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# COMPETITION IN THE HEALTHCARE SECTOR IN SINGAPORE - AN EXPLORATIVE CASE STUDY

*Andrea Gideon*<sup>\*</sup>

## Abstract

Market mechanisms have increasingly been introduced into the public service regimes of many countries over recent decades. This was meant to foster competition and choice which in turn was thought to increase quality while decreasing prices. Such progressive liberalisation led to public services increasingly falling within the ambit of competition laws which in turn partly required further liberalisation in some competition law regimes. However, there are certain tensions between providing such services in a competitive market and, at the same time, allowing them to retain their public interest character including such elements as universal provision, trust based relationships or equality of access. The ASEAN countries, in which competition law is still a relatively new area of law, might face such tensions with increasing application of competition law to these areas. Yet, the application of competition law to public services in ASEAN countries has thus far received virtually no attention.

The explorative case study 'Competition in the healthcare sector in Singapore' aims to make a first step in filling this gap in the research by exploring the healthcare sector in Singapore from a competition law perspective. It will leave to one side questions on medical research, pharma firms' interaction with the market and primary care. Instead it focuses its analysis on hospital care; more specifically on in-patient care (i.e. mainly secondary care). The research will explore in how far the notion of undertaking is applicable to hospital in-patient services in Singapore. Since the notion of undertaking in Singaporean competition law has received hardly any attention so far this is of relevance beyond the case study. It will then proceed to analyse in how far there might be potential issues with competition law application (s 34, 47 and 54 of the Competition Act) and if there would be recommendations beyond the legal analysis.

Key words: Competition law in Singapore, Competition Act 2004, undertakings, single economic unit, healthcare, hospitals

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# Introduction

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Market mechanisms have increasingly been introduced into the public service<sup>2</sup> regimes of many countries over recent decades. Such moves were meant to foster competition and choice which in turn was thought to increase quality while decreasing prices. Such progressive liberalisation led to public services, which initially were not the main focus of competition law regimes, to increasingly fall within the ambit of competition laws. The application of competition law to these services then in turn required further liberalisation in some competition law regimes.<sup>3</sup> However, there are certain tensions between providing such services in a competitive market and, at the same time, allowing them to retain their public interest character including such elements as universal provision, trust based relationships or equality of access.<sup>4</sup> The ASEAN countries, in which competition law is still a relatively new area of law, might face such tensions with increasing application of competition law to these areas. Yet, the application of competition law to public services in ASEAN countries has thus far received virtually no attention.

The explorative case study 'Competition in the healthcare sector in Singapore' aims to make a first step in filling this gap in the research by exploring the healthcare sector in Singapore from a competition law perspective. This is relevant in two ways for ASEAN's objectives as set out in the AEC Blueprint 2025.<sup>5</sup> Firstly, it will shed some light on the interplay between competition law and public services and can thus inform future efforts in ASEAN competition law integration.<sup>6</sup> Secondly, it can contribute by informing efforts regarding the promotion of a strong healthcare industry in ASEAN<sup>7</sup> which as sub-aims contains the promotion of market liberalisation as well as of medical tourism. For both of these sub-aims the potential application of competition law to the healthcare sector is highly relevant.

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<sup>2</sup> Public services is understood here as comprising services such as the utilities as well as more social services such as employment and health services which is in line with the use of the term in other pieces of literature on competition law and public services (see, for example, Sauter W, Public Services in EU Law (CUP 2015) p 9).

<sup>3</sup> For more on the inclusion of public services into EU competition and internal market law see, for example, T Prosser, 'EU competition law and public services' in E Mossialos et al (eds), *Health Systems Governance in Europe* (Cambridge University Press, Cambridge 2010), Neergaard U, 'Services of general economic interest under EU law constraints' in Schiek D, Liebert U and Schneider H (eds), *European Economic and Social Constitutionalism after the Treaty of Lisbon* (CUP, Cambridge 2011) p. 174 seq, Sauter (n 2) p .

<sup>4</sup> See, for example, with a view to healthcare C Newdick, 'Charities in the Health Care Market: Can Trust survive NHS competition?' (2007) 18 The King's College Law Journal 415, Ramesh M, 'Autonomy and Control in Public Hospital Reforms in Singapore' (2008) 38 The American Review of Public Administration 62 p 63 seq.

<sup>5</sup> The AEC Blueprint 2025 builds on the AEC Blueprint 2015 and sets out the main objectives for the next decade to further develop ASEAN after the AEC Blueprint 2015 objectives have mainly been achieved (a few points will continue to be worked on until the end of 2016 and there is some 'homework' for some countries till 2018). See ASEAN ECONOMIC COMMUNITY BLUEPRINT 2025 p. 1.

<sup>6</sup> Objective B1: 27 v AEC Blueprint 2025.

<sup>7</sup> Objective C7 AEC Blueprint 2025.

The competition law analysis will leave to one side questions on medical research, pharma firms' interaction with the market and primary care. Instead it focuses its analysis on hospital care; more specifically on in-patient care (i.e. mainly secondary care). The research will explore the questions 1) in how far the notion of undertaking is applicable to hospital in-patient services, 2) in how far there might be potential infringements of competition law (s 34, 47 and 54 of the Competition Act) and 3) if there would be recommendations beyond the legal analysis.

The study is structured as follows. It will begin by giving a general overview over Singapore's healthcare sector (section 2) and competition law (section 3). This will be followed by exploring the notion of 'undertaking', which has so far only received limited attention, and its application to hospitals (section 4). Section 5 will explore the exemptions in s 33 CA and in the Third and Fourth Schedule and analyse in how far these would take hospitals out of the ambit of competition law. Section 6 contains some remarks on market definition. Section 7 to 9 discuss the substantive prohibitions in s 34, 47 and 54 CA respectively. The penultimate section (section 10) then raises some issue for a broader discussion before concluding (section 11).

## 2. The healthcare sector in Singapore

On Independence Singapore inherited a, by then very recently introduced,<sup>8</sup> largely taxation based healthcare system similar to the British National Health Service (NHS) model<sup>9</sup> aiming at universal healthcare coverage (through affordable prices and free healthcare for those who could not pay at all). The People's Action Party government initially continued the inherited system, in which the private sector hardly played a role<sup>10</sup> and which provided some services entirely for free, but soon introduced user fees.<sup>11</sup>

In 1983 a comprehensive health plan was introduced which foresaw, inter alia, the establishment of Medisave, the world's first compulsory medical savings account for employed persons, as part of the Central Provident Fund (CPF) which initially had been established by the British colonial government as a retirement savings account.<sup>12</sup> Furthermore, the plan led to significant reforms of the

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<sup>8</sup> After decades of very limited efforts in the healthcare sector the colonial government in 1948 introduced the first ever ten year health plan. See further Luk SCY, *Health insurance reforms in Asia* (Routledge 2014) p. 77, 79 seq, Lim M-K, 'Health Care Reforms in Singapore' in Okma KGH and Crivelli L (eds), *Six countries, six reform models : the healthcare reform experience of Israel, the Netherlands, New Zealand, Singapore, Switzerland and Taiwan : healthcare reforms "under the radar screen"* (World Scientific 2010) p. 111, 128.

<sup>9</sup> Further on the British healthcare system see Wendt I and Gideon A, 'Services of general interest provision through the third sector under EU competition law constraints: The example of organising healthcare in England, Wales and the Netherlands' in Schiek D, Liebert U and Schneider H (eds), *European Economic and Social Constitutionalism after the Treaty of Lisbon* (CUP 2011).

<sup>10</sup> Luk (n 8) p. 84 seq, Finkenstädt V, 'Das Gesundheitssystem in Singapur' (2013) 3 WIP-Diskussionspapier 1 p. 5, 8, Lim (n 8) p. 111.

<sup>11</sup> Haseltine WA, *Affordable Excellence* (Brookings Institution Press 2013) p. 7, Luk (n 8) p. 88, 91, Lim (n 8) p. 128, Ramesh (n 4) p 67.

<sup>12</sup> Haseltine (n 11) p. 4 seq, 9 seq, Luk (n 8) p. 77, 88 seq, 95 seq, Meister U, *Das Sparkonto als Krankenversicherung* (avenir suisse, 2014) <<http://www.avenir-suisse.ch/37942/medical-savings-account-das->

government hospital structure in the 1980s. The government had originally planned to privatise the hospitals, but 'in a rare instance of retreat in the face of negative public opinion'<sup>13</sup> it decided to go for corporatisation instead. The hospitals continued to be entirely owned by the government through a private limited holding company (now called Ministry of Health Holdings Pte Ltd or MOHH) which is equally entirely owned by the government. However, their organisational form was restructured making them companies with autonomy in certain financial and operational aspects. This was supposed to give more choice to patients, increase efficiency and to stabilise the price system, as the unsubsidized wards were meant to serve as a benchmark in terms of quality and price for the private sector.<sup>14</sup> While the corporatisation indeed increased efficiency and patient satisfaction, it also led to staff poaching, drastic salary increases, a focus on fully paying patients, non-cooperation with other public hospitals where this would have been useful to exploit economies of scale, high-end purchases to have a market advantage and, due to all these development, ultimately to higher prices. Further, as doctors were paid by volume fears arose as to over-supplying patients paired with (already existing) fears that too much choice would nurture the appetite of the people to try unnecessary new treatments.<sup>15</sup>

A review of the system in the early 1990s led to the White Paper 'Affordable Health Care'<sup>16</sup> which became the basis for future reforms and which had the objectives of promoting good healthcare as well as individual responsibility, ensuring access to healthcare for all and encouraging competition in the healthcare market while allowing government intervention when needed.<sup>17</sup> In the 1993 White Paper the government defined its approach as 'neither a totally regulated national health service nor a pure free market system' but instead as a hybrid.<sup>18</sup> The government thus intends to continue tight regulation including the number of doctors, public hospitals, hospital beds (and distribution in between wards), revenue limits, costly equipment and insurance programmes.<sup>19</sup> While non-essential and cosmetic services as well as the latest technologies will not always be available to all 'regardless

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sparkonto-als-krankenversicherung/> accessed 8 October 2015, Finkenstädt (n 10) p. 5, 8, 12, 16 seq, Lim (n 8) p. 112 seq, Ramesh (n 4) p 67 seq.

<sup>13</sup> Lim (n 8) p. 125.

<sup>14</sup> Haseltine (n 11) p. 10, Lim (n 8) p. 124 seq, Ramesh (n 4) p 62, 67 seq.

<sup>15</sup> Ministry of Health, *Affordable Health Care - A white paper* (Ministry of Health 1993) p. 3, Haseltine (n 11) p. 13 seq, Luk (n 8) p. 88, 97, Lim (n 8) p. 124 seq, Ramesh (n 4) p 62, 66 seq.

<sup>16</sup> Ministry of Health (n 15).

<sup>17</sup> Ministry of Health (n 15) p. 2, Haseltine (n 11) p. 11 seq, Lim (n 8) p. 112, 117, Ramesh (n 4) p 68 seq, 72 seq.

<sup>18</sup> Ministry of Health (n 15) p. 10.

<sup>19</sup> Ministry of Health (n 15) p. 3 seq, 8, 10, 19, 39, Haseltine (n 11) p. 13 seq, Phua KH and Pocok N, 'Transforming the ASEAN Economic Community (AEC) into A Global Services Hub: Enhancing the Competitiveness of the Health Services Sectors in Singapore' in Tullao TS and Lim HH (eds), *Developing ASEAN Economic Community (AEC) into A Global Services Hub* (ERIA Research Project Report, ERIA 2012) p. 118, Lim (n 8) p. 129, Ramesh (n 4) p 62, 67 seq, 73.

of [the patient's] quality of life and prospects of recovery',<sup>20</sup> the standard methods are accessible to everybody. This basic package is supposed to be regularly up-dated in accordance with medical developments.<sup>21</sup> Medisave was extended to the self-employed and supplemented by a public insurance program (MediShield) and an endowment fund (Medifund) as a safety net.<sup>22</sup> However, it has been argued that, due to the fact that helping mechanisms step in only after all other means including the patient's and the family member's savings have been exhausted, healthcare costs can nevertheless leave families being deprived of their resources.<sup>23</sup>

Despite the reform, costs kept rising, partly attributed to the hospital restructuring, and additional reforms were deemed necessary. In an attempt to (re-)limit competition, the government established two clusters (National Healthcare Group and Singapore Health Service or SingHealth) which were supposed to compete with each other while competition between the entities within the clusters was supposed to be limited. The clusters, whose boards are appointed by the Ministry of Health (MoH) to whom they also report directly, are owned by MOHH and comprise hospitals, polyclinics, specialty centres, research service units and community hospitals.<sup>24</sup> By now there are all together six clusters (Alexandra Health System, Jurong Health Services, National University Health System and Eastern Health Alliance in addition to the two initial clusters).<sup>25</sup> The establishment of the clusters was followed by the introduction of diagnosis related group pricing and budgeting rules and compulsory medical record sharing between the clusters.

Since 2003 private and public hospitals are required to publish certain price information. Quality related measures were equally put in place; hospitals now have their own quality assurance measures, a Quality Steering Committee and are publishing quality related information on their websites. Central oversight over clinical performance is exercised by MoH.<sup>26</sup> SingaporeMedicine was also launched in this decade as an official policy to attract medical tourists and promote Singapore as a global medical hub.<sup>27</sup> However Phua and Pocok mention some disconnect between the trade policy aim of promoting Singapore as a medical services hub and MoH's policy focus on providing

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<sup>20</sup> Ministry of Health (n 15) p. 4.

<sup>21</sup> Ministry of Health (n 15) p. 2 seq, 18, 22 seq, Haseltine (n 11) p. 1, 4 seq, 12 seq, Lim (n 8) p. 112, 129. It was not actually possible to find a description of the basic package anywhere and in the 1993 White Paper MoH indeed says that 'it is not practical to enumerate all the items' and refers to some of the judgements needing to be taken by doctors (Ministry of Health (n 15) p. 23).

<sup>22</sup> Haseltine (n 11) p. 4 seq, 10, Luk (n 8) p. 88 seq, Finkenstädt (n 10) p. 12, 18, 22, 27, Lim (n 8) p. 112.

<sup>23</sup> Finkenstädt (n 10) p. 28. Similar Ramesh (n 4) p 74 seq.

<sup>24</sup> Lim (n 8) p. 126 seq, 129, Ramesh (n 4) p 67 seq, 70.

<sup>25</sup> MoH Holdings and BrightSparks, 'About the public healthcare family' (2015) <<http://student.brightsparks.com.sg/profile/mohh/abouthealthcare.php>> accessed 20 November 2015, Ministry of Health, 'About Us' (2014) <[https://www.moh.gov.sg/content/moh\\_web/home/about-us.html](https://www.moh.gov.sg/content/moh_web/home/about-us.html)> accessed 16 November 2015.

<sup>26</sup> Lim (n 8) p. 126 seq, 129 seq, Ramesh (n 4) p 71.

<sup>27</sup> Phua and Pocok (n 19) p. 111, 115 seq, Lim (n 8) p. 112, 123.

affordable healthcare for all and keeping costs low which has led to the medical tourism aspect being less pronounced in recent years.<sup>28</sup> MediShield was also being reformed as it had run a deficit due to private insurance companies cherry picking the young and healthy and MediShield being left with the elderly and unhealthy who claimed more than their premiums brought in. This was not only unsustainable, but equally unsatisfactory for the patients since the claim limits were low. During the reforms the integrated plans were developed which required Medisave approved private plans to contain MediShield as a basic component which is then topped-up.<sup>29</sup> Since 2013 all new-borns are automatically covered under MediShield<sup>30</sup> and since November 2015 MediShield has been replaced by MediShield Life which aims to reduce the individual contributions and provide broader cover.<sup>31</sup>

Over time Singaporean healthcare thus transformed from a system based on general taxation to a 'multi-layered health care financing system based on savings, insurance and taxation'.<sup>32</sup> The quality of medical professionals is high<sup>33</sup> and the patient to medical staff ratio is comparatively low.<sup>34</sup> Yet, Lim sees the approach mainly as avoiding models of other countries that are deemed to have failed by trial and error rather than 'a clear vision of what the perfect model looks like'.<sup>35</sup> This would indicate that constant adjustments will continue to have to be made to address some current concerns (sections 2.4.). The sector is therefore expected to carry on changing, growing and probably gaining in importance.<sup>36</sup>

## 2.1. Market structure

MoH is the body mainly responsible for the healthcare system. It has regulatory as well controlling and educational functions. All providers need a license from MoH under the Private Hospitals & Medical Clinics (PHMC) Act/Regulations and are required to maintain high standards. The relevant professional bodies (e.g. Singapore Medical Council, Singapore Dental Council) regulate the professions and are under the auspices of the MoH. The Agency for Integrated Care is responsible for the path of patients between care levels.<sup>37</sup> In primary care, the private sector takes the lion share

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<sup>28</sup> Phua and Pocok (n 19) p. 116, 122.

<sup>29</sup> Luk (n 8) p. 103, Ministry of Health, 'Medisave-approved Integrated Shield Plans' (2015) <[https://www.moh.gov.sg/content/moh\\_web/home/about-us.html](https://www.moh.gov.sg/content/moh_web/home/about-us.html)> accessed 23 October 2015.

<sup>30</sup> Luk (n 8) p. 103.

<sup>31</sup> Ministry of Health, 'MediShield Life ' (2015) <[https://www.moh.gov.sg/content/moh\\_web/home/costs\\_and\\_financing/schemes\\_subsidies/Medishield.html](https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/Medishield.html)> accessed 17 November 2015.

<sup>32</sup> Luk (n 8) p. 105. Similar Lim (n 8) p. 118.

<sup>33</sup> Emerging Markets Direct, *Healthcare* (EMD Reports - Singapore, 2015) p. 6, Phua and Pocok (n 19) p. 123.

<sup>34</sup> Emerging Markets Direct (n 33) p. 15.

<sup>35</sup> Lim (n 8) p. 129.

<sup>36</sup> Lim (n 8) p. 135, Ramesh (n 4) p 67.

<sup>37</sup> Emerging Markets Direct (n 33) p. 1 seq, 6, Haseltine (n 11) p. 10, 93, 101 seq, Ministry of Health, 'Healthcare Services and Facilities' (2015)



with 80% primary healthcare services being provided by the private sector. The picture is reversed when it comes to secondary care.<sup>38</sup> In the overall picture of healthcare provision the public sector has been outweighing the private sector.<sup>39</sup>

The public healthcare system is divided into six regional clusters which are overseen by a Regional Hospital and contain a variety of healthcare providers on different levels (primary, secondary, etc.). The public providers and facilities are owned by MOHH, the government holding company. The government appoints the members of MOHH's board and it is chaired by the Permanent Secretary of MoH. MOHH also serves as an intermediate organisation executing MoH's policy, giving directions on the overall human resources strategy and joint procurement and implementing an information technology strategy.<sup>40</sup> The hospitals are free in the day to day running of their affairs including pricing and, to an extent, recruitment, while MoH/MOHH retain the possibility to give directions if they see fit and the hospitals are accountable to MoH, especially as regards the use of government subsidies. This unique mix of autonomy and control has been described as 'defiance of the traditional notions of division between public and private'.<sup>41</sup>

Providers of medical services are free to set their individual prices and may have different pricing methods.<sup>42</sup> In the past (1987-2007) the Singapore Medical Association had issued Guidelines on Fees providing a price range they deemed reasonable for each procedure. However, the practise was stopped after the implementation of competition law in Singapore.<sup>43</sup> The only limits to pricing are thus ethical considerations, since the High Court, agreeing with a challenged decision of the Singapore Medical Council, a statutory board, has found that vastly exorbitant prices are unethical.<sup>44</sup> Indeed, the Singapore Medical Council set out in its Ethical Code and Ethical Guidelines 2016 that fees must be ethical, reasonable and that no additional charge for services rendered by another should be made by doctors.<sup>45</sup> Yet, in order to create transparency in pricing, MoH has been

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<[https://www.moh.gov.sg/content/moh\\_web/home/our\\_healthcare\\_system/Healthcare\\_Services.html](https://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services.html)> accessed 13 October 2015.

<sup>38</sup> Emerging Markets Direct (n 33) p. 4, Ministry of Health, 'Costs and Financing' (2015) <[https://www.moh.gov.sg/content/moh\\_web/home/costs\\_and\\_financing.html](https://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html)> accessed 1 September 2015, Finkenstädt (n 10) p. 10, Phua and Pocok (n 19) p. 117, Lim (n 8) p. 112, 120 seq.

<sup>39</sup> Khoo L, 'Singapore Healthcare Market-Share Analysis' (2003) 02 MOH Information Paper.

<sup>40</sup> Emerging Markets Direct (n 33) p. 1 seq, 6, Haseltine (n 11) p. 10, 93, 101 seq, Ministry of Health (n 37), MOH Holdings, 'What we do' (2016) <<http://www.mohh.com.sg/what-we-do.html>> accessed 5 October 2016. There is no legislation or official government document setting out the details of the relationship and decision making structure between MoH, MOHH and the hospitals.

<sup>41</sup> Ramesh (n 4) p 64, 70 (quote on p 60).

<sup>42</sup> Finkenstädt (n 10) p. 10.

<sup>43</sup> Decision CCS 400/001/09 *Guideline on Fees*.

<sup>44</sup> *Lim Mey Lee Susan v Singapore Medical Council* [2013] SGHC 122.

<sup>45</sup> Singapore Medical Council 'Ethical Code and Ethical Guidelines 2016 Edition' p. 60. The new edition of the code will enter into force on 1<sup>st</sup> January 2017 (ibid p. 2).

publishing bills sizes since 2003 based on actual bills for various conditions and procedures. This has helped in decreasing prices and MoH has begun to equally make information about outcomes and facilities accessible.<sup>46</sup> Since 2014 MoH has begun to publish information on total operation fees in addition to the information on bill sizes. Again, this is based on historical bill information. Since 2016 this includes private providers which have to break down the information into surgeon's fee, anaesthetist's fee and facilities.<sup>47</sup> Clinics are obliged to make current prices available.<sup>48</sup> Yet, despite these moves the information on prices on MoH's website shows that for many procedures (e.g. child delivery, appendix surgery, lung cancer treatment) the private sector still often charges twice as much or more than one would pay in public A wards.<sup>49</sup>

The utilisation of the healthcare providers is described very differently. Some state that most providers can run at full capacity at all times<sup>50</sup> or even that there is a shortage requiring further providers to enter the market.<sup>51</sup> Others claim that only the public hospitals are oversubscribed while the private hospitals are often only half full.<sup>52</sup> It has also been stated that public hospitals occasionally need to rent beds from private providers.<sup>53</sup> MoH itself states an average occupancy rate of 85% for the public hospitals.<sup>54</sup> The demand for healthcare derives from the Singaporean population as well as from medical tourism. The private sector is far more involved in medical tourism than the public sector for which it only plays a very small role. As regards the former, however, Singaporean players are competing with foreign players especially those from Malaysia and Thailand, though those countries cater more for slightly lower income patients. Despite a recent recess in the public promotion of medical tourism, this area is expected to grow. Within Singapore itself larger

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<sup>46</sup> Ministry of Health (n 38), CCS, 'MOH Publishes Data on Total Operation Fees for Common Procedures' (2014) <<https://www.ccs.gov.sg/media-and-publications/policies-and-positions/moh-publishes-data-on-total-operation-fees-for-common-procedures>> accessed 31 August 2015, Lim (n 8) p. 112, 129 seq, Ramesh (n 4) p 71.

<sup>47</sup> Khalik S, 'Listing of op fees at private hospitals: More transparent fees 'a positive step'' The Straits Times (6 October 2016) <<http://www.straitstimes.com/singapore/health/more-transparent-fees-a-positive-step>> accessed 7 October 2016.

<sup>48</sup> CCS (n 46).

<sup>49</sup> Ministry of Health, 'Hospital Bills Sizes' (2015) <[https://www.moh.gov.sg/content/moh\\_web/home/costs\\_and\\_financing/HospitalBillSize.html](https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/HospitalBillSize.html)> accessed 29 October 2015.

<sup>50</sup> Emerging Markets Direct (n 33) p. 4, 13.

<sup>51</sup> Phua and Pocok (n 19) p. 117.

<sup>52</sup> Lim J and Lee D, 'Re-Making Singapore Healthcare' in Kang SH and Leong C-H (eds), *Singapore Perspectives 2012* (World Scientific 2013) p. 75.

<sup>53</sup> Haseltine (n 11) p. 99.

<sup>54</sup> Ministry of Health, 'Hospital Services' (2015) <[https://www.moh.gov.sg/content/moh\\_web/home/our\\_healthcare\\_system/Healthcare\\_Services/Hospitals.html](https://www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Hospitals.html)> accessed 13 October 2015.

players are dominating the market while SME have to find niche areas for themselves.<sup>55</sup> Market entry of new providers including foreign providers is encouraged and assistance is provided.<sup>56</sup> Yet, licensing requirements for professionals (and number controls) and land release policies can serve as a certain barrier to entry / expansion. Furthermore, the price of private sector healthcare, especially in the secondary and tertiary healthcare markets can serve as barrier to accessing care from private providers from the patient's perspective.<sup>57</sup>

There is strong competition in downstream services and equipment markets inter alia since public hospitals have been encouraged by MoH to commission supplementary routine work such as processing of X-rays rather than conducting it in-house to save costs. MoH conducts random quality checks on such supplementary services<sup>58</sup> and the Health Science Authority is responsible for regulating the downstream markets (medical equipment and medicines).<sup>59</sup> Research in healthcare is divided between academic research and cost-efficiency research, the former is provided by the National University of Singapore (NUS) and the latter by government hospitals. NUS is also responsible for undergraduate teaching in medicine. Cutting edge practical research is not encouraged by the 1993 White Paper due to its financial implications. The National Medical Research Council, established in 1994, provides funding. Recently research expenditure has been rising and the government aims to provide a research supportive environment.<sup>60</sup>

## 2.2. Providers

Public primary care is provided through the 18 publicly subsidised polyclinics and through private providers.<sup>61</sup> More specialist primary care is often provided as an outpatient service in public and private hospitals to which patients need to be referred<sup>62</sup> and patients also consult practitioners of traditional medicine.<sup>63</sup> In addition to primary care providers and secondary / tertiary care in hospitals, which will be discussed in more detail in the following, there are community hospitals, chronic sickness hospitals, nursing homes and in-patient hospital care providers (also referred to as step down care sector) which is dominated by third sector organisations which are mostly

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<sup>55</sup> Emerging Markets Direct (n 33) p. 4, 13, Haseltine (n 11) p. 98, Phua and Pocok (n 19) p. 124 seq, Lim (n 8) p. 123, Ramesh (n 4) p 67.

<sup>56</sup> Emerging Markets Direct (n 33) p. 4, Phua and Pocok (n 19) p. 124.

<sup>57</sup> Emerging Markets Direct (n 33) p. 4, Phua and Pocok (n 19) p. 126, 130.

<sup>58</sup> Lim (n 8) p. 130 seq.

<sup>59</sup> Emerging Markets Direct (n 33) p. 6.

<sup>60</sup> Ministry of Health (n 15) p. 9, 52, Haseltine (n 11) p. 13, Phua and Pocok (n 19) p. 114, Lim (n 8) p. 124.

<sup>61</sup> Haseltine (n 11) p. 7, 93 seq, Ministry of Health (n 37), Finkenstädt (n 10) p. 10.

<sup>62</sup> Haseltine (n 11) p. 96, Finkenstädt (n 10) p. 10.

<sup>63</sup> Ministry of Health (n 37), Lim (n 8) p. 121 seq.

reimbursed by the government.<sup>64</sup> Healthcare for the elderly can either be residential or in the community and is provided by the third and the private sector.<sup>65</sup>

### 2.2.1. Public hospitals

There were 26 hospitals in Singapore in 2015 including 10 private institutions.<sup>66</sup> The latter tend to be smaller than the public hospitals. The medical services provided are of a high quality in both private and public hospitals, but the range is wider, the facilities more luxurious and the waiting times shorter in private hospitals. Technically patients are free to choose where to receive treatment, though for many this will in fact be limited by the ability to pay. Public hospitals have to provide care regardless of the ability to pay.<sup>67</sup> While they are wholly publicly owned, the hospitals are run as private companies on a not-for-profit basis and competition is encouraged, though MoH intervenes if it believes competition is going in the wrong direction. They receive an annual subsidy for supported medical services, are to follow government policy guidance and CEOs and boards members of the hospitals are appointed by MoH and accountable to MOHH. New, more accurate accounting systems have been introduced to provide the hospitals with a better insight into costs.<sup>68</sup>

The public providers are divided into eight hospitals (six general hospitals, women and children hospital (KKH) and a psychiatric hospital (IMH)) and eight specialised institutions.<sup>69</sup> The general hospitals provide acute medical treatment which is integrated with room facilities, specialist outpatient services and emergency care.<sup>70</sup> The different ward categories in the hospitals are differently subsidised (section 2.3.1) as determined by MoH. The vast majority of beds (81%)<sup>71</sup> are available in the highly subsidised C and B2 wards. The non-subsidised A wards are supposed to be 'a benchmark for the private sector'<sup>72</sup> which is facilitated by the major role the public sector plays in secondary.<sup>73</sup> The demand for ward A beds is mainly derived from Singaporean patients rather than from medical tourists.<sup>74</sup> More severe cases will be referred to the speciality centres which provide

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<sup>64</sup> Ministry of Health (n 38), Emerging Markets Direct (n 33) p. 14, Haseltine (n 11) p. 7, 100, Ministry of Health (n 54), Ministry of Health (n 37), Finkenstädt (n 10) p. 10.

<sup>65</sup> Emerging Markets Direct (n 33) p. 12.

<sup>66</sup> Ministry of Health (n 54).

<sup>67</sup> Haseltine (n 11) p. 98 seq.

<sup>68</sup> Emerging Markets Direct (n 33) p. 1 seq, Haseltine (n 11) p. 10, 98 seq, Ministry of Health (n 54), Ministry of Health (n 15) p. 34, Phua and Pocok (n 19) p. 117, Lim (n 8) p. 122 seq.

<sup>69</sup> Emerging Markets Direct (n 33) p. 1 seq, 14, Haseltine (n 11) p. 98, Ministry of Health (n 54), Finkenstädt (n 10) p. 10, Ministry of Health (n 15) p. 29, 32.

<sup>70</sup> Haseltine (n 11) p. 99 seq, Ministry of Health (n 54), Ministry of Health (n 37), Finkenstädt (n 10) p. 10.

<sup>71</sup> Ministry of Health (n 54).

<sup>72</sup> Ministry of Health (n 15) p. 36.

<sup>73</sup> Emerging Markets Direct (n 33) p. 1 seq, Haseltine (n 11) p. 10, Ministry of Health (n 54).

<sup>74</sup> Ministry of Health (n 54), Finkenstädt (n 10) p. 15, Phua and Pocok (n 19) p. 117.

the full range of services from 'preventative to rehabilitative' and also serve as a place for teaching and research.<sup>75</sup> The specialty centres receive public subsidies which allows them to charge a low price to Singaporeans and Permanent Residents (PR) who have been referred to them (though a lower subsidy rate applies to PR than to citizens). Patients who are not Singaporeans or PR or who have not been referred by a polyclinic or public hospital have to pay about three times as much.<sup>76</sup>

### 2.2.2. Major private providers

The private hospital in-patient sector is very concentrated. One of the largest private healthcare providers is Raffles Medical Group.<sup>77</sup> Established in 1976, Raffles Medical Group provides comprehensive services in its more than 75 primary care clinics and in Raffles Hospital in Singapore. In addition the group owns medical centres and hospitals abroad and supplies related services such as healthcare equipment, a travel clinic and consultancy services.<sup>78</sup>

Parkway Group is an integrated comprehensive healthcare provider offering primary care, secondary care and supplementary services. Its holding company, Parkway Pantai Ltd controls hospitals in Singapore and other countries in ASEAN and beyond. The group's players in Singapore include Parkway Group Healthcare Pte Ltd, Parkway Shenton Pte Ltd (a large primary care provider), providers of supplementary services (e.g. radiology) and Parkway Hospitals Singapore Pte Ltd. The latter subsidiary operates the Singaporean hospitals.<sup>79</sup> The roughly 300 bed Gleneagles Hospital caters especially to expatriates and provides medical and surgical acute tertiary care services specialising, in particular, in cardiology, internal medicine, obstetrics and gynaecology. Mount Elizabeth (Orchard) with over 300 beds is one of the largest and most renowned hospitals in South-East Asia. It is a tertiary care hospital providing surgical and medical services; especially cardiology and neurology. Parkway East is a secondary care hospital with about 100 beds and an outreach specialist centre which focuses on surgery, cardiology and gynaecology, obstetric and paediatrics. The new Mount Elizabeth Novena Hospital is a luxurious tertiary care hospital with over 300 beds with a wide range of specialties including cardiology, oncology and general surgery.<sup>80</sup>

Health Management International Ltd. which has been established in 1998 and operates in Singapore and other ASEAN countries, provides facilities and offers services from primary to tertiary

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<sup>75</sup> Haseltine (n 11) p. 99 seq, Ministry of Health (n 54), Ministry of Health (n 37), Finkenstädt (n 10) p. 10.

<sup>76</sup> Finkenstädt (n 10) p. 16, Ministry of Health, 'Revised Healthcare Subsidy Rates for Permanent Residents' (2012) <[https://www.moh.gov.sg/content/moh\\_web/home/pressRoom/pressRoomItemRelease/2012/revised\\_healthcaresubsidyratesforpermanentresidents0.html](https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2012/revised_healthcaresubsidyratesforpermanentresidents0.html)> accessed 23 October 2015.

<sup>77</sup> Emerging Markets Direct (n 33) p. 17, 24.

<sup>78</sup> Emerging Markets Direct (n 33) p. 17 seq, 24, Haseltine (n 11) p. 93, 98, Phua and Pocok (n 19) p. 126, 136.

<sup>79</sup> Haseltine (n 11) p. 93, 98, Phua and Pocok (n 19) p. 126, 134 seq.

<sup>80</sup> Phua and Pocok (n 19) p. 135 seq, Parkway Hospitals, 'Mount Elizabeth Novena' (2015) <<http://www.parkwayhospitals.com/about-us/mount-elizabeth-novena>> accessed 3rd November 2015, Parkway Hospitals, 'Mount Elizabeth Orchard' (2015) <<http://www.parkwayhospitals.com/about-us/mount-elizabeth-orchard>> accessed 3rd November 2015.

care as well as management, consultancy, education and training services.<sup>81</sup> Thomson Medical Pte Ltd provides consultancy and management services abroad and owns one hospital in Singapore providing comprehensive 'fully integrated services including medical, surgical, therapeutic, diagnostic and preventive healthcare, and specialised services such as fertility treatment'. It focuses on gynaecology, obstetrics and paediatrics.<sup>82</sup> Finally, Econ Healthcare Group provide a variety of supplementary services and own care centres and nursing homes, community hubs for the elderly as well as West Point Hospital, an acute and convalescent hospital.<sup>83</sup>

### 2.3. Funding

Unlike in many other developed countries, the ratio of private expenditure (out-of-pocket payments, coverage through insurance and employer benefits) is high (over 60%) in Singapore.<sup>84</sup> This is due to the focus on individual responsibility and avoiding large government expenditure while still attempting to balance this with providing universal healthcare.<sup>85</sup> The financing system is thus mixed with a large variety of funding mechanism with different purposes and follows a market based approach.<sup>86</sup> MoH differentiates between four different tiers for public healthcare funding.

#### 2.3.1. Subsidies

As the first tier, the government covers 20% in B1 wards to up to 80% in C wards of costs in public acute hospitals from general taxation which forms the majority of public expenditure on healthcare. Within the heavily subsidised B2 and C ward classes the subsidy levels are determined by a needs assessment. More affluent patients will receive a lower rate of subsidy (65% in C and 50% in B2 wards) than those who are needing it more allowing to cross-subsidise the latter.<sup>87</sup> While both Singaporeans and PR have access to C and B2 wards,<sup>88</sup> PR have a lower maximum subsidy rate (half of the rate Singaporeans of equal income can receive, except for the lowest income group who can receive 55% in C wards and 40% in B2 wards).<sup>89</sup> Foreigners who are not PR cannot receive any

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<sup>81</sup> Emerging Markets Direct (n 33) p. 19 seq.

<sup>82</sup> Phua and Pocok (n 19) p. 126, 137 (quote on p 137).

<sup>83</sup> Haseltine (n 11) p. 99, ECON Healthcare Group, 'About ECON Healthcare Group' (2015) <<http://www.econhealthcare.com/aboutus.html>> accessed 3 November 2015.

<sup>84</sup> Lim and Lee (n 52) p. 72 seq, Emerging Markets Direct (n 33) p. 2, Meister (n 12), Lim (n 8) p. 117 Ramesh (n 4) p 65.

<sup>85</sup> Lim and Lee (n 52) p. 62, Ministry of Health (n 38), Phua and Pocok (n 19) p. 118.

<sup>86</sup> Ministry of Health (n 38), Luk (n 8) p. 91, Emerging Markets Direct (n 33) p. 16, Phua and Pocok (n 19) p. 118, Lim (n 8) p. 117.

<sup>87</sup> Ministry of Health (n 38), Ministry of Health (n 15) p. 3, 6, Haseltine (n 11) p. 13, Meister (n 12), Finkenstädt (n 10) p. 14 seq, Lim and Lee (n 52) p. 62 seq, Lim (n 8) p. 119 seq, Ramesh (n 4) p 66.

<sup>88</sup> Contact Singapore, 'Healthcare' (2015) <<https://www.contactsingapore.sg/en/investors-business-owners/why-singapore/living/healthcare>> accessed 30 October 2015.

<sup>89</sup> Ministry of Health (n 76).

subsidies.<sup>90</sup> More affluent patients can also opt to attend non-subsidised wards or private hospitals. However, many nevertheless chose the higher subsidised ward classes. The difference between the wards is entirely related to comfort levels (beds per room, air-conditioning, etc.), while the medical services themselves are the same quality for all patients.<sup>91</sup>

### 2.3.2. Medisave

The second tier is Medisave which could be summarised as a compulsory, tax-free savings account for medical expenses to which all economically active Singaporeans and PR contribute part of their monthly income. In the case of employed (rather than self-employed) economically active persons, the employer equally contributes a certain percentage. The individual keeps their Medisave account when changing employers or when retiring and upon death it becomes part of the estate.<sup>92</sup> Interest on the savings is assured by the government and was set at 4% in 2013.<sup>93</sup> Medisave accounts are capped at S\$43,500. If the ceiling is reached, the contributions will be automatically transferred to other accounts in the individual's CPF account set. After reaching the age of 55, individuals can withdraw money from the account as long as levels stay above S\$38,500.<sup>94</sup> The account is meant for covering the individual's contribution of their medical bills or relatives' medical bills. One can also use future Medisave savings to pay for a procedure in instalments. The details as to how (i.e. on what and to which extent) Medisave savings can be spent are regulated by the government and include a variety of limitations, in particular for using Medisave on private providers. However, the government revises this regularly (e.g. Medisave can be used for chronic disease management since 2006 and since 2010 for elective hospitalisation and with two partner providers in Malaysia). The government has been using surpluses to provide selected top-ups to Medisave accounts; for example for the elderly as part of the Pre-Medisave-Top-up-Scheme. According to MoH, there are almost S\$17,000 in an average Medisave account which would allow the individual to cover their share for roughly ten 'hospitalisation episodes' in the public acute hospitals. However, due to restrictions on Medisave citizens pay still a large amount of healthcare costs themselves.<sup>95</sup>

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<sup>90</sup> Ministry of Health, 'Revision of Hospital Subsidy for Foreigners' (2006) <[https://www.moh.gov.sg/content/moh\\_web/home/pressRoom/pressRoomItemRelease/2006/revision\\_of\\_hospital\\_subsidy\\_for\\_foreigners.html](https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2006/revision_of_hospital_subsidy_for_foreigners.html)> accessed 30 October 2015.

<sup>91</sup> Ministry of Health (n 38), Ministry of Health (n 15) p. 3, 6, Haseltine (n 11) p. 13, Meister (n 12), Finkenstädt (n 10) p. 14 seq, Lim and Lee (n 52) p. 62 seq, Lim (n 8) p. 119 seq.

<sup>92</sup> Ministry of Health (n 38), Haseltine (n 11) p. 10, 96, Luk (n 8) p. 89, 95, 100 seq, Meister (n 12), Finkenstädt (n 10) p. 16 seq, Lim (n 8) p. 112 seq.

<sup>93</sup> Finkenstädt (n 10) p. 19, Lim (n 8) p. 113.

<sup>94</sup> Finkenstädt (n 10) p. 19.

<sup>95</sup> Ministry of Health (n 38), Haseltine (n 11) p. 10, 96, Luk (n 8) p. 89, 95, 100 seq, Meister (n 12), Finkenstädt (n 10) p. 16 seq, n 19 (n 19) p. 118, Lim (n 8) p. 113 seq.

### 2.3.3. MediShield

The third tier is MediShield<sup>96</sup> a voluntary, risk pooling public medical insurance scheme to cover emergency situations which cannot be covered by subsidies and Medisave alone. Yet, there are limits to what and how much (claimable limits) can be reimbursed as well as a personal excess per year (deductibles) and a personal excess percentage per claim (co-insurance), so that the individual might still have to pay a significant amount of their medical expenses themselves.<sup>97</sup> 80% of large class C and B2 ward of the individual's bills are on average covered by MediShield. If used in other wards or private hospitals the proportion covered will be significantly lower.<sup>98</sup> The CPF, which is administering MediShield, used to have an existing condition exclusion clause allowing to deny a contract or only conclude a contract under certain conditions. However, since 2013 all new-borns are automatically insured under MediShield (though an opt-out is possible) and since November 2015, when MediShield was replaced by MediShield Life, the existing condition clause has been eliminated. MediShield Life also provides life cover while previously MediShield contracts ended with 90.<sup>99</sup> Most (92%)<sup>100</sup> of eligible individuals (Singaporeans and PR) have a MediShield account. The low-cost premiums, which vary according to risk (i.e. are higher for older insured persons), are paid from Medisave accounts (one's own or that of a close relative). If the individual's Medisave account has been exhausted and the premium has neither been paid from a relatives account for more than two months, the contract ends automatically.<sup>101</sup>

Individuals can opt for additional private insurance in the so-called Integrated Shield Plans as an add-on to MediShield which cover the same spectrum of services, but reduce or eliminate the out-of-pocket payment and thus make it easier to seek treatment in higher ward classes or private sector hospitals. Such Integrated Shield Plans can be paid from Medisave accounts. Employers can also purchase such plans as a group insurance for their employees. The majority of eligible persons have an Integrated Shield Plan.<sup>102</sup>

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<sup>96</sup> In addition, ElderShield is a low premium insurance scheme providing cover in cases of severe disability, especially due to old age, through monthly pay outs to assist with care for the person with a disability. See further Ministry of Health (n 38), Luk (n 8) p. 91, Finkenstädt (n 10) p. 27, Lim (n 8) p. 118.

<sup>97</sup> Ministry of Health (n 38), Luk (n 8) p. 89 seq, 100, Meister (n 12), Finkenstädt (n 10) p. 22 seq, Lim (n 8) p. 114, MediShield Life, 'How MediShield Life Claims Work' (2015) <[https://www.moh.gov.sg/content/moh\\_web/medishield-life/about-medishield-life/how-medishield-and-medishield-life-claims-work.html](https://www.moh.gov.sg/content/moh_web/medishield-life/about-medishield-life/how-medishield-and-medishield-life-claims-work.html)> accessed 17 November 2015.

<sup>98</sup> Lim (n 8) p. 116, Ministry of Health (n 31).

<sup>99</sup> Ministry of Health (n 31), Ministry of Health (n 38), Luk (n 8) p. 89 seq, 100, Meister (n 12), Finkenstädt (n 10) p. 22 seq, Lim (n 8) p. 114.

<sup>100</sup> Finkenstädt (n 10) p. 31.

<sup>101</sup> Ministry of Health (n 38), Luk (n 8) p. 89 seq, 100, Meister (n 12), Finkenstädt (n 10) p. 22 seq, Lim (n 8) p. 114.

<sup>102</sup> Ministry of Health (n 38), Ministry of Health (n 29), Luk (n 8) p. 89 seq, 100, Meister (n 12), Finkenstädt (n 10) p. 22 seq, Lim (n 8) p. 114 seq.



#### 2.3.4. Medifund

The fourth tier, Medifund, is a special public endowment fund aimed to help citizens<sup>103</sup> to pay their medical bills, if they are unable to do so, because they are either not covered or have exhausted Medisave and MediShield and the costs can also not be covered by their own savings or by their family members. Unlike Medisave and MediShield, Medifund is not part of the CPF, but has been set up separately by the government which continues to invest surpluses into it.<sup>104</sup> The capital (S\$3 billion in 2013)<sup>105</sup> itself is not touched for payments, but rather the interest it generates is utilised. Medifund operates on a means/needs test basis providing payments in form of grants for which patients have to apply. The applications are decided upon by Medifund committees in the hospitals on the basis of the Medifund Advisory Council's guidelines. The grant, the amount of which depends on the bill size and the financial situation of the patient, is paid directly to the institution. Applications can only be made for treatment in approved public hospitals and only for C and B2 wards or for certain approved third sector hospitals which would be covered by Medisave. Patients who have regularly paid into Medisave and have purchased a MediShield insurance can receive higher grants through Medifund.<sup>106</sup> While Medifund is an important last resort, it has been argued that it steps in so late (after all other means including the patient's and the family members savings have been exhausted) that it can leave whole families being deprived of their resources. Critics have also contended that there is not enough transparency in decision making.<sup>107</sup>

#### 2.3.5. Additional private funding

Private expenditure outside the four tiers can take the form of out-of-pocket payments (in addition to the out of pocket payments from Medisave accounts), employer benefits and private insurance. Employers are obliged to cover consultation costs for employees who have been employed for over three months and to provide medical insurance for certain groups of resident foreigners (Work Permit and S-Pass holders). They often also provide additional protection for their employees which is agreed contractually or by trade agreement. The government provides incentives for certain options of such additional cover through tax deductions.<sup>108</sup> The market for private insurance schemes (other than Integrated Shield Plans) is relatively small and mainly comprises resident

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<sup>103</sup> In 2007 a third of Medifund was converted into Medifund Silver which is specifically dedicated to help elderly citizens with their medical bills due to concern about an aging population. 2007 also saw the introduction of Medifund junior for minors in need. See further Luk (n 8) p. 90 seq, Lim (n 8) p. 118.

<sup>104</sup> Ministry of Health (n 38), Luk (n 8) p. 90, Lim (n 8) p. 116, 118.

<sup>105</sup> Luk (n 8) p. 90 with reference to MoH.

<sup>106</sup> Luk (n 8) p. 90, Finkenstädt (n 10) p. 27 seq, Lim (n 8) p. 116.

<sup>107</sup> Finkenstädt (n 10) p. 28.

<sup>108</sup> Finkenstädt (n 10) p. 26 seq, Ministry of Manpower, 'Portable medical benefits for employees' (2015) <<http://www.mom.gov.sg/employment-practices/schemes-for-employers-and-employees/portable-medical-benefits>> accessed 30 October 2015, Ministry of Manpower, 'Are employers required to buy medical insurance for Employment Pass holders?' (2015) <<http://www.mom.gov.sg/faq/employment-pass/are-employers-required-to-buy-medical-insurance-for-employment-pass-holders>> accessed 30 October 2015, Ministry of Manpower, 'Medical insurance requirements for foreign worker' (2015) <<http://www.mom.gov.sg/passes-and-permits/work-permit-for-foreign-worker/sector-specific-rules/medical-insurance>> accessed 30 October 2015.

foreigners, since they are not eligible for the four public funding tiers. Private insurances cover a broader spectrum of services than the public funding mechanism (e.g. dental care and medication).<sup>109</sup> Medical insurances are regulated and previously had a cap on the amount of illnesses a critical illness plan would cover. This cap has now been removed which has been welcomed by the Competition Commission Singapore (CCS), as it allows a broader product variety.<sup>110</sup>

## 2.4. Areas of potential reform

It seems widely recognised that, despite the good international standing of Singapore's healthcare system, reform is necessary due to an aging population,<sup>111</sup> a consumerist attitude, changes in disease patterns from acute to chronic diseases prevailing,<sup>112</sup> higher healthcare expenditure<sup>113</sup> and more sophisticated and expensive treatment methods.<sup>114</sup> Lim and Lee describe the basic principles of the system as sound, but encourage reforms especially as regards transparency and avoiding the harsher effects of limiting spending.<sup>115</sup> Ramesh similarly raises concerns about the equity of the system.<sup>116</sup> How and Fock argue that providers should be identified as such and not considered as stakeholders.<sup>117</sup> Many have encouraged a strengthening of primary care, in particular if the alternative was visiting the emergency room. This should be aligned with collaboration efforts to allow a 'seamless transition of care' and avoid duplication of services. Also outreach programmes could help in prevention and to combat disease from early stages by reducing risk factors.<sup>118</sup>

Another issue regularly mentioned is the significant brain drain from the public to the private sector due to the private sector paying higher salaries and due to specialists being required to provide elective services in the private sector. This has already been a problem for a while and was part of the reason to grant autonomy to the hospitals in the 1980s and was again mentioned in the 1993 white paper. The public sector had to increase salaries to partly very high levels which led to rising

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<sup>109</sup> Finkenstädt (n 10) p. 25, 27, Ramesh (n 4) p 66.

<sup>110</sup> CCS, 'LIA Removes Cap on 30 Critical Illnesses' (2014) <<https://www.ccs.gov.sg/media-and-publications/publications/e-newsletter-competitive-edge/issue-9/highlights/lia-removes-cap-on-30-critical-illnesses>> accessed 31 August 2015.

<sup>111</sup> Lim and Lee (n 52) p. 62 seq, Emerging Markets Direct (n 33) p. 6, 12, 16, Ministry of Health (n 38) , Luk (n 8) p. 99, 102, Finkenstädt (n 10) p. 7.

<sup>112</sup> Lim and Lee (n 52) p. 62 seq, Emerging Markets Direct (n 33) p. 13, 16.

<sup>113</sup> Luk (n 8) p. 100.

<sup>114</sup> Lim and Lee (n 52) p. 62 seq.

<sup>115</sup> Lim and Lee (n 52) p. 66 seq, 73 seq. As regards the latter they pointed inter alia to policies covering patients only till a certain age. Yet, since November 2015 MediShield Life has no age limit anymore (see above subsection 2.3.3).

<sup>116</sup> Ramesh (n 4) p 74.

<sup>117</sup> How CH and Fock KM, 'Healthcare in Singapore: the present and future' (2014) 55 Singapore Med J 126.

<sup>118</sup> How and Fock (n 117), Luk (n 8) p. 101, Lim and Lee (n 52) p. 74 seq.

medical costs.<sup>119</sup> Having to pay higher salaries is estimated to be a continuous concern for the public sector, especially in tertiary care, and measures such as fee and salary guidelines have been encouraged.<sup>120</sup>

Phua and Pocok also raise a variety of points in connection with medical tourism. According to them the Singaporean healthcare sector caters mainly for on the one hand, subsidised patients (Singaporeans and PR) and on the other hand high-income foreign patients mainly from the neighbouring countries. They suggest that a market for middle income patients is missing which could become a problem in the future when middle classes globally are growing. Equally they are encouraging co-operations between providers and insurances to promote healthcare services in Singapore regionally.<sup>121</sup>

### 3. Overview of competition law in Singapore

Having provided an overview of the healthcare market in Singapore in the last section, this section will now outline some general features of Singapore's competition law before turning to an in-depth analysis of the in-patient hospital care sector with its mixed public-private elements from a competition law perspective in the following sections (sections 4.-9.). Singapore is a highly developed, but small open market economy. It is a common law jurisdiction with the Court of Appeal being the highest judicial authority. While it is a free market economy, the government does reserve its right to intervene in so far as it sees fit to address market failures and achieve social justice.<sup>122</sup> These characteristics are reflected in Singapore's competition law which was introduced in 2004 in line with a more general economic reform programme that included liberalisation of formerly public services and the entering into trade agreements, which included competition law chapters, by Singapore.<sup>123</sup>

Parliament passed the Competition Act (CA) in 2004 which then entered into force in 2006<sup>124</sup> and is mainly influenced by Anglo-European competition law. While UK and EU law are not binding precedent in Singapore, they are considered for interpretative guidance.<sup>125</sup> The CA is currently

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<sup>119</sup> Lim and Lee (n 52) p. 76, Ministry of Health (n 15) p. 8, Phua and Pocok (n 19) p. 119, Lim (n 8) p. 123, Ramesh (n 4) p 66.

<sup>120</sup> Phua and Pocok (n 19) p. 119, 128.

<sup>121</sup> Phua and Pocok (n 19) p. 125 seq.

<sup>122</sup> Lim CK and Ng E-K, *Competition Law in Singapore* (Kluwer 2014) p. 16 seq, 20. Some have criticised the economy as too concentrated and public sector dominated; e.g. Williams M, 'The Lion City and the Fragrant Harbor: The political economy of competition policy in Singapore and Hong Kong' (2009) 54 *The Antitrust Bulletin* 517, p. 558 seq

<sup>123</sup> See further Ong B, 'The Origins, Objectives and Structure of Competition Law in Singapore' (2006) 29 *World Competition* 269, Lim and Ng (n 122) p. 21.

<sup>124</sup> See the Lim and Ng (n 122) p. 23 seq on the earlier or delayed entering into force of certain provisions.

<sup>125</sup> See further on the origins of Singapore's competition law Ong (n 123) p. 269 seq, McEwin RI and Anandarajah K, 'Singapore' in McEwin RI and Anandarajah K (eds), *ASEAN competition law* (LexisNexis 2010)

supplemented by six Regulations (inter alia on notifications, transitional provisions, fees and appeals) and two orders; the Competition (Financial Penalties) Order 2007 and the Competition (Block Exemption for Liner Shipping Agreements) Order 2006.<sup>126</sup> The CA applies only to undertakings, a notion that will be discussed in more detail below (section 4), and covers anti-competitive collusion (s 34 CA), abuse of a dominant position (s 47 CA) and anti-competitive mergers (s 54 CA). It has explicit extraterritorial application (s 33 (1) CA) in that s 34 CA applies to collusion which has been entered into abroad and parties to the collusion may be situated outside Singapore. Equally, with regard to s 47 CA, the undertaking does not have to be established in Singapore or even hold dominance in a market in Singapore for any abusive conduct to fall under the CA and, with regard to s 54 CA, mergers that limit competition in Singapore are included no matter where the undertakings are situated.<sup>127</sup>

The relevant enforcement authority is CCS established under s 3 CA in January 2005 who, in addition to enforcement, also educate about competition law and provide advice for the government.<sup>128</sup> CCS is an independent statutory board under the auspices of the Ministry of Trade and Industry (MTI). Its board consists of the Chairman, the Chief Executive and seven Commissioners appointed by MTI. CCS has issued a variety of guidelines (currently 12)<sup>129</sup> on how it plans to enforce the CA in respect of the prohibitions, enforcement and procedure. However, these are not binding. In addition to CCS, there are sector-specific bodies who, besides their other duties also regulate competition in their sectors: the Civil Aviation Authority responsible for airport services, the Energy Markets Authority responsible for the electricity and gas markets, the Infocomm Development Authority responsible

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para 1 seq, ASEAN, *Handbook on Competition Policy and Law in ASEAN for Business 2013* (ASEAN, 2013) p. 52, Chia K and Seng YL, 'Singapore' in Baker & McKenzie (ed), *Asia Pacific Antitrust & Competition Law Guidebook* (Baker & McKenzie, 2013) p. 71, Lim and Ng (n 122) p. 23 seq, Shiau D, 'Singapore' in Groshinski K and Davies C (eds), *Competition law in Asia Pacific : a practical guide* (Kluwer 2015) p. 573 seq, 595.

<sup>126</sup> For an up-date on competition legislation see CCS website on <https://www.ccs.gov.sg/legislation>.

<sup>127</sup> Ong B, 'Exporting Article 82 EC to Singapore: Prospects and Challenges' (2006) 2 *The Competition Law Review* 99 p. 109 seq, McEwin and Anandarajah (n 125) para 51 seq, ASEAN (n 125) p. 53 seq, Chia and Seng (n 125) p. 76, Lim and Ng (n 122) p. 27 seq, Shiau (n 125) p. 577, 615.

<sup>128</sup> See further on CCS' activities Toh HL, 'Singapore: Competition Commission Singapore' *The Asia-Pacific Antitrust Review* 2015  
<<http://globalcompetitionreview.com/reviews/69/sections/235/chapters/2763/singapore-competition-commission-singapore/>> accessed 28 August 2015. See also Ong (n 123) p. 270.

<sup>129</sup> CCS Guidelines on the Major Provisions (Major Provision Guidelines), CCS Guidelines on the Section 34 Prohibition (s 34 Guidelines), CCS Guidelines on the Section 47 Prohibition (s 47 Guidelines), CCS Guidelines on the Substantive Assessment of Mergers (Merger Guidelines), CCS Guidelines on Merger Procedures 2012 (Merger Procedure Guidelines), CCS Guidelines on Market Definition (Market Definition Guidelines), CCS Guidelines on the Powers of Investigation (Investigation Guidelines), CCS Guidelines on Enforcement (Enforcement Guidelines), CCS Guidelines on Lenient Treatment for Undertakings Coming Forward with Information on Cartel Activity Cases 2009 (Leniency Guidelines), CCS Guidelines on Filing Notifications for Guidance or Decision with respect to the Section 34 Prohibition and Section 47 Prohibition (Filing Guidelines), CCS Guidelines on the Appropriate Amount of Penalty and CCS Guidelines on the Treatment of Intellectual Property Rights all available on <https://www.ccs.gov.sg/legislation/ccs-guidelines>.

for telecommunications and postal services, the Casino Regulatory Authority, the Monetary Authority, the Media Development Authority and the Singapore Police Force responsible for 'auxiliary police force services'. However, not all these regulators have the power to review all potential anti-competitive behaviour which is why in some cases CCS will nevertheless be responsible or will coordinate multi-sector review.<sup>130</sup> Parties can appeal a CCS decision in front of the Competition Appeal Board (CAB) who can confirm or set aside the decision, change the penalty, remit the matter to CCS or give any direction or make any decision as CCS could itself have done (s 72, 73 CA).<sup>131</sup> This is again subject to appeal to the High Court and, subsequently, to the Court of Appeal on a point of law or as to the amount of the penalty (s 74 CA). In merger cases, the parties also have the opportunity to apply to the Minister,<sup>132</sup> to exempt the merger on public policy reason in which case the Minister's decisions are final (s 58 (3) and (4)).<sup>133</sup>

#### 4. The notion of undertaking

The Singaporean competition law only applies to undertakings (Major Provision Guidelines para 1.1).<sup>134</sup> Section 2 (1) of the CA defines an undertaking as a 'person, being an individual, a body corporate, an unincorporated body of persons or any other entity, **capable of carrying on commercial or economic activities** relating to goods or services [emphasis added]'. CCS specifies this further in the Major Provisions Guidelines as 'any natural or legal person who is capable of engaging in economic activity, regardless of its legal status and the way in which it is financed' (para 1.1). A combination of both definitions is given in the s 34 Guidelines (para 2.5) and s 47 Guidelines (para 2.4) which both define an 'undertaking' as

<sup>130</sup> On CCS and the other regulatory authorities see Ong (n 123) p. 269, McEwin and Anandarajah (n 125) para 205 seq, ASEAN (n 125) p. 52 seq, Chia and Seng (n 125) p. 71, 76, Lim and Ng (n 122) p. 23 seq, Shiao (n 125) p. 573 seq, 577 seq. Further on the background to having separate regulators see also MTI, Competition Bill - Second Consultation Paper: Annex B: Exclusions from draft Competition Bill - Third and Fourth Schedules (MTI, 2004) p. 1 seq.

<sup>131</sup> The Competition Appeal Board received 13 applications (none on s 54, one on s 47 and the rest on s 34) and issued eight decisions (three applications were withdrawn, two applications were joined and one is still pending). Of these decisions one was on s 47. In the decisions it sometimes reduced penalties, but generally concurred with CCS findings. The applications to and Decisions of the CAB can be found on: [https://www.mti.gov.sg/legislation/Pages/Summary-of-appeals-received-by-the-Competition-Appeal-Board-\(CAB\).aspx](https://www.mti.gov.sg/legislation/Pages/Summary-of-appeals-received-by-the-Competition-Appeal-Board-(CAB).aspx).

<sup>132</sup> There are currently two Ministers for Trade and Industry; Mr Iswaran (Industry) and Mr Lim (Trade). CCS is under the ambit of Mr Lim Hng Kiang, the Minister for Trade and Industry (Trade). See further Prime Minister's Office Singapore, 'Transcript of Prime Minister Lee Hsien Loong's Statement at the Press Conference on the new Cabinet Line-Up on 28 September 2015' (2015) <<http://www.pmo.gov.sg/mediacentre/transcript-prime-minister-lee-hsien-loongs-statement-press-conference-new-cabinet-line>> accessed 30 May 2016.

<sup>133</sup> On review and appeals see McEwin and Anandarajah (n 125) para 1955 seq, ASEAN (n 125) p. 59, 61 seq, Chia and Seng (125) p. 74 seq, 79 seq, Shiao D and Cheng C, 'Compliance under the Singapore Competition Regime: Penalties, Leniency and Private Action' (2013) 34 European Competition Law Review 590, Lim and Ng (n 122) p. 36 seq, Shiao (n 125) p. 578 seq, 591 seq, 598, 624 seq.

<sup>134</sup> See on these and other Guidelines n 129 above.

*any person, being an individual, a body corporate, an unincorporated body of persons or any other entity, **capable of carrying on commercial or economic activities** relating to goods or services. It includes individuals operating as sole proprietorships, companies, firms, businesses, partnerships, co-operatives, societies, business chambers, trade associations and non profit-making organisations, **whatever its legal and ownership status (foreign or local, government or non-government)**, and the way in which it is financed [emphasis added].*

It is thus clear, and the developments leading up to the passing of the CA support this, that generally government owned entities conducting such ‘commercial or economic activities’ are included in this definition.<sup>135</sup> Further, it is stated in the para 2.6 of the s 34 Guidelines and para 2.5 of the s 47 Guidelines respectively that ‘an entity may engage in commercial or economic activity in some of its functions but not others’ indicating that CCS is intending to regard the concept of undertaking as relative and to follow a functional approach as regards the question whether or not an entity is an undertaking.

#### 4.1. Economic activity

However, the CA, the Major Provision Guidelines, the s 34 Guidelines and the s 47 Guidelines do not define the term ‘commercial or economic activities’ or ‘economic activities’. Yet, the s 34 Guidelines in para 2.6 and the s 47 Guidelines in para 2.5 respectively make clear that the actual or potential engagement in such activities is ‘the key consideration in assessing whether an entity is an undertaking’. A discussion of these decisive notions thus seems necessary; in particular since there appears to be no guidance in academic literature or decisional practice either. The definitions seem to have been almost literally adopted from EU competition law, where the Court of Justice of the European Union (hereinafter Court or CJEU) in *Höfner*<sup>136</sup> defined an undertaking as ‘every entity engaged in an economic activity, regardless of the legal status of the entity and the way in which it is financed’. Since there is no authority in Singaporean competition law, EU law shall be discussed as persuasive guidance.<sup>137</sup>

In EU law ‘economic activity’ is defined as ‘offering goods or services on a market’<sup>138</sup> if this can, in principle, be conducted by a private company with a view to making profit. It is thus irrelevant if reimbursement has been received for a particular activity, whether the entity makes a profit or forms part of the state’s administration as long as the activity itself can at least in principle be performed commercially. In addition, the EU courts have acknowledged two exceptional situations that are not considered as economic in nature. Firstly, the exercise of sovereign power when an entity acts in the service of the state’s prerogatives to conduct acts of official authority is of a non-

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<sup>135</sup> Ong (n 123) in particular p. 273/274 seq, 276, Lim and Ng (n 122) p. 29. This is also confirmed in the speech by former Senior Minister of State for Trade and Industry Dr Vivian Balakrishnan (Parliament of Singapore, ‘Speech for the Competition Bill by the Senior Minister of State for Trade and Industry Dr Vivian Balakrishnan and debate’ (Column No: 863 Competition Bill Order for Second Reading, Singapore, 19 October 2004) p. 3).

<sup>136</sup> C-41/90 *Höfner* para 21.

<sup>137</sup> On EU law as persuasive guidance see CCS 400/001/09 *Guideline on Fees* para 34, Lim and Ng (n 122) p. 24.

<sup>138</sup> 118/85 *Commission v Italy* paragraph 7.

economic nature, irrespective of whether this authority is executed by a public or private entity.<sup>139</sup> In Singapore these situations are likely to be captured by s 33 (4) CA discussed below (section 5.1). Secondly, the offering of services governed by the principle of solidarity where an entity fulfils an exclusively social function has been found to be non-economic in nature. This was, for example, deemed to be the case in national health or pension schemes. Decisive factors were contributions (if any) disproportionate to the risks, benefits that had no relation to the amount of the contribution (if any), schemes involving elements of cross-subsidy between different categories of people and the necessity of public and/or compulsory schemes to ensure their financial equilibrium.<sup>140</sup> Generally, it also appears from case law, Commission decisions and Commission documents that the more commercial elements a system adopts, the more likely it becomes that the entities operating therein will be regarded as undertaking. In its Decision 2006/225/EC the Commission has phrased this as follows:

*'[...] the concept of economic activity is an evolving concept linked in part to the political choices of each Member State. [...] Member States may also create the conditions necessary to ensure the existence of a market for a product or service that would otherwise not exist. The result of such state intervention is that the activities in question become economic and fall within the scope of the competition rules.'*<sup>141</sup>

Finally, it should be noted that, while the functional approach adopted in EU law (as in the CCS Guidelines), requires an assessment per activity rather than per entity, there may be activities which are inseparable from non-economic activities (e.g. purchasing activities to conduct a non-economic activity).<sup>142</sup> These thus must be assessed together and would equally be regarded as non-economic.<sup>143</sup>

The question then remains what this means for the Singaporean healthcare sector. In its *Guidelines on fees* Decision CCS stated that 'it is clear that professionals engaged in private practice, including selfemployed medical practitioners, can constitute undertakings'.<sup>144</sup> CCS does not provide further

<sup>139</sup> C-364/92 *Eurocontrol* paragraph 19 seq, in particular paragraph 30 and 31, C-343/95 *Diego Cali v SEPG* paragraph 16 seq, C-113/07 P *SELEX* paragraph 65 seq, C-138/11 *Compass*. See also Commission Decision SA.34646 *TenderNed* para 67 which is currently being challenged (T-138/15 *Aanbestedingskalender*).

<sup>140</sup> C-159, 160/91 *Poucet et Pistre* paragraph 18 seq, C-218/00 *Cisal* paragraph 38 seq, C-264, 306, 354, 355/01 *AOK Bundesverband* paragraph 45 seq, T-319/99 *FENIN* para 39 and C-205/03 P *FENIN* para 25 seq as well as Commission Decision 2015/248/EU *Measures implemented by Slovak Republic for Spoločná zdravotná poisťovňa, a. s. and Všeobecná zdravotná poisťovňa, a. s.* OJ [2015] L 41/25.

<sup>141</sup> Commission Decision 2006/225/EC on the aid scheme implemented by Italy for the reform of the training institutions OJ [2006] L 81/13 paragraph 50.

<sup>142</sup> C-205/03 P *FENIN*.

<sup>143</sup> See, for example, C-205/03 P *FENIN*, C-185/14 *EasyPay*. It has been argued that in the latter case the Court has applied a stricter test as to the inseparability (Sanchez-Graells A and Herrera-Anchustegui I, 'Revisiting the concept of undertaking from a public procurement law perspective – A discussion on EasyPay and Finance Engineering' (2016) 37 *European Competition Law Review* 93).

<sup>144</sup> Decision CCS 400/001/09 *Guidelines on fees* para 53.

explanations, but references the CJEU' judgment in *Pavlov*.<sup>145</sup> In that case the Court underlined that self-employed medical specialists who are providing medical services on a market are undertakings. It might thus be assumed that CCS was equally referring to self-employed professionals and private medical practices as entities on the whole.<sup>146</sup> More, generally, it seems clear that private sector providers of healthcare who are offering medical services on a market are conducting economic activities. This seems less clear for public sector providers, a question CCS had not engaged with in that decision.

When it comes to hospital in-patient care, the subsidised ward services,<sup>147</sup> and within that group in particular the C and B2 ward services, could arguably be classified as non-economic in nature. Firstly, one could argue that it is a closed public system in which no private sector competition is allowed. In so far the services would not be provided on a market. There are various points supporting this argument. For starters, C and B2 wards (and subsidised hospital care in general) are not provided by the other sectors, but only by the public sector without competition. The situation might be different if public money could also be used for private providers like in the 'any willing provider' scheme in the NHS in England.<sup>148</sup> In that case the Member State arguably did 'create the conditions necessary to ensure the existence of a market for a product or service that would otherwise not exist'. In the Singaporean case, however, the C and B2 ward healthcare is provided only in public hospitals and patients cannot choose private providers instead and take their subsidies with them to pay for the private sector treatment. The system is also closed as regards the 'customers', since only citizens and PRs have access to the C and B2 wards. Furthermore, the system in the public hospitals is, despite restructuring, still tightly regulated and controlled (number of beds, standard of service, basic package, subsidy levels, etc.) to ensure the financial equilibrium. All this seems to indicate that this area of healthcare provision cannot be regarded as a services provided on a market.

Secondly, even though the services are not entirely free at the point of delivery, one could argue that this is a system based on solidarity. The services in B2 and C wards are highly subsidised (up to 80% in C wards) and the three Ms (Medisave, Medifund and MediShield)<sup>149</sup> can partly only be utilised in the public B2 and C wards. The various funding schemes also contain elements of cross-subsidy. For example, the subsidy levels in the wards differ according to need in that the people who need it more will receive a higher subsidy. This allows cross-subsidy between different patient groups and between the general tax payer and the patients in need of highly subsidised healthcare. There is in so far no correlation between taxation paid and subsidies received. The publicly funded endowment fund Medifund is equally only available in these wards and on a needs basis. Further, even MediShield, while being available in private hospitals as well and requiring higher premiums

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<sup>145</sup> Joined cases C-180/98 to C-184/98 *Pavlov*.

<sup>146</sup> The statement could also be read as CCS concluding that the individual employees are undertakings, an area that is highly controversial. See further Lucey MC, 'Should Professionals in Employment Constitute 'Undertakings'? Identifying 'False-Employed'' (2015) 6 Journal of European Competition Law & Practice 702.

<sup>147</sup> On the different ward classes see section 2 above (in particular section 2.2.1. and 2.3.1.).

<sup>148</sup> Wendt and Gideon (n 9).

<sup>149</sup> See section 2.3. above.



from older patients, does not have an existing condition clause anymore requiring access for everybody and still involves elements of cross-subsidy between risk, income and age groups. The solidarity of these schemes (especially the subsidies and Medifund) and the necessity of having a public, integrated scheme with tight regulation to ensure the financial equilibrium thus seem to point to the non-economic character of these services.

In the B1 wards the maximum subsidy is 20% and it does not differ according to need, nor is Medifund available in this ward class. There is thus significantly less solidarity present which might point to the fact that an economic activity is being conducted in this regard. On the other hand, this is also an integrated system in the sense that the subsidies are not transferable to private providers. For patients who cannot afford non-subsidised healthcare there is in so far no open market and no choice except for other public hospitals. Yet between the public hospitals it is envisaged to have not too much replication, so even that choice might be significantly limited. In so far it is arguable that the services received in B1 wards are still not being offered on a market. However, this argument is significantly weaker than in the case of the B2 and C wards. Service received by A ward patients are undoubtedly of an economic nature. They are not subsidised and one of the stated aims of the A wards is to compete with the private sector and serve as a benchmark. Public hospitals are thus undertakings at least for the part of their activities that concern services provided to A ward patients.

The A and B1 ward services also seem severable from the non-economic activities. The government already limits the provision of A and B1 ward services to around 20%.<sup>150</sup> It seems entirely possible for the government to limit this further or to abolish A ward services. There seems to be no intimate or essential connection between the services provided as part of the different ward categories. The services in B2 and C wards are financed by direct subsidies and the three Ms. While cross-subsidy may happen, it does not appear intrinsically necessary to have the A ward services to finance the B2 and C wards.

To summarise, it is argued here that, applying EU law as persuasive guidance, hospital care provided in the B2 and C ward categories is of a non-economic nature, while care in A wards is economic. Public hospitals are therefore undertakings for those activities. As regards B1 wards this question is more difficult as the services provided under the B1 wards scheme contain fewer elements which may classify them as non-economic in nature. It is therefore conditionally assumed here that they are economic in nature.

#### 4.2. Single economic unit

In note 1 of its Major Provision Guidelines, para 2.7-2.8 of its s 34 Guidelines and para 2.6 of its s 47 Guidelines CCS states that it will apply a single economic unit (SEU) doctrine in that it will regard the economic unit as the undertaking. Thus a conglomerate of entities might be regarded as a single undertaking, if one entity controls the others as regards their course of action and the subsidiaries have no economic independence. CCS will determine if such a situation is given by assessing shares the parent holds, control of the board of directors, compliance with directions on sales and marketing, etc. CCS's is adopting the approach that (close to) 100% ownership creates a strong assumption of a SEU, but this can be rebutted.<sup>151</sup> In cases of a SEU, agreements between the entities

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<sup>150</sup> Ministry of Health (n 54).

<sup>151</sup> Decision CCS 700/003/11 *Air Freight Forwarders Cartel* para 70 seq, 537, 545 etc.

of the conglomerate will not fall under competition law, behaviour may be attributed to the parent and the market share of the whole group might have to be considered as the share of one undertaking. CCS makes the assessment relevant to the individual case/context. Therefore differences may occur in the assessment depending on whether it takes place in order to determine if agreements between the entities are agreements between undertakings, on the one hand, and the assessment whether behaviour of the subsidiary is attributable to the parent, on the other hand. Assessments in other jurisdictions are regarded as persuasive, but not as binding.<sup>152</sup>

In Singapore all public hospitals are 100% owned by MOHH, the public holding company,<sup>153</sup> which creates a rebuttable assumption of control. Equally the CEOs and board members of the hospitals are appointed by MoH and accountable to MOHH which supports the assumption. That leaves the question in how far directions are followed or economic independence is asserted. The hospitals have to follow government policy guidance (e.g. on services provided and levels of care) and cannot simply ignore directives from MOHH. MOHH implements joint human resources, IT and procurement strategies, the hospitals are subsidised by the government and the government has the power to reorganise them (as it did with the clusters when it felt that competition between them had led to negative results). Ramesh also points to

*the unusual nature of its [the government's] ownership relationship [...] [which] provides the government with an instrument for receiving market feedback and controlling hospital's behaviour. As an owner, the government can shape hospital's behaviour without having to resort to onerous regulations or purchase negotiations that would be necessary if they were truly private firms. For instance, this has been particularly useful for controlling user charges, physicians' remunerations, and the number of hospital beds in different ward classes.*<sup>154</sup>

The government asserts the mentioned control through MOHH and the clusters. These are thus all arguments speaking against economic independence of the hospitals.

On the other hand, competition is encouraged to an extent and the hospitals are free in the day to day running of their affairs (including pricing) and the hospitals have some autonomy to start own initiatives if they fund these themselves. In *Akzo*<sup>155</sup> the European Commission essentially decided that the fact that the subsidiary can conduct day-to-day market transactions independently is not enough to rebut the assumption which was upheld by the Courts. If this was considered as guidance, this may point to a SEU. Yet, it is difficult to determine this for certain, as it is not entirely clear what exactly is decided by the hospitals, what is instructed by MOHH and what is regulated by the government, since there is no legislative act or much official documentation or detailed literature on the internal decision making structures available in the public domain.

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<sup>152</sup> Lim and Ng (n 122) p. 39 seq with reference to Decision CCS 400/003/06 *Qantas/Orangestar*.

<sup>153</sup> On MOHH and its relationship to the hospitals see above section 2 (in particular section 2.1. and 2.2.1.).

<sup>154</sup> Ramesh (n 4) p 76.

<sup>155</sup> T-112/05 *Akzo* and, on appeal, C-97/08 P *Akzo*.

If we were to assume that the hospitals and MOHH are not an SEU, the question whether the clusters (National Healthcare Group, SingHealth, Alexandra Health System, Jurong Health Services, National University Health System and Eastern Health Alliance) are SEUs remains. A regional hospital is supposed to oversee the clusters and they have specifically been created to (re-)limit competition, as the clusters were supposed to compete with each other while competition between the entities within the clusters was supposed to be limited. There would in so far appear to be a large amount of steering that might be a sign of limited economic independence of each hospital from the cluster. However, the cluster itself does not own the entities within it or appoint the board members or CEOs. Instead it seems rather like an intermediate level between MOHH/MoH (who appoint the cluster's boards and to whom the boards report) and the providers through which steering is conducted. Thus if anything, the existence of these intermediate levels of control/steering might point to the existence of a SEU among MOHH and the hospitals. Yet, as mentioned above, the question cannot be answered with definitive certainty, in particular, as CCS makes assessments depending on the facts of the individual case and it is thus difficult to provide an answer in general. Suffice to say, that there are certainly a number of indicators which do point to the hospitals and MOHH being an SEU.

## 5. Exemptions

In addition to the question if and in how far public services fall under the notion of undertaking, a discussion of the exemptions is relevant to define the scope of competition law in this area. For this, it is necessary to consider the general exemptions in the CA itself as well as the exemptions in the Third and Fourth Schedule.<sup>156</sup> Some exemptions (in particular for government activity, certain sectors/activities, services of general economic interest and public policy) have been criticised as unfair and/or too broad when the law was first debated.<sup>157</sup> Yet, they were deemed necessary by the government because there may be 'times when the goals of public policy may need to trump the market and that is why this Competition Act should not be an overarching blunderbuss law that acts to fetter all other exercises of Government or statutory bodies'.<sup>158</sup> Additionally, certain sectors had only just begun to be liberalised and they required specific knowledge and would therefore be better regulated by a sector regulator.<sup>159</sup> In the debate it was deliberated to liberalise some currently excluded sectors eventually,<sup>160</sup> though this has not happened yet.

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<sup>156</sup> According to s 2(2) CA parts of an agreement exempted from s 34 CA can still be considered with the rest of an agreement to decide whether the agreement as whole infringes the competition act. The Minister can extend the Schedules according to s 92 CA.

<sup>157</sup> Parliament of Singapore (n 135) p. 5 seq, 9 seq, 14 seq, 18 seq, 23 seq. See also Burton J, 'Singapore competition law criticised as biased' Financial Times (21 October 2004) <<http://www.ft.com/cms/s/0/253de8d6-2358-11d9-ae55-00000e2511c8.html#axzz3xfb993jn>> accessed 25 August 2015, Ong (n 123) p. 277 seq.

<sup>158</sup> Parliament of Singapore (n 135) p. 41.

<sup>159</sup> Parliament of Singapore (n 135) p. 4. See also Ong (n 123) p. 277 seq.

<sup>160</sup> Parliament of Singapore (n 135) p. 4, 37.

### 5.1. Government activity

S 33 (4) CA exempts from competition law ‘the Government; any statutory body; or any person acting on behalf of the Government or that statutory body, as the case may be, in relation to that activity, agreement or conduct’ unless explicitly prescribed otherwise by order by the Minister published in the Gazette (s 33 (5) CA). Generally, this provision aims to distinguish market behaviour by public bodies from governmental functions.<sup>161</sup> Yet, the extent of the exception is still somewhat unclear.

The exception has been discussed in the *SISTIC* decision.<sup>162</sup> Here CCS had investigated SISTIC, a dominant public ticketing services provider for abuse of dominance by requiring their trade partners to enter into exclusivity agreements. CCS established for SISTIC and one of the other parties, The Esplanade Co. Ltd, that they were not ‘part of the Government or a statutory body’ themselves, that the agreement was ‘commercial in nature’ and that there had been no indication that either of the parties ‘was acting on behalf of the Government or a statutory body in relation to the activity(s), agreement(s) or conduct(s)’. It therefore did not apply the s 33 (4) CA exclusion despite the bodies having close ties through ownership to the government/statutory bodies. With respect to the Singapore Indoor Stadium, CCS established that it is ‘part of a statutory body within the meaning of section 33(4)(b)’. Yet it had not been the statutory body who had abused its dominance, but SISTIC. In CCS’ opinion ‘the relevant question is whether the obligations are imposed by a statutory body as opposed to whether the obligation is imposed upon a statutory body’. In the latter case the s 33 (4) CA exclusion would not apply. This clearly indicates CCS’ approach to interpret the exemption narrowly and this was neither disputed by SISTIC or became otherwise contentious before the CAB.

Healey even goes further and suggests that the exclusion might only apply to ‘activities of the Government as a Government’ and that ‘Government bodies carrying on business will be caught as undertakings’.<sup>163</sup> This seems a similar interpretation to the sovereignty exception in EU competition law which excludes activities to fulfil the state’s prerogatives by conducting acts of official authority. Yet, the wording of the provision and the reading of the exclusion by CCS in *SISTIC* might contravene this interpretation to an extent. It seems hard, even with a narrow interpretation, to get around the explicit wording of s 33 (4) CA and in *SISTIC* CCS equally seemed only be able not to apply the exclusion since it was not the statutory body who was acting but was the victim of the abuse. If the government or a statutory body was acting it would seem that the clear wording of the CA would lead to an automatic exclusion. Yet, this will have to be seen in future decisional practice.

However, this is different when assessing ‘a person acting on behalf of the government or that statutory body’. Here the distinction between acts of official authority/acts as government seems useful to determine if the entity in question is indeed acting for or on behalf of the government. In

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<sup>161</sup> Major Provision Guidelines p. 3 n 1. See further Ong (n 123) p. 276, Lim and Ng (n 122) p. 29.

<sup>162</sup> Decision CCS 600/008/07 *SISTIC* para 4.2.1. seq.

<sup>163</sup> Healey D, ‘Application of Competition Laws to Government in Asia: The Singapore Story’ (2011) 25 ASLI Working Paper Series 1 p. 13.

any case there needs to be a 'relationship of agencies' or something akin for an entity to be regarded as acting on behalf of the government or the statutory body.<sup>164</sup>

For our purposes, the question would arise in how far this can be applied to the healthcare sector. All acts by MoH would likely be excluded through this provision. MOHH and the hospitals are government owned companies. They are thus neither part of the government nor a statutory body instead they could only be 'acting on behalf of the government'. As they are not per se conducting acts of official authority/acts of a governmental nature, it seems that this exclusion would not automatically take them out of competition law entirely. However, this would be different if they received a clear instruction/order (as opposed to general guidance/policy announcements) from the government to act in a certain way, as then the conduct could be attributed directly to the government. We can thus assume that there may be cases where they receive direct instructions and thus do fall under s 33 (4) CA for particular activities. This has to be decided on a case by case basis. In particular, the more detailed instructions on how to organise and what to provide in the B2 and C wards may be partly regarded as such.

## 5.2. Sector Regulators

S 33 (2) CA provides that if another regulatory authority is responsible for regulating and controlling a sector neither that authority nor CCS prevails. The Minister could make regulations in this regard (s 33 (3)), but this option has not yet been made use of.<sup>165</sup> Therefore, the relevant regulator and CCS would need to find a way in which to address such circumstances,<sup>166</sup> unless that regulator has specific responsibility on competition matters referred to it by law as we will see below (section 5.3.6). CCS can, according to s 87 (1) CA enter into agreements with other authorities to ease cooperation. For our case this would mean that MoH or regulators under it and CCS are simultaneously responsible if competition matters should arise, since the regulators in the healthcare sector do not have specific competition responsibility.

## 5.3. Third Schedule

According to s 35 and 48 CA the Third Schedule is applicable to s 34 and 47 CA respectively. It provides a variety of exemptions on which there is very little guidance in literature and which will be discussed in the following.

### 5.3.1. Services of general economic interest

The Third Schedule provides in para 1 that neither

*the section 34 prohibition nor the section 47 prohibition shall apply to any undertaking entrusted with the operation of services of general economic interest or having the character of a revenue producing monopoly in so far as the prohibition would obstruct the performance, in law or in fact, of the particular tasks assigned to that undertaking.*

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<sup>164</sup> Guideline on Fees para 31.

<sup>165</sup> Whish R, 'Anti-competitive Agreements' in Bull C and Lim CK (eds), *Competition Law and Policy in Singapore* (Academy Publishing 2015) p. 119.

<sup>166</sup> Healey (n 163) p. 13 seq.

In the Guidelines on s 34/s 47 (Annex D in each Guidelines) CCS states that it intends to apply the services of general economic interest (SGEI) exemption very narrowly (para 11.1 and 12.1 respectively). Firstly, there needs to be a service of general interest which is deemed to have to be 'provided in all cases whether or not there is sufficient economic incentive for the private sector to do so' (para 11.4/12.4). Such services should be widely available and not restricted to certain groups. The concept of SGEIs is clearly based on EU law (Article 106 (2) TFEU) where services such as utilities, telecommunications and transport services<sup>167</sup> as well as health insurance, pension schemes or environmental protection services (if considered economic activities in the first place)<sup>168</sup> have been recognised as SGEIs. According to the case law of the CJEU, to qualify as being of general interest the service must entail some kind of a public duty and cater for general rather than particular interests. It also must be of a uniform and binding nature, although these latter two criteria are not interpreted strictly (e.g. it is not required that the provider receives instructions laying out all details of the service).<sup>169</sup>

Secondly, CCS' Guidelines state that there needs to be an entrustment act by a public authority.<sup>170</sup> Such an act will only apply to the SGEI entrusted to the undertaking and not to the undertaking in general (Guidelines on s 34/s 47, Annex D para 11.2 seq/12.2 seq). This shows, that CCS, as is the case in EU law,<sup>171</sup> intends to apply a functional approach similar to the one applied to the question if an entity is an undertaking in the first place in that only certain activities will be exempted as SGEIs. Thirdly, the application of competition law would clearly have to obstruct the performance of the SGEI. According to para 11.6/12.6 of the Guidelines, CCS intends to apply a strict proportionality test with a focus on necessity.<sup>172</sup> The threshold would, however, be economically unacceptable conditions according to para 11.7/12.7 (even if the example given goes to economic viability).<sup>173</sup>

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<sup>167</sup> Communication 'Services of general interest in Europe' OJ [2001] C 17/04 Annex II.

<sup>168</sup> See, for example, case T-289/03 *BUPA*.

<sup>169</sup> T-289/03 *BUPA* para 172 seq, para 186 seq.

<sup>170</sup> In EU law it has been made clear that the entrustment act should include a description of the SGEI. Commission Decision 2012/21/EU on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest OJ [2012] L 7/3 Article 4.

<sup>171</sup> See, for example, 18/88 *RTT* para 22.

<sup>172</sup> The CJEU has conducted a strict test focussing on necessity, as advocated by CCS, in some cases (e.g. C-203/96 *Dusseldorp* para 67). However, in others no explicit proportionality test was conducted or the test evolved around overall proportionality rather than strict necessity (e.g. C-475/99 *Ambulanz Glöckner* para 62 seq). See further Neergaard (n 3), p 190 seq, Prosser (n 3), p 325, Sauter W, 'Services of general economic interest and universal service in EU law' (2008) 33 *European Law Review* 167, p 186, Sauter (n 2), p. 27, 227.

<sup>173</sup> The CJEU had initially regarded an SGEI to be obstructed if the viability of the undertaking had been threatened (e.g. 155/77 *Sacchi* para 15 and C-41/90 *Höfner* para 24). Later, however, it was deemed sufficient if the undertaking would have not been able to conduct the SGEI under 'economically acceptable conditions' (e.g. C-475/99 *Ambulanz Glöckner* para 57).

The provision of affordable healthcare in public institutions providing a wide range of treatments and the benchmarking function of the A wards could potentially qualify as a service in the general interest. The A and B1 wards are mainly frequented by middle income patients while high income patients choose the private sector and low income patients the subsidised wards. Prices between A wards and private sector providers for many procedures are significantly different<sup>174</sup> which may indicate that there is (currently at least) little incentive for the private sector to cater for middle income patients and, arguably, without the benchmarking function, prices in the private sector could be even higher. Further, the history of the healthcare sector has shown that before the state stepped in to provide universal healthcare large groups of society in Singapore did not have access to affordable healthcare.<sup>175</sup> The services are also widely available, since every Singaporean and PR can access the subsidised wards and everybody the A wards. It could thus be argued that in-patient hospital services in A and B1 wards would fulfil the first condition of para 1 of the Third Schedule, namely that they qualify as a service of general interest.<sup>176</sup> If the services provided in the subsidised wards would, in contrast to what has been argued above,<sup>177</sup> be regarded as economic activities and the public hospitals thus as undertakings for those parts of their activities, it would seem even more likely that they would qualify as a service in the general interest.

As regards the second condition (i.e. that the service has to be entrusted to the undertaking in an entrustment act), the government has assigned care for lower and middle income patients to the public hospitals and indeed lays down specific rules, for example regarding number of beds in each ward and the services that can be expected as part of the basic package, which seems could constitute an entrustment act. It may depend here on how exactly the hospitals receive these instructions. There is no legislation on the matter, though it seems likely that this happens through internal regulation / orders. The more clearly the government has instructed the hospitals to conduct a certain service in a certain way, the more likely it is that it can qualify as an entrustment act. When it comes to the third condition, namely whether the application of competition law obstructs the performance of the SGEI in a disproportionate way, this would have to be evaluated

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<sup>174</sup> See section 2.1. above, especially text before n 49.

<sup>175</sup> See section 2. above, especially text

<sup>176</sup> In this regard it should be noted that the EU courts have been somewhat more lenient when it came to areas of more social services such as health and education (which are also a primary responsibility of the Member States) than in areas such as the utilities (e.g. T-289/03 *BUPA*). It remains to be seen how CCS would approach this. See further on this in EU law (as regards and beyond the SGEI exemption) Hatzopoulos V, 'Services of General Interest in Healthcare: An Exercise in Deconstruction?' in Neergaard U, Nielsen R and Roseberry L (eds), *Integrating Welfare Functions into EU Law - From Rome to Lisbon* (DJØF Forlag 2009), p 236 seq, Sauter (n 2), p 142 seq, Gideon A and Sanchez-Graells A, 'When are universities bound by EU public procurement rules as buyers and providers? - English universities as a case study' (2016) *Ius Publicum* 1, p 42 seq, 53. Szyszczak suggested that healthcare in particular seems to be emerging as a unique area under EU economic law where the European institutions are more willing to protect national schemes (see Szyszczak E, 'Services of General Economic Interest and State Measures Affecting Competition' (2015) 6 *Journal of European Competition Law & Practice* 681, Szyszczak E, 'Services of General Economic Interest and State Measures Affecting Competition' (2016 (forthcoming)) 7 *Journal of European Competition Law & Practice*).

<sup>177</sup> See section 4.1. above.

individually for each potential infringement of the CA. Since CCS is planning to apply the exemption narrowly and bases the strict proportionality test on necessity, it can be assumed that potential infringements will only be exempted in some cases.

### 5.3.2. Legal requirements

Behaviour that is required by law is exempted from the s 34 and s 47 CA prohibition according to para 2 of the Third Schedule. The fact that the Third Schedule exempts any behaviour resulting from a legal requirement, shows a significant difference to EU law where also behaviour resulting from government regulation can be reviewed.<sup>178</sup> However, CCS works informally with other bodies to raise awareness, assists in drafting policy that avoids anti-competitive effects and generally advises the government on competition issues (s 6 (1)(f) CA).<sup>179</sup> The exemption for legal requirements clearly takes out of the scope of the competition Act any behaviour by hospitals that is required by law. It would have to be checked on a case by case basis whether this is applicable. However, as the majority of the hospitals practises do not seem to be based on legislation, but rather internal instruction / decision making processes, this exemption seem less likely to be applicable.

### 5.3.3. Public policy

S 34 and 47 CA also do not apply to behaviour which is necessary due to an exceptional and compelling reasons of public policy and subject of an order by the Minister (para 4 Third Schedule). There is no authority as to what exactly would qualify as an 'exceptional and compelling reason',<sup>180</sup> or indeed if public policy is to be regarded as referring only to public security and order or also to more social reasons. In theory it is conceivable that this provision could be used by the Minister to exempt any potential issues in the healthcare sector from the application of competition law.

### 5.3.4. Vertical agreements<sup>181</sup>

According to para 8 of the Third schedule s 34 CA does not apply to vertical agreements relating to purchase, sale or resale conditions of goods and services unless the primary objective of the agreement is related to intellectual property rights (para 4.8. Major Provisions Guidelines). Further, a disguised horizontal agreement will fall under s 34 (e.g. price-fixing by retailers disguised through fixed resale prices from the manufacturer).<sup>182</sup> The Minister can issue an order declaring the CA applicable to vertical agreements if deemed necessary (para 8 of the Third Schedule, para 2.12 of the s 34 Guidelines). However, this has not happened yet. The exemption does not cover s 47 CA. Therefore dominant undertakings imposing agreements on non-competitor undertakings cannot

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<sup>178</sup> 13/77 *INNO v ATAB* para. 30 seq, 18/88 *RTT* paragraph 23 seq, C-49/07 *MOTOE* paragraph 50.

<sup>179</sup> Healey (n 163) p. 13 seq, Chia and Seng (n 125) p. 82, Lim and Ng (n 122) p. 26. For more details see the CCS, Government and Competition - A Toolkit for Government Agencies (CCS, 2016).

<sup>180</sup> Healey (n 163) p. 16. See also the concern raised in this respect by Mr. Sin Boon Ann in the parliamentary debate (Parliament of Singapore (n 135) p. 31).

<sup>181</sup> Unless otherwise specified the term 'agreement' is used here as an umbrella term also including concerted practices and decisions of associations of undertakings (on these different forms see below section 7).

<sup>182</sup> Yet, as Whish points out, a genuine vertical agreement between two undertakings that might normally be competitors (e.g. two wholesalers) would be captured (Whish (n 165) p. 126).



benefit from this exemption if such conduct would amount to an abuse of their position.<sup>183</sup> Obviously, this exemption applies to hospitals in cases of potential vertical agreements.

#### 5.3.5. Net economic benefits

Anti-competitive agreements which provide for net economic benefits (NEB) are exempted according to para 9 Third Schedule. Again, this only applies to the s 34 CA prohibition and not to the s 47 CA prohibition. In order to benefit from this exemption the agreement must have efficiency gains which outweigh the negative effects on competition,<sup>184</sup> must be necessary and must not eliminate competition.<sup>185</sup> The hardcore restrictions price-fixing, bid-rigging, market sharing and output limitation are unlikely to be able to benefit from the NEB exemption. According to para 4.9 of the Major Provision Guidelines, undertakings have to determine themselves if they fall under this provision. If so the agreement is exempted by s 35 CA without any individual exemption needing to be sought from CCS. If CCS disagrees and starts to investigate the agreement, the burden of proof for showing that the exemption applies is on the undertaking. The applicability of this exemption would thus depend on the individual agreements. It would not appear, that it can per se take hospitals out of the ambit of competition law, though individual practices may benefit from this exemption.

#### 5.3.6. Other Third Schedule exemptions

The Third Schedule also provides exemptions for behaviour that is:

- required by international obligations of Singapore and subject of an order by the Minister (para 3)
- in the ambit of another authority with its own legal provisions relating to competition (para 5)<sup>186</sup>
- related to a 'specified activity'; namely postal services, piped portable and wastewater services, schedules bus services, rail services under the Rapid Transport Systems Act and shipping cargo terminal services (para 6)<sup>187</sup>

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<sup>183</sup> On the exemption for vertical agreements see Ong (n 123) p. 276, ASEAN (n 125) p. 65, Chia and Seng (n 125) p. 72, Shiau (n 125) p. 596 seq, 604.

<sup>184</sup> Interestingly, unlike in EU competition law, there is no notion of the consumer receiving a fair share since the Singaporean competition law focus on total rather consumer welfare. See also Bull C, Lim CK and Ng EK, 'Competition Policy and Law' in Lim CK and Bull C (eds), *Competition Law and Policy in Singapore* (Academy Publishing 2015) p. 20 seq and, with reference to the Qantas/Orangestar Decision (CCS 400/003/06), Ong B, 'Competition Law Takes of in Singapore: An Analysis of Two Recent Decisions' (2007) 3 *Competition Policy International* 101 p. 129.

<sup>185</sup> For an example of the application of this exemption see ICF SH&E, *Market Study on the Airline Industry* (CCS Market Studies, 2014) <<https://www.ccs.gov.sg/~media/custom/ccs/files/media%20and%20publications/publications/market%20studies/2014-02-11%20icf%20sh-e%20ccs%20airline%20study%20summary%20report.ashx>> accessed 31 August 2015.

<sup>186</sup> See also section 3. and 5.2. above. See further on the background to this exemption MTI (n 130) p. 1 seq. CCS might work, together with the regulators, on case where cross-sectoral issues are concerned (see Bull, Lim and Ng (n 184) p. 24).

- related to the Automated Clearing House established under the Banking (Clearing House) Regulations (para 7)<sup>188</sup>
- related to a merger (para 10 and 11).

Since none of these exemptions appear particularly relevant to the healthcare sector they will not be discussed further.

#### 5.4. Fourth schedule

According to s 55 CA the fourth schedule is applicable to the section 54 CA prohibition. It provides exemptions for mergers which:

- have been approved by a Minister or regulatory authority<sup>189</sup> or the Monetary Authority Singapore on the basis of a legal requirement (para 1 a and b)
- fall under the auspices of another regulatory authority with competences in competition matters (para 1 c)
- are related to the specified activities named in the Third Schedule (para 2)<sup>190</sup>
- have NEB (para 3).

If hospitals were to merge and this had been approved by the Minister on the basis of a legal requirement, they would obviously benefit from the first of these exemptions. Further, if such a merger had NEB it could fall outside the scope of the CA according to the latter of the above named exemption. Aside from this, these exemptions seem to have little general bearing on the healthcare sector.

## 6. Market definition

For certain aspects of the prohibitions discussed below, it is necessary to know the market share of an undertaking. To determine this requires to define the relevant market. CCS is using a hypothetical monopolist test for market definition (para 2.2 seq Market Definition Guidelines). This tests asks which products would be considered substitutes if a hypothetical monopolist would raise prices by 10%. CCS considers the product market (demand and supply side substitution, indirect substitution in downstream markets), the geographical market (demand and supply side substitution and imports) and the temporal market (off-peak services v peak time services, seasonal products or services, innovation). Generally, CCS considers previous analyses in other jurisdiction (e.g. EU, US) as well as own previous analysis, but it does not regard itself bound to do so. Instead, CCS may conduct market

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<sup>187</sup> See further on the background to these exemptions MTI (n 130) p. 3 seq.

<sup>188</sup> See further on the background to this exemption MTI (n 130) p. 6.

<sup>189</sup> See further on the background to this exemption MTI (n 130) p. 6 seq.

<sup>190</sup> See further on the background to this exemption MTI (n 130) p. 6 seq.

definition anew for a particular case to address the current market conditions and the facts of a case appropriately.<sup>191</sup>

In its *Guidelines on Fees* Decision CCS considered primary and hospital care to be in separate markets.<sup>192</sup> It then determined that (were they to be regarded as economic services in the first place, which CCS did not go into) subsidised hospital care is not in the same market as private hospital care. CCS based this finding on the differences in the service levels, the perceptions from the demand side that the services are not substitutes and the impossibility for hospitals due to capacity constraints to switch between the different ward categories from a supply side perspective.<sup>193</sup> It could also be added from the demand side perspective that for a significant number of patients (i.e. everyone who is not Singaporean and PR), there is an insurmountable barrier to switch to subsidised wards as they are not eligible. To remain on the side of caution CCS had included unsubsidised public hospital care in the same market as private hospital care.

However, in specific cases the market may need to be defined in more detail. If we were to consider subsidised medical care as economic services, which, as is outlined above (section 4.1.), the C and B2 ward services are arguably not, it would need to be evaluated if the different ward categories were in the same market. In that case, it might be conceivable that at least the B1 wards with a significantly lower subsidy level and different service levels are not in the same category as C and B2 wards. It might be conceivable, instead, that for middle income patients B1 and A wards can be considered as substitutes. The usually much more expensive and more luxurious private sector services, on the other hand, may form their own market. Of course, if prices changed significantly in the private sector or in the A wards, the A ward service could at least face potential competition from the private sector and they are indeed supposed to serve as competitors and a benchmark for the private sector. However, as the market currently appears with prices for many procedures twice as high or even higher in the private sector, it appears unlikely that a 10% increase in the prices for A ward service would induce many people to switch. Yet, in this market there may be competition from providers in neighbouring countries (e.g. Thailand and Malaysia) where prices are generally lower and considering that Medisave now also includes Malaysian partners. The market may just have to be defined including foreign providers.

Further, it could be asked if hospital in-patient care could really be regarded as one market. At least from a demand side perspective procedures are clearly not interchangeable, but depend on the medical needs of the patient. Even from a supply side perspective, certain procedures might require certain specialists and specific equipment. Such considerations could limit the market significantly to just one specific procedure. However, this would depend on the specifics of the case. In *Guideline on Fees*, for example, the guidelines had contained prices for a variety of procedures. It thus made sense to define the market more broadly. If, on the other hand, a case would relate, for example, to

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<sup>191</sup> Market Definition Guideline, Chia and Seng (125) p. 79, Shiau (n 125) p. 580 seq, Lim and Ng (n 122) p. 44 seq, McEwin and Anandarajah (n 125) para 402 seq.

<sup>192</sup> *Guideline on Fees* para 42.

<sup>193</sup> *Ibid* para 46 seq.

the abuse of a dominant position in the market for certain cardiology services which require specialists and special equipment, it might be necessary to define the market much more specifically.

Similarly, as regards the geographical market, it might depend on the specific service and who the majority of patients for this service are. A particular private sector health service mainly consumed by medical tourists, might, for example, have to be defined across borders including providers in neighbouring countries or even worldwide. Finally, the temporal market might in some cases have to be considered and require a definition limited to certain emergency or otherwise time sensitive services.

## 7. The s 34 CA prohibition

S 34 CA prohibits collusion in the form of agreements, concerted practices and decision by associations of undertakings which have as their object or effect the appreciable<sup>194</sup> prevention, restriction or distortion of competition in Singapore. The examples of anti-competitive behaviour in s 34 (2) CA (price fixing, limiting outputs, market sharing, discrimination of trading parties and forcing additional unrelated conditions upon other trading parties) are not exhaustive. However, some of these are considered hardcore restrictions (price fixing, bid-rigging, market sharing and output limitation) which are always deemed appreciable according to para 3.2 of the s 34 Guidelines. Any infringement of s 34 (1) CA is, according to s 34 (3) CA, void. Anti-competitive agreements that have ended can still be sanctioned as long as they have been in force after the entry into force of the s 34 CA prohibition (i.e. after 1 January 2006).<sup>195</sup>

The Minister can release a Block Exemption Order (BEO), on recommendation by CCS (s 36 (1) CA), for certain types of agreements if they have an efficiency gain, are necessary to achieve that gain and do not eliminate competition. They may contain conditions (s 41 CA). Currently, there is only a BEO for liner shipping in place which has recently been extended till 2020.<sup>196</sup> Other exemptions are named in the Third Schedule (see subsection 5.3 above).

### 7.1. Application to public hospitals

S 34 CA will apply to hospitals, firstly, if and in in so far as they conduct an economic activity (section 4.1.) and, secondly, if they are either seen as individual undertakings (i.e. not as an SEU; section 4.2. above) which enter into agreements with each other or if they enter into agreements with other undertakings. If the hospitals are to be regarded as SEU the issues discussed in the following may partly either not be relevant or may have to be addressed under s 47 CA instead.

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<sup>194</sup> CCS considers it unlikely that competition is appreciably affected if the combined market share of the undertakings party to the collusion is below 20% for competitors and the individual market share of each party below 25% for non-competitors. If the nature of the collusion is difficult to determine the lower threshold applies. CCS also provides that a collusion of SME is unlikely to ever effect competition appreciably. See s 34 Guidelines para 2.19.

<sup>195</sup> On the s 34 prohibition see McEwin and Anandarajah (n 125) para 553, ASEAN (n 125) p. 53, Chia and Seng (n 125) p. 71, Lim and Ng (n 122) p. 29 seq, 37, 59 seq.

<sup>196</sup> Competition (Block Exemption for Liner Shipping Agreements) (Amendment) Order 2015.

## 7.2. Pricing

In its *Guidelines on Fees* Decision, CCS decided that the issuing of guidelines providing a price range for fees the members of the Singapore Medical Association (SMA) should charge for each procedure would be anti-competitive. Such guidelines had been issued from 1987 till 2007. After the implementation of competition law in Singapore, the guidelines had been notified<sup>197</sup> to CCS but voluntarily withdrawn before CCS issued its decision.<sup>198</sup>

Since then, there have been no indicators on pricing, except for ethical guidelines, or any known cases of price fixing.<sup>199</sup> However, as discussed in section 2.1., MoH has been publishing total bill sizes since 2003 based on actual bills for various conditions. Since 2014 they are also making total operation fees available which since 2016 includes private providers. Clinics are obliged to publish current prices. These moves have been welcomed and are not regarded as anti-competitive by CCS.<sup>200</sup> However, as CCS observes in its Petrol Market Study:

*pricing transparency can be a double-edged sword. Transparent prices may be used by competitors as a means of exchanging price information, and such price signals can make it easier for competitors to move into price coordination, which is anti-competitive. If a cartel exists in the market, it is easier for cartel members to monitor one another's compliance, if prices are openly broadcasted. When a seller knows that its competitors are able to observe and respond quickly to any price reductions, the incentive to cut prices in the first instance is weakened, as the ability to gain market share through such a move is short-lived.*<sup>201</sup>

The hospital sector is recognised as being an oligopolistic market.<sup>202</sup> In such a market the information does not need to be shared with competitors directly, but just making it available can lead to others raising prices accordingly which could inhibit competition. It is said so far that prices have decreased since price information has been published. Yet, the information on prices on MoH's

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<sup>197</sup> Undertakings may, if they are unsure about their conduct, apply to CCS to receive guidance (s 43 and s 50 CA for agreements and unilateral conduct respectively) or a decision (s 44 and 51 CA respectively) against a filing fee. Undertakings party to an agreement are immune to punishment from notifying until the date set in the reply by CCS (s 43 (4) CA). On notifications see ASEAN (n 125) p. 54 seq, Chia and Seng (n 125) p. 74, 80 seq, Lim and Ng (n 122) p. 35, Shiau (n 125) p. 583, 598 seq, 618 seq. See for more details the Filing Guidelines and the Competition (Notification) Regulations.

<sup>198</sup> See also on the case Shiau (n 125) p. 603.

<sup>199</sup> However, vastly exorbitant prices are potentially unethical (*Lim Mey Lee Susan v Singapore Medical Council* [2013] SGHC 122).

<sup>200</sup> CCS (n 46).

<sup>201</sup> Fung H, Seah T and Ming Jie N, *An Inquiry Into the Retail Petrol Market Study in Singapore* (CCS Market Studies 2011)  
<<https://www.ccs.gov.sg/~media/custom/ccs/files/media%20and%20publications/publications/market%20studies/inquiry%20into%20retail%20petrol%20market%20in%20singapore%20may%202023.ashx>> accessed 31 August 2015 p. 8 seq.

<sup>202</sup> Ong (n 127) p. 113.

website shows that for many procedures (e.g. child delivery, appendix surgery, lung cancer treatment) the private sector still often charges twice as much or more than one would pay in public A wards indicating that these are not really competing alternatives. If one only compares the prices of private sector providers, one can find that some procedures are only provided by few private sector hospitals and that these have very similar bill sizes.<sup>203</sup> This could be an indication that the price publication could contribute to restricted price competition in an oligopolistic market as the in-patient hospital market. It would therefore be worthwhile for CCS to occasionally monitor the situation in order to ensure that the transparency does not lead to higher prices.

However, price coordination does not always have to be negative. In literature, it has, for example, been suggested that price guidelines could be a solution to the issues of brain drain from the public to the private sector.<sup>204</sup> Similarly, the SMA had made some conceivable arguments in favour of their Guidelines on Fees (e.g. the information asymmetry between patients and healthcare providers).<sup>205</sup> In the case, as held by CCS, the Guidelines on Fees did not actually achieve the stated purposes (e.g. they went into too great technical details making it impossible for patients to estimate overall prices). CCS also questioned the reasonableness of the fees themselves. The Minister had obviously agreed with CCS, since the Minister refused to exempt the guidelines on public policy considerations.<sup>206</sup> However, the arguments for fee guidelines might in general still be regarded as compelling and guidelines actually delivering the claimed benefits could be drafted by MoH (rather than by the private sector institutions) or the Singapore Medical Council, as such guidelines could then benefit from the exemption in s 33 (4) CA. Even if undertakings would create guidelines which actually served the claimed purposes it might potentially be possible to benefit from the NEB exemption, seek an exemption from the Minister or, in the case of public hospitals entrusted with the task of providing affordable care, the SGEI exemption.

### 7.3. Market division

If we were to assume that the public hospitals are not to be regarded as a SEU, the clusters could be problematic from a competition law perspective. The clusters were created in an attempt to (re-)limit competition, since the government had felt that competition between the hospitals had become too fierce. The entities within the clusters were henceforth supposed to compete only with other clusters, but not within the clusters anymore and there is a point about not replicating expensive equipment and joint procurement.<sup>207</sup> The whole object of the clusters is thus to restrict competition between the entities within and, to an extent, even between the clusters since they are vaguely covering different regions and partly different specialties. Whether this amounts to an anti-competitive agreement depends partly on the question in how far such market division is attributable to the hospitals. If it is entirely based on government regulation, it may not be, while, if

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<sup>203</sup> Ministry of Health (n 49).

<sup>204</sup> Phua and Pocok (n 19) p. 119, 128.

<sup>205</sup> The SMA's arguments can be found in *Guideline on Fees* para 97-104.

<sup>206</sup> Whish (n 165) p. 140.

<sup>207</sup> Lim (n 8) p. 126 seq, 129.

the hospitals determine this partly themselves or it is dictated through MOHH rather than MoH (and provided they are individual undertakings rather than an SEU), it may well be.

There is, of course, the possibility that exemptions apply, if this was to be considered as anti-competitive market division. The minister could exempt the clusters for public policy reasons, the clusters could argue that they have efficiency gains or the instruction to form the clusters could be seen as a direct order from the government, even if it leaves the hospitals to determine the details, and the hospitals (and other entities) therefore as acting on behalf of the government under s 33 (4) CA. They could also be exempted as SGEIs, if the application of competition law would obstruct the performance of their public healthcare tasks. After all, in addition to re-limiting competition, the clusters now also fulfil tasks in respect of concerns due to an aging population by facilitating procession through the care levels and promoting a community approach and Ramesh asserts that there have been improvements as regards integration of care.<sup>208</sup> This could be regarded as an SGEI and the instructions by the government to provide healthcare through clusters as an entrustment act. To apply competition law to the market division through the clusters would arguably obstruct them in this endeavour. Depending how strictly CCS would apply the provision, this could thus be a suitable avenue to exempt any potential infringement.

On the other hand, Lim criticised that there is no evidence that the clustering has led to improved competitive conditions to justify the increased overheads.<sup>209</sup> In the UK, the sector regulator Monitor issued guidance about setting aside competition law to provide integrated care and to make allowances for patient interests. Discussing this from a competition law perspective, Sanchez-Graells argues that such guidance can only be reconciled with EU competition law if interpreted restrictively. In particular, there should be close scrutiny of 'the existence of demonstrable and relevant (non-economic) qualitative efficiencies that justify any potential restriction of competition'.<sup>210</sup> Similarly, and in the view of the fact that CCS tends to interpret exemptions narrowly, more evidence of the benefits of the clustering may be required. In addition, the clusters arguably amount to market division which is a hardcore restriction and thus more difficult to justify. It could thus potentially be possible that conflicts with competition law arise if a very strict interpretation was followed and the hospitals and MOHH were not considered an SEU.

#### 7.4. Vertical agreements

Related to the above, the clusters do not only contain competing entities, but also non-competitors such as polyclinics and community hospitals. While in healthcare, one cannot exactly talk about a distribution chain in the sense that a certain product is sold on from a wholesaler to retailer, there is arguably a chain in which the services are provided since it is usually a primary care provider who refers the patient to a hospital or tertiary care provider and any of these providers could refer the patient to a community hospital. In so far one could regard the clusters as vertical agreements since the providers within one cluster are supposed to compete with other clusters, but not within, which

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<sup>208</sup> Ramesh (n 4) p 74.

<sup>209</sup> Lim *ibid* p. 126.

<sup>210</sup> Sanchez-Graells A, 'New Rules for Health Care Procurement in the UK: A Critical Assessment from the Perspective of EU Economic Law' (2015) *Public Procurement Law Review* 16

makes internal referrals more likely to the detriment of the competitors. Similarly, as regards the private sector, healthcare providers are often vertically integrated. In literature this is encouraged. Phua and Pocok, for example, suggest that ‘more could be done by HSP [Health Service Providers] to promote tie-ups with insurance companies’ to promote the Singaporean entities they cooperate with to their clients<sup>211</sup> and How and Fock encourage coordination between providers at different levels.<sup>212</sup> This equally would mean that the undertakings within the collaboration refer patients to each other rather than outside competitors. However, if such collaboration would indeed fall under the definition of a vertical agreement it could benefit from the exemption of para 8 of the Third Schedule.

### 7.5. Limitation of outputs

The supply of public hospital care in A wards is limited since hospitals only have a certain capacity that they can use for A wards. Such a limitation may be regarded as distorting competition since hospitals are not able to provide more A ward services even if they felt the demand was higher. However, this would only conflict with s 34 CA if the limitation of outputs was based on an agreement between the hospitals or between the hospitals and MOHH rather than direct regulation by MoH. Even if there was an agreement, such limitations could be exempted by s 33 (4) CA. As mentioned above, CCS interprets that exemption narrowly and the direction to make such an agreement would have to come clearly from MoH. If the contingents are decided upon within MOHH or the clusters without clear instructions and we are to assume that MOHH and the hospitals are not just an SEU, this exemption might not be applicable. In that case the SGEI exemption could apply since the application of competition law would obstruct the performance of the hospitals in the neighbouring non-economic, social activities of providing subsidised healthcare. Yet, there would also need to be a clear entrustment act for the SGEI exemption to apply.

## 8. The s 47 CA prohibition

Dominant undertakings are, according to s 47, prohibited from abusing their dominance in a market in Singapore irrespective of where they are established. Undertakings can be dominant individually or collectively. Dominance is given if the undertaking has substantial market power in the relevant market. A market share above 60% is considered as an indication of dominance (para 3.8 s 47 Guidelines). However, other factor such as the position of other undertakings in the market and barriers to entry are equally considered and dominance may also exist at lower market shares. S 47 CA applies to exploitative and exclusionary conduct, but the focus is clearly on exclusionary conduct.<sup>213</sup> The list of anti-competitive conduct in s 47 CA (predatory behaviour towards competitors,

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<sup>211</sup> Phua and Pocok (n 19) p. 126.

<sup>212</sup> How and Fock (n 117).

<sup>213</sup> Lim and Ng (n 122) p. 113, Ong (n 127) p. 105. In *SISTIC*, for example, the price raise in itself was not investigated as abuse, but rather seen as an indication for dominance (para 6.2.1. seq). In so far as it pays less attention to exploitative abuses, Singaporean competition law seems to be informed by US (Chicago School) thinking. See also Williams (n 122) especially p. 555 seq. Similar Ong (n 127) p. 108. On the other hand, the range of exclusionary abuses that can be investigated seems broad (e.g. including discriminatory trading conditions and general exclusionary behaviour), while the EU Commission recently adopted a narrower ‘more economic approach’ which places higher demands on exclusionary behaviour that it will investigate (‘Guidance



limiting outputs, discrimination between trading partners, forcing additional, unrelated conditions upon other parties) is not exhaustive.<sup>214</sup> More examples can be found in Annex C and para 4.6 of the s 47 Guidelines. The dominance, the abusive conduct and the effects of such conduct do not all need to be in the same market. CCS will consider whether the conduct might actually be efficient, whether there is a proportionate objective justification and whether there are any proportionate benefits to the conduct when assessing potential abuses (s 47 Guidelines para 4.1 seq). The possibility of a BEO is not foreseen for s 47, but there the exemptions in the Third Schedule mentioned above.<sup>215</sup>

### 8.1. Dominance of the public sector

The first question for all potential conflicts with the s 47 CA prohibition would be if the public sector hospitals held dominance (collectively or individually). This would depend on how the market is defined which in itself would have to be established on a case by case basis and might be wider or smaller (section 6 above). However, with only 26 hospitals of which eight are speciality centres, two are more specialised hospitals (KKH, IMH) and only ten private institutions, the market is rather concentrated. Furthermore, around 80% of hospital care is provided through the public sector. It is thus conceivable that there may be cases where the public sector hospitals (individually or collectively) hold a significant market share.

In additions, questions could be raised about barriers to entry. It is generally said that market entry of new providers including foreign providers is encouraged and facilitated.<sup>216</sup> Yet, at least in the private sector, there is plenty of supply for all kinds of healthcare so that the market is relatively saturated which might discourage new entries. Also, licensing requirements for professionals, number controls and land release policies can serve as a barrier to entry / expansion.<sup>217</sup> On the other hand, in certain cases the market may have to be defined across borders and barriers to entry would then have to be considered in other jurisdictions as well.

It cannot therefore be conclusively said in the abstract, if a public hospital or the public hospitals collectively/as an SEU would be dominant. However, it certainly does not seem implausible that there will be situations where this is the case.

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on the Commission's enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings' (OJ [2009] C 45/02). In *Sistic* (the currently only s 47 case) it became clear that CCS only has to prove an effect or likely effect on the competitive process. On the scope of exclusionary behaviour see also Shiau (n 125) p. 612, Ong (n 127) p. 108.

<sup>214</sup> The first example here is 'predatory behaviour towards competitors' rather than 'directly or indirectly imposing unfair purchase or selling prices or other unfair trading conditions' as in Article 102 TFEU thereby eliminating exploitative abuses from the example. See further Ong (n 123) p. 281 seq. However, since the list of examples is not exhaustive, exploitative behaviour could still technically fall under the provisions. Whish R, 'Abuse of a Dominant Position' in Bull C and Lim CK (eds), *Competition Law and Policy in Singapore* (2 edn, Academy Publishing 2015) p. 172 seq.

<sup>215</sup> On s 47 see McEwin and Anandarajah (n 125) para 801, ASEAN (n 125) p. 55 seq, Chia and Seng (n 125) p. 73, 78, Lim and Ng (n 122) p. 33 seq, 57 seq, 63 seq, Shiau (n 125) p. 604 seq.

<sup>216</sup> Emerging Markets Direct (n 33) p. 4, n 19 (n 19) p. 124.

<sup>217</sup> Emerging Markets Direct (n 33) p. 4, Phua and Pocok (n 19) p. 126, 130.

## 8.2. Pricing

Assuming that the public sector hospitals would have to be regarded dominant, one question that could be raised is if the prices of A and B1 ward beds (if the latter were to be regarded as an economic service in the first place) could be regarded as predatory since they are in general significantly lower than the private sector which has been said to make entry more difficult especially for small and medium sized enterprises.<sup>218</sup> In the s 47 Guidelines (Annex C para 11.3) CCS defines predatory pricing as pricing below costs with an intention to exclude and the feasibility of recouping losses. It is hard to say in how far prices are below costs. The A wards do not benefit from any subsidies, thus one may assume that they price at least at a level to cover direct costs incurred. However, if no full economic costing methodology was used (i.e. overheads are not calculated into the prices), prices could be below average total cost levels. B1 wards receive 20% subsidies and therefore prices are certainly below costs. Yet, since there is no prohibition of state aid, all aid could be regarded as legitimate and could be considered which may lead to a finding of abnormality being excluded at least for the B1 wards. With the A wards, which are supposed to serve a benchmark purpose, one could assume, however, that no aid (through not considering overheads) is intended and pricing below full cost (plus) levels is abnormal.

When it comes to the feasibility of recouping losses, public hospitals, due to public funding, need to be less worried about this and they could raise prices significantly before they even come close to the private sector prices for some treatments. Yet, it is questionable if there is an intention to exclude. Currently, due to the low prices, there is very limited competition for a certain segment of the market (mid-income to higher income Singaporeans and PR). In so far there is no need to exclude any competitors. However, there is also no obvious reason why the public sector would even want to exclude competitors if they were to contest this segment of the market. It rather seems that it simply makes no economic sense for them to do so as the prices are low. With currently only one decision on s 47, it is difficult to say with certainty whether the application of a 'no economic rationale' test (para 11.11 s 47 Guidelines) in itself is enough to constitute abuse in this case.

Even if the low prices for the A (and B1) wards would be considered as abuse of dominance, it seems possible that one of the exemptions applies. If the pricing arises from strict instructions by MoH, which seems unlikely as the hospitals are free in day to day running of their affairs and their prices differ, s 33 (4) CA might be applicable. Otherwise, the provision of affordable healthcare by public institutions could constitute an SGEI and the application of competition law could obstruct the performance thereof. However, this would also require an entrustment act entrusting the A ward services to the hospitals.

Overall, it appears that the B1 ward services are unlikely to be considered as predatory pricing. It may be somewhat more conceivable when it comes to the A ward services, as these are supposed to serve as competitors and benchmark for the private sector, yet the prices are significantly lower. However, the exemptions might still apply. In the private sector itself, there seem to be no obvious examples of predatory pricing. If anything, there might be instances of exploitative pricing.<sup>219</sup>

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<sup>218</sup> Ibid.

<sup>219</sup> *Lim Mey Lee Susan v Singapore Medical Council* [2013] SGHC 122.

However, not only is it difficult to say in the abstract if the undertakings are dominant, more importantly, CCS is not focussing on exploitative abuses and, in particular, does not intent to act as a price regulator which is why such cases would be unlikely to be investigated under s 47 CA.

### 8.3. Vertical coordination

Vertical restraints are not exempted from s 47 CA. If, therefore, in the cases described above (section 7.4) a dominant undertaking or collectively dominant undertakings utilise such vertical arrangements (e.g. enter into collaborations with insurances to promote specific providers) to the detriment of competitors this can amount to the abuse of dominance. Such cases could involve public coordination (clusters or the collaboration between Integrated Shield Plans and certain providers) or private integrated healthcare conglomerates referring patients internally as well as collaboration between not previously integrated undertakings (as suggested by Phua and Pocok). Of course, in a specific case, the question of market definition and whether entities are a SEU would be decisive to determine if there even is dominance in the first place.

Any potentially anti-competitive vertical coordination under s 47 CA in the public sector, might be able to benefit from the s 33 (4) CA or SGEI exemption depending on the individual case. There seem to be no obvious exemptions for private sector conduct, though private sector collaborations might claim that there are proportionate benefits to the conduct when assessing potential abuses (s 47 Guidelines para 4.4 seq).

### 8.4. Limitation of outputs

If a public hospital or the hospitals as an SEU, were to be regarded as dominant, one could raise the question if the limitations on bed numbers and procedures/development<sup>220</sup> could amount to output limitation 'to the prejudice of the consumer'. In the past there had been fiercer competition on the basis of high end purchases, new technologies and highly paid specialists between the public hospitals which was deliberately curbed as it was not considered beneficial. However, there are a variety of points speaking against this constituting limitation of outputs / being likely to be investigated. Firstly, if this is based entirely on regulation and there is no real commercial discretion for the hospitals/MOHH, this would not constitute abuse on the side of hospitals/MOHH.<sup>221</sup> Secondly, CCS is more concerned about exclusionary rather than exploitative abuses, it is thus unlikely that this would be investigated. Further, the reason behind the restriction of competition as regards procedures/development was that prices had increased, there were less beds in the subsidised wards and the system was not regarded as efficient as it could be. Instead the government had identified this as market failure.<sup>222</sup> In so far, even if this were to be regarded as an anti-competitive limitation of outputs, the application of competition law might also obstruct the SGEIs provided in the public hospitals and the exemption could potentially be utilised. Equally, if the instructions came directly from MoH s 33 (4) CA could apply.

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<sup>220</sup> The care provided in public hospitals 'will reflect good up-to-date medical practice, but it will not provide the latest and the best of everything'. See Ministry of Health (n 15) p. 18.

<sup>221</sup> See CJEU case law on this, for example, C-280/08 P *Deutsche Telekom* para 80.

<sup>222</sup> Ministry of Health (n 15) p. 3.

## 9. The s 54 CA prohibition

S 54 CA prohibits concluded or prospective mergers which substantially reduce competition in a market (or a segment thereof) in Singapore. The term merger, according to s 54 (2) CA, comprises acquisitions and lasting joint ventures. The decisive element is the concept of (legal or de facto) control (s 54 (3) CA).<sup>223</sup> The following are not regarded as mergers: undertakings acting as receiver or liquidator, intergroup mergers, inheritance and acquisitions by undertakings dealing in securities which do not get involved in any strategic considerations (s 54 (7) CA). CCS generally does not investigate small mergers with an annual turnover of each of the undertakings of less than S\$5M and a combined annual world turnover below S\$50M (Merger Procedure Guidelines). Whether a merger substantially lessens competition is to be determined on a variety of criteria (competitive constraints for the merged entity, pre- and post-merger competition in the market and other competitive constraints such as barriers to entry). The main focus is on horizontal mergers, though non-horizontal mergers may also be investigated.<sup>224</sup> Generally, according to para 3.6 of the Merger Procedure Guidelines, CCS will most likely not investigate mergers which result in an entity with a market share below 40% in the relevant market(s) unless, in cases of merged entities with a market share of 20-40%, the merger would lead to a market situation in which the three largest entities together have a market share of over 70%.<sup>225</sup> Mergers can be approved subject to commitments and exempted due to public interest considerations<sup>226</sup> by the Minister of Trade and Industry (s 57 (3), 58 (3) and 68 (3) CA). Certain mergers are excluded from the CA under the Fourth Schedule as discussed above (section 5.4).<sup>227</sup>

The public hospitals could only fall under s 54 CA for mergers between public hospitals, if they are individual entities rather than an SEU. Further, they could fall under s 54 CA if the hospitals / MOHH aim to merge with other providers.<sup>228</sup> In both cases, it would depend on the annual turnover

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<sup>223</sup> Ownership of over 50% leads to legal control. 30-50% leads to a presumption of decisive influence which can be rebutted. De facto control is assessed on a case by case basis. Chia and Seng (n 125) p. 78 seq.

<sup>224</sup> Vertical and conglomerate mergers may be investigated in specific circumstance, e.g. when competitors in the downstream market 'lack a reasonable alternative to the vertically integrated firm'. Shiao (n 125) p. 616. See further on non-horizontal mergers CCS' Merger Guidelines p 26 seq.

<sup>225</sup> This is not an absolute rule and CCS has investigated mergers below these quantitative thresholds (Cases CCS400/005/09 – *Glencorel Chemoil* and CCS 400/004/12 *Proposed Acquisition by UPS of TNT*) due to other factors such as barriers to entry.

<sup>226</sup> In his speech at the occasion of the second reading of the CA, Dr Balakrishnan defined this narrowly as 'considerations such as national security, defence and other strategic interests' (see Parliament of Singapore (n 135) p. 3, 35). Indeed an application has been declined because it did not fall under this narrow definition (see Lim CK and Chew C, 'Mergers' in Bull C and Lim CK (eds), *Competition Law and Policy in Singapore* (2 edn, Academy Publishing 2015) p. 205).

<sup>227</sup> On s 54 CA see McEwin and Anandarajah (n 125) para 1052 seq, ASEAN (n 125) p. 56 seq, Chia and Seng (n 125) p. 73, 78 seq, Lim and Ng (n 122) p. 29, 35 seq, 64 seq, Shiao (n 125) p. 579, 615 seq.

<sup>228</sup> In Decision CCS 100/1303/08 *Acquisition of SFI by SATS* SFI belonging to Ambrosia Investment which itself was a wholly owned subsidiary of Temasek was assessed for its own market share and Temasek as a government holding company was not brought into the equation. However, Temasek holds companies in

requirements if these would be investigated and, inter alia, on market definition if these would likely lessen competition. While there have been no cases on hospitals yet, decisions in the healthcare sector more widely seem to indicate that the market may need to be defined more specifically for merger cases than was necessary for the purposes of the *Guidelines on Fees* Decision. Such cases include the Fresenius /Asia Renal Acquisition<sup>229</sup> and the Asia Renal/Orthe Acquisition<sup>230</sup> both on dialysis services/products as well as the Johnson/Synthes Acquisition<sup>231</sup> concerning spine devices, trauma devices and bone graft substitutes. All of these were cleared. The acquisition by Parkway Holdings of Radlink-Asia was abandoned after a provisional CCS Decision indicated that the transaction would infringe s 54 CA. The transaction concerned the markets for radiological pharmaceuticals and imaging services.<sup>232</sup> With more narrow market definition it may become more difficult for entities to merge as certain services are only provided by few entities<sup>233</sup> which may then have a high market share. S 54 CA should therefore be carefully considered by the relevant parties and/or authorities before deciding to conduct any mergers.

## 10. Non-legal issues

In addition to the issues discussed above, there may be certain aspects which do not cause legal tensions, but may be causing constraints in the workings of the healthcare market more generally. In particular, formerly mainly public sectors might display issues as regards competitive neutrality (e.g. by placing public provides in an advantageous position). The idea behind competitive neutrality is that competition works best if there is a level playing field for participants where they can compete freely and uninhibitedly.<sup>234</sup> In the Hilmer Review of competition in Australia, it was found that market participation of public undertakings can distort this level playing field due to, for example, public funding and tax exemptions. The application of, inter alia, competition law was seen as a solution.<sup>235</sup> In the EU, on the other hand, there has been increasing research that points to challenges of the application of economic law<sup>236</sup> including competition law to public service areas.<sup>237</sup>

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various markets and countries and it may be doubtful in how far any conclusions from the SIF/SATS merger can be drawn for the in-patient hospital sector in general terms.

<sup>229</sup> Decision CCS 400/005/10 *Fresenius /Asia Renal*.

<sup>230</sup> Decision CCS 400/008/12 *Asia Renal/Orthe*.

<sup>231</sup> Decision CCS 400/009/11 *Johnson/Synthes*.

<sup>232</sup> Decision CCS 400/010/14 *Parkway Holdings/Radlink-Asia*.

<sup>233</sup> For example, judging from the information on bill sizes for individual procedures in 2015/16, appendix surgery was only provided in six public hospitals and in Raffles Hospital and hip replacement as A ward service only in one public hospital. See Ministry of Health (n 49).

<sup>234</sup> Healey (n 163) p. 1.

<sup>235</sup> Healey (n 163) p. 2 seq with reference to the Hilmer Review. The review has recently been repeated (see Harper I and others, *Competition Policy Review Final Report* (Commonwealth of Australia, 2015)).

In the following it shall be assessed if, even if currently unproblematic from a competition law perspective, changes seem advisable as regards competition in the healthcare sector in Singapore.

One issue raised in the literature as a challenge for the private sector is that of medical tourism. Since Singaporeans mainly utilise public sector services (C and B2 ward for lower income groups and A and B1 for mid to higher income groups), the private sector would benefit from medical tourism, as it is hard for the sector, as mentioned above (section 8.2), to match the low public sector prices. Previously, medical tourism was encouraged through SingaporeMedicine. However, recently policies to promote medical tourism have been curbed and Phua and Pocok encourage that more could be done to assist the private sector in accessing this market such as a dedicated medical tourist visa.<sup>238</sup> On the other (and presumably the reason behind not further encouraging medical tourism), medical tourists may equally realise that quality in public A wards is high and prices compared to the private sector low which could put a strain on the provision of A ward services. Further, to make market entry for private providers easier, it has been suggested to revise land release policies which are deemed as partly restrictive and incoherent and therefore as limiting the chances of the private sector to compete on a level playing field. The same issues has been raised in regards to other restrictions such as doctor number controls and licensing requirements.<sup>239</sup>

Others have more generally criticised the system with the state/public sector in the dual role of competitor and regulator. Claiming that this gives public providers advantages while at the same time they could not meet demand, they suggest that the state should focus on funding rather than provision.<sup>240</sup> Such suggestions would go in the direction of starting an 'any willing provider' scheme like in the UK where public funding could be utilised to access all providers in all sectors equally. However, that would require major changes to the system and probably the establishment of public procurement law. There would probably also need to be more price control as the equilibrium of public finances could be threatened if high private sector prices would have to be paid from the public purse.<sup>241</sup> Further, in such a scenario all providers would likely be hit with the full force of

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<sup>236</sup> The internal market is governed, in addition to competition law, by free movement law (free movement of goods Article 34 TFEU, workers Article 45 TFEU, establishment Article 49 TFEU, services Article 56 TFEU and capital Article 63 TFEU), state aid law (Article 107 TFEU) and public procurement law (Directive 2014/24/EU on public procurement and repealing Directive 2004/18/EC OJ [2014] L 94/65).

<sup>237</sup> See, for example, the contributions in de Burca G and de Witte B, *Social Rights in Europe* (OUP 2005), Neergaard U, Nielsen R and Roseberry L, *Integrating Welfare Functions into EU Law - From Rome to Lisbon* (DJØF 2009), Mossialos E and others, *Health systems governance in Europe: the role of EU law and policy* (CUP 2010), Schiek D, Liebert U and Schneider H, *European Economic and Social Constitutionalism after the Treaty of Lisbon* (CUP 2011), Neergaard U and others, *Social Services of General Interest in Europe* (T.M.C. Asser 2013), Schiek D, *The EU Economic and Social Model in the Global Crisis* (Ashgate 2013).

<sup>238</sup> Phua and Pocok (n 19) p. 125 seq.

<sup>239</sup> Ibid p. 131.

<sup>240</sup> Lim and Lee (n 52) p. 75.

<sup>241</sup> As regards schemes where private providers are paid from the public purse, a story emerged recently about dentists (and potentially other practitioners) making false claim for non-performed procedures, though some of these appear to have been 'Robin Hood' practitioners who submitted the false claims to raise funds to

competition law, as they would be operating on a market without social solidarity elements which may make it more difficult to execute social policies. Finally, studies regarding the effectiveness of introducing choice and competition in healthcare systems to achieve better quality and lower prices have had mixed results<sup>242</sup> and Singapore's own experience has shown that stricter controls were deemed necessary to reduce the negative effects of introducing competition in the healthcare market. Indeed, Ramesh asserted that 'reliance on market competition requires more state intervention than often realized [...] to deliver outcomes that are not only economically efficient [...] but also politically acceptable'.<sup>243</sup> If the system was to be opened more, it would, in any case, be advisable to equip MoH with more sector regulatory functions (including sector specific competition oversight) like in some other sectors such as energy or media to better control competition and regulate the market without having to sacrifice the policies the government wants to follow to the application of economic law if this is not seen as suitable to retain the social character of the services.

## 11. Conclusion

Competition law is still a relatively new area of law in ASEAN countries and the application of competition law to public services has thus far received virtually no attention. This explorative case study had set out to make a first step in filling this gap in the research by exploring the healthcare

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conduct one bigger procedure for certain patients which could not otherwise have been covered. See further Khalik S, 'Health Ministry must do more to deter fraud' *The Straits Times* (4 July 2016) Opinion <<http://www.straitstimes.com/opinion/health-ministry-must-do-more-to-deter-fraud>> accessed 4 October 2016.

<sup>242</sup> While some tendency to prefer providers with a higher quality has been measured after the introduction of choice in England for certain heart surgeries, it has also been stressed that other factors such as distance play a role and that higher quality and lower prices can equally be achieved with regulatory price and quality control (Charlesworth A and Kelly E, *Competition in UK health care* (Institute for Fiscal Studies and Nuffield Trust, 2013) <[http://www.nuffieldtrust.org.uk/sites/files/nuffield/document/131218\\_competition\\_in\\_uk\\_health\\_care.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/document/131218_competition_in_uk_health_care.pdf)>). The King's Fund equally concluded that '[c]ompetition can bring benefits but these benefits can be outweighed by costs and difficulties of competitive process' (The King's Fund, 'The King's Fund's verdict: Is the NHS being privatised?' (2015) <<http://www.kingsfund.org.uk/projects/verdict/nhs-being-privatised>> accessed 26 October 2015). Similarly, the European Commission's Expert panel concluded that '[t]he conditions for competition to be a useful instrument vary across countries, health care subsectors and time. There is no golden rule or unique set of conditions that can be met to ensure that competition will always improve the attainment of health systems goals' (EXPH, *Competition among health care providers in the European Union* (Preliminary Opinion, European Commission, 2015)). Others argue that competition can be most effective only if linked to broader reforms of the market structure rather than just introducing selected market based elements (Dash P and Meredith D, 'When and how provider competition can improve health care delivery' McKinsey & Company - Insights & Publications <[http://www.mckinsey.com/insights/health\\_systems\\_and\\_services/when\\_and\\_how\\_provider\\_competition\\_can\\_improve\\_health\\_care\\_delivery](http://www.mckinsey.com/insights/health_systems_and_services/when_and_how_provider_competition_can_improve_health_care_delivery)> accessed 20 October 2015) or that '[c]hoice on its own has been shown not to be conducive to cost-containment' and that in fact the true drivers behind introducing choice and competition policies are far more diverse than the usually stated one of increasing quality and decreasing prices (Costa-Font J and Zigante V, 'Are Health Care 'Choice - and - Competition' Reforms really Efficiency Driven?' (2012) 26 LSE Working Paper Series).

<sup>243</sup> Ramesh (n 4) p 62.

sector in Singapore from a competition law perspective. It can thereby serve to inform future efforts in ASEAN in competition law integration as well as regarding the promotion of a strong healthcare industry. The competition law analysis has focused on hospital in-patient care and explored the questions 1) in how far the notion of undertaking is applicable to hospital in-patient services, 2) in how far there might be potential infringements of competition law (s 34, 47 and 54 of the Competition Act) and 3) if there would be recommendations beyond the legal analysis.

The analysis has shown that the structure of the hospital care market has oligopolistic tendencies and contains risks of anti-competitive practices. However, there are still many open questions as regards tensions between competition law and the healthcare policies regarding hospitals in Singapore. Firstly, if EU case law would be considered as persuasive guidance it seems likely that at least the hospital treatments received in C and B2 would not be regarded as economic service, but as services based on the principle of solidarity and thus the hospitals would not be undertakings for those parts of their activities. Secondly, the public hospitals could be potentially be regarded as a SEU, since MOHH owns them entirely, appoints the CEO and board members and they receive directions. Thirdly, there are a variety of exemptions, such as the exemption for government activity (s 33 (4) CA) or those found in the Third Schedule (especially for SGEIs) from which the public hospitals might benefit. These preliminary questions determine many of the later questions on potential tensions with competition law. Yet, some initial areas have been investigated.

As regards pricing there seems no coordination at present, but due to the oligopolistic characteristic of the market it might be worthwhile to monitor if transparency can create conflicts with s 34 CA in the future in particular in the private sector. CCS has made clear that guidelines on pricing would be anti-competitive, yet this is often suggested in literature to counter-act doctor poaching and increasing healthcare costs. If such guidelines came directly from MOH, this would be possible since it could rely on the s 33 (4) CA exemption. When it comes to abusive pricing (provided that there is dominance in the relevant market) the low pricing of public A (and B1) wards have been considered under s 47, but without exclusionary intent this might not amount an infringement and there may potentially also be exemptions. Potential exploitative pricing is generally not CCS' concern.

The clusters (unless MOHH and the hospitals are a SEU) could raise concerns, if this was based on coordination between undertakings, as their stated aim is to reduce competition between the entities in the cluster. It is possible, however, that they could benefit from an exemption. The clusters do not only combine hospitals at the same level, but also at different levels of the competitive process (primary, secondary, tertiary and community care). Since competition should be reduced within a cluster, it seems likely that referrals will happen mainly internally to the detriment of competitors to the entities at the different levels which may be regarded as anti-competitive. However, vertical agreements are from s 34 CA under the Third Schedule. If one of the undertakings or the undertakings collectively or as SEU were dominant, it might be possible to raise concerns under s 47 CA. Private sector providers in vertically or horizontally integrated structures could, of course, face the same tensions with competition law. Again, it is possible that some of the exemptions apply to any identified anti-competitive behaviour in particular as regards the public sector.

Limitation of outputs is taking place through a cap on the number of beds as well as through limitations on the services that can be offered in public sector entities. However, this would only be



anti-competitive if it would arise through agreements of independent undertakings or by a dominant undertaking. In the latter case, this might also be of less concern since this would, if at all, amount to an exploitative rather than exclusionary abuse and CCS is focussing on exclusionary unilateral conduct. It seems also likely that the application of competition law would obstruct the task of providing affordable healthcare and subsidised healthcare in the neighbouring non-economic markets and therefore this limitation could be exempted as an SGEI, if it does not already fall under s 33 (4) CA.

There do not seem to be any obvious tensions with s 54 CA. However, experience in the healthcare sector more widely show that market definition has been conducted more narrowly here than in the *Guidelines on Fees* Decision and merging parties should thus consider the provision before merging.

The regulatory regime seems to have led to three segments in the market; the private sector for high income patients and medical tourists, the A and B1 wards for mid to higher income Singaporeans and PR and the C and B2 wards for lower income Singaporeans and PR. Competition in the latter two is limited between the six clusters. Competition in the private sector segment faces certain constraints as barrier to entry due to doctor number control and land release policies. Limited assistance with attracting medical tourists has equally named as an issue. Various suggestions have been made in literature on how to improve competition. Yet, it should be carefully considered if any such changes would negatively impact the hospital care provided as public service by the public hospitals.

Based on this explorative case study, tensions between competition law and in-patient hospitals service provision in public hospitals seems limited. This is, inter alia, the case because Singaporean competition law offers a variety of exemptions which provide the government with more room to implement policies on public service provision. Any potential concerns could also be addressed between CCS and MoH in CCS' advisory/advocacy capacity.

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