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Merger Control in the Healthcare Sector in Portugal

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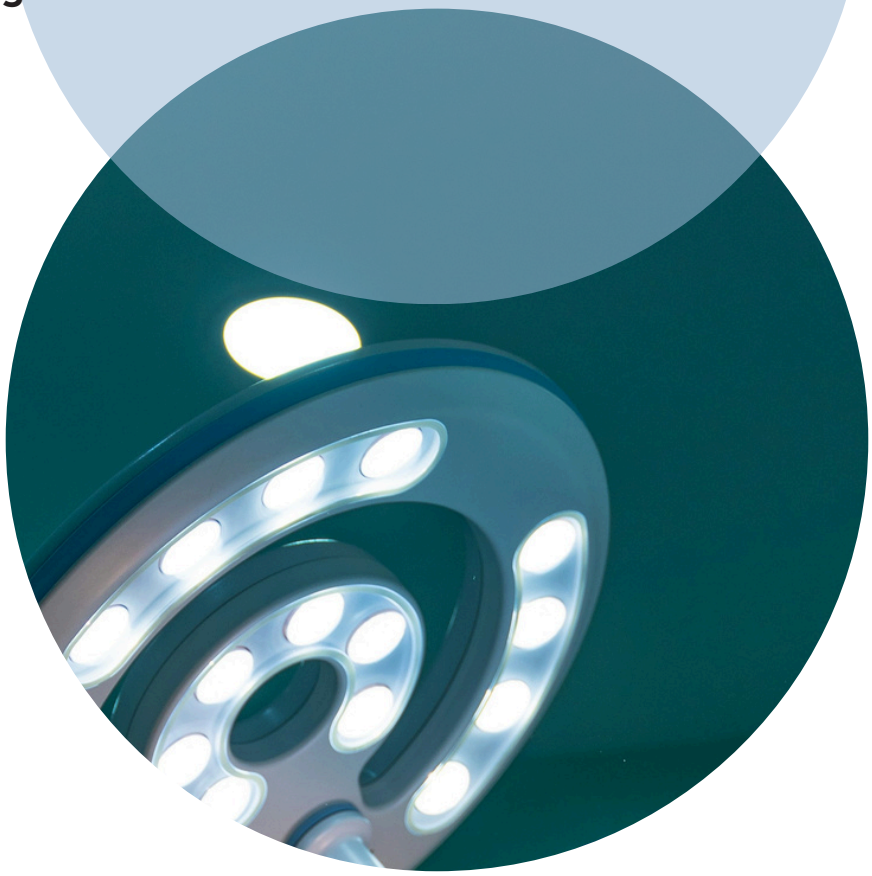

1. Introduction: coordination between the competition authority and the healthcare regulator in merger control

Among the functions of the Portuguese Health Regulatory Authority (henceforth, "ERS") are the promotion and protection of competition in market segments open to competition, in cooperation with the Portuguese Competition Authority ("AdC"),[1] as well as, at the AdC's request, the issuance of competition assessment opinions on concentrations affecting markets subject to its sectoral regulation.[2] Between January 2015 and December 2025, the ERS issued 34 opinions pursuant to Article 55 of the Competition Act, 18 of which concerned operators in the private hospital sector.

However, in 2026, in Case Ccent. 23/2025 – CUF/HPA[3], the AdC adopted what, to the extent ascertainable from its published decisional practice, appears to be the first non-opposition decision subject to conditions and obligations in the market for the provision of hospital healthcare services by private units.[4] The fact that the transaction involved the acquisition of the fifth-largest operator by the market leader is likely to have contributed to the outcome, whereas healthcare acquisitions previously notified to the AdC had concerned smaller, local operators, as part of a strategy of gradual market-share consolidation and expansion of geographic coverage.

2. Product market definition for healthcare services provided by private hospitals

As in the competitive assessment of other economic sectors, relevant market definition in healthcare is primarily based on identifying the constraints on operators arising from substitutability on both the demand and supply sides.

With regard to demand-side substitutability, the AdC's consistent decisional practice has distinguished product markets according to the nature of the provider – i.e., public[5] or private/social-sector – and has considered that public hospitals (part of the SNS, including hospitals operated under Public-Private Partnership arrangements) do not exert direct competitive pressure on non-public operators. This is mainly due to the low degree of substitutability, from the patient's perspective, between public and non-public offerings – with provider characteristics such as waiting times, convenience and comfort of facilities, and institutional image and reputation being valued differently – as well as differences in access procedures, since only in the private sector can patients choose their provider.[6]

1 Article 16 of Decree-Law No 126/2014 of 22 August, which restructured the Health Regulatory Authority (ERS) and defines its functions, organisation and operation.
2 Article 55(1) of Law No 19/2012 of 8 May (the "Competition Act"), which provides that "[w]here a concentration between undertakings affects a market subject to sector-specific regulation, the AdC, before adopting a decision bringing the proceedings to an end, shall request the relevant regulatory authority to issue an opinion on the notified transaction […]".
3 Available at https://www.concorrencia.pt/.
4 The legal basis for the adoption of commitments in Portugal is Article 51 of the Competition Act, further elaborated in soft law by the "Guidelines on the Adoption of Commitments in Merger Control", available at https://www.concorrencia.pt/, as well as by the Commission Notice on remedies acceptable under Council Regulation (EC) No 139/2004 and under Commission Regulation (EC) No 802/2004, 2008/C 267/01 ("Remedies Notice").
5 Since 1979, the Portuguese healthcare system has been based on a National Health Service (Serviço Nacional de Saúde – SNS) providing universal coverage and access that is generally free of charge, financed through taxation.
See the Lei de Bases da Saúde (Framework Health Act), approved by Law No 95/2019 of 4 September, whose Base 20 provides for a principle of access being generally free of charge.
6 Whereas access to public hospitals follows referral from the public primary healthcare network, significantly restricting patient choice, non-public hospitals may be accessed through multiple channels, including health insurance, health subsystems, SNS agreements or direct out-of-pocket payments by patients.

Still on the demand side, patients may access private hospitals through two channels: (i) the direct channel, under which private patients bear the costs directly ("out-of-pocket payments"); and (ii) the intermediated channel[7], which includes insurance undertakings and supplementary health schemes that contribute to the cost of beneficiaries' access to contracted services. The economic literature identifies a concave relationship[8] between the value of a network and its size: the broader the network, the greater its value; however, the marginal value of adding an additional hospital unit or bed decreases as the network expands.

Given the multi-product nature of hospital establishments, the AdC and the ERS have adopted a 'cluster-market' approach, rather than segmentation by type of activity, defining a market for the provision of hospital healthcare services by private units. This approach rests on the following premises:

a. the joint provision of complementary healthcare services is justified by supply-side cost advantages (economies of scope) and patient preferences, as patients generally prefer to use a single provider for a range of services; and
b. the units of a given operator act in a coordinated manner as part of a network, allowing referrals and patient mobility between units belonging to the same healthcare network.

The market is also characterised by barriers to entry that tend to favour incumbent operators, including, inter alia, substantial upfront investment, particularly in infrastructure, technology and medical equipment; lengthy licensing procedures; and shortages of qualified human resources in certain areas, which make it difficult to assemble complete clinical teams.

2.1. Geographic market definition

Geographic market definition is, in turn, based on an analysis of demand characteristics, with a view to determining whether different operators constitute alternative points of supply for consumers within a given geographic area, identified by reference to catchment areas. The ERS has traditionally delineated catchment areas using a maximum travel time of 90 minutes. The AdC's decisional practice, by contrast, has frequently used NUTS III regions as proxies for catchment areas, although in certain decisions[9] it has considered isochrones of 30 minutes for services generally and 90 minutes for surgery.

However, when the market for hospital healthcare services is considered in conjunction with the health insurance market, negotiations involving intermediaries take place on a supraregional or even national basis, whereas patient demand is local.

7 Such intermediation takes place through a chain of transactions: (i) execution of a healthcare services agreement between the insurer and a set of healthcare units – directly or through a network; (ii) execution of a health insurance contract between the insurer and the patient; (iii) selection of a healthcare unit by the patient; and (iv) payment by the insurer to the healthcare unit of the contractually agreed reimbursement.
8 In practice, this "concavity" may mean that, for example, in an area with four equally sized providers and an insurance network, although the network's value (and therefore the amount the policyholder is willing to pay for a given plan) increases as the offering expands, the incremental value of each additional provider is less than proportional, such that the customer would be willing to pay almost the same for a plan including three hospitals as for one including all four.
9 Ccent/2017/21 – Luz Saúde/British Hospital, available at https://www.concorrencia.pt/.

3. Competitive assessment: competitive pressure and degree of concentration

Two parallel trends can be observed in Portugal's hospital sector: (i) on the demand side, the relative and absolute importance of the private hospital sector has increased significantly, driven by the rise in the number of beneficiaries of health insurance and supplementary health schemes[10], as also reflected in increased household expenditure in the sector[11]; and (ii) as regards market structure, concentration levels have been increasing – for example, the national median Herfindahl-Hirschman Index (HHI) rose from a moderate level (1,965) to a high level (2,502) by 2025[12]. Moreover, no municipality in the country records an HHI below 1,000, while ten municipalities have an HHI of 10,000[13], corresponding to a monopoly. The increase in concentration has been driven not only by organic growth and the opening of new hospital units, but also by sustained consolidation among the main hospital groups – which, according to the AdC, completed an average of three acquisitions per year over the past decade (mainly involving medium-sized regional units).

One of the main risks associated with increasing concentration in the sector is the strengthening of large hospital operators' bargaining power vis-à-vis insurers, resulting in higher costs for insurers that may be passed through to consumers in the form of higher insurance premiums. As the healthcare regulator notes, in highly concentrated regions, nonpublic providers may enjoy a stronger bargaining position and obtain more favourable terms when contracting with public purchasers (in particular, the SNS). However, the regime governing healthcare agreements ("convenções") – a specific model under which the State contracts with private operators through standard-form contracts whose terms are predetermined by the Ministry of Health[14] – allows different procurement methods to be used on the basis of criteria such as the level of competition and the geographic area in which services are provided.

In the CUF/HPA case, the AdC identified the risk of a significant strengthening of the Parties' bargaining power vis-à-vis payers as a potential theory of harm[15]. This theory can be understood through a bilateral bargaining model ("Nash bargaining"), based on the parties' reservation prices, corresponding to the value or cost of their respective outside options.

10 Between 2020 and 2024, the total number of beneficiaries of supplementary health schemes increased by around 11%. The largest of these schemes is ADSE, the scheme for civil servants and State pensioners, which covers around 12% of Portugal's population and constitutes an important demand channel for private providers.
11 ERS (2025), Estudo sobre a Concorrência no Setor Hospitalar Não Público, available at https://www.ers.pt/pt/flipbooks/estudo_concorrencia-nao-publico-2025/, pp. 13-14 and 36. Consistent with these data, the Portuguese Insurance and Pension Funds Supervisory Authority (ASF) stated in a 2024 study that "health insurance more than doubled over a decade". At the same time, market concentration decreased, with the combined market share of the three largest insurance undertakings standing at 69.7% in 2023, compared with 73.6% in 2019. Study available at https://www.asf.com.pt/.
12 ERS (2025), p. 39.
13 ERS (2025), pp. 33-34.
14 Cf. Article 4 of Decree-Law No 139/2013 of 9 October.
15 On the effects of concentration on network value and outside options, cf. Hemphill, C. Scott and Rose, Nancy L., "Mergers that Harm Sellers" (9 March 2018), 127 Yale Law Journal 2078 (2018), available at https://ssrn.com/abstract=3113679. On the modelling of bilateral bargaining in the hospital sector, cf., inter alia, Gowrisankaran, Gautam et al., "Mergers When Prices Are Negotiated: Evidence from the Hospital Mergers" (2015), 105 American Economic Review 172.

For an insurer, the reservation price is, in simplified terms, the maximum amount it would be willing to pay to avoid the loss in value associated with excluding a given provider from its network. A concentration that worsens the insurer's outside option therefore strengthens the merged entity's bargaining leverage, allowing it to negotiate more favourable commercial terms. In addition to the distributive effect (the healthcare provider's capture of consumer surplus), there may also be a loss of allocative efficiency (equivalent to deadweight loss) due to the exclusion of smaller providers from insurance networks, as well as a reduction in effective competition and an increase in incumbents' market power.[16]

This effect will be stronger where different insurance products are substitutable and providers' offerings are more differentiated, potentially leading an insurer's customers, in a noagreement scenario, to switch insurer in order to retain access to the same provider's services.

4. Conclusions in Case Ccent. 23/2025 and rationale for the commitments adopted

The AdC applied a counterfactual analysis and concluded that, absent the transaction, organic entry by CUF into the Algarve region was more likely than not. Accordingly, in addition to strengthening bargaining power, the transaction would eliminate a source of potential competition.

To address the competition concerns identified, the Notifying Party submitted a set of Commitments. The package ultimately adopted included two structural commitments (divestments, one aimed at enabling the entry of a new hospital in the Algarve, the region most affected by the possible loss of potential competition) and four behavioural commitments.

The latter included a commitment to maintain the commercial terms agreed with insurers and supplementary health schemes that were in force at the closing of the transaction, subject only to limited, indexed annual adjustments for a fixed period, as well as a prohibition on increasing list prices for uninsured patients beyond the relevant indexation limits. Another behavioural commitment consisted of "full unbundling" (i.e., no bundle, portfolio or volume discounts linked to the joint contracting of units available within the Parties' network), so that the price for contracting with a given unit does not vary depending on the number of units contracted.

The behavioural remedies therefore perform an essentially complementary and transitional function: they are intended to preserve the contractual status quo and mitigate the strengthening of bargaining power while the structural divestments are implemented. The AdC accordingly emphasises that the various commitments must be assessed as an integrated package rather than in isolation.

16 See, to that effect, Hemphill, C. Scott and Rose, Nancy L. (2018), pp. 2095–2098.

Thinking about tomorrow? Let's talk today.

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