

# Summary

## The reference

1. On 4 April 2012, the Office of Fair Trading (OFT) made a market investigation reference to the Competition Commission (CC) under sections 131 and 133 of the Enterprise Act 2002 (the Act) regarding the supply or acquisition of privately funded healthcare services in the UK.
2. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom’. If the CC decides that there is such a feature or combination of features, then there is an adverse effect on competition (AEC).<sup>1</sup>
3. This document sets out our provisional findings in this investigation based on the evidence we have reviewed and the analysis we have carried out to date. We are required to publish our final report by 3 April 2014.

## Market characteristics

4. The main focus of our investigation has been on the interactions between consultants, hospital operators, patients and, where relevant, private medical insurers (PMIs).<sup>2</sup>
5. We identified a number of market characteristics which assisted in developing our theories of harm.

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<sup>1</sup> [Section 134\(2\)](#) of the Act.

<sup>2</sup> Our reference relates to privately funded healthcare services and we examined the conduct of PMIs in those markets. The market(s) for private medical insurance were not referred to us for investigation.

### ***Market structure***

6. At a national level, both private hospital ownership and the provision of private medical insurance are highly concentrated. The five main hospital groups account for approximately 70 per cent of privately funded healthcare revenues in the UK. The four largest PMIs account for approximately 87 per cent of UK insurance premium revenue, with the two largest alone accounting for 65 per cent. On the other hand, the provision of consultant services is highly fragmented. Consultants generally work on a stand-alone basis and sometimes as members of relatively small groups.

### ***Cost structure of the industry***

7. The cost of designing, building and equipping a private hospital able to provide a full range of inpatient, day-case and outpatient facilities is substantial, and a proportion of such costs would be regarded as sunk. Many costs of running a hospital do not vary according to the volumes of admissions or patients. Land, buildings, equipment and labour in particular represent substantial fixed costs to private hospital operators.

### ***Demand and excess capacity***

8. Revenues from privately-funded healthcare services have been largely static since 2005.
9. The five main hospital groups have reported spare capacity in their hospitals. We were told that it is important for private hospitals to maintain an element of planned spare capacity in terms of beds, theatre availability and staff, to deliver quick access to privately-funded healthcare services. However, private hospital operators have benefitted, to varying degrees, from the large increase in NHS expenditure at private hospitals and this has helped their capacity utilization. Utilization of overnight beds in private hospitals has declined as the proportion of inpatient treatment has reduced.

## **The NHSs**

10. The privately-funded healthcare sector is a relatively small part of the wider UK healthcare sector, most of which is funded via each nation's respective public healthcare systems. Each of the NHSs interacts in a number of ways with the privately funded healthcare sector.
11. Publicly funded health services are an alternative to privately funded healthcare. Prospective purchasers of PMI can be expected to take account of the alternative of NHS provision in their purchasing decision. Self-pay patients will also consider NHS provision at time of treatment, as will some insured patients.
12. The NHS in England is an important supplier of privately funded healthcare services. The Health and Social Care Act 2012 removed the private patient income cap on NHS facilities in England and has the potential to allow considerable expansion of NHS private patient units (PPUs) but it is not at all clear how rapid any such expansion would be.
13. In recent years usage of private hospitals by the NHS in England to provide publicly funded services has grown substantially. This is now an important source of revenue for some private hospital operators.

## **Theories of harm**

14. In order to provide focus and structure to the competitive assessment, early on in the investigation we identified seven theories of harm (ToHs):
  - (a) ToH1: a private hospital operator may have market power with respect to patients in a particular geographic area.
  - (b) ToH2: individual consultants or consultant groups in some local areas may have market power over their patients.

(c) ToH3: a private hospital operator may have market power with respect to PMIs in national negotiations.

(d) ToH4: a PMI may have buyer power over individual consultants.

(e) ToH5: there may be barriers to entry into the supply of privately funded healthcare services.

(f) ToH6: there may be information asymmetries and limited information available to patients (as well as GPs and possibly PMIs).

(g) ToH7: there may be vertical linkages that lead to significant harm to competition.

15. We used these ToHs to structure our investigation. We reported on the progress of our investigation under each of these ToHs when we published our annotated issues statement in February.<sup>3</sup> In our discussion of ToH5 (barriers to entry), we also identified the existence of a wide range of schemes offered to consultants by hospital operators. We regarded these as important and examined them in detail.

### **The relevant markets**

16. We defined distinct product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient care. For the purposes of the assessment of competitive constraints we aggregated most of the specialties where we thought it appropriate.

17. In order to identify the set of private hospitals and PPUs to be considered in each individual hospital competitive assessment, we used the hospital's catchment area as a starting point and looked at any overlap with other private hospitals' and PPUs' catchment areas, including hospitals inside and outside the hospital's catchment area.

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<sup>3</sup> Annotated issues statement (AIS), paragraphs 47–159.

18. We considered the area covering the private hospitals and PPUs in central London as a separate geographic market, due to its special demand-side and supply-side characteristics.
19. In our competitive assessment we considered constraints from outside the markets exerted by NHS hospitals, as providers of NHS-funded treatments, and constraints from outside the geographic market, on a case by case basis, where we had evidence that these exert a competitive constraint.

### **Competitive assessment of hospitals**

20. We focused our analysis on private hospitals and PPUs that provide inpatient care. We did this for three reasons. First, providers of inpatient care account for a substantial share of the revenue generated by private patients in the UK. Secondly, concentration is higher in the provision of inpatient care than in the provision of day-patient and outpatient care. Thirdly, barriers to entry and expansion into the provision of inpatient care are higher than those for the provision of day-patient and outpatient care.
21. We noted that, while in general providers of inpatient care compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of day-patient and/or outpatient care, this is unlikely to hold across the full range of day-patient and outpatient treatments. Certain day-patient and outpatient treatments (for example, those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) are likely to be subject to similar competitive conditions to those arising in the provision of inpatient treatments.

### ***Barriers to entry and expansion***

22. We examined barriers to entry in order to determine the extent to which incumbent providers of inpatient care are constrained by the threat of entry or expansion. In addition to considering the evidence and submissions of the parties we conducted three case studies into entry episodes.
  
23. In relation to de novo entry, over the last few years very few new firms have started offering healthcare services by the provision of full service hospitals, the notable exception being the entry of Circle. We have seen examples, but not many, of existing hospital operators opening full service hospitals in new areas. We are aware of a number of examples of entry of day-care facilities over the last few years.
  
24. We found that the necessity of incurring high levels of sunk costs to set up a hospital with inpatient services meant that in a static market any incumbent could be expected to react very aggressively to entry, and that this expected reaction would deter entry. We found that there were significant capital costs of building and equipping a full service hospital, and that there were large economies of scale relative to the size of local markets such that many local markets were only large enough to support a small number of efficiently sized hospitals. We also found that demand for private health services had been fairly static over the last five years and that no significant growth was expected for the foreseeable future. We found that in combination these features constituted the greatest barrier to entry. We found that the barriers relating to sunk costs were present in all areas and that the barrier relating to the economies of scale was likely to be present in many areas also.
  
25. We also found that there were barriers related to site availability and the need for consultant commitment to new facilities.

### ***Local competitive constraints (including concentration)***

26. We assessed local competitive conditions in order to determine whether or not the competitive constraints exerted by hospitals on each other at the local level were too low.
  
27. We identified those hospitals which were unlikely to cause concern and did not require further examination. We then examined the remaining hospitals in more detail, taking into consideration several factors, including: (a) results of different concentration measures; (b) the hospital's own individual characteristics as well as the characteristics of the nearby private hospitals and PPUs, either competitor hospitals or hospitals under the same ownership; (c) characteristics of the local area in which the hospital is situated; (d) internal documentary evidence submitted by the parties; and (e) the views of the parties.
  
28. As a result of the competitive assessments of individual hospitals, we found 101 hospitals outside central London to be a concern. These hospitals allow us to identify local areas where there could be an AEC.
  
29. We found the central London market to be highly concentrated and that the competitive constraints currently exerted on HCA by other private hospital operators and PPUs in central London are weak. We also considered hospitals in the greater London area and the NHS, and found these to be weak constraints on HCA. We formed the view that HCA's position in central London can may also be potentially reinforced by any ability it has to outbid its competitors for future PPU management contracts and to acquire further GP practices.

### ***Bargaining between PMIs and hospital operators***

30. The hospital operators and PMIs put forward very different positions on their relative bargaining strength.
  
31. Several PMIs, including Bupa, the largest, argued that some hospital operators had hospitals to which access was essential for PMIs ('must have' hospitals). As a result, they argued, these hospital operators had market power in negotiations with PMIs. PMIs also argued that because in many cases the decision which hospital to use was made by patients without PMI input they had limited opportunity to influence their use of hospitals, except by 'delisting' them (ie not allowing policyholders to use these hospitals). Bupa told us that hospital operators negotiated in such a way that if a PMI wanted to use a certain number of hospital operator's hospitals, it would be penalized unless it also recognized all of that operator's other hospitals ('one in, all in negotiations').
  
32. The hospital operators argued that they had very few, or no, 'must have' hospitals. They also argued that even if they had such hospitals the buyer power of the PMIs was sufficient that hospital operators could derive no advantage from these. They said that the potential to delist hospitals gave PMIs great power as the effects of delisting on a hospital's finances [X]. They also argued that PMIs could also reduce use of hospitals by use of restricted networks or by 'guided referrals' whereby PMIs were involved in the choice of consultant, and thereby of hospitals. Hospital operators forcefully denied that they engaged in 'one in, all in negotiations'.
  
33. We considered the one major incident of delisting. In 2011, following protracted negotiations in which no agreement was reached, Bupa removed 37 BMI hospitals from its hospital networks. An agreement between Bupa and BMI was later reached and Bupa reinstated most, but not all, of the BMI hospitals in its networks. Hospital

operators argued that this supported their claims whereas Bupa argued that the circumstances were exceptional and that the event demonstrated the difficulty of using successfully the possibility of delisting.

34. It appeared likely to us that both BMI and Bupa suffered substantial direct damage from the 2011 delisting; however delisting does not in our view indicate that all of the BMI hospitals that were delisted were dispensable to Bupa in the medium or long-term or that they had no market power. It is not possible to evaluate what net benefit Bupa derived from the delisting, especially as reputational effects are difficult to ascertain. It is not possible to predict the outcome of future negotiations, or who generally holds the upper hand in negotiations, on the basis of this one delisting event.
35. We concluded that there are a number of factors that are important in the negotiations between hospital operators and PMIs: the number of hospitals, their locations and the competitive conditions in each area. These same factors were also important when PMIs and hospital operators were considering the threat of delisting and restricted networks.

## ***Market outcomes***

### *Pricing*

36. We tested statistically whether prices charged to self-pay patients are higher in areas where private hospitals face fewer competitive constraints, using a technique known as price-concentration analysis (PCA). Our analysis showed that there is a causal relationship between self-pay prices and local concentration. Private hospital operators, on average, currently charge somewhat higher prices in local areas where they face fewer competitive constraints.

37. We analysed the prices charged by hospital operators to PMIs for treatments provided to insured patients. The prices of individual treatments are generally not set at the hospital level, but are the same for each PMI across the hospital operator's portfolio of hospitals.
38. We found that compared with the other four largest hospital operators (ie BMI, Spire, Nuffield and Ramsay), HCA charged significantly higher prices to PMIs. We recognized that HCA, as a central London operator, was likely to have higher costs. However, on the basis of comparison with another central London operator we considered that a proportion of the price differences was not explained by the central London location and/or the different mix of treatments and cases provided and that the prices charged by HCA were significantly higher than those of other operators.
39. Of the other four largest hospital operators, BMI has consistently charged the highest price to PMIs on average for each of the last five years. The next highest charges were made by Spire but this was not the case for all years.
40. We examined possible explanations for these differences in prices. We found that hospital portfolios which are less substitutable to PMIs were correlated with higher average insured prices. We assessed what was the likely cause of this correlation. In our view, a PMI has a weaker position when it is negotiating with a hospital operator that has more hospitals facing weak competitive constraints, especially if these are in locations that are important to the PMI. We thus formed the view that higher insured prices at the national level arise due to a lack of sufficiently strong competitive constraints faced by hospital operators at the local level.
41. We established that the two larger PMIs, Bupa and AXA PPP, achieve significantly lower prices than the smaller PMIs. We concluded that smaller PMIs had no

countervailing buyer power, and that larger PMIs had some countervailing buyer power, Bupa more than AXA PPP. However, we found that no PMI had countervailing buyer power that could fully offset the market power of those hospital operators that have it.

### *Profitability*

42. An important indicator of the extent of competition in a market is the level of profits of the firms involved. We assessed the profitability of the seven largest private hospital operators in the UK, which account for 74 per cent of the market for privately funded acute healthcare. We conducted the assessment in line with our Guidelines,<sup>4</sup> valuing assets on the basis of replacement costs.<sup>5</sup>
43. From our analysis, we concluded that BMI, HCA and Spire have, during the period under review, been earning returns substantially and persistently in excess of the cost of capital. Ramsay has also earned returns in excess of the cost of capital in the last three years of the period, although not in the first two and a half years. This evidence is consistent with HCA, BMI and Spire, having market power and with our finding of barriers to entry.

### *Provisional conclusions on competitive assessment of hospitals*

44. We concluded that HCA, BMI and Spire, have market power in negotiations with PMIs arising from high concentration and insufficient competitive constraints at the local level, ie that a number of their hospitals have relatively few effective competitors.

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<sup>4</sup> Guidelines, Annex A, paragraph 14.

<sup>5</sup> This approach is likely to produce different result to that shown in published accounts, particularly where businesses have been acquired at a cost that is much more than the replacement cost of the assets.

45. We also concluded that hospitals that faced insufficient competitive constraints at a local level had market power with regard to prices charged to self-pay patients.

## **Consultants**

46. We considered two theories of harm related to consultants: that individual consultants or consultant groups in some local areas may have market power over their patients and that a PMI may have buyer power over individual consultants.
47. We received submissions from Bupa that individual consultants or consultant groups have market power, including strong claims of problems caused by anaesthetists forming groups.
48. We conducted three case studies of prices charged by anaesthetist groups. However, we found no clear evidence that the presence of anaesthetist groups led to higher prices.
49. In relation to other consultant groups, we did not receive evidence of widespread concerns across many local areas or in particular specialties as we did for anaesthetist groups. We do not presume any competitive harm in professionals forming groups and recognize that there may be benefits to patients from such groupings. Our pricing analysis of anaesthetist groups did not suggest that other consultant groups should become a focus for further investigation.
50. We found that there were factors which would indicate that some individual consultants and some consultant groups in some local markets may have market power. However, the evidence we received and reviewed did not show that any such local market power by individual consultants is giving rise to competitive harm.

51. We received many complaints about the conduct of the PMIs in their dealings with consultants (a high proportion relating to Bupa). Many were from consultants, but there were also many from policyholders. Trade bodies and some hospital operators supported these concerns.
52. We found that the two largest PMIs at least, Bupa and AXA PPP, have buyer power in relation to consultants but we found no evidence to suggest that it is being exercised in such a way as to harm competition, for example, by leading to a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, the incentive is on PMIs to promote competition among consultants and maintain innovation and quality to protect and indeed improve demand for PMI.
53. Whilst we have not received persuasive evidence that the other issues raised by consultants and trade associations in relation to PMIs indicate a current competition problem in the provision of consultant services, we consider that PMIs, and in particular Bupa as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about consultants and the reasons for recommending some consultants or for advising against the use of particular consultants.

### **Clinician incentives**

54. One of the ways that private hospitals attract business is by encouraging consultants to treat private patients at their facilities. As most patients are referred to consultants by GPs, hospitals may also try to encourage GPs to refer patients to consultants who use their facilities. In doing so, private hospitals can be expected to take account of the GMC advice contained in its Good Medical Practice and associated guidance.

55. Private hospitals encourage consultants to use their facilities in a variety of ways. They promote themselves to consultants (or GPs) in communications or at events, where they describe the quality of their staff and the facilities and equipment that they have invested in. They commonly offer access to resources to make using their facilities more convenient for a clinician, for example, making consulting rooms or secretarial services available. They may also operate schemes which provide financial benefits to consultants using their facilities.
56. We examined whether any or all of these schemes may distort competition.
57. We found that schemes to attract business by encouraging consultants to refer patients to, or treat patients at, private hospital operators' facilities were widespread.
58. We found that such schemes were not confined to particular areas of the country or hospital types: some independent private hospitals as well as most of the main private hospital groups (ie BMI, Spire, HCA, Nuffield and Ramsay) had, to a greater or lesser extent, adopted them. However, there was some evidence that schemes which directly rewarded consultants for referrals were most likely to be adopted during periods, in geographic areas and in medical specialisms where hospital competition for consultants was strongest.
59. Private hospital operators, in their submissions on this issue, generally argued that in some parts of the country the practice of offering incentives to consultants had become commonplace since it was necessary to do so in order to attract key consultants and that competition for consultants was intense. Some said that they would welcome clarification from us on the merits and de-merits of various types of scheme.

60. The PMIs generally condemned incentive schemes for consultants, expressing concerns about both medical and competitive effects. Bupa and AXA PPP both made extensive submissions on the subject, including evidence which they said demonstrated that harmful effects were occurring.
61. Our annotated issues statement raised the question as to whether incentive schemes gave rise to barriers to entry and some of the responses received (most notably that from HCA) focused on that issue. HCA argued that there was no concrete evidence that consultant incentives created any foreclosure effects in the market. HCA also said that Circle's consultant incentive model had been important to its entry. Spire said that an outright ban on consultant incentives may have unintended consequences.
62. Patients rely to a large extent on the advice of GPs and consultants. In general, any arrangement by which the economic benefit to the adviser varies according to the advice given has the potential to distort competition.
63. We were concerned that consultant incentives might tempt consultants to refer patients to a hospital that they would not have chosen on grounds of either quality or of price and that they might lead to overtreatment or unnecessary diagnostic tests.
64. We examined the evidence and provisionally concluded that incentive schemes did affect consultant behaviour. We believe that an intention of these schemes is to affect consultants' referral decisions and that the schemes have this effect. We also found that, on balance, the evidence indicated that incentive schemes are likely to lead to excessive diagnostic tests or consultations. These effects distort the market.

65. We therefore provisionally concluded that the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities give rise to an AEC. We also concluded that equity ownership by consultants of private health facilities is a feature that gives rise to harmful effects on competition, except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.

### **Information availability and asymmetry**

66. We considered information availability and asymmetry in three contexts: choosing a consultant, choosing a treatment option; and choosing a private hospital.

67. For competition between consultants to function well, patients need to know, in addition to the consultant's fee structure, information about the consultant's qualifications, areas of expertise and performance.

68. Information on the qualifications and specialisms of consultants was readily available across the UK via private and NHS hospital websites, portals such as Dr Foster and the consultants' own websites. In England, initiatives are underway, though not yet complete, to disclose individual consultant performance data in ten specialisms. We understand that no equivalent programmes to disclose consultant performance information are envisaged for the rest of the UK.

69. We could not be sure when or whether the remaining consultant performance data will be disclosed in England will appear nor whether plans to disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. We therefore provisionally concluded that a lack of sufficient publicly available

performance and fee information on consultants prevents the proper functioning of competition between consultants.

70. We found that patient information on treatment options was readily available across the UK.
71. Information on the performance of private hospitals has been below the standard of the information available on NHS hospitals. During the course of our investigation a fresh initiative (the PHIN) was launched to improve the quality of information that is available to patients. Whilst this information is expected to improve in terms of hospital coverage and range of indicators, we provisionally conclude that, at present, it is insufficient to promote competition between private hospitals.

### **Provisional findings**

72. We identified two structural features in the provision of privately funded healthcare by hospitals:
- (a) high barriers to entry for full service hospitals; and
  - (b) weak competitive constraints in many local markets including central London.
- Together these features give rise to AECs in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with PMIs.
73. We identified the operation of incentive schemes by private hospital operators to encourage patient referrals for treatment at their facilities as a conduct feature in the provision of privately funded healthcare by private hospitals. This feature gives rise to an AEC due to the distortion of referral decisions to particular hospitals and the distortion of patient choice of diagnosis and treatment options, except for those

equity ownership schemes that result in a reduction to barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.

74. We identified the lack of sufficient publicly available performance information on private hospital performance as a conduct feature in the provision of privately funded healthcare by hospitals. This feature gives rise to an AEC due to the distortion of competition between private hospital operators by preventing patients from exercising effective choice in selecting the private hospitals at which to be treated. This reduces competition between private hospital operators on the basis of quality and price.
  
75. We identified the lack of sufficient publicly available performance and fee information on consultants as a conduct feature in the provision of privately funded healthcare by consultants. This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.