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COMPETITION IN HOSPITAL SERVICES

-- Brazil --

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1. Introduction

1. This contribution addresses competition issues related to the health sector in Brazil, in particular those that affect hospital services. First, it presents the general Brazilian regulatory framework in the health sector. Then, it analyses some aspects of market definition for hospitals services, before describing the health insurance market, which is responsible for the main competition concerns in health sector in Brazil. Finally, a few comments on market failure aspects of the sector are made before reaching a brief conclusion of the topic.

2. Regulatory framework

2. The current Brazilian Federal Constitution from 1988 is the first Brazilian Constitution to provide for a specific constitutional section to the health sector (Articles 196 *et seq.*). It states that health is a right to all individuals and an obligation for the State to provide it, guaranteeing the right to have access to a public health system to all individuals. At the same time, it also sets forth the right for private business to economically exploit the health sector.

3. For this reason, hospital services may be provided by both public and private hospitals. The health sector regulation is basically set within two regulatory frameworks: the *Sistema Único de Saúde* ("SUS") and the *Agência Nacional de Saúde Suplementar* ("ANS").

4. Within the SUS, hospital services are provided directly by public funds, and thus access to these services represents no additional or particular financial burden on patients. This can be done through both private and public hospitals. However, long waiting periods for services provided by SUS results in incentives for alternative hospital services, which include private hospitals that are not part of SUS, as well as health insurance companies.

5. ANS is the governmental agency responsible for the regulation of private supplementary health market. It was created in November 1999 by the Provisory Act nº 1.928, which became Law nº 9.961 from 28 January 2000, after Congressional approval. The legal framework for the private health sector as whole, including health insurance companies, is mainly set forth by Law nº 9.656 from 3 June 1998. Among other items, it provides for a minimum set of services and products that must be included in all health insurance contracts, in order to guarantee the individual constitutional right to access health care.

6. Finally, a reference must be made to the Brazilian National Health Surveillance Agency (ANVISA – *Agência Nacional de Vigilância Sanitária*), a governmental body responsible for the regulation and surveillance of products related to health in general, such as medical, pharmaceutical, cosmetics and hospital products. One example of ANVISA's regulatory control is the regulation of advertisements relating to products that concern human health.

7. All three of them – SUS, ANS and ANVISA – are linked to the Brazilian Ministry of Health.

3. Market definition for hospital services

8. Market definition for hospital services is a difficult topic in both demand and supply perspectives, particularly because of the complexity and diversity of types of treatments and exams.

Nevertheless, two major aspects are frequently considered by the Brazilian competition authorities for an initial analysis.[1]

9. A first general distinction is drawn between hospital services provided or not through SUS. This aims to distinguish the services provided entirely from public funds, with no additional costs to patients, from the services provided by private funds (either from patients themselves or from health insurance companies). If hospital services exist outside of the SUS structure is because there are patients willing to pay for alternative hospital services. This choice may be explained by the existence of a differentiated level of quality services, for instance faster services, better technology for exams and treatments, or higher standard of comfort for patients.

10. A second and more common approach concerns the geographic dimension of the market definition. The Brazilian experience indicates that consumers are in general willing to move for about 30 to 40 minutes to reach alternative hospitals services, which typically corresponds to a 20km distance. This explains why the geographic dimension of the relevant market is usually considered as the town of the hospital's location, or occasionally a group of small towns.

4. Health insurance companies

11. In Brazil, the main debate on competition issues relating to the health market is focused on the private supplementary health market and, more precisely, on health insurance activities within this market.

12. Given the importance of health insurance companies in the Brazilian health sector and after an overview of the general regulatory framework, this paper will now examine two important aspects of health insurance: (i) the legal provision that provides for a minimum set of services and products that must be included in all health insurance activities and (ii) the increase in mergers and acquisitions within this particular market.

4.1. Minimum set of health services and products

13. As mentioned above, Law nº 9.656 from 3 June 1998 sets forth a minimum set of services and products that must be offered by all health insurance contracts, in order to guarantee the individual constitutional right to access health care. For this reason, it is worth to examine this legal provision:

> "Article 10. The reference-plan for health assistance is created, covering medical-ambulatory and hospital assistance, including birth and treatments, provided exclusively in Brazil, with nursing services, intensive-care unit, or similar standard, when a hospital care admission is necessary, of diseases indicated by the International Statistical Classification of Diseases and Related Health Problems, set forth by the World Health Organization, observed the minimum conditions provided for by Article 12 of this Law, with the following exceptions:
>
> I – experimental clinic treatment or surgery;
>
> II – clinic or surgery procedures for esthetical purposes, as well as orthotics and prosthesis for the same purpose;
>
> III – artificial insemination;

[1] For further information, see: Merger file nº 08012.008853/2008-28 from 22 July 2009. The case is also particularly interesting because CADE blocked a hospital merger that would result in the acquisition of a 90% market share on a relevant market analyzed.

IV – rejuvenation or weight loss for esthetical purposes;

V – to provide medical products imported and not nationalized;

VI – to provide medical products for home treatments;

VII – to provide prosthesis, orthotics, and accessories not related to the surgery act;

VIII – (revoked);

IX – illegal or immoral treatments, as defined by medical standard, or not recognized by competent authorities;

X – cases of cataclysms, wars, and internal disorders, when declared by the competent authority."

14. ANS periodically publishes administrative resolutions to guide the application of the minimum reference-plan for health services and products. For instance, ANS clarified that the bariatric weight-loss surgery to reduce obesity is not considered an esthetical surgery, and that it must be included in the minimum reference-plan, accordingly to ANS' Resolution RN nº 2011, from 11 January 2010.

15. The application of the minimum set of health services and products is excluded from certain health domains, including most dental care services, and esthetical services in general, *i.e.* plastic surgery and dermatology.

4.2. Increase in mergers and acquisitions

16. Over the past recent years, there was a considerable increase in mergers and acquisitions in the health sector, including health insurance companies, hospitals, laboratories and pharmacies. Most of these mergers were horizontal mergers, but some vertical integration was also noticed.[2]

17. The scheme below shows the evolution of the horizontal mergers that took place in the health insurance market.

[2] For further information about this topic, see: Carlos Emmanuel Joppert Ragazzo; and Kenys Menezes Machado. "Desafios da análise do CADE no setor de planos de saúde". In: Para entender a saúde no Brasil. Perillo, Eduardo; e Amorim, Maria (org.). vol. 4. São Paulo: LCTE, 2011.

Number of Active Health Insurance Companies with Beneficiaries[3] in Brazil

Class of Beneficiaries	1999/12	2001/12	2004/12	2006/12	2008/12
Class 1 to 100	195	141	58	36	34
Class 101 to 1,000	297	251	175	137	109
Class 1,001 to 2,000	164	160	144	111	101
Class 2,001 to 5,000	246	264	255	223	187
Class 5,001 to 10,000	146	172	177	192	178
Class 10,001 to 20,000	84	133	202	191	181
Class 20,001 to 50,000	80	108	160	175	178
Class 50,001 to 100,000	22	41	74	72	78
Class 100,001 to 500,000	20	32	53	56	59
Class Superior to 5,000,000	3	3	7	11	15
Total	1.257	1.305	1.305	1.204	1.120

Source: SEAE (2010). Information from the ANS's database for health insurance companies.

18. The scheme testifies that there were 1,120 health insurance companies in 2008, whereas 1,257 companies existed in 1999. However, the main structural changes are related to the size and the specific market of these companies. It is possible to notice a considerable reduction of companies that provide services for a small group of beneficiaries and a major increase of those that provide services for a larger class of beneficiaries. Moreover, both the reduction in the number of small companies and the increase in the number of larger companies are present during the past ten years, characterizing a tendency of market concentration for the competition analysis.

19. Concerning the vertical mergers, it is also possible to notice a trend of concentration of hospitals and health insurance companies. CADE's case law indicates that a significant amount of hospitals in some cities were controlled by one or a few corporate groups. This was the case in the Merger file nº 08012.000229/2008-82 in which CADE acknowledged that 30% of the hospital beds of several Brazilian relevant geographical markets were owned by one single corporate group.

5. Market failures

20. The health market is usually characterized by market failures that require special attention from competition agencies and explain a strong regulation from regulatory bodies.

21. A major market failure concerns the asymmetry of information. It exists in different levels, for instance between health insurance companies and health service providers (hospitals, clinics and laboratories), as well as between health service providers and consumers.

22. In the first case, health service providers retain more information regarding patients than insurance companies. As a result, hospitals, clinics and laboratories may have incentives to make an

[3] Active health insurance companies, with exception to those exclusively intended to dental care and to those without beneficiaries, considering the criterion of the residency of the beneficiary.

inefficient use of health services, since the bill will be afforded totally or mainly by the health insurance companies.

23. In the second case, patients themselves usually do not fully understand their health problem nor the exact extent of the risks. Thus, patients may also have incentives to make an inefficient use of health services because their marginal cost for extra services is close to zero, considering that health insurance covers total or most of the health care costs.

24. In despite of the asymmetric information problem, ANS only disposes of regulatory powers in the field of health insurances. Hospitals, clinics, and laboratories are not subject to ANS' regulation. However, all these markets are submitted to CADE's jurisdiction on competition grounds and the latter has been working in cooperation with ANS to avoid that anticompetitive practices may harm consumers.

6. Conclusion

25. The regulation of the Brazilian health sector is basically organized under two main frameworks: one within the *Sistema Único de Saúde* (SUS) and the other by the *Agência Nacional de Saúde Suplementar* (ANS), both linked to the Brazilian Ministry of Health. While services are provided directly by public funds within SUS, the ANS is responsible for regulating health insurance companies.

26. The main competition debate is held within the second framework, focusing particularly on business activities carried out by health insurance companies. Health insurance companies maintain business relations, on the one hand, with medical professionals and private hospitals, and, on the other hand, with final consumers or patients. In this context, different types of competition tensions may arise from these relationships, in particular those related to the abuse of market power. Nevertheless, CADE has jurisdiction over anticompetitive practices and mergers in all markets related to the health sector in Brazil.

27. Finally, a topic that requires special attention by both competition agencies and regulatory bodies relates to market failures, in particular asymmetric information. Thus, efforts are continuously made to guarantee a minimum standard of quality in health services to final consumers.