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# Facilities' Market Concentration

## Comments on Proposed Remedies

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# Overview

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# Framework for the Consideration of Remedies

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## HMI's Provisional Findings (PFs)

- Appropriateness – "*the remedy must be measured against the harm it wishes to address, the effect on the stakeholders involved, and the purpose it wishes to achieve*"
- Practicality – "*whether its recommendations would be practical to implement*"
- "*Lessons were also drawn from the criteria used by the UK CMA when considering its remedial action*"

## UK CMA Guidelines for market investigations

1. Is there an adverse effect on competition / a detrimental effect on consumers?
2. If so, need to consider:
    a. Effectiveness
    b. Reasonableness and proportionality
    c. Overall effect of the remedy (weigh up positive and negative effects)

## This high evidentiary burden for sustaining invasive remedies (such as divestiture) was illustrated in the UK Private Healthcare Investigation

- Where divestiture remedies were limited to a single hospital group and ultimately withdrawn

# Concentration and Competitive Harm

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## The HMI's view on the link between concertation and competitive harm

- The HMI itself appears to acknowledge that it has not provided clear evidence of how (if) concentration gives rise to market power and competitive harm
  - The HMI states that it *"remains concerned that highly concentrated markets have the potential to be conducive to collusion and abuse of power"*
  - The HMI also submits that *"high concentration in local facilities' markets may impact how local stakeholders behave"* but that it has not *"been able to conduct an in-depth study"* in this regard
- The HMI also *"acknowledges that the existence of high concentration in the facilities market may not necessarily lead to the exercise of market power or to perverse outcomes"*
  - And that *"there may be valid reasons for high concentration"* (such as the efficiencies achieved through economies of scale)
- This is particularly relevant given that HMI states that remedies *"will need to be proportionate to the harm identified"*

# Concentration and Competitive Harm

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## High concentration is not a form of competitive harm in and of itself

- As the PFs correctly acknowledge, high concentration is also not a direct indicator of market power
  - There is no sound economic basis to link a particular market share or HHI level with the ability to exercise market power
- It is therefore essential to understand how (if) concentration gives rise to market power (and in turn competitive harm)
  - This requires examining the linkage between concentration and market power using industry-specific data
- If the link between concentration and market power is not well understood then how can remedies focussed on addressing concentration be expected to be effective at constraining market power? Or proportionate?
  - Imposing remedies focussed on addressing concentration without probative evidence of the link between concentration and market power would be irrational
  - Indeed, presenting such evidence would be required by the Commission in most proceedings before the Competition Tribunal

# Market Power Indicators

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## Excessive profits

- The PFs conclude that the profitability analyses show "*consistently and increasingly high profits over a longer period across the hospital groups*"
  - However, the PFs do not find the level of these profits to be excessive: "*based on the profitability analysis, profits of all three hospital groups are not excessive*"
- Excessive profits can be used as an indicator of market power since under effective competition profits would be competed away so that they are no longer excessive
  - Sustained (but not excessive) profits therefore do not constitute evidence of market power
- Moreover, the conclusion that profits have consistently been increasing is not supported by the KPMG analysis
  - LHC's profits are shown to decline from 2013 onwards
- The KPMG analysis is any event materially flawed in ways that cause it to overstate the hospitals' profitability

## National negotiations

- The HMI asserts that funders "*cannot avoid contracting any of the three big hospital groups*", affording each group a "*must-have*" status (and thus market power)
  - This "*must-have*" status can logically only arise from the private hospital groups possessing solus facilities (where there are no other private hospitals in the area and therefore no outside options, or alternatives, for funders)
- However, the available evidence indicates that solus facilities are unlikely to convey material bargaining power to hospital groups during national negotiations
  - They account for a relatively small proportion of national admissions
  - Funders can (and do) break up their DSPs to prevent private hospital groups from leveraging solus facilities into broader negotiations
  - Certain funders have completely excluded LHC from their DSP networks (e.g. Bankmed and Medihelp Necesse) despite LHC possessing 7 solus facilities (as per the PFs)
  - Funders have also partially excluded LHC from their DSP networks (e.g. Bonitas removed 14 LHC hospitals from its DSP network)

## National negotiations (2)

- The HMI does not appear to have considered that facilities are substitutes from the perspective of funders but schemes are not substitutes from the perspective of facilities
  - This gives funders inherent countervailing power
- Empirical evidence does not support a finding that facilities possess significant market power
  - The profits of facilities are not excessive (implying that tariffs are not excessive)
  - Funders have been able to negotiate materially lower tariffs through the implementation of DSP networks

# The HMI's Proposed Recommendations

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## The HMI's concentration-related recommendations

- The HMI appears to be considering two recommendations that are focused on addressing the "*problem of concentration*"
  - Divestiture of existing facilities
  - A moratorium on new hospital licences for groups with a national share of ≥20%
- However, since there is no robust evidence of the link between high levels of concentration in general and the exercising of market power (or competitive harm) there is no basis to expect that outcomes will be improved simply by making the facilities market less concentrated
- Recommendations can, by definition, only affect the future
  - The HMI itself presents analysis showing that the HHI consistently falls below the threshold for finding the market to be *"highly concentrated"*
  - The HMI also concludes that "*barriers to entry are not prohibitive*"

# Divestiture Recommendation

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## Divestiture is unlikely to solve the problem of perceived market power

- The HMI has not indicated on what basis divestitures would be identified (or by whom)
- Possibility 1: Divestiture based on a national market share threshold
  - No basis in economic theory for a given threshold
  - No empirical evidence that a national share above a certain level results in the ability to exercise market power
  - Hospital groups would actively be disincentivised to engage in competitive behaviour for fear of breaching the threshold (+ what if share increases due to exogenous factors?)
- Possibility 2: Divestiture of solus facilities
  - If solus facilities convey market power due to *"must-have"* status this will just result in such market power being transferred to the purchaser
  - Since hospitals cannot be divided the only way to erode such market power would be through encouraging entry into solus areas

# Divestiture Recommendation

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## Divestiture raises a number of practical considerations

- If divestiture is required to bring national shares below a certain threshold who will determine which facilities will be divested?
  - Scope for opportunistic divestiture of least desirable facilities
- How would a fair price be established for the assets to be divested (given that the negotiating position of the seller will be extremely weak by definition)?
- How would purchasers be selected?
  - There appears to be a significant risk that prospective purchasers would be less efficient (e.g. due to lower economies of scale)

# Divestiture Recommendation

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## Forced divestiture may have a significant adverse effect on the facilities market (1)

- Notably, divestiture would be at odds with the HMI's SID theory of harm
  - HMI finds that SID occurs when markets are less concentrated

- As noted earlier, divestiture may disincentivise firms from competing in order to grow share (e.g. by expanding capacity)
- Divestiture will impose significant costs on hospital groups
  - Hospital groups may also not fully recover the cost of past investments
  - Major input costs (e.g. nurses and electricity) are already increasing above CPI

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## Forced divestiture may have a significant adverse effect on the facilities market (2)

Increased fragmentation of the facilities market may result in market participants (both the groups and the divested hospitals themselves) being less efficient overall (e.g. via reduced economies of scale)

- Reduced efficiency has the potential to give rise to worse outcomes for consumers (directly and if the viability of other currently profitable facilities is undermined)

There is also the possibility that the rate of adoption of ARMs could fall

- Divested hospitals and hospital groups will have less ability to diversify utilisation risk (i.e. across fewer hospitals), which may logically be expected to cause them to seek to reduce risk elsewhere
  - ARMs themselves involve hospitals taking on significant utilisation risk

Potential knock-on implications for the provision of services under NHI

# Moratorium Recommendation

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## The moratorium is unlikely to address the problem of perceived market power

- There is no basis in economic theory or empirical evidence that indicates that firms with market shares above 20% (or any other arbitrary threshold) posses market power
- The major hospital groups may often be the best placed to invest in new facilities due to an ability to leverage off their existing positions
  - Hence the moratorium actually creates the risk of less entry
  - Potentially better to consider national market share when choosing between multiple licence applications for the same area
- No reason to expect that the moratorium will increase the countervailing power of funders during negotiations with private hospital groups
  - Reducing the number of solus facilities requires more entry not less
  - Potentially better to prevent entry by the same operator in solus areas
- Practically, it is also unclear what would happen if market shares increase due to exogenous factors (i.e. other hospital groups lowering capacity)

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## Proposed approach to remedies

- Recommendations should be based on addressing the relevant aspect of concentration and its linkage to the ability of firms to exercise market power
  - This is particularly so given that applying the divestiture recommendations is likely to be costly (and would therefore need to be weighed up against the anticipated benefits)
- The HMI should consider remedies with fewer downside risks that could address any perceived competitive harm by stimulating further competition in the market
  - Regulatory (and other) changes aimed at lowering barriers to entry – particularly for new entrants
    - Revising the licensing to favour new entrants in certain local markets
  - Enhancing incentives for new entry by making entry more attractive – e.g. growing the market by stabilising the risk pool (such as through the NHI or mandatory membership) and more generally encouraging public facilities to acquire excess capacity from private facilities

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