hospital plan, the drafting of the plans also has a regulatory effect with regard to market entry. The objective of the requirements planning of the *Länder* is to prevent the oversupply and misallocation of hospital services and to ensure the necessary level of supply.

Nevertheless, the requirements planning of the *Länder* was not able to prevent overcapacities in the past. A limitation of the number of health care providers as a result of requirements planning has proved difficult, in particular for political reasons. According to the German Federal Statistical Office[1] in 2004 there were 2.157 hospitals in Germany (preventive care and rehabilitation centres excluded) with approximately 528.000 planned beds. The average bed occupancy was 77.6 per cent[2] (2003), the average hospital stay 8.7 days. Compared to previous years there has been a steady cost increase in health care services while the measurable quantity of services has dropped just as steadily. This applies to the number of hospitals, planned beds, patients, the average duration of hospital stays and the average bed occupancy. The overall effect of these developments is that considerable overcapacities have emerged, in particular in the conurbations. These overcapacities ultimately lead to a competition for patients. The exact size of these

1 Status 29 April 2005, the data for 2004 are still preliminary.

2 In the opinion of the Länder the ideal bed occupancy rate would be 85%.

overcapacities is unclear. Some claim that around 80.000 beds are redundant. Indeed, with 64 beds per every 10.000 inhabitants Germany ranks first in Europe.

It are therefore health insurance funds in Germany, in particular, that criticise the requirements planning as being too statistic and inflexible. They claim that many of the hospitals listed in the hospital plans are no longer necessary to meet requirements.

4. Remuneration of Hospital Services

The previous hospital financing system focused on the costs incurred by the hospitals, not on the services they actually provided. With the Health Reform undertaken in 2000 the system was therefore changed from financing costs to financing services. The conversion to the system of Diagnosis Related Groups, DRG, which had been optional since 1.1.2003, became binding as of 1 January 2004. As of this date almost all hospital services have been covered by DRGs.

One of the objectives of such a service-oriented grouping system is to avoid wrong incentives emanating from a remuneration system based on patient days, which leads to patients staying longer, and to replace it by a performance-oriented remuneration system which provides sustainable incentives for economic efficiency. Another essential aspect in this context is the fact that the introduction of DRG in Germany has improved transparency regarding the type and volume of services provided by hospitals. This increased transparency provides information on the hospitals' areas of focus and specialisation and makes it possible to compare individual clinics (benchmarking). These improved possibilities of comparison have also strengthened the health insurance funds' strategic position in budget negotiations with the hospitals.

Although the DRG system only became binding in Germany in 2004 and quantitative data on initial experience with its implementation are still limited, the providers of hospital services are already reacting to financial incentives for a more efficient provision of hospital services. The following reactions can be observed:

- Reduced length of stay within acute in-patient units

- Improvement of the economic framework conditions for service provision: Increasing number of mergers and co-operations between hospitals, more systematic admission and discharge of patients, optimisation of internal processes (e.g. by using clinical treatment paths)

- Indications of increased orientation towards the patient's needs: avoidance of unnecessary waiting time for diagnosis and surgery through optimised process organisation, enhanced service structures in the different regions through increased co-operations, emergence of competence centres, improved quality of medical services through increasing specialisation.

Due to the DRG system it is to be expected that losses incurred by hospitals which are not used to full capacity or which are uneconomic for other reasons, will increase further. More and more public and non-profit operators of hospitals will be forced to either close down their hospitals or sell them to commercial operators.

5. Ensuring the Quality of Hospitals

In Germany, great emphasis is placed on quality assurance. Hospitals which do not adhere to agreed measures of quality assurance may therefore e.g. have to face cuts in remuneration.

The following quality assurance measures are applicable to hospitals:

- Hospitals are obliged to introduce and further develop an internal quality management system.

- Hospitals are obliged to adhere to comparative quality assurance measures. Any irregularities may be subject to selective intervention.

- The quality of diagnostic and therapeutic services and the necessity of their provision are assessed on the basis of uniform criteria; in this respect, expensive medical-technology services are of particular significance.

- Hospitals must fulfil minimum requirements regarding structural quality and quality of results.

- In cases where the quality of the treatment results depends in particular on the quantity of services provided, such medical services may only be provided if a minimum number of operations can be proved.

- Hospitals have to compile regular reports on the extent and results of their quality assurance efforts. These reports are available on the Internet and must be updated every two years.

The conflict between efficiency and quality is of particular significance since the German hospital market is characterised by large overcapacities which result in fierce competition between the hospitals. Hospitals can only be competitive in the long term if care is taken to ensure the quality of their services. In order to deal with this conflict between efficiency and quality there must be an improvement in transparency in health-care services. This cannot only be achieved by implementing the DRG system per se. In Germany, the publication of quality reports also contributes to meeting this objective. On the basis of these quality reports accredited physicians and the insured persons can be provided with comparative information on the hospitals' quality characteristics, and health insurance funds can recommend certain hospitals. Furthermore, information on the effects of the DRG system, also on the quality of care, is to be gained through accompanying research on the new remuneration system to be carried out by the parties involved in the self-management system. Adequate transparency on the provision of in-patient care ultimately also enables the German *Länder*, which are in charge of hospital planning, to check compliance with their provisions on in-patient care.

6. Competition Law Enforcement

6.1. Applicability of competition law in the hospital sector

Competition law, and in particular merger control, is applicable to the hospital sector without limitations, notwithstanding the fact that the hospital market is a highly regulated market. However, it should be noted that due to the turnover threshold of EUR 500 Mio. per year only mergers with overall economic significance are notifiable to the Bundeskartellamt. Internal consolidations of a hospital operator are not subject to merger control and mergers between public and non-profit hospital owners usually do not reach the turnover threshold indicated above.

Social law and hospital planning on the one hand and merger control on the other regulate completely different areas. Social law regulates the service relations between health insurance funds and service providers in the health care sector. The objective of hospital planning is to provide requirements-oriented acute hospital care for the population. Merger control, on the other hand, aims at maintaining competitive framework conditions in this economically highly significant and socially sensitive area where planning requirements and market-economy control mechanisms exist alongside one another. Enforcing competition as a controlling mechanism does not jeopardise the provision of health care services to the population but ensures a long-term offer of choices for patients in the interest of high-quality care. In addition, the

decisive factor is the relationship between patients and hospitals. The patients are direct consumers of hospital services. They decide independently whether to go into a hospital, and if so, which hospital to choose.

Moreover, despite high regulatory density, hospitals still have sufficient scope for competitive action. Particularly because patients can choose freely between hospitals, the latter compete against each other without restrictions in terms of quality and investment. This competition applies to the main medical services and nursing services, as well as other factors, such as the attractiveness of rooms, e.g. in terms of size, sanitary facilities and bed occupancy, or the quality and range of the food offered.

6.2. Individual cases of merger control

Due to the existing overcapacities in the hospital sector new hospitals are rarely opened. Consequently, there is strong competition for the acquisition of established hospitals. This competition mainly takes place between private hospital operators, in particular large hospital groups. Public or non-profit operators only pursue an acquisition policy at a local level, if at all, due to their lack of capital. At least no case is known where a public or non-profit operator took over a hospital which before was under private ownership.

This year the Bundeskartellamt for the first time prohibited two mergers in the hospital sector; in both cases a large private hospital group had planned to acquire public hospitals which would have led to a strengthening of its dominant position. Another case was only allowed subject to conditions. Both prohibition decisions have been appealed against. The parties to the merger doubt the applicability of the Act against Restraints of Competition. The undertakings have claimed that competition law is not applicable to their case because the competitive situation in the German hospital sector is regulated by the state in the form of numerous social provisions and the hospital planning of the *Länder*. The Bundeskartellamt, however, assumes unlimited applicability of competition law.

In the cases named above the product and geographical market definition is controversial. The product market affected is the market for acute hospitals. The market comprises of all general hospitals and specialised clinics in Germany. A more narrow market definition, e.g. involving specialised hospital departments, is considered inappropriate as two thirds of all hospital beds are accounted for anyway in the specialised areas of internal medicine, surgery and gynaecology which can be found in almost any general hospital. In addition it was established that the distinction between specialised departments is blurred in medical practice and that the hospitals' areas of activity overlap one another. Therefore general hospitals are competitors of specialised clinics in terms of product. Out-patient treatment as well as rehabilitation and other nursing centres are not covered by this product market. From the patient's perspective, the services provided by these institutions cannot be substituted by hospital services. While hospital treatment is concerned with combating diseases, rehabilitation treatment aims at preventing, removing or improving the consequences of diseases, such as ability dysfunctions or impairments.

To define the geographical market the Bundeskartellamt conducted a comprehensive survey of patient flows. The investigations showed that a vast majority of patients only choose hospitals located within a relatively short distance to their home.

Based on the number of hospital cases the Bundeskartellamt established the market position of the hospitals involved in the affected product and geographical markets. The planned mergers would have resulted in an increase of market shares of approx. 25% to approx. 65% or 75%; the market share lead over the next largest competitor would have been well above 50%. Also with regard to other competitive structural factors, such as financial resources, product range and access to the sales market, the parties to

the merger were in a much more advantageous position than other competing hospitals which was another reason to expect a strengthening of dominant positions in the hospital market.