

Barriers to entry and expansion

Introduction

1. In our issues statement we set out a number of theories of harm that we proposed to consider as part of our investigation into the private healthcare market. Theory of harm 5 posited that there may be barriers to entry and expansion in the private healthcare market.
2. We set out here our emerging thinking on the basis of evidence collected for the purpose of preparing four papers on barriers to entry and expansion:
 - (a) Circle's entry in Bath;
 - (b) The London Clinic's extension of its cancer treatment facilities;
 - (c) The Edinburgh Clinic and Aspen's entry and Spire's expansion in Edinburgh; and
 - (d) arrangements adopted by private healthcare providers and their effect on clinician incentives.
3. The three case studies on entry or expansion were selected on the grounds that they were recent enough to be relevant but happened sufficiently long ago to permit conclusions to be drawn about their outcomes. We also chose episodes which were capable of illustrating differences that might exist in healthcare markets in different parts of the UK. However, we note that the number of examples of entry or expansion in this market was limited: we found only seven examples of entry in the last five years.¹
4. In the course of undertaking the first three case studies, we became aware that certain arrangements between hospital groups and consultants might have the effect of restricting entry or expansion, for example by preventing a consultant working for a rival through an exclusivity agreement. We decided that it would be inappropriate to consider these arrangements in the context of one specific episode. Instead, we reviewed the practices of all the major hospital groups as regards these arrangements, including those whereby a hospital group has acquired private GP or other primary care facilities. For completeness, we also examined the one case where a private hospital (the Cromwell) has been acquired by a PMI (Bupa).

Background

5. Barriers to entry and expansion can be defined as any feature of the market that gives incumbent suppliers an advantage over efficient potential entrants or expansive incumbent firms. 'Barriers' may thus encompass a variety of restrictions on the ability of firms to compete and hence to prevent the benefits of entry or expansion materializing.²

¹ These were: Circle Bath and Reading, Nuffield Health in Cardiff and Guildford, BMI in London, The Edinburgh Clinic and Kingsbridge hospital in Belfast. In addition, we are aware of Spire's development of a full-service hospital in Brighton and that there may be more examples of entry at a smaller scale.

² [Draft Guidelines for Market Investigations](#), June 2012, paragraph 207.

6. Our guidelines for market investigation references³ set out three broad categories of barriers to entry and expansion:
 - (a) natural or intrinsic barriers;
 - (b) regulatory barriers; and
 - (c) strategic barriers.

7. Natural or intrinsic barriers are the unavoidable costs incurred when setting up or expanding a commercial operation. These involve the cost of putting the production process in place, gaining access to essential facilities or inputs and the acquisition of any necessary intellectual property rights. Our guidelines note that an important consideration in evaluating the effects of such barriers is the extent to which the costs associated with them are 'sunk'. In addition, the guidelines recognize that:

In industries where economies of scale are significant, entry or expansion on a small scale may not be profitable unless the firm is aiming at a 'niche' in the market or can develop a new production strategy which offsets the disadvantages of small-scale production. Entry or expansion on a large scale will often entail a high risk because it will generally be successful only if the firm can expand the total market significantly, or substantially replace one or more existing firms.⁴

8. Our guidelines, while noting that regulations are beneficial for a variety of reasons, point out that they may inhibit the extent to which competition can flourish, citing as an example circumstances where only firms with a relevant licence are permitted to compete. Our draft guidelines on market investigations, reflecting our current practice, propose a broader definition of regulatory barriers than would normally be the case, encompassing, for example, intellectual property law, the planning regime, voluntary or compulsory standards and codes of practice.⁵

9. Our guidelines note that strategic barriers can be created by incumbent firms acting to lower post-entry profitability by, for example, making it harder for customers to switch their business to the incoming rival.

Natural or intrinsic barriers to entry or expansion

10. The cost of designing, building and equipping a private hospital able to provide a full range of inpatient, day-case and outpatient facilities is significant. In addition, the ability to recoup these costs in the event that entry fails to be viable is limited: probably to selling the assets to the incumbent or, possibly, and depending on the building's location and layout, changing its use, to hotel or commercial for example.

11. Three of our case studies dealt with episodes where the party entering/expanding had to build and/or convert and equip a new facility. In Bath, Circle built a new hospital on a business park 9 miles south of the city at a cost of around £30 million. In London, the cost of acquiring the site, building and equipping The London Clinic's Cancer Centre adjacent to Harley Street was approximately £90 million. In Edinburgh, Spire built a new day-case hospital (Shawfair Park) near the new site of the Royal Infirmary of Edinburgh at a total cost of around [£]. The Edinburgh Clinic,

³www.competition-commission.org.uk/assets/competitioncommission/docs/pdf/non-inquiry/rep_pub/rules_and_guide/pdf/cc3.pdf.

⁴ Draft Guidelines for Market Investigations, June 2012, paragraph 213.

⁵ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/consultations/market_guidelines_main_text.pdf.

which entered the market on a smaller scale, was able to acquire and convert an existing building.

12. In Circle's case, it is difficult to see an obvious exit strategy that would not have entailed considerable loss had its bid to enter the market failed, though we assume that the options open to the property company which owned the building would have included renting it to another hospital operator or, possibly, securing a change of use. Similarly, in the case of The London Clinic, sale to another hospital operator or change of use to, for example, residential may have been an option, though the latter would have been likely to entail significant loss to The London Clinic. In neither of these cases, however, did the costs of entry appear to act as a deterrent, despite the fact that they were, once committed, effectively sunk.
13. In both cases the parties were able partly to mitigate the risks of investing in the new facilities by committing funds on a staged basis. In Circle's case, this took the form of obtaining an option to acquire the site earmarked for development and applying for outline planning permission prior to receiving binding commitments from local consultants to undertake 50 to 60 per cent of their private work at the new hospital. Having obtained consultant commitments and outline planning permission, Circle could begin raising the necessary finance and apply for detailed planning permission. Commitments of large sums could therefore be matched with milestones confirming support for the venture.
14. The experience of The Edinburgh Clinic also demonstrates that entry into the healthcare market does not need to take place on a large scale. In this case, entry took place through the establishment of a diagnostic and outpatient facility rather than the building or acquisition of a general (full-service) hospital. Over time such a facility may extend the range of treatments that it offers, increasing the proportion of the local private healthcare services market that is contested. As such, entry at a small scale, via a specialized clinic, appears to offer a lower-risk means of entry into a market.
15. We are aware of a number of other examples of small-scale, niche entry over the last few years, including: the Prospect Eye Clinic (Altrincham, May 2009); Cathedral Eye Clinic (Belfast, March 2008); Midland Eye Clinic (2012); the Hand to Elbow Clinic (Bath, 2008); Nucleus Healthcare, a gastroenterology hospital (Cardiff, 2012); and the Cambridge Heart Clinic (2006).⁶
16. However, the competitive interactions witnessed in Edinburgh indicate that a small-scale entrant is unlikely to be able to offer inpatient services at an efficient cost given the economies of scale in their provision. Hence, for an entrant to compete successfully for inpatient work, it would need to invest more heavily in facilities and staff be able to capture significant patient volumes. Further, barriers to PMI recognition may be higher for facilities offering in-patient care, as we discuss below.
17. [✂]
18. On the basis of the evidence that we have seen, we do not think that the capital costs associated with market entry create barriers to entry or expansion. However, we consider that the combination of economies of scale and limited market size may restrict entry by firms wishing to enter or expand in the inpatient segment of the healthcare market. These factors may apply more in certain geographic areas than in others, eg sparsely populated or less prosperous geographic areas will have much less poten-

⁶ Laing's Healthcare Market Review, 2011-2012. We understand that Nucleus Healthcare ceased trading in October 2012.

tial demand for private inpatient care than, say, London. On the other hand, entry costs will be much higher in London than in other geographic areas.

Regulatory barriers

19. New healthcare facilities are subject to industry-specific and general regulatory requirements and permissions. A new hospital facility will have to be approved by the relevant regulator and will require planning permission, for example.

Industry-specific regulation

The regulation of healthcare facilities

20. In England, the Care Quality Commission (CQC) is responsible for regulating, auditing and inspecting providers of healthcare (and adult social care) services, including services provided by acute independent hospitals and services. Its role is to register healthcare providers to ensure that they meet common safety and quality standards and, with Monitor, to develop a joint licensing process.⁷ The CQC is responsible for inspecting healthcare facilities and has enforcement powers including the imposition of fines, public warnings or closures if standards are not met.
21. In Scotland the regulator is Healthcare Improvement Scotland,⁸ in Wales it is Healthcare Inspectorate Wales and in Northern Ireland it is the Regulation and Quality Improvement Authority.⁹
22. None of the larger hospital groups, including those that had opened new facilities in Scotland and Wales, reported any problems with obtaining approval for these from the relevant regulator.
23. Circle, in Bath, and The London Clinic told us that they had not encountered any material problems as regards CQC registration, though Circle said that it was required by the CQC to undertake some additional building works in the theatre and recovery areas and that these contributed to a short delay in the hospital's opening.

Healthcare facility regulation as a potential barrier

24. We therefore think that healthcare facility regulation is unlikely to restrict new entrants in the private healthcare market.

General regulatory requirements

Planning regulations

Circle

25. Circle told us that the planning process was identified early on as a significant barrier for its development programme. It said that with no allocations for hospitals/medical facilities in local plans, the default position of local authorities had been to require the applicant to demonstrate 'need' for new medical facilities to override existing land use policy. Circle also explained that it had had to work closely with local authorities to

⁷ CQS will thus register independent hospitals but NHS Trusts will not have to register PPU's separately.

⁸ www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_regulation.aspx

⁹ NHS Handbook 2012/13, p147.

guide them through unfamiliar territory when assessing healthcare 'need'. In particular, it told us, in the absence of government guidance to local authorities it had been necessary to persuade both officers and planning committee members that many of the views of local hospital trusts (and incumbent private hospital providers) should be seen as partial. It said that such objections should be regarded in the same way that one would view an objection by one supermarket operator that there was no need for a rival to establish itself in the area.

26. Circle told us that it faced no problems in obtaining planning permission for its hospital in Bath. It did, however, contrast the ease of obtaining planning permission for its new-build hospital in Bath with a similar development in Southampton which was taken to appeal, and in Warwick, where it came close to having planning permission refused.

Southampton

27. Circle told us that in Southampton it faced opposition from three incumbent private hospitals and the Southampton University Hospital Trust (articulated, it said, through the Test Valley Borough Council).
28. The appeal over the refusal of planning permission for its proposed hospital at Adanac Park culminated in a two-week planning inquiry. The arguments put forward at the inquiry centred on whether the current allocation of the site for 'employment use' would or should be changed by the proposal, whether the hospital might impact negatively on NHS healthcare and whether there was a 'need' for the new hospital given existing hospital capacity (NHS and private).
29. The Inspector considered but dismissed arguments that the proposed hospital would affect local NHS provision. He said that clinicians who had given evidence to the inquiry had said that Circle's presence would not reduce their NHS commitments, and while the proposed hospital might give rise to some difficulty in filling radiographer positions, for example, this did not constitute an insurmountable problem. Finding in favour of Circle, he concluded that 'there is good reason to believe that the proposed hospital would be an important addition for meeting existing and future healthcare needs in South Hampshire'.¹⁰

Warwick

30. Circle told us that Nuffield Health and Warwick NHS Hospital were very nearly successful in preventing Circle from obtaining planning permission for its hospital at Tournament Fields. Tournament Fields had been allocated for 'employment use' in the local plan. As hospitals do not qualify as employment use, Warwick Council required need for a new hospital to be demonstrated. Circle told us that Glen Burley, the Chief Executive of Warwick NHS Hospital, wrote to the head of planning, stating that the Circle hospital would undermine the viability of his hospital as Circle planned to treat NHS patients under Choose and Book. In the letter, Mr Burley said that he did not think that there was a need for additional healthcare capacity in the area. Circle said that, in parallel, the Chief Executive of Nuffield Health encouraged opposition to Circle's plans through the local press and MP.
31. Warwick District Council commissioned research from consultants which concluded that the presence of a Circle facility would not undermine the NHS hospital but would

¹⁰ Appeal decision, November 2011 (MQ Q 60f.10STH_ Appeal Decision, paragraph 64).

increase capacity and thus choice for both private and NHS patients. On this basis, Circle's application went to the Planning Committee with a Council recommendation to approve and the application was granted, albeit after a close vote.

Other hospital groups

32. While Circle has had more experience of developing new hospital facilities than the major hospital operators, we noted some instances of the larger groups deciding to open new hospitals. These included Spire's hospitals in Brighton (Montefiore) and Edinburgh (Shawfair), which it did proceed with, and BMI's in Edinburgh, which it did not. Neither told us that it had faced any significant planning problems. Similarly, HCA and Ramsay both told us that they had not encountered planning problems in the development of new facilities. Nuffield Health, however, told us that its plans for a £ [⌘] million refurbishment of its Chesterfield hospital in Bristol had been delayed following objections from English Heritage on listed building and conservation grounds. Planning permission was subsequently granted but with a number of conditions, including a BREEM energy assessment. It said that these factors had delayed the project and raised its cost but it had proceeded with it

The London Clinic

33. The London Clinic told us that, given the nature of some of the radiotherapy equipment it was installing, strict health and safety requirements had to be met as regards radiation shielding, and that there were some minor planning issues but none of these caused significant delays. The planning issues arose from objections raised by English Heritage over the height of the atrium and by Transport for London over the removal of a tree.

Planning regulations as a potential barrier

34. Circle has submitted that, although it succeeded in obtaining planning permission for all the hospitals that it had sought to develop, it should not be concluded that the planning system was no longer a significant barrier for new entrants, particularly those less well funded and resourced than Circle. We note, however, that of the nine planning applications that Circle told us about, only three presented difficulties due to competitive responses by incumbents and, as Circle recognized, all were overcome eventually. In addition, none of the larger hospital groups submitted that they had encountered any planning issues, albeit on the basis of less experience than Circle, and The London Clinic faced no significant problems in obtaining planning permission for its major development in the centre of London. We think, therefore, that the planning regime does not impose significant restrictions on new entrants.

Strategic barriers

35. We have observed two potential restrictions on entry and expansion which fall into this category: PMIs declining to recognize new healthcare facilities, and arrangements between private healthcare providers and clinicians which may deter clinicians from working with the entrant.

PMI recognition

36. The high fixed costs of hospital businesses make their profitability very sensitive to variations in patient volumes. For this reason, private hospital providers (PHPs) are willing to offer significant price discounts to PMIs who are able to deliver large

numbers of patients. The PMIs have adopted a variety of strategies to maximize the patient volumes that they can deliver to particular PHPs.

37. PMIs, for example, offer products to employers who wish to provide private health cover for employees, despite the relatively low margins PMIs may earn from this line of business. This is because corporate clients bring patient volumes and PMIs can use these volumes as leverage in their price negotiations with PHPs.
38. Selective recognition of hospital facilities provides another means of delivering volume to a PHP, by channelling all or most of the PMI's customers to the PHP facility that has offered the most favourable terms.
39. AXA PPP has chosen to recognize healthcare facilities on a selective basis in its acute inpatient and day-case network, in effect inviting tenders for recognition on it. Though AXA PPP's agreements with PHPs may not impose exclusivity obligations on AXA PPP as such, a rival to the successful provider which is denied recognition will not have access to patients funded by AXA PPP who hold a network policy unless that patient is granted a medical exemption but will nevertheless currently have access to AXA PPP patients requiring outpatient diagnostics and treatment. Further, the agreement between AXA PPP and the PHP may contain an obligation on the parties to review prices if volumes vary beyond certain specified limits as a result of AXA PPP's decision to recognize another provider.
40. Aviva has 2 main hospital lists: its Key list of hospitals as well as its more extensive, premium Extended list containing, additional, generally more expensive hospitals. The majority of its customers hold a product that provides access to the hospitals on its Key list. A smaller proportion of customers hold a product that provides access to its Extended list and can choose to access one of the additional hospitals recognized on this list. We saw in our Bath case study that AXA PPP's refusal to recognize the new Circle hospital in Bath for day-case and inpatient treatment caused Circle significant difficulties. Not only did AXA PPP represent about 25 per cent of the PMI market but, because consultants tend to be reluctant to split their work between two hospitals if this can be avoided, Circle faced the risk that surgeons would continue to treat all patients at BMI's Bath Clinic.
41. Because of this, Circle chose, as a temporary measure, to treat AXA PPP customers at its own expense while continuing to try and negotiate recognition terms with AXA PPP. Circle did the same with Aviva patients, though the financial contribution made by Aviva was greater than AXA PPP's.
42. Circle told us that AXA PPP's decision not to recognize its Bath facility, and to a lesser extent Aviva's, had negatively impacted its profitability by forcing it to treat the patients concerned at its own expense, and that as a result it would become profitable later than originally anticipated.
43. Nuffield Health told us that AXA PPP had excluded its Leeds hospital from AXA PPP's main acute hospital network and that it faced difficulties similar to those described in our case study on Bath.
44. Dr Errington, previous owner and founder of The Edinburgh Clinic, told us that AXA PPP's decision not to recognize it other than for outpatient treatment effectively prevented its expansion into areas of treatment requiring day-case or inpatient care.
45. We did not, however, find PMI recognition to be a problem in the case of The London Clinic's expansion.

PMI recognition as a potential barrier

46. Lack of recognition by one of the larger PMIs appears to be capable of restricting the profitability of new companies entering the market by denying them access to that PMI's customers and potentially customers of other PMIs because of 'consultant drag'.
47. We have seen no evidence that hospital groups have the ability to deter entry by forcing a PMI to deny recognition to an entrant even if they have an incentive to do so. We found commercial arrangements which would make it extremely unattractive to a PMI to risk failing to achieve agreed volume targets, by recognizing a rival for example, but there was no evidence to suggest that the PMIs involved were unwilling parties to these arrangements, given the discounts that meeting volume thresholds could bring.

Incentives arising from arrangements between clinicians and PHPs

The extent and range of agreements

48. We examined a wide variety of arrangements between clinicians and PHPs whose objectives were, broadly, to reward individual clinicians for conduct that would take forward the hospital operator's business, for example by encouraging referrals to its facilities. These varied in sophistication from a simple payment per referral/admission scheme (rare), through subsidized consulting rooms on the hospital's premises (very common) to longer-term incentives based on a stake in a vehicle jointly owned by clinicians and hospital operators (becoming more common).
49. Such arrangements have not been confined to a particular geographic area, such as London, nor to particular hospital types, say large groups rather than independents. However, it appears that incentive schemes, particularly short-term ones, are most likely to be adopted in geographic areas where a PHP is facing or anticipates competition and within clinical specialties where competition for consultants is particularly strong, for example oncology.
50. [X] scheme for consultants was launched in, where it faced a competitive threat [X]. BMI operated a pilot scheme in Bath whereby it made payments to GPs for pre-operative assessments on BMI patients. Under the terms of the scheme, where patients were referred to the Bath Clinic for an out-patient consultation and it was determined that surgery was necessary, a pre-operative assessment (which would otherwise be carried out at Bath Clinic) was booked with the referring GP. The GP would be paid according to the type of assessment they undertook, with payment being dependent on the patient completing their care pathway at the Bath Clinic. Between six and eight local GP surgeries joined the scheme.
51. Similarly, The London Clinic adopted various arrangements aimed at encouraging referrals from prominent oncologists when faced with a threat to its expansion plans from HCA. We note that in areas of practice such as oncology, where individual consultants may be capable of generating many millions of pounds in revenue for a hospital, competition for their loyalty may be intense.
52. Arrangements between PHPs and clinicians could potentially restrict entry or expansion in the private healthcare market in two ways:
 - (a) agreements with key clinicians could require or incentivize them to work predominantly or exclusively for a PHP and thus deny potential rivals access to some or all of their services; and

(b) agreements with clinicians providing primary care services, including GPs, could require or incentivize them to channel referrals to the PHP rather than its rivals.

Obligations and incentives to work predominantly or exclusively for one PHP

53. We found some examples of agreements which obliged consultants to work predominantly or exclusively for one PHP¹¹. Spire, for example told us of a few such arrangements that it had either with individual clinicians [redacted] or with groups of consultants [redacted].
54. HCA's agreements in some cases restricted a partner in its joint ventures from undertaking similar work for rivals in London,¹² for example both the LOC LLP and the Cyberknife partnership agreements. The London Clinic's agreements with two clinicians specifically prevented them from working at any HCA facility, though with a 'best and clinical interests of the patient' caveat.
55. In some cases, clinicians were not obliged by the terms of their contracts to work exclusively for the PHP but this may have been the result in practice. Although consultants were only asked to commit to undertaking 50 to 60 per cent of their private work at Circle Bath, for example, carrying out all of their private work there could have been more convenient than splitting their lists.
56. Unless all consultants in a particular specialty, or a sub-set capable of generating very significant amounts of revenue, decided to undertake all or most of their private work at the same hospital such arrangements would not necessarily act as a barrier, though we note that it is becoming more common for consultants to form groups (partnerships or 'chambers') which might make such conduct more common in future.

Obligations or incentives to refer or admit

57. Agreements obliging consultants, GPs and others to use their best endeavours to refer or admit patients to the PHP's hospitals were common prior to 2012 but many were then amended or abandoned. It would appear, as a result of the OFT and CC's investigations. These amendments generally removed the direct link between referrals and payments, caveated referral obligations or denied them altogether.
58. HCA told us that its professional services agreement had been amended to read that the clinician 'shall be under no obligation to refer patients to any [HCA] hospital'. Similar amendments had been made, in 2012, to the partnership or shareholder agreements of other entities including Roodlane and the LOC.
59. Bupa Cromwell Hospital (BCH) told us that it provided consulting rooms for [redacted] GPs on its premises and that the rental for these rooms was calculated according to a pre-agreed schedule in (inverse) relation to the anticipated fees that may be generated at the hospital. BCH confirmed that it had now removed the direct link in these agreements between the office rental and fees.
60. BCH also told us that it had operated schemes which provided consultants with direct financial incentives to refer patients to the hospital. These included [redacted]

¹¹ Such agreements will usually provide that the referral obligation will not apply where such referral would be against the patient's best clinical interests or if the patient's insurer will not authorise treatment at the relevant facility or if it is the patient's express wish to be treated elsewhere.

¹² Within a 10-mile radius of the Cyberknife clinic.

Clinician agreements and barriers to entry

61. Increasingly, and coincident with OFT/CC intervention, hospital groups are:
 - (a) withdrawing less sophisticated schemes which might attract criticism on ethical (or regulatory) grounds, for example volume-related incentive schemes; and/or
 - (b) caveating the obligations which they place on clinicians with an overriding obligation to serve the best clinical interests of the patient; and/or
 - (c) extending caveats in agreements still further to the effect that clinicians should feel under no obligation whatsoever to refer patients to the hospital group concerned on the basis of either the terms or the existence of agreements entered into.
62. Notwithstanding the caveats that some hospital operators have introduced, we think it is possible that some tension may arise between the, in particular, referral obligations of clinicians as strictly defined in these agreements and the financial rewards to which they are entitled under them. A consultant or a GP may, strictly, be bound by an obligation to refer a patient only on the basis of the patient's best and clinical interests but, if that clinician has a financial stake in a facility that is a possible referral route or could benefit in some other way by referring a patient to a particular facility, some conflict of interest may arise.
63. If this is so, some of these agreements may still be capable of influencing clinicians in ways that would restrict the prospects of new entrants in the healthcare market who had no such arrangements in place.

Other factors

64. Evidence of persistent profits above the competitive level within the industry or among large incumbents is consistent with a finding that barriers are considerable and that entry is therefore unlikely. But it is neither a necessary nor a sufficient effect. Data showing that incumbents consistently fail to earn high profits is generally consistent with low entry barriers, but it does not prove that barriers are low and that competition is working dynamically.
65. As noted in our profitability working paper, we have found that the private hospital operators analysed, on average, are making profits in excess of the cost of capital, which may suggest that there are barriers to entry in the provision of private healthcare services.

Barriers to entry and expansion

66. We have examined the extent to which new entrants may face restrictions arising from certain features of the private healthcare market. We do not think that regulatory barriers to entry are significant. We are of the view that there are certain features of the market, including economies of scale, PMI recognition and incentives and obligations arising from PHP relationships with GPs and consultants, which may give rise to barriers to entry and expansion.