

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Annotated issues statement

28 February 2013

#### Introduction

1. We published the statement of issues for the private healthcare investigation in June 2012 which set out the theories of harm we would be exploring in this investigation. We are now providing this document—the annotated issues statement—which sets out our current thinking based on the evidence received and the analyses we have undertaken to date. In this document we highlight those issues which we currently consider are likely to be the focus of the investigation going forward and those issues where we have fewer concerns.
2. We have structured the annotated issues statement in a similar way to the statement of issues to enable parties to see more readily the analyses we have carried out and our current thinking in relation to each of the issues we identified in the June statement of issues. We have included appendices which set out in more detail the methodology and analysis of the major pieces of work, including key results where possible.<sup>1</sup> The remainder of this annotated issues statement is therefore structured as follows:
  1. Progress of the investigation to date and next steps
  2. Characteristics of privately-funded healthcare
  3. Market definition
  4. Profitability
  5. Theories of harmAppendices:
  - A. Product markets
  - B. Local competition
  - C. Anaesthetist groups
  - D. Bargaining
  - E. Barriers to entry and expansion
  - F. Employers' private healthcare schemes

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<sup>1</sup> Some information has been excluded because it is confidential

## Progress of the investigation to date and next steps

3. As set out in the statement of issues,<sup>2</sup> the Office of Fair Trading (OFT) did not refer for investigation the private medical insurance market. Nevertheless, a key issue for this investigation is the way in which the privately-funded healthcare sector is affected by the conduct of, and interaction with, the private medical insurers (PMIs). We are also considering the impact on privately-funded healthcare providers of the different legislative frameworks and policies of the NHSs in each of the nations.
4. We are focussing our investigation on privately-funded acute healthcare services provided primarily in private hospitals. These are the services which were the focus of the competition issues that had been identified by the OFT in its market study<sup>3</sup> and by parties in their submissions. We have not considered in detail those types of privately-funded healthcare services that are often provided by different providers to those that provide hospital-based acute services, where the nature of demand is different and where such services are frequently not covered by insurance. Except where indicated, we have not analysed the treatments listed below.
  - (a) Elective cosmetic surgery: we exclude those treatments that are done purely electively, including minor laser eye and skin treatments. However, cosmetic procedures following trauma have been included.
  - (b) Standard maternity treatments: we have not analysed in any detail the provision of maternity-only services by specialist providers. However, in some parts of our analysis we have included emergency/non-routine hospital maternity treatments.
  - (c) Fertility treatments and pregnancy termination treatments: we have not included in our analysis the provision of specialized fertility treatments or specialist pregnancy termination services.
  - (d) Mental health treatments: these have not been analysed as they are extremely varied and are generally offered by very specialist providers.
  - (e) Dentistry: dentistry has only been included if provided within a hospital facility.
  - (f) Specialist outpatient services: specialist outpatient services such as physiotherapy and nutrition have not been included.
5. Over the last 11 months, we have gathered an extensive amount of information from a wide range of parties. Between August and November 2012 we sent out market and data questionnaires to a large number of providers of privately-funded healthcare providers and to the six largest PMIs. Financial questionnaires were sent out in July 2012 to the larger insurers and the largest hospital operators. Questionnaires were sent to the 30 largest corporate customers of the five largest private medical insurers and to over 100 anaesthetist groups. We have also undertaken surveys of general practitioners (GPs), private consultants and patients.
6. We also obtained through site visits, meetings, calls and submissions, the views of and submissions from hospital operators, consultants, trade and professional organizations, government departments, agencies and regulators, PMIs and private medical insurance policyholders and patients. We have begun holding hearings with a number of parties.

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<sup>2</sup> Paragraph 4.

<sup>3</sup> *Private Healthcare Market Study, OFT1412, April 2012.*

## **Next steps**

7. We invite parties to comment on our current thinking so as to inform our further analysis. Comments should be submitted by no later than 2 April 2013.<sup>4</sup> We have not reached any provisional conclusions at this stage and our views as set out in this document may change in light of comments and further evidence we receive and any further analysis we may carry out. We do not intend to publish working papers in respect of those aspects of our analysis covered in this annotated issues statement. In respect of any additional analysis which is ongoing, we will disclose the results and our views for comment.

## **Characteristics of privately-funded healthcare**

8. As described in the statement of issues, certain characteristics appear to be particularly relevant when assessing competition in the provision of privately-funded healthcare services. Identification of these characteristics has informed our analyses and our thinking on the theories of harm.
9. Privately-funded healthcare services are highly varied. They are provided by consultants and other medical and clinical specialists from a variety of facilities including hospitals, clinics and private patient units (PPUs). Treatments depend on clinical judgements taking into account patient (consumer) circumstances. Not all hospitals or consultants offer the same range of treatments or the same services or approaches for each treatment.
10. The five largest hospital operators account for approximately 70 per cent of privately-funded healthcare revenues in the UK.<sup>5</sup>
11. Almost 80 per cent of UK patients<sup>6</sup> using privately-funded healthcare services are funded by insurance. The other 20 per cent are 'self-pay' patients. These healthcare services are also used by overseas patients, particularly in London.
12. PMIs influence the selection and delivery of services through factors such as:
  - (a) approving hospitals, consultants and other healthcare professionals under their policies;
  - (b) provisions in insurance products that direct patients towards or away from certain facilities or limit access to particular services or consultants and other medical and clinical professionals; and
  - (c) setting of financial caps for individual treatments.
13. The four largest private medical insurers account for approximately 87 per cent of insurance premium revenue with the two largest alone accounting for 65 per cent.<sup>7</sup>

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<sup>4</sup> Please email [Private-Healthcare@cc.gsi.gov.uk](mailto:Private-Healthcare@cc.gsi.gov.uk) or write to: Inquiry Manager, Private Healthcare Market Investigation, Competition Commission, Victoria House, Southampton Row, London, WC1B 4AD

<sup>5</sup> Laing & Buisson Healthcare Market Review 2012–2013.

<sup>6</sup> These are patients who are UK citizens.

<sup>7</sup> Laing & Buisson Healthcare Market Review 2012–2013.

## *Insured patients*

14. Most insured patients are covered by policies provided by their employers. Employers typically determine the extent and level of insurance cover for the employees and either purchase an insurance policy from an insurance company or self-insure (in whole or in part) using an insurance company to provide an administration service which includes dealing with claims, negotiating terms with hospitals<sup>8</sup> and dealings with consultants (thus for self-insured employers the insurer normally provides a full operational service but without the underwriting of risk). A fuller description of our work on employers' private healthcare schemes is provided in Appendix F.
15. For patients who do not have private medical insurance via their employer but pay for it themselves, payments for insurance are made separately from, and in advance of, decisions on the need to seek healthcare. As a result, at the time of seeking treatment insured patients may have very limited need to consider the costs of such healthcare and possible alternatives. Referral patterns under traditional referral mechanisms that specify the consultant give insurers little influence on the choice of consultant or hospital except where the patient has purchased an insurance product that specifies a substantially restricted network of hospitals. As a result, the link between price for private hospital services and consultant services and demand is weak.
16. For insured patients there are typically separate arrangements for hospital fees and consultant fees.
17. The price paid for hospital services by the insurer when one of its policyholders<sup>9</sup> is treated depends on the rates the insurer has negotiated with the healthcare provider in question. Typically, where a private healthcare provider owns a chain of hospitals, it negotiates a single price for a given treatment with each insurer that will apply at all, or almost all, of its hospitals.
18. Consultants normally determine the amount that they will charge for their services but this charge is subject to a schedule of maximum payments operated by the insurer for different procedures. Insurers appear to vary in the extent to which they will exercise flexibility to pay more than their normal maximum taking into account individual circumstances. Sometimes a consultant charges more than the insurer's maximum and the patient is billed by the consultant for the difference. We refer to this as a 'shortfall' or as a 'top-up fee' if the patient had agreed in advance to the arrangement. In some cases, such as under Bupa's fee assured scheme, consultants have agreed with insurers not to charge more than the insurer's rate.
19. Patients may take into account possible consequential changes to their insurance costs, for example due to the loss of no-claims bonuses. There are also some financial issues which have a bearing on insured patients' decisions. Whilst they can expect most of their costs to be covered, they may have excesses or other limits on their policies and they may wish to pay a top-up fee to use a particular consultant

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<sup>8</sup> We have seen a very small number of cases where the employer has been involved, or sought to be involved, with hospital negotiations.

<sup>9</sup> Including patients whose employer self-insures but uses the insurance company to administer its scheme.

### *Self-pay patients*

20. Self-pay patients are sometimes offered a package rate by a hospital, which includes the costs of both the consultant's services and the hospital services.
21. Self-pay patients, who do not pay in advance for private healthcare, are likely to be characterized by greater price sensitivity than insured patients at the time of seeking healthcare. As our patient survey shows, they are also likely to be more willing to consider NHS treatment as an alternative.

### *Patient referrals*

22. Decisions by patients on the need to seek specialist healthcare, and as to which consultant to be referred to, are usually made with substantial input from the patient's GP.<sup>10</sup> However there are a number of alternative referral mechanisms, and patient pathways, including 'open referral' systems where the GP does not refer the patient to a named consultant, and the PMI, typically, provides the patient with a choice of consultants from its own lists.
23. Decisions as to where a patient is to be treated will normally be made by the patient and consultant. Such decisions are affected by consultants' working patterns and in particular which hospitals they tend to practise at. Thus the choice of consultant is likely to determine, or substantially narrow, the choice of hospital.
24. Some, limited, comparative information on consultants and private hospitals is available to patients.

### *The NHSs*

25. 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 as a:
  - (a) supplier of national health services to patients free at the point of delivery, representing an alternative to privately-funded healthcare;
  - (b) main employer of most consultants who provide privately-funded healthcare services;
  - (c) supplier of privately-funded healthcare services through PPUs;
  - (d) partner with private hospital operators, for example through PPU partnerships or through the development/provision of specialist treatments, equipment or research;
  - (e) customer of the private hospital operators when NHS patients are treated in private hospitals;
  - (f) main funder of most GPs; and
  - (g) source of all training for almost all other medical and clinical professionals.

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<sup>10</sup> We are aware that some other health professionals can also refer patients for treatment but we intend to focus on referrals by GPs.

26. Our analysis to date has confirmed that these characteristics play a key role in assessing competition in the provision of privately-funded healthcare services. They are considered in more detail as they arise below.

## Market definition

27. As set out in *Market Investigation References: Competition Commission Guidelines, CC3* (paragraph 1.21), we have approached this market investigation through consideration of two related issues:
- the identification of the relevant market or markets for the goods or services concerned; and
  - an assessment of competition in the market and whether any features of the market create an adverse effect on competition.
28. We consider the definition of the relevant market(s) and the examination of competition within that market(s) to be overlapping parts of the same analysis. For example, the analysis of competition in a local area (see theory of harm 1 below) is closely associated with the analysis to determine the scope of the relevant geographic market. Our examination of competition is not constrained by market definition; we take into account, as necessary, constraints outside the relevant market and/or segmentation within the relevant market, or other ways in which some constraints are more important than others.
29. In the statement of issues, we noted several issues to take into account when considering the relevant product market(s), which remain apposite:
- (a) Treatments are characterized by varying degrees of complexity and are highly differentiated products:
- (i) not all hospitals/consultants offer the same range of treatments or the same services/approaches for any type of treatment (eg outpatient versus inpatient care, surgery versus physiotherapy); and
  - (ii) treatments supplied by different hospitals/consultants may also differ in terms of the way in which treatment is provided.
- (b) The ability of patients to switch between treatments is likely to be very limited as patients cannot typically replace one treatment for another. However, in certain cases, there could be some substitutability between alternative approaches for a particular treatment (eg surgery versus physiotherapy).
- (c) Private hospitals may be able to change the treatments they supply if they supply a range of different treatments and may be able quickly to change how they operate. Supply-side substitution by consultants is likely to be more limited than supply-side substitution by private hospitals.
- (d) In the absence of demand-side substitution, treatments (or specialties) that should be defined as separate markets may be aggregated into clusters of treatments (or specialties). This may be appropriate when a group of suppliers each supply a range of treatments across which they can switch (see paragraph 29(c)) and the competitive conditions are the same for each treatment. However, as discussed in paragraph 30(b) below, aggregation of treatments could lead to distortions when determining the scope of the relevant geographic market(s).

- (e) The identity of competitors in each relevant product market may vary according to the specific treatments (or specialties) within that product market offered by each hospital provider. We need to understand the extent to which PPU and the NHS represent competitive constraints on private hospital operators.
30. We also note several issues to take into account when considering the relevant geographic market(s):
- (a) Both local and non-local factors are likely to be relevant for geographic market definition:
- (i) Local aspects may arise because patients may prefer not to travel far to hospitals or because there may be limits on patients' ability to travel (eg limited geographic coverage by the insurer or GPs referring primarily to local consultants).
- (ii) Non-local aspects may arise as negotiations between PMIs and private hospital operators take place at a hospital group level.
- (b) Patients may be willing to travel different distances depending on the type of treatment (eg patients may be willing to travel further for treatments for more serious conditions). Whether several treatments are aggregated in the same product market may therefore impact on the relevant geographic market at the local level.<sup>11</sup>
- (c) Competition between hospitals may take place between hospital chains (networks) as well as between individual hospitals.

### **Product markets**

31. We have analysed evidence on demand- and supply-side substitution across medical treatments. In doing so, we have examined how type of care (inpatient, day-patient and outpatient care) and medical specialty (eg dermatology or cardiology) affect the competitive constraints and thus the appropriate market definition.
32. With regard to type of care (inpatient, day-patient and outpatient care):
- (a) Asymmetric constraints appear to exist among different competitors. In particular, general hospitals providing inpatient care may constrain day- and outpatient clinics, but the reverse constraint may not apply. As a consequence, inpatient, day-patient and outpatient care appear to be distinct product markets.
- (b) So far, we have focused our analysis of competitive constraints largely on the provision of inpatient care and, to a lesser extent, on day- and outpatient care. We have done this because the supply of inpatient care appears to be both the most concentrated and most significant in financial terms.
- (c) We have identified a set of 215 general private hospitals and PPUs providing inpatient care across the UK, which we have used as the basis for much of our analysis.

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<sup>11</sup> For example, if patients have different willingness to travel for different types of treatment, identifying a very broad product market such as 'privately-funded acute general hospital care' (based on supply-side substitution considerations and clustering of services due to a common set of competitors) may disguise the fact that competition takes place over a smaller geographic area for certain treatments.

33. With regard to medical specialty:
- (a) We have identified 16 specialties that are offered by the vast majority of general private hospitals and PPUs in the competitor set defined in paragraph 32(c).<sup>12</sup> We have considered these specialties together.
  - (b) Oncology is offered by a lower proportion of general private hospitals and PPUs in the competitor set defined in paragraph 32(c), but it represents a significant share of patient admissions and revenue. We have therefore, where possible, considered it separately (see Annex 1 to Appendix B on local competition).

We may look at other specialties and would welcome evidence on which we should consider.

34. We are considering whether other clusters of the product market may be appropriate. In particular, we are considering the possibility of looking at individual specialties (rather than specialties in aggregate) and at a high-acuity cluster (possibly based on ICU facilities). These seem to be important in London, particularly central London.
35. A fuller description of our work on product markets is provided in Appendix A.

### **Geographic markets**

36. We have considered local markets in our analysis of competitive constraints for theory of harm 1 (see paragraph 51). In this analysis we have used hospital 'catchment areas' and weighted market shares for all geographic sub-markets, both of which can be viewed as a proxy for local geographic markets.
37. We are considering whether based on demand and supply factors it is appropriate to define a national market in addition to local markets. This will depend upon our assessment of the nature of negotiations between hospital groups and insurers, which we are evaluating under theory of harm 3 (see paragraph 83).
38. Based on our analysis to date, we consider that it is appropriate to focus our competitive analysis on the provision of inpatient care for the cluster of 16 specialties and separately for oncology, at a local and, possibly, at a hospital-group level. To the extent relevant, we also examine competition within and outside this area.

### **Profitability**

39. We have undertaken a profitability analysis of the seven largest private hospital operators providing privately-funded healthcare services. Profitability can be a useful indicator of competitive conditions in a market since an efficient firm in a competitive market would generally be able to earn no more than a 'normal' rate of profit in the long run. Our profitability analysis in this investigation has a number of purposes, including (a) as an indicator of whether prices are too high, (b) as evidence about entry conditions, and (c) as evidence about trends in profitability.
40. In November 2012, we published two consultation documents relating to the analysis of profitability in the market for private healthcare services. In February 2013, we also

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<sup>12</sup> These specialties are: Obstetrics and gynaecology, General surgery, Trauma and orthopaedics, Anaesthetics, Urology, Gastroenterology, Ophthalmology, Otolaryngology, Dermatology, Plastic surgery, Cardiology, General medicine, Neurology, Oral and maxillofacial surgery, Rheumatology, Clinical radiology.



published a working paper setting out our initial findings and the proposed methodology.<sup>13</sup>

41. We have not carried out profitability analyses for consultants since we consider that this would be impractical. However, we have carried out some analysis on the prices charged by consultant groups (see paragraphs 74 to 82). We have done some limited financial analyses of the PMIs but profitability analysis is of less relevance as their revenues are obtained outside of the market for privately-funded healthcare.

### *Our approach*

42. Detailed profitability analysis has been conducted on the seven largest private hospital operators. Our approach has been to compare the return on capital employed of each of these operators with an estimate of the relevant cost of capital.
43. The main challenge has been to estimate the economic value of the capital employed in the industry. This capital is composed largely of land, buildings and equipment. Several parties have argued that intangible assets (such as IT systems, patient, GP and consultant relationships, clinical processes and regulatory approvals) are also significant but our view is that it is not appropriate to include most of these items in the capital base.<sup>14</sup>
44. We note that a number of the seven hospital groups analysed have significant amounts of goodwill on their balance sheets arising from acquisitions. We do not normally consider it appropriate to treat goodwill from acquisitions as part of the capital base. As a result of this and the use of the economic value of assets,<sup>15</sup> the profitability of hospital groups under our analysis may be significantly higher than that shown in the companies' reported results.
45. Full details of the approach taken are set out in the profitability working paper.<sup>16</sup>
46. Our current thinking is that the private hospital operators analysed, on average, are making profits in excess of the cost of capital, with an average return on capital employed of about 18 per cent compared with a cost of capital of about 9 per cent.

### **Theories of harm**

47. In the statement of issues, we set out seven theories of harm to frame the investigation. In relation to each of those theories, we set out below what analyses we have undertaken and what is our current thinking based on what these analyses show. We also highlight those areas where we propose to undertake further work and those areas where we would be particularly grateful to receive additional comments and evidence. We have not reached any provisional views on any of these theories but have identified those issues where our current thinking suggests that we should focus our analysis going forward.
48. The theories of harm we identified in the statement of issues are:

(a) theory of harm 1: market power of hospital operators in certain local areas;

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<sup>13</sup> See also our methodology paper at [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/121107\\_profitability\\_methodology.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/121107_profitability_methodology.pdf).

<sup>14</sup> The profitability working paper sets out in more detail the approach we have taken to each category of intangible assets and our reasoning. This can be found on our website.

<sup>15</sup> Rather than the market value or historic cost.

<sup>16</sup> This can be found on our website. It has been published as a separate document.

- (b) theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas;
  - (c) theory of harm 3: market power of hospital operators in negotiations with insurers;
  - (d) theory of harm 4: buyer power of insurers in respect of individual consultants;
  - (e) theory of harm 5: barriers to entry at different levels;
  - (f) theory of harm 6: limited information availability; and
  - (g) theory of harm 7: vertical effects.
49. We have reviewed these theories of harm and considered whether they remain appropriate, taking into account the evidence we have obtained and the analyses that we have undertaken. Our view is that they remain relevant. At this stage, we do not consider that it is appropriate to dismiss any of the theories or add any new theories.
50. The statement of issues noted that ‘we may need to consider a separate theory of harm, whereby the insurers have buyer power over hospital operators, such that insurers may exert too much pressure on the price paid to the hospital operator’; however, we have not seen persuasive evidence that any buyer power insurers have over hospital operators is harmful. Therefore, at this stage, we do not propose to consider this further.

***Theory of harm 1: Market power of hospital operators in certain local areas***

51. Our first theory of harm is that a private hospital operator may have market power with respect to patients in a particular local geographic area.
52. Several factors may result in a private hospital operator holding market power in a particular local area. These include:
- (a) a limited number of rival hospitals nearby;
  - (b) a limited number of rival hospitals nearby that offer or specialize in a particular treatment; or
  - (c) a limited number of rival hospitals nearby with significant spare capacity.
53. Constraints provided by rival private hospitals in a local area may differ depending on the treatment being sought. As such, it is possible that private hospitals in certain locations may have market power in respect of some treatments but not for others (see paragraph 29(e) above).

***Our approach to identifying local areas where private hospitals may potentially have market power***

54. We have undertaken a quantitative assessment of competition in local areas to create ‘filters’ for the purpose of identifying hospitals which appear to face relatively limited competition. Hospitals that are caught by our filters are defined as ‘hospitals of potential concern’. This is a starting point of our analysis and we will carry out further work to identify which of these hospitals we regard as problematic ones.

55. Our analyses have focused on: (a) the 215 general private hospitals and PPUs providing inpatient care and active in one or more of the 16 specialties discussed in paragraph 33(a); and (b) the 126 general and specialized private hospitals and PPUs providing oncology, where this could be analysed separately. Oncology was grouped with the other specialties for the weighted average market shares but was analysed separately from the 16 other specialties in the 'fascia count'.
56. In our analyses we did not include NHS hospitals because based on our survey evidence, taken as a whole, NHS hospitals do not constrain private hospitals. The survey indicates that one-fifth of insured patients considered having their treatment on the NHS but that only 3 to 4 per cent would have switched to the NHS if their chosen private hospital was unavailable. The readiness of self-pay patients to use the NHS was significantly higher but insured patients are much more numerous than self-pay patients. We are mindful of this difference between insured and self-pay patients.
57. We adopt two approaches, which we use together, to measure the concentration of private hospitals at the local level.
58. The first approach (described as 'weighted average market shares') considers the market shares of competitor hospitals, and thus takes into account the relative strength of these hospitals as measured by their market shares. Calculating the appropriately weighted market shares requires data at a very granular level. Because of limitations in the data we could obtain, we have had to omit certain private hospitals from our analysis. This concentration measure is therefore likely, in a limited number of instances, to understate the level of competition.
59. The second approach (described as 'catchment areas and fascia counts') identifies, for each private hospital, the catchment area over which it draws the majority of patients and the number of competitor hospitals within this catchment area. Most hospitals have a catchment area between 10 and 25 miles. This approach treats all hospitals as equal, regardless of size and range of specialties offered or of the market share of the hospitals. Since some of the private hospitals may not be effective competitors, this concentration measure may in some cases overestimate the likely level of competition.
60. We identify as hospitals of potential concern those hospitals that either have a weighted average market share of 40 per cent or higher, or face no more than one competitor hospital in their catchment area.
61. We recognize that there are limitations with these approaches, particularly with the catchment areas and fascia counts, and we will be considering these limitations in our detailed examination of the hospitals of potential concern identified.

### *Results*

62. We identified 147 hospitals of potential concern. One hundred and twenty-two hospitals had weighted average market shares of 40 per cent or higher and a further 25 hospitals faced no more than one relevant competitor in their catchment area.
63. Following this filtering process we will carry out more detailed examination of the hospitals of potential concern identified.
64. We also note that some private hospitals that have not been identified as hospitals of potential concern by this methodology may have market power for particular

specialties or services. This may apply in particular to London, for which we are also carrying out a more detailed analysis.

### *London*

65. Many PMIs expressed concerns that HCA hospitals in London have market power.
66. There are a substantial number of private hospitals in London, and London private hospitals differ from those in the rest of the UK in that they offer different sets of specialties, some hospitals are very specialized and their patients may work in London but reside further away.<sup>17</sup> The local analysis identified some 'hospitals of potential concern' in London but it may not fully capture the extent of any competition problems in London.
67. We are investigating the extent of competitive constraints on HCA in London in more detail:
  - (a) Our analysis of shares of capacity (theatres), admissions and revenue held by private hospitals/PPUs located in central/Greater London shows that HCA is by far the largest private hospital operator operating in the London area.
  - (b) HCA appears to be particularly strong in a number of specialties, including, for example, cardiology, gastroenterology, oncology and radiology.<sup>18</sup>

### *Price concentration analysis*

68. We are investigating the relationship between local prices for self-pay patients and local competition using an econometric model.<sup>19</sup> Our initial analysis shows a statistically significant relationship between price and concentration, indicating that prices are expected to be, on average, higher in more concentrated local markets. Because prices to insured patients are not generally set on a hospital by hospital basis, it is not possible to observe local variation in prices to insured patients. For insured patients, the price paid is normally the result of negotiation between the hospital operator and the PMI. The effects on price will depend on the results of these negotiations; these are discussed under theory of harm 3.
69. Our current thinking is that some private hospital operators have market power in local areas. We have found a number of areas where hospitals face only limited local competition. Since distance or travel time is important to patients, we expect this to confer some market power to the operators of these hospitals.
70. We will consider the 'hospitals of potential concern' in more detail. Whilst we have not identified the precise number of private hospitals with market power at the local level, we consider it likely that a significant number of the 'hospitals of potential concern' do have such market power.
71. Market power in local areas is consistent with our current thinking that the hospital groups are earning returns in excess of the cost of capital.

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<sup>17</sup> We think that commuting is most likely to affect our results significantly in London.

<sup>18</sup> We note that the set of specialties offered by most of London hospitals is somewhat different from the set of 16 specialties that we identified as typical across the UK as a whole.

<sup>19</sup> Our work on modelling is described in Appendix B, Annex 3

72. In general, we would expect limited competition in particular local areas to be likely to lead to higher prices for treatment and/or a lower quality of service.<sup>20</sup> We are in the process of evaluating the price effects by considering self-pay prices and negotiations between hospital operators and insurers.
73. A fuller description of our work on local competition is provided in Appendix B.

***Theory of harm 2: Market power of individual consultants and/or consultant groups in certain local areas***

74. Theory of harm 2 hypothesizes that consultants or consultant groups in certain local areas have market power over their patients. We note that consultants usually (at least in the case of insured patients) provide a separate bill specifying their charges.
75. Consultant market power may be caused by several factors, some specific to the location in which the consultant works and others reflecting the way in which privately-funded healthcare services are purchased. These factors include:
- (a) a limited number of consultants in a particular local area for specific treatments or specialties;
  - (b) the way that referrals are made and consultants selected; we note that the process of choosing anaesthetists for a patient differs from that for other consultants and typically involves less input from the patient and/or GP; and
  - (c) joint setting of prices by some consultant groups.
76. So far, our focus has been on groups of anaesthetists, both because patients in practice typically have relatively little input into the selection of the anaesthetist (often first meeting them shortly before the medical procedure), and because we have received most complaints about the conduct of these groups.
77. We are carrying out a number of case studies on anaesthetist groups. We have been unable to carry out a systematic analysis of all anaesthetist groups because there is no definitive list of such groups.
78. From our survey of consultants we found that:
- (a) 39 per cent of anaesthetists in our consultants survey were in groups. 22 per cent of other consultants were in groups.
  - (b) 60 per cent of anaesthetists in a group said that they used the guidelines set by the group to set their fees. The proportion for other consultants was 51 per cent.
  - (c) In terms of all anaesthetists (ie those in and not in groups), 24 per cent said that they used the guidelines set by the group to set their fees (14 per cent at the level specified by the group and 10 per cent with reference to the guidelines specified by the group). The proportions for other consultants are: 10 per cent (split 4 per cent and 6 per cent).
  - (d) 10 per cent of those in consultant groups and aware of consultants not in a group said that those in groups charge higher prices than those not in groups. Allocat-

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<sup>20</sup> In referring to 'quality', we include all attributes of the product/service which may provide value to the consumer, including but not limited to: clinical outcomes, speed and convenience of treatment, comfort of accommodation, standards of customer service etc.

ing ‘don’t knows’ increases this proportion to 16 per cent. For those not in consultant groups, aware of consultant groups and aware of other consultants not in a group, the proportions are 16 per cent and 37 per cent.<sup>21</sup>

79. Our current view is that some anaesthetist groups appear likely to have market power. We intend to undertake more analysis to test this further. A fuller description of our work on anaesthetist groups is provided in Appendix C.
80. Our analysis so far has provided some evidence that prices charged by the anaesthetist groups we analysed may be higher than those charged by non-groups, eg prices of these groups appear to be higher than prices of non-groups in comparable geographic areas, and when the groups were formed, prices rose by more than those of non-groups in comparable geographic areas.
81. We would welcome further evidence on the behaviour of these, and any other price-setting, consultant groups.
82. In relation to the conduct of consultants acting individually, we have not received evidence of any harm to competition. Therefore, we do not intend to pursue this further at this stage but we will consider any further evidence supplied to us.

### ***Theory of harm 3: Market power of hospital operators in negotiations with insurers***

83. Theory of harm 3 concerns negotiations between private hospital operators and PMIs over the price that the PMI pays when its insured patients are treated in a hospital owned by the private hospital operator. As noted in paragraph 17 above, typically, where a private hospital operator owns a chain of hospitals, it will negotiate with each insurer a single price for a given treatment that will apply at all, or almost all, of its hospitals. This theory of harm hypothesizes that private hospital operators have market power in these negotiations.
84. We see two distinct aspects to this theory of harm:
  - (a) If a hospital operator has market power in its negotiations with a PMI, this is likely to derive, at least in part, from the hospital operator’s market power in certain local areas and the scale of its set of hospitals. Thus, theory of harm 3 is closely related to theory of harm 1.
  - (b) It may also be that there are aspects of these negotiations which add to any advantage that a private hospital operator derives from its position in local markets, if it owns a chain of hospitals.
85. Such market power in negotiations might lead to higher prices and/or more favourable contract terms for the private hospital operator than would otherwise be the case.
86. We consider it helpful to divide the adverse effects depending on how they arise—ie their relationship to paragraph 84(a) and 84(b) above. For example, if the market power gives rise to higher prices:

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<sup>21</sup> The relevant references in the consultants survey for subparagraphs (a)–(e) are, respectively, E2/4, E3, E3, E6, E6.

- (a) prices charged might correspond to some form of weighted average of the prices that would apply in local markets where the private hospital operator has market power and those prices that would apply in the competitive local markets; and
  - (b) prices might be higher than in 86(a) above if private hospital operators are able to 'leverage' their overall advantage in local markets through the negotiating process.
- 87. For theory of harm 3 to hold, a private hospital operator would have market power which is not totally offset by any buyer power of the PMI. A PMI's negotiating position is likely to turn on the credibility of any threat it may make not to include a given hospital or private hospital operator in its network(s), or only to include certain treatments at a particular hospital (so-called 'delisting').
- 88. PMIs have told us that if a private hospital operator owns some hospitals which confer upon it market power in local areas, the PMI has little or no choice but to contract with the hospital operator and recognize such hospitals because it will need to be able to offer these hospitals to policyholders if it is to offer an insurance policy to consumers living or working in that area (either directly or via the policyholder's employer). The PMIs have also told us that some private hospital operators offer terms in negotiations such that the PMI has little or no choice but to recognize all or most of the private hospital operator's hospitals, including those that it might not wish to, because the terms offered for a smaller set of hospitals are substantially worse. That is, the price rises that a PMI would face were it to restrict its use of a hospital chain to a small number of hospitals that had market power in local areas would be so large as to make this option impractical.
- 89. However, we note that PMIs may have some countervailing bargaining power in these negotiations through two mechanisms, both related to the PMI asserting control over where the patient is treated:
  - (a) first, if the PMI can credibly use the threat of 'delisting' hospitals, it can expect to obtain a better price from a private hospital operator; and
  - (b) second, the PMI may be able to develop mechanisms to influence the patient's choice of hospital or 'steer' patients away from one private hospital operator/hospital to another.

### *Our analyses*

- 90. We have analysed an extensive body of internal documents provided by private hospital operators and PMIs relating to their negotiations. We have considered the negotiating positions adopted, any disputed issues, and the outcomes of various negotiations. We have assessed this evidence in the round and our view is that it is consistent with some large hospital groups having market power in some negotiations.
- 91. We have also analysed prices charged by private hospital operators to PMIs. These price differences are likely to be affected by various factors, especially costs. We are considering further work on private hospital operators' costs for insured patient business.
- 92. Our current evaluation of theory of harm 1 is that private hospital operators have market power in certain local areas. An implication of this is that prices for insured patients negotiated at a hospital operator level will be higher than if they did not have this local market power.

93. Our current thinking on hospital profitability is consistent with some hospital groups having market power in these negotiations.
94. Our current thinking is that certain private hospital operators have market power in negotiations with PMIs. We are undertaking more detailed work on the price differences that arise from different private hospital operator/PMI pairings and the factors that affect these.
95. We have not yet formed any views as to whether hospital chain negotiations and uniform pricing across hospitals provide private hospital groups with any greater advantage than if charges were negotiated on a hospital-by-hospital basis.
96. A fuller description of our work on bargaining is provided in Appendix D.

#### ***Theory of harm 4: Buyer power of insurers in respect of individual consultants***

97. This theory of harm hypothesizes that insurers may possess buyer power in relation to consultants.
98. In the statement of issues, we stated that if insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. We also considered that insurer conduct may distort competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). We said that in the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector.
99. We have received a large number of submissions, particularly from consultants, related to this theory of harm. That, in itself, is not surprising since there are many consultants. However, the breadth of concerns expressed is notable and has led us to extend our consideration to other issues in addition to consultant fees. We discuss consultant fee levels first, then the issue of top-fees, and then the other issues raised.
100. We note that Bupa and Axa-PPP, the two largest PMIs, have embarked on a number of initiatives to seek to control the costs they pay for consultant (and hospital) services. In the absence of insurer action, either to influence the choice of consultants or to limit the fees charged, it is not clear that there would be effective constraints on the fees charged for insured patients.

#### ***Consultant fees***

101. Most of the submissions we have received from consultants are particularly critical of Bupa. Other insurers have not come in for similar criticism of their schedules of fee maxima.
102. It appears to us that this focus on Bupa in part reflects specific initiatives that Bupa has undertaken with the aim of controlling this area of expenditure, and in part the perception that, for most consultants, Bupa recognition is essential for the operation of a successful private practice.
103. Many consultants have written to us that fee schedules have not been revised upwards since the 1990s and that for certain specialties (such as ophthalmology) the fee maxima have been dramatically reduced.



104. Bupa told us that considering the fee schedules in isolation was potentially misleading as it ignored the efficiency gains that had been achieved over time. Due to technological and other improvements, BUPA argued that consultants were now able to conduct many of the procedures much more rapidly than when the fee schedules were set.
105. It is difficult for us to ascertain what the net effect of these changes has been on consultants' incomes over time and whether consultants' incomes today are more or less correct than at some point in the past.
106. Although there is a clear disparity in size between an individual consultant and an insurer, in this context the consultant is the supplier of a service and the insurer is the buyer. Where a supplier reduces its price in the face of a strong buyer, this is usually likely to lead to lower prices for consumers. We also note that it would probably be against an insurer's interest to reduce prices to such an extent that it had an inadequate supply of consultants.
107. We have not seen evidence that indicates that Bupa's fee schedules are leading to a lower quality of service, to lower incentives to innovate, or dissuading consultants from entering private practice, or remaining active in it, in such a way as to result in a long-term detriment.

#### *Preventing consultants from charging top-up fees*

108. We understand that Bupa is now only recognizing new consultants if they enter into a contract with Bupa directly which stipulates how much they will charge to its patients. As part of this contract, consultants also agree not to charge patients for 'shortfalls'—ie they agree not to charge the patient more than the insurer's maximum. We understand that Axa-PPP has undertaken a similar initiative.
109. This enables Bupa to offer customers the assurance that fees will be fully covered, with 'no surprises'.
110. We find the argument that Bupa recognition is critical to many consultants persuasive. Bupa in particular, and Bupa and Axa-PPP together, represent a very large proportion of the private market for consultants. As such, they have a significant effect on the operation of the market as a whole.
111. Whilst we appreciate that unexpected costs are unwelcome to patients, it is not evident to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice.
112. We are concerned that these practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers. Whilst purchasers of private medical insurance might be expected to switch supplier in response to changes to the service they receive when claiming on their insurance, we are concerned that customer response may be muted, especially since the market share of Bupa in the insurance market is around 40 per cent and the combined market share of Bupa and Axa-PPP in the insurance market is around 65 per cent.

#### *Other issues*

113. The other main criticisms of insurers' conduct with regard to consultants fall into the following categories:

- (a) providing misleading information on the status of consultants;
- (b) arbitrary 'de-listing' consultants and a lack of transparency in insurers' handling of such matters;
- (c) recommending inappropriate consultants for certain procedures; and
- (d) using staff that lack appropriate medical qualifications to provide advice on medical matters.

As before, most of the complaints that we have received relate to Bupa, with some relating to Axa-PPP.

- 114. We note that the complaints we have received may not be generally representative of the views of consultants or of the PMIs' conduct.
- 115. Several of these complaints raise matters of importance. However, the focus of our investigation is on competition in the market for privately-funded healthcare and we have not seen persuasive evidence that these complaints indicate a competition problem in that market.
- 116. Our current thinking is that the buyer power of Bupa, or of Bupa and Axa-PPP together, restricts patient choice in the market for consultants through the prevention of 'top-up' fees. We have not seen evidence that indicates that Bupa's fee schedules are damaging competition and we have not received persuasive evidence that many of the consultants' specific complaints have significant effects on competition in the market for privately-funded healthcare.

### ***Theory of harm 5: Barriers to entry***

- 117. This theory of harm hypothesizes that there are barriers to entry which reduce competition, either directly or by providing the necessary conditions for the other theories of harm to have effect. In the statement of issues, we identified four classes of potential barriers to entry:
  - (a) barriers to entry into privately-funded healthcare provision resulting from bargaining between insurers and hospital operators;
  - (b) barriers to entry into privately-funded healthcare provision resulting from the relationships between hospital operators and consultants or GPs;
  - (c) other barriers to entry into privately-funded healthcare provision; and
  - (d) barriers to entry into the provision of consultant services in private practice.
- 118. We have conducted an analysis of barriers to entry, including three case studies looking at particular examples of market entry/expansion in the Bath, Edinburgh/Lothian and London areas and we have examined arrangements between hospital operators and clinicians that may restrict entry or expansion. Our analysis is summarized in Appendix E.
- 119. These case studies, combined with our work on profitability and theory of harm 1, indicate that entry is restricted. We note in particular that there are some economies of scale to private hospitals, and there are substantial fixed costs, such that small-scale entry (particularly in order to offer inpatient facilities) is unlikely to be efficient. In many local markets, overall demand is not sufficient to support an additional,

efficiently sized, private hospital. We do not treat this as a separate element of theory of harm 5, but we do regard it as an important element in our consideration of other theories of harm.

120. We review each of the classes of potential barrier to entry, as described above, in turn.

***5(a) Barriers to entry into privately-funded healthcare resulting from bargaining between insurers and hospital chains***

121. This theory of harm hypothesizes that bargaining between PMIs and hospital chains creates barriers to new local entrants. In particular, it may result in contractual terms that disincentivize PMIs from recognizing new entrants. This bargaining pattern may lead to a hospital operator placing pressure on PMIs to continue to recognize all the hospital operator's hospitals and not to recognize hospitals of new entrants.
122. High fixed costs of hospitals make it attractive for hospital groups to offer 'volume for discount' deals to PMIs, if by doing so they can secure business from the insurer that they would not otherwise receive. As PMIs cannot guarantee to provide this volume in advance, these discounts may sometimes be paid retrospectively, in aggregate, to them.
123. Similarly, hospital groups will wish to cover their fixed costs even if they lose volume; as a result, they may react to the prospect of potential volume reductions by seeking to raise prices. Some contracts that we have seen provide for prices to be increased or reviewed in the event that patient volume falls below thresholds set out in the contract.
124. PMIs may be deterred from recognizing new hospitals by the prospect of losing volume-related discounts, or by threats of substantial price rises if volumes are reduced.

***5(b) Barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants or GPs***

125. Barriers to entry may arise due to:
- (a) relationships between hospital operators and consultants:
    - (i) the need for a new entrant to obtain commitment from sufficient consultants to work in the new hospital in order to get financial backing from investors for the project and, more generally, sufficient 'demand' for its services; and
    - (ii) incentives provided by hospital operators to consultants; and
  - (b) incentives provided by hospital operators or consultants to GPs.

*Relationship between hospital operators and consultants*

126. Consultants' relationships are very important to hospital operators since patients are usually referred by their GP to a consultant rather than to a hospital. Consultants play a major role in bringing patients into a hospital and generating revenue for the hospital operator. Where a small number of consultants are responsible for a large proportion of the revenue generated within a particular specialism, this may make it particularly important for hospitals to attract those key consultants.

127. A new entrant may be reluctant to build a new hospital without first obtaining the commitment of consultants that they will practise at the facility once it is built.
128. We note that there are two mechanisms by which an incumbent private hospital operator could deter entry using its relationships with consultants. The first is where the new entrant is not recognized by one or more of the larger insurers, such that consultants are not able to switch all of their work to the new entrant. In this case, an incumbent may be able to implement a volume-related financial incentive scheme with consultants that makes it prohibitively costly for those consultants to switch a proportion of their work to the entrant. The second is where the incumbent is able to enter long-term, exclusivity agreements with (groups of) consultants that prevent them from switching to a new entrant.
129. An incumbent hospital operator with market power may also have other mechanisms to discourage consultants from switching to new entrants. Where a hospital has market power in a particular area, local consultants may also have a limited choice of hospitals where they can practise. Given that there is often a long lead time between planning to enter a market and actual entry, the incumbent may be in a position to place restrictions on its consultants that discourage them from committing to work at the new entrant.

#### *Findings from our case studies*

130. We found a wide range of schemes which had recently or were currently being offered, including volume-related incentive payments, discounts for services provided to consultants by private hospital providers, exclusive contract terms with consultants, and long-term equity interests in JVs.
131. The information we have reviewed indicates that the use of such schemes is more common where competition for consultants is intense in terms of geography, for example in London, and/or specialism, for example oncology.

#### *GP incentives*

132. As noted in the statement of issues, the OFT reported<sup>22</sup> receiving evidence that some GPs may have been offered incentives in return for referring patients to a particular private hospital operator.<sup>23</sup> GPs play a critical role in assisting patients in selecting the most appropriate consultant and hospital. Where a hospital operator with market power in a local area is involved in incentivizing GPs in this way, it could restrict the ability of a new entrant to attract patients based on clinical need or the quality of facilities. A similar situation would arise if a consultant similarly provided incentives to GPs.

#### **5(c) Other barriers to entry into the provision of privately-funded healthcare services**

133. In the statement of issues, we stated that there may be other potential barriers to entry that make construction of new private hospitals difficult:
  - (a) Capital requirements and sunk costs: for example, the potentially high capital cost of new hospitals combined with the high exit costs deriving from the limited

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<sup>22</sup> *Private Healthcare Market Study, OFT1412, April 2012*, paragraphs 8.78 & 8.79.

<sup>23</sup> We note that this may be in breach of British Medical Association Guidelines on GP conduct.

alternative uses for hospitals may be a barrier to entry. We note that this may vary depending on the type of facility and the types of treatments provided.

(b) Planning delays and the strategic use of the planning regime by incumbents may significantly delay the construction of new facilities.

134. Our case studies do not suggest that either capital requirements or planning issues constitute a significant barrier. However, we note that the significant costs associated with entering a market, combined with limited overall demand in many cases, may deter 'hit-and-run' competition in markets where an incumbent is making excess profits.

#### ***5(d) Barriers to entry into the provision of consultant services in private practice***

135. As described in the statement of issues, this theory of harm, which is closely related to theory of harm 2, hypothesizes that there may be barriers to entry into the provision of consultant services in private hospitals that may prevent new consultants entering in response to the high prices and thus protecting the market power of incumbents.

136. We have seen little evidence that this is a significant problem, although we have observed that the readiness of hospitals to admit new consultants does vary with the specific circumstances.

#### *Our current thinking on barriers to entry*

137. Our current thinking is that there are barriers to entry to hospital operations, at least so far as is required to operate general or specialized hospitals with inpatient facilities. These derive from the economics of the industry. We have considered a number of specific potential barriers to entry. We do not have a current view as to whether any of these constitute a barrier to entry but we do consider that neither capital requirements nor planning issues constitute a barrier to entry.

138. We think that there are barriers because there are some economies of scale to hospitals, and there are substantial fixed costs, such that small-scale entry (particularly in order to offer inpatient facilities) is unlikely to be efficient. In many local markets, overall demand is not sufficient to support an additional, efficiently sized, hospital.

139. Our views on the other specific areas examined are:

(a) We have not formed a clear view as to whether bargaining between insurers and hospital chains creates barriers to entry. This is related to theory of harm 3. We will undertake further work on this.

(b) We think the conduct of PMIs, particularly the larger ones, in respect of new hospital recognition may impede entry. However, we note that strategies are available to private hospital operators which may mitigate the effects of non-recognition, albeit at a possibly high or arguably unsustainable cost.

(c) To the extent that incentive schemes and similar aspects of relationships between private hospital operators and consultants either preclude or deter clinicians from working for a rival, we think they may point to a barrier to entry/expansion.

(d) We have not formed a view as to the prevalence of relationships between private hospital operators and GPs, or that consultants and GPs create barriers to entry. We are undertaking further work on this.

(e) Neither capital requirements nor planning issues constitute a barrier to entry.

140. Our current thinking is that there are no insurmountable barriers to entry into the provision of consultant services in private practice.

### ***Theory of harm 6: Limited information availability***

141. This theory of harm argues that information asymmetries and the limited information available to patients (as well as GPs and possibly PMIs) may distort competition as they limit a patient's ability to make an informed choice about the most appropriate hospital/consultant for their condition.

142. The majority of submissions suggest that the market is characterized by:

(a) information asymmetries;

(b) the absence of information on the quality and performance of clinicians and facilities in private medicine; and

(c) the absence of easily comparable information on both consultant and private hospital charges, particularly for self-pay patients.

### ***Information asymmetry***

143. There is a clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient. While some price information will be available, though not readily, to the patient, information about the appropriateness of various treatments may be harder to find and information of the medical skills and experience of individual clinicians will be very difficult to come by. Further, the patient, if insured, will have little incentive to seek out price information as the insurer will be paying for the treatment. Given these asymmetries, combined with the industry's fee for service model, there is an inherent incentive for the provider to take advantage of that asymmetry and refer patients for unnecessary or more elaborate diagnostic tests or forms of treatment for reasons other than the patient's best interest. This derives from the nature of private healthcare systems and is a recognized issue in other countries. (It may also be considered that publicly-funded capitation models such as the NHSs in the UK face incentives to 'under-treat'.)

144. We would be concerned if in addition we identified financial or other incentives designed to capitalize or exploit the asymmetry, for example by private hospital providers offering incentives to consultants to perform additional tests or procedures at their facilities.

145. We note that a number of PMIs are taking steps to limit the effects of this asymmetry, either generally or for specific conditions such as back pain, generally by modifying referral mechanisms. We note that this may in turn give rise to another consumer detriment: patients not being referred for particular tests or treatment for reasons other than their best interest.

## *Survey results*

146. Our consumer survey demonstrates that people consider clinical expertise important and try to choose consultants on these grounds. The single most important reason for choosing a consultant was 'clinical expertise' (cited by 38 per cent of respondents), but good information on clinical expertise is not readily or universally available.
147. Typically patients look to their GP for advice. 32 per cent of people surveyed said that the GP's recommendation was the most important factor in choosing a consultant.
148. GPs, in turn, also lack information. Nine out of ten GPs said that they did not have enough information about at least one of the criteria they would consider in identifying the most appropriate consultant for a patient. More GPs said that they lacked information on consultants' fees than any other single subject.
149. In total, 5 per cent of PMI patients in our survey chose a consultant who was not fully covered by their insurance, resulting in them having to pay for some or all of their treatment. Of these, 92 per cent were made aware of any monetary restrictions in their policy regarding the consultant fees.<sup>24</sup>
150. 14 per cent of self-pay patients would have liked to have had some further information, although there were no specific areas where information gaps were identified. 17 per cent of PMI patients said the same.<sup>25</sup>
151. Our current view is that limited information availability is likely to distort competition as the patient's ability to make an informed decision is restricted.
152. We are investigating further whether the type of information currently collected and the format it is recorded in contributes to the problem.
153. At this stage we have been presented with no evidence to suggest that the information available to private patients should not be at least as extensive as that available to patients treated on the NHS.

## ***Theory of harm 7: Vertical effects***

154. In the statement of issues, we noted that Bupa, through ownership of the Cromwell Hospital in London, is vertically integrated. We also noted that Bupa and possibly some other PMIs may also own some primary care facilities. At that stage, we said that we did not consider that these vertical linkages were likely to lead to significant harm to competition but that we would keep an open mind to any potential vertical theory of harm as our investigation progressed.
155. Vertical linkages do not necessarily give rise to competition concerns, but we would be concerned if there was a viable mechanism whereby a vertically-integrated firm could foreclose competitors either in the upstream or downstream market.
156. We have seen no evidence which leads us to alter our view that Bupa's ownership of the Cromwell Hospital is unlikely to give rise to competitive concerns, although we note that Bupa's move to open referrals gives it more control over the flow of patients

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<sup>24</sup> G3 to G8, patients survey

<sup>25</sup> F3, patients survey

and is likely to enhance its ability to direct patients to its hospital. We have not yet formed any view as to whether full or part ownership of primary care or outpatient diagnostic centres by PMIs is likely to give rise to competitive concerns.

157. We have concerns regarding the ownership by private hospital groups of primary care and outpatient diagnostic centres principally, but not exclusively, in London. These concerns centre on the possibility that such facilities might lead to patient referrals predominantly being made to hospitals in the same group or for testing or treatment for reasons other than the patient's best interest. This could be a concern if it was likely to foreclose rivals from a significant proportion of customers, or from a significant group of customers that may be particularly important to rival hospitals if they are to compete effectively (eg policyholders at large corporate clients). Whilst the ownership of primary care or outpatient diagnostic centres does not in itself establish a competition problem, we would nevertheless want to consider the matter further.
158. For each type of primary care facility, we are considering the incentives of clinicians to refer patients to private hospitals in the same group, whether the volume of patients referred in this way is material, the types of patients these groups treat, and the extent to which patients are aware of the common ownership of primary and secondary care facilities.
159. We have not formed a current view as to whether any vertical issues are likely to distort competition. We will investigate further the effects, if any, on competition arising from joint ownership of primary and secondary care facilities in the same geographic area may give rise to distortions of competition. We are doing further work to:
  - (a) better understand these types of arrangements;
  - (b) where possible test whether referral patterns are affected; and
  - (c) understand patient awareness of primary care facility ownership.