

PRIVATE HEALTHCARE MARKET INVESTIGATION

Provisional findings report

Notified: 28 August 2013

The Competition Commission has excluded from this published version of the provisional findings report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [⌘]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

Contents

Page

Summary	1
The reference	1
Market characteristics	1
Market structure	2
Cost structure of the industry	2
Demand and excess capacity	2
The NHSs	3
Theories of harm	3
The relevant markets	4
Competitive assessment of hospitals	5
Barriers to entry and expansion	6
Local competitive constraints (including concentration)	7
Bargaining between PMIs and hospital operators	8
Market outcomes	9
Pricing	9
Profitability	11
Provisional conclusions on competitive assessment of hospitals	11
Consultants	12
Clinician incentives	13
Information availability and asymmetry	16
Provisional findings	17
Provisional findings	19
1. The reference and our statutory task	19
Background to the reference	20
The OFT's reference decision	20
Conduct of the investigation	22
Structure of provisional findings	24
2. Industry background	26
Introduction	26
The nature of private healthcare	26
Background	26
Private hospitals	27
Clinicians	27
Trends in private healthcare	28
Trends in the NHS	28
Trends in spending	29
Trends in delivery	31
Spending in private healthcare	32
Expenditure on privately-funded healthcare services	32
NHS expenditure on privately-funded healthcare services	34
Purchasers of private healthcare	37
The patient pathway	39
The GP	40
Paying for privately-funded healthcare services	41
The consultant—making the appointment	43
The consultant—initial appointment	43
Treatment and follow-up	44
Variations	45
The regulatory regime	46
Regulating private hospitals and clinics	47
Regulating doctors	51
Regulating PMIs	53
3. The parties	55

The main hospital groups	55
BMI Healthcare.....	55
Spire Healthcare.....	58
Hospital Corporation of America	61
Nuffield Health.....	65
Ramsay Health Care	69
Other private hospitals and private hospital operators	71
The London Clinic	71
Bupa Cromwell Hospital	72
Aspen.....	73
Circle.....	75
Independent hospitals	76
NHS Private Patient Units	77
Clinicians.....	79
Overview	79
Associated organizations.....	80
GPs.....	81
Consultants	83
PMI—products and providers	85
Background	86
The cost of private medical cover	87
Market shares.....	87
PMI products	88
PMI business models	90
PMI practice on patient guidance.....	90
Bupa.....	92
AXA PPP.....	93
Aviva Health	94
PruHealth	95
Other PMI providers	96
4. Framework for our competitive assessment	98
Market characteristics of privately-funded healthcare services	98
Market structure	99
Cost structure of the industry.....	99
Demand and excess capacity.....	99
Patients and the role of PMIs.....	100
The NHSs.....	103
Other characteristics.....	105
Theories of harm	107
Unilateral market power including market concentration.....	108
Barriers to entry.....	110
Weak customer response	112
Vertical integration.....	113
5. Market definition.....	114
Introduction	114
Product markets	115
Demand-side substitution by patients	116
Supply-side substitution by consultants	119
Supply-side substitution by hospitals	120
Same set of hospitals	128
Conclusions on product market(s)	133
Geographic markets.....	136
Conclusion on geographic market(s)	140
6. Competitive assessment: Private hospital operators	142
Introduction	142
Structure	144

	Barriers to entry and expansion	144
	Case studies on entry	145
	Potential barriers to entry or expansion	152
	Local competitive constraints (including concentration)	164
	Bargaining between PMIs and hospital operators	194
	Market outcomes self-pay prices	207
	Insured prices	211
	Profitability	232
	Provisional conclusions	246
7.	Consultants	250
	Introduction	250
	ToH 2—Local market power	250
	Individual consultants	253
	Consultant groups	255
	Anaesthetist groups	256
	Analysis	256
	Results	260
	Other consultant groups	262
	ToH 4—countervailing power of PMIs	263
	PMIs constraining consultant fees	265
	Review of PMI fee schedules	267
	Consultant fee capping	269
	Guided referral	273
	Analysis of key potential concerns regarding PMIs’ buyer power	276
	PMI reimbursement rates	276
	Top-up fees	279
	Other issues with regard to PMIs and consultants	282
	Summary of our findings on consultants	285
8.	Hospital competition for clinician referrals	287
	Introduction	287
	Schemes adopted by the main hospital groups	288
	BMI	289
	Spire	293
	HCA	295
	Nuffield Health	301
	Ramsay	304
	Other private hospital operators	306
	Circle	306
	Bupa Cromwell Hospital	307
	The London Clinic	308
	Aspen	310
	Views of the parties	311
	Hospital operators’ views	311
	PMIs’ views	316
	The GMC	318
	Clinicians’ representatives	318
	Provisional conclusions	320
9.	Information availability	326
	Introduction	326
	Choosing a consultant	327
	What the parties told us	327
	PMIs	327
	Private hospital operators	329
	Our surveys	330
	Current and future information availability on consultants	330
	Assessment—choosing a consultant	331

Choosing a treatment option	332
Overview	332
What the parties told us.....	333
Information available on treatment options	335
Patient decision aids.....	337
Assessment—choosing a treatment option	340
Choosing a hospital.....	341
Information available currently.....	341
Hospital operators' views.....	345
Provisional conclusions.....	346
Choosing a consultant.....	346
Choosing a treatment option.....	347
Choosing a private hospital	348
13. Provisional findings	349

Appendices

1.1	Terms of reference and conduct of our investigation
2.1	Employers' private healthcare schemes
3.1	Private Patient Unit expansion
6.1	Entry and expansion case study 1: Circle Holdings PLC, Bath
6.2	Entry and expansion case study 3: Edinburgh and the Lothians
6.3	Entry and expansion case study 2: The London Clinic
6.4	Measuring local concentration using the LOCI measure
6.5	Initial filtering of hospitals
6.6	Hospital list
6.7	Local competitive assessments
6.8	Local assessment: hospital characteristics
6.9	Price-concentration analysis for self-pay patients
6.10	Central London
6.11	National negotiations
6.12	Empirical analysis of price outcomes in negotiations between hospital operators and PMIs
6.13	Assessment of profitability
6.14	Assessment of the cost of capital
6.15	DTZ report—provision of land consultancy services
6.16	Land valuations
7.1	Anaesthetist groups
7.2	Consultant remuneration
7.3	Summary of consultant and trade body/professional association submissions by theme
7.4	Information availability

Summary

The reference

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

Market characteristics

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

¹ [Section 134\(2\)](#) of the Act.

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

Market structure

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

Cost structure of the industry

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

Demand and excess capacity

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

The NHSs

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

Theories of harm

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

- (c) ToH3: a private hospital operator may have market power with respect to PMIs in national negotiations.
- (d) ToH4: a PMI may have buyer power over individual consultants.
- (e) ToH5: there may be barriers to entry into the supply of privately funded healthcare services.
- (f) ToH6: there may be information asymmetries and limited information available to patients (as well as GPs and possibly PMIs).
- (g) ToH7: there may be vertical linkages that lead to significant harm to competition.

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

The relevant markets

16. We defined distinct product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient care. For the purposes of the assessment of competitive constraints we aggregated most of the specialties where we thought it appropriate.
17. In order to identify the set of private hospitals and PPU's to be considered in each individual hospital competitive assessment, we used the hospital's catchment area as a starting point and looked at any overlap with other private hospitals' and PPU's catchment areas, including hospitals inside and outside the hospital's catchment area.

³ Annotated issues statement ([AIS](#)), paragraphs 47–159.

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

Competitive assessment of hospitals

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

Barriers to entry and expansion

22. We examined barriers to entry in order to determine the extent to which incumbent providers of inpatient care are constrained by the threat of entry or expansion. In addition to considering the evidence and submissions of the parties we conducted three case studies into entry episodes.

23. In relation to de novo entry, over the last few years very few new firms have started offering healthcare services by the provision of full service hospitals, the notable exception being the entry of Circle. We have seen examples, but not many, of existing hospital operators opening full service hospitals in new areas. We are aware of a number of examples of entry of day-care facilities over the last few years.

24. We found that the necessity of incurring high levels of sunk costs to set up a hospital with inpatient services meant that in a static market any incumbent could be expected to react very aggressively to entry, and that this expected reaction would deter entry. We found that there were significant capital costs of building and equipping a full service hospital, and that there were large economies of scale relative to the size of local markets such that many local markets were only large enough to support a small number of efficiently sized hospitals. We also found that demand for private health services had been fairly static over the last five years and that no significant growth was expected for the foreseeable future. We found that in combination these features constituted the greatest barrier to entry. We found that the barriers relating to sunk costs were present in all areas and that the barrier relating to the economies of scale was likely to be present in many areas also.

25. We also found that there were barriers related to site availability and the need for consultant commitment to new facilities.

Local competitive constraints (including concentration)

26. We assessed local competitive conditions in order to determine whether or not the competitive constraints exerted by hospitals on each other at the local level were too low.

27. We identified those hospitals which were unlikely to cause concern and did not require further examination. We then examined the remaining hospitals in more detail, taking into consideration several factors, including: (a) results of different concentration measures; (b) the hospital's own individual characteristics as well as the characteristics of the nearby private hospitals and PPU's, either competitor hospitals or hospitals under the same ownership; (c) characteristics of the local area in which the hospital is situated; (d) internal documentary evidence submitted by the parties; and (e) the views of the parties.

28. As a result of the competitive assessments of individual hospitals, we found 101 hospitals outside central London to be a concern. These hospitals allow us to identify local areas where there could be an AEC.

29. We found the central London market to be highly concentrated and that the competitive constraints currently exerted on HCA by other private hospital operators and PPU's in central London are weak. We also considered hospitals in the greater London area and the NHS, and found these to be weak constraints on HCA. We formed the view that HCA's position in central London can may also be potentially reinforced by any ability it has to outbid its competitors for future PPU management contracts and to acquire further GP practices.

Bargaining between PMIs and hospital operators

30. The hospital operators and PMIs put forward very different positions on their relative bargaining strength.

31. Several PMIs, including Bupa, the largest, argued that some hospital operators had hospitals to which access was essential for PMIs ('must have' hospitals). As a result, they argued, these hospital operators had market power in negotiations with PMIs. PMIs also argued that because in many cases the decision which hospital to use was made by patients without PMI input they had limited opportunity to influence their use of hospitals, except by 'delisting' them (ie not allowing policyholders to use these hospitals). Bupa told us that hospital operators negotiated in such a way that if a PMI wanted to use a certain number of hospital operator's hospitals, it would be penalized unless it also recognized all of that operator's other hospitals ('one in, all in negotiations').

32. The hospital operators argued that they had very few, or no, 'must have' hospitals. They also argued that even if they had such hospitals the buyer power of the PMIs was sufficient that hospital operators could derive no advantage from these. They said that the potential to delist hospitals gave PMIs great power as the effects of delisting on a hospital's finances [X]. They also argued that PMIs could also reduce use of hospitals by use of restricted networks or by 'guided referrals' whereby PMIs were involved in the choice of consultant, and thereby of hospitals. Hospital operators forcefully denied that they engaged in 'one in, all in negotiations'.

33. We considered the one major incident of delisting. In 2011, following protracted negotiations in which no agreement was reached, Bupa removed 37 BMI hospitals from its hospital networks. An agreement between Bupa and BMI was later reached and Bupa reinstated most, but not all, of the BMI hospitals in its networks. Hospital

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

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

Market outcomes

Pricing

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

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

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

Profitability

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

Provisional conclusions on competitive assessment of hospitals

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

⁴ [Guidelines](#), Annex A, paragraph 14.

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

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

Consultants

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

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

Clinician incentives

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

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

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

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

Information availability and asymmetry

66. We considered information availability and asymmetry in three contexts: choosing a consultant, choosing a treatment option; and choosing a private hospital.
67. For competition between consultants to function well, patients need to know, in addition to the consultant's fee structure, information about the consultant's qualifications, areas of expertise and performance.
68. Information on the qualifications and specialisms of consultants was readily available across the UK via private and NHS hospital websites, portals such as Dr Foster and the consultants' own websites. In England, initiatives are underway, though not yet complete, to disclose individual consultant performance data in ten specialisms. We understand that no equivalent programmes to disclose consultant performance information are envisaged for the rest of the UK.
69. We could not be sure when or whether the remaining consultant performance data will be disclosed in England will appear nor whether plans to disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. We therefore provisionally concluded that a lack of sufficient publicly available

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

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

Provisional findings

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

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

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

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

Provisional findings

1. The reference and our statutory task

- 1.1. On 4 April 2012, the OFT made a market investigation reference to the CC under sections 131 and 133 of the Act regarding the supply or acquisition of privately-funded healthcare services in the UK.
- 1.2. The terms of reference for our investigation are provided in Appendix 1.1. This document sets out our provisional findings from this investigation based on the evidence we have reviewed and the analysis we have carried out to date. We are required to publish our final report by 3 April 2014.
- 1.3. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom’. If the CC decides that there is such a feature or combination of features, then there is an AEC.¹
- 1.4. Under section 131(2) of the 2002 Act, a ‘feature’ of the market refers to:
 - (a) the structure of the market concerned or any aspect of that structure;
 - (b) any conduct (whether or not in the market concerned) of one or more than one person who supplies or acquires goods or services in the market concerned; or
 - (c) any conduct relating to the market concerned of customers of any person who supplies or acquires goods or services.
- 1.5. If the CC finds that there is an AEC, it is required under section 134(4) of the Act to decide whether action should be taken by it, or whether it should recommend the taking of action by others, for the purpose of remedying, mitigating or preventing the

¹ [Section 134\(2\)](#) of the Act.

AEC, or any detrimental effect on customers² so far as it has resulted from, or may be expected to result from, the AEC; and, if so, what action should be taken and what is to be remedied, mitigated or prevented. The Act requires the CC 'to achieve as comprehensive a solution as is reasonable and practicable to the AEC and any detrimental effects on customers so far resulting from the AEC'.³ In considering remedies, the CC may take into account any relevant consumer benefits, as defined in the Act, arising from the feature or features of the market.⁴

- 1.6. Our terms of reference (see Appendix 1.1) state that for the purpose of the reference, privately-funded healthcare services are services provided to patients via private facilities/clinics including private patient units (PPUs), through the services of consultants, medical and clinical professionals who work within those facilities.
- 1.7. In the remainder of this section, we set out (a) the background to the reference; (b) our conduct of the investigation to date; and (c) the structure of these provisional findings.

Background to the reference

The OFT's reference decision

- 1.8. The OFT commenced a [market study](#) of privately-funded healthcare in March 2011. The OFT published a consultation document on a proposal to refer the market in December 2011. Following that consultation, it decided to refer the market to the CC having identified a number of features. These features appeared to result in reduced patient choice in privately-funded healthcare services and restricted competition between private healthcare providers, the expected outcome of which might be

² A detrimental effect on customers is defined in [section 134\(5\)](#) of the Act as one taking the form of: (a) higher prices, lower quality or less choice of goods or services in any market in the UK (whether or not the market to which the feature or features concerned relate); or (b) less innovation in relation to such goods or services.

³ [Section 134\(6\)](#) of the Act.

⁴ [Section 134\(7\)](#) of the Act.

higher prices and lower quality of services for patients, and a stifling of innovation in the privately-funded healthcare market.

1.9. The OFT identified the following features which might adversely affect competition:⁵

- information asymmetries resulting from a shortage of accessible, standardized and comparable information provided to patients and their advisers in relation to private healthcare providers;
- concentration in the provision of privately-funded healthcare at the national level and at the local level areas of extreme concentration;
- concentration of anaesthetists as a result of the prevalence of anaesthetists who are part of groups; and
- barriers to entry as a result of conditions imposed by larger hospital operators as part of recognition of their facilities on PMI networks, the need for wide PMI network recognition and the consultant drag effect, incentives paid by hospital operators to consultants and possibly financial incentives paid by hospital operators to GPs.

1.10. The OFT also made two recommendations to other organizations to address two issues that arose during the course of its market study. First, responding to concerns by consumers as to the level of extra payments sought from some consultants that are not covered under their PMI (shortfalls), the OFT engaged with the Financial Services Authority (FSA) now the Financial Conduct Authority (FCA) on this issue. The CC understands that the Association of British Insurers (ABI) has confirmed to the FSA, on behalf of its members, that PMI providers will either cover the total costs so that no shortfall arises or will make clear the possibility of a shortfall payment as a result of the limits which apply to the amount payable under their policies at point of sale and claim. Secondly, having noted the development of partnership

⁵http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf .

arrangements between PPUs and hospital operators, the OFT made a recommendation to the NHS and foundation trusts that when seeking to agree partnership arrangements, they should consider that the PPUs may be at a potential competitive advantage in the privately-funded healthcare market due to any implicit, non-market benefits they could receive from their connections to the NHS.

Conduct of the investigation

- 1.11. The following paragraphs provide an overview of the process we followed in our investigation and how we analysed the evidence, data and information we received. Further details can be found in Appendix 1.1.
- 1.12. We published an issues statement on 22 June 2012 taking into account the OFT's market study report and the initial information and evidence we had received in response to our initial requests for information and submissions. The issues statement identified seven hypotheses or theories of harm (ToH) to help frame the conduct of the investigation. In the issues statement we recognized that the industry involves a variety of suppliers and acquirers of services within the reference market including hospital operators, consultants, GPs, other medical and clinical professionals, the NHS and PMIs. However, whilst we would be investigating the various facets of the industry including how the conduct of PMIs affects the provision of privately-funded healthcare, we did not investigate how competition functions in the PMI market, as this market was not referred by the OFT for investigation.⁶ Similarly, healthcare services funded by the NHS, whether carried out in the NHS or privately-operated facilities were also outside our terms of reference.⁷

⁶ IS, paragraph 3.

⁷ IS, paragraph 3.

1.13. We also identified at an early stage of the investigation that the role of pharmaceutical companies and equipment suppliers would not form part of the investigation.⁸ In preparing our extensive questionnaires to parties, we decided to focus the investigation on privately-funded acute healthcare services provided primarily in private hospitals, as these were the focus of the OFT's market study and of submissions received from parties in the earlier phases of the investigation. We also decided not to consider in detail privately-funded healthcare services that are offered by different providers to those that provide private hospital-based acute services where the nature of demand is different and where such services are not covered by insurance. The following treatments were not analysed in detail as a result:

- Elective cosmetic surgery: meaning those treatments done purely electively, including minor laser eye and skin treatments although cosmetic procedures following trauma were included.
- Standard maternity treatments: meaning maternity-only services by specialist providers although in some parts of or analyses we included emergency/non-routine acute private hospital maternity treatments.
- Fertility and pregnancy termination treatments.
- Mental health treatments.
- Dentistry unless provided within an acute private hospital facility.
- Specialist outpatient services such as physiotherapy and nutrition.⁹

1.14. We held 11 site visits, seven to private hospitals and four to the premises of PMIs. Between February and April 2013, we held 17 hearings with interested parties. We have had extensive contact with and/or received submissions from a large number of interested parties including hospital operators, consultants, GPs, trade and

⁸ IS, footnote 7.

⁹ AIS, paragraph 4.

professional organizations, government departments, agencies and regulators, PMIs, PMI policyholders and patients.

- 1.15. On 28 February 2013, we published an annotated issues statement which set out our thinking based on the evidence received and the analyses we had undertaken by that time. The document highlighted those issues which we considered would be the focus of the investigation going forward and those issues which were of lesser concern. The annotated issues statement contained a number of working papers as appendices and we published further working papers between February and June 2013.
- 1.16. We published a considerable number of documents on the CC website. These include non-confidential versions of parties' written submissions, some non-confidential versions of summaries of hearings with a number of parties,¹⁰ parties responses to our issues statement and annotated issues statement. Further details can be found in Appendix 1.1.

Structure of provisional findings

- 1.17. This document, together with its appendices, constitutes our provisional findings. It refers, where appropriate, to material published separately on the CC website. The report, however, is self-contained and is designed to provide all material necessary for an understanding of our provisional findings. The accompanying Notice of Possible Remedies sets out details of remedies the CC identified as possibly addressing the AEC effectively, and is the starting point for a discussion of remedies with the relevant parties to the investigation.

¹⁰ Further summaries will be published as soon as possible.

1.18. Following consideration of responses to these provisional findings and our Notice of Possible Remedies, as well as any further evidence received, we shall publish our final report.

1.19. The remainder of these provisional findings is set out as follows:

- Section 2 describes the background to the industry including relevant policy frameworks and regulation of the industry.
- Section 3 provides information on the main hospital operators, on clinicians and PMI companies active in the provision of privately-funded healthcare.
- Section 4 sets out the framework for our competitive assessment.
- Section 5 considers market definition.
- Section 6 sets out our analysis and assessment of competition in the supply of privately-funded healthcare by hospital operators.
- Section 7 sets out our analysis and assessment of competition in the supply of privately-funded healthcare by consultants.
- Section 8 sets out our analysis and assessment of the issues relating to certain arrangements between hospital operators and clinicians.
- Section 9 sets out our analysis and assessment of the issues relating to the availability of information and information asymmetries.
- Section 10 presents our provisional findings in relation to the statutory questions that we are required to answer.

1.20. Appendices supporting each section are numbered according to the first section where they are relevant and are listed in full in the table of contents at the beginning of this report.

2. Industry background

Introduction

- 2.1 In this section, we summarize the nature of privately-funded healthcare, outline industry trends, explain how privately-funded healthcare services are provided and consumed, and describe the regulatory regime for this industry.
- 2.2 We begin with a high-level overview of private healthcare provision in the UK, including some of the main trends that have emerged.

The nature of private healthcare

Background

- 2.3 Privately-funded healthcare services comprise a variety of medical treatments that are paid for directly by individuals or through PMIs.¹ For the purposes of this investigation, such services have been defined as services provided to patients by private hospitals and other facilities, including PPUs, through the services of consultants, and medical and clinical professionals who work within these facilities.²
- 2.4 Of the estimated 572 hospitals operating in the private healthcare sector in mid-2012, 495 of them were owned and managed by private companies (led by the main hospital groups), and 77 were dedicated facilities within NHS hospitals.³ In addition to these, there were between 500 and 600 medical clinics which are not registered as hospitals but which carry out some private healthcare treatments alongside their core general medical services.⁴

¹ They may also be paid for by overseas self-payers or by patients funded by third parties such as embassies.

² OFT Private Healthcare Market Study, 2.14, www.of.gov.uk/shared_of/marketstudies/OFT1396_Private_healthcare.pdf.

³ In this report, we refer to all facilities within NHS hospitals for privately-funded patients as PPUs.

⁴ Laing & Buisson, Private Acute Medical Care 2012, p7–8.

Private hospitals

- 2.5 Private hospitals typically provide a broad range of healthcare services to patients, covering the majority of medical specialties.⁵ Some private hospitals also provide a full range of oncology treatment.
- 2.6 There are a number of differences between the range of services provided by private hospitals in the UK as compared with the NHS, including:
- (a) private hospitals generally do not offer accident and emergency (or trauma) services which are, in any case, not generally covered by PMI policies, but rather focus on elective/planned treatments, both medical and surgical;
 - (b) many private hospitals do not have intensive care or high dependency units, though, as we show later, some hospital groups have focused on procedures which require level 3 intensive care facilities; and
 - (c) private hospitals offer a range of treatments that may not generally be funded by the NHS or which may entail a long wait for treatment, including cosmetic and bariatric surgery and IVF treatments.

Clinicians

- 2.7 As at 31 December 2011, there were approximately 214,000 registered and licensed doctors across England, Scotland, Wales and Northern Ireland.⁶ The majority of consultants providing privately-funded healthcare services also hold an NHS contract—very few practise exclusively in the private sector. Both the number of consultants and the number of GPs has been increasing over the last decade, with the number of GPs growing by about 16 per cent and the number of consultants growing by about 41 per cent.

⁵ See paragraph 3.67.

⁶ [The state of medical education and practice in the UK 2012](#), p141.

Trends in private healthcare

Trends in the NHS

- 2.8 The overwhelming majority of hospital admissions in the UK are to NHS hospitals. In 2011/12, there were around 8.8 million waiting list and planned admissions for surgery to NHS hospitals in the UK. This compares with an estimated 1.24 million privately-funded admissions for surgical procedures in UK private hospitals in 2012.
- 2.9 Over the last decade, major changes have taken place in the NHS. Improvements in the fabric of NHS hospitals and, in particular, reductions in the length of waiting lists for surgery in the mid-2000s increased the degree of competitive tension between private healthcare and its free rival, and this was further reinforced by the economic downturn in 2008.
- 2.10 In England, the Darzi reforms⁷ have sought to provide patients and the public with more information and greater choice, including the possibility of being treated as an NHS patient at a private hospital.⁸ The NHS was funding the treatment of NHS patients at private hospitals prior to these reforms, but growth in NHS spending with private hospitals has been such that the NHS is now a customer of the private acute healthcare sector with a budget equivalent in size to that of some major PMIs.
- 2.11 There are differences in policy across the nations regarding the use of private facilities for treating NHS patients. In Scotland, there is no longer any central procurement of private hospital services, although NHS authorities can still procure private services locally on an *ad hoc* basis to meet their waiting time targets or in cases where local services become unavailable for a period. Current Scottish policy is that all healthcare spending should first be channelled through the NHS, with the

⁷ [High Quality Care for All](#), DoH, 2008.

⁸ Since April 2009, patients have had the legal right to be referred to a [hospital of their choice](#) provided it meets NHS cost and quality requirements.

aim of improving quality and where the use of the private sector is marginal. Similarly in Wales, commissioning of private providers to carry out NHS work is very low and NHS Wales' intention is that it continues to decrease. Only in exceptional cases, primarily in the sphere of mental health and access/waiting time targets, would the NHS Local Health Boards commission private providers to provide NHS healthcare.

Trends in spending

- 2.12 In 2011, the UK market for privately-funded healthcare services was worth an estimated £6.42 billion, which reflects depressed spending on these services in the last two years.⁹ In real terms, the market for privately-funded healthcare services has virtually stood still since 2005 (up only 0.3 per cent in real terms between 2006 and 2011).¹⁰ In other circumstances, this would have been expected to constrain revenue growth in private hospitals. However, private hospital operators have, to some extent, been sheltered from the decline in private expenditure on healthcare, due in part to an increase in self-pay spending in the past three years, and real growth in NHS purchasing from the private sector.¹¹
- 2.13 Total expenditure on acute healthcare at private hospitals and clinics in the UK was £4.1 billion in 2011, 70 per cent of which was generated by the main hospital groups (see Table 2.1).

⁹ Laing & Buisson Private Acute Medical Care 2012, pi.

¹⁰ *ibid* p i.

¹¹ *ibid* p i.

TABLE 2.1 Top ten independent hospital providers by acute medical/surgical revenue, 2005 to 2011

Provider and range	2005 £m	2006 £m	2007 £m	2008 £m	2009 £m	2010 £m	2011 £m	2011 share %
1. General Healthcare Group	612.0	644.0	665.1	746.2	807.4	836.2	885.5	21.4
Netcare Healthcare UK		23.0	23.8	26.4	24.1	19.0	2.2	0.1
2. Spire Healthcare	468.1	420.6	449.3	564.1	620.0	643.0	674.0	16.3
3. HCA	304.3	331.3	368.2	419.7	448.0	490.3	586.0	14.1
4. Nuffield Health	512.5	448.5	455.4	420.2	389.2	391.6	414.2	10.0
5. Ramsay Health Care UK	219.1	224.1	244.1	288.7	326.1	351.4	357.7	8.6
Top five providers	2,115.0	2,091.5	2,205.9	2,465.3	2,614.8	2,731.5	2,919.6	70.4
6. Care UK	10.8	32.4	42.3	121.1	138.6	145.0	150.0	3.6
Partnership Health Group	25.1	32.0	54.4					
7. Trustee of the London Clinic	66.5	75.0	81.3	94.1	102.5	114.7	124.3	3.0
8. Circle			13.0	35.0	63.1	76.2	74.6	1.8
9. Bupa's Cromwell Hospital	62.1	65.5	61.9	63.6	64.7	67.3	73.0	1.8
10. Aspen Healthcare	49.2	52.1	59.0	65.8	67.2	66.4	69.0	1.7
Top ten providers	2,329.6	2,348.5	2,517.8	2,844.9	3,050.9	3,199.7	3,410.5	82.3
Other providers	521.2	619.5	681.2	650.1	667.4	683.3	734.0	17.7
All independent acute providers	2,850.8	2,967.9	3,199.0	3,495.0	3,718.3	3,883.0	4,146.0	100.0

Source: Laing's Healthcare Market Review, 2012–2013, Laing and Buisson.

2.14 Since 2004, when it began using the private sector to clear waiting lists, NHS England spending on privately-funded healthcare services has more than quadrupled in real terms and, in 2011, exceeded £1 billion for the first time.¹² Currently, for example, nearly 20 per cent of NHS expenditure on hip and knee replacements is with private hospitals and clinics.¹³ As we show when we describe private healthcare provision in more detail, most hospital groups, but Ramsay in particular, have benefited from the growth of NHS expenditure on private treatment.¹⁴

2.15 Not all private hospitals have seen winning higher-volume, lower-acuity NHS work as a key part of their business strategy. While representing a threat to private hospitals in one respect, the increasing cost and sophistication of medical technology used to diagnose, monitor and treat patients has been identified as a major opportunity by certain hospital groups. They have chosen to develop a strategy focused on high-value, high-acuity medical specialties, which require heavy expenditure to enter and

¹² Laing & Buisson Private Acute Medical Care 2012, p15. This includes Independent Sector Treatment Centres which accounted for about one-quarter of the NHS total expenditure in the private healthcare sector in 2011.

¹³ [Public Payment and Private Provision](#), Nuffield Trust and Institute for Fiscal Studies, 2013. However, the authors suggest that this may include some patient substitution from the private sector to the NHS.

¹⁴ See paragraph 3.33.

expand into. Our case study on The London Clinic's (TLC's) Cancer Centre (see Appendix 6.3) illustrates the willingness of some providers, particularly TLC and HCA, to make very significant investments in equipment and facilities to try and secure an increased share of certain segments of the healthcare market, particularly oncology.

Trends in delivery

- 2.16 Trends relevant to the delivery of privately-funded healthcare services include a declining proportion of patients being admitted to private hospitals as inpatients and shorter hospital stays for those that are.
- 2.17 NHS hospitals have sought to reduce costs by treating more patients on a daypatient basis and, where they are admitted as inpatients, reducing their length of stay. The average length of stay in NHS hospitals has fallen by a third in the last ten years¹⁵ through the adoption of, for example, less invasive surgical techniques for which recovery periods are shorter, and the adoption of procedures that can be undertaken on a daypatient basis. The number of daypatient-only beds in the NHS almost doubled between 2002/03 and 2012/13,¹⁶ and the most recent figures available (for April 2013) indicate that over 80 per cent of NHS elective admissions in England are on a daypatient basis.¹⁷ Outpatient treatments have also increased across the UK, though this has occurred more noticeably in England than in Scotland, Wales or Northern Ireland.¹⁸
- 2.18 The trend is similar in the private healthcare sector but less pronounced. Between the mid-1990s and mid-2000s overnight bed capacity in the sector gradually con-

¹⁵ Length of stay in hospital in England, Nuffield Trust.

¹⁶ www.nuffieldtrust.org.uk/data-and-charts/day-only-hospital-beds-england.

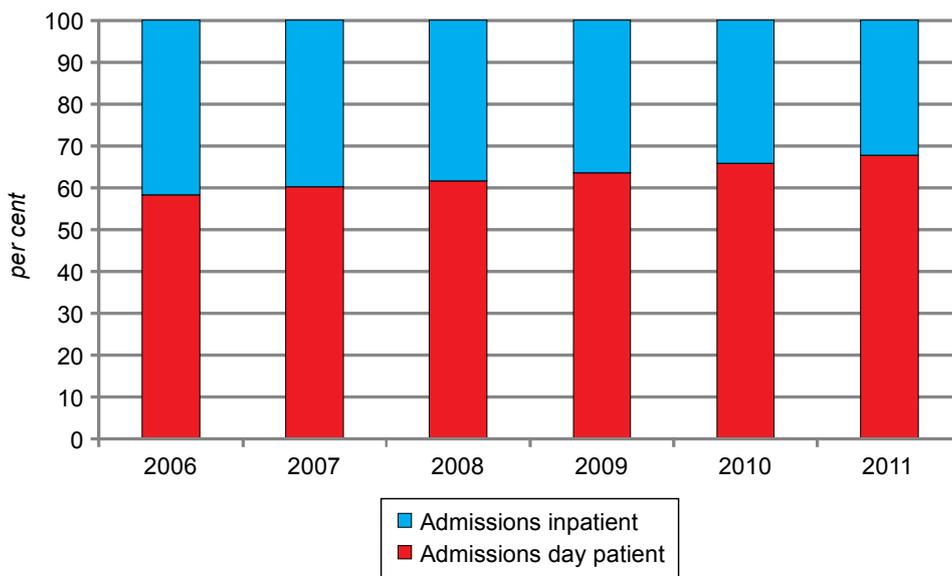
¹⁷ www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/MAR-April-13-SPN-v2-89036.pdf.

¹⁸ www.nuffieldtrust.org.uk/data-and-charts/outpatient-appointments-uk.

tracted by around a fifth to a low of 9,250 at 2004.¹⁹ Daypatient admissions by the main hospital groups represented 68 per cent of all admissions in 2011 (see Figure 2.1), and the majority (73.5 per cent) of the 1.64 million patient admissions for surgical procedures in the first half of 2012 were for daypatient procedures.²⁰

FIGURE 2.1

Daypatient and inpatient admissions at the major hospital groups, 2006 to 2011



Source: BMI, HCA, Nuffield, Ramsay, Spire.

Spending in private healthcare

2.19 We now look at where the money is being spent on privately-funded healthcare services, and by whom.

Expenditure on privately-funded healthcare services

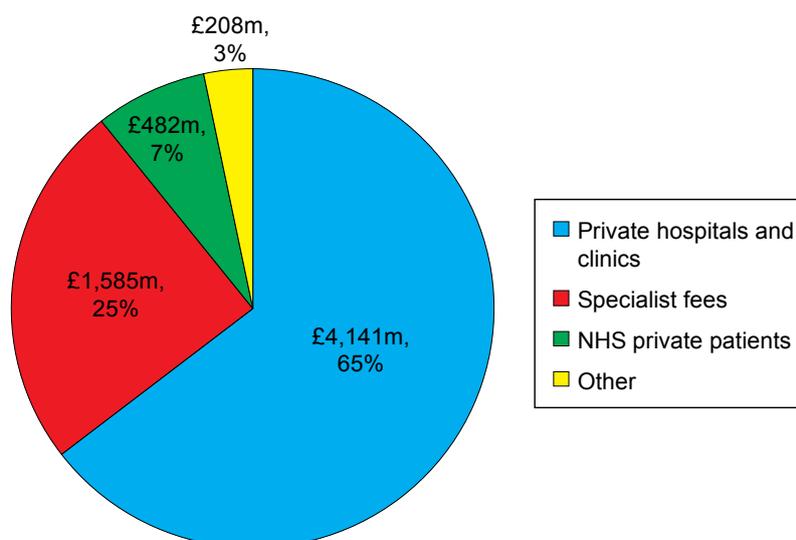
2.20 Roughly two-thirds of expenditure on privately-funded healthcare services is on private hospitals. The next largest category of expenditure is specialists' fees and the third largest is the NHS (money spent treating private patients at NHS facilities such as PPUs). The breakdown of expenditure by segment is shown in Figure 2.2.

¹⁹ Laing & Buisson Private Acute Medical Care 2012, p34.

²⁰ Ibid p8.

FIGURE 2.2

Private healthcare—revenue and share by sector, 2011

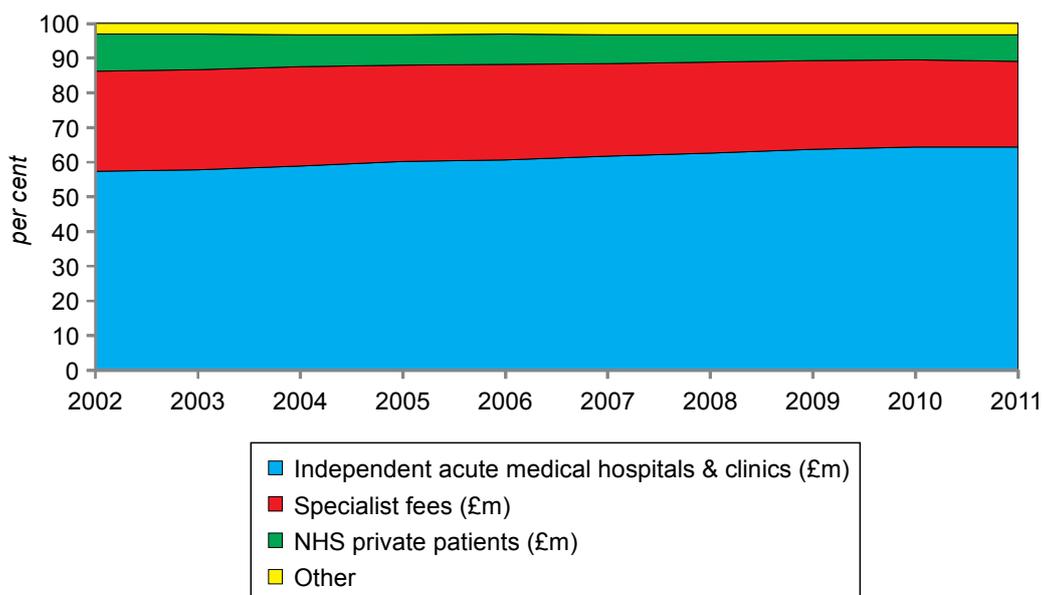


Source: Laing & Buisson, Private Acute Medical Care 2012.

2.21 In the last ten years, the share of private healthcare revenue earned by the NHS through private beds and PPU's has fallen, while the share earned by hospitals and consultants has increased (see Figure 2.3).

FIGURE 2.3

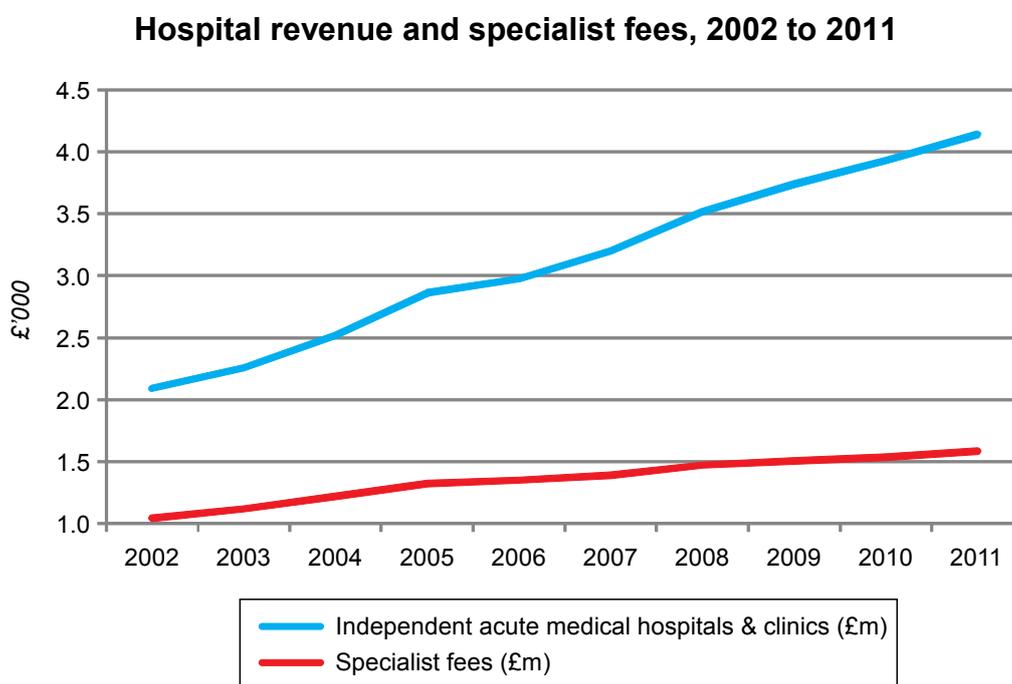
Trends in private healthcare revenue shares, 2002 to 2011



Source: Laing & Buisson, Private Acute Medical Care 2012.

2.22 Expenditure on private hospital charges grew much more rapidly than expenditure on consultants' fees (see Figure 2.4).

FIGURE 2.4



Source: Laing & Buisson, Private Acute Medical Care 2012.

2.23 This was despite the low (nominal) growth of private expenditure on healthcare and the reduction in episode costs that might have been expected to flow from the increase in the proportion of daypatient, rather than inpatient, admissions to private hospitals.

NHS expenditure on privately-funded healthcare services

2.24 As noted above in paragraph 2.12, private hospital revenues were being driven to a greater or lesser extent, depending on the operator, by increased volumes of NHS work and in other cases, as discussed at paragraph 2.15, by hospitals focusing on high-acuity treatments.

2.25 NHS England currently generates slightly less than £0.5 billion a year from privately-funded healthcare services (0.8 per cent of hospital revenues), either in dedicated

PPUs or in private beds in NHS hospitals. 96 per cent of total UK NHS private patient revenues are generated in England while 1.9 per cent of revenues are generated in Scotland, 1.2 per cent in Wales and 1.1 per cent in Northern Ireland.²¹ The majority of PPU capacity is located in London and south-east England.²² Again, the differences in the nations may be explained, in part, by the different policies in place: in Wales, for example, there are very few PPUs, and while it is recognized that for some procedures there is scope for the local health boards to offer these on a private basis, it is critical that such private provision does not impact negatively on NHS provision.

2.26 The top ten NHS Trusts by private patient earnings are shown in Table 2.2.

TABLE 2.2 Top ten private patient earning NHS Trusts

	<i>Private patient income 2011/12 £m</i>	<i>Private patient income 2010/11 £m</i>	<i>Annual growth 2011/12–2010/11 %</i>	<i>Share of total private patient income 2011/12 %</i>
1. Royal Marsden FT	51.2	44.6	14.8	10.6
2. Royal Brompton & Harefield FT	29.1	24.4	19.2	6.0
3. Imperial College Healthcare	28.6	26.2	9.2	5.9
4. Great Ormond Street FT	28.5	25.0	14.0	5.9
5. Guy's & St Thomas' FT	21.2	19.0	11.5	4.4
6. Royal Free Hampstead	19.2	18.5	4.0	4.0
7. Moorfields Eye Hospital FT	17.9	16.2	10.9	3.7
8. King's College Hospital FT	15.4	12.5	22.7	3.2
9. The Christie FT	10.7	8.5	26.2	2.2
10. Chelsea & Westminster FT	10.5	9.8	6.3	2.2
Top 10 Trusts	232.2	204.7	13.5	48.2
Other Trusts	249.7	240.3	4.0	51.8
Total NHS (UK)	482.0	445.0	8.4	100.0

Source: Laing & Buisson, Private Acute Medical Care 2012.

2.27 As can be seen, the average rate of revenue growth among the top ten PPUs is high (13.5 per cent). Some individual PPUs are achieving growth rates significantly higher than this and, in the case of The Christie Clinic in Manchester managed by HCA, nearly double the top ten average²³ (some other NHS Trusts' private patient earnings growth also feature prominently—see Table 2.2 above). It is also notable that the top

²¹ Laing & Buisson Private Acute Medical Care 2012, p82.

²² Around 60 per cent of PPU beds are in London or the southern Home Counties, the notable exception being The Christie Clinic in Manchester (Laing & Buisson Private Acute Medical Care 2012, p89).

²³ HCA told us that the annual growth figure for 2011 reflected a major investment programme at The Christie Clinic: in 2012, HCA said that it had invested £[redacted] into The Christie Clinic (equating to around [redacted] per cent of its 2011/12 revenue).

ten PPUs comprised 48.2 per cent of the total private patient income in 2012, while all the other PPUs combined (approximately 205, including both dedicated units and private beds in NHS hospitals) made up just over half of that.

2.28 Of the 77 dedicated PPUs in the UK, 69 are managed in-house by the NHS and nine are managed by private hospital groups. HCA manages the Harley Street at University College Hospital, London, the Harley Street at Queens, Romford, The Christie Clinic in Manchester, and will operate and manage a new PPU at Guy's and St Thomas'; BMI operates the Coombe Wing at Kingston Hospital; Spire manages the Royal Orthopaedic Hospital Trust's PPU at Stanmore; Ramsay manages the Orwell Cardiothoracic PPU at Basildon University Hospital; Nova Healthcare runs a PPU at St James' Institute of Oncology in Leeds; and East Kent Medical Services manages the Spencer Wings at Ashford and Margate.²⁴

2.29 Industry observers expect PPU revenue to grow now that the limit on the proportion of Foundation Trusts' gross income that can be earned from private healthcare has been raised to 49 per cent, though they do not anticipate that any Foundation Trust will reach this level of private patient income.²⁵ There is evidence that the leading PPUs, for example the Royal Marsden, Moorfields and Chelsea and Westminster NHS Foundation Trust, are gearing up for growth. However, the degree to which any increase in PPU activity will constitute greater competition for private hospitals will be affected by the number of Foundation Trusts which decide to expand in partnership with private hospitals, if and with whom they partner, and on what terms,²⁶ among other things.

²⁴ Laing & Buisson Private Acute Medical Care 2012, p84.

²⁵ *ibid* p90.

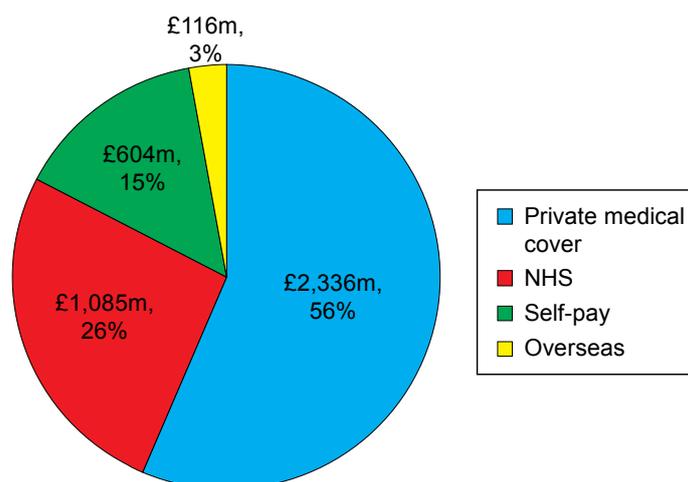
²⁶ See footnote 17 on PPU expansion at paragraph 3.50.

Purchasers of private healthcare

2.30 Private hospitals have four main revenue sources: overseas patients, self-pay patients, NHS-funded patients and, by far the largest category, patients with PMI. We set out the value of these in Figure 2.5 and discuss each in turn.

FIGURE 2.5

Sources of funding of private acute healthcare at private hospitals, 2011



Source: Laing & Buisson, Private Acute Medical Care, 2012.

2.31 The relative dependence of the main hospital groups on each of these sources varies—see Figure 2.6.

FIGURE 2.6

Hospital groups' revenue sources, 2012



Source: Parties and CC analysis.

Overseas

2.32 The overseas sector comprises overseas residents who come to the UK, and to central London in particular, for medical treatment. This would include what is sometimes referred to as the 'embassy' sector, since the London embassy of the country concerned may be responsible for negotiating rates with hospitals, arranging treatment, and paying the fees involved. The size of this market segment is put by

Laing & Buisson at £116 million,²⁷ though information submitted by the parties suggested that it may be worth somewhat more than this.

Self-pay

2.33 The self-pay market was worth just over £600 million to private hospitals in 2011 and comprised non-cosmetic (£400 million) and cosmetic treatments (£200 million).

2.34 The most significant driver of the self-pay market appears to be the economic cycle/ GDP growth, though industry commentators have pointed to a growth in self-pay demand from 2008 when the economy was contracting. This may have been related to increased NHS waiting times, but also may have resulted from increased marketing of self-pay by hospital groups.²⁸

The NHS

2.35 The second largest customer of private hospitals and the fastest-growing source of revenue for privately-funded healthcare services in the last ten years has been the NHS, through the practice of Trusts (largely in England) funding the treatment of NHS patients at private hospitals. As described in paragraph 2.14, the NHS's spending with private hospitals has more than quadrupled in real terms since 2004. Just over a quarter of private hospitals' revenue, on average, comes from the NHS which is, therefore, a significant additional revenue source as well as, to a much lesser extent, a competitor of the private hospital operators. As noted earlier, the growth of NHS revenue has, to some extent at least, sheltered private hospitals from the weak state of the privately paid for healthcare sector.

2.36 However, the amount of NHS work that hospital groups and individual hospitals undertake varies quite considerably. HCA, for example, earns very little from treating

²⁷ Laing & Buisson Private Acute Medical Care 2012, p32.

²⁸ *ibid* p26.

NHS patients, whereas almost [30] of Ramsay's admissions were NHS patients in 2010/11, which amounted to 27.6 per cent of NHS-funded elective surgery admissions to private hospitals.²⁹ There is also geographic variation, as explained in paragraph 2.11: the extent to which the NHS will fund the treatment of NHS patients in private hospitals is much more common in England than in Scotland or Wales, for example.

PMI

2.37 Payments from PMIs account for the largest source of funding for private hospitals, at approximately 56.4 per cent in 2011 (see Figure 2.5). However, while there was positive real growth in 2008 and 2009, recessionary effects fed through to 2011, resulting in a contraction of about 2.9 per cent in payouts in that year.³⁰

2.38 The future of PMI spending on privately-funded healthcare services looks mixed. There has been some improved demand for cover by employers in 2011, which has resulted in some degree of market stability. On the other hand, companies have been largely unwilling to improve the cover offered to their employees, and are looking to make cost savings on their employee benefit schemes. In addition, individual purchases of PMI continue to shrink. Overall, the longer-term 'prosperity of health cover is dependent on employers' spending on health and wellness benefits overall and there are opportunities and threats for medical cover in a more mixed, more competitive, healthcare economy'.³¹

The patient pathway

2.39 Competition in the private healthcare sector can be characterized as a contest for control of the patient pathway, since the destination of the patient determines the

²⁹ Laing & Buisson Private Acute Medical Care 2012, p18.

³⁰ *ibid*, p12.

³¹ *ibid*, p15.

recipient of the payment for the patient's treatment. We now describe some of the different pathways that a patient might follow to receive treatment.

The GP

- 2.40 The pathway to private healthcare for most people starts with a visit to a GP,³² who may be the patient's NHS GP or a doctor whose services are provided by their employer. The GP will assess the patient's condition and, if necessary, recommend that they see a specialist in the treatment of the condition that the GP has diagnosed (ie a consultant).
- 2.41 If the patient wishes to be treated privately, unless the condition is particularly rare or the treatment specialized, the GP will probably recommend a consultant³³ who practises locally.³⁴ Once the patient has decided which consultant to see, either the GP will contact the consultant, setting out the preliminary diagnosis and reasons for the referral, or will give the patient a letter of referral.
- 2.42 GPs in our survey told us that patients were more likely to know which hospital they wanted to use (44 per cent) than which consultant (28 per cent). This would be consistent with patients having some knowledge of local hospitals, but might also indicate that choice may be limited for many patients. It would also suggest that patients place greater reliance on GPs for advice on consultants than they do for advice on choice of hospital.

³² In our [patient survey](#), 60 per cent of respondents said that they had been referred by a GP. Other pathways included a referral by one consultant to another or self-referral or referral from a PMI to, for example, a physiotherapist.

³³ In our [patient survey](#), 50 per cent of respondents said that their GP suggested a particular consultant, 20 per cent said that the GP did not refer them to a named consultant and 20 per cent said that their GP had suggested two or more consultants.

³⁴ In our [patient survey](#), the average travel time to a hospital being attended was just over 30 minutes. However, around half of all patients said that they would travel further if the GP recommended that they did so or if it was the only way they could see the consultant recommended. The proportion of those who felt their condition was severe or affected their life who would be willing to travel further was higher.

- 2.43 Patients in our survey said that they used their GP more than any other source of information regarding the choice of a consultant. It was especially the case for self-pay patients that they also researched both consultants and hospitals online. 16 per cent of patients said that they would have liked some further information, although could not identify the gaps in their information specifically.
- 2.44 Nearly half (47 per cent) of the GPs in our survey, on whom consumers clearly rely quite heavily for advice, felt that they lacked information as regards the fees charged by consultants, the length of time their patient would have to wait for an appointment and whether they were recognized by the patient's PMI. Just over a quarter of GPs (26 per cent) felt they lacked information on consultants' clinical expertise, the factor they considered most important in making a referral.

Paying for privately-funded healthcare services

- 2.45 Consumers wishing to receive privately-funded healthcare services may fund it in one of three ways:
- (a) they may pay for it themselves;
 - (b) they may seek reimbursement from their PMI under a policy they have taken out themselves; or
 - (c) they may seek reimbursement from their PMI under an employer's private medical cover scheme (see Appendix 2.1).
- 2.46 If the consumer does not have private health cover at all, or if they do but the condition is not covered by their policy or has certain excesses under their policy,³⁵ they will need to fund the treatment themselves if they wish to proceed. We refer to this form of funding as 'self-pay'. A consumer may elect to pay privately for healthcare

³⁵ Most policies and schemes, for example, do not cover purely cosmetic surgical procedures or assisted conception treatments such as IVF.

services for a number of reasons. The treatment or procedure concerned may not be covered by their insurance policy or employer's scheme, for example cosmetic or bariatric surgery, or it may not be available at all through the NHS or only available after a long wait, for example IVF treatment or non-urgent surgery such as hernia repair. Most PMIs and hospital groups offer package pricing to self-pay patients. This means that even if a patient is not covered by a PMI policy, they may be able to access private treatment by buying a treatment package or paying a one-off price, which may include, for example, coverage for hospital charges and drugs for in-patients, a private room, nursing and medical care, and consultant and consultation fees. Package pricing usually requires a patient to pay in advance.³⁶

- 2.47 If, as is more commonly the case, the consumer does have private cover, they may next contact their PMI or the organization which administers their employer's scheme (typically a PMI) to obtain the PMI's authorization to proceed with an initial, outpatient consultation.
- 2.48 PMIs tend to have fewer rules regarding outpatient consultations than for daypatient or inpatient treatment. They tend to recognize all or most private hospitals for outpatient consultations or treatments and set annual outpatient consultation fee maxima rather than operating a procedure-based fee schedule as they do for daypatient or inpatient treatment.³⁷ However, depending on the PMI, the patient may be informed at this stage that the consultant they are contemplating seeing may charge fees outside the PMI's fee maxima (a non-fee-assured consultant). If the patient prefers to see a non-fee-assured consultant, the PMI may inform them that they may be responsible to pay a top-up fee (a fee over and above the PMI's

³⁶ www.netdoctor.co.uk/focus/selfpay/selfpay_pmi.htm.

³⁷ Bupa, noting this, submitted that as a result, outpatient consultation fees had risen faster than other consultant costs (Bupa response to IS, paragraph 6.79).

reimbursement maximum, which has been pre-agreed). PMIs' policies on top-up fees are considered in more detail in paragraphs 7.67 to 7.74.

- 2.49 The BMA survey of consultants indicates that the average fee for an initial outpatient consultation is around £170, with not much variation between specialties. However, fees for an initial outpatient consultation vary regionally: the highest average fee was in London (£200) and the lowest in Wales (£123).

The consultant—making the appointment

- 2.50 The patient will then make an appointment to see the consultant (for the insured patient, once authorization has been obtained), usually at a private hospital.³⁸ The patient may have a choice of hospitals at which to see the consultant, as consultants usually have practising rights at more than one hospital.³⁹ However, in practice consultants tend to use one hospital as their main location, supplemented by one or two others. In our survey of consultants, 34 per cent said that they had treated patients at two hospitals in the previous 12 months, and 15 per cent said that they treated patients at three. 45 per cent, though, said that they had only seen patients at one hospital in the previous 12 months and 76 per cent said that they had treated three-quarters of their patients at one hospital.

The consultant—initial appointment

- 2.51 The patient's next step is to see the consultant selected. The consultant may propose certain tests or types of examination before coming to a firm diagnosis, or may recommend a particular form of treatment, for example a surgical procedure. The insured patient may then re-contact their PMI to seek its authorization to proceed

³⁸ The BMA survey indicated that 65 per cent of initial consultations took place at a private hospital.

³⁹ In our [GP and consultant survey](#), roughly two-thirds of consultants told us that they had practising rights at more than one private hospital.

with the treatment recommended, the hospital or clinic proposed for the treatment and the consultant(s) who will be administering it.

2.52 Practice varies, but the PMI will typically check whether the consumer's policy or scheme covers the proposed procedure⁴⁰ and whether it entitles the consumer to use the hospital or clinic concerned.⁴¹ The PMI will also usually check whether the consultant is either 'recognized' or 'approved' by it and, in some cases, whether the consultant has agreed to set their fees within the PMI's reimbursement rates.

2.53 In the case of surgical procedures, the patient may also need to provide the PMI with the name of the proposed anaesthetist, and the PMI may check whether they, like the surgeon, set their fees within the PMIs reimbursement rates.

Treatment and follow-up

2.54 The patient will then proceed to the recommended treatment. On completion, the hospital and consultant will submit their bills (unless the patient has taken package pricing), probably direct to the payer. In some cases, where the payer is a PMI and where there are unforeseen or unexpected costs associated with treatment, the patient must pay a 'shortfall', the difference between the consultant's fee and the amount the PMI is willing to pay for that procedure.

2.55 The patient may be invited for a follow-up consultation by the consultant. A follow-up consultation generally takes less time than an initial consultation and the fee tends to be less (an average of £108 compared with £170 for an initial consultation).⁴²

⁴⁰ Including whether the consumer has a policy excess or has exhausted an annual claim limit, if any.

⁴¹ The consumer should be aware of the hospitals and clinics they may attend as the list of these facilities will be available on joining an employer's scheme or from the PMI's promotional material.

⁴² BMA survey of consultant income, May 2011.

Variations

- 2.56 Figure 2.7 illustrates some possible alternative patient pathways.⁴³ In one, the pathway is as described above: the patient visits a GP who makes a referral to a consultant who then treats the patient.
- 2.57 Variants illustrated include a guided referral where the patient obtains from their GP a referral letter which specifies the type of consultant recommended but not a named individual. The patient is then either guided to a consultant identified as appropriate by the PMI or to, for example, a physiotherapy clinic rather than, say, a consultant orthopaedic surgeon.⁴⁴
- 2.58 In other cases, where a patient has cancer for instance, they may be referred by a consultant surgeon to another consultant (a clinical or medical oncologist for radio- or chemotherapy) and their treatment may be managed by a multidisciplinary team (MDT) rather than by an individual consultant.
- 2.59 While not a variant per se, in Scotland, the Scottish Care Information (SCI) Gateway is a national portal for healthcare communications that facilitates the exchange of patient-based clinical information and integrates GP practice systems and secondary care systems.⁴⁵
- 2.60 For self-pay patients, a GP referral may not be necessary where, for example, a patient seeks IVF or cosmetic treatment.

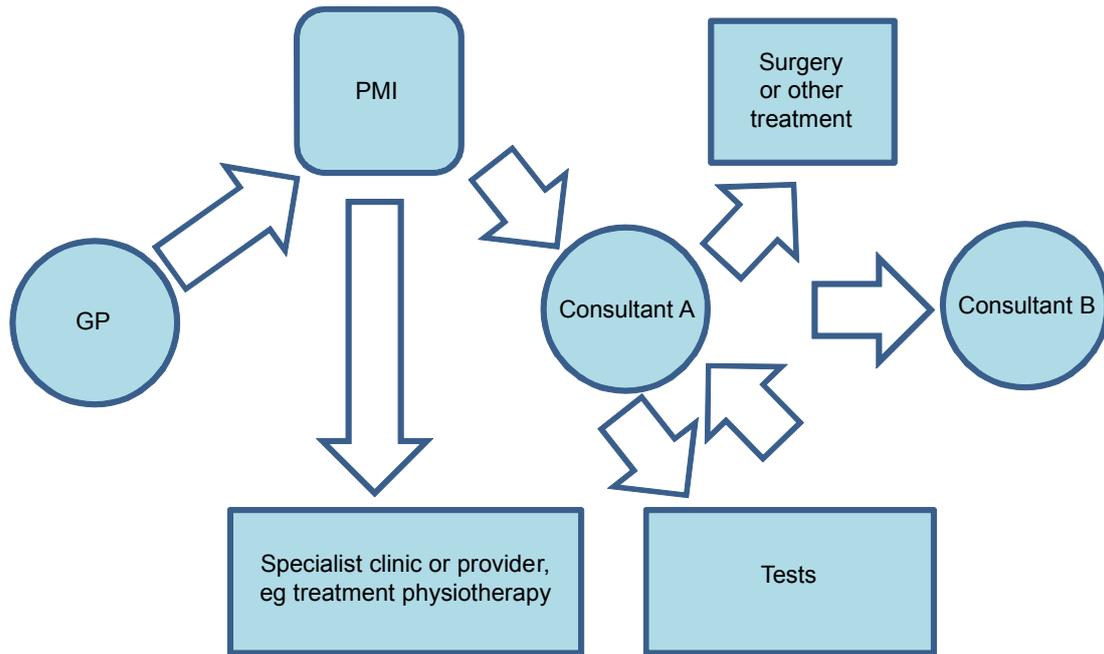
⁴³ The OFT research identified four pathways: GP led, self-led, NHS hospital-led and PMI-led. See [The Patient Journey](#).

⁴⁴ [X]

⁴⁵ www.nisg.scot.nhs.uk/currently-supporting/sci-gateway.

FIGURE 2.7

Consumer pathways to private healthcare



Source: CC.

The regulatory regime

2.61 Regulation varies between the nations to some degree, and we have described differences where they arise.

2.62 There are three key spheres of regulation which apply to those operating in the private healthcare sector:

- (a) regulation of the quality and safety of private hospitals and clinics;
- (b) regulation of clinicians practising in the private healthcare sector; and
- (c) regulation of PMIs.

2.63 In addition, private healthcare providers are, of course, subject to non-sector-specific regulatory requirements relating to planning control, health and safety at work and, as regards commercial relations between doctors and hospitals, the Bribery Act

2010. We describe here the regulatory regime only as it applies specifically to those operating in the private healthcare sector.

Regulating private hospitals and clinics

2.64 Private hospitals and clinics are subject to the same regulatory regime as NHS hospitals and other healthcare facilities. Oversight of healthcare providers is divided between a number of different organizations whose roles are changing with the implementation of the Health and Social Care Act 2012 (the 2012 Act). Further, oversight provisions may differ between the nations and, where relevant, we indicate this.

2.65 Some of these organizations are regulators in the strict sense, but others may play an important role in the regulatory process in future, particularly as regards the quality of service delivered by the regulated parties. We have therefore included these here too.

The healthcare regulators

2.66 In England, the CQC is responsible for regulating, auditing and inspecting providers of healthcare (and adult social care) services, including services provided by acute independent hospitals, GPs and other primary medical 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.⁴⁶ 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.

⁴⁶ The CQC will thus register independent hospitals, but NHS Trusts will not have to register PPU separately.

2.67 In Scotland, the regulator is Healthcare Improvement Scotland,⁴⁷ which scrutinizes the quality and safety of care provided by NHS Scotland and the independent sector.⁴⁸ In Wales, the Healthcare Inspectorate Wales ensures the safety and quality of health services by reviewing and inspecting standards in Welsh NHS bodies against a range of policies, guidance and regulations.⁴⁹ In Northern Ireland, the Regulation and Quality Improvement Authority is an independent body that is responsible for monitoring and inspecting the availability and quality of health and social care services through registration and inspection.⁵⁰

Monitor

2.68 Monitor is the independent regulator of Foundation Trusts in England. It is currently responsible for supporting NHS Trusts in becoming Foundation Trusts, assessing whether NHS Trusts are ready to be Foundation Trusts, and ensuring that Foundation Trusts comply with their obligations and are well led and financially robust.

2.69 The 2012 Act makes changes to the way healthcare is regulated in England, and Monitor's role is changing significantly as a result. Under the new legislation, Monitor has already begun to manage additional key aspects of healthcare regulation, and will continue to add to its responsibilities over the next few years. This will include regulating prices, enabling services to be provided in an integrated way, promoting effective competition between providers;⁵¹ and supporting commissioners so that they can ensure that essential healthcare services continue to run if a provider gets into financial difficulties. This will be in addition to its current role as the independent regulator of Foundation Trusts.

⁴⁷ www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_regulation.aspx.

⁴⁸ *NHS Handbook 2012–13*, p213.

⁴⁹ *ibid* p227.

⁵⁰ *ibid* p235.

⁵¹ In the 'mixed economy' that the Coalition Government is developing in the healthcare sector, Clinical Commissioning Boards may purchase services from 'Any Willing Provider' and patients may express their preferences through the 'Choose and Book' facility.

2.70 From 2014, Monitor will regulate all providers of NHS-funded services in England (ie including independent hospitals providing services to the NHS⁵²) through its licensing scheme. In addition to being registered by the CQC, all providers of NHS-funded services in England will have to be licensed by Monitor. Monitor will use the provider licence to fulfil much of its new duty ‘to protect and promote the interests of people who use health care services’.⁵³ Monitor’s role will continue to encompass supervision and interpretation of the private patient income cap rules.⁵⁴

National Institute for Health and Care Excellence and equivalent organizations

2.71 The National Institute for Health and Care Excellence (NICE) develops quality standards and promotes best practice for the NHS in England and Wales. In Scotland, two bodies perform similar functions: the Scottish Medicines Consortium provides advice to NHS Boards and their Area Drug and Therapeutics Committees across Scotland about the status of newly-licensed medicines, formulations of existing medicines and new indications for established products and works to ‘improve financial and service planning within NHS Boards through the provision of early intelligence on new medicines in development’,⁵⁵ and the Scottish Intercollegiate Guidelines Network develops evidence-based clinical practice guidelines for the NHS in Scotland.⁵⁶

2.72 NICE guidance is made available to NHS Scotland healthcare professionals by Health Improvement Scotland,⁵⁷ and links exist between NICE and the Northern Ireland Executive to enable NICE guidelines to be reviewed for their applicability to Northern Ireland.⁵⁸ NICE is developing a library of quality standards to provide guid-

⁵² Though the DoH is currently consulting on this—see proposition 5 in its consultation document: www.wp.dh.gov.uk/publications/files/2012/08/Protecting-and-promoting-patients-interests-licensing.pdf.

⁵³ www.monitor-nhsft.gov.uk/monitors-new-role/-introduction-monitors-new-role.

⁵⁴ On 1 October 2012, the cap increased to 49 per cent of a Foundation Trust’s income.

⁵⁵ www.scottishmedicines.org.uk/About_SMC/What_we_do/Remit.

⁵⁶ <http://sign.ac.uk/about/index.html>.

⁵⁷ www.healthcareimprovementscotland.org/programmes/nice_guidance_and_scotland.aspx.

⁵⁸ www.nice.org.uk/niceMedia/pdf/2006-030-NI-Executive-formalises-link-with-NICE.pdf.

ance to clinicians, commissioners and patients.⁵⁹ These efforts will be reinforced through incentive payments to healthcare providers through the Commissioning for Quality and Innovation (CQUIN) scheme.⁶⁰

Department of Health

- 2.73 Whilst, again, not strictly a 'regulatory' body, the DoH in England and its associated bodies (formerly the Primary Care Trusts and Strategic Health Authorities, now the NHS Commissioning Board, the regional commissioning boards and the clinical commissioning groups), as purchasers of privately-funded healthcare services, have an important role monitoring quality and intervening when problems arise. For example, it seems likely that the Francis inquiry into the Mid Staffordshire NHS Foundation Trust will suggest that some of the responsibility for monitoring quality lies with the clinical commissioning groups, as well as the CQC and Monitor.
- 2.74 Purchasing of privately-funded healthcare services in the nations is far less significant. However, part of Welsh Assembly Government policy to improve patient quality of care is to set national minimum standards for independent healthcare providers, and in Scotland for example, the Government provides guidance to NHS Boards regarding situations where patients receive private healthcare in addition to NHS care. The Health and Social Care Board in Northern Ireland has responsibility for commissioning health services for the public and ensuring that these are sufficient to meet the needs of the population.

⁵⁹ www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp.

⁶⁰ www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html.

Regulating doctors

The GMC, the royal colleges and the deaneries

- 2.75 The GMC registers doctors to practice medicine in the UK.⁶¹ It is overseen by the Professional Standards Authority for Health and Social Care, a statutory body responsible to Parliament and charged with promoting best practice and consistency in professional self-regulation in nine bodies responsible for different branches of the healthcare profession across the whole of the UK.
- 2.76 To treat patients, a doctor must be registered with the GMC and have a licence to practise. From December 2012, doctors have to renew their licence periodically through revalidation, the process by which doctors must demonstrate to the GMC that they are up to date and fit to practise.⁶²
- 2.77 The GMC publishes advice to doctors on the standards expected of them. All doctors must follow the advice given in the GMC's *Good Medical Practice*⁶³ and its explanatory guidance, which includes advice on avoiding and dealing with conflicts of interest.
- 2.78 The GMC's *Good Medical Practice*, which was updated in April 2013, precludes doctors from accepting any inducement, including financial incentives, that may affect or be seen to affect the way that they treat or refer a patient or commission services—if they have a financial interest in a hospital or clinic to which they plan to refer a patient, this must be disclosed to the patient and recorded in the patient's notes.

⁶¹ www.gmc-uk.org/about/index.asp.

⁶² www.gmc-uk.org/doctors/licensing.asp.

⁶³ www.gmc-uk.org/guidance/good_medical_practice.asp.

2.79 The medical royal colleges are each responsible for a different specialty within the medical field.⁶⁴ The medical royal colleges are charged with setting standards within their field and for supervising the training of consultants within that specialty.

2.80 The deaneries are responsible for the management and delivery of postgraduate medical education and for supporting the continuing professional development of all doctors.⁶⁵

Other organizations

2.81 Three other organizations are relevant to doctors' revalidation in particular, and the promotion of service quality more generally:

- (a) the Academy of Medical Royal Colleges;
- (b) Independent Healthcare Advisory Services (IHAS); and
- (c) the Doctors and Dentists Pay Review Body (DDRB).

- *The Academy of Medical Royal Colleges*

2.82 The Academy facilitates the work of the medical royal colleges, in particular the development of specialty-specific guidance on training and supporting information, and the development of quality assurance proposals.

- *IHAS*

2.83 IHAS is a trade body representing PHPs, providing members with assistance in the revalidation process and supporting quality issues across its membership.⁶⁶

⁶⁴ See paragraph 3.67.

⁶⁵ www.mmc.nhs.uk/colleges__deaneries/deaneries.aspx.

⁶⁶ www.independenthealthcare.org.uk/.

- *DDRB*

2.84 Under the Clinical Excellence Awards scheme in England, clinicians may be awarded annual payments in addition to their salary in recognition of their contribution to the NHS.⁶⁷ Awards are made at regional and national level at different levels, the highest of which is 'Platinum' which attracts an annual award of over £75,000.⁶⁸ DDRB is currently reviewing the scheme which may, in future, be more closely linked to service quality.⁶⁹

Regulating PMIs

The FCA

2.85 Until April 2013, PMIs in the UK were regulated by the FSA. On 1 April 2013, the FSA was abolished and the majority of its functions transferred to two new regulators: the Prudential Regulation Authority (PRA) and the FCA. The FCA inherited the majority of the FSA's roles and functions and, for the short term at least, adopted the FSA handbooks.

2.86 In 2007, the FSA adopted a differentiated approach to the regulation of insurance products. It distinguished between 'pure protection' products (eg critical illness cover) and payment protection insurance (PPI), to which additional and detailed rules would apply, and 'other' products (all general insurance including PMI) which would be covered by rules deriving from the more general Principles for Business (or 'Principles').⁷⁰ This change of approach was reflected in the FSA's new *Insurance: Conduct of Business Sourcebook* (ICOBS) which replaced *Insurance: Conduct of Business* sourcebook (ICOB).

⁶⁷ www.dh.gov.uk/health/tag/accea.

⁶⁸ www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_132860.

⁶⁹ www.dh.gov.uk/ab/ACCEA/DDRBReview/index.htm.

⁷⁰ <http://fsahandbook.info/FSA/html/handbook/PRIN>.

2.87 Following consultation, the FSA concluded that none of the respondents who wanted PMI included in the 'pure protection' category provided convincing evidence of how or how much detriment would arise to support their views. It said that the PMI market generally worked well for consumers and that there appeared to be little detriment experienced by them. Accordingly, it said that it had decided to keep PMI in the 'other' category but review the PMI market in due course to see if any detriment had arisen from this classification.⁷¹

Association of British Insurers

2.88 Whilst not a regulator, the ABI has produced a 'Statement of Best Practice for Sales of Individual and Group Private Medical Insurance'.⁷² The ABI said that the Statement was in addition to any regulatory or legal requirements and was mandatory for all PMIs that were ABI members. It said that the code could therefore be taken into account by the Financial Ombudsman Service.⁷³

⁷¹ www.fsa.gov.uk/pubs/policy/ps07_24.pdf. The FSA's post-implementation review in 2010 found that there was no clear evidence of increased risk of consumer detriment in the PMI market: www.fsa.gov.uk/pubs/other/icobs_review.pdf.

⁷² www.abi.org.uk/~media/Files/Documents/Publications/Public/Migrated/Health/ABI%20statement%20of%20best%20practice%20for%20sales%20of%20individual%20and%20group%20private%20medical%20insurance.ashx.

⁷³ The Financial Ombudsman Service is the statutory dispute resolution scheme set up under the Financial Services and Markets Act 2000 and the Consumer Credit Act 2006.

3. The parties

3.1 Following our description of the industry background in Section 2, in this section, we describe in more detail the major parties to the investigation, namely the private hospitals and hospital groups, clinicians and PMIs.

The main hospital groups

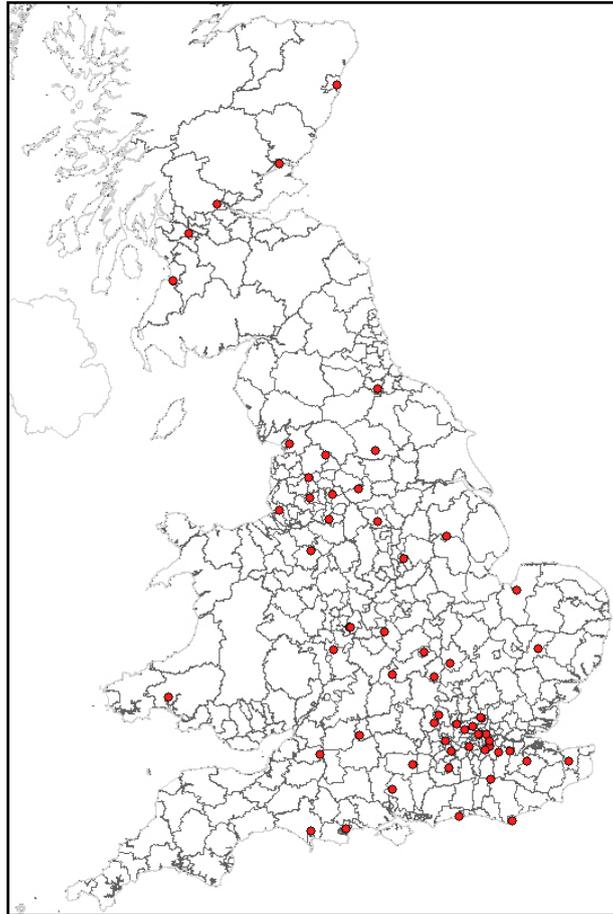
BMI Healthcare

3.2 BMI Healthcare (BMI) is the largest private hospital operator in the UK. It is the trading subsidiary of General Healthcare Group (GHG). BMI operates 69 hospitals and treatment centres, including three hospitals (Three Shires Hospital, Foscoote Hospital and McIndoe Surgical Centre) managed for third parties or joint ventures and a number of NHS PPUs, including the Coombe wing at Kingston Hospital in Surrey. BMI's hospitals have a combined overnight bed capacity of 2,711 (see Figure 3.1). BMI operates a number of joint venture arrangements with consultants. As discussed elsewhere (see paragraphs 8.10 and 8.11), it also offered a consultant incentive scheme in Bath that was designed to mimic the equity ownership model of Circle.

3.3 GHG was formed in the 1980s by the US provider American Medical International. In 1997, it was acquired by Cinven together with GHG's French sister company Générale de Santé and merged with Amicus, which Cinven had formed in 1995 from the hospital interests of Compass Group. In 2000, GHG was acquired by BC Partners, a private equity group, which subsequently sold GHG's psychiatric and occupational health services businesses. In 2006, a consortium led by Netcare acquired the business for £2.35 billion. Netcare itself now has a 53.7 per cent share of GHG, with the remainder being owned by a consortium of UK investors comprising Apax Partners Worldwide LLP and London and Regional Properties, and the balance held by management and senior staff.

FIGURE 3.1

BMI portfolio of hospitals



Source: BMI.

3.4 BMI has expanded in the UK, including via a number of acquisitions. In 2008, BMI acquired nine hospitals from Nuffield Health, and in 2010 it acquired the Abbey Hospitals' portfolio of four hospitals (two near Liverpool and two in Scotland). Both transactions resulted in OFT inquiries, and as a result BMI sold two of the Nuffield hospitals (to Spire Healthcare and Ramsay Health Care) and agreed to divest one of the Abbey hospitals. However, BMI was unable to find a suitable purchaser for that Abbey hospital and was released from its obligation to sell by the OFT in March 2011.

- 3.5 In 2008, BMI bought a majority stake in the 22-bed Oxford Clinic for Specialist Surgery. This business was sold to Nuffield in 2012 and the unit subsequently closed. In 2008, BMI also acquired the 38-bed Woodlands Hospital in Darlington and a private GP business, City Medical, with two consulting suites in central London.
- 3.6 In 2009, BMI acquired the Fitzroy Square Hospital in London and a stake in Phoenix Hospital Group which operated a 17-bed hospital in Weymouth Street and a consulting and diagnostic clinic in Harley Street. Also in 2009, it secured the contract to operate the 22-bed Coombe Wing at Kingston Hospital.
- 3.7 During 2010, BMI established a joint venture with Sentosa UK to run Syon Clinic in Brentford and acquired a stake in the Phoenix day-surgery hospital in Southend (now the BMI Southend Hospital).
- 3.8 Table 3.1 provides a summary of the financial performance of General Healthcare Mixer Partnership LLP (which includes both BMI OpCo and GHG PropCo combined) between FY07 and FY11. BMI has experienced rapid growth in revenues from NHS patients, while revenues from self-pay patients have declined over the same period. Following its leveraged buyout in 2006, BMI is highly geared with significant annual interest expenses.

TABLE 3.1 **General Healthcare Mixer Partnership LLP* summary financial information**

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Self-pay patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
NHS patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Other	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total revenue	683,642	778,320	830,436	850,644	886,398
Gross profit	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
EBITDA	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Interest expense	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Capital expenditure	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total debt	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Cash	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Net debt	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: BMI.

*Summary of financial information includes both BMI OpCo and GHG PropCo combined.

3.9 In FY11, BMI admitted approximately 280,000 patients for treatment. Figure 3.2 shows the rapid growth in NHS admissions at BMI hospitals between FY08 and FY11. In contrast, the number of private patients declined from FY09/FY10 onwards.

FIGURE 3.2

BMI inpatient and day-patient admissions, FY07 to FY11

[REDACTED]

Source: BMI.

Spire Healthcare

3.10 Spire is the second largest private hospital operator in the UK, with 38 hospitals and 31 satellite clinics¹ located throughout England, Wales and Scotland. The Spire business was acquired by funds managed or advised by Cinven (a private equity firm), which acquired the business in two stages, reassembling the portfolio of hospitals that had been owned by Bupa. The first stage involved the buyout of Bupa Hospitals in August 2007 and the second involved the acquisition of the Classic

¹ These satellite clinics generally offer consulting rooms and a range of outpatient and diagnostic services. In some cases, they may also have facilities for minor surgical procedures.

Hospitals Group in February 2008.² Spire later acquired the Gerrards Cross private hospital (now known as Spire Thames Valley) from BMI Healthcare in March 2008. As at 3 October 2012, Spire's facilities comprised 116 theatres, 479 consulting rooms, 1,564 overnight beds and 210 day-beds.

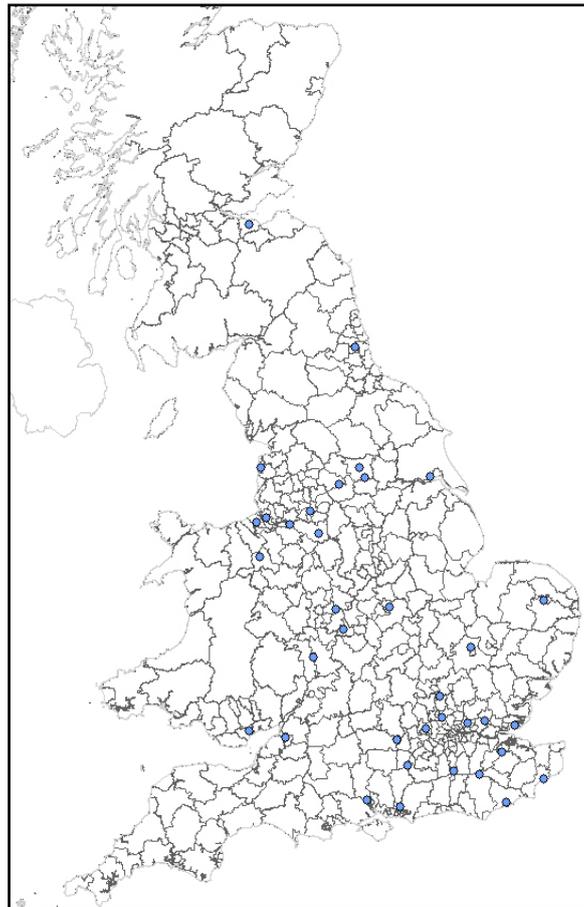
3.11 Spire has invested heavily in developing its service offering in recent years, acquiring 12 MRI and 16 CT scanners for its hospitals as well as expanding its theatre capacity in a number of areas. Spire has pursued a strategy of increasing its ability to provide higher acuity treatments to patients. Spire also operates a limited number of joint ventures, [X].

3.12 Figure 3.3 shows the location of Spire's portfolio of hospitals.

² The Classic Hospitals portfolio had been part of Bupa Hospitals but was sold to Legal & General Ventures in 2005.

FIGURE 3.3

Spire portfolio of hospitals



Source: Spire.

3.13 Table 3.2 provides a summary of the financial performance of Spire between FY07 and FY11. Spire has grown both its revenues and its margins significantly over the period, with the latter resulting largely from improvements in efficiency. Revenues from NHS patients have [✂].

TABLE 3.2 **Spire summary financial information**

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]
Interest expense	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]
Debt*	[X]	[X]	[X]	[X]	[X]
Cash	[X]	[X]	[X]	[X]	[X]
Net debt	[X]	[X]	[X]	[X]	[X]

Source: Spire.

*[X]

3.14 Figure 3.4 shows the composition of Spire's inpatient and day-patient admissions between FY07 and FY11. [X]

FIGURE 3.4

Spire inpatient and day-patient admissions, FY07 to FY11

[X]

Source: Spire.

Hospital Corporation of America

3.15 HCA is the third-largest provider of healthcare services in the UK and the largest in London by revenue. HCA UK is a subsidiary of HCA Holdings Inc, the largest hospital group in the US. HCA Holdings operates 163 hospitals and 109 surgery centres in the US and is listed on the New York stock exchange. In 2011, HCA UK generated turnover of £[X] and EBITDA of £[X] from its hospital operations in the UK. [X]

3.16 HCA began providing private healthcare in the UK in 1996 with its purchase of a 50 per cent share in the Harley Street Clinic, Wellington, Princess Grace and

Portland hospitals, in a joint venture with what was, at the time, PPP healthcare. HCA expanded in 2000, buying out PPP's share in the joint venture. HCA also acquired St Martin's Healthcare (comprising the London Bridge, Lister and Devonshire³ hospitals) in 2000 from the Kuwait Investment Office.⁴ HCA submitted to us that it had significantly invested in each of these hospitals.

3.17 HCA has also created or acquired a number of outpatient and diagnostic clinics and developed a new ambulatory care centre (the Platinum Medical Centre), as well as winning competitive bids to operate three NHS PPUs including, in London, University College Hospital (UCH) (incorporating Harley Street at UCH and the MacMillan Cancer Centre for outpatient and day-patient treatments),⁵ Queens Hospital (Romford) and, most recently, Guy's and St Thomas' Hospital where HCA will manage a PPU within the Trust's new Cancer Treatment Centre (due to open in 2016).⁶

3.18 In 2010, HCA expanded outside the Greater London area for the first time, winning a tender to develop jointly a new private patient cancer centre at the Christie NHS Foundation Trust Hospital in Manchester, the Christie Clinic. The Christie Clinic is the UK's largest specialist cancer treatment centre outside of London.

3.19 HCA currently has a total of 416 consulting rooms, 44 theatres, 790 overnight beds and 167 day-beds across its UK hospitals. HCA has invested in its critical care offering so that all of HCA's main hospitals have an intensive care unit and are capable of offering HDU (high dependency unit) services too. These facilities, HCA's investment in building clinical and nursing support teams, and new medical

³ The Devonshire Hospital was converted into an outpatient and diagnostic facility.

⁴ HCA [website](#).

⁵ www.harleystreetatuch.co.uk/the-uch-macmillan-cancer-centre/.

⁶ HCA outpatient clinics include the Platinum, New Malden, Chelsea, Brentwood, City of London, Old Broad Street, Docklands and Sevenoaks medical centres. OFT decision regarding HCA and Guy's and St Thomas' commercial agreement: www.of.gov.uk/shared_of/mergers_ea02/2012/HCA.pdf.

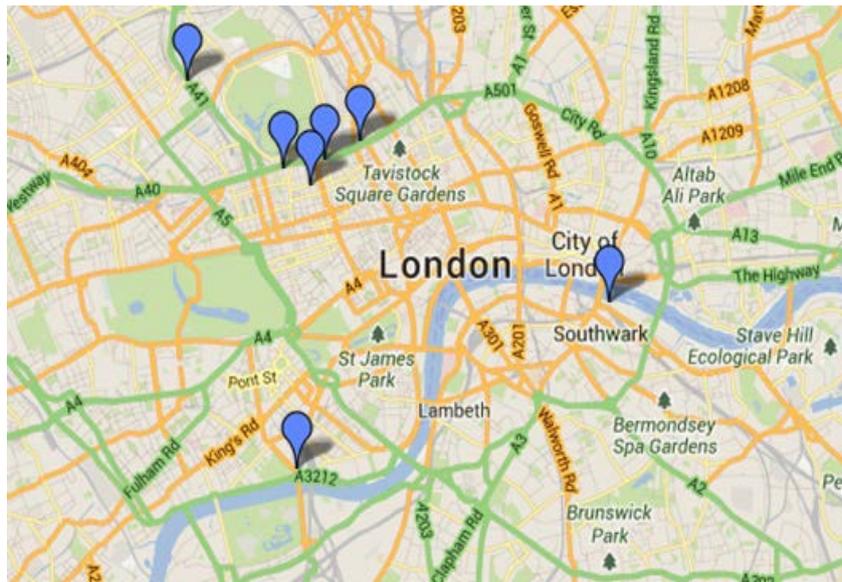
technology such as the CyberKnife Robotic Radiosurgery System, all support the high-acuity work carried out at HCA hospitals. HCA also has a number of joint venture relationships with consultants, in six cases with consultants who have invested in the joint venture alongside HCA and in other cases with HCA buying equity in a vehicle created by a group of consultants.⁷

3.20 Figure 3.5 shows the location of HCA's hospitals and PPU's.

⁷ HCA has a number of joint ventures with entities including the London Oncology Clinic, the Harley Street Clinic at the Groves, Chelsea Outpatient Centre, Robotic Radiosurgery and Wellington Diagnostic Services. In addition, HCA has six types of agreements that it may offer to consultants: Consulting Room Licence Agreements, Fully Managed Practice Agreements, Professional Service Agreements, Recruitment Agreements, Recruiting Agreements and Galen Consultant Agreements.

FIGURE 3.5

HCA's portfolio of hospitals



Source: HCA.

3.21 In addition to its secondary care facilities, HCA has invested in the primary care sector, albeit to a relatively smaller extent, by acquiring an ownership interest in three providers of private GP surgeries and occupational healthcare providers: Blossoms Healthcare (April 2012), Roodlane (August 2011) and General Medical Clinics (July 2012).

3.22 Table 3.3 provides a summary of the financial performance of HCA between FY07 and FY11. HCA does minimal quantities of NHS work but does earn a significant proportion of its revenues from overseas patients. HCA UK is financed as part of HCA Holdings Inc.

TABLE 3.3 HCA summary financial information*

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
Overseas patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA†	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]

Source: HCA.

*[X]
†[X]

3.23 Figure 3.6 shows the number of inpatient and day-patient admissions to HCA hospitals over the 2007 to 2011 period. Total admissions increased by [X] overall, with the number of [X] patients being treated by HCA increasing more rapidly than other types of patients.

FIGURE 3.6

HCA inpatient and day-patient admissions, FY07 to FY11

[X]

Source: HCA.

Nuffield Health

3.24 Nuffield Health (Nuffield), a registered charity, is the fourth largest private hospital group in the UK by revenue and the largest of the not-for-profit providers. It operates 31 hospitals with a total of 1,345 inpatient beds. Nuffield was established in the late 1950s by Bupa to acquire and build new community hospital facilities to offer choice

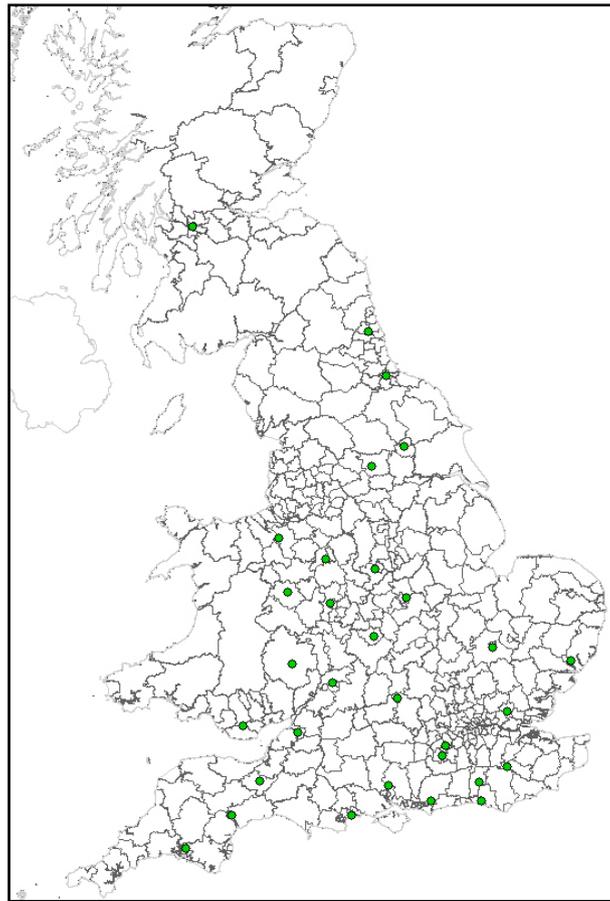
in healthcare. It began initially by renovating nursing homes, but then opened purpose-built hospitals. Its first new hospital was opened in Woking in 1962.

- 3.25 Nuffield is an independent not-for-profit organization. It has neither shareholders nor investors, and its surplus is put back into its hospitals' infrastructure, refurbishments and staff. As a charity, it may benefit from some tax advantages.⁸
- 3.26 Between 2000 and 2004, Nuffield acquired five hospitals and built five new ones to replace existing facilities. In 2008, it sold nine of its hospitals to GHG in a transaction cleared by the OFT and subsequently sold its hospital in Hull to the NHS. It opened the Vale clinic in South Wales in a joint venture with a consultant-led partnership based in Cardiff and, in another venture with a clinician group, Independent Healthcare Specialists, opened a day-patient clinic in Guildford in 2009. In 2010, Nuffield acquired full ownership of both hospitals. In 2012, Nuffield acquired BMI's Oxford clinic from GHG and integrated it into its Nuffield Manor Hospital. Figure 3.7 shows the location of Nuffield's hospitals in the UK.

⁸ www.hmrc.gov.uk/charities/tax/basics.htm.

FIGURE 3.7

Nuffield portfolio of hospitals



Source: Nuffield.

3.27 Table 3.4 provides a summary of the financial performance of Nuffield between FY07 and FY11. Total revenue has increased slightly over the period, with EBITDA fluctuating significantly (largely as a result of the sale of hospitals).

TABLE 3.4 Nuffield summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]

Source: Nuffield.

[X]

3.28 Nuffield’s overall health strategy over the last ten years has been to move towards both prevention and cure. This strategic direction led to Nuffield purchasing Sona Healthcare in 2005, Health Club Investment Group, parent of Cannons Health and Fitness in 2007, Bladerunner in 2010 and Greens Health and Fitness in 2012. These acquisitions have seen the group now running 65 Fitness and Wellbeing centres and nearly 200 corporate sites as well as the 31 hospitals. The prevention aspect of its strategy has seen the group look to find synergies between private hospitals and wellness and fitness services offering health assessments and a range of services in the health and fitness facilities that it operates.

3.29 Figure 3.8 shows how the composition of Nuffield’s admissions has changed between 2007 and 2011, with growth in the number of NHS patients offsetting a decline in the number of private patients.

FIGURE 3.8

Nuffield inpatient and day-patient admissions, 2007 to 2011

[X]

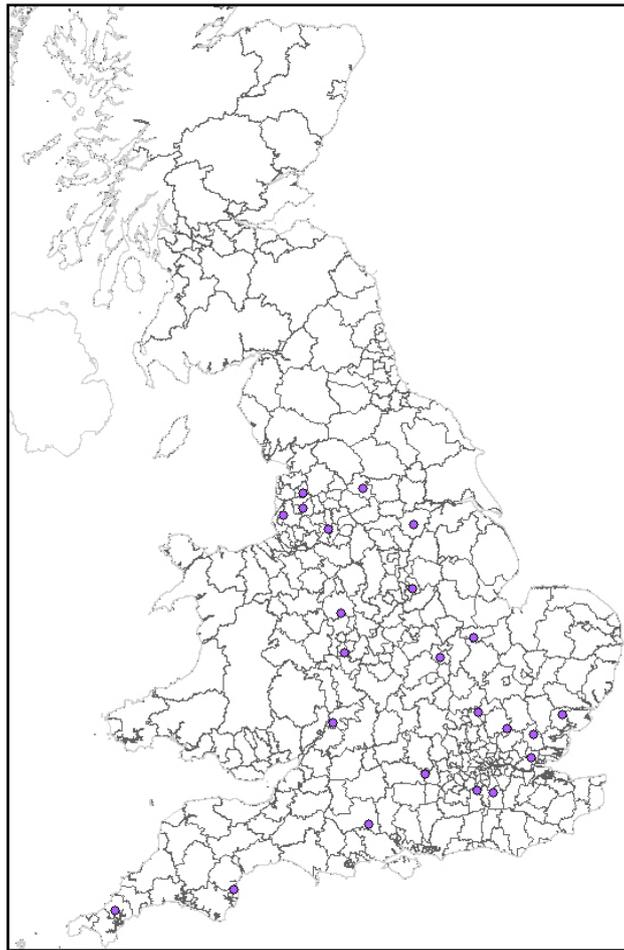
Source: Nuffield.

Ramsay Health Care

- 3.30 Ramsay is the UK's fifth largest private hospital operator with 30 hospitals with 947 beds, including two Independent Sector Treatment Centres (ISTCs). Ramsay also operates a PPU on behalf of Basildon and Thurrock University NHS Foundation Trust.
- 3.31 Ramsay is the largest private hospital operator in Australia and also operates in France and Indonesia. It entered the UK market in 2007 with its purchase of Capiro Healthcare's UK hospital operating business. Capiro AB, a Swedish private equity investor, had acquired Community Hospitals Group in 2001 and was itself acquired in 2006 by a partnership between Apax Partners and Nordic Capital. The new owner sold its hospital premises to the Prestbury Consortium which leased them back to Capiro before it sold the hospital operation business to Ramsay.
- 3.32 Figure 3.9 shows the locations of Ramsay's hospitals in the UK.

FIGURE 3.9

Ramsay portfolio of hospitals



Source: Ramsay.

3.33 Ramsay differs from the other major private hospital operators in the amount of work it undertakes for the NHS across a range of procedures including, for example, hip and knee replacements (see Figure 3.10). Between 2008 and 2012, Ramsay substantially increased the number of NHS patients treated at its facilities, allowing it to grow total admissions by 50 per cent over the period.

FIGURE 3.10

Ramsay inpatient and day-patient admissions, 2007 to June 2012



Source: Ramsay.

3.34 Table 3.5 provides a summary of the financial performance of Ramsay between January 2007 and June 2012.

TABLE 3.5 Ramsay summary financial information

	£'000				
	FY08*	FY09	FY10	FY11	FY12
Insured patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Self-pay patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
NHS patients	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Outpatient	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Other	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total revenue	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Gross profit	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
EBITDA	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: Ramsay.

*[REDACTED]

Other private hospitals and private hospital operators

The London Clinic

3.35 The London Clinic opened in 1932 and was granted charitable status in 1935. Its current facilities are located in and around Harley Street in central London and comprise 74 consulting rooms, 13 operating theatres, a level 3 intensive care unit, 181 overnight beds and 59 day-beds. TLC, which describes itself as the largest 'independent'⁹ private hospital in London, admitted slightly fewer than 22,000 patients in 2011.¹⁰ It focuses on high-acuity treatments and provides most of the major clinical specialties with the exception of cardiac surgery, obstetrics and psychiatry. In 2009, TLC opened its Cancer Centre adjacent to its main clinic in Devonshire Place.

⁹ In the sense that it is independent of the main hospital groups (BMI, HCA, Nuffield, Ramsay and Spire).

¹⁰ Admissions figures do not include outpatient consultations. In 2011, TLC held just under 110,000 outpatient consultations.

3.36 As a charity, TLC is governed by a Chairman and Board of Trustees, with all surpluses reinvested into the hospital and, like other charities, may benefit from certain tax relief and exemptions.¹¹

3.37 The turnover of TLC grew from £[x] in 2006 to £[x] in 2011, an average annual growth rate of [x] per cent (see Table 3.6). Over the same period, [x] increased from £[x] to just over £[x], with margins remaining constant at [x] per cent. TLC's revenue is generated largely from insured patients, who account for around [x] per cent of the total. The remaining [x] per cent of its revenue is split evenly between self-pay and international patients, with almost no revenue generated from NHS patients.

TABLE 3.6 TLC summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[x]	[x]	[x]	[x]	[x]
Self-pay patients	[x]	[x]	[x]	[x]	[x]
Overseas patients	[x]	[x]	[x]	[x]	[x]
Other	[x]	[x]	[x]	[x]	[x]
Total revenue	[x]	[x]	[x]	[x]	[x]
Gross profit	[x]	[x]	[x]	[x]	[x]
EBITDA	[x]	[x]	[x]	[x]	[x]

Source: TLC.

Bupa Cromwell Hospital

3.38 Bupa, which had previously sold all of its hospitals, acquired the Cromwell hospital in 2008. The 131-bed hospital is located on Cromwell Road in Kensington and provides care across more than 50 subspecialties with a particular focus on [x].

3.39 The hospital has five operating theatres and 29 consulting rooms. In 2011, Bupa Cromwell Hospital (BCH) generated £[x] in revenues and £[x] (see Table 3.7).

¹¹ See www.hmrc.gov.uk/charities/tax/basics.htm.

Revenues were split between insured patients ([x] per cent), overseas patients ([x] per cent), self-pay patients ([x] per cent) and NHS-funded patients ([x] per cent).

TABLE 3.7 BCH summary financial information

	£'000			
	FY08	FY09	FY10	FY11
Total revenue	[x]	[x]	[x]	[x]
EBITDA	[x] [x]	[x] [x]	[x] [x]	[x] [x]

Source: BCH.

Aspen

3.40 Aspen Healthcare has eight facilities in the UK, five of which are based in and around London, with one each in Sheffield, Edinburgh and Solihull (see Figure 3.11). These vary in size from a full-service hospital with a high dependency unit and dedicated cancer centre (Parkside) to consulting rooms that offer day-patient and minimally invasive procedures (Chelmsford Medical Centre). In total, Aspen's hospitals contain 16 theatres, 81 consulting rooms, 191 overnight beds and 34 day-beds. In the financial year ended 31 December 2011, the business generated £[x] of revenue and £[x] (excluding General and Administrative (G&A)).

FIGURE 3.11

Location of Aspen's hospitals and clinics



Source: Aspen.

Note: In addition to the locations shown, Aspen also has a facility in Chelmsford.

3.41 Aspen is currently owned by Welsh Carson Anderson and Stowe (a US-based private equity house), having been originally formed in 1998 via a management buyout of Paracelsus UK from Paracelsus Kliniken Deutschland GmbH. At the time of the transaction, Aspen owned the Parkside and Holly House hospitals. In 2003, the business completed the construction of Cancer Centre London, and acquired the Highgate Hospital, followed in 2011 and 2012 by the acquisition of The Edinburgh Clinic, The Claremont (Sheffield), the Midland Eye Clinic and The Chelmsford Private Day Surgery Hospital.¹²

¹² Aspen [website](#).

3.42 Aspen pursues a flexible expansion strategy, acquiring both full-service hospitals and Ambulatory Surgical Centres (ASCs), depending on the characteristics of the local market and the opportunities that arise.¹³ [X]

3.43 Table 3.8 provides a summary of the financial performance of Aspen between 2007 and 2011.

TABLE 3.8 Aspen summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Total revenue	[X]	[X]	[X]	[X]	[X]
EBITDA (excl G&A)	[X]	[X]	[X]	[X]	[X]

Source: Aspen.

Circle

3.44 Circle, was set up in 2004, originally as Centres of Clinical Excellence. The feature that distinguished its business model from other private hospital operators' was that, in return for committing to undertake a certain proportion of their work at a Circle facility, consultants would be entitled to an equity stake in the business. Circle told us that 1,200 consultants had entered into contractual commitments with it.

3.45 Circle's strategy was to provide healthcare to both private and NHS patients from its facilities, the latter arising from what it saw as the growing demand for independently-provided healthcare services created by NHS reforms.

3.46 Circle's first acquisition was made in 2007, when it bought Nations Healthcare, an operator of three NHS ISTCs in Bradford, Burton and Nottingham. Two of these

¹³ ASCs provide a range of diagnostic testing as well as day-patient surgery and medical treatments but not inpatient services.

contracts have now expired, with the Nottingham facility still operated by Circle.¹⁴ In addition to its NHS-focused activities, Circle opened its first private hospital in Bath in March 2010, followed by its Reading hospital in August 2012. At the current time, Circle is seeking to secure sufficient consultant commitments and raise financing for a third private hospital in Manchester.

3.47 Circle's business model relies on consultants committing to undertake a proportion of their work at a Circle facility in return for an equity stake in the Circle Partnership and a role in managing and organizing the delivery of services. The consultant may terminate his/her commitment with 12 months' notice at any time following the first anniversary of the relevant facility's opening.

3.48 Table 3.9 provides a summary of financial information of Circle between 2009 and 2012.

TABLE 3.9 Circle summary financial information

	£'000			
	FY09	FY10	FY11	FY12
Revenue	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]
Operating profit	[X]	[X]	[X]	[X]

Source: Circle Holdings plc.

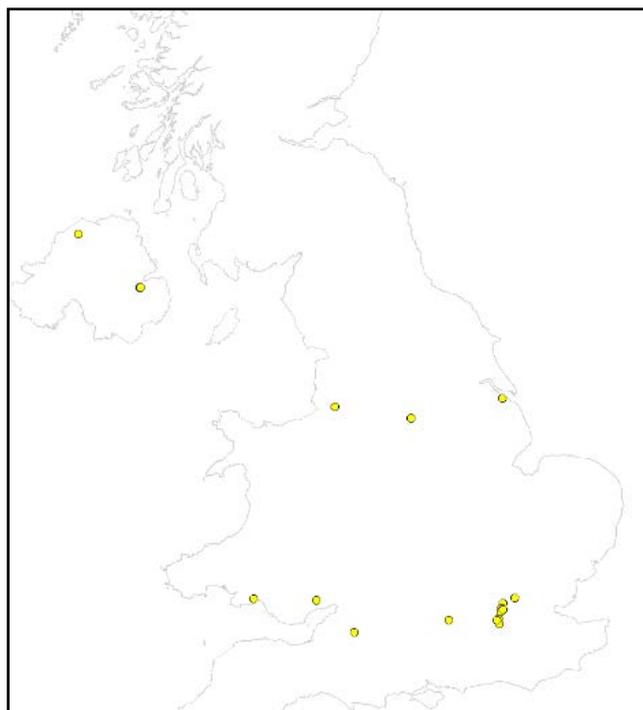
Independent hospitals

3.49 On top of the main hospital groups, other private hospital providers and larger private hospitals, there are a number of smaller, independent private hospitals in the UK. These are often operated as (religious) charities and are located throughout the country, with a concentration in London (see Figure 3.12).

¹⁴ AIM Admission Document June 2011, p47.

FIGURE 3.12

Location of independent hospitals



Source: CC analysis.

Note: This map includes Circle, TLC and BCH.

NHS Private Patient Units

3.50 In addition to the private hospital operators, the NHS also provides private healthcare services to patients via PPUs.¹⁵ There are 77 PPUs in the UK,¹⁶ with a total of 1,195 dedicated beds and approximately 1,500 non-dedicated beds, which are used to treat private patients on an irregular basis, which have historically had a private patient occupancy rate of about 10 per cent (see Figure 3.13).¹⁷ The largest and most active PPUs are generally attached to teaching hospitals and located in London and the South-East.

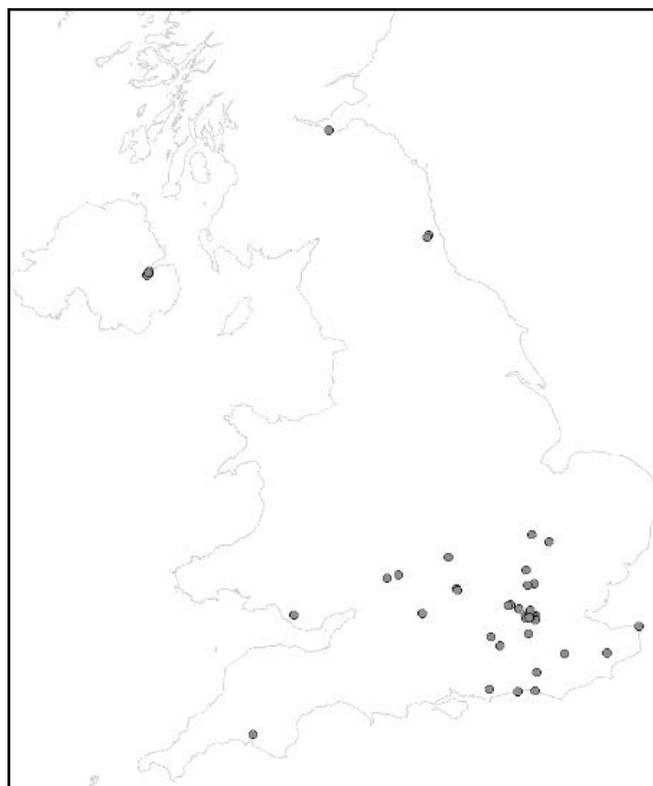
¹⁵ For information on the impact of PPU expansion following the lifting of the private patient income cap, see Appendix 3.1.

¹⁶ Laing & Buisson Private Acute Medical Care 2012, p84.

¹⁷ Laing & Buisson Healthcare Market Review 2012, p30.

FIGURE 3.13

Location of PPU



Source: CC analysis.

- 3.51 Table 3.10 shows the total revenue earned by PPU in 2010/11 and 2011/12, together with their share of the total. Only one of the top ten PPU is located outside London (the Christie Clinic in Manchester). Many of the largest PPU specialize in certain types of treatment rather than offering a broad range of healthcare services. For example, the Royal Marsden specializes in the treatment of cancer and Great Ormond Street focuses on paediatrics.
- 3.52 The revenue of the largest PPU increased by 13.5 per cent between 2010/11 and 2011/12, while the smaller PPU grew their revenues by 4 per cent.

TABLE 3.10 Revenue of NHS PPU's

	<i>£ million</i>		
	<i>2010/11</i>	<i>2011/12</i>	<i>% share NHS PP revenue</i>
Royal Marsden FT	44.6	51.2	10.6
Royal Brompton & Harefield FT	24.4	29.1	6.0
Imperial College Healthcare	26.2	28.6	5.9
Great Ormond Street FT	25.0	28.5	5.9
Guy's & St Thomas' FT	19.0	21.2	4.4
Royal Free Hampstead	18.5	19.2	4.0
Moorfields Eye Hospital FT	16.5	17.9	3.7
King's College Hospital FT	12.5	15.4	3.2
The Christie FT	8.5	10.7	2.2
Chelsea & Westminster	9.8	10.5	2.2
Top 10 Trusts	204.7	232.2	48.2
Other Trusts	240.3	249.7	51.8
Total NHS	445.0	482.0	100.0

Source: Laing & Buisson Private Acute Medical Care 2012 Table 4.2.

Clinicians

Overview

- 3.53 In the UK, the term 'doctor' is used to refer to a wide range of medical practitioners including GPs, consultants (specialists), specialty doctors (previously referred to as staff and associate specialist doctors, foundation doctors, specialty (including GP) post-graduate doctors in training, and doctors not entered on the specialist register).¹⁸
- 3.54 As at 31 December 2011, there were approximately 214,000 licensed doctors on the GMC's medical register¹⁹ in the UK, broken down as follows between the nations: England—178,000, Scotland—19,000, Wales—10,400 and Northern Ireland—6,500.²⁰ Of these, approximately 68,000 were on the GMC's Specialist Register and 59,000 were on the GP Register.²¹ Both the number of consultants and the number of GPs increased from 2010, and have been increasing since 2001: the number of GPs has grown by 16 per cent in the last decade (though in the past year, there has

¹⁸ The state of medical education and practice in the UK 2012 (TSMEP 2012) p17:

www.gmc-uk.org/The_state_of_medical_education_and_practice_in_the_UK_2012_0912.pdf_49843330.pdf.

¹⁹ In addition, there is a GP Register and a Specialist Register on which GPs and consultants, respectively, must also be registered.

²⁰ TSMEP 2012, p141.

²¹ TSMEP 2012, p17. Bupa estimated that it recognised approximately 22,000 consultants in private practice.

been a 0.1 per cent decline) and the number of consultants has grown by 41 per cent in the same period (3 per cent in the past year).²² However, the BMA suggested that the proportion of consultants who practise privately has been in decline in recent years, and has estimated that fewer than 10 per cent of new consultants practise privately.²³ ‘The BMA estimated that in 2005, 59 per cent of NHS Consultants were also practising in the private sector. By 2006 the National Audit Office put the figure at 55 per cent of the total workforce.’²⁴ This suggests that growth in the population of consultants practising privately in the last ten years is probably more modest than the overall growth rate for consultants,²⁵ a result of the narrowing of the gap in earnings between private practice and the NHS.

3.55 For the purpose of the market referred to us, we have concentrated on GPs and consultants, as their practices are most relevant to the issues considered in this investigation.

Associated organizations

3.56 In Section 2, we describe the regulatory regime for private healthcare, including how doctors are regulated in the UK—we complement that information here.

3.57 The GMC ensures proper standards in the practice of medicine (see paragraph 2.75), and has four mandated functions under the Medical Act 1983:

- (a) keeping up-to-date registers of qualified doctors;
- (b) fostering good medical practice;
- (c) promoting high standards of medical education and training; and

²² <http://bma.org.uk/working-for-change/nhs-watch-how-many-doctors-work-in-the-uk>. In England, these figures are slightly higher, with the average annual increase of FTE consultants at 4.4 per cent and the average annual increase of FTE GPs at 2.1 per cent (*NHS Workforce : Summary of Staff in the NHS: Results from September 2012 Census*: <https://catalogue.ic.nhs.uk/publications/workforce/numbers/nhs-staf-2002-2012-gene-prac/nhs-staf-2002-2012-over-rep.pdf>, p6)

²³ Lang & Buisson Private Acute Medical Care 2012, p123.

²⁴ Program of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants. (Program of Research), www.of.gov.uk/shared_of/market-studies/Population-Overview-Report-1.pdf.

²⁵ Laing & Buisson Private Acute Medical Care 2012, p123.

(d) dealing firmly and fairly with doctors whose fitness to practise is in doubt.

- 3.58 In order to practise medicine in the UK, doctors must be both registered with and licensed by the GMC.²⁶ The medical royal colleges are charged with setting standards within their field and for supervising the training of doctors within their specialties, but ultimate responsibility for ensuring that those standards are applied rests with the GMC.
- 3.59 The BMA is the trade union and professional association for doctors in the UK. As a trade union, it provides individual and collective representation to the country's doctors, and as a professional association, it leads debate on key ethical, scientific and public health matters through research and publication.²⁷
- 3.60 The Health and Social Care Act 2008 requires providers of regulated activities, which includes consultants, to be registered with the CQC.²⁸ However, a consultant with practising privileges is deemed to be an employee of the relevant facility and will benefit from that facility's registration. A consultant who sets up their own clinic or consulting rooms either alone or with other consultants or who otherwise does not have practising privileges will need to be registered.

GPs

- 3.61 The services provided by GPs are defined under the General Medical Services (GMS) contract,²⁹ and fall into three different categories: essential, additional and enhanced. Essential services are those for patients who have acute, chronic or terminal illnesses or conditions. GP practices are expected (but not required) to

²⁶ See paragraphs 2.75–2.78.

²⁷ <http://bma.org.uk/about-the-bma/what-we-do>.

²⁸ The sections of this Act that relate to the CQC are applicable in England and Wales.

²⁹ The GMS is a UK-wide contract governing the relationship between general practices and primary care organizations for delivering primary care services to local communities.

provide additional services, such as minor surgery procedures or maternity services. Enhanced services are those essential or additional services that are delivered to a higher standard, or more specialized services. They are commissioned and developed either under national direction with national specifications and benchmark pricing to cover the relevant patient population or locally.³⁰

- 3.62 GPs also provide a link to further health services and work closely with other health-care colleagues, developing those services and arranging hospital admissions and referrals to consultants.
- 3.63 All doctors working in general practice in the health service in the UK³¹ are required to be included on the GP Register. While a significant amount of data is available about GPs practicing in the NHS, the same breadth and amount of data is not available with regard to private sector GPs. However, the information that is available suggests that the 'private GP workforce is very small, since in 2009 just 3 per cent of total GP consultations were carried out privately'.³²
- 3.64 There are some differences across the UK in the oversight and delivery of GP services. In England, clinical commissioning groups (CCGs) and local area teams (LATs) are responsible for the planning and delivery of primary healthcare services. Primary care services are managed by 14 regional health boards in Scotland and coordinated by seven health boards in Wales which provide information about local GP services. In Northern Ireland, there is one Health and Social Care Board which is responsible for the overall management of local health services.³³

³⁰ The New General Medical Services contract: www.nhsemployers.org/SiteCollectionDocuments/gms_contract_cd_130209.pdf.

³¹ Other than doctors in training such as GP Registrars (TSMEP 2012).

³² Program of Research, p16.

³³ *It's Your Practice: A patient guide to GP services.*

Consultants

- 3.65 Consultants accept ultimate responsibility for the care of patients referred to them, and therefore are in a position of considerable responsibility.³⁴ This is especially the case in private practice: 'when a surgeon has patients under their care within the NHS, the patients tend to be looked after by a large team, including a variety of grades of trainees. Care in the private sector is generally delivered entirely by the consultant.'³⁵
- 3.66 A consultant typically works in a hospital, where their primary duty is to establish a diagnosis, and then to give advice and provide treatment where appropriate. Consultants are also involved in and lead multidisciplinary teams. The aim is to deliver joined-up care by taking a comprehensive view of the care pathway, and managing other team members (eg nurses, anaesthetists, physiotherapists, pharmacists etc) accordingly. Another important aspect of the consultant's role is to be involved in teaching and training students and junior doctors, and to contribute research to their field of specialty through research.³⁶
- 3.67 A consultant is a senior doctor who practises in one of the medical specialties. There are 65 such specialties. Each specialty has its own college or faculty that sets standards and all consultants have to be a member of a relevant college or faculty to be able to practise. Consultants undergo the same basic training as other doctors in general medicine and surgery with additional training and experience in their relevant specialism. It takes approximately ten years to qualify as a consultant. Key specialties include:
- (a) obstetrics and gynaecology: female reproductive conditions including pregnancy;
 - (b) general surgery: treatment of conditions by internal operation;

³⁴ www.rcplondon.ac.uk/medical-careers/consultant-physicians.

³⁵ <http://surgicalcareers.rcseng.ac.uk/surgeons/practising-as-a-surgeon/independent-practice>.

³⁶ www.rcplondon.ac.uk/medical-careers/consultant-physicians.

- (c) trauma and orthopaedics: injuries to the musculoskeletal system;
- (d) anaesthetics: the use of medicines to anaesthetize patients during surgery and medical procedures;
- (e) urology: conditions of the urinary tract and male reproductive organs;
- (f) gastroenterology: conditions of the digestive system;
- (g) ophthalmology: conditions of the eye;
- (h) otolaryngology: conditions of the ear, nose and throat;
- (i) dermatology: conditions of the skin;
- (j) plastic surgery: 'correction' or restoration of form and function;
- (k) cardiology: conditions of the heart;
- (l) general medicine: the effects of different medication including side effects and how medicines interact;
- (m) neurology: conditions of the nervous system;
- (n) oral and maxillofacial surgery: surgery to treat conditions in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region;
- (o) rheumatology: conditions of the joints, soft tissues, autoimmune system, vascular system and connective tissues;
- (p) clinical radiology: the use of imaging to diagnose, treat and monitor various disease processes; and
- (q) oncology: treatment of tumours and cancer.

3.68 In order to establish and operate a private practice, a consultant must be fully registered and licensed by the GMC in accordance with the Medical Act 1983, approved by an Advisory Appointments Committee as part of the NHS Consultant appointment process and have medical indemnity insurance.

3.69 All private hospitals have Medical Advisory Committees (MACs) comprising consultants of all specialties offered at the private hospital. In order to practise at a private

hospital, a consultant will require admission rights or practising privileges. The MAC will determine the standards required to be met by consultants wishing to practise as well as the clinical governance requirements whilst in practice. We looked at the requirements of the main hospital groups in terms of practising privileges. These are relatively standard and cover eligibility, confidentiality and legislative requirements, scope of procedures, review and suspension of practising privileges and rights of appeal, and document management, among other things.

- 3.70 To treat insured patients, a consultant will need to register with a PMI. In order to do so, the PMI may request copies of documents that will satisfy it that the consultant is suitably qualified to provide medical care to their customers.
- 3.71 A consultant in private practice will also require indemnity insurance. Consultants practising in the NHS benefit from the NHS Indemnity, under which NHS bodies take direct responsibility for costs and damages arising from clinical negligence of their employees including consultants. Consultants practising both in the NHS and privately must be aware of work which does not fall strictly within their NHS contract, as it is not covered by the NHS Indemnity, and must decide what separate indemnity cover they need for any work they undertake outside their NHS contract. The most common way of securing indemnity insurance is through membership of one of the three medical defence organizations.³⁷

PMI—products and providers

- 3.72 Below we describe the background to the PMI industry in so far as it relates to private healthcare. We also examine the individual providers, their business strategies and their products.

³⁷ Medical Defence Union, Medical Protection Society and the Medical and Dental Defence Union of Scotland.

Background

- 3.73 There were around 6.8 million³⁸ company-paid and individual-paid subscribers to PMI in the UK at the end of 2011, though there are marked regional and socio-economic variations in penetration.
- 3.74 Estimates put average UK PMI penetration at 10.9 per cent at the end of 2011.³⁹ The available regional information (which, unfortunately, is not very recent) shows that penetration ranged from over 18 per cent in London to 8 per cent or less in the North-East and Northern Ireland.⁴⁰ Since the areas of highest PMI penetration are also some of the most densely populated parts of the UK, the absolute numbers of people with PMI cover are highest in London and the South-East, and we have no reason to believe that relative rates of penetration across the UK have changed significantly.
- 3.75 The majority of people with private health cover receive it as an employee benefit. Approximately 5.2 million people are covered under an employer's scheme compared with about 1.6 million who subscribe individually.⁴¹ Since 2000, the number of people covered by their employer's scheme has been falling. This has also been the case for the number with individual cover since the mid-1990s.⁴²
- 3.76 An employer wishing to provide its employees with private medical cover can choose to be fully insured, in effect paying a premium to the PMI in respect of its employees or—and more commonly for large companies—it can establish a self-insured scheme.⁴³ Typically this will involve setting up a trust to fund claims and appointing a third party, usually a PMI, to administer the process, including claims handling. SMEs are more likely to be fully insured.

³⁸ Laing & Buisson Health Cover 2012, p15.

³⁹ *ibid*, p15.

⁴⁰ *ibid*, pp15–16.

⁴¹ *ibid*, p14.

⁴² *ibid*, p14.

⁴³ One advantage of doing so is that the firm does not need to pay Insurance Premium Tax, currently levied at the rate of 6 per cent.

3.77 The PMIs differ in the amount of individual, large corporate (trust or otherwise) and SME business they undertake. We show in Figure 3.14 the lives each covers in the various categories of scheme.

FIGURE 3.14

Lives covered by PMI and by category, 2011



Source: Bupa, AXA PPP, Aviva and PruHealth.

The cost of private medical cover

3.78 The cost of private medical cover has been rising for both individual subscribers and corporate clients. The average price per individual subscriber paid for private medical cover more than doubled between 1995 and 2011, increasing by 60 per cent in real terms.⁴⁴

3.79 The cost of private healthcare to employers has also risen over the same period, though at a slower rate than for individual subscribers. The average price per life covered doubled in nominal terms and rose by about a third in real terms.⁴⁵

Market shares

3.80 The ranking of the largest PMIs has been relatively stable for the past 20 years.⁴⁶ The PMI industry is concentrated (see Figure 3.15), and the top four PMIs' share of the private health cover market reached about 87 per cent in 2010, with the remaining 13 per cent being accounted for by 15 smaller providers. This growth has been driven more by the third- and fourth-ranked PMIs with the share of the top two rising only very slightly. The share of the third- and fourth-ranked PMIs grew from

⁴⁴ Laing & Buisson, Health Cover 2012, p23.

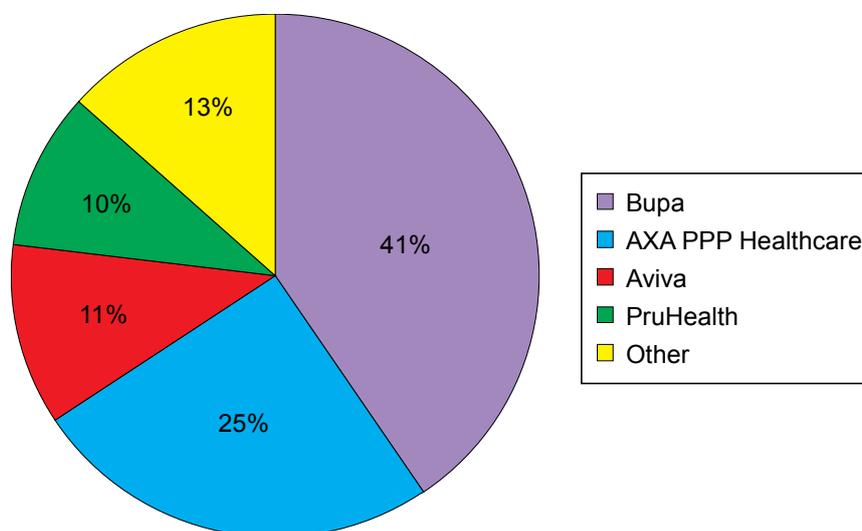
⁴⁵ *ibid*, p23. The price per life is lower for corporate clients since the cost of claims is likely to be lower due to the risk profile of the insured base. A corporate scheme will be open to low- and higher-risk members but individual subscribers are self-selecting.

⁴⁶ *ibid*, p117.

14.5 per cent in 2000 to 21.6 per cent in 2011.⁴⁷ Major share movements have tended to be as a result of acquisition rather than organic growth.⁴⁸

FIGURE 3.15

PMI market share by revenue, 2011



Source: Laing & Buisson, Health Cover 2012.

PMI products

3.81 PMI offers the same kinds of benefits as do other forms of general insurance: the policy pays out if the event insured against occurs. In the case of PMI, the risk being insured against is an acute illness or condition.

3.82 The cost of the premium will vary with the coverage and benefits provided, for example the range of hospitals the insured may use in the event of a claim, and with the likelihood and probable cost of a claim. The likelihood of a claim will vary in particular with the age⁴⁹ and lifestyle of the individual policyholder and the cost of claims may vary with the geographical location of the insured.

⁴⁷ *ibid*, p118.

⁴⁸ See the descriptions of the individual providers below for examples of acquisitions.

⁴⁹ The premium for a 70 year old is typically at least three times that of a 35 year old. See [Which?](#), November 2012.

- 3.83 As with other forms of general insurance, policyholders can reduce the level of premium by accepting some of the risk themselves, say the first £250 of a claim. This amount is known as the policy 'excess'.⁵⁰
- 3.84 One important difference between PMI and other types of general insurance is that the individual may already be suffering from a condition, or may have done so in the recent past, when they take out a policy. In these circumstances insurers will, through a process known as 'full medical underwriting', ask the prospective policyholder for details of their medical history and will specify on their insurance certificate what conditions are excluded from cover. Alternatively, the insurer may offer 'moratorium underwriting' as an option. In this case, the prospective policyholder will not be asked to provide their medical history but any pre-existing conditions that they have received treatment or medication for, received advice about or experienced symptoms of within a specified time period will automatically be excluded. Moratorium underwriting is normally cheaper, though offers less certainty to the policyholder as to what exactly is covered and what is excluded.
- 3.85 Other exclusions from cover will, in all cases, be long-term, chronic conditions and, in most cases, policies will exclude cover for accident and emergency treatment, drug abuse, HIV/AIDS, normal pregnancy and injuries incurred from participation in dangerous sports or hobbies ('hazardous pursuits').
- 3.86 PMI differs from health cash plans in that the latter are intended to help cover the cost of everyday healthcare such as visits to the optician or the dentist⁵¹ rather than, as in the case of PMI, the whole of the cost of hospital treatment. Some PMIs, however, will offer subscribers the option of taking a cash payment if they elect to be

⁵⁰ In 2010, PruHealth offered its subscribers another way to reduce the level of their premiums through 'co-insurance' with its Value product in 2010. This required the policyholder to make a co-payment in the event of a claim, for example £100 for each inpatient admission. This product was bought by around 160 customers only over three years.

⁵¹ See the ABI guide to [health cash plans](#).

treated on the NHS rather than at a private hospital. Bupa, for example, provides a cash payment option for subscribers who choose to have an NHS knee replacement.⁵²

PMI business models

3.87 The current PMI businesses originated in two different ways. Some, like Bupa and WPA, grew out of provident associations, established specifically to provide health-care for members. Other PMIs, like AXA PPP, Aviva and PruHealth, are part of larger insurance businesses whose parent or associated companies offer a range of insurance and other financial services products.⁵³

3.88 These differences in origin may have a bearing on or place restrictions on how they do business. Aviva, for example, has been able to make discounts on its motors, home and travel insurance products available to members of some of its corporate health cover schemes which the former provident associations could not.⁵⁴

PMI practice on patient guidance

3.89 The extent to which PMIs seek to 'guide' patients to particular hospitals, consultants and care pathways is a relevant consideration for our investigation into the private healthcare market. PMIs use these guided referrals to avoid customer shortfalls and to control costs (see, for example, paragraphs 7.53 to 7.59).

3.90 All the major PMIs offer products which are differentiated by the range of hospitals they permit policyholders day patient and inpatient access to. Typically, the PMI will offer a 'value' product with access to certain private hospitals and PPUs but not the most expensive ones which will only be available to policyholders opting for the

⁵² See Bupa website, [knee replacement](#).

⁵³ The PMIs that are part of insurance businesses generally go beyond just indemnifying risk. All the larger ones offer 'well-being' information, advice and, in the case of [PruHealth](#), rewards for adopting a healthier lifestyle.

⁵⁴ See Aviva [website](#).

‘premium’ product, possibly with a mid-level product to complete the range.⁵⁵ For example, PruHealth used to offer a ‘guided options’ list of hospitals, for both individual and corporate customers. Policyholders who took this up must ask their GP for a guided referral letter and provide this to PruHealth which will contact the nearest appropriate hospital on the list. The hospital will then refer the patient to an appropriate consultant.

3.91 PMIs differ in the degree to which they guide patients towards particular consultants. All four of the largest PMIs (Bupa, AXA PPP, PruHealth and, very recently, Aviva) have adopted or expanded processes for some of their subscribers which guide them to ‘approved’ or ‘recognized’ consultants.⁵⁶

3.92 For example, Bupa’s Open Referral process, which is mandatory for members of some of its corporate schemes and an option for individual subscribers, requires the patient’s GP to make a referral not to a specific, named consultant but to a consultant with the particular specialism suggested as appropriate by the GP’s initial diagnosis. Bupa advisers will then recommend one of their recognized, fee-assured consultants (ie consultants who have agreed to work within Bupa’s fee maxima).

3.93 AXA PPP similarly provides guidance to patients whose employers have adopted its Healthcare Pathway product,⁵⁷ as has Aviva, which has recently launched a new product called GuideWell for large corporate customers.⁵⁸

3.94 PruHealth claims to be the only PMI to offer a ‘full refund’ policy and does not decline to recognize consultants on the basis of their fees. It recognizes all consultants who

⁵⁵ See, for example, the [WPA Premium hospital list](#) or Simplyhealth’s [hospital directory](#).

⁵⁶ See paragraphs 7.53–7.59.

⁵⁷ [Healthcare Pathway](#). Patients will be referred via their consultant for treatment at one of the hospitals on a list which, among others, includes TLC, and some or all of BMI, Nuffield, Aspen and Spire hospitals.

⁵⁸ [GuideWell](#).

are registered with the GMC, hold a licence to practise and who are on the Specialist register.⁵⁹ It publishes what it considers are 'customary and reasonable' rates, which it derived from a benchmarking operation in 2011. PruHealth's website warns consultants that fees that fall outside this guidance may be challenged and that consultants who persistently bill outside of its guidelines face derecognition.⁶⁰

- 3.95 PMIs offering these options may also employ processes to guide patients towards particular healthcare pathways. Aviva, for example, offers its BacktoBetter service for musculoskeletal conditions, providing an alternative clinically case-managed approach to the traditional GP to consultant referral pathway. Bupa offers direct access to its Back Care service as an alternative to visiting a GP⁶¹ and PruHealth offers subscribers the option of visiting members of its physiotherapy network on a self-referral basis.⁶²

Bupa

- 3.96 In 1947, 17 provident associations amalgamated to form the British United Provident Association, a company limited by guarantee with no shareholders. Bupa is now the largest of the PMIs with a market share of just over 40 per cent by revenue in 2011 and UK revenues of around £1.5 billion. It confines its activities to the healthcare sector, though not necessarily to health insurance: for example, it has expanded into healthcare provision, acquiring care homes and dental practices and moving back, at least to a limited extent, into running acute hospitals.⁶³

⁵⁹ See PruHealth [website](#).

⁶⁰ See PruHealth [website](#). PruHealth said that it did not record numbers of consultants derecognized on these grounds but that it was a very small number.

⁶¹ [Bupa back care](#).

⁶² See PruHealth [website](#).

⁶³ Bupa acquired the Cromwell Hospital in 2008.

- 3.97 Like other PMIs, Bupa provides services to individual PMI subscribers and to employers. Figure 3.14 shows the proportion of lives covered by Bupa in these different segments.
- 3.98 Bupa for You is Bupa's individual PMI cover, which is customized by the subscriber's choice of core health insurance options, hospital network and additional healthcare options. Bupa also has Bupa Health Solutions for corporates, offering SMEs flexible coverage through its Foundation (working in conjunction with the NHS), Select (most comprehensive cover offering three different tiers: key, enhanced and complete) and Superior (geared towards executives) products, and bespoke coverage for larger businesses. Bupa's Open Referral is the default option for corporate customers, guiding patients to consultants who have agreed to charge within Bupa's fee structure.
- 3.99 Table 3.11 shows Bupa's financial performance between 2004 and 2011. Between FY08 and FY10, Bupa was significantly affected by a combination of declining numbers of policyholders and continued growth in claims costs.

TABLE 3.11 Bupa summary financial information

	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[X]							
Net claims	[X]							
Loss ratio	[X]							
Underwriting expenses	[X]							
Underwriting result	[X]							
Combined ratio	[X]							

Source: Bupa.

AXA PPP

- 3.100 AXA PPP is the second largest PMI in the UK, with a market share of around 25 per cent and revenue of £940 million. The original Private Patient Plan business was acquired by Guardian Royal Exchange in 1998 which was itself acquired by Sun Life, part of the AXA insurance group, the following year. To reflect this change of

ownership, the business was subsequently renamed AXA PPP healthcare. AXA PPP bought the Legal & General medical cover business in 2007.

3.101 The relative size of AXA PPP's customer segments is shown in Figure 3.14. AXA PPP's Health Select product offers core cover to individual PMI subscribers, with up to nine different add-on options, ranging from extra outpatient cover to dentist and optician cash-back. The Business Health Select product covers SMEs, and offers tailored options which can be enhanced with different add-ons similar to those for individuals. For corporate clients, AXA PPP offers the Corporate Health Plan (which leaves the choice of hospital and consultant to the member and the GP), the Corporate Health Plan Plus (which leaves the choice of hospital and consultant to the member, and the GP and does not have any cap on consultant fees) and the Healthcare Pathway (which uses guided referral, guiding members to its list of consultants and hospitals for treatment).

3.102 Table 3.12 shows AXA PPP's financial performance between FY04 and FY11.

TABLE 3.12 AXA PPP summary financial information

	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Net claims	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Loss ratio	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Underwriting expenses	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Underwriting result	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Combined ratio	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]

Source: AXA PPP.

Aviva Health

3.103 With a current market share of over 11 per cent, Aviva Health is the third largest PMI in the UK and is part of the Aviva group providing life insurance, general insurance and investment management services.

3.104 Aviva offers subscribers a range of policy options. Its Healthier Solutions product offers individual subscribers the choice to enhance their cover with additional health-care benefits. Its Extended list offers the most comprehensive selection of hospitals including the more expensive ones. Its more restrictive lists are its Key, Fair+Square, Trust and Signature lists. In addition, Aviva has created tailored lists for some of its corporate customers based on the location of the firms' employees.

3.105 The relative size of Aviva's customer segments is set out in Figure 3.14.

3.106 Table 3.13 shows Aviva's financial performance between FY04 and FY11. Aviva has grown its revenues by almost 60 per cent between 2004 and 2011.

TABLE 3.13 Aviva summary financial information

	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Net claims	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Loss ratio	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Underwriting expenses	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Underwriting result	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Combined ratio	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]

Source: Aviva.

PruHealth

3.107 PruHealth, with a market share of 10 per cent and UK revenues of £364 million, is owned by Prudential and Discovery Holdings, a leading South African PMI.

PruHealth acquired Standard Life Healthcare in 2010.

3.108 PruHealth offers three policy options. Its Local hospital policy now includes all of the BMI, Spire, Ramsay, Aspen and Nuffield hospitals as well as The Christie, St Anthony's and New Victoria, but excludes all central London hospitals and NHS PPU's. Its Countrywide policy, in addition, includes TLC and King Edward VII Sister Agnes and some central London PPU's. Its Premier hospital list includes all the HCA central London hospitals and PPU's.

3.109 The relative size of PruHealth’s customer segments is shown in Figure 3.14.

3.110 Table 3.14 shows PruHealth’s performance between FY04 and FY12.

TABLE 3.14 PruHealth summary financial information

	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY12
Total income	[REDACTED]							
Net claims	[REDACTED]							
Loss ratio	[REDACTED]							
Underwriting expenses*	[REDACTED]							
Underwriting result	[REDACTED]							
Combined ratio	[REDACTED]							

Source: PruHealth.

*[REDACTED]

Other PMI providers

3.111 There are various other smaller insurers operating in the PMI market—some of them are in fact provided by the major PMIs, such as Tesco health insurance, which is provided by AXA PPP. We briefly describe two of these smaller PMIs, Simplyhealth and WPA, below.

3.112 Simplyhealth has its roots in the cash plan sector, providing cash back for primary care activities. In 2004, it expanded into PMI, and now offers individuals different level of cover under its Simply Personal Health product: the basic Diagnosis cover, the optional Treatment cover and the Heart and Cancer cover. It also offers three different hospital networks: (1) Connections, which has the lowest costs, the fewest hospitals to choose from and operates a directed care claims process, (2) National and (3) Metropolitan, each of which are more expensive but allow greater choice of hospital. Corporate clients may build on one of two plans: Simply Employee Health (for SMEs) and Care for Corporates (100+ employees), both of which have options for reduced or enhanced benefits.⁶⁴

⁶⁴ www.simplyhealth.co.uk/sh/pages/homepage.jsp.

3.113 WPA was founded as the Bristol Hospital Fund and acquired a Reading Contributory Fund to become the insurer now known as Western Provident Association. A third of WPA's business comes from each of the private client business, the SME business, and the large corporate business. Over the past ten years, WPA succeeded in earning a modest underwriting profit. WPA's Individual Health Insurance product allows private clients to choose from three different levels of cover (Essentials, Premier and Elite), each of which can be customized. Enterprise Flexible Benefits is for SMEs, and can be tailored according to customer needs; large corporate clients can build a bespoke product according to what they want. WPA also offers a risk-sharing option through its Shared Responsibility option, where a subscriber is able to reduce the cost of PMI materially by sharing the risk with the insurer ('co-insurance') and agreeing to pay a percentage of each claim, up to a limit which the customer selects.⁶⁵

⁶⁵ WPA Shared Responsibility.

4. Framework for our competitive assessment

4.1 In this section, we explain the framework we used for our competitive assessment of privately-funded healthcare services.

4.2 We describe certain characteristics relating to the provision and acquisition of privately-funded healthcare services we have identified as important in assessing competition for such services and which have informed our thinking. We then set out how we have developed our ToH, ie our hypotheses of how harmful competitive effects might arise in a market and adversely affect customers.¹

Market characteristics of privately-funded healthcare services

4.3 In order to develop robust findings on whether or not features in a market are harming competition, the CC needs to understand how a market operates and reach a view about its performance. A part of its investigation is therefore the analysis of the main characteristics of the market referred and the outcomes of the competitive process within that market.² According to the Guidelines (paragraphs 97 to 102), pertinent market characteristics may include market shares, the nature and characteristics of the products or services, the nature of the customer base, the legal and regulatory framework that applies to the reference market, industry practices, and the history of the market, including recent competitive developments and any significant changes that are anticipated in the market in the foreseeable future.

4.4 Certain market characteristics appeared to be particularly relevant when assessing competition in the provision of privately-funded healthcare services. Identification of these characteristics informed our analyses and our thinking on the ToH as they developed.

¹ The Guidelines, paragraph 163.

² The Guidelines, paragraph 97.

Market structure

4.5 At a national level, both private hospital ownership and the provision of PMI are highly concentrated. The five main hospital groups account for approximately 70 per cent of privately-funded healthcare revenues in the UK.³ The four largest PMIs account for approximately 87 per cent of insurance premium revenue, with the two largest alone accounting for 65 per cent.⁴ On the other hand, the provision of consultant services is highly fragmented. Consultants generally work on a stand-alone basis and sometimes as members of relatively small groups (paragraphs 7.5 and 7.8).

Cost structure of the industry

4.6 The cost of designing, building and equipping a private hospital able to provide a full range of inpatient, day-case and outpatient facilities is substantial, and a proportion of such costs would be regarded as sunk.⁵ For a full service hospital, there are high fixed operating costs.⁶ Many costs of running a hospital do not vary according to the volumes of admissions or patients seen. Land, buildings, equipment and most labour in particular represent substantial fixed costs to private hospital operators.⁷

Demand and excess capacity

4.7 As observed in the industry background section,⁸ revenues from privately-funded healthcare services have been largely static since 2005. This has been in part due to increased government spending which led to reduced NHS waiting times coupled

³ See paragraph 2.13 and Table 2.1.

⁴ See paragraph 3.80 and Figure 3.15.

⁵ Costs as a potential barrier to entry are considered in more detail in Section 6.

⁶ See Section 6.

⁷ See Section 6.

⁸ See paragraph 2.12.

with a struggling self-pay sector during the recent economic downturn. In the past two years (2010 and 2011) there has been a real contraction in funding from PMIs.⁹

4.8 The five main hospital groups have reported spare capacity in their hospitals.¹⁰ We were told that it is important for private hospitals to maintain an element of planned spare capacity in terms of beds, theatre availability and staff, to deliver quick access to privately-funded healthcare services. However, private hospital operators have benefitted, to varying degrees, from the large increase in NHS expenditure at private hospitals¹¹ and this has helped their capacity utilization. Utilization of overnight beds in private hospitals has declined as the proportion of inpatient treatment has reduced.¹²

Patients and the role of PMIs

4.9 Private patients generally prefer to be treated locally and, all things being equal, will choose a local hospital and local consultant for their treatments. This is considered in more detail in paragraphs 5.55 et seq.

4.10 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.¹³ As our patient survey shows,¹⁴ they are also likely to be more willing to consider NHS treatment as an alternative. According to our patient survey,¹⁵ key drivers for selecting privately-funded healthcare were, excluding having the PMI which was the main reason, reduced waiting times (55 per cent) and greater

⁹ Laing & Buisson, *Private Acute Medical Care* 2012, p12.

¹⁰ On average capacity utilization of theatres and overnight beds is below [] per cent.

¹¹ See paragraphs 2.12 & 2.24.

¹² See paragraphs 2.17 & 2.18. We note that use of beds measures only one aspect of capacity utilization.

¹³ AIS, paragraph 21.

¹⁴ Table B2, [CC patient survey](#).

¹⁵ Table B1, [CC patient survey](#).

availability of appointment times (55 per cent). However, the vast majority¹⁶ of patients using privately-funded healthcare services are funded by PMI. The insured patient, usually advised by their GP, makes their decision based primarily on clinical and convenience grounds having little or no regard to cost.¹⁷ Submissions and our surveys¹⁸ suggest that at the point of treatment, therefore, insured patients will have limited or no sensitivity to the price of treatment unless they have relevant limits on reimbursement under their policies or, for example, the consultant alerts the patient that their fees may not be fully reimbursed under the patient's PMI policy.

4.11 Whilst the central contractual arrangements, at the point of treatment, are between the patient (the consumer) and the consultant(s) and the private hospital respectively (the providers/suppliers), PMIs, as the funders of treatments, may be regarded as having the characteristics of a buyer, both with regard to hospitals and consultants. As a result, the arrangements between the PMI and the policyholder, the PMI and the hospital operator, and sometimes the PMI and the consultant(s) are of greater significance in assessing competition than the contractual arrangements between the patient/consumer and the providers/suppliers.¹⁹

4.12 PMIs influence the selection, pricing and delivery of services, mainly through the following mechanisms:²⁰

- (a) the terms of the policies as to which conditions and which treatments are covered;
- (b) approving (or recognizing) hospitals, other facilities, consultants and other healthcare professionals under their policies that their policyholders can access;

¹⁶ 5.2 million company-paid subscribers to private medical cover at the end of 2011, compared with 1.6 million individual paid subscribers. Laing & Buisson, Health Cover 2012, p14.

¹⁷ 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. See paragraphs 5.9 and 5.10.

¹⁸ [CC patient survey](#) Table D5; CC Clinician Survey Table E6, F5, H2 and H3.

¹⁹ There are also important contractual arrangements between consultants and the hospital, but these are less relevant in this context.

²⁰ [AIS](#) paragraphs 12, 17 and 18.

- (c) provisions in policies or other methods, for example through guidance or pre-authorization procedures, enabling the PMI to direct patients towards or away from certain facilities or providers or types of treatment;
- (d) setting of financial caps for individual treatments such as out-patient excesses;
- (e) agreeing with hospital providers their charges for the PMIs policyholders; and
- (f) publishing fee schedules for consultants and agreeing reimbursement rates with individual consultants.

Competition between private hospital operators

- 4.13 Competition at a local level mainly manifests itself through hospital activity directed towards attracting consultants and patients. If a private hospital is very attractive to potential patients it is likely to be important to PMIs—excluding such a private hospital from an insurance product may make that product less attractive to local individual customers, or to corporate customers that have staff based in the local area.
- 4.14 Private hospitals provide facilities to consultants where they can diagnose and treat patients. They also seek to attract consultants, who in turn attract patients. Consultants may have admission rights at several private hospitals or just at one:²¹ in the first case they have to decide where to see specific patients if the patient does not have a preference, in the second (if a choice is available), which private hospital to practice at. In making these decisions, consultants may take into account:²²
- (a) whether the hospital is recognized by the main PMIs;
 - (b) the location of the hospital, both for the consultant's convenience and for patients';

²¹ See paragraph 2.50.

²² See [GP and consultant survey](#), [OFT survey](#) and [BMA survey](#).

- (c) the capability of the hospital, including the quality of the facilities (including outpatient and diagnostic facilities), of the clinical staff and of administration;
- (d) convenience of access for consultants to consulting rooms and theatres;
- (e) the costs of working at this hospital.

The NHSs

4.15 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 also provide privately-funded healthcare services;
- (c) supplier of privately-funded healthcare services through dedicated and non-dedicated NHS facilities;
- (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 medical and clinical professionals.

4.16 We discuss (a), (c) and (e) further below.

Free NHS services as an alternative to privately-funded healthcare

- 4.17 The availability of publicly-funded health services via the NHS can affect the take-up of PMI and of privately-funded healthcare services.²³
- 4.18 Prospective purchasers of PMI can be expected to take account of the alternative of NHS provision in their purchasing decision. Perceptions of the quality of the NHS service, including waiting times, treatment quality and hospital quality will have a bearing on the attractiveness of PMI.
- 4.19 As well as affecting demand for PMI, this may also affect the demand for privately funded healthcare services. Our patient survey also indicated that one-fifth of insured patients considered having their treatment carried out by the NHS.²⁴ Patients covered by a PMI policy may also use publicly-funded NHS services for a variety of reasons including:
- (a) conditions not covered by their PMI, or because of concerns that the condition will not be covered;
 - (b) perceptions that for the treatment required, the NHS option is likely to be better or more convenient for the patient;²⁵
 - (c) recommendation of the treating consultant, for example if the patient is high risk or for the consultants' convenience;
 - (d) costs of claiming under PMI, including excesses and loss of no-claims bonus; and
 - (e) cash payments from PMIs to insured patients who use the NHS.

²³ See paragraph 5.13.

²⁴ Table B2 [CC patient survey](#). See further paragraph 5.13 on self-pay patients.

²⁵ In some areas the provision of privately-provided ICUs is relatively sparse.

The NHS' as a supplier of privately-funded healthcare services

4.20 The NHS', to varying degrees throughout the UK, are a supplier of privately-funded healthcare services through dedicated as well as non-dedicated facilities. In this report we refer to PPU's as including both dedicated and non-dedicated NHS facilities used by private patients. PPU's are described in paragraphs 3.50 to 3.52.²⁶

4.21 The Health and Social Care Act 2012 removed the private patient income cap on NHS facilities in England and has the potential to allow considerable expansion of PPU's.²⁷ However, as discussed in Appendix 3.1 on PPU expansion, it is not clear how rapid any such expansion will be. Thus, although we expect some expansion, we do not expect this to change the competitive environment radically in the near future.

The NHS as a customer of the private hospital operators

4.22 As discussed in paragraphs 2.12 and 2.24, one of the important trends of recent years has been the significant growth in usage of private hospitals by the NHS in England. Over a quarter of private hospitals' revenue, on average, comes from the NHS which is, therefore, an additional source of revenue for many of the private hospital operators.

Other characteristics

4.23 Various parties drew out what they saw as important characteristics in their responses to the annotated issues statement. Below we describe some of the more significant points made that are not covered earlier.

²⁶ See also paragraphs 2.25–2.29.

²⁷ See Appendix 3.1.

- 4.24 Bupa²⁸ told us that ‘There have been sustained high rates of healthcare cost inflation over the past 15 years. Research by Laing and Buisson indicates that private hospital/clinic revenues rose from £1.1 billion in 1995 to £4.1 billion in 2011—a rise of over 130 per cent in real terms.²⁹ Private specialist revenues rose from £0.6 billion in 1995 to £1.6 billion in 2011—a 65 per cent rise in real terms. Therefore, private healthcare spend by customers has risen at around 8 per cent per annum.’ Bupa argued that this had driven up premiums and was threatening both the PMI and privately-funded healthcare markets.
- 4.25 BMI³⁰ told us that ‘Demand is very thin. Of 10,500 GP practices in the UK, only [X] are within 30 minutes of a BMI hospital. PMI penetration is low and strongly correlated to factors extraneous to private hospitals, particularly professional employment and UK economic growth’. BMI also told us that industry characteristics such as low capacity utilization and low or negative growth are the result of factors unrelated to competition, including for example, discount pricing by the NHS and PMIs that affect how private healthcare providers grow volume.
- 4.26 BMI³¹ also expressed concern that it had very little visibility as to whether and to what extent any discounts that it provided to PMIs were passed on to policyholders, and that this meant that the rate of pass-through was an important consideration for BMI in negotiating discounts to support PMI products. We recognize that a hospital operator would wish for such discounts to be passed on in lower premiums to stimulate or maintain demand for PMI and thereby for privately-funded healthcare services.

²⁸ [Bupa response to AIS, paragraph 2.4.](#)

²⁹ Laing and Buisson, Private Acute Medical Care 2012.

³⁰ [BMI response to AIS, paragraph 4.3\(i\).](#)

³¹ [BMI response to AIS, paragraphs 4.3\(iii\).](#)

Theories of harm

4.27 In order to provide focus and structure to its competitive assessment, the CC sets out one or more ToHs: 'In beginning to formulate its theories of harm, the CC looks to the work done by the referring body.'³²

4.28 Building on the observations about the supply of privately-funded healthcare made by the OFT in its market study and the early submissions received following the OFT's reference, we identified seven ToHs in our issues statement:³³

(a) ToH1: a private hospital operator may have market power with respect to patients in a particular geographic area.

(b) ToH2: individual consultants or consultant groups in some local areas may have market power over their patients.

(c) ToH3: a private hospital operator may have market power with respect to PMIs in national negotiations.³⁴

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

(e) ToH5: there may be barriers to entry into the supply of privately-funded healthcare services as a result of: (i) national bargaining between insurers and hospital operators; (ii) the relationships between hospital operators and consultants or GPs; (iii) other barriers that make construction of new private hospitals difficult; and/or (iv) barriers into the provision of consultant services in private practice.

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

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

³² The Guidelines, paragraph 165.

³³ IS, paragraph 20.

³⁴ We have also investigated whether PMIs may have buyer power over some hospital operators in national negotiations.

4.29 We used these ToHs to structure our investigation, and we reported on the progress of our investigation under each of these ToHs when we published our annotated issues statement.³⁵ In addition, in the annotated issues statement we explained in more detail certain areas of concern in our investigation under several of the ToHs. For example, under ToH4 we found that some PMIs, in particular Bupa and AXA PPP, were requiring some individual consultants to agree not to charge patients more than the relevant PMI's maximum reimbursement rate as a requirement to be recognized and therefore, to treat the PMIs' policyholders. Under ToH5, we also identified the existence of a wide range of schemes which had recently or were currently being offered to consultants by hospital operators which included volume-related incentive payments, discounts for services provided to consultants by private hospital providers, exclusive contract terms with consultants and long-term equity interests. Finally, we also identified as an area of concern under ToH7, ownership by hospital operators of primary care and outpatient diagnostic centres principally, but not exclusively, in London.

- 4.30 Competitive harm can flow from five main sources:
- (a) unilateral market power (including market concentration);
 - (b) barriers to entry and expansion;
 - (c) coordinated conduct;
 - (d) vertical relationships; and
 - (e) weak customer response.³⁶

*Unilateral market power including market concentration*³⁷

4.31 This is particularly relevant to three of our ToHs. Under ToH1, we posit that some private hospital operators have market power within relevant local markets as a result

³⁵ AIS, paragraphs 47–159.

³⁶ The Guidelines, paragraph 170; paragraph 172 notes that these sources are not mutually exclusive.

³⁷ See the Guidelines, paragraphs 178–181, 185, 187–188, 192 & 198.

of market concentration and barriers to entry. Such private hospital operators would have the ability to set higher prices than would otherwise be the case, or reduce the quality of other aspects of their offer, as a result of limited competition from other private hospital operators and limited threat of entry or expansion into the market by other private hospital operators. We examine these issues in Section 6.

4.32 Under ToH2, we identified that individual consultants and/or consultant groups in certain local areas may have market power over their patients, arising from three particular factors: (a) there may be a limited number of consultants in a particular area providing particular treatments or specialties; (b) the way in which patients are referred to consultants; and (c) joint setting of prices by some consultant groups. In relation to the last of these factors, we concentrated on anaesthetist groups, as patients generally have little input into the selection of their anaesthetist and because we received the highest number of complaints about this group of consultants. These issues are examined in Section 7.

4.33 Under ToH3, we considered whether private hospital operators might have market power in negotiations with PMIs over the price that PMIs pay when their insured patients are treated in a private hospital owned by a private hospital operator. In so far as a private hospital operator may derive its market power from its position in certain local areas and the scale of its collection of hospitals, we found that this theory was closely linked to ToH1. A private hospital operator might have an added advantage if it owns a chain of hospitals, through leveraging its local market advantage or securing weighted average prices that would then also apply in more competitive markets. Private hospital operators' market power in negotiations with PMIs might lead to higher prices and/or more favourable contract terms for them than would otherwise be the case. However, we also considered whether private hospital operators' market power might be offset by PMIs' countervailing buyer power. PMIs

might be able to exercise such power through credible threats to ‘delist’ certain private hospitals, or by developing mechanisms to steer patients towards particular private hospitals. We examine these issues in Section 6.

*Barriers to entry*³⁸

- 4.34 Our ToH5 set out that there may be barriers to entry that reduce competition either directly or by creating the conditions in which other ToHs can take effect, and that these could be classed into four different groups:
- (a) barriers to privately-funded healthcare services arising from national negotiations between insurers and private hospital operators;
 - (b) barriers to privately-funded healthcare services arising from relationships between private hospital operators and consultants or GPs;
 - (c) other barriers to privately-funded healthcare services; and
 - (d) barriers to the provision of consultant services in private practice.
- 4.35 Assuming that private hospital operators have market power in certain local areas (ToH1) and in national negotiations (ToH3), bargaining between insurers and private hospital operators may create barriers for new local entrants, and in particular, may give rise to contractual terms that prevent or disincentivize PMIs from recognizing new entrants. The private hospital operators may try and use their local market power to negotiate in respect of their hospitals in more competitive areas, and if PMIs want to be able to offer nationwide coverage, they may have to contract with most of the private hospital operators, and at least in relation to the private hospitals in areas where the private hospital operators have local market power. Private hospital operators might try and use their local market power in national negotiations to

³⁸ See the Guidelines, paragraphs [206–208](#), [213](#) & [214](#), [217–222](#), [223–226](#) and [219](#).

pressure PMIs into recognizing all of their hospitals and not to recognize those of new entrants.³⁹

- 4.36 Barriers might also result from the relationships between private hospital operators, consultants and GPs in three ways: (a) due to the need of private hospital operators, on the one hand, to secure commitments from consultants in order to gain PMI recognition, and on the other hand, to guarantee enough PMI recognition to attract consultants to their facilities; (b) because of incentives provided by private hospital operators to consultants to work in their facilities, (and deterrents to consultants from committing to switch to new entrants); and (c) because of incentives provided by private hospital operators and consultants to GPs to refer patients. These barriers may be aggravated by ToH2, where there are limited numbers of consultants, and because of the way in which patient referrals are made.
- 4.37 Other potential barriers might include the combination of high capital costs with high exit costs, depending on the type of facility and types of treatments provided. Construction of new facilities might also be hindered because of planning delays and/or incumbents strategically obstructing the planning regime, as well as the availability of appropriate sites.⁴⁰
- 4.38 There may also be barriers to the provision of privately-funded healthcare services that may prevent new consultants from entering. This is closely tied to ToH2 to the extent that there may be shortages of consultants in some local areas. This might also be tied to ToH4 in that where PMIs may have buyer power in respect of consultants, which results in the latter's fees being too low, consultants may be further discouraged from entering. These issues are examined in Section 8.

³⁹ See the Guidelines, especially paragraphs 227–234, which explain how the CC assesses the impact of entry barriers in the past, present and future, in order to test a ToH based on the effects on competition.

⁴⁰ See the Guidelines, especially paragraph 211 regarding 'natural' or 'intrinsic' barriers to entry.

Incentives provided by hospital operators to clinicians may also operate as a barrier to entry and these are considered in Section 6.

*Weak customer response*⁴¹

4.39 Our ToH6 argues that information asymmetries and limited information available to patients (as well as to GPs and possibly also to PMIs) may distort competition to the extent that they limit the patient's ability to make an informed choice regarding an appropriate consultant and/or private hospital for treatment. In particular, it has been put to us that the market is characterized by: (a) information asymmetries, especially between patients and consultants or private hospital providers as regards the appropriateness, quality and price of various treatment options available to the patient; (b) the absence of information on the quality and performance of consultants and private hospitals in the provision of privately-funded healthcare services; and (c) the absence of easily comparable information on consultant and private hospital charges, particularly for self-pay patients.⁴²

4.40 Information asymmetries may also be relevant to ToH2: to the extent that consultants may have market power over their patients, this may be reinforced by information asymmetries. These issues are examined in Section 9.

4.41 In the annotated issues statement, we identified that financial and other incentives provided by private hospital operators to clinicians may exploit these information asymmetries. We subsequently also considered whether such incentives may distort competition between hospital operators. Our assessment of clinician incentives is contained in Section 8.

⁴¹ See the Guidelines, paragraphs 296–304, 306, 311 & 312 and 315.

⁴² See paragraphs 9.7–9.10 and 9.21–9.32.

*Vertical integration*⁴³

4.42 Under ToH7, we consider the potential of vertical integration to adversely affect competition. We did not receive evidence of Bupa's vertical linkages through its ownership of the Bupa Cromwell Hospital or any other insurers which might own primary care facilities being likely to lead to significant harm to competition. In the annotated issues statement, we expressed concern that the ownership by private hospital groups of primary care and outpatient diagnostic centres might lead to patient referrals being predominantly made to hospitals in the same group or to over-servicing (eg additional tests). The former could, in particular, foreclose rivals from a significant proportion of rivals. This was a concern principally, but not exclusively, in central London. Our assessment of this issue is in Section 6.

⁴³ See the Guidelines, paragraphs [267–269](#), [271](#) and [273–274](#).

5. Market definition

Introduction

- 5.1 This section sets out our analysis and main findings in relation to product and geographic markets for privately-funded hospital and consultant services. The results of this analysis provide a framework for the assessment of competitive constraints, in terms of the set of medical treatments and relevant (private) healthcare providers which our analysis has largely focused on.
- 5.2 The Guidelines¹ state that defining the relevant market enables the CC to focus on the sources of any market power and provides a framework for its assessment of the effects on competition of features of a market. In practice, the analysis of the identification of the market or markets and assessment of competitive effects largely overlaps, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Market definition is thus a useful tool, but not an end in itself, and identifying the relevant market involves an element of judgement. The boundaries of the market do not determine the outcome of the CC's competitive assessment of a market in any mechanistic way. The competitive assessment will take into account any relevant constraints from outside the market, segmentation within it, or other ways in which some constraints are more important than others.²
- 5.3 The OFT made a reference to the CC for an investigation into the supply or acquisition of private healthcare in the UK. As stated in the terms of reference,³ for the purposes of this market reference, private healthcare means 'privately-funded healthcare services. These are services provided to patients via private

¹ CC3, paragraph 132.

² CC3, paragraph 133.

³ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/healthcare_terms_of_reference.pdf.

facilities/clinics including private patient units, through the services of consultants, medical and clinical professionals who work within such facilities.’

5.4 These services consist of highly differentiated medical treatments that can be segmented, to a large extent, by type of care (ie inpatient, day case and outpatient) and by specialty (eg cardiology, orthopaedic). Privately-funded healthcare services are provided to patients mainly by self-employed consultants, who work within private hospitals, private day-only clinics and NHS PPU. These services are mainly funded by patients themselves or by PMIs. In what follows, we take these segmentations into consideration as appropriate.

Product markets

5.5 The Guidelines⁴ state that while the composition of a relevant market is usually determined by the degree of demand substitutability, the CC will where relevant include supply-side factors in defining the market. There might, for example, be a possibility that firms supplying non-substitute products have the capabilities and assets to redirect production to goods and services that would be substitutes for those in the market. Alternatively, the same firms might compete to supply the non-substitute products under similar conditions of competition; in that case aggregating the supply of these products and analysing it as one market does not affect the competitive assessment (for example, in markets characterized by bidding and tendering processes).⁵

⁴ CC3, [paragraph 134](#).

⁵ The CC/OFT [Merger Assessment Guidelines \(CC2\)](#) also provide the following guidance ([paragraphs 5.2.7 & 5.2.17](#)):

- (a) The relevant product market is identified primarily by considering the response of customers to an increase in the price of one of the products of the merger firms (demand-side substitution).
- (b) There are circumstances where the Authorities may aggregate several narrow relevant markets into a broader one on the basis of considerations about the response of suppliers to changes in prices. They may do so when:
 - (i) production assets can be used by firms to supply a range of different products that are not demand-side substitutes, and the firms have the ability and incentive quickly (generally within a year) to shift capacity between these different products depending on demand for each; and
 - (ii) the same firms compete to supply these different products and the conditions of competition between the firms are the same for each product; in this case aggregating the supply of these products and analysing them as one market does not affect the Authorities’ decision on the competitive effect of the merger.

- 5.6 We followed this guidance in our approach to market definition. To this end, when defining the product market(s), we first looked at evidence on demand-side substitution by patients across different medical treatments and across privately-funded and NHS-funded medical treatments. We then considered whether, in the absence of demand-side substitutability across medical treatments, private healthcare providers (consultants and hospitals) have the capabilities and assets to redirect production across medical treatments (supply-side substitution). In addition, in relation to hospitals, we also considered whether the set of private healthcare providers and the conditions of competition are similar across medical treatments.
- 5.7 We considered, in particular, whether and to what extent we could aggregate treatments/cluster of treatments together on the basis of supply-side factors along the following dimensions:
- (a) within and between specialties; and
 - (b) for a given specialty, between inpatient, daypatient and outpatient care.
- 5.8 We looked at supply-side factors for consultants and hospitals separately.

Demand-side substitution by patients

- 5.9 To assess the degree of demand-side substitution across medical treatments, we considered whether patients would switch to an alternative treatment in response to an increase in price or a decrease in quality of a given treatment. A change in quality rather than a change in price is more relevant for insured patients as, on the whole, they do not pay for specific treatments as these are covered by their medical insurance policy.
- 5.10 While patients are the final consumers of private healthcare, they typically rely on GPs, consultants and other clinicians' advice when deciding the type of healthcare

services they need.⁶ A patients' choice of treatment is largely determined by their clinician's advice on the basis of clinical need. As a result, there is very limited scope for substitution across treatments that address different clinical needs. Even when there is some limited scope for substitution between treatments addressing the same clinical need, the final choice is likely to be mostly driven by clinical considerations.

- 5.11 We noted that PMIs may have some ability to affect insured patients' demand for privately-funded healthcare services. Firstly, insured patients are normally required to obtain pre-authorization from their PMI prior to seeking treatment, which means the PMI can reject the treatment if it is not covered by the patients' policy. Secondly, in some cases, PMIs can influence the choice of healthcare provider, such as their choice of consultant or hospital where they are treated. PMIs are, however, less able to affect patients' choice of treatment (for example, the type of operation performed), which is typically based on their clinicians' advice. PMIs are therefore unlikely to affect most insured patients' demand in a way that leads insured patients to substitute across different treatments.
- 5.12 Patients may consider having their treatment funded by the NHS instead of funding it privately themselves or through their PMI. Hence, we have considered whether patients of privately-funded healthcare would switch to NHS-funded healthcare in the case of a small change in prices or quality of the services provided.
- 5.13 We have looked at the results of our survey of patients. While this survey indicates that one-fifth of insured patients considered having their treatment on the NHS,⁷ only 3 per cent would have switched to the NHS if their chosen private hospital was unavailable.⁸ Furthermore, 90 per cent of insured patients stated that a reason for

⁶ See industry background on 'patient pathways'.

⁷ Table B2 of [CC patient survey](#).

⁸ Table D6 of [CC patient survey](#).

choosing privately-funded healthcare was to make use of their PMI.⁹ As expected, the readiness of self-pay patients to consider the NHS was significantly higher, with 68 per cent of self-pay patients considering having their treatment on the NHS;¹⁰ however, only 12 per cent would have switched to the NHS if their chosen private hospital was unavailable.¹¹

5.14 Among the reasons for choosing privately-funded healthcare, patients have most commonly cited that they wanted to take advantage of the reduced waiting times (76 per cent of insured patients and 75 per cent of self-pay patients), the better comfort and quality of accommodation (54 per cent of insured patients and 37 per cent of self-pay patients), the greater availability of appointment times (55 per cent of insured patients and 35 per cent of self-pay patients), and the ability to choose a specific private consultant (39 per cent of insured patients and 42 per cent of self-pay patients).¹²

5.15 We have also considered previous CC and OFT decisions as well as EU merger investigations.¹³ The view taken in these cases is that, although the NHS provides an element of price constraint, the willingness of consumers to pay an extra charge for private acute healthcare is an indication of this being a different market from the NHS. The NHS as a whole has therefore been considered to be in a separate market from private acute healthcare.¹⁴ We considered that the results of our survey of patients are consistent with this conclusion.

5.16 Based on the above considerations, demand-side substitution by patients across different treatments, if any, appears to be very limited. As such, the starting point for

⁹ Table B1 of [CC patient survey](#).

¹⁰ Table B2 of [CC patient survey](#).

¹¹ Table D6 of [CC patient survey](#).

¹² Table B1 of [CC patient survey](#).

¹³ See OFT Private Healthcare Market Study, April 2012, paragraphs 4.36–4.41, for references to relevant OFT, CC and European Commission Decisions. http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf

¹⁴ See, in particular, CC [Bupa/CHG merger report](#), December 2000, paragraph 4.54.

product market definition is one of narrowly delineated product markets covering each different medical treatment. In addition, privately-funded medical treatments appear to be in a separate product market from NHS-funded medical treatments as a whole.¹⁵ We note that constraints from NHS hospitals on private healthcare providers have been taken into account in the competitive assessment, on a case by case basis, where we have evidence that these exert a competitive constraint. In what follows, for simplicity, we will use the term medical treatments to refer to privately-funded medical treatments.

Supply-side substitution by consultants

- 5.17 There is supply-side substitution if a private healthcare provider (ie a consultant or a hospital) has the ability and incentive to switch production capacity easily and rapidly into the provision of a treatment in the event of an increase in the relative market price of that treatment. Switching can refer to starting the provision of a treatment that was not previously offered, or merely to increasing the provision of a treatment that was already offered, by dedicating additional capacity to its provision.
- 5.18 Consultants are typically qualified to work in a single specialty.¹⁶ Obtaining the qualifications and skills needed to start working in additional specialties requires a substantial investment, both in terms of time and of financial resources. Consultants are often specialized in the provision of certain treatments within the specialty they are qualified in. However, there appears to be some ability for consultants to provide a wider range of treatments within these specialties, especially in the case of more routine treatments.

¹⁵ As set out in paragraph 5.4, we have considered PUs in NHS hospitals as providers of private healthcare in the UK.

¹⁶ Consultants who practice within the UK health service must be on the GMC specialist register. Before being entered on the specialist register the GMC will check that the consultant is appropriately qualified in their specialty. Source: http://www.gmc-uk.org/doctors/before_you_apply/background.asp. See paragraph 3.67.

5.19 Overall, we considered that in the provision of consultant services, there is typically no supply-side substitution across treatments in different specialties, but there is some degree of supply-side substitution across treatments within the same specialty. We therefore concluded that each specialty should be viewed as a separate product market in the provision of consultant services.

Supply-side substitution by hospitals

5.20 Hospitals combine a series of production assets and inputs to provide a range of treatments in a number of different specialties. These assets and inputs include, for instance, hospital facilities, medical equipment, healthcare professionals and consultants. With the exception of consultants and some specialized medical equipment, most of the hospitals' production assets and inputs can be used for the provision of a wide range of treatments. This is, for instance, the case for overnight rooms, consulting rooms, theatres, or most medical equipment. Healthcare professionals employed by the hospital (for example nursing staff) are often qualified to collaborate in the provision of a variety of treatments in different specialties. Hospitals have the ability to switch these production assets and inputs into the provision of different treatments if required.

5.21 As set out below, the evidence submitted to us shows that hospitals continuously introduce new treatments into their product range. On one hand, this is a consequence of new health technologies being gradually adopted, either replacing older technologies or enlarging the range of technologies available. On the other hand, hospitals incorporate new treatments as a response to changing market conditions (eg new demand, changing competitive environment). For the purpose of market definition and the identification of the relevant competitive constraints, we are primarily interested in the latter, as they are likely examples of the hospitals' ability to switch the use of production assets easily and rapidly.

Within and between specialties

- 5.22 We looked at the evidence provided on the hospitals' ability rapidly and easily to switch capacity into the provision of new medical treatments within specialties already provided at the hospitals ('existing' specialties) or into the provision of treatments in specialties not previously provided ('new' specialties).
- 5.23 BMI submitted that 'switching between treatments within a specialty ... and between specialties ... occurs in the usual competition sense, ie in response to relatively modest changes in returns available from the assets of the hospital'. Spire submitted evidence that it 'has used both existing capacity and investment in its hospitals to develop new services, expand into new therapeutic areas, and increase the quality/ range of services offered to patients'.
- 5.24 The evidence presented below shows that there is significant variation in the cost incurred when switching capacity into the provision of new treatments and in the time requirements to execute the switch. In a number of cases, switching capacity has involved no cost or little cost and hospitals have been able to start providing the new treatments either immediately or after a few months. In some other cases, switching capacity has involved larger investments (up to a few million pounds) and longer time frames (up to a year).
- 5.25 Most examples provided in response to the market questionnaire involved cases of hospitals switching capacity into the provision of new treatments within specialties already offered by the hospital, for example:
- (a) Chemotherapy for lung cancer at BMI Blackheath:
- No capital was required for this treatment (as it falls within an existing specialty—oncology) and there were no significant switching costs. The hospital utilised existing spare capacity in its

Oncology Suite and attracted new consultants from HCA London Bridge and Guy's and St Thomas's NHS Hospitals.

(b) Urodynamics at Spire Portsmouth:

The expansion of current urodynamics service was considered necessary to support a full service in conjunction with the Well Women physiotherapy service. The necessary equipment was rented from an external company on six monthly rental agreement totalling [£]. A bank of urodynamics nurses were recruited to perform urodynamics tests. It took [£] to launch the service, which included: sourcing the equipment; negotiating the service contract; and recruiting the specialised nurses. The total cost of the project was [£].

(c) Hip arthroscopies at Ramsay Duchy:

In order to be able to provide this new service Duchy purchased a hip scope set at a cost of [£]. All of the other equipment required, including a table attachment and camera system were already available. Accordingly, this service was immediately commenced upon purchase of the relevant equipment.

(d) Static CT at Spire Gatwick Park:

The development of the static CT necessitated the hire of radiographers to operate the new scanner at 1.5 whole time equivalents. There were no implications for consultant recruitment ... Building costs were [£] with a further [£] for the purchase of the scanner. The capital project cost was [£] and took approximately [£] to complete.

5.26 In relation to switching capacity into new treatments within a specialty already offered by the hospital, BMI submitted that this 'is fast, common and subject to low switching

costs. Often, a hospital can switch to a new medical treatment without requiring capital expenditure and using existing equipment and consultants.'

5.27 There have been relatively fewer cases of private hospitals that started the provision of treatments in new specialties since 2006. The cases below were typically more costly and took more time than in the cases where the hospital already offers some treatments in the relevant specialty, for example:

(a) Neurosurgery at BMI Shirley Oaks:

The hospital has also started a neurosurgery service that was not previously offered. A new consultant was recruited. There was no impact on staffing although capital costs were in the region of [£].

(b) ICU plus head & neck surgery at HCA Lister:

The development of intensive care services has facilitated the development of new service lines such as head and neck surgery which could not have been undertaken at the hospital in the absence of an intensive care unit. ... The service was created by redeveloping 6 out-patient consulting rooms at the hospital. ... New consultants were recruited from the Royal Marsden, Hammersmith and Chelsea and Westminster NHS Hospitals. ... There was a need to recruit new staff to operate the intensive care services including experienced intensive care nurses. The development has cost approximately [£] million.

(c) Liver surgery and transplantation at HCA London Bridge:

HCA developed a new liver surgery and transplantation unit at the London Bridge Hospital. HCA attracted a liver transplantation team comprising nurses, intensivists and interventional radiologists which enabled the service to be developed.

(d) BMI Blackheath Intensive Care Unit:

BMI Blackheath is installing an ITU facility at the moment at a budgeted capital cost of [REDACTED] with the time to complete the facility being six to nine months.

(e) Spire provided a number of examples of switching to provide treatments in new specialties including the introduction of cardiac surgery at Spire Cambridge Lea and Spire Cardiff and the introduction of neurosurgery and cardiology at Tunbridge Wells.

5.28 In relation to switching into new specialties, Spire submitted that 'since 2007 ... many hospitals have started to offer medical treatments in a specialty the hospital did not previously provide'. The ease with which hospitals can switch capacity into the provision of new treatments, especially in a new specialty, seems critically to depend on the availability of qualified consultants. According to BMI, 'the ease or difficulty of switching between specialities depends on two linked factors: ... the nature of the change required, and ... the availability of suitably qualified consultants'. Ramsay also submitted that '[REDACTED] in determining whether a hospital can deliver a new service/new type of treatment is the consultant'.

5.29 The extent to which hospitals have spare capacity has an impact on their ability and incentives to introduce new treatments both within existing specialties and in new specialties. Evidence suggests that most private hospitals in the UK have substantial spare capacity. The five largest hospital groups (which combined account for approximately 70 per cent of revenues) have reported substantial spare capacity in their hospitals (below [REDACTED] per cent utilization of operating theatres and overnight beds on average). For instance, in response to our Market Questionnaire, Ramsay submitted that [REDACTED]. A BMI presentation to PMIs also described a problem of over capacity in the industry, and stated that on average only 40 per cent of hospitals were profitably utilized. In the presentation, BMI also outlined its proposals to reduce

overcapacity through offering directional power for PMIs to opt to concentrate their demand at the best hospitals, rationalising the supply side, increasing utilization, bringing down average episode cost, bringing down prices to PMIs and ultimately lower private insurance premia.

- 5.30 Substantial spare capacity is likely to imply relatively low opportunity costs of introducing new treatments if the result is a higher level of capacity utilization. This contributes to enhance the incentives to supply-side substitution.
- 5.31 We have received evidence of switching into the provision of new treatments both within existing specialties and in new specialties. The evidence indicates that this switching has been more common for treatments within specialties already provided by the hospitals than for treatments in new specialties.¹⁷ In relation to the latter, the availability of qualified consultants appears to be the main factor constraining the ease with which hospitals can switch into the provision of treatments in new specialties. We also note that the examples we have reviewed indicate that introducing treatments in new specialties can involve a higher capital expenditure and it can take more time.

Between inpatient, daypatient and outpatient care

- 5.32 Outpatient treatments are generally defined as those treatments which do not require a patient to be admitted to hospital, whereas inpatient treatments require patients' admission to hospital (and also involve an overnight stay). There is also an 'in-between' case where a patient is admitted but the treatment is completed within the day (ie patients do not stay overnight): these are referred to as 'day cases' or daypatient treatments. Most of the specialties have both an inpatient and an

¹⁷ We note however that the fewer examples of switching capacity into new specialties may be explained by the fact that most hospitals already provide most of the main specialties typically available in private healthcare (see Table 5.2).

outpatient element (though there are some specialties that include only, or to a very large extent, outpatient treatments, eg rheumatology).

- 5.33 Outpatient care includes first and follow-up consultant appointments but also diagnostic treatments that do not require admission. In some cases, outpatient treatments will form part of an admitted care pathway, for example being assessed in an outpatient appointment before (or after) being admitted to have a surgical treatment. In some cases, patients can receive outpatient treatments from the same hospital, integrated with their inpatient treatment. In other cases, outpatient treatments will be offered on a stand-alone basis.
- 5.34 We looked at the evidence on the ability of private healthcare providers (hospitals and day-only clinics) to rapidly and easily switch capacity into the provision of new medical treatments across inpatient, daypatient and outpatient care for a given specialty.
- 5.35 Data from the five largest hospital operators shows that daypatient admissions accounted for 58 per cent of total admissions (in-patient plus daypatient) in their hospitals in 2006, and for 68 per cent in 2011. Revenue data shows a similar trend: revenue from daypatient admissions in hospitals of the five largest hospital operators accounted for 29 per cent of total revenue from admitted patients (inpatient plus daypatient) in 2006, and for 37 per cent in 2011. These figures indicate that there has been a trend from inpatient towards daypatient treatments and that hospitals with inpatient capacity have been able to switch capacity effectively towards daypatient care.
- 5.36 Parties pointed out the increasing importance of outpatient and daypatient care both in terms of number of outpatient visits and daypatient admissions, and in terms of

revenue. For instance, BMI submitted that ‘modern private hospitals are places where the great majority of people treated are on an outpatient, day case and walk-in walk-out basis. Looking at inpatient work alone does not reflect the true nature of competition between hospitals.’ Spire submitted that ‘it is wrong to think that day-case and outpatient treatments are peripheral to private healthcare priorities in the UK: in fact, they represent the core of the business and there is trend toward moving more procedures to a day-case or outpatient environment’.

5.37 Parties also commented on the competitive constraints between inpatient, daypatient and outpatient care. For example, Bupa submitted that ‘care in an outpatient and/or day-case setting offers little constraint on care that must be delivered in an inpatient setting’. However, Spire submitted that ‘one recent model for entry into private healthcare services is to start with a smaller facility providing outpatient and/or day-case services and then expand into inpatient services’.¹⁸

5.38 While we acknowledge the trend from inpatient towards daypatient and outpatient care, we note that there are asymmetries between private hospitals, which provide inpatient care, and day-only clinics, which provide only day-case and/or outpatient care, in their ability rapidly and easily to switch capacity into the provision of new medical treatments across inpatient, daypatient and outpatient care for a given specialty. In particular, hospitals that provide inpatient care also typically provide daypatient and outpatient care in the same specialty. As a result, hospitals with overnight capacity could quickly and easily switch capacity across inpatient, daypatient and outpatient care. The figures presented above that hospitals with inpatient capacity have effectively switched from inpatient care to daypatient and outpatient care over the last years (see paragraph 5.35) support this conclusion.

¹⁸ [Spire response to AIS](#), paragraph 3.7.a. Spire provided one example of such an entry event: Nuffield Vale in Cardiff ‘started by providing outpatient consulting services on the premises of a leisure club and has expanded to become a full-service hospital with two operating theatres and twenty-five bedrooms’.

5.39 Day-only clinics, on the contrary, because of the scale of the investment and the time required, appear to have a very limited ability rapidly and easily to switch capacity into the provision of inpatient care. Any such switching appears more relevant to the assessment of entry rather than of supply-side substitution. In fact, we found only one record of a day-only clinic having entered into the provision of inpatient care at least since 2006.

Conclusion on supply-side substitution by hospitals

5.40 Overall, there appears to be a significant degree of supply-side substitution across treatments within the same existing specialty. Within each given specialty, however, supply-side substitution appears to be greater for more routine treatments, which do not require highly-specialized equipment and staff, than for more complex treatments. There is more limited evidence of hospitals switching to treatments in new specialties. Moreover, within each given specialty, while there appears to be scope for providers of inpatient care to switch capacity into the provision of daypatient and outpatient treatments, the ability to switch by providers of outpatient and/or daypatient care into the provision of inpatient treatments appears very limited (ie asymmetric constraints appear to exist).

Same set of hospitals

5.41 We looked at whether the same hospitals compete to provide different medical treatments under similar conditions of competition.

5.42 We have looked at a set of 255 private hospitals and PPUs across the UK, including:

- (a) all 169 private hospitals owned by BMI, HCA, Nuffield, Ramsay and Spire;
- (b) another 23 of the largest private hospitals (including Aspen, Circle, and HMT);
- (c) all 16 PPUs managed by BMI, HCA, Ramsay and East Kent Medical Services;

and

(d) 47 PPUs operated by the 30 largest NHS trusts across the UK.

5.43 According to Laing & Buisson,¹⁹ the total revenue of private independent acute medical hospitals and clinics was £4,141 million in the UK in 2011. The revenue of the operators owning or managing the 192 private hospitals we have looked at account for more than 80 per cent of this total revenue. Also according to Laing & Buisson, the total revenue generated by NHS private patients was £482 million in the UK in 2011. The 30 largest NHS trusts by private patient revenue account for 50 per cent of total NHS private patient revenue. Overall, the set of 255 private hospitals and PPUs we have looked at accounted for more the 75 per cent of all private patient revenue in the UK in 2011.

5.44 As part of our assessment of local competitive constraints, the conditions of competition in each local market were assessed on a case by case basis for those hospitals we identified as being of potential concern (see Section 6).

General versus specialized providers

5.45 In terms of the range of specialties provided, the vast majority of the private hospitals and PPUs we analysed are not specialized in a single specialty (or treatment)—hereafter, we refer to them as ‘general’ private hospitals and PPUs. As shown in Table 5.1, out of 255 private hospitals and PPUs we analysed, 185 are general private hospitals and 51 are general PPUs providing a varying range of specialties and treatments.

¹⁹ Laing and Buisson, *Private Acute Medical Care*, UK Market Report 2012, Tables 3.3 & 4.1.

TABLE 5.1 **Number of general and specialized hospitals/PPUs by operator**

<i>Operator</i>	<i>General private hospitals</i>	<i>Specialized private hospitals</i>	<i>General PPU</i> s	<i>Specialized PPU</i> s
BMI	59	0	10	0
HCA	12	5	1	2
Nuffield	32	0	0	0
Ramsay	24	0	0	1
Spire	37	0	0	0
Independent	21	2	2	0
NHS Trusts	0	0	38	9
Total	185	7	51	12

Source: CC analysis.

*These figures do not include a general private (day-only) hospital owned by Aspen and a general private hospital owned by Spire, either acquired or open after the submission of responses to the Market Questionnaire.

Inpatient, daypatient and outpatient care

- 5.46 Focusing on general private hospitals and general PPUs, 164 out of 185 general private hospitals and all general PPUs provide inpatient, daypatient and outpatient care. This adds up to 215 general private hospitals and general PPUs offering inpatient, daypatient and outpatient care. In particular, all general private hospitals and PPUs providing inpatient care also provide daypatient and outpatient care.
- 5.47 The general private hospitals and PPUs we have looked at do not include a substantial number of day-only clinics active across the UK. According to Laing & Buisson, there were 251 day-only clinics in the UK in 2011. Most of them are relatively small clinics: according to Lang & Buisson they account for 38 per cent of all private day-case admissions in the UK in 2011, while the remaining 62 per cent of admissions took place in private hospitals that also provided inpatient care.²⁰
- 5.48 General private hospitals and general PPUs providing inpatient care compete with each other in the provision of inpatient care and are the only providers of inpatient care. In general, they compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of daypatient and/or outpatient care. In relation to the latter, however, we note that day- and outpatient-only clinics may not

²⁰ *ibid*, Tables 3.2 & Table 6.1.

be competing with general private hospitals and general PPUs across the full range of daypatient and outpatient treatments. For example, because of their complexity, some daypatient treatments may take place predominantly in hospitals able to provide inpatient care as back-up if needed. Also, outpatient visits are often ancillary to inpatient and day-case treatments, either as part of the diagnostic stage or as follow-ups, and may frequently take place in the same hospital where the main inpatient or daypatient treatment has taken or will take place.

Specialties most commonly provided

- 5.49 While most general private hospitals and PPUs provide a range of specialties, not every specialty is offered at every single general private hospital and PPU. In order to assess the extent to which the same providers are active in the provision of treatments across different specialties, we have identified the specialties most commonly offered by the 215 general private hospitals and PPUs offering inpatient care in our set.
- 5.50 Table 5.2 shows that 16 specialties²¹ are offered by 80 per cent or more of these 215 general private hospitals and PPUs. These 16 specialties account for 86 per cent of all patient admissions and for 75 per cent of total revenue at these general private hospitals and PPUs.

²¹ 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 and clinical radiology.

TABLE 5.2 Set of specialties offered by at least 80 per cent of the 215 hospitals/PPUs in 2011

Specialty	<i>per cent</i>		
	Share of hospitals offering the specialty	Share of total admissions (inpatient and day case)	Share of total revenue (inpatient, day case and outpatient)
Obstetrics and gynaecology	95.4	7.6	6.9
General surgery	93.5	13.5	9.5
Trauma and orthopaedics	93.0	27.0	30.5
Anaesthetics	93.0	2.3	0.9
Urology	91.6	6.7	4.1
Gastroenterology	88.9	6.1	3.0
Ophthalmology	88.8	5.8	2.3
Otolaryngology	88.4	3.6	2.2
Dermatology	86.5	0.3	0.6
Plastic surgery	86.5	4.0	3.1
Cardiology	85.6	1.3	4.5
General medicine	83.3	3.2	3.3
Neurology	82.8	0.3	1.1
Oral and maxillofacial surgery	80.9	3.2	0.8
Rheumatology	80.9	0.1	0.3
Clinical radiology	80.0	1.1	1.5
Total	N/A	86.1	74.6

Source: CC analysis.

Note: N/A = not applicable.

5.51 Oncology stands out as the main specialty accounting for a relatively large share of admissions and revenue that is not among the specialties offered by more than 80 per cent of general hospitals and PPUs with inpatient care.²² In particular, oncology accounted for 9.6 per cent of patient admissions and 7.5 per cent of total revenue in these 215 general private hospitals and PPUs in 2011. However, oncology care was only provided by 68.8 per cent of these general hospitals and PPUs. Moreover, a number of private hospitals and PPUs are specialized in the provision of oncology care. The set of providers for oncology appears therefore to be different from the set of providers active across the 16 specialties identified above. Out of 215 general private hospitals and PPUs providing inpatient care, 135 have been reported to offer oncology treatments. In addition to these, four specialized private hospitals and PPUs providing inpatient care have been reported to specialize in oncology.

²² Hence, the 16 specialties plus oncology accounted for more than 95 per cent of admissions and more than 82 per cent of total revenue in 2011. All other specialties together accounted for 5 per cent of admissions and part of the remaining 18 per cent of total revenue, while the remainder was revenue from non-patient-related activity.

Conclusions on product market(s)

5.52 On the basis of the evidence and analysis set out in the previous sections, we found that:

- (a) Due to the fact that demand-side substitution by patients across different medical treatments is likely to be very limited, the starting point for product market definition is one of narrowly delineated product markets covering each different medical treatment. In addition, privately-funded medical treatments appear to be in a separate product market from NHS-funded medical treatments as a whole.
- (b) In the provision of consultant services, there is typically limited supply-side substitution across treatments in different specialties, but there is some degree of supply-side substitution across treatments within the same specialty.
- (c) In the provision of hospital services:
 - (i) There is a significant degree of supply-side substitution across treatments within the same existing specialty. Within each given specialty, however, supply-side substitution is greater for more routine treatments, which do not require highly-specialized equipment and staff, than for more complex treatments. There is more limited evidence of hospitals switching to treatments in new specialties. Within each given specialty, while there appears to be scope for providers of inpatient care to switch capacity into the provision of daypatient and outpatient treatments, the ability to switch by providers of outpatient and/or daypatient care into the provision of inpatient treatments appears very limited (ie asymmetric constraints appear to exist).
 - (ii) Focusing on the 215 general private hospitals and PPU's which provide inpatient care,²³ 16 specialties are offered by 80 per cent or more of these hospitals and PPU's. These 16 specialties account for 86 per cent of all

²³ Including: (a) all private general hospitals with inpatient care owned by BMI, HCA, Nuffield, Ramsay and Spire; (b) 19 of the largest other private general hospitals with inpatient care (including Aspen and Circle); (c) all general PPU's with inpatient care managed by BMI, HCA, Ramsay and East Kent Medical Services; and (d) the 40 largest general PPU's with inpatient care by revenue.

patient admissions²⁴ and for 75 per cent of total revenue²⁵ at the hospitals of the five largest hospital groups in 2011.

- (iii) Oncology is the main specialty accounting for a relatively large share of patient admissions and revenue that is not among the specialties offered by more than 80 per cent of private general hospitals and PPUs with inpatient care. In particular, oncology accounts for 9.6 per cent of patient admissions and 7.5 per cent of total revenue at the hospitals of the five largest hospital groups in 2011. Oncology is currently offered by 135 (64.7 per cent) of the 215 general private hospitals and PPUs which provide inpatient care, plus four specialized private hospitals and PPUs providing inpatient care.

5.53 On the basis of these findings, the approach we took in relation to product market definition is the following:

- (a) In the provision of consultant services, each specialty is considered as a separate product market.
- (b) In the provision of hospital services:
 - (i) Given the significant degree of supply-side substitution across treatments within an existing speciality, the market is not limited to the treatment, but extends to the speciality. Given the more limited supply-side substitution across treatments in new specialities, the market is no wider than each speciality.
 - (ii) Given the existence of asymmetric constraints among different providers, for each specialty, inpatient, daypatient and outpatient care are considered to be distinct product markets.

²⁴ Including inpatient and daypatient.

²⁵ Including inpatient, daypatient and outpatient care.

5.54 On the basis of the above findings, we took the following approach in relation to the assessment of competitive constraints in the provision of hospital services:

- (a) Although we have defined separate markets for inpatient, daypatient and outpatient care, the boundaries of these markets are blurred to some extent. As noted in paragraph 5.48, some daypatient and outpatient treatments (eg, those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) are likely to be provided within an inpatient care setting by providers of inpatient care. Hence, while we acknowledge that in general providers of inpatient care compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of daypatient and/or outpatient care, this is unlikely to hold across the full range of daypatient and outpatient treatments. In particular, some daypatient and outpatient treatments are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments.
- (b) We concluded that each specialty is considered as a separate product market. However, supply-side substitution appears to be greater across treatments in different specialties when the hospital already provides the relevant specialties. Given that many hospitals in our set are already active in the provision of treatments across a set of 16 specialties, and are therefore well placed to expand into new treatments across each of those specialties, for the purposes of the assessment of competitive constraints we have aggregated the 16 specialties together where we considered it appropriate. Given that fewer hospitals in our set are active in the provision of oncology compared with the other 16 specialties, we have looked at oncology separately in our competitive assessment where possible.
- (c) Given that, within each specialty, supply-side substitution appears to be greater for more routine treatments than for more complex treatments, in our competitive assessment we considered constraints within these markets arising in the

provision of more complex treatments (also referred to as ‘high acuity’ or ‘tertiary’ care);²⁶ and

(d) In our competitive assessment we considered constraints from outside the markets exerted by NHS hospitals, ie providers of NHS-funded treatments, on a case by case basis, where we have evidence that these exert a competitive constraint.

Geographic markets

5.55 As set out in the CC Guidelines,²⁷ geographic markets may be based on the location of suppliers and defined as an area covering a set of firms or outlets which compete closely because enough customers consider them to be substitutes (as in the case of retail markets and some industrial markets).

5.56 In the provision of (private) healthcare, most patients have a preference to travel shorter distances, everything else equal, and to choose local consultants and hospitals to receive medical treatment.²⁸ The results of our survey of patients indicate that both the actual journey time and the willingness to travel of patients were very similar for consultant and hospital services.²⁹ These indicate that the geographic scope of competition in the provision of private healthcare services is local for both consultant and hospital services, and is likely to be broadly similar in the two cases.³⁰

5.57 In relation to consultant services, we conclude that the market is local. However, for the purposes of our analysis, it is not necessary to define these markets, as this will not have any impact on our provisional findings.

²⁶ See Appendix 6.7. We looked for example at ‘tertiary’ treatments—those requiring a referral from a consultant to another consultant.

²⁷ CC3, [paragraph 145](#).

²⁸ As indicated by most parties to this inquiry, as well as the CC patient survey and patient invoice data.

²⁹ [CC patient survey](#), questions E1A, E1B, E2A, E2B, Survey of Patient Report, slides 48-49.

³⁰ It is possible that in some cases the geographic markets for consultant services could be slightly wider than those for hospital services due to consultants using several hospitals and patients being normally referred by GPs for secondary care to see a consultant rather than a hospital.

- 5.58 In relation to hospital services, local geographic markets may thus be defined as the areas covering sets of private hospitals and PPUs competing closely because enough patients consider them to be substitutes. Having regard to patients' preferences, the relevant dimension of closeness of competition for this purpose is the distance between providers and their location.
- 5.59 As set out in more detail in Appendix 6.10, we observe that market conditions in central London,³¹ both on the demand side and on the supply side, differ markedly from those prevailing elsewhere in the UK or are more evident in central London than elsewhere. In particular, central London is characterised by a high PMI penetration rate, in part arising from the large presence of corporate PMI customers; a significant number of patients travelling from greater London and outer London into central London; a significant number of private hospitals and PPUs, with a widespread offer of complex treatments or specialties; strong reputation of some private hospitals and PPUs which are perceived by patients as offering a higher quality of care than private hospitals and PPUs elsewhere in the UK; and private hospitals and PPUs in general drawing patients from very wide geographic areas. These characteristics suggest that the area covering the set of private hospitals and PPUs located in central London should be regarded as a distinct geographic market. The private hospitals and PPUs located in central London are identified in our competitive assessment for central London.
- 5.60 We note, however, that as location and distance are important to patients (and to GPs referring patients to secondary care) when they choose a hospital, even within central London, hospitals providing the same services in different locations are not perfect substitutes for one another and, other things being equal, hospitals that are

³¹ For the purpose of our analysis, we refer to central London as being the area inside the North and South Circular Roads.

near one another may be expected to exert a stronger competitive constraint than hospitals located further away.

- 5.61 Taking the above consideration into account, regardless of the precise boundaries of the geographic market, in our competitive assessment for central London we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within central London on each other. We have also taken into account the competitive constraints exerted on private hospitals/PPUs located in central London by private hospitals/PPUs located outside central London and we have considered constraints by NHS hospitals where we have evidence that these exert a competitive constraint.
- 5.62 Outside central London, recognizing that there is a significant number of private hospitals throughout the UK, we based the geographic market definition on catchment areas.
- 5.63 Catchment area analysis is a pragmatic approach that has been used by the OFT and the CC in several previous inquiries involving a large number of local markets.³² However, this approach has a number of limitations.³³ We note, in particular, the following points.
- 5.64 The catchment area around a hospital reflects the area from which the hospital draws the majority of its patients and does not necessarily fully reflect patients' willingness to travel in response to a small change in the price or quality of the services provided by the hospital they have attended. This may result in geographic markets defined on the basis of catchment areas possibly being too narrow in some instances. However,

³² See CC3, [paragraph 148\(a\)](#); CC2, [paragraph 5.2.25](#); *Commentary on retail mergers*, a joint report by the OFT and the CC, March 2011. In relation to (private) healthcare, see references in the OFT [Private Healthcare Market Study](#), April 2012, paragraphs 4.46–4.48.

³³ See Oxera, [Report prepared for the OFT, Techniques for defining markets for private healthcare in the UK](#), November 2011.

as explained below, we have considered in our local competitive assessment the constraints on each hospital, whether arising within or outside the hospital's catchment area.

- 5.65 In addition, as location and distance are important to patients (and to GPs referring patients to secondary care) when they choose a hospital, even within the local geographic markets thus defined, hospitals providing the same services in different locations are not perfect substitutes for one another and, other things being equal, hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away. We have taken into account these different levels of constraints in our competitive assessment.
- 5.66 Moreover, hospitals are different and some have different size catchment areas, which in turn may depend on a number of factors such as the size of the hospital, the range of specialties/treatments provided (including whether the hospital provides high-acuity/complex treatments) and the area where the hospital is located (major conurbations, urban or rural areas). For example, having a large catchment area does not necessarily imply that the hospital is constrained by all hospitals located within its catchment area. Similarly, a small catchment area does not necessarily imply that the hospital is not constrained by hospitals located outside its catchment area.
- 5.67 Finally, we note that hospitals' catchment areas can overlap, to a greater or lesser extent, with each other, and this may provide an indication of the extent to which different hospitals are considered by patients to be substitutes for each other.
- 5.68 Taking these considerations into account, for the rest of the UK (ie excluding central London) we have used each hospital's catchment area as a pragmatic definition of

the geographic market. However, regardless of the precise boundaries of these geographic markets, in our local competitive assessments for each hospital we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within the hospital's catchment area and we have considered constraints provided by private hospitals/PPUs located outside the hospital's catchment area. In particular, we have looked at any overlap with other private hospitals' catchment areas, including hospitals inside and outside the hospital's catchment area, to identify, for each hospital, the set of private hospitals/PPUs which the assessment of competitive constraints should focus on. We have also considered constraints provided by NHS hospitals where we have evidence of them being a constraint.

5.69 In Appendix 6.4 we set out the details of our methodology to identify catchment areas. For each hospital, the catchment area size (in terms of road distance) and the set of private hospitals/PPUs which the assessment of competitive constraints has focused on are presented in the individual hospital competitive assessment in Appendix 6.7. The same applies to NHS hospitals where we have evidence of them acting as a constraint.

Conclusion on geographic market(s)

5.70 On the basis of the evidence and analysis set out above, we decided upon the following approach to geographic market definition for the provision of private healthcare and the assessment of competitive constraints:

- (a) We treat the geographic scope of competition in the provision of private health-care services as local for both consultant and hospital services.
- (b) In relation to consultant services, for the purposes of our analysis we did not consider it necessary to identify these local geographic markets, it being sufficient to understand them as similar in scope to hospital services markets.

(c) In relation to hospital services, we have defined the local geographic markets on the basis of the location of suppliers. Local geographic markets are defined as the areas covering sets of private hospitals and PPUs competing closely because enough patients consider them to be substitutes in terms of distance. In particular:

- (i) we have considered the area covering the private hospitals and PPUs in central London as a separate geographic market, due to its special demand-side and supply-side characteristics;
- (ii) in the rest of the UK, we have identified the local geographic markets as corresponding to each hospital's catchment area; and
- (iii) regardless of the precise boundaries of these geographic markets, in our local competitive assessments for central London and for individual hospitals outside central London, we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within these geographic markets. We have also considered competitive constraints provided by private hospitals/PPUs located outside these geographic markets and constraints provided by NHS hospitals where we have evidence of them being a constraint.

6. Competitive assessment: Private hospital operators

Introduction

- 6.1 In this section, we set out our assessment of whether there are features of the markets we defined that give rise to one or more AECs through unilateral market power of private hospital operators or PPUs. This assessment addresses our ToH 1, 3 and 5 (see paragraphs 4.28 and 4.29). It also addresses certain aspects of ToH 7 (see paragraph 4.42).
- 6.2 As set out in paragraph 5.52(c), we have defined distinct product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient care. For the purposes of the assessment of competitive constraints we have aggregated most of the specialties we have considered where we think it appropriate (see paragraph 5.54(b)).
- 6.3 For the reasons set out in paragraph 5.52(c)(i), our analysis of competitive constraints has focused on private hospitals and PPUs providing inpatient care, as defined in paragraph 5.51(c)(ii) and (iii), or subset of these. Similarly, our analysis of barriers to entry and our profitability analysis have focused largely on providers of inpatient care.
- 6.4 We have focused on private hospitals and PPUs providing inpatient care for the following reasons. First, providers of inpatient care account for a substantial share of the revenue generated by private patients in the UK (see paragraph 5.43). Secondly, concentration is relatively higher in the provision of inpatient care than in the provision of day-patient and outpatient care. For example, according to Laing & Buisson, there were 251 day-only clinics in the UK in 2011 and most of them were relatively small clinics (see paragraph 5.47). Thirdly, barriers to entry and expansion into the provision of inpatient care are higher than those into the provision of day-

patient and outpatient care (see paragraph 6.42). In relation to the last two points, we noted that, while in general providers of inpatient care compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of day-patient and/or outpatient care, this is unlikely to hold across the full range of day-patient and outpatient treatments. In particular, certain day-patient and outpatient treatments (for example, those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments (see paragraph 5.54(a)).

- 6.5 Depending on the specificity of each analysis, our analyses of competitive constraints have considered inpatient treatments and/or day-patient and outpatient treatments. For example, our self-pay PCA has looked at inpatient treatments, while our insured price analysis has looked at inpatient, day-patient and/or outpatient treatments. Our profitability analysis has looked at all of the activities carried out by the hospitals operators including inpatient, day-patient and/or outpatient treatments funded by private individuals, PMIs and the NHS. In what follows, we will set out the framework we have used for each of our analyses.
- 6.6 As set out in paragraph 5.70(c), we have defined local geographic markets as being central London and, for the rest of the UK, each hospital's catchment area and we have considered competitive constraints within and outside of these markets.
- 6.7 This section has three main subsections: first structure, second market outcomes and third provisional conclusions. Within the structure subsection we discuss barriers to entry, local competitive constraints (including concentration) and bargaining between PMIs and hospital operators. Within the market outcomes subsection we discuss self-pay prices, insured prices and profitability.

Structure

Barriers to entry and expansion

- 6.8 In this section we examine the extent to which incumbent providers of inpatient care are constrained by the threat of entry or expansion.
- 6.9 Our guidance defines barriers to entry and expansion as any feature of the market that gives incumbent suppliers an advantage over-efficient potential entrants or rival incumbent firms.¹ 'Barriers' may thus encompass a variety of restrictions on the ability of firms to compete.
- 6.10 We consider various possible barriers in turn. Before that we provide a description and summary of our case studies on barriers to entry.
- 6.11 We have observed very few new firms entering the relevant market through the establishment of full service hospitals, the only examples in the last five years being that of Circle and the 3fivetwo Group's Kingsbridge Hospital.² We note that the KIMS hospital in Maidstone is due to open in April 2014.
- 6.12 Over the same period, we have seen examples, but not many, of existing hospital operators opening full service hospitals in new areas. These include Spire's Montefiore hospital in Hove and Nuffield's hospital in the Vale of Glamorgan.
- 6.13 We are aware of a number of examples of small-scale 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 (Newport, 2008); and the

¹ CC3 (Revised), [paragraph 207](#).

² Kingsbridge Hospital is located in Belfast and is the first full service hospital opened by the 3fivetwo Group. It has 16 beds and offers a fairly full range of services.

Cambridge Heart Clinic (2006).³ We note, however, that some of these ventures failed, for example the Nucleus Healthcare hospital which went into administration in October 2012.⁴

Case studies on entry

- 6.14 We conducted three case studies⁵ where entry or expansion had taken place to see whether this would help us understand why it was unusual and what constraints an entrant would face and whether these varied depending upon the operator or local circumstances. We published working papers on these case studies and include updated versions of these as Appendices 6.1, 6.2 and 6.3.⁶
- 6.15 The case studies were selected on the basis that they demonstrated a range of entry or expansion experiences, both successful and unsuccessful. In Bath, a new operator (Circle) successfully entered the market with a full-service hospital. In London, an existing operator (TLC) expanded its facilities in a particular medical specialty (oncology). In Edinburgh, one operator tried and failed to enter (Circle), another chose not to attempt entry (BMI), a third entered with a small, consultant-owned day-case clinic (The Edinburgh Clinic) and a fourth expanded with a large day-case hospital on a new site (Spire). These case studies were chosen to highlight the factors that could impede or facilitate entry and to allow us to assess their relative importance.
- 6.16 In the paragraphs below we draw out some of the key points from each of the case studies conducted.

³ Laing's Healthcare Market Review, 2011–2012.

⁴ www.bbc.co.uk/news/uk-wales-south-east-wales-20093059.

⁵ www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/working-papers.

⁶ Appendix 6.1, Circle's entry in Bath; Appendix 6.2, The Edinburgh Clinic's and Aspen's entry in Edinburgh; and Appendix 6.3, TLC's expansion of its cancer treatment facilities.

Bath case study

- 6.17 In Bath, Circle built a new hospital on a business park 9 miles south of the city at a cost of around £30 million.
- 6.18 Circle told us that it faced no problems in obtaining planning permission for its Bath hospital. Circle also told us that it 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.
- 6.19 BMI launched a number of schemes to encourage consultants to continue practising at the Bath Clinic. However, Circle told us that its Partner/consultant business model had been effective in attracting the support of local consultants and that consultants' willingness to become Partners in the hospital had been important in winning support from financial backers.
- 6.20 AXA PPP and Aviva declined to recognize the new Circle hospital in Bath on their main lists for day-case and inpatient treatment. Not only did AXA PPP represent about 25 per cent of the private medical insurance 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. 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.⁷ Circle did the same with Aviva patients, though the cost of doing so was lower than in the case of AXA PPP since fewer patients were insured with Aviva and Aviva made a contribution to the cost of their policyholders' treatment at Circle Bath whereas AXA PPP did not.

⁷ This allowed Circle to attract consultants to do their full surgical lists at the hospital, with Circle only foregoing payment on AXA PPP patients.

- 6.21 Circle told us that AXA PPP's, and to a lesser extent Aviva's, decision not to recognize the Circle Bath facility had negatively impacted its profitability by forcing it to treat the patients concerned at its own expense, and that as a result the facility would become profitable later than originally anticipated.
- 6.22 We found that AXA PPP had declined to recognize Circle Bath even though it would have been slightly better off by doing so. AXA PPP told us that its decision was taken in the context of its broader, national, relationship with BMI, including the need to secure agreement over BMI's participation in AXA PPP's Corporate Pathways product.
- 6.23 The outcome in Bath was that Circle won roughly half of the acute private healthcare market there, although its performance was below that forecast in its original plans for the business.

London case study

- 6.24 In London, an existing operator, TLC, expanded its oncology facilities to create a dedicated cancer treatment centre opposite its main hospital in the Harley Street area. Finding a suitable site and obtaining the necessary permissions to build it took 3.5 years. The cost of acquiring the site, building and equipping its Cancer Centre adjacent to Harley Street was approximately £90 million.
- 6.25 TLC told us that it had not encountered any material problems with CQC registration.
- 6.26 TLC told us that it encountered difficulties in retaining key oncologists. It had had a cooperation agreement with the London Oncology Clinic but this expired and the London Oncology Clinic was acquired by HCA. It told us that it had been required to

offer some consultants large financial incentives to retain their practice at the London Clinic.

- 6.27 AXA PPP recognized the new facility almost immediately, despite attempts by HCA to persuade it not to include additional radiotherapy facilities in its network in London. TLC is now available to clients of AXA PPP's Corporate Pathways product whereas HCA facilities are not.
- 6.28 We found that while TLC had been successful in expanding in central London it had encountered difficulties in doing so, the main ones being acquiring and obtaining permissions for a suitable site and retaining and attracting oncologists to practise at its clinic. As a result, the revenue performance of the Cancer Centre had been below budget expectations.

Edinburgh case study

- 6.29 Prior to 2009, there was a single private hospital in Edinburgh, Spire Murrayfield, located on Corstorphine Hill to the west of the city centre. Several private hospital operators identified an opportunity to enter or expand in Edinburgh based on three main factors. First, with around 40,000 people holding private medical insurance, Edinburgh is a relatively large market for private healthcare. Prior to the financial crisis, the market was also growing due to the presence (and strength) of a large number of financial services firms and corporate headquarters in the city. Second, several parties highlighted the fact that the Edinburgh market was under-served by private facilities. Circle told us that the Murrayfield hospital was capacity constrained, while BMI highlighted the under-provision of diagnostic and outpatient facilities in the city as well as the lack of ICU facilities at Murrayfield, such that more complex cases went to the Edinburgh Royal Infirmary, an NHS hospital. Third, following the move of the Edinburgh Royal Infirmary to a new site to the south-east of the city centre, there

was an opportunity for an entrant to provide facilities close to the new hospital, which would have been more convenient for consultants who had their main NHS practice at the Edinburgh Royal Infirmary. This offered an entrant the possibility of capturing market share from Murrayfield, as well as serving the latent demand in the local area.

- 6.30 Circle sought to enter the Edinburgh market in 2008/09 with a full-service hospital, located in close proximity to the Edinburgh Royal Infirmary. However, despite having achieved its target level of consultant revenue commitments and acquiring a suitable site, with planning permission for a hospital, it was unable to secure the necessary funding to build the hospital.⁸ Circle's attempted entry, together with the broader market opportunity, prompted Spire to expand in Edinburgh with its Shawfair hospital. Spire built the new day-case facility near the new site of the Edinburgh Royal Infirmary at a total cost of around £[redacted]. Spire concluded that, following the completion of this hospital, it was unlikely that Circle or any other competitor would seek to enter the market.
- 6.31 The Edinburgh Clinic, which entered the market on a smaller scale, was able to acquire and convert an existing building in the Morningside area (south-west of the centre). This facility, which opened in 2008, focused initially on offering outpatient consulting rooms, minor treatments and diagnostic facilities, although it has developed its service offering to cover a range of day-case procedures.
- 6.32 Aspen, which acquired The Edinburgh Clinic, told us that small-scale entry into the inpatient market, for example with five overnight beds, was not viable due to the costs of staffing a facility 24 hours a day. Hence, for an entrant to compete successfully for inpatient work, it would need to invest more heavily in facilities and staff to be able to capture significant patient volumes.

⁸ Circle's attempt to raise funding in Edinburgh took place in 2009, coinciding with the financial crisis. We would expect funding to be more readily available under more normal market conditions.

- 6.33 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 initially impeded its expansion into areas of treatment requiring day-case or inpatient care. In contrast, an agreement with the NHS to provide minor surgical and diagnostic procedures to publicly-funded patients served to increase volumes and raise the profile of the facility among local GPs and consultants.
- 6.34 BMI considered entering the market by building a full-service private hospital but was deterred from doing so due to the limited size of the local market and its view that it would need to take around [redacted] of Spire's market share, or grow the market significantly, in order to enter profitably. [redacted]
- 6.35 We found that, whilst there had been examples of both successful entry and expansion in Edinburgh, attempts at new entry with full-service facilities were deterred by a combination of the size of the local market and the economies of scale involved in operating a full-service hospital. In this case, this barrier appears to have been increased by the incumbent's actions in increasing its capacity in the market. In contrast, we found that obtaining suitable sites in terms of both location and planning permission was relatively straightforward in Edinburgh and hence did not pose a barrier to entry. The experience of The Edinburgh Clinic demonstrated that niche entry, for example with a day-case clinic, can be successful but this does not appear to constrain incumbent inpatient facilities.
- 6.36 Spire's expansion has increased the range of private medical services offered to patients in Edinburgh, particularly in terms of IVF, oncology and cardiology. However, this expansion also appears to have deterred entry from full-service competitors which could have been expected to put downward pressure on prices. The Edinburgh

Clinic noted the limited response from Spire to its entry, which suggests that Spire may not view the clinic as a significant competitor.

Assessment of the case studies

- 6.37 Circle's entry in Bath represented a major financial commitment and risk. It appears that Circle would have suffered a 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.⁹
- 6.38 TLC's expansion represented a major financial commitment and risk. Should TLC have been unsuccessful, some value may have been recoverable by the sale of its Cancer Centre to another hospital operator. However this would have been likely to result in significant loss.
- 6.39 Each of the cases of entry involved major capital expenditure and apparently significant risks, other than that of The Edinburgh Clinic.
- 6.40 BMI made the decision not to enter Edinburgh, for example, on the basis that it would need either to take [X] of Spire's market share or grow the market significantly in order for entry to be profitable. The scale of the investment required to enter the market with a full service hospital relative to the size of the market, the policy of the Scottish Government not to use private health facilities for NHS patients,¹⁰ and the first-mover advantages that Spire had, made new entry unattractive in Edinburgh.

⁹ However, given the highly specialised nature of the building, it seems likely that a change of use would be costly reducing the returns to the owner from this form of exit.

¹⁰ A particular concern was the uncertainty of the likely volume of NHS work in the future. Different parties put different views to us on the likelihood of this work ceasing and related timings.

- 6.41 In addition, BMI was aware of Circle's prospective entry in Edinburgh since Circle had acquired a site for a new hospital.
- 6.42 The experience of The Edinburgh Clinic/Aspen indicates that entry into the health-care market or expansion on a small scale, faces fewer barriers than larger-scale entry (ie opening a full-service hospital, which both BMI nor Circle considered in Edinburgh, but neither ultimately did). However, we have seen no evidence that it is easier to expand to full service operations from a position of small scale entry than it is to enter on a large scale.
- 6.43 Medical regulatory requirements do not appear to have been an important factor in any of the case studies.
- 6.44 Planning permission and site availability was an important factor in the case of TLC.
- 6.45 PMI recognition, particularly by AXA PPP, was a very important issue for Circle in Bath and also of some importance to The Edinburgh Clinic. It did not create a difficulty for TLC.

Potential barriers to entry or expansion

Cost and economies of scale

- 6.46 The cost of designing, building and equipping a private hospital able to provide a full range of inpatient, day-case and outpatient facilities is high. In addition, the ability to recoup these costs in the event that attempted entry is unsuccessful is limited: the options are realistically confined to selling the assets to an incumbent (if there is one)—or changing their use, to hotel, residential or commercial for example (depending on the building's location and layout).

- 6.47 In many local areas there is a high level of concentration (see paragraphs 6.102 to 6.144). Moreover, as described in paragraph 2.12 and 4.7, although hospital operators in England have seen increases in their business due to work for the NHS, the market for private healthcare has been flat for several years, and is expected to remain so for the foreseeable future. In many cases therefore a potential new entrant's success will be largely determined by whether it can take a significant amount of business from a small number of nearby hospitals. Incumbent hospitals can be expected to respond aggressively, as we saw in Bath. BMI's response included attempting to persuade PMI's not to recognize the entrant, the introduction of a 'consultant loyalty scheme' and price reductions in the self-pay sector.
- 6.48 There are some economies of scale associated with private hospitals, particularly full service hospitals with inpatient facilities, and there are substantial fixed costs. As a result small-scale entry in order to offer inpatient facilities is unlikely to be profitable. In many areas of the UK an efficiently sized new hospital would be relatively large compared with the local market. Moreover, many local markets are only large enough to support a relatively small number of efficiently sized hospitals with inpatient facilities. Thus unless there is substantial unsatisfied local demand, or the local market is very large (as may be the case in a few large conurbations) if a new hospital enters the outcome may well be that all of the hospitals become unprofitable. In these circumstances an entrant would only be successful if it attracted very high volumes, an outcome that in many situations would be implausible taking account of the likely competitive responses of rivals.
- 6.49 We consider the high sunk costs of incumbents and the effects of economies of scale described above each constitute a barrier to entry.

The regulation of healthcare facilities

- 6.50 The regulatory background for healthcare facilities is set out at paragraphs 2.64 to 2.74.
- 6.51 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.
- 6.52 Circle, in Bath, and TLC 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.
- 6.53 In light of the above mentioned evidence, we do not consider the various healthcare regulatory requirements to constitute a barrier to entry.

Site availability and planning regulations

- 6.54 We examined whether site availability and planning regulations could be a barrier to entry. We received submissions from a number of hospital operators, including Circle, which has been seeking to expand and which provided extensive submissions relating to planning issues it had encountered.
- 6.55 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'¹¹ for new medical facilities to override existing land use policy. Circle also explained that it had had to work closely with local authorities

¹¹ 'Need' has a specific meaning in the planning context. In this case the applicants were required to identify local demand that was not served by existing healthcare facilities.

to 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.

- 6.56 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.
- 6.57 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).
- 6.58 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). 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’.¹²

6.59 Circle told us that Nuffield 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 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, Warwick NHS Hospital said that it 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 encouraged opposition to Circle’s plans through the local press and MP. Warwick District Council commissioned research from consultants which concluded that the presence of a Circle facility would not undermine the NHS hospital but would 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.

6.60 While Circle has had more recent experience of developing new hospital facilities than the major hospital operators, we observed some instances of the larger groups deciding to open new hospitals. These included Spire’s hospitals in Brighton (Montefiore) and Edinburgh (Shawfair, a daycare facility), both of which did proceed to implementation, and BMI’s in Edinburgh, which did not. Neither BMI nor Spire told us that it had faced any significant planning problems outside of central London.

¹² Appeal decision, November 2011 (MQ Q 60f.10STH Appeal Decision, paragraph 64).

Similarly, HCA and Ramsay both told us that they had not encountered planning problems in the development of new facilities.

- 6.61 HCA told us that suitable sites were available in central London and that it did not encounter any difficulties in obtaining planning permission for its 2011–2012 development on Devonshire Street, the site of its Harley Street Diagnostic Centre, despite the need to convert offices and residential accommodation to medical use. It said that to offset the loss of residential space planning consent was linked to nearby developments to convert office space into residential accommodation.¹³ We note, though, that HCA already had a presence in the Harley Street area and had relationships with landlords there which may have, for example, facilitated the use-swap which made the package acceptable to the City of Westminster.¹⁴ We note, further, that internal documents indicate that HCA has itself found difficulties in identifying suitable sites in central London. It was encountering capacity constraints at London Bridge Hospital, for example, which it described as ‘landlocked,’ but landlords of adjacent buildings were not willing to lease them premises for medical use.
- 6.62 Nuffield told us that its plans for a £[~~30~~] 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 BREAM energy assessment. It said that these factors had delayed the project and raised its cost but it had proceeded with it.
- 6.63 BMI told us that central London posed unique difficulties for hospital operators in terms of barriers to entering the market. It said that the most prominent issue was the

¹³ HCA comments on barriers to entry case studies, p7.

¹⁴ See the planning decision.

lack of suitable land and buildings in the core W1 Marylebone area. It said that it had tried to overcome these hurdles in respect of BMI Fitzroy Square. It said this building was ill-suited to efficiently provide private healthcare services and while this might have been improved had BMI been able to develop a second theatre these plans were frustrated by both planning constraints and the costs of development.¹⁵

- 6.64 TLC told us that the process of acquiring the land and obtaining planning permission for its Cancer Centre took [X] years and [X] year respectively, entailing ‘use swaps’ with other premises and cost over £[X] million. It said that this process was facilitated by the Clinic’s existing presence in the Harley Street vicinity, its reputation and its relationship with landlords which a new entrant would not have.¹⁶

Assessment

- 6.65 On the basis of the evidence set out above, we provisionally concluded that finding a site and obtaining planning permission for a new general hospital site, certainly in central London but also in some other parts of the UK, could raise the costs and the risks of entry or expansion, thus giving incumbent hospitals a cost advantage and, therefore, constituting a barrier to entry.

Strategic barriers

- 6.66 We have observed two potential restrictions on entry and expansion which could be characterized as strategic:¹⁷ PMIs declining to recognize new healthcare facilities, and arrangements between private healthcare providers and consultants which may deter or prevent consultants from working with the entrant.

¹⁵ BMI response to AIS, paragraphs 9.3 & 9.4.

¹⁶ TLC response to AIS, paragraph 4.2.

¹⁷ Our Guidelines identifies three entry barriers: natural, regulatory and strategic. CC3 (Revised) paragraph 210.

- *PMI recognition*

- 6.67 The high fixed costs of hospital businesses make their profitability very sensitive to variations in patient volumes. For this reason, private hospital operators are willing to offer significant price discounts to PMIs who are able to deliver large or increased numbers of patients. The PMIs have adopted a variety of strategies to maximize the patient volumes that they can deliver to particular hospital operators.
- 6.68 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. AXA PPP told us that this is because corporate clients bring patient volumes and PMIs can use these volumes to negotiate discounts from hospital operators.
- 6.69 Selective recognition of hospital facilities provides another means of delivering volume to a hospital operator, by channelling all or most of the PMI's customers to the facility of the hospital operator that has offered the most favourable terms in a particular geographic area.
- 6.70 AXA PPP, the UK's second largest PMI, 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 that network. A rival to the successful provider which is denied recognition will therefore 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, some agreements between AXA PPP and hospital operators 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.

6.71 Nuffield 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.

6.72 We did not find that PMI recognition, in itself, was a barrier to entry. However, we have found that some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant locally, even one offering lower prices or higher quality services.

Barriers arising from schemes to encourage clinicians to use hospital operators' facilities

6.73 While we found that there was no shortage of consultants in aggregate, from our case studies and other evidence we found that the availability of consultants can act as a constraint on potential new entrants. Most consultants have practising privileges in more than one private hospital, but the majority find it convenient to work principally in one, together with their main NHS hospital. Consultants are sometimes incentivized to select a particular hospital as their main base by the hospital operator.

6.74 Such schemes would constitute a barrier to entry if incumbents were able to provide greater incentives to consultants than were potential entrants and thus deny entrants access to sufficient consultants to make the new hospital viable. In particular, we have seen evidence from episodes of entry that we have studied that the financial backers of new hospitals would wish to be certain that sufficient consultants had committed to undertake private work at that hospital such that it would be capable of performing according to its plan.

6.75 Although very few episodes of new entry have been seen in the last five years, in each case the entrant has secured binding commitments from consultants in exchange for an equity stake or equivalent interest in the new hospital business. This

would suggest that entrants are able to match the incentives available to incumbent hospitals though we note that the ability to do so may be a necessary but is not a sufficient condition of entry: Circle did not enter Edinburgh despite having agreed partnership arrangements with what it considered sufficient consultants in the area.

6.76 On the other hand, our case studies have only focused on examples of attempted, and generally successful, entry and expansion. There may have been other instances where potential operators were deterred from proceeding as a result of such schemes or would have been if they could not have matched the benefits offered by the incumbent. It is certainly the case that the incumbent would benefit from a pre-existing relationship with local consultants and would have the ability to launch a scheme and begin making payments under it months if not years before the entrant was scheduled to open, as we saw in Bath.

6.77 We did not find that, in general, consultant incentive schemes constituted a barrier to entry. However, we did find that the need to persuade consultants to commit to a new hospital, often much before it became operational, did constitute a barrier to entry.

Conclusions on barriers to entry and expansion

6.78 We have examined the extent to which new entrants may face restrictions arising from certain aspects of the private healthcare market.

6.79 We found that there were significant capital costs of building and equipping a full service hospital, and that there were large economies of scale relative to the size of local markets. We also found that demand for private health services had been fairly static over the last five years and that no significant growth was expected for the foreseeable future. We provisionally concluded that in combination economies of

scale and high capital costs in a static market constituted the greatest barrier to entry.

- 6.80 We found that industry-specific regulatory requirements such as the need to obtain CQC registration in England, and its equivalent bodies elsewhere in the UK, did not constitute a significant barrier to entry.
- 6.81 We found that finding a site and obtaining planning permission for a new general hospital, certainly in central London but also in some other parts of the UK, could raise the costs and the risks of entry or expansion, thus giving incumbent hospitals a cost advantage and, therefore, constituting a barrier to entry.
- 6.82 We did not find that, in general, consultant incentive schemes constituted a barrier to entry.
- 6.83 We found that the need to persuade consultants to commit to a new hospital, often much before it became operational, constituted a barrier to entry.
- 6.84 We did not find that PMI recognition, in itself, was in general a barrier to entry. However, we have found that some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant locally, even one offering lower prices or higher quality services.
- 6.85 In our view these barriers are likely to add to the effects of each other.
- 6.86 Our profitability analyses, set out at paragraphs 6.249 to 6.285, indicates that BMI, HCA and Spire have, during the period under review (ie between January 2007 and June 2012) earned returns substantially and persistently in excess of the cost of capital. These firms account for more than half (53 per cent) of the private healthcare

industry, indicating that the industry as a whole is likely to be making excess returns on average. This analysis was carried out on a replacement cost basis and therefore suggests that, in the absence of barriers to entry, a new entrant could expect to produce strong returns. The extent of entry at the full service hospital level (essentially Circle's two private hospitals) is less than we would expect were there not high barriers to entry. Indeed in the absence of high barriers to entry we would expect entry and/or the threat of entry to have driven prices to a level that did not allow returns in excess of the cost of capital to be persistently obtained. We therefore find that our profitability analyses suggest that there are high barriers to entry.

- 6.87 We concluded that the barriers relating to sunk costs were present in all areas and that the barrier relating to the economies of scale was likely to be present in many areas also. We concluded that there were often barriers related to site availability and the need for consultant commitment to new facilities. We also concluded that the barriers related to sunk costs and economies of scale barriers were high and that combination with the other barriers increased the overall level. Our conclusion in respect of the barriers related to site availability and consultant commitment has been reached based upon the evidence we received from various hospital operators. We recognize that the evidence received is location and circumstance specific and therefore does not necessarily apply to the whole of the UK. It does, however, reflect the experiences of those firms who have sought planning permission in recent years. Our finding of barriers is supported by our finding that BMI, HCA and Spire have, during the period under review (ie between January 2007 and June 2012) earned returns substantially and persistently in excess of the cost of capital in the last three years of that period. Additionally, we note that there have been relatively few incidences of entry.

Local competitive constraints (including concentration)

Introduction

6.88 In this section we present the methodology and the main findings of our local competitive assessments of hospitals. The purpose of our local competitive assessments is to investigate whether the competitive constraints currently exerted by hospitals on each other at the local level appear to be sufficient to prevent hospital operators from exercising unilateral market power, or, on the contrary, these competitive constraints appear to be insufficient. In this section, we first describe our initial filtering exercise which led us to identify a first set of hospitals that we refer to as the ‘hospitals of potential concern’. We then present the approach and a summary of the main results of our local competitive assessments of the 139 hospitals of potential concern identified by the filters and located outside central London, and of any additional hospital we found to be of potential concern on the basis of further evidence and a more detailed analysis. Finally, we present our competitive assessment in relation to hospitals located in central London.

Initial filtering

6.89 The aim of our initial filtering exercise was to identify and exclude from further analysis those hospitals where we could, by a systematic method, form a view that there were unlikely to be competition problems. The remaining hospitals were identified as ‘hospitals of potential concern’ and evaluated in more detail. Our approach to filtering has been conservative, ie more likely to filter in a hospital where there is no problem than filter out a hospital where there is a problem (for example, in relation to the catchment area delineation and the selection of the thresholds for our filters). We considered this to be appropriate because it decreases the risk of overlooking hospitals that may be a concern.

- 6.90 For the purpose of our initial filtering, we adopted two approaches, which we used together, to measure the concentration of hospitals at the local level: one concentration measure based on fascia counts within a pre-specified catchment area and another measure referred to as LOCI. Our general approach to filtering and the main results are set out below. Full details of the LOCI measure, including comments received from the parties and our responses, are set out in Appendix 6.4. A full description of our approach and results, as well as the main comments raised by the parties and our responses, are presented in Appendix 6.5.
- 6.91 As described in paragraph 5.52(c), our competitive assessment has focused on: (a) the 215 general private hospitals and general PPUs providing inpatient care and active in one or more of the 16 specialties; and (b) the 135 general private hospitals and PPUs (out of 215 in total) plus four specialized private hospitals and PPUs providing inpatient care and offering oncology. The list of these hospitals is provided in Appendix 6.6.
- 6.92 In relation to these hospitals, we have used catchment areas, the areas where most hospital patients live, for two purposes. First, as discussed in paragraphs 5.55 to 5.68, they were used to inform our understanding of the local geographic market for each hospital located outside central London. We take a hospital's catchment area to be indicative of the relevant geographic market for that hospital but we consider competitive constraints from outside the market. Second, we have used the catchment areas to calculate fascia counts.
- 6.93 We defined a hospital's catchment area as the radius within which a given percentage of the hospital's patients originate from. We have used 80 per cent¹⁸ as the proportion of patients, and have measured the radius based on road-distances (in

¹⁸ The CC and the OFT have used catchment areas based on an 80 per cent distribution in a number of their inquiries. See CC/OFT 'Commentary on retail mergers', March 2011.

miles) between patient home postcodes and hospital postcodes.¹⁹ We have used insured patients data for inpatient treatments within the 16 specialties and oncology together over the period 2009 to 2012 (part year) to derive individual hospital catchment areas.²⁰ We found that most hospitals have a catchment area with a radius of between 10 and 25 miles, although we observed significant variation in these catchment areas.

- 6.94 Having delineated the hospital catchment areas, we have defined the fascia count concentration measure as the total number of competitors that lie within a hospital's catchment area; a competitor is defined as one or more private hospitals/PPUs that are owned or managed by the same rival operator (eg if a hospital has a fascia count of 1, it has one rival operator, owning one or more hospitals, in its catchment area).
- 6.95 We have used two fascia count measures: (a) a fascia count that includes as competitors all general private hospitals and general PPUs providing inpatient care and offering one or more of our set of 16 specialties (215 general private hospitals and general PPUs in total); and (b) a fascia count that includes as competitors only those general and specialized private hospitals and PPUs providing inpatient care and also offering oncology services (139 oncology providers in total, comprised of general private hospitals, general PPUs and specialized private hospitals and PPUs).
- 6.96 The second concentration measure that we have used is the LOCI measure. The LOCI measure we have used is defined as 'one minus a hospital's weighted-average market share' and is therefore a market share-based concentration measure. Market shares are adjusted to take into account the common ownership of other hospitals

¹⁹ In response to our working paper 'Local competition assessment of hospitals of potential concern', Spire queried why we had not used journey times as used in previous CC inquiries. Our reason for using miles is given in Appendix 6.2.

²⁰ Hospital-specific catchment areas have been calculated for 173 hospitals which are included in the Healthcode data. For the remaining hospitals not included in the Healthcode data we have made assumptions to identify an indicative catchment area.

located in any area where the hospital draws its patients.²¹ The weighting scheme assigns more weight to those areas where a hospital draws a large proportion of its total patients—in practice this typically means more weight is given to those areas nearby to a hospital. LOCI always lies between zero and one; zero can be thought of, in theory, as a monopoly benchmark and one as a perfectly competitive benchmark. A higher LOCI corresponds to a lower weighted average market share, and therefore a ‘low LOCI’ hospital faces a higher degree of local concentration than a ‘high LOCI’ hospital.

6.97 To calculate the LOCI measures for the purpose of the filtering exercise we have used the same data on insured patient visits as for catchment areas.²² We have computed two LOCI measures: one based on patient visits (ie volume shares) and one based on revenue shares.

6.98 We consider the LOCI measure to have several benefits in the context of this investigation, in particular if compared with the fascia count measure. As described in more detail in Appendix 6.4, where we also address the comments received from the parties, the LOCI measure takes into account the geographic differentiation between hospitals, accurately reflects where the patient demand originates from, and does not rely on a fixed catchment area or other geographic market definition. Therefore it is our view that the LOCI measure, as compared to fascia count, is likely to provide a more accurate reflection of local competitive constraints facing a hospital.

6.99 We have identified a hospital as being of potential concern if either of the following conditions are met:

(a) LOCI (patient share) and/or LOCI (revenue share) is below 0.6; or

²¹ In Appendix 6.4 we refer to this LOCI measure as ‘network LOCI’.

²² This means we were able to calculate LOCI for 173 hospitals.

(b) fascia count (set of 16 specialties) and/or fascia count (oncology) is equal to or below 1.

6.100 The role of the filters and related thresholds is to determine which hospitals we evaluate in more detail. Each hospital's fascia count and LOCI measures provide some background data for the assessment of local competitive constraints for individual hospitals but, as we explain later in this section, do not determine the outcome of our competitive assessment in any mechanistic way. As noted earlier, we consider it important that this initial filtering exercise is conservative so that we do not overlook any hospitals that may be a potential concern. We took this into account when selecting the above thresholds. To determine the LOCI threshold, we considered the market share thresholds that have often been used by the OFT, the CC and the EC to exclude cause of concern, namely less than 40 per cent in undifferentiated product markets.²³ This level corresponds to a LOCI of 0.6. We selected the fascia count threshold on a similar basis: a fascia count of one corresponds to a local area with two competitors, which if evenly sized would imply market shares of 50 per cent.

6.101 On the basis of the filters described above, we have found 143 hospitals of potential concern.²⁴ Our LOCI approach identified 119 hospitals of potential concern (116 based on patient shares and a further 3 based on revenue share) and our fascia count approach identified an additional 24 hospitals of potential concern (19 based on our 16 specialties and a further 5 based on oncology). Of the 143 hospitals of potential concern, four are located in central London and these and other private hospitals in central London are considered in paragraphs 6.119 to 6.143. The list of

²³ CC/OFT Merger Assessment Guidelines, paragraph 5.3.5. European Commission, 'Guidelines on the assessment of horizontal mergers under the Council Regulation on the control of concentrations between undertakings', 2004/C 31/03.

²⁴ In our AIS we noted that our filters had identified 147 hospitals of potential concern. The reduction from 147 to 143 hospitals of potential concern has been caused by two data updates: (a) a correction to the Healthcode revenue data; and (b) an update to the list of PPU's providing oncology services. Update (a) led to three hospitals being removed from the list of hospitals of potential concern. Update (b) led to a number of hospitals being reclassified as oncology providers (when previously they had not been) and this led to a net decrease of one hospital of potential concern.

the 143 hospitals of potential concern identified by our filters is presented in Appendix 6.6.

Competitive assessment of hospitals of potential concern (excluding central London)

6.102 In this section we present the approach and a summary of the results of our local competitive assessments of the 139 hospitals of potential concern identified by the filters and located outside central London, and of any additional hospital we found to be of potential concern and we further evaluated. We note, in particular, that the fact that a hospital was not identified by our filters as being of potential concern does not preclude the possibility that we would evaluate it as a source of potential concern on the basis of further evidence and a more detailed analysis. In this section we also present the main arguments raised by hospital operators and PMIs in response to the working paper 'Local competition assessment of hospitals of potential concern'.²⁵ Our competitive assessments of each of the hospitals (outside central London) we provisionally found to be of concern are presented in Appendix 6.7. Barriers to entry and expansion are addressed in paragraphs 6.8 to 6.87.

6.103 The purpose of our local competitive assessments is to investigate whether the competitive constraints currently exerted on each hospital of potential concern appear to be sufficient to prevent the hospital operator from exercising unilateral market power, or, on the contrary, these competitive constraints appear to be insufficient. We have looked at the set of 16 specialties and considered oncology separately. We considered competitive constraints provided by competitor private hospitals and PPU's located within and outside each hospital's catchment area, as well as any constraint provided by NHS hospitals as set out below. Private hospitals (or PPU's) under common ownership were not considered to provide a competitive constraint.

²⁵ The working paper was published on the 21 May 2013.

6.104 As explained in paragraph 5.68, in order to identify the set of private hospitals and PUs to be considered in each individual hospital competitive assessment, we have used the hospital's catchment area as a starting point and we have looked at any overlap with other private hospitals' and PUs' catchment areas, including hospitals inside and outside the hospital's catchment area. The catchment area size and the set of private hospitals and PUs considered are set out in each individual hospital competitive assessment.

6.105 In order to assess the extent of any competition faced by each hospital of potential concern, we have taken into consideration several factors, including: (a) results of the different concentration measures; (b) the hospital's own individual characteristics as well as the characteristics of the nearby private hospitals and PUs, either competitor hospitals or hospitals under the same ownership (identified as described in paragraph 6.104); (c) characteristics of the local area in which the hospital is situated; (d) documentary evidence submitted by the parties; and (e) the views of the parties. To help our analysis, we have also used maps of catchment areas and population density by local authority.²⁶ Details of the different factors are provided below.

6.106 In relation to concentration measures, for each hospital of potential concern we have considered the network LOCI (patient share and revenue share)²⁷ and the fascia count in the catchment area (for the 16 specialties together and for oncology) as background data for the competitive assessment.²⁸ As noted in paragraph 6.100, we have not used any of these concentration measures in a mechanistic way to determine the outcome of our competitive assessment (eg threshold values have not

²⁶ Population density data is taken from the ONS website (2010 data).

²⁷ We have also considered whether and to what extent the LOCI figures were likely to be underestimated because of the presence of missing invoice hospitals.

²⁸ The CC guidelines for Market Investigations state that in general, a highly concentrated market might be an indicator that one or more firms hold unilateral market power.

been used, except in the filtering). We have also considered any network effect associated to each hospital of potential concern (measured by the difference between network and individual LOCI, patient share²⁹), as an indicator of the increase in concentration that results from the common ownership of other private hospitals (or PPU) in nearby areas (see paragraph 6.112(e)).

6.107 As for hospital individual characteristics, in respect of each hospital of potential concern and nearby private hospitals and PPU (identified as described in paragraph 6.104), we have considered the factors listed below:

- (a) range of specialties offered—we have looked at how many of the 16 specialties are offered and whether oncology is also offered;
- (b) availability and type of ICU—we have looked at whether an ICU was present and, if so, at whether critical care level 2 or critical care level 3 was offered;
- (c) hospital size by total admissions (inpatient and day-patient), inpatient admissions, total revenue (inpatient, day-patient and outpatient) and inpatient revenue—we have looked at all measures of size where the data is available and no particular measure has been determinative;
- (d) hospital patient mix as measured by the hospital's shares of admissions (inpatient and day-patient) accounted for by insured, self-pay, overseas and NHS patients—NHS admissions have been used to assess the proportion of the hospital activity that is non-private, as well as the hospital capacity that exists but is currently not dedicated to the private market;
- (e) location and distances between hospitals;³⁰ and
- (f) size of the catchment area in miles and the extent of any overlap between catchment areas.

²⁹ See Appendix 6.4.

³⁰ We note that, for convenience, in the hospital characteristics table provided in Appendix 6.8, for each hospital we included information about the distances of the two nearest hospitals only (whether competitor hospitals or under common ownership).

- 6.108 We explain the relevance of these factors to our analysis of whether a particular hospital provides a competitive constraint on another hospital in paragraph 6.112 below. Appendix 6.8 provides a list of the individual hospitals considered in our analysis and the characteristics of these hospitals.
- 6.109 As regards the characteristics of the local area in which the hospital is situated, we have considered in particular population density by local authority, proximity to urban centres, road network and transport connections.
- 6.110 In relation to documentary evidence submitted by the parties, we have considered internal documents provided by the hospital operators (BMI, Spire, Nuffield and Ramsay) and by the PMIs (Bupa, AXA PPP and Aviva). Internal documents have been used to assess whether these parties consider, in their normal course of business, private hospitals and PPUs to represent a competitive constraint on each other in local areas (and the extent of any such constraint) and whether these internal documents support the views expressed by the parties. We have also considered whether these documents are consistent or inconsistent with our analysis of whether a particular hospital faces a strong, moderate or weak constraint from another hospital and whether it is sufficiently or insufficiently constrained overall. For the hospital operators listed above, we have considered all internal documents provided in response to our questions on local competition in the Market Questionnaire,³¹ as well as a number of internal documents provided in the course of this investigation which either they highlighted to our attention or we found to be relevant to the assessment of local competition.
- 6.111 As regards the views of the parties, we have considered the views expressed by the hospital operators (BMI, Spire, Nuffield and Ramsay) and the PMIs (Bupa and AXA

³¹ In particular questions 12 to 16 in the Market Questionnaire.

PPP) in response to our working paper 'Local competition assessment of hospitals of potential concern' and our initial competitive assessments of the hospitals of potential concern³² as set out in paragraphs 6.113 and 6.114. Where views are not given, this should not be taken to imply that the parties did not have views. For example, Bupa's response to our working paper and initial assessment focused on how we should expand our existing list of hospitals of potential concern (for example, naming hospitals not on our list that should be included, and proposing we should move to a specialism level analysis). Nuffield told us that although it had commented on specific hospitals, this did not mean that it necessarily agreed with the classification of the remaining hospitals. AXA PPP did not comment on any of the providers not owned by one of BMI, Spire, Nuffield and Ramsay. Spire told us that its lack of commentary on particular hospitals in its response to our working paper did not reflect its view as to whether or not any individual competitor hospital imposed a constraint on Spire hospitals. It said that, in fact, in many instances, these hospitals were seen as significant competitors, as outlined in Spire's internal documents such as hospital-level three year plans. Spire told us that it focused its response to our working paper on those Spire hospitals that the CC identified as being of potential concern.

6.112 When assessing each hospital identified as being of potential concern, we considered all the factors listed above in combination to reach a conclusion on whether or not the competitive constraints faced by the hospital in aggregate were sufficient. In particular, the approach we have adopted is:

(a) We have assessed the extent to which the hospital of potential concern is similar to other nearby private hospitals and PPUs (as identified in paragraph 6.104), in terms of size, patient mix, range of 16 specialties and oncology, availability and type of ICU. All these factors reflect the different strength of competitive

³² We sent our initial local competitive assessments of the hospitals of potential concern to relevant hospital operators and to Bupa and AXA PPP in May 2013.

constraints implied by different hospital sizes and product ranges. For example, the breadth of the product range is relevant to the likelihood of PMIs, who want to secure a package of services, switching between hospitals.

(b) We have considered the location and distances between hospitals, the size of the catchment areas, the extent of any overlap between catchment areas, and the characteristics of the local area (as described in paragraph 6.109). These factors reflect the different strength of competitive constraints implied by different hospital geographic locations (relative to each other as well as relative to the location of the population). In particular, we note that when hospitals are similar, ie they have similar characteristics including size and they are located close to each other with similar catchment areas, they are likely to impose strong competitive constraints on each other. However, this does not mean that hospitals that are different do not impose a strong constraint on each other, eg a larger hospital (in terms of characteristics including size) can be a strong constraint on a smaller hospital (again in terms of characteristics including size) when these hospitals are not close together but there is a large overlap in their catchment areas. The extent of this constraint will largely depend on the number of patients willing to consider both hospitals when choosing where to go for treatment. The analysis of the hospital location, catchment areas, overlaps of catchment areas and the location and density of population are central in understanding patients' willingness to consider different hospitals in their choice set. The overlap between catchment areas must be large and, relative to the population within the catchment areas, cover densely populated areas and the distances that patients would have to travel to use another hospital should not be very different to that they currently travel to the hospital that they currently use for us to consider that there is likely to be a strong constraint. We have used density of population as a proxy measure for density of potential private patients. After

the provisional findings we will assess the density of potential private patients by using location of private patients.

(c) In large urban areas (eg Manchester and Birmingham), patients are more likely to travel inwards (from outside towards the inner city) than outwards, in particular for work reasons. The relatively larger catchment areas that we generally observe for hospitals located in the centre of large urban areas provide evidence of this. This greater propensity to travel into large urban areas together with the characteristics of the hospitals located in these areas may suggest that hospitals in large urban areas impose a competitive constraint on hospitals outside these areas, whereas the reverse may not be the case. First, hospitals located in the centre of large urban areas tend to be larger and offer a wider range of treatments than other hospitals, thus attracting patients from a wider geographical area. Second, the density of hospitals tends to be higher in the centre of large urban areas. Consequently, patients living within the centre of a large urban area tend to have several alternative hospitals nearby. On the contrary, patients outside the centre of a large urban area tend to have a more limited set of nearby hospitals, which may prompt them to travel further. For these patients, hospitals in the centre of the urban area may be a convenient alternative to hospitals outside the centre due to the transportation links connecting the outskirts with the centre.

(d) Hospitals in Greater London (but outside of central London) and in the surrounding commuter areas are likely to be constrained to some extent by hospitals in central London, particularly for non-routine, high-acuity treatments. This constraint has been considered, taking into account the relative location of hospitals in suburban areas, the evidence on catchment areas, the common ownership of several hospitals (see point (f) below), travel patterns and the prices charged, noting that hospitals in central London, on the whole, have higher prices than hospitals outside central London.

- (e) The common ownership of several hospitals by the same operator in nearby local areas strengthens the position of a hospital operator vis a vis its competitors because of the larger overall size and because of the nearby location of these hospitals. In this situation, the hospital operator may have greater incentives to increase the prices or worsen the quality of the services provided as it may expect to recoup some of the patients diverted from one of its hospitals through its hospitals nearby. For each hospital of potential concern, in assessing whether common ownership was a concern, we have taken into account the ownership and location of other nearby private hospitals or PPUs as identified in paragraph 6.104, and the network effect as measured by the difference between the individual and the network LOCI. Hospitals that are not classified as being of potential concern on their own, can still be part of a problematic common ownership group, as these hospitals can give the group greater incentives to, for example, worsen the quality of service by enabling the group to capture some of the lost business from the hospitals worsening the quality of service.
- (f) A number of private hospitals utilize a substantial share of their capacity to treat NHS patients. These hospitals may be potentially stronger competitors than their current share of supply of private healthcare services suggests to the extent that they may be able to switch the utilization of their capacity from NHS patients to private patients. In assessing the potential constraint imposed by these hospitals, we have taken into account that the ability to switch quickly and easily may be constrained by commitments to prioritize NHS patients over private patients, the need for some investment to adjust the facilities to the requirements of private patients, and the business strategies decided upon at national level.
- (g) NHS hospitals (as opposed to PPUs) are not included in our market definition. In order to consider constraints from NHS hospitals (ie constraints from outside the market), we have asked hospital operators (HCA, BMI, Spire, Nuffield and Ramsay) to provide, for each of their hospitals, evidence supporting their view

that any NHS hospital represents a competitor. We have considered the evidence provided on a case by case basis. We have received very limited evidence in this regard, and, on the whole, do not find the evidence compelling in its support for NHS hospitals acting as a competitive constraint on any of the private hospitals under analysis. We note that the internal documents we have received show that there is a degree of interaction between NHS and the private healthcare industry—for example, because consultants often split their work between NHS and private hospitals—but the evidence does not indicate that private hospitals compete with the NHS for patients. For example, we have not received widespread compelling evidence that shows that private hospitals monitor the NHS product and quality offering, or adjust their competitive offering in response to changes made at NHS hospitals, eg quality improvements, or consider any reduction in waiting time at NHS hospitals to influence price outcomes for PMIs or self-pay patients.

(h) As noted in paragraph 6.102, we discuss barriers to entry and expansion in paragraphs 6.8 to 6.87. In our local assessments we have taken account of entry where we have supporting evidence, for example KIMS in Maidstone and Spire Montifiore in Brighton.

6.113 In our working paper ‘Local competition assessment of hospitals of potential concern’ we described our competitive assessments of hospitals of potential concern using the following categories: (a) insufficiently constrained in a multi-provider environment, (b) insufficiently constrained in a symmetric duopoly, (c) insufficiently constrained in an asymmetric duopoly, (d) insufficiently constrained as solus hospital, and (e) sufficiently constrained.³³ These were used as shorthand descriptions summarizing the assessment of competitive constraints faced by each hospital of potential

³³ See working paper ‘[Assessment of hospitals of potential concern \(excluding central London\)](#)’, published on the 21 May 2013, paragraphs 5(a), 5(b) & 6.

concern. Taking into account comments received from the parties, and to avoid this terminology being misinterpreted, our local competitive assessments of individual hospitals no longer refer to these categories (although we continue to refer to them when reporting the parties' views). However, in this respect, we note:

(a) We consider hospitals which face no or weak competitive constraints from other hospitals to be insufficiently constrained.

(b) In the absence of other constraints (or when these are weak), in general, we consider two hospitals (or hospital operators in case of common ownership of hospitals nearby) imposing a similar competitive constraint on each other to be insufficiently constrained as they would not be expected to compete effectively against each other. Similarity, as discussed above, is assessed having regard to a number of hospital characteristics, including size, range of specialties, ICU, location and distances. However, we recognize that there may be circumstances where two similar operators may provide adequate constraints. For example, high fixed costs and spare capacity may provide an incentive to price so as to increase volume. We have taken into account the views of, and evidence provided by, the parties on this specific issue in our competitive assessments but unless we have seen evidence of competition (or potential competition), for example, hospitals having adjusted their competitive offering in response to changes made or expected by other hospitals, we do not regard two similar competitors to be sufficient.

6.114 The approach set out in paragraph 6.113 is supported by the evidence that links local concentration with price outcomes, including the results of our PCA presented in paragraphs 6.190 to 6.202, and our interpretation of what the parties told us and a review of the qualitative evidence as set out in paragraph 5 of Appendix 6.9.

6.115 As noted in paragraph 6.111, we have considered the views expressed by the hospital operators (BMI, Spire, Nuffield and Ramsay) and the PMIs (Bupa and AXA PPP) in response to our working paper and the initial competitive assessments of the hospitals of potential concern. These parties raised a number of general comments in relation to our methodology and specific comments on the individual assessments. The latter are addressed in our individual hospital competitive assessments. In relation to the former, many of them related to clarifications around our approach which is set out in paragraphs 6.104 to 6.113. We outline below a few general comments on our methodology highlighted by some of these parties:

(a) BMI told us that profitability was highly sensitive to volume in a high fixed cost environment and that its hospitals suffered from relatively low levels of capacity utilization so that it had a powerful incentive to price so as to increase volume. It said that the vast majority of private hospitals were not capacity constrained—hence even small hospitals were able to take on significant additional work from larger hospitals. BMI also considered that we had found low barriers to entry and expansion as a general matter and that there were no specific barriers that were preventing ‘small’ hospitals from growing. As a result, BMI said that we should take account of capacity constraints, or rather the lack of them, and barriers to entry or expansion, or rather the lack of them, in our local assessments. BMI is incorrect when it refers to our view on barriers to entry. Our views and reasoning are set out in paragraphs 6.8 to 6.87 but, in summary, we have found high barriers to entry both in central London and outside central London. As a general principle, we accept that excess capacity should influence how operators behave and set prices, and in our local assessments we have looked for evidence of hospital operators’ actual behaviour, for example whether they reduced prices in the face of excess capacity or due to competition from other operators. We have taken account of this evidence from internal documents in our local assessments

but, in general, we have not seen a great deal of evidence of this sort for individual hospitals.

(b) Nuffield noted that the importance of the level of corporate activity in any given hospital market has to be taken into account and suggested that the density of PMI policyholders could be used as an alternative to the density of population we used as a proxy measure for density of potential private patients. As noted above, although we consider that this may represent an alternative measure, we note that we do not have data on density of PMI policyholders by local authority to conduct such assessment, but after the provisional findings, we will assess the density of potential private patients by using location of private patients.

(c) In relation to our approach to the 16 specialties and oncology, Bupa noted that:

The CC's assumption of supply-side substitution across the 16 common specialisms was too strong, and as such the aggregation of specialisms would hide pockets of market power; certain specialisms outside those considered in the CC's analysis (the 16 common specialisms and Oncology) confer significant bargaining power [...]. On the basis of BHF's concerns, the CC should undertake its analysis at a specialism level. For example, this would illustrate that some of the "symmetric duopolies" identified by the CC had a high degree of asymmetry across specialisms.³⁴

In the context of a market investigation and on the basis of the considerations made in the market definition section, we have considered it appropriate to look at the 16 specialties largely together in our local assessment, with the exception of oncology which is considered separately. In central London, given the greater focus on high acuity and tertiary work relative to the rest of the UK, we have also looked at subsets

³⁴ Bupa response to AIS, section 2.

of these 16 specialties corresponding to more complex specialties and treatments.

(d) In relation to Greater London hospitals, Bupa noted that [REDACTED].³⁵ We have taken into account this consideration in our competitive assessment of individual hospitals located in Greater London.

(e) On the issue of whether two hospitals are sufficient,³⁶ AXA PPP noted that: ‘To the extent that there are two major hospitals in a moderately sized city, in a broadly symmetric duopoly, it will not always necessarily be the case that the PMI provider has to “stock” both hospitals. As such, the hospitals may (if offered individually) compete to be listed. [...] However to the extent that two hospitals in adjacent but separate cities compete with each other at a self-pay level, for example because people living between the two cities could “drive either way”, in the PMI context the insurer may still need to list one or both. [...]’ We have set out our approach in this respect in paragraph 6.113(b). In particular, unless we have seen evidence of competition (or potential competition), we do not regard two similar competitors to be sufficient.

6.116 Following the approach set out above, for each hospital of potential concern, we have assessed whether the competitive constraints exerted by each individual competitor private hospital or PPU as identified in paragraph 6.104 (as well as NHS hospitals where relevant) are strong, moderate or weak and whether these competitive constraints are in aggregate sufficient or not. For each hospital of potential concern, we have also assessed whether common ownership was a concern. We have considered the set of 16 specialties and oncology separately. Virtually all of the hospitals we have found to be facing insufficient competitive

³⁵ [REDACTED]

³⁶ In its comments, Bupa referred to some hospitals as being part of a duopoly. Bupa told us that operators could still be dominant within a duopoly market. Bupa noted that even in what it regarded as a multi-provider market, there could be hospitals of potential concern. Bupa stated that where it saw no need or desire for a continuing relationship with a particular hospital, this hospital might still be of significant importance to another PMI and the hospital may hold a dominant position for self-pay patients.

constraints are competing with, at most, either one strong or one moderate competitor. In many of these local areas, the hospitals are only competing with weak competitors. As noted in paragraph 6.113(a), hospitals are considered to be insufficiently constrained where they face competition from one or more weak competitors. As noted in paragraph 6.113(b), hospitals are considered to be insufficiently constrained where they are competing with one other strong competitor. In a small number of local areas (two), hospitals that are considered to be insufficiently constrained are competing with one strong and one moderate competitor. We reached the same view in a small number of local areas (three) where hospitals are competing with two moderate competitors. As noted in paragraph 6.114, this approach is supported by the evidence that links local concentration with price outcomes, including the results of our PCA presented in paragraphs 6.190 to 6.202, and our interpretation of what the parties told us and a review of the qualitative evidence as set out in paragraph 5 of Appendix 6.9.

6.117 As a result of the competitive assessments of individual hospitals, we have found 101 hospitals outside central London to be a concern. Out of 139 hospitals outside central London that were identified as hospitals of potential concern by the filters, we have identified 97 hospitals that the evidence indicates are subject to insufficient competitive constraints. We have identified a further four hospitals that were not identified by the filters, but the evidence indicates they are subject to insufficient competitive constraints. These hospitals allow us to identify local areas where there could be an AEC. Tables 6.1 and 6.2 below show the breakdown of individual hospitals and the results of our competitive assessments of hospitals outside central London, by hospital type and hospital operator respectively. Our competitive assessments and conclusions in relation to each hospital of concern are set out in Appendix 6.7. Appendix 6.6 shows the full list of individual hospitals considered in our analysis and the results of our competitive assessment.

TABLE 6.1 Results of competitive assessments of hospitals outside central London, split by hospital type

<i>Hospital type</i>	<i>Total hospitals</i>	<i>Hospitals of potential concern</i>	<i>Hospitals of concern, ie subject to insufficient competitive constraints</i>
General private hospitals	149	122	92
General PPU's	42	17	9
Specialised oncology hospitals	2	0	0
Total	193	139	101

Source: CC analysis.

TABLE 6.2 Results of competitive assessment of hospitals outside central London, split by operator

<i>Hospital operator</i>	<i>Total hospitals</i>	<i>Hospitals of potential concern</i>	<i>Hospitals of concern, ie subject to insufficient competitive constraints</i>
BMI	56	[REDACTED]	[REDACTED]
HCA	2	[REDACTED]	[REDACTED]
Nuffield	31	[REDACTED]	[REDACTED]
Ramsay	22	[REDACTED]	[REDACTED]
Spire	36	[REDACTED]	[REDACTED]
Other—general private hospitals	14	[REDACTED]	[REDACTED]
Other—general PPU's	31	[REDACTED]	[REDACTED]
Other—specialized oncology hospitals	1	[REDACTED]	[REDACTED]
Total	193	139	101

Source: CC analysis.

6.118 AXA PPP told us that the following additional hospitals were problems: [REDACTED]. Bupa said that the CC should further assess competitive constraints at the following additional hospitals: [REDACTED]³⁷ Nuffield identified additional hospitals that it believed met the CC's criteria for being of potential concern: [REDACTED]. Taking into account the evidence provided by the parties, we saw no reason to change our provisional view on these hospitals.

Competitive assessment of hospitals located in central London

6.119 We discuss here our assessment of competitive constraints in relation to hospitals located in central London. For the purposes of our analysis, we refer to 'central London' as the area inside the north and south circular roads, and 'Greater London'

³⁷ [REDACTED]

as the area outside central London but within the London Government Office Region.^{38,39} We use the term 'London' to refer to the combined areas of central London and Greater London.

6.120 Private provision of healthcare services in central London substantially outweighs any other single region of the UK. In sum, central London accounts for around 30 per cent of all UK private hospital revenue and the proportion is higher for inpatient revenue, at around 37 per cent. Central London also contains a significantly higher number of private hospitals than other regions in the UK, with 16 private hospitals and ten PPUs providing inpatient care. It is therefore of key importance to patients, PMIs and hospital operators.

6.121 There are 26 private hospitals and PPUs located in central London. These are as follows:

- (a) HCA operates eight hospitals: it owns seven private hospitals and manages one PPU;
- (b) BMI owns and operates four private hospitals;
- (c) Aspen owns and operates one private hospital;
- (d) there are four hospitals owned and operated by independents: the Bupa Cromwell Hospital, the Hospital of St John and St Elizabeth, the King Edward VII's Hospital Sister Agnes, and TLC; and
- (e) there are nine PPUs (excluding the PPU managed by HCA) owned and operated by several NHS trusts.

³⁸ Government Office Regions are defined by the ONS and a map can be found at: www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/maps/index.html.

³⁹ In terms of private hospital and PPU locations, our definition of central London and greater London coincides with the NUTS2 regions 'Inner London' and 'Outer London', respectively. NUTS stands for 'Nomenclature of Territorial Units for Statistics' and is a delineation of geographic areas developed and regulated by the EU. There are three NUTS delineations, from NUTS1 (most aggregated) to NUTS3 (most disaggregated). A map of UK NUTS regions can be found at: www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/maps/index.html.

6.122 In the OFT reference, it was noted that PMI and hospital operators had raised concerns in relation to the London area.⁴⁰ We have also received a significant number of complaints from industry participants about the perceived lack of competition between private hospital operators in central London. These complaints have come from PMIs, but also from certain hospital operators. The complaints have typically cited the lack of competition and the strong market position of HCA.

6.123 In our assessment of competitive constraints in relation to central London hospitals we have adopted, in many respects, a similar approach to that used in our competitive assessment of hospitals in the rest of the UK. However, given the importance of the central London area to PMIs and patients and the extent and types of the complaints we have received in relation to it (eg high acuity treatments and vertical integration), our assessment has addressed these concerns, eg high acuity treatments and vertical integration. In particular, as set out in the remainder of this section, we have considered:

- (a) shares of supply (including by specialty), shares of capacity and competitive constraints currently exerted by private hospitals and PPUs located in central London on each other. We have in particular considered the different strength of the competitive constraints exerted by these hospitals on each other on the basis of their product offer (in particular, whether and to what extent they provide certain specialties and complex treatments) and their respective locations. We have also considered factors that may reinforce the existing constraints; and
- (b) competitive constraints exerted on private hospitals and PPUs located in central London from outside the market, in particular by private hospitals and PPUs located in Greater London and by NHS hospitals, where we have received evidence that they represent a constraint.

⁴⁰ OFT, 'Private Healthcare Market Study', April 2012.

- *Competitive constraints by private hospitals and PPU's in central London*

- 6.124 We have considered the shares of supply of private hospitals and PPU's located in central London. Shares have been measured by patient admissions (inpatient only and inpatient plus day-patient) and revenue (inpatient only and total). Our analysis has been conducted at an aggregated level (all specialties and treatments), and at several disaggregated levels (eg by specialty). Hospitals belonging to a single operator have been considered together.
- 6.125 Our analysis of shares of supply at the aggregated level indicated that central London is a highly concentrated market and that HCA has high shares of supply relative to its competitors. HCA has a share of supply in central London above 45 per cent by admissions (inpatient and inpatient plus day-patient) and above 55 per cent by revenue (inpatient and total). On the basis of total admissions, the hospital operators with the next largest shares are: TLC ([10-15] per cent), BMI ([5-10] per cent) and Bupa Cromwell ([5-10] per cent). Also on this basis: all other private hospital operators have a share below 5 per cent; the nine PPU's each individually have shares below 5 per cent; and, the nine PPU's collectively have a share of [10-15] per cent. The results are similar for shares on the basis of inpatient admissions, inpatient revenue, and total revenue.
- 6.126 Our disaggregated analysis evaluated shares of supply for individual specialties, and also in segments of the central London market that may be indicative of the more complex, specialised or high acuity work. These segments are: the more complex specialties (ie cardiology and oncology), hospitals that have critical care level 3 beds

(ie that can offer the highest level of intensive care), and tertiary treatments (ie those that require a referral from one consultant to another consultant).⁴¹

- 6.127 Our disaggregated analysis indicated that HCA has a high share of supply in many specialties, and that HCA's share is particularly high when considering the complex segment of the central London market. In particular, it showed that:
- (a) HCA has the highest share by admissions in 12 of 17 specialties;
 - (b) HCA has a share by admissions of over 40 per cent in 11 of 17 specialties;
 - (c) HCA has a share by admissions of over 55 per cent in each of the four most common specialties ([60-70] per cent in oncology, [60-70] per cent in trauma and orthopaedics, [50-60] per cent in gastroenterology, [60-70] per cent in obstetrics and gynaecology);
 - (d) HCA has a share of over 60 per cent in specialties that might be considered more complex (ie oncology and cardiology);
 - (e) HCA has a share by admissions of over 50 per cent when considering only those central London providers that have critical care level 3 beds (ie slightly higher than when considering all central London providers); and
 - (f) HCA has a share by inpatient admissions of over 60 per cent in tertiary treatments.

- 6.128 In relation to providers other than HCA, our disaggregated analysis showed that TLC, for most measures, has the shares of supply that are closer to HCA than other hospital operators. For example, TLC has the second largest share by admissions, after HCA, in three specialties (gastroenterology, urology, clinical radiology), a share by admissions of [10-20] per cent among providers that have critical care level 3

⁴¹ Our definition of tertiary treatments is based on information provided by Spire, who provided us with a list of tertiary treatments performed at their hospitals. Spire noted that there are a number of different approaches to defining tertiary care and that the provision of this information necessarily involved an element of subjective judgement by the individual Hospital Directors because there is no universally accepted definition of tertiary care and individual Hospital Directors may have different views on what amounts to tertiary care at their hospitals.

beds, and a share by inpatient admissions of [10-20] per cent in tertiary treatments. TLC shares, by most measures, are, however, substantially smaller than HCA shares and in several cases they are below one-third of the HCA share. We note that TLC has the largest share by admissions in three specialties (ophthalmology, oral and maxillofacial surgery, otolaryngology). Other providers typically had shares by admissions that are even lower than TLC, and are below 10 per cent for most individual specialties,⁴² among providers that have critical care level 3 beds, and for tertiary treatments.

6.129 We have also analyzed the capacity of central London hospitals. We considered four measures of capacity: number of overnight beds, number of theatres, number of consulting rooms and number critical care level 3 beds. PUs have not been included in this analysis because we do not have reliable information about the capacity at NHS hospitals that is dedicated to private patients.

6.130 The results of our share of capacity analysis support the results of our shares of supply analysis. HCA owns over [50] per cent of private hospitals' overnight bed capacity in central London. The results are similar for theatres (over [45] per cent) and consulting rooms (over [50] per cent). In the case of critical care level 3 beds, HCA has an even higher share of private hospitals' capacity, at over [65] per cent. The second largest operator in terms of private hospitals' capacity is TLC which accounts for [10-20] per cent of overnight beds, [10-20] per cent of theatres, [10-20] per cent of consulting rooms, and [10-20] per cent of critical care level 3 beds. The third and fourth largest providers by private hospitals' capacity are BMI and Bupa Cromwell.

⁴² BMI is the exception to this and has a share by total admissions above 10 per cent in six of 17 specialties (trauma and orthopaedics, general surgery, urology, anaesthetics, otolaryngology, and rheumatology).

6.131 In response to our capacity analysis, HCA has provided calculations showing that there is sufficient capacity at non-HCA hospitals to absorb the volume of AXA PPP or BUPA patients currently treated at HCA hospitals. They have calculated the number of Bupa and AXA PPP patients admitted to HCA facilities on an 'average day', and compared this level of admissions to the total number of beds in non-HCA hospitals in central London. They also submitted a similar analysis in relation to beds for critical care level 2 and 3. HCA concluded that non-HCA hospitals in central London could 'easily absorb' the number of Bupa and AXA PPP patients admitted to HCA hospitals on an average day. HCA told us that the Bupa Cromwell alone had 118 beds and that their Bupa patient average daily census for all HCA hospitals in central London was [REDACTED].

6.132 We do not consider HCA analysis to demonstrate that substitution between HCA and non-HCA hospitals is feasible for AXA PPP and Bupa for the following reasons. First, even if there was sufficient capacity at alternative hospitals, the current shares of supply suggest that patients do not see the non-HCA hospitals as substitutes for HCA hospitals. Second, the HCA analysis takes no account of: the existing number of patients in rival hospitals (reducing the amount of available capacity); the availability of consultants to perform procedures; and the capacity situation at peak times of year.

6.133 The parties in this investigation have commented on the competition between HCA and other providers in central London. Several parties specifically highlighted TLC. AXA PPP described TLC as the only non-HCA 'must have' hospital for their large corporate clients in London. HCA stated that TLC and Bupa Cromwell were 'probably the most formidable competitors' that they faced in Central London. TLC argued that 'there are seven elite hospitals in London' and that this consisted of TLC (one hospital) and HCA (six hospitals).

6.134 On the basis of our shares of supply analysis described above, we consider central London to be a highly concentrated market. Our analysis of hospital operators' shares of capacity also supports this. The shares of supply indicate that patients (and PMIs that represent their policyholders) do not see non-HCA hospitals, including private hospitals and PPU, as good substitutes for HCA hospitals. Limited substitutability will weaken the competitive constraints that HCA faces.

6.135 The differentiated nature of healthcare provision in central London suggests that substitutability should also be considered across a number of dimensions, including product offer and location. As our disaggregated shares of supply shows, HCA has an even stronger position when considering the most common specialties and the more complex specialties and treatments. TLC is HCA's closest competitor but it is substantially smaller than HCA. With regard to location, we note that HCA hospitals are well-located and near important areas of central London (eg Harley Street, the City of London) while non-HCA hospitals are not all located in comparable areas. TLC is located very close to HCA Harley Street hospitals, but, for example, Aspen and two of the larger BMI hospitals (Blackheath, London Independent) are located outside central London's inner transport network (ie, zone 1) and Bupa Cromwell is on the fringe of this network. Thus, with regard to product offering and location, the degree of substitutability between HCA and certain rivals is particularly limited.

6.136 There are other factors that may limit substitutability between HCA hospitals and its rivals, for example brand, reputation and patient perceptions. These may limit patient (and PMIs which represent patients) switching to (or searching for) alternative

hospitals. We also note that certain PMIs have contractual clauses with HCA that make it more difficult for them to signal the higher cost of HCA hospitals.⁴³

6.137 On the basis of the points highlighted above, we consider that HCA faces weak competitive constraints in central London. It is our view that HCA's closest competitor is TLC, which has the second largest share of supply and capacity and is centrally located, but that even TLC only represents a weak constraint, on account of its capacity which is between two and three times smaller than HCA.

6.138 HCA has argued that it faced competitive constraints from PPUs, and that PPUs were set to expand in the near future. HCA has also highlighted that PPU capacity was not reflected in our analysis of shares of capacity, and that, according to Laing & Buisson, PPUs accounted for 25 per cent of total bed capacity in central London. In response to this, we note that our patient survey showed patients typically do not view PPUs as a substitute for private hospitals.⁴⁴ This is supported by the shares of supply analysis discussed above. Thus, regardless of the level of capacity that PPUs have, it does not appear that patients see these as substitutes to HCA hospitals (and in general, private hospitals).

6.139 Regarding the expansion of PPUs, we discuss this issue in more detail in Appendix 3.1 but note here that: we have not seen evidence to suggest the expansion of PPUs would alter patients' perceptions; the extent of PPU expansion remains uncertain; and, the expansion would have to be very significant to fundamentally alter the results of our analysis described above. In addition, we also note that HCA currently manages one PPU in central London, and may be successful in winning further tenders for PPU contracts in the future, as its higher profits in central London may

⁴³ See section 'New networks and adjusting network composition' in Appendix 6.11.

⁴⁴ When asked 'Had the hospital you attended not been available (eg say it had closed down), which other hospital would you have used?' only 10 per cent of patients answered a PPU. See CC patient survey, question D6, slide 48.

allow it to outbid its rivals for PPU contracts in the same area. This would only further strengthen HCA's position in central London.

6.140 HCA has also argued that it faces competitive constraints from outside central London and from the NHS. We have received very limited evidence in either regard. In relation to Greater London providers, our analysis in Appendix 6.10 shows that patients resident in central London rarely travel for treatment to Greater London hospitals. This suggests that patients in central London do not see hospitals in Greater London as good substitutes for hospitals in central London. In relation to the NHS, as noted above in relation to the rest of the UK (see paragraph 6.112(g)), we do not find that the evidence shows that NHS hospitals act as a competitive constraint on any of HCA's private hospitals.

6.141 We have also considered other existing factors that may reinforce HCA's position in central London. In particular, we have considered the role of vertical integration between HCA and certain GP practices. As set out in our ToH7, vertical integration of this nature has the potential to affect horizontal competition between hospital operators in central London. This could happen if the vertically integrated hospital operator could influence the referral patterns of GPs, such that its rivals' hospitals can be foreclosed from patients. We have found that currently these vertical relationships between HCA and GP practices are limited in scale (ie account for a small proportion of private and NHS GPs that refer patients to HCA hospitals), and do not appear to have influenced GP referral rates (ie they have remained similar before and after the HCA acquisitions). This evidence did not indicate that it was likely that vertical integration is currently leading to significant harm. However, we note that the ownership of GP practices is likely to reinforce HCA's current position (for example, by resisting attempts by PMIs to direct patients away from HCA,

particularly with respect to key corporate clients) and that further acquisitions of GP practices would only further strengthen HCA's current position.

- *Conclusions on competitive constraints faced by HCA in central London*

6.142 We consider the central London market to be highly concentrated. Our analysis suggests that the competitive constraints currently exerted on HCA by other private hospital operators and PPUs in central London are weak. PPUs in central London, in particular, appear in aggregate to be a weak constraint, and the future expansion of PPUs does not appear likely to substantively change this conclusion. We have also considered Greater London hospitals and the NHS, and consider these to impose weak competitive constraints on HCA.

6.143 It is also our view that HCA position in central London can also be potentially reinforced by any ability it has to outbid its competitors for future PPU management-contracts, and any ability to acquire further GP practices. It has achieved both of these outcomes in the recent past. If HCA continues to be successful in these regards, by winning further PPU management-contracts and acquiring GP practices in central London, then it is likely that its market position will be strengthened.

Conclusions on local competitive constraints (including concentration)

6.144 Having undertaken our local competitive assessments, we concluded that the competitive constraints currently exerted by private hospitals and PPUs on each other at the local level are likely to be insufficient to prevent hospital operators from exercising unilateral market power in a number of areas of the UK, including central London. On the whole, we did not find that the evidence indicated that NHS hospitals are an effective competitive constraint on any of the private hospitals under analysis.

Bargaining between PMIs and hospital operators

Introduction

6.145 In this section we examine how hospital operators and PMIs negotiate the charges to be paid by PMIs for hospital services. This is of particular relevance to our third theory of harm: market power of hospital operators during national negotiations with PMIs.

6.146 Contracts between a hospital operator and a PMI are typically the product of bilateral negotiations where an agreement is reached over price and the terms on which the parties will trade with each other. There is normally a principle contract that governs the relationship between a hospital and a PMI. In the case of smaller PMIs, this is often a loose annual agreement that is focused on the price of particular services. In the case of the larger PMIs, this is usually a more detailed multi-year contract that along with prices sets a number of detailed conditions. In some cases this may be augmented by smaller separate agreements covering a new policy or specific services.

6.147 Contracts between hospital operators and PMIs do not generally specify a volume of business. Thus when a PMI agrees a contract with a hospital operator it is not generally obliged to place any particular volume of business with that operator; indeed typically once a contract is in place the use of the hospital may depend less on PMI decisions than on referral decisions by GPs, patient choices and consultant working patterns or advice. However, as discussed later, PMIs may affect the use of a hospital or set of hospitals by guided referrals, use of restricted networks and delistings, and hospital operators offer discounts to encourage increased use of their hospitals. (See paragraphs 6.161 et seq, 6.171 et seq. and 6.176 et seq.)

The parties' views on negotiating strength

6.148 PMIs told us that their negotiating positions were driven by the nature of each hospital operator's portfolio of hospitals, in particular the number, where they are

located and the competitive conditions in each area. Ownership of key hospitals in locations that PMIs require access to in order to offer an attractive insurance product to customers, in particular corporate customers, provide hospitals with a degree of negotiating leverage.

6.149 Bupa argued that its analysis showed that [REDACTED] were ‘must have’; it also thought [REDACTED] owned significant number of ‘must have’ hospitals.⁴⁵ Bupa stated that a hospital operator’s bargaining power stemmed not just from the number of ‘must have’ hospitals within its portfolio but also the importance of these hospitals, in particular their impact on corporate accounts.⁴⁶ [REDACTED]

6.150 AXA PPP argued that there were some hospitals in London that it regarded as ‘must have’ for servicing corporate customers which had employees in the South-East. These hospitals were distinguishable on the basis of their professional reputation (both in terms of facilities and/or consultants) and the broad range of treatments undertaken.⁴⁷ Six of the seven hospitals it identified were operated by HCA. AXA PPP also stated that the number and proportion of ‘solus’ hospitals owned by BMI outweighed AXA PPP’s bargaining power. Although it did not think BMI had sought to leverage its very strong position, it was concerned that it could do in the future.⁴⁸

6.151 Aviva also told us that the number of ‘must have’ hospitals mattered as an operator with a strong portfolio of hospitals could take steps that would disadvantage the PMI in the event of a dispute.⁴⁹

⁴⁵ [Bupa response to the IS](#), paragraph 5.31.

⁴⁶ [Bupa response to the AIS](#), p28.

⁴⁷ [AXA PPP response to the AIS](#), paragraph 2.6.

⁴⁸ [AXA PPP response to the AIS](#), pp3 & 20.

⁴⁹ [Aviva response to IS](#), paragraphs 1.16 & 1.17.

6.152 Hospital operators told us that PMIs had substantial buyer power and that hospital operators were highly dependent on PMIs.

6.153 Hospital operators rejected the proposition that PMIs might be constrained in their ability to steer patients as a result of limited choice of alternative hospitals in a particular area.⁵⁰ They argued that there was generally sufficient alternative provision in the areas where they operated and their hospitals could not reasonably be characterized as being essential ('must have') to PMIs.^{51,52} The hospital operators also argued that even if there were areas with relatively few alternative providers there was little they could do to take advantage of this in negotiations.

6.154 In response to PMIs' complaints that hospital operators tended to threaten to raise prices in response to any reduction in volume, several hospital operators argued that this was simply because price was closely tied to volume.⁵³ The high fixed costs required to provide hospital services meant that a loss in volume would result in an increase in unit costs.

Relative bargaining strength

6.155 The relative strength of parties' positions in negotiations depends upon their options if an agreement is not reached (their 'outside options'). The outside options for the PMIs are the other hospitals they could use to replace those hospitals they currently use or are contemplating using. (For example, how would Bupa replace a particular BMI hospital or a set of BMI hospitals?) The outside options for the hospital operators are alternatives business to replace that they currently have or are contemplating. (For example, how would BMI replace lost Bupa business?) Other things being equal, PMIs will pay higher (lower) prices the weaker (stronger) their outside options.

⁵⁰ [Spire response to AIS, paragraph 4.20.](#)

⁵¹ [HCA response to IS, paragraph 10.21.](#)

⁵² [Ramsay response to AIS, paragraph 7.15.](#)

⁵³ For example, [HCA response to AIS, paragraph 5.31.](#) [BMI response to AIS, paragraph 8.8\(a\).](#)

The relationship holds for hospital operators—they will receive higher (lower) prices the stronger (weaker) their outside options.

6.156 The possibility of ‘delisting’ of one or more hospitals by a PMI is an important potential option. PMIs and hospital operators have different views of the viability and effectiveness of delisting.

6.157 The PMIs’ assessments⁵⁴ of their bargaining positions when a delisting is being contemplated are typically influenced by a detailed assessment of the local competitive conditions of each hospital. In particular they assessed:

- (a) the availability and suitability of alternative hospitals for each hospital which the PMI may consider delisting in the event of a dispute;
- (b) the cost of sending patients to these alternative hospitals, taking into account the terms that would apply or could be agreed; and
- (c) any anticipated increase in price imposed by the hospital operator that faces having some of its hospitals delisted at any hospitals retained on the network. For example, at hospitals the PMI thinks it cannot delist as there are no alternatives nearby.

6.158 Hospital operators also seek to assess the strength of the PMI’s negotiating position and we identified several instances where hospital operators attempted to consider the strength of the PMI’s position by a detailed consideration of the above issues, with a particular focus on the extent their hospitals faced competitive alternatives.

6.159 Both hospital operators and PMIs also consider the effects of delisting on the hospital operator. Hospital operators appear most unlikely to be able to replace any lost business rapidly and would be severely impacted by delisting. The most immediate

⁵⁴ As well as the submissions of the parties we also reviewed many of their internal documents relating to negotiation. This analysis draws upon that review (see Appendix 6.11).

effect would be loss of revenue. The potential loss of consultants, who will normally wish to continue to be able to treat the PMI's policyholders, is also a major issue.

6.160 We are only aware of one example of a PMI removing a group of hospitals from all of its networks as a result of failing to reach an agreement over a revised contract. This stemmed from negotiations between BMI and Bupa in 2011. The contract (initially signed in 2008) expired on 31 December 2011 and despite protracted negotiations no agreement was reached, resulting in Bupa removing 37 BMI hospitals from its hospital networks. An agreement between Bupa and BMI was later reached and Bupa reinstated most, but not all, of the BMI hospitals in its networks.

- *Threats of delisting*

6.161 Hospital operators stated that the risk that a PMI might remove their hospital(s) from its network(s) was likely to strongly influence the outcome of a negotiation. Most hospital operators argued that the threat of delisting was a credible and powerful threat used by PMIs, [REDACTED]. They argued that were they to face a 'full delisting' this could have [REDACTED].⁵⁵ Given the volume of revenue they represent hospital operators argued that it was essential to be included on both Bupa and AXA PPP's networks. Hospital operators also point to the difficulty of retaining consultants in the event of a delisting—consultants will wish to be able to treat as many potential patients as possible, so loss of a PMI's recognition will encourage consultants to use other hospitals.⁵⁶ BMI also told us that this could continue after the hospital was relisted.^{57,58}

⁵⁵ [REDACTED]

⁵⁶ [Spire response to AIS](#), paragraph 4.22. [Nuffield response to IS](#), paragraph 3.36.

⁵⁷ [BMI response to AIS](#), paragraph 8.7.

⁵⁸ [BMI response to AIS](#), paragraph 8.7.

6.162 Spire told us [REDACTED].⁵⁹ Spire also said that if a hospital operator was delisted from a major PMI's network there would be little action it could take to mitigate the effect and replace lost PMI business.⁶⁰ Ramsay told us that the high fixed costs of hospitals give the delisting threat a significantly disciplining effect.⁶¹

6.163 Several hospital operators also argued that the recent Bupa delisting of BMI significantly enhanced Bupa's reputation and the credibility of any threat to delist.⁶² HCA pointed out that Bupa has publically stated that it intended to continue to exclude hospital operators that it regards as too expensive.⁶³ BMI argued that this extended to other PMIs, noting that if Bupa could redirect a very high proportion of BMI's volume so could other PMIs.⁶⁴

6.164 PMIs argued that in practice delisting could seriously damage their business. As well as the risk that the hospital would take retaliatory action (for example increasing prices charged at 'must have' hospitals as discussed in paragraph 6.157(c) above) they argued that it damaged their position in the market for private medical insurance. They argued that negative publicity was damaging to their sales. They also argued that corporate customers wanted access to a full range of hospitals. These customers considered that it was the PMI's job to provide this access and that the PMI was failing if it failed to do so, for whatever reason.

6.165 Bupa argued that its delisting of BMI hospitals in 2011 was exceptional and depended critically on the circumstances of that particular negotiation and BMI's financial difficulties at the time.

⁵⁹ [REDACTED].

⁶⁰ [Spire response to AIS](#), paragraph 4.11. [HCA response to IS](#), paragraphs 10.54-10.63.

⁶¹ [Ramsay response to AIS](#), paragraph 7.9.

⁶² [Spire response to AIS](#), paragraph 4.35. [HCA response to AIS](#), paragraph 5.49.

⁶³ [HCA response to AIS](#), paragraph 5.129.

⁶⁴ [BMI response to AIS](#), paragraph 8.13.

- *Our view*

6.166 With regard to the 2011 delisting:

(a) it appears likely to us that both BMI and Bupa suffered substantial direct damage from the 2011 delisting; however, it is not possible to evaluate what net benefit Bupa derived from the delisting, especially as reputational effects are difficult to ascertain and the signalling of its willingness to carry out a delisting could be expected to have an effect on future negotiations with BMI and other large hospital operators;

(b) this is the only example cited to us of a major delisting; and

(c) the ability of Bupa to carry out a delisting does not tell us much about the ability of other PMIs to do so, particularly the smaller PMIs; we are not convinced that this was a unique opportunity for Bupa but we do think that the financial strength or weakness of a hospital operator would have a strong bearing on the outcomes of a delisting and therefore on the credibility of it as a threat.

6.167 It is not possible to predict the outcome of future negotiations, or who generally holds the upper hand in negotiations, on the basis of this one delisting event. However, we found the way that PMIs and hospital operators plan for potential delistings to be informative about the factors that PMIs and hospital operators consider to be important in negotiations. In particular we found that local factors were very important. (See Appendix 6.11.)

6.168 Bupa's conduct in the BMI dispute appeared intended to inflict substantial and rapid pressure on BMI, in order to achieve a satisfactory renegotiation before suffering too much reputational damage with its policyholders and potential new customers. As such this delisting does not indicate that all of the BMI hospitals that were delisted were dispensable to Bupa in the medium or long-term or that they have no market power. In order to maximize the effect of Bupa's actions in this example, including the

reputational effect with the hospital operators, it would be beneficial to Bupa to delist some BMI hospitals with market power. In planning for such a dispute the financial strength or weakness of the hospital operator appears to us to be very relevant. However, although Bupa doubtless felt that it was a favourable moment to delist BMI we are not convinced that the circumstances were unique.

6.169 The major PMIs and the major hospital operators are dependent upon each other. It does not appear to us that either side anticipates that it would survive without substantial damage in the event of a complete delisting. In our view the credibility of the delisting threat depends upon the relative strengths of the PMI and hospital operator and their ability at the relevant time to 'hold out' and not be forced back to the negotiating table.

6.170 In the case of a PMI the credibility of that threat is likely to be enhanced the larger it is, as this would mean that more volume is potentially at risk at any hospitals that were to be delisted. In the case of a delisting by the largest PMIs the risk that consultants may choose to move their practice to a different site also appears to be real. However, the more hospitals that a hospital operator owns in areas where there are limited competitive alternatives, and where there were significant number of PMI customers, the stronger its bargaining position will be. Where there is a lack of hospital competition even a threat by the largest PMI to delist is unlikely to be a credible constraint. We did not see any evidence to suggest that the number of hospitals owned by the hospital operator was in itself a significant factor in negotiations.

Restricted networks

6.171 Where PMIs operate relatively restrictive networks they have more scope to adjust these whilst maintaining satisfied customers who recognize that they have foregone

some choice in exchange for other benefits (typically a lower price). However even in these circumstances PMIs still need to be able to offer an acceptable range of hospitals.

6.172 One important form of restrictive network involves exclusion of many central London hospitals (often HCA hospitals) which tend to be more expensive to use. Such policies include AXA PPP's Pathways product (for corporate customers) and the Aviva 'Key' network list. Whilst our review of employee PMI schemes highlighted that policies which enable corporate clients to contain costs, including those referred to above, appear to be growing in attractiveness among corporate customers, many corporates do require policies to allow access to a wide range of London hospitals. (See Appendix 2.1.)

Strategic recognition of new facilities

6.173 Where hospital operators purchase or build a new facility they will have to seek separate approval of each PMI in order to have the hospital added to the PMI's networks. The PMI may seek to withhold recognition if it perceives that by doing so it can secure improved terms in return for recognition. However in some cases contracts between PMIs and hospital operators specify how price and/or recognition will apply in the event of a hospital operator making an acquisition.

6.174 Several hospital operators have made representations about PMIs' strong negotiating position where a hospital operator asks a PMI to recognize a new facility that was not previously included on the hospital network.⁶⁵ BMI said that given the risks of PMIs refusing to recognize a facility once a hospital provider had sunk

⁶⁵ [Spire response to AIS](#), p32.

investment to create or purchase it was expected that providers would seek terms to mitigate this.⁶⁶

6.175 We agree with the hospital operators that the PMIs generally have a relatively strong negotiating position under these circumstances.

Guided referral

6.176 The more flexibility and control a PMI can exert over where a given policyholder is treated and thus the quicker they can reward low-cost hospitals with more patients, or withdraw patients from high-cost facilities, the better their bargaining position is likely to be. Guided referral processes may allow PMIs to strengthen their negotiating positions.

6.177 Hospital operators told us that guided referral was a growing trend in the market and was highly significant. Hospital operators told us that guiding in this way was no longer 'new' with AXA PPP and Bupa both now having established open referral policies offered to corporate customers. HCA noted that our review of corporate clients suggested there was strong support for open referral.⁶⁷

6.178 Bupa told us that its open referral service launched in 2011 improved the incentives of hospitals and doctors to compete. It said that while the service was receiving very positive feedback from customers, it was facing significant resistance from some providers. Bupa argued that the service was still in its infancy and was not yet on a scale to provide effective discipline on hospitals.⁶⁸ Bupa also said that open referral was likely to be of limited use if a single hospital operator dominated a local area.

⁶⁶ BMI response to AIS, p36.

⁶⁷ HCA response to AIS, paragraph 5.135.

⁶⁸ Bupa response to IS, paragraph 1.81.

6.179 Guided referral policies are becoming more established and more common. We have seen some evidence of guided referral being cited by some PMIs in negotiations and internally some hospital operators have expressed concern about how it could improve PMI bargaining positions. We have also seen examples where some PMIs have negotiated preferential rates for directing open referrals to specific hospital operators. However, we have seen no evidence that PMIs have successfully used this device to divert significant numbers of patients from or to specific operator's hospitals. Thus whilst it may have the potential to change the balance of negotiating power, we do not think that this has happened yet to any significant degree. Moreover, it is not clear whether guided referral policies will gain widespread customer acceptance and whether in practice they will strengthen substantially the PMIs negotiating positions.

One in, all in negotiations

6.180 Bupa told us that hospital operators negotiated in such a way that if a PMI wanted to use certain of hospital operator's hospitals it would be penalized unless it also recognized all of that operator's other hospitals. Bupa said that this could arise as the result of hospital operators increasing their rates disproportionately in response to a reduction in volumes; if prices at other hospitals were increased substantially as a result of excluding a hospital then it might never be worthwhile for a PMI to exclude a hospital.

6.181 [REDACTED]

6.182 Other PMIs also stressed that were they to exclude some of the hospitals owned by the large hospital operators on their network, they would expect to face price rises at any 'must have' hospitals that remained on the network. This they argued

discouraged them from taking such steps, even in areas where there may be a cheaper provider that they would prefer to encourage patients to use.

6.183 Hospital operators forcefully denied Bupa's claim, saying that they did not insist on 'one in all in negotiations' and that there was no evidence to support Bupa's contention.

6.184 As noted earlier (see paragraph 6.154), hospital operators told us that such increases resulted from the high proportion of fixed costs that a hospital operator faced. In addition [✂].

- *Our view*

6.185 Hospital operators do typically seek to have all of their hospitals recognized. In negotiations, hospital operators that were not recognized, or only recognized on certain products, would often seek recognition for these hospitals. It is also clear that volume plays a role in hospital operator/PMI negotiations. In the negotiations we have reviewed pricing is often explicitly linked to, or justified, on the basis of the total volume of patients a PMI can deliver across a hospital operator's portfolio. For this reason hospital operators were also sensitive to the effect of a PMI recognizing rivals' hospitals that might affect revenue drawn from local markets. Although contracts with PMIs do not contain explicit volume commitments, hospital operators will seek as full recognition for as many of their facilities as possible, often reinforced by pricing mechanisms designed to incentivize additional volume. Our examination of the factors determining the prices charged by hospital operators to PMIs is set out in paragraphs 6.230 to 6.242.

6.186 All the volume discount schemes we have reviewed appear designed to reward the PMI for growing its volume across the whole portfolio of hospitals. We have not found

any schemes of the major hospital operators that rewarded a PMI for growing its business at specific sites. By rewarding incremental growth relative to total national volumes in this way, the hospital operator creates an incentive to maximize recognition for a given operator and a disincentive to recognize rival hospitals.

6.187 As noted in paragraphs 6.157 and 6.158 we have seen that a factor PMIs and hospital operators take into account internally when contemplating a possible delisting is whether prices will be higher if the PMI only allows policyholders to access some of the hospital operator's hospitals. The fact that the best price is likely to be achieved where the PMI includes the full portfolio of hospitals on its network creates a strong incentive for full recognition being the default outcome of a negotiation. Consistent with this we note that there are relatively few examples where the major PMIs do not recognize the full portfolio of the major hospital operators on at least some of their networks. In the case of the BMI/Bupa price schedule [X].

Conclusions on bargaining

6.188 In addition to our view on delisting and 'one in all in negotiations' (see paragraphs 6.166 to 6.170 and 6.185 to 6.187 respectively), we conclude that there are a number of factors that are important in the negotiations between hospital operators and PMIs: the number of hospitals, their locations and the competitive conditions in each area. The hospital operators and PMIs differ in their views on the ability of the PMIs to steer patients to alternative hospitals. These same factors are also important when PMIs and hospital operators are considering the threat of delisting and restricted networks.

6.189 We did not find that the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power. PMIs do have scope to take some business away from hospital operators, but that does not of itself

constitute buyer power. Under certain circumstances the scope to delist hospitals, because of the potential damage to a hospital operator, could give a PMI buyer power. However delisting is damaging to a PMI and is not an option that can be freely used. The evidence does not indicate that it is a realistic option for any PMIs other than the largest (Bupa and AXA-PPP) and it does not indicate that for these PMIs the bargaining strength conferred amounts to fully countervailing buyer power. Other things being equal, PMIs will pay higher (lower) prices the weaker (stronger) their outside options. The relationship holds for hospital operators—they will charge higher (lower) prices the stronger (weaker) their outside options. The evidence shows that where there is a plurality of hospitals in a local area, to the extent that these are reasonable substitutes, PMIs consider their outside options to be stronger.

Market outcomes self-pay prices

6.190 We have considered whether prices charged to self-pay patients indicate that private hospitals have market power at the local level. This may happen in local areas where private hospitals face fewer competitive constraints (and concentration is higher). If this is the case then, all else equal, we expect to observe higher prices in such areas. It would also imply that self-pay prices may fall if more competition were present in certain local areas.

6.191 Our understanding of the industry and our review of the qualitative evidence suggests that such outcomes are likely to be the case. In particular, hospital operators have told us that self-pay prices are set locally and with the local competitive conditions in mind. We have also found support for this in internal documents, including business plans, results of mystery shopping exercises, and in specific guidance for setting self-pay prices. In one example we were told of self-pay prices being reduced directly in response to market entry.

6.192 To statistically test the hypothesis that prices charged to self-pay patients are higher in areas where private hospitals face fewer competitive constraints, we have undertaken a regression analysis. This is also known as price-concentration analysis (PCA). The term concentration refers to the use of ‘concentration measures’ that reflect the likely competitive constraints present in a local area—more concentrated local areas are expected to be less competitive, and the firms present in these areas may have a degree of market power. Regression analysis is a standard statistical technique for testing and quantifying the relationship between two variables. A key merit of this approach is that it allows for the influence of other factors to be taken into account so that a like-for-like comparison is achieved. We set out the details of this analysis in Appendix 6.9.

6.193 We have analyzed the self-pay prices of four specific treatments received by patients at hospitals owned by the five main hospital operators over the period 2009 to 2012. The four treatments are: hip replacement, knee replacement, prostate resection and gallbladder removal.⁶⁹ We consider these treatments to be representative of the inpatient treatments received by self-pay patients. They account for almost 60 per cent of acute inpatient episodes in our cleaned dataset, and over 60 per cent of revenue.

6.194 In our analysis we have used a measure of price defined as the amount paid by a self-pay patient for the inpatient hospital services (excluding the cost of consultant fees and ancillary items) associated with the specific treatment received during a single hospital visit. To measure the local competitive conditions facing each hospital, we have used two concentration measures and these are the same as those we adopted in our initial filtering exercise (see paragraphs 6.95 and 6.96). One

⁶⁹ In an earlier version of this analysis we had considered eight treatments. Following comments made by the parties, we have excluded four of these original treatments from our analysis. See Appendix 6.9, footnote 14.

concentration measure is based on a hospital's (weighted average) share of self-pay patients in the areas it serves and we refer to this as LOCI. The other concentration measure is based on the number of rival hospital fascia in the local area (defined according to three different distance radii) and we refer to this as fascia count.⁷⁰

6.195 We have used the regression analysis to evaluate the relationship between these self-pay price and concentration measures. This analysis accounts for the influence of factors that may influence self-pay prices and may also be related to local concentration. Such factors have the potential to distort our analysis. Our analysis has accounted for factors that include: period of time, hospital operator, treatment received, patient characteristics, hospital direct costs and local supply and demand conditions. We have also considered the possibility that additional factors that are not observed in the data may also distort our analysis (referred to as an endogeneity issue). We have modified our analysis to take into account these unobservable factors, and we are satisfied that the results are reliable in this regard.

6.196 The results of our analysis show that there is a causal relationship between self-pay prices and local concentration and that, all else equal, self-pay prices are higher in more concentrated local areas. This conclusion is the same when we use either of the two concentration measures.

6.197 Our analysis also provides estimates of the strength or magnitude of this relationship. We have estimated that hospitals facing one additional rival fascia (within a nine-mile radius) or, similarly, hospitals with a lower weighted-average market share by around 20 per cent,⁷¹ are expected to charge self-pay prices that are, on average, between 2

⁷⁰ In an earlier version of this analysis we had used on a LOCI measure based on hospitals' shares of insured patients. Following our further analysis and arguments put forward by the parties, we have adopted a LOCI measure based on hospitals' shares of self-pay patients. We note that the two measures are highly correlated.

⁷¹ A reduction in weighted-average market share of 20 per cent is equivalent to an increase in our LOCI measure of 0.2. This is broadly comparable to the reduction in LOCI that would occur if the number of equally-sized rival fascia were to increase from one to two.

and 6 per cent lower. From this range, the results that we attach most weight to are between 3 and 4 per cent. These estimates are based on an average across the five main hospital operators and the hospitals that they own.

6.198 To assess the reliability of our results, we have undertaken an evaluation of our analysis and considered whether it is robust to a number of technical issues. Two particular considerations have been whether the results of our analysis differ when it is applied separately for each treatment, or for each hospital operator. In general we found that the results of our analysis were robust to the issues we have considered and our evaluation did not uncover results that contradicted the results described above.

6.199 The parties have questioned our conclusions and the reliability of our results, particularly in light of the results of our analysis applied separately for each operator. They have argued that our analysis, applied in this way, does not estimate a reliable price-concentration relationship for four of five operators. The parties have argued that this demonstrates that our estimate (which is an average over the five operators) is not reliable.

6.200 We disagreed with the parties' interpretation of the results of our analysis applied separately for each operator. As we have explained in Appendix 6.9, we considered that the analysis applied separately for each operator is a weaker approach, compared with the analysis pooled across operators, and that it is likely to produce less precise and less reliable estimates. When applied separately for each operator, we found that the results of our analysis did lack precision and, moreover, we did not consider these results to contradict the results described above.

6.201 The parties provided a number of further comments in relation to our initial analysis that we presented in a working paper and made available during a Data Room exercise. In response to these comments we have made a number of modifications to our initial analysis, and we have commented on these points in Appendix 6.9.

Conclusions on self-pay prices

6.202 Our PCA shows that there is a causal relationship between self-pay prices and local concentration. Private hospital operators, on average, currently charge higher self-pay prices in local areas where concentration is higher and they face weaker competitive constraints. This result is consistent with our interpretation of what hospital operators have told us, ie that self-pay prices are set locally and with the local competitive conditions in mind, and of the internal documents submitted to us (see paragraph 5 of Appendix 6.9). As a result, we conclude that hospital operators with hospitals in relatively more concentrated areas, thus facing insufficient competitive constraints, have market power in relation to self-pay patients in these areas. Self-pay prices in these areas are currently at higher levels than would be expected if there were lower levels of local concentration.

Insured prices

Introduction

6.203 This section provides a summary of our analyses and the most relevant results in relation to 'insured prices', ie the prices charged by hospital operators to PMIs for treatments provided to insured patients. Insured prices are an outcome of bilateral negotiations between hospital operators and PMIs. During these negotiations, discussions typically focus on the price of the overall bundle of a hospital operator's services (or the associated revenue), with relatively little focus on the price of individual treatments. The prices of individual treatments are generally not set at the hospital level, but are constant across the hospital operator's portfolio of hospitals

contracted with the PMI, thus reflecting an average (national) price of each treatment. Our analyses of insured prices focus largely on the five largest hospital operators (HCA, BMI, Spire, Nuffield and Ramsay) and the six largest PMIs (Bupa, AXA PPP, Aviva, PruHealth, Simplyhealth and WPA).

6.204 The section is structured in three parts. In the first part we analyze the prices charged by different hospital operators to each PMI and on average. In the second part, we consider drivers of these insured prices. In particular we compare, across hospital operators, insured prices (outcomes of negotiation) and characteristics of their hospital portfolios (inputs of negotiations), including characteristics reflecting the different degree of substitutability of hospitals in these portfolios to PMIs. In the third part, we analyze the prices charged to different PMIs by each hospital operator and on average and we compare insured prices relative to self-pay prices across hospital operators. Finally, we present some concluding remarks in relation to these analyses. In this section we also present the main arguments raised by hospital operators in relation to our methodology in response to the working paper ‘Empirical analysis methodology of price outcomes in negotiations between hospital operators and PMIs’.⁷² The methodology and the full results of our analyses of insured prices are set out in Appendix 6.12, to which we refer throughout this section.

6.205 The analyses of price outcomes and drivers of price outcomes across hospital operators can provide a useful insight into the degree of any market power held by hospital operators in negotiations with PMIs, while the analysis of price outcomes across PMIs and relative to self-pay can provide a useful insight into the degree of any buyer power held by PMIs in these negotiations.

⁷² The working paper was published on 6 June 2013.

Insured price outcomes across hospital operators

- *Methodology*

6.206 We have first analyzed the prices charged by different hospital operators to each PMI and on average. Our analysis has considered two different insured price measures: (a) insured total revenue per admission earned by hospital operators from each PMI⁷³ (in what follows we will refer to this measure as ‘insured revenue per admission’); and (b) insured price index based on a common basket of treatments offered by the different hospital operators to each PMI.⁷⁴ Our analysis compares the prices charged by the five largest hospital operators (and TLC, in the comparison with HCA) to each of the six main PMIs and on average, in 2007 to 2011. Consistency of results across measures and over time provides greater confidence that results are robust, unless there are reasons to indicate that this should not be the case. We are not aware of such reasons.

6.207 The hospital operators who responded to our working paper ‘Empirical analysis methodology of price outcomes in negotiations between hospital operators and insurers’ raised a number of points in relation to our methodology.⁷⁵ In particular:

- (a) the price measures considered do not control for differences in costs, including those arising from different mixes of treatments and/or cases within any given treatments;
- (b) some hospital operators have a charitable legal status (eg in central London the London Clinic, King Edward VII, St Johns and Elizabeths and St Anthony’s Hospital), which gives them a cost advantage;
- (c) the price measures do not control for differences in hospital quality;

⁷³ Revenue includes inpatient, day-case and outpatient. Admissions include inpatient and day-patient (we have used admissions as data on outpatient visits appear less reliable and recording of visits appears to differ across operators). Based on Market Questionnaire data.

⁷⁴ It includes inpatient and day-case treatments only (CCSD codes are mostly used for inpatient and day-patient treatments only). Based on Healthcode data.

⁷⁵ Responses to our working paper have been received by HCA, BMI and Spire.

- (d) hospital operators and PMIs may include ‘retroactive’ rebates in their contractual arrangements. These rebates have the effect of lowering the effective price to a PMI. The price-lowering effect of this rebate would not be captured in the prices used in the proposed methodology as the rebate is paid in the following financial year;
- (e) inferences drawn from comparisons between self-pay and insured prices must be undertaken carefully. In particular, when a firm with two or more customers or customer groups must incur a single fixed cost of operation to serve them, it may be economically efficient to recover those fixed costs using prices which differ across customers/customer groups. In this case, there are costs which are fixed in the short/medium term at both the hospital level and also at the hospital operator level;
- (f) prices are negotiated across a bundle of outpatient, inpatient and day-case treatments. Excluding outpatient treatments may lead to measurement errors and distort the analysis;
- (g) Healthcode data may not be comparable across hospital operators due to, for example, different ways of recording pre-assessment and post-operative care (either in the price for certain treatments or separately under outpatient care); and
- (h) the price paid by a PMI will depend on the volume directed to a particular hospital operator; when comparing the price index for a fixed set of patient volumes across hospital chains, the analysis is implicitly engaging in a great deal of movement of patients across hospital chains—and therefore implicitly ignoring a great deal of implausible travel and inconvenience suffered by patients; the interpretation of its price index raises the question of why the PMI in question did not in fact decide to spend less at one hospital chain rather than another.

6.208 We have considered the advantages and disadvantages of each price measure used. In particular the insured revenue per admission is the most inclusive price

measure, as the revenue corresponds to all the treatments provided by each hospital operator to insured patients, but it does not control for the different mix of treatments and cases that hospital operators may have. In addition, the revenue included in this measure is the focus of the negotiations between hospital operators and PMIs. The insured price index, on the other hand, considers a subset of treatments only, accounting for approximately between 12 and 39 per cent of the total insured revenue of hospital operators, with an average of 27 per cent.⁷⁶ However, it is constructed to control for the mix of treatments provided by different hospital operators, although it does not control for the mix of cases within each treatment (for example, more complex versus less complex cases, inpatient versus day-case) that hospital operators may have. Hence, while the insured price index allows better 'like with like' comparisons and is, in this respect, preferable to the insured revenue per admission, given price negotiations between hospital operators and PMIs typically focus on the bundle of all treatments provided to insured patients, rather than a subset of treatments, our view is that both measures are informative and have to be considered in conjunction.

6.209 We also acknowledge that some hospital operators and some PMIs have various types of retrospective rebates in their contractual arrangements,⁷⁷ which have the effect of lowering the effective price charged to a PMI. Our insured price index, which is based on invoice data, does not include any rebate paid retrospectively. We have reviewed the level of rebates actually paid by hospital operators to PMIs between 2007 and 2011. Only three PMIs were paid rebates during this period and no PMI received a rebate in every single year. On the whole, the value of these rebates is small as a proportion of the total fees paid. We reviewed our analysis on the insured

⁷⁶ For each hospital operator (a) we calculate the share of revenue accounted for by admissions in the basket constructed for each PMI out of the hospital operators' total insured revenue (inpatient, day-cases and outpatient), and (b) we calculate a simple average of the revenue shares of the baskets across all PMIs. Figures in the text refer to the range and the average of the latter across all hospital operators. Total insured revenues are based on Market Questionnaire data.

⁷⁷ We asked PMIs to provide details of all rebates paid between 2007 and 2011. In responses. [30]

revenue per admission in light of these rebates and we found that they are not sufficient to have a material impact on our overall results.

6.210 Furthermore, we have considered that some variation in price may arise due to differences in costs. For the purpose of this analysis, our view is that relevant cost differences are those arising from differences in the mix of treatments and cases between hospital operators; from any differences in the quality of the services provided by different hospital operators; and from local or regional variation in (some) input costs.

6.211 In relation to the mix, we have discussed the limitations of the insured price measures we considered in paragraph 6.208. We note that the impact on prices of cost differences due to the mix is expected to be more significant for the insured revenue per admission, which does not control for the mix of treatments and cases, than for the insured price index, which controls for the mix of treatments.

6.212 Overall, our view is that cost differences, in particular due to variations in the mix of treatments and/or cases and local/regional variations in (some) input costs, are likely to have a significant impact on prices for HCA relative to the other four largest operators, but we have no reason to believe the same applies to the other four largest operators relative to each other. We have therefore attempted to control for these likely cost differences for HCA, relative to the other four largest operators, by comparing its insured prices with those of TLC, its closest competitor in central London (see paragraphs 6.219 to 6.221).

6.213 In relation to quality, whilst we recognize that there will be some quality variation between hospitals, both within a hospital operator and between hospital operators, we have seen no evidence as to a consistent pattern; moreover, there are no

comprehensive quality indicators or ways of linking quality and cost. We have therefore found it necessary and appropriate to analyze prices without factoring in any effects of variation in quality.

6.214 Finally, we know that a number of the private hospital groups active in the UK, including Nuffield and TLC (which are relevant in relation to this analysis), have charitable status which confers tax advantages that are not enjoyed by the 'for-profit' operators. In particular, these firms benefit from lower business rate charges on their properties and pay less VAT on inputs.⁷⁸ These tax advantages may be expected to have an impact on the cost base of these businesses. Research commissioned by HCA and conducted by Cass Business School⁷⁹ indicates that Nuffield and TLC may benefit from reduced costs relating to VAT and business rates equivalent to 3.6 per cent and 2.9 per cent of their revenues respectively. In addition, charities are not liable to pay corporation tax on their profits; although quantification of this benefit is not straightforward as the size of a corporation tax liability depends, inter alia, on both the capital structure and the profitability of a business. To the extent that we are comparing hospital operators that compete with each other, eg in central London, we would expect prices to be determined by the more efficient operator and would not expect that certain higher costs, for example due to tax disadvantages compared with operators with charitable status, would lead to higher prices in a competitive market.

⁷⁸ The provision of medical services by a hospital is exempt from VAT. This means that hospital operators do not have to charge VAT to patients, but also means that they are unable to reclaim input VAT on many of the goods and services they buy. By being able to buy some of their inputs without paying VAT, charities are able to reduce the cost of irrecoverable VAT to their business.

⁷⁹ Cass Business School, 'Research into the tax advantages of charitable status for private hospitals', prepared for Pielle Consulting on behalf of HCA International, May 2013, Annex 1 of HCA's comments in relation to TLC case study.

- *Results*

6.215 Tables 6.3 and 6.4 show the results of the insured revenue per admission and the insured price index respectively across hospital operators, by PMI and on average,⁸⁰ in 2011. The ranking across hospital operators is shown in parenthesis (1 corresponding to the highest price measure and 5 to the lowest). The last row in each table shows the percentage difference in the average price measure between pairs of operators consecutive in the ranking (for example, 1–2 indicates the percentage difference in the average price measure between the highest price operator and the second highest price operator). Tables 6.5 and 6.6 show the results of the average insured revenue per admission and the average insured price index respectively in each year between 2007 and 2010.⁸¹ The results split by PMI in 2007 to 2010 are presented in Appendix 6.12.

TABLE 6.3 Insured revenue per admission (£), by PMI and average—all operators, 2011

<i>PMI</i>	<i>BMI</i>	<i>HCA</i>	<i>Nuffield</i>	<i>Ramsay</i>	<i>Spire</i>	<i>PMIs' volume share (admissions) (%)</i>
BUPA	[X]	[X]	[X]	[X]	[X]	51
AXA PPP	[X]	[X]	[X]	[X]	[X]	26
Aviva	[X]	[X]	[X]	[X]	[X]	11
PruHealth	[X]	[X]	[X]	[X]	[X]	6
Simplyhealth	[X]	[X]	[X]	[X]	[X]	3
WPA	[X]	[X]	[X]	[X]	[X]	3
Weighted average revenue per admission	[X]	[X]	[X]	[X]	[X]	100
Percentage difference (%)	[X]	[X]	[X]	[X]	[X]	

Source: CC analysis.

⁸⁰ Averages are calculated by weighting prices by volumes, expressed as number of admissions, accounted for by each PMI. In the insured price index, PMIs' volume shares are calculated as total admissions in each PMI's basket relative to the total number of admissions in all baskets.

⁸¹ Note that the insured price index for each year between 2007 and 2011 has been constructed on the basis of common baskets of treatments for each PMI across hospital operators in each year.

TABLE 6.4 Insured price index, by PMI and average—all operators, 2011

PMI	BMI	HCA	Nuffield	Ramsay	Spire	PMIs' volume share (admissions in the basket) (%)
Bupa	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	55
AXA PPP	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	26
Aviva	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7
PruHealth	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7
Simplyhealth	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3
WPA	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2
Weighted average price index	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	100
Percentage difference (%)	[redacted]	[redacted]	[redacted]]	[redacted]	

Source: CC analysis.

TABLE 6.5 Average insured revenue per admission (£)—all operators, 2007 to 2010

	BMI	HCA	Nuffield	Ramsay	Spire
2010 Weighted average revenue per admission	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2009 Weighted average revenue per admission	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2008 Weighted average revenue per admission	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2007 Weighted average revenue per admission	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: CC analysis.

TABLE 6.6 Average insured price index—all operators, 2007 to 2010

	BMI	HCA	Nuffield	Ramsay	Spire
2010 Weighted average price index	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2009 Weighted average price index	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2008 Weighted average price index	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2007 Weighted average price index	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Percentage difference (%)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: CC analysis.

- HCA

6.216 In comparison with the other four largest hospital operators (ie BMI, Spire, Nuffield and Ramsay), HCA charges significantly higher prices to PMIs, individually and on average, on the basis of both price measures in 2011 (Tables 6.3 and 6.4). The price difference with the second highest price operator on average, BMI, is larger in terms of insured revenue per admission (approximately [redacted] per cent) than insured price index (approximately [redacted] per cent).

6.217 Similar results arise throughout the period 2007 to 2010 (Tables 6.5 and 6.6). In particular, in terms of the insured revenue per admission HCA price premium relative to the second highest price operator, BMI, ranges between [redacted] and [redacted] per cent over the period, while in terms of the price index HCA price premium over the second highest price operator, BMI, ranges between [redacted] and [redacted] per cent over the period.

6.218 We assessed whether the marked price differences between HCA and the other largest hospital operators could be explained by differences in costs. In particular, the cost profile of a hospital operator such as HCA, which has almost all its hospitals located in central London, is likely to be different from the cost profile of hospital operators that do not have a significant central London presence. These cost differences may arise because of (some) costs in central London being higher than in other parts of the UK and/or because of the different mix of treatments and cases provided in central London compared with the rest of the UK (eg high acuity, complex treatments).

6.219 In order to control for these possible cost differences better, we constructed a separate price index considering HCA and TLC only, for 2011 and for 2007 to 2010 (for Bupa and AXA PPP only).⁸² TLC was selected as it is based in central London only and, based on our review of the evidence and our analysis, it appears to be the closest competitor to HCA in terms of range of treatments and/or cases provided. As such, the price index comparison between HCA and TLC should control better for cost differences arising from higher costs and/or from differences in the mix of treatments and cases provided in central London.

6.220 Our analysis, which is shown in Appendix 6.12, shows that on the basis of the weighted average price index TLC is cheaper than HCA by approximately [redacted] per

⁸² The 2007 to 2010 results focus on Bupa and AXA PPP only, as for these PMIs historical data appear to be more complete than for other PMIs.

cent in 2011. In relation to individual PMIs, TLC is cheaper than HCA for all PMIs in 2011 (with the differences in the price indices ranging between [X] per cent and [X] per cent), with the exception of [X] for which HCA is [X] per cent more expensive than TLC. Similar results hold for 2007 to 2010, [X].

6.221 These results indicate that, in comparison with TLC, HCA has a substantially higher price index on average and for individual PMIs, with the exception of [X], in three out of the five years considered. Overall, this is consistent with at least part of the difference in prices between HCA and the other large hospital operators (ie BMI, Spire, Nuffield and Ramsay) not being explained by differences in costs, ie by (some) costs for HCA being potentially higher because of the central London location and/or the different mix of treatments and cases provided.

- *BMI*

6.222 Of the other four largest hospital operators (ie excluding HCA), on both price measures, BMI has consistently charged the highest price to PMIs on average for each of the last five years. In 2011, the price difference based on the average insured revenue per admission was [X] per cent and [X] per cent based on the price index (Tables 6.3 and 6.4). In both of these cases, BMI's prices are compared with those of Spire, which was the second highest price operator.

6.223 Over the period 2007 to 2010, the price difference between BMI and the second highest price operator ranges between [X] and [X] per cent based on the average insured revenue per admission and between [X] and [X] per cent based on the insured price index (Tables 6.5 and 6.6).

6.224 In relation to individual PMIs, [X].

6.225 Similar results arise when we compare the price index across hospital operators on the basis of a common basket of treatments for Bupa and AXA PPP over the period 2007 to 2011 (see Appendix 6.12, paragraph 33).

- *Spire*

6.226 Of the other four largest hospital operators (ie excluding HCA), Spire charged the second highest price, followed by Nuffield and Ramsay, on the basis of both price measures in 2011. The price difference based on both price measures was [redacted] per cent between Spire and Ramsay, [redacted] (Tables 6.3 and 6.4).

6.227 In relation to individual PMIs, [redacted].

6.228 Over the period 2007 to 2010 Spire is the second highest price operator on average over the period on the basis of the insured revenue per admission, but not on the basis of the insured price index (Tables 6.5 and 6.6). [redacted]

6.229 Similar results arise when we compare the price index across hospital operators on the basis of a common basket of treatments for Bupa and AXA PPP over the period 2007 to 2011 (see Appendix 6.12, paragraph 33).

Drivers of insured price outcomes

- *Methodology*

6.230 Having found that insured prices differ across hospital operators, we have sought to understand whether and to what extent such differences in prices (outcomes of negotiations) are associated with differences in characteristics of the hospital portfolios (input of negotiations) reflecting the degree of substitutability of hospitals in these portfolios to PMIs. This allowed us to assess our view that a hospital operator that has more hospitals facing weak competitive constraints (ie less substitutable for

a PMI) in locations that are important to PMIs charges higher prices to PMIs; as well as considering whether there are other factors, such as the size of the hospital operator, which may explain the differences in insured prices we have found.⁸³

6.231 From the hospital operators' side, the principal inputs to the negotiations are:

(a) the individual hospitals; and

(b) collectively, the portfolio of hospitals that each hospital operator has to offer.⁸⁴

6.232 A particular hospital within a hospital operator's portfolio may be less substitutable for a PMI—and for the insured patients on behalf of whom the PMI is acting—because of its characteristics relative to individual hospitals that another hospital operator has to offer in the local area. For example, hospitals located in more concentrated areas are those for which a PMI has fewer alternatives (ie outside options) to consider when negotiating with the hospital operator, and, therefore, are less substitutable for the PMI. At the extreme, some hospitals may be 'must-have' for a PMI, ie the PMI does not have any outside option if it wants to offer PMI coverage in the local area. In this respect, substitutability between hospitals by patients and PMIs is assessed at the local level taking into account the competitive position of the different hospital operators in individual local areas.

6.233 We have also considered whether a hospital operator's portfolio as a whole may be less substitutable for a PMI because of certain characteristics relative to the portfolio of another hospital operator (for example, a larger footprint may be important if the PMI has to offer national coverage to certain corporate customers). In a bargaining context, the alternative portfolios of hospitals would be the PMIs' outside options. In this respect, substitutability has to be assessed in relation to portfolios of hospitals

⁸³ We addressed other factors such as costs in paragraphs 6.210 to 6.212.

⁸⁴ From the PMIs' side, the principal inputs to the negotiations are the PMI customers in each local area and in aggregate. We have taken into account the importance of different areas in terms of PMI penetration in our 'weighted average concentration' measures as set out below in this section.

offered to PMIs, taking into account the competitive position of the different hospital operators in terms of their entire portfolios.

6.234 We have investigated whether, and to what extent, a low substitutability of hospitals at the local level and, possibly, a low substitutability of hospital portfolios as a whole lead to higher insured prices. We note that any relationship between the degree of substitutability at the local level and insured prices cannot be investigated on a hospital by hospital basis because we only observe average prices for insured patients, as these prices are generally negotiated between each PMI and each hospital operator for the portfolio of hospitals rather than for individual hospitals (ie prices are set at the national level rather than at the local level). Because of the national pricing, in order to investigate any such relationship we have to focus on average hospital characteristics across the hospitals in the portfolio owned by each operator, rather than individual hospitals' characteristics, and on the only four hospital operators that own an extensive portfolio of hospitals across the UK (ie BMI, Spire, Ramsay and Nuffield). We have excluded HCA from this analysis because the characteristics of its portfolio of hospitals are, in many aspects, different from those of the other large hospital operators: HCA has a smaller network of hospitals and these hospitals are all located in central London (which we have delineated and analyzed as a separate geographic market). This means that we are limited to comparing the average (national) insured prices and the hospital portfolio's average characteristics of the four national hospital operators.

6.235 We analyzed several characteristics of hospital portfolios reflecting, in various ways, the average substitutability of hospitals at the local level and/or the substitutability of hospital portfolios as a whole to PMIs. These were:

(a) 'local concentration'—a number of metrics were considered;

- (b) 'large and/or high acuity hospitals'—the number of high admissions hospitals and of those providing CCL3;
- (c) 'size'—the total size of the hospital operator measured by number of insured patient admissions;
- (d) 'footprint'—the representation of that hospital operator across the UK by a number of metrics; and
- (e) 'weighted local concentration'—in order to take into account that some local areas or regions are more important to PMIs because of a higher penetration of PMI, we constructed a number of weighted local concentration measures.

6.236 The 'local concentration' and 'large and/or high acuity hospitals' characteristics arise from the attributes of individual hospitals and their locations and reflect the average competitive position of the hospital operator at the local level. Concentration is affected by the ownership of nearby hospitals. 'Size' and 'footprint' are mainly characteristics of the hospital operator's portfolio as a whole.⁸⁵

- *Results*

6.237 We found that the hospital portfolios of the four national hospital operators (ie BMI, Spire, Nuffield and Ramsay) differ significantly between each other by many of the characteristics considered. BMI is the largest operator for every characteristic, followed by Spire; Nuffield is the third largest operator for most characteristics (although it has the same rank as Ramsay in one case), but it is fourth after Ramsay on the basis of all weighted local concentration characteristics (see Table 14 in Appendix 6.12). For example, in relation to some of these characteristics, we note that: BMI has 20 hospitals with low LOCI, compared with 10 Spire hospitals, 6 Nuffield hospitals and 3 Ramsay hospitals; the average network effect is [15-20] per

⁸⁵ We note that one of the metrics we consider to characterise 'Footprint' is the number of hospitals in high PMI penetration regions. In relation to this metric, footprint involves a local element in that a hospital located in a high PMI penetration region may be less substitutable for a PMI, everything else equal, than a hospital in a low PMI penetration region as the disruption to PMIs customers caused by delisting such a hospital would be greater in the high PMI penetration region.

cent for BMI, [5-10] per cent for Spire, [5-10] per cent for Nuffield and [less than 5] per cent for Ramsay; BMI has 25 high admissions hospitals compared with 13 Spire hospitals, 2 Nuffield hospitals and 2 Ramsay hospitals; BMI has [X] insured admissions in 2011, compared with [X] for Spire, [X] for Nuffield and [X] for Ramsay; and BMI has 31 hospitals in high PMI penetration regions, Spire has 17, Nuffield has 11 and Ramsay has 8.

6.238 We also found that the ranking of the four national hospital operators by average insured prices is, in almost all cases, consistent with the ranking by the characteristics of hospital portfolios we considered and that the correlation between average insured prices and characteristics is generally high (see Tables 15 and 16 in Appendix 6.12). In particular, the analysis shows that hospital portfolios which are less substitutable to PMIs, in terms of either the average substitutability of the hospitals at the local level or the substitutability of the hospital portfolios as a whole, are associated with higher average insured prices. For example, BMI and Spire are shown to obtain higher average prices with PMIs than Nuffield and Ramsay, and it is also the case that, on the basis of the characteristics considered, BMI and Spire have hospitals which are less substitutable at the local level on average and/or hospital portfolios which are less substitutable as a whole.

6.239 We note that this analysis of insured price outcomes and their drivers does not, on its own, provide evidence of a causal relationship between a given characteristic reflecting the substitutability of hospitals on average at the local level (eg concentration) and/or of hospital portfolios as a whole (eg size) and insured price outcomes. Moreover, the analysis, on its own, does not allow us to distinguish the impact of any individual characteristic considered on the insured price outcomes. In other words, it cannot inform whether and to what extent the price outcomes we observe are driven by a characteristic such as local concentration, or by a

characteristic such as size, or by a combination of characteristics.⁸⁶ Finally, other characteristics that have not been considered here may have an impact on insured prices. As noted above, our price measures do not fully control for differences in the mix and the analysis does not control for all factors that influence negotiations.

6.240 We have considered these issues and we have assessed what is the likely driver of the relationships we observe between characteristics of hospital portfolios and insured prices. In our view, a PMI has weaker outside options when it is negotiating with a hospital operator that has more hospitals facing weak competitive constraints in locations that are important to the PMI (and its customers). In these circumstances, we would expect the hospital operator to charge higher prices to the PMI. We have found this to be the case for the following reasons. First, our analysis of the drivers of insured price outcomes is consistent with this relationship. Second, evidence from the PCA shows that weak competitive constraints at the local level result in higher prices for self-pay patients. Third, evidence from the negotiations, and the planning of negotiations, between hospital operators and the larger PMIs indicated that the position of the hospital operators in one or more local areas is important to hospital operators and PMIs (see paragraphs 6.157 and 6.158, and Appendix 6.10).

6.241 Our analysis of the drivers of insured price outcomes also shows that higher insured prices are associated with larger hospital portfolios. We have considered whether PMIs have weaker outside options when negotiating with a hospital operator that has, for example, a larger number of hospitals. In our view, this is unlikely to be the case for the following reasons. First, we note that this view is consistent with our findings on HCA, namely that it has the highest insured prices but it is smaller than

⁸⁶ We note that several of these characteristics are correlated, and thus a number of the observed relationships may be driven by a single or a few relationships. Rather than being selective, our approach has been to include all characteristics in our analysis and consider whether results differ depending on the characteristic considered.

BMI, Spire, Nuffield and Ramsay on a number of metrics. Furthermore, we considered that, in areas where hospital operators face strong competition, PMIs' outside options should be strong unless these competing hospitals are capacity constrained or there is some reason which prevents PMIs using these hospitals. With regard to the former, most private hospitals have some excess capacity. With regard to the latter, the pricing agreements and the related discount schedules, with prices rising when volumes fall at the hospital operator level (this is the case, for example, in the [X] and [X] discount schedule), creates an incentive for PMIs to maximize recognition for a given operator and a disincentive to recognize rival hospitals. However, in our view, these pricing agreements are a mechanism used by hospital operators to take advantage of their hospitals that face weak competitive constraints at the local level, ie they are not an additional reason for the higher insured prices.

6.242 Overall, on the basis of the considerations above, we consider that higher insured prices at the national level arise because of the lack of sufficient competitive constraints faced by hospital operators at the local level.

Insured price outcomes across PMIs and relative to self-pay

6.243 On the basis of price indices on common baskets of treatments,⁸⁷ we analyzed the prices charged to different PMIs by each hospital operator, and insured prices relative to self-pay patients' prices in 2011.

6.244 Table 6.7 shows the results of the insured price index across PMIs by hospital operator and Table 6.8 shows the results of the insured price index relative to self-pay prices. The ranking across PMIs for each hospital operator is shown in parenthesis (1 corresponding to the highest insured price index and 6 to the lowest).

⁸⁷ Price indices include inpatient and day-case treatments only (CCSD codes are mostly used for inpatient and day-patient treatments only). Based on Healthcode data for insured patients and hospital data for self-pay patients.

TABLE 6.7 Insured price index by hospital operator—all PMIs, 2011

Hospital operator	Bupa	Axa	Aviva	PruHealth	Simplyhealth	WPA	Basket size	Share of revenue (inpatient and day-patient with single CCSD code) accounted for by basket %
BMI	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
HCA	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Nuffield	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Ramsay	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Spire	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: CC analysis.

TABLE 6.8 Insured price index relative to self-pay by hospital operator—all PMIs, 2011

Hospital operator	Bupa	AXA	Aviva	PruHealth	Simplyhealth	WPA	Weighted average Across insures	Basket size	Share of revenue (inpatient and day-patient with single CCSD code) accounted for by basket %
BMI	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
HCA	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Nuffield	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Ramsay	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Spire	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: CC analysis.

*Weights used are the shares of admissions in each operator's basket accounted for by each PMI out of the total admissions across all PMIs.

6.245 As shown by Table 6.7, the two larger PMIs, Bupa and AXA PPP, achieve significantly lower prices than the smaller PMIs. [X].

6.246 In comparison with self-pay patients, PMIs on average achieve significantly lower prices. As Table 6.8 shows, more detailed analysis indicates that it is the large PMIs, Bupa and AXA PPP, which achieve significantly lower prices than self-pay patients, while the smaller PMIs generally pay prices at least as high as self-pay patients (with few exceptions).

Conclusions on insured prices

6.247 The main findings from our analysis of insured price outcomes are the following:

- (a) In comparison with the other four largest hospital operators (ie BMI, Spire, Nuffield and Ramsay), HCA charges significantly higher prices to PMIs (on average and for individual PMIs) based on both price measures and over time. HCA's insured prices on the basis of the price index are also significantly higher than those of TLC, its closest competitor in central London (on average and for individual PMIs, with the exception of [redacted]). This is consistent with HCA's higher insured prices relative to the other four largest hospital operators not being fully explained by differences in costs, ie by (some) costs for HCA being potentially higher because of the central London location and/or the different mix of treatments and cases provided.
- (b) Of the other four largest hospital operators, BMI charges higher prices to PMIs on average than Spire, Nuffield and Ramsay on the basis of both price measures and over time. The difference with Spire, the second highest price operator, on the basis of the average price index in 2011 is just above [redacted] per cent and, on the basis of insured revenue per admission, [redacted] per cent. In terms of individual PMIs, [redacted].
- (c) Spire is the second highest price operator, after BMI, to PMIs on average on the basis of the insured revenue per admission in 2011 and over time, and on the basis of the price index in the last two years 2010 to 2011 [redacted]. In terms of individual PMIs, Spire [redacted].
- (d) Considering BMI, Spire, Nuffield and Ramsay, characteristics of hospital portfolios reflecting a lower substitutability to PMIs of hospitals at the local level on average and/or of hospital portfolios as a whole are found to be associated with higher insured prices. BMI and, to a lesser extent, Spire are shown to obtain higher insured prices with PMIs on average than Nuffield and Ramsay, and it is also the case that, on the basis of the characteristics considered, BMI and, to a lesser extent, Spire have hospitals and/or hospital portfolios that are less substitutable. HCA has been excluded from the analysis of the insured price

drivers because of the different characteristics of its portfolio of hospitals, relative to the other large hospital operators. However, our analysis of insured prices shows that HCA's prices on the basis of the price index are significantly higher than those of its closest competitor in central London, TLC, and, as our analysis of competitive constraints in central London shows, these higher prices are associated with a high concentration and a low substitutability of HCA hospitals at the local level (see paragraphs 6.119 to 6.144).

- (e) As set out in paragraphs 6.240 to 6.242, our view is that having hospitals facing low levels of competition in one or more local areas (ie hospitals which are less substitutable for the PMIs at the local level on average) strengthens the position of a hospital operator in negotiations with PMIs and is likely to lead, in the absence of countervailing factors, to higher prices to PMIs at the national level. Our view is also that the overall size of hospital operators is unlikely to have an impact on insured prices in addition to the impact of insufficient competitive constraints at the local level on average.
- (f) The analysis shows that Bupa and AXA PPP obtain much lower prices than the other PMIs, Bupa obtaining lower prices than AXA PPP. The smaller PMIs generally pay prices at least as high as self-pay patients (with few exceptions).

6.248 These findings:

- (a) are consistent with HCA, BMI and Spire having market power in negotiations with PMIs arising from high concentration and an insufficiency of competitive constraints at the local level; and
- (b) show that smaller PMIs have no countervailing buyer power, that larger PMIs have some countervailing buyer power, Bupa more than AXA PPP and that no PMI had countervailing buyer power that could fully offset the market power of all hospital operators.

Profitability

Introduction

6.249 An important indicator of the extent of competition in a market is the level of profits of the firms involved. A competitive market is likely to generate significant variations in profit levels between firms as supply and demand conditions change, but with an overall tendency towards levels commensurate with the cost of capital of those firms. At particular points in time, the profits of some firms may exceed what might be termed the 'normal' level. Reasons for this could include, for instance, cyclical factors, transitory price or other initiatives, the fact that some firms may be more efficient than others and the fact that some firms may be earning profits gained as a result of past innovation. However, competition should put pressure on profit levels, so that they move towards the cost of capital in the medium to long run. A situation where profits are persistently above the cost of capital for firms that represent a substantial part of the market could be an indication of limitations in the competitive process.

6.250 We have assessed the profitability of the private hospital operators in accordance with the principles set out in our Guidelines.⁸⁸ These Guidelines highlight three key elements of our approach to profitability analysis:

- (a) we compare the returns made by firms against their cost of capital, as estimated using the capital asset pricing model (CAPM);⁸⁹
- (b) we are concerned to understand whether firms representing a *substantial* proportion of the market are making returns which are *persistently* in excess of their cost of capital;⁹⁰ and

⁸⁸ www.competition-commission.org.uk/assets/competitioncommission/docs/2013/publications/cc3_revised_.pdf.

⁸⁹ Guidelines, Annex A, paragraph 16.

⁹⁰ Guidelines, paragraphs 116–119.

(c) we are concerned with economic rather than accounting measures of profit and may, therefore, make adjustments to the financial information of the firms being analysed in order to identify economic profits.⁹¹

6.251 Our approach to analyzing the returns made by the private hospital operators is set out in detail in Appendix 6.13, and our assessment of their cost of capital is detailed in Appendix 6.14.

Our approach to the profitability assessment

6.252 We have conducted an assessment of the profitability of the seven largest private hospital operators in the UK (the relevant firms).⁹² These firms account for 74 per cent of the market for privately-funded acute healthcare in the UK.⁹³ The rest of the market is accounted for by a large number of smaller and specialist operators.⁹⁴

6.253 We have assessed the financial performance of the private hospital operations of each of the relevant firms, without seeking to exclude the revenues and costs generated from either their publicly-funded activities or services such as cosmetic surgery, mental health, fertility or maternity care.⁹⁵ We did, on the other hand, exclude all activities that were not carried out within the firms' acute private hospitals, including fitness centres, primary care facilities, ISTCs and separate facilities specializing in cosmetic and IVF treatments. This approach was adopted to avoid making potentially arbitrary allocations of costs among the various revenue streams of the businesses.⁹⁶

⁹¹ [Guidelines](#), paragraph 115.

⁹² These firms are: Bupa Cromwell Hospital (BCH), General Healthcare Group (BMI), HCA, Nuffield, Ramsay, Spire and TLC.

⁹³ Laing & Buisson, 2012.

⁹⁴ All of these smaller operators have market shares of less than 2 per cent.

⁹⁵ This approach included NHS PPUs and pay beds within the relevant market, although no NHS trust had large enough private revenues to be included as one of the relevant firms.

⁹⁶ These revenues are generated using the same assets.

6.254 Our analysis is based on the financial performance of the relevant firms over the five financial years ending between January 2007 and June 2012. We consider that a five-year period is sufficiently long for us to evaluate the persistence of profitability, although we have taken into account both the likely impact of the recession and the growth in NHS demand on the profits of the relevant firms over the period. Moreover, we note that changes in the structure of the market mean that the financial performance of the sector prior to 2007 is unlikely to be a relevant indicator of the current competitive conditions in the market.

6.255 We used the return on capital employed (ROCE) approach to assess the profitability of the relevant firms, making a number of adjustments to their financial statements in order to ensure that our analysis was economically meaningful.

6.256 Most of the relevant firms raised no concern with our use of a return on capital approach. Spire suggested that rather than adopting the ROCE approach, we should assess profitability using the IRR on the grounds that 'internal rate of return (IRR) and Net Present Value (NPV) are conceptually the correct methods for measuring profitability because they take into account the cash inflows and outflows of a business activity (rather than accounting revenues and costs, which include accruals and non-cash items)'.⁹⁷ While we agree that conceptually the IRR is an appropriate method of measuring the profitability of a given project, we believe that the approach we have adopted in estimating the ROCE not only closely approximates to the IRR methodology, but also has the advantage of avoiding the difficulties inherent in

⁹⁷ [Spire response to profitability methodology working paper](#), paragraph 5.1. BMI also raised this point.

identifying the cash flows of a given activity within a broader business, and is thus a more appropriate measure in the current case.⁹⁸

Adjustments to the relevant firms' accounting information

- 6.257 As set out in our Guidelines, in a competition investigation we are interested in understanding the economic rather than accounting profitability of firms. Economic costs are the costs of resources used at a price at which they would be traded in a highly competitive market, where entry to and exit from the market is easy. The value of resources consumed and assets used should reflect their current value to the business.⁹⁹
- 6.258 We based our assessment on the relevant firms' accounting profit as set out in their financial statements, but with certain adjustments. There were no significant issues in identifying the relevant revenue streams and, on the whole, we accepted the firms' own cost allocation methods in allocating corporate overhead costs to their private hospital businesses. Therefore, we made few adjustments to the profit and loss data submitted to us by the relevant firms, with a notable exception being to the depreciation charge on buildings to ensure consistency with the value of capital used in our analysis.
- 6.259 Under the approach set out in our Guidelines, the value at which assets are capitalized should reflect their current value to the business, which is the loss the entity would suffer if it were deprived of the asset involved. The method of determining the value to the business of an asset is set out in Figure 6.1.

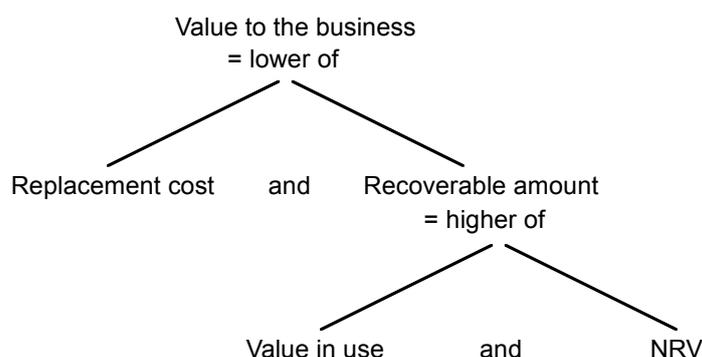
⁹⁸ Ramsay and Spire told the CC that they were unable to separate out the cash flows of their private hospitals from those of their other activities. HCA told the CC that it did not track cash flow at a UK level. It was consolidated as part of its parent company accounts.

⁹⁹ Income should also be included at its economic level. This will generally be the case where all sales and costs of inputs are recorded at arm's length or market values.

6.260 Where an entity is putting an asset to profitable use, the deprival value of the asset will be equal to its replacement cost. Similarly, the (depreciated) replacement cost of an asset represents the investment that a new entrant would need to make in order to provide a service of the same quality as an incumbent operator.

FIGURE 6.1

Establishing which valuation basis for an asset gives its value to the business



Source: UK Accounting Standards Board, Statement of Principles (1999).

6.261 There are two main types of adjustments that can be made to balance sheets of businesses in a competitive assessment. The first adjustment is to the assets and liabilities that are recognized in the capital of the business. In our analysis, we made some adjustments to the intangible assets recognized. The second is to the value which is attributed to both tangible and intangible assets and liabilities. We made a number of substantial adjustments to the value at which tangible assets were recognized in the capital base of the relevant firms.

6.262 In some cases, our estimates of the capital employed by the relevant firms were significantly below those of the firms themselves due to the exclusion of the majority of purchased goodwill and a downward revision to the carrying values of land and buildings.¹⁰⁰ As a result, in these cases our estimates of the ROCE of the relevant firms were significantly higher than the return on investment earned by the owners of

¹⁰⁰ Although, in other cases, we have revised upwards the carrying value of land and/or buildings.

the firms. However, in the context of a competitive assessment, we are concerned with understanding whether specific operational assets are able to earn a return in excess of the cost of capital for those assets, rather than identifying whether specific owners or investors are earning such a return. Indeed, we would expect that, where there is an active market for firms, the price at which they are exchanged should allow the purchaser to earn a normal return on their investment even if the underlying return on the assets is above or below this level as the price would adjust accordingly. In the longer run, a return in excess of the cost of capital can only be earned on the assets employed if there are barriers to entry, while a return below the cost of capital would result in assets exiting the industry (unless there are barriers to exit).

Recognition of intangible assets

6.263 The principle intangible asset recognized on the balance sheets of some of the relevant firms was purchased goodwill.¹⁰¹ For some of the relevant firms, notably BMI and Spire, this balance was substantial.¹⁰² Goodwill reflects the difference between the price paid for the business on acquisition and the value of the separately identified fixed assets, both tangible and intangible, recorded on the balance sheet. Businesses are generally acquired on the basis of their (sustainable) earnings or profits rather than the value of the assets they employ. Hence, purchased goodwill is generally composed of two elements: the first is the value of intangible assets that were not separately identified on acquisition, while the second is the value of expected future economic profits of the business. For profitability analysis, we wish to identify and apply a value to the former but exclude the latter since the purpose of our analysis is to quantify the profits of the relevant firms. Hence, our approach was to identify and value intangible assets according to the criteria set out in our

¹⁰¹ BMI, Spire, Ramsay and HCA all had purchased goodwill recorded on their balance sheets due, largely, to changes of control of the businesses and/or subsequent business acquisitions.

¹⁰² However, as of September 2012, the consolidated GHG's goodwill was written down by £811 million, following an impairment review.

Guidelines.¹⁰³ Any additional goodwill on the firms' balance sheets was excluded from capital employed in our analysis.

6.264 We reviewed the relevant firms' submissions a range of potential intangible assets, including staff training and development, IT systems, regulatory approvals, a reputation for providing high quality service, relationships with patients, GPs and consultants and clinical and administrative processes and procedures, and determined that the main category of intangible assets held by the businesses that should be capitalized in our analysis were IT systems. We considered that many of the other categories of intangibles proposed by the relevant firms did not represent expenditure that was additional to that necessarily incurred in running their businesses, or separable from the business. However, we took into account in our qualitative assessment the fact that an operational business incurs some additional costs during a start-up phase—over and above the cost of replacing the tangible and current assets—and that our estimates of ROCE will be (slightly) overstated by not quantifying these in our analysis. As discussed in paragraph 6.280 below, we do not believe that this overstatement would have a material impact on our findings.

Valuation of assets

6.265 The main categories of fixed assets recorded on the balance sheets of the relevant firms were land, buildings and equipment. The carrying value of these assets had been determined either with reference to the historic cost of acquiring the asset, or at a market value at a certain date as the result of a fair value adjustment (on acquisition) or revaluation of the asset to support a refinancing transaction.

¹⁰³ CC3, [Annex A](#), paragraph 13.

Equipment

6.266 In light of the relatively short useful economic life (UEL) of the equipment, which was generally less than ten years, we considered that the carrying value of these assets in the accounts of the relevant firms were likely to be a reasonable approximation of their economic value. BMI, Ramsay and Spire highlighted the issue of assets that were fully depreciated in their accounts but still in use and which, using this approach would be undervalued. We noted this issue and have taken it into account in our qualitative assessment.¹⁰⁴

Land and building

6.267 For land and buildings, which had very long UELs, we considered that the historic cost was likely to significantly understate the current economic cost (or depreciated replacement cost) due to inflation and changing real prices over the period since the asset had been acquired. On the other hand, where the carrying values of land and buildings were determined as part of a revaluation, we considered that their value may be overstated according to the principles set out in Figure 6.1. These carrying values had been determined with reference to the market values of the hospitals,¹⁰⁵ which were based on the level of profits generated by the private hospital business and the multiples¹⁰⁶ that investors were prepared to pay for private hospital businesses at the date of valuation. We considered that these valuations were circular from the point of view of profitability analysis as the profits of the business determined the value of the asset, which would then be used, in turn, to examine profitability. We did not consider, therefore, that they provided a reliable value for land and buildings in the context of our analysis.

¹⁰⁴ We considered that we did not have sufficient information to make quantitative adjustments to rectify this issue.

¹⁰⁵ These values were estimated by surveyors.

¹⁰⁶ A multiple refers to the scaling factor applied to the profits of a business to reach the price that a purchaser will pay for that business. For example, if a business generates £10 million per year and an investor is prepared to pay £100 million for it, the multiple is ten times. Multiples reflect a number of factors, including expectations regarding the level of profits in the future.

6.268 The approach that we took was to gather information on the costs of replacing the hospital assets owned by the relevant firms, ie the costs of acquiring the plots of land and constructing the buildings. This approach is consistent with our Guidelines, which highlight that we consider the ‘replacement cost’ or ‘Modern Equivalent Asset value’ to be the economically meaningful measure.¹⁰⁷ The main sources of information we relied on were a DTZ report on land prices (see Appendix 6.15) that we commissioned for the purposes of this assessment, and the relevant firms’ reinstatement cost estimates for their buildings.¹⁰⁸ We also conducted a number of sensitivities on our analysis based on information and reports submitted by the relevant firms where these contained asset values that were different from those used in our ‘base case’ and where we considered that there was uncertainty over the correct level or approach to estimating the replacement cost of an asset. A fuller discussion of our approach to assessing the replacement cost of land is set out in Appendix 6.16.

Relevant firms’ views on our approach to valuing assets

6.269 BMI argued that where there was ‘significant uncertainty, or where adjustments to MEA values lead to questionable results’ we should ‘place more emphasis on values which are known with certainty (ie book values)’.¹⁰⁹ We do not agree with BMI that either one of the reinstatement values or the market values of the relevant firms’ assets, which form the basis of the accounting book values, is more certain than the other. These valuations were prepared on different bases and, for the purposes of our analysis, we consider that the reinstatement cost is appropriate and the market value is not due to the potential for capitalizing excess profits in the value of the capital employed. Hence, we have used the former.

¹⁰⁷ [Guidelines](#), Annex A, paragraph 14. The MEA value is the cost of replacing an old asset with a new one with the same service capability allowing for any differences both in the quality of output and in operating costs.

¹⁰⁸ These estimates were prepared for the firms by surveyors and formed the basis of the relevant firms’ insurance policies.

¹⁰⁹ [BMI response to the Profitability working paper](#).

6.270 Ramsay made a similar argument with respect to intangible assets, noting that 'Ramsay's preferred approach to the valuation of intangible assets is to calculate the total value of the business based on discounted future cash flows'. As in the case of tangible assets, we do not agree that this approach is suitable for the purposes of our analysis due to circularity. Hence, we adopted a cost-based approach to valuing intangible assets.

6.271 The other private hospital operators generally did not disagree with the replacement cost approach; although several made submissions regarding how replacement costs should be measured. We took these submissions into account and made adjustments to our approach as necessary, including applying a number of sensitivities to our estimates of ROCE.

Profitability analysis

6.272 Table 6.9 shows the ROCE of each of the relevant firms, together with the weighted average ROCE for all these firms combined.

TABLE 6.9 Profitability analysis, ROCE of relevant firms

	FY07	FY08	FY09	FY10	FY11	FY12
<i>BCH</i>						
EBIT		[X]	[X]	[X]	[X]	
Capital employed		[X]	[X]	[X]	[X]	
ROCE (%)		[X]	[X]	[X]	[X]	
<i>BMI</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>HCA</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>Nuffield</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>Ramsay</i>						
EBIT		[X]	[X]	[X]	[X]	[X]
Capital employed		[X]	[X]	[X]	[X]	[X]
ROCE (%)		[X]	[X]	[X]	[X]	[X]
<i>Spire</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>TLC</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
Weighted average ROCE	13.4	15.4	16.5	18.2	18.3	

Source: CC analysis.

*This is calculated on an annual basis (ie the capital employed has been grossed up to 1.5 times the year-end level to take into account the fact that the EBIT relates to an 18-month rather than 12-month period).
The weighted average ROCE includes Ramsay's results for each year in the previous financial year. For example, Ramsay's results for FY09 are added in to the FY08 average. This is because Ramsay has a 30 June year-end and hence falls between the two calendar years.

6.273 This analysis indicates that the profitability of the industry has improved over the period from 13.4 per cent in FY07 to 18.3 per cent in FY11, with a weighted average of 16.4 per cent for the period as a whole.

6.274 We estimated a range for the nominal pre-tax cost of capital for a typical stand-alone UK private hospital operator of between 7.2 and 9.9 per cent, with a mid-point estimate of 8.6 per cent. More detail on our calculations of the cost of capital, including the relevant firms' views on our approach and our response to them, is in Appendix 6.14.

6.275 Our assessment of the ROCE of the relevant firms indicates that BMI, HCA and Spire have persistently made profits in excess of their cost of capital.¹¹⁰ In addition, Ramsay has demonstrated a significant increase in profitability over the period, moving from a position of making profits that were less than its cost of capital to generating returns in excess of that level. Nuffield has [REDACTED], whilst BCH and TLC are making returns that are around their cost of capital on average.

6.276 We considered whether the firms making returns above the cost of capital represented a substantial part of the market. BMI, HCA and Spire together comprise 53 per cent of the market for privately-funded healthcare in the UK, with Ramsay accounting for an additional 5 per cent.

6.277 We considered how the existence of and growth in NHS revenues may have affected the profitability of the relevant firms. As set out in Section 2: Industry background, four of the relevant firms (BMI, Nuffield, Ramsay and Spire) have experienced [REDACTED] increases in the volume of NHS work undertaken over the period.¹¹¹ As of FY11, BMI, Spire and [REDACTED], while Ramsay generated [REDACTED] its revenues from NHS patients. To the extent that NHS revenues generate lower margins than private revenues,¹¹² we considered that our estimate of ROCE may understate that earned on the provision of services to private patients. We thought that the growth in NHS revenue over the period was likely to have allowed BMI, Nuffield, Ramsay and Spire to improve their capacity utilization. However, to the extent that this effect has supported profitability in excess of the cost of capital, we note that it relies on the

¹¹⁰ See Appendix 6.14 for our assessment of the cost of capital.

¹¹¹ HCA, BCH and TLC do a negligible quantity of NHS work.

¹¹² BMI (in its response to the [AIS](#)) and Nuffield (in its response to the financial questionnaire) told the CC that this was the case.

prices charged to private patients not falling in response to the lower unit costs¹¹³ that result from the higher volume of patients treated.

6.278 The results of our analysis are robust to the inclusion of relatively large sensitivities on the value of land and buildings.

Conclusions on profitability

6.279 The assessment of profitability in competition investigations will necessarily require some estimation and reliance on assumptions. In this case we have used accounting information but made a number of adjustments to the values of capital employed to reflect economic rather than accounting costs. We have relied on a range of information on the replacement cost of assets, including accounting records, external reports on land values, surveyors' estimates of building reinstatement costs and the Valuation Office Agency's estimates of building obsolescence. We have applied a range of sensitivities to our results and these do not change our findings.

6.280 We considered whether the lack of quantification of start-up costs and fully depreciated assets in our analysis could result in the material misstatement of the level of returns being earned by the relevant firms. We concluded that if these could be quantified, it is likely that they would reduce our ROCE estimates, although not to the extent that they would substantially reduce the gap between the ROCE of the relevant firms and their cost of capital. Moreover, we considered that our approach was also likely to have overstated capital employed to the extent that no adjustments were made to reflect the low levels of capacity utilization in the industry, and hence our ROCE estimates were likely to be understated in this respect. Overall, we believe that our estimates provide a reasonable approximation of the returns being earned by the relevant firms.

¹¹³ The high fixed cost nature of the industry means that an increase in the volume of patients should result in a decline in the unit cost of treating each patient.

6.281 We also note that our analysis has been conducted over a period during which the UK economy has suffered a severe recession. The evidence indicates that in spite of the recession and a reduction in the number of people with private medical insurance policies, expenditure on privately-funded healthcare services increased over the relevant period. It seems probable, therefore, that under more normal economic conditions the relevant firms would have earned higher revenues and therefore profits than they did between 2007 and 2012.

6.282 From our analysis, we conclude that BMI, HCA and Spire have, during the period under review, been earning returns substantially and persistently in excess of the cost of capital. Ramsay has also earned returns in excess of the cost of capital in the last three years of the period, although not in the first two and a half years. As a result, we consider that there is insufficient evidence to reach a conclusion as to whether Ramsay is able to earn returns that are persistently in excess of its cost of capital. In this respect we note that Ramsay has experienced a particularly large increase in the revenues generated from providing services to the NHS, and this may be obscuring the returns earned on private patients both over the relevant period and in the longer run. We consider that the potential for growth in NHS revenues to be distorting the results of BMI and Spire is significantly less due to their lower proportion of NHS revenues and the greater persistence of their excess profits.¹¹⁴

6.283 We consider that the fact that firms¹¹⁵ accounting for between 53 and 58 per cent of the market are making returns that are substantially and persistently in excess of the cost of capital indicates that there are some limitations in the competitive process.

¹¹⁴ HCA is unaffected by changes in NHS demand as it does a negligible quantity of NHS work.

¹¹⁵ HCA, BMI and Spire account for 53 per cent of the market between them. Ramsay accounts for an additional 5 per cent of the market.

6.284 Our finding of excess profitability suggests that the price of private healthcare services may be high in relation to the costs incurred by private hospital operators in providing those services, and thus higher than we would expect to find in a competitive market. We consider more evidence on the level of prices in 6.190 to 6.248, and set out our estimates of the level of consumer detriment caused by these high prices in Section 10.

6.285 In addition, we consider that the difference between the replacement cost of the assets employed by the relevant firms and the market value of those same assets and, indeed, of the relevant firms as a whole, indicates that there are likely to be significant barriers to entry in the private hospital sector.

Provisional conclusions

6.286 As set out in paragraph 6.144, we have found high levels of concentration and an insufficiency of competitive constraints in the provision of hospital services by private hospitals and PPUs providing inpatient care in central London and in a number of local areas across the UK. This particularly applies to the hospitals of HCA in central London and to a number of hospitals of BMI, Spire, Nuffield and Ramsay outside central London. Outside of central London we have identified 101 private hospitals that are subject to insufficient competitive constraints.

6.287 In relation to HCA, we have found that currently the vertical relationships between HCA and GP practices in central London are limited in scale and do not appear to have influenced GP referral rates, thus indicating that it was unlikely that vertical integration is currently leading to significant harm.

6.288 As set out in paragraph 6.87, we concluded that there were barriers to entry and expansion relating to sunk costs in all areas and a barrier relating to economies of

scale was likely to be present in many areas also. We concluded that there were often barriers related to site availability and the need for consultant commitment to new facilities. We also concluded that the barriers related to sunk costs and economies of scale barriers were high and that combination with the other barriers increased the overall level. Our finding of barriers is supported by our finding that BMI, HCA and Spire have, during the period under review (ie between January 2007 and June 2012) earned returns substantially and persistently in excess of the cost of capital in the last three years of that period. Additionally, we note that there have been relatively few incidences of entry.

6.289 With regard to self-pay-patients, prices of treatments are generally set at the hospital level, thus varying across hospitals within a hospital operator's portfolio (ie prices are set at the local level). As discussed in paragraph 6.202, our PCA showed that private hospital operators, on average, currently charge higher self-pay prices in local areas where concentration is higher and they face weaker competitive constraints. We therefore concluded that hospital operators with hospitals in relatively more concentrated areas, thus facing insufficient competitive constraints, have market power in relation to self-pay patients in these areas.

6.290 With regard to insured patients, prices of treatments are set in national negotiations between hospital operators and PMIs, and are generally the same for all hospitals in the hospital operator's portfolio of hospitals contracted with the PMI, thus reflecting average prices of each treatment. Whilst this applies to HCA, HCA is slightly different from the other large hospitals operators as its hospitals are mainly located in central London. As discussed in paragraph 6.247, we found that certain characteristics of hospital portfolios, including in particular there being an insufficiency of competitive constraints on average at the local level, were associated with high levels of insured prices at the national level. We found this to be the case for BMI and Spire. For HCA,

we found that it faces weak competitive constraints in central London and it has the highest prices. These findings on their own did not demonstrate that an insufficiency of competitive constraints at the local level caused higher insured prices. However, we note that, in imperfectly competitive markets, higher concentration and weaker competitive constraints are expected to lead to higher prices in the absence of countervailing factors. In addition, this relationship is supported by evidence from the PCA, which found a relationship between price and concentration for self-pay patients; and evidence from the negotiations, and the planning of negotiations, between hospital operators and the larger PMIs, which showed that the position of the hospital operators in one or more local areas is important. On the basis of these findings and considerations, we formed the view that the position of a hospital operator in negotiation with PMIs is strengthened when in one or more local areas it operates hospitals that face low levels of competition. This in turn is likely to lead to, in the absence of countervailing factors, higher prices to PMIs at the national level.

6.291 We examined the extent of countervailing buyer power by PMIs in negotiations with hospital operators. Based on the prices paid to each hospital operator by different PMIs, including prices relatively to self-pay, we found that, similarly to self-pay patients, smaller PMIs had no countervailing buyer power and that larger PMIs had some countervailing buyer power, Bupa more than AXA PPP. Based on the prices paid to different hospital operators by each PMI, however, we found that no PMI had countervailing buyer power that could fully offset the market power of all hospital operators.

6.292 From our profitability analysis, we concluded that BMI, HCA and Spire have, during the period under review, been earning returns substantially and persistently in excess of the cost of capital. Ramsay has also earned returns in excess of the cost of capital

in the last three years of the period. However, we note that Ramsay's profits appear to have increased due to significant growth in the volume of NHS patients treated over the period. Our finding of excess profitability suggests that the price of private healthcare services may be high in relation to the costs incurred by private hospital operators in providing those services, and thus higher than we would expect to find in a competitive market.

6.293 Overall, on the basis of the considerations in paragraphs 6.290 to 6.292, in relation to insured patients, we therefore concluded that HCA, BMI and Spire, have market power in negotiations with PMIs arising from high concentration and an insufficiency of competitive constraints at the local level.

6.294 We provisionally conclude that:

- (a) an insufficiency of competitive constraints in the provision of hospital services by private hospitals and PPU's providing inpatient care in a number of local areas across the UK and in central London, combined with barriers to entry, leads to higher prices being charged by hospital operators to self-pay patients; and
- (b) an insufficiency of competitive constraints in the provision of hospital services by private hospitals and PPU's providing inpatient care in a number of local areas across the UK and in central London, combined with barriers to entry, leads to higher prices being charged by HCA, BMI and to a lesser extent Spire to PMIs for insured patients.

7. Consultants

Introduction

- 7.1 This section considers the competition issues raised in respect of consultants. As set out in Section 4, we initially identified two ToHs relating specifically to consultants. Our ToH2 related to the potential market power of consultants over patients whether individually and/or of particular consultant groups in certain local areas. Our ToH4 considered whether PMIs have buyer power in respect of individual consultants, for example, by suppressing consultant fees to a level below those which would prevail in a competitive market, thereby leading to a reduction in the quality of service provided to patients and affecting consultants' incentives to innovate. Further, in the annotated issues statement we identified that PMIs may be distorting competition between consultants by imposing caps on the reimbursement of fees on some consultants and not others, which, in the longer term, may result in a shortage of consultants willing to practice and in a reduction in the potential output of the sector.
- 7.2 As described in Section 5, we found that each consultant specialty could be viewed as a separate market in the provision of consultant services. We also found that, as with private hospital services, the geographic market is local. We have not, however, needed to define each such local area for the purposes of our provisional findings.

ToH 2—Local market power

- 7.3 We identified a number of factors that suggested that some consultants and/or consultant groups may have local market power:
- (a) In some local areas, there are a limited number of consultants in private practice for particular specialties or for particular types of treatment. The number of consultants in any local area will be driven by the requirements of the NHS as the

vast majority of consultants¹ will have NHS consultant posts. This may be due to the nature of the treatment and/or specialty;² limited demand for the particular specialty, sub-specialty or treatment making it uneconomic for a consultant to be in private practice in the area; the nature of the local services provided at private hospitals and other private facilities which may mean that consultants are unable to practice particular specialties, sub-specialties or offer certain treatments in the area; the extent to which there is capacity for such specialties or treatments at such hospitals and facilities; and, if the patient is insured, the extent of recognition of particular consultants in the area by the patient's PMI.

- (b) As described in more detail elsewhere,³ patients are generally referred to consultants by another clinician, whether a GP or another consultant. Historical referral patterns and the fact that referrals are made for reasons other than cost (eg clinical need) may, for example, confer local market power. It may also be the case that as a patient progresses through their treatment their ability to switch consultant will reduce significantly, as patient switching costs increase and other consultants in private practice may be unwilling to take over responsibility for a patient mid-treatment.
- (c) In relation to anaesthetists, it will generally be the consultant carrying out the surgery who will select the anaesthetist and will generally require the same anaesthetist for a particular theatre list.⁴ The surgical consultant will not generally consider cost to be a factor in the selection of the anaesthetist and, together with historical preferences of the surgical consultant, the patient's choice of available anaesthetists in an area may therefore be limited.

¹ The OFT's survey by GHK in August 2011 found that only 4 per cent of consultants in private practice did not have an NHS consultant post. www.of.gov.uk/shared_of/market-studies/Final-Survey-Report-08-2011.pdf. See also paragraphs 2.7 and 3.55.

² There is significant variation in the number of consultants registered in different specialties and within those specialties, those who specialise in particular parts of the body or particular types of treatment. In terms of consultants willing to practice in the private sector, this will similarly vary for the same reasons.

³ See paragraphs 2.39 to 2.60.

⁴ 71 per cent of anaesthetists in our consultant survey stated that they were appointed through the primary consultant, a further 18 per cent by the private hospital and only 1 per cent by the patient. Table D6 [GP and consultant survey](#).

- (d) Groups of consultants—usually those practising in the same specialty in a local area or practising at a particular hospital—may jointly set prices. This is most common in relation to anaesthetists but parties provided some evidence that consultants in a wide range of specialties are similarly forming groups and jointly negotiating or setting prices.
- (e) Private hospitals compete to attract those consultants who are likely to generate the most revenues for them. Whilst hospitals generally do not impose restrictions on consultants from practising at other facilities or offer exclusivity to consultants,⁵ some private hospitals in some areas will have limited capacity in terms of, for example, the availability of consulting rooms, other outpatient facilities and theatre slots. This may limit the number of consultants in particular specialties or providing particular treatments in some local areas.
- (f) Consultant services are highly differentiated and in many cases highly specialized. Patients rely on the consultant as well as other clinicians such as their GP to determine their requirements. Patients will frequently lack the knowledge or have limited capability to determine what treatments they may require and from whom. Some patients may also be quite vulnerable at the time of requiring treatment and as with many professional services, are in a difficult position to assess not only what services they require but also quality and cost/value for money.⁶
- (g) Insured patients have limited or no sensitivity to price at the point of selecting their consultant and/or treatment.

7.4 Some PMIs⁷ submitted that some consultants and consultant groups may have market power due to some or all of the factors above. Some of these PMIs argued

⁵ However, some private hospital operators may impose on a small number of selected consultants some limitations on practising elsewhere. [§] Restrictions on practising elsewhere are more common in the context of incentive schemes which are considered in Section 8.

⁶ Issues relating to the lack of available information and information asymmetries are covered in more detail in Section 9.

⁷ AXA PPP and Bupa responses to IS; Aviva response to IS .

that these factors not only lead to local market power but also result in a lack of effective competition between consultants as these factors significantly limit the incentives of consultants to compete, in particular on price and quality.⁸ PMIs also said that there are no incentives on consultants to control costs, and indeed Bupa⁹ commented that the interests of consultants in private practice do not always align with those of their patients as some consultants are motivated by profit with the consequent risk that consultants might not only overcharge but over-treat (undertake a higher specification of treatment) or over-diagnose (undertake more tests and consultations than are required).

Individual consultants

7.5 A number of factors suggest that most individual consultants in most areas are unlikely to have market power:

- (a) As described in Sections 2 and 3, of the evidence we have received and reviewed does not show a shortage of consultants. There are over approximately 37,000 full-time-equivalent consultants in England, with an estimated 22,000 undertaking some element of private work.¹⁰
- (b) Whilst qualification as a consultant is a long process and varies from specialty to specialty, approximately 1,200 new doctors are made consultants each year.¹¹
- (c) There are no significant barriers to a consultant starting in private practice. The main additional requirement is to obtain professional indemnity, the cost of which can be significant depending on the specialty. However, many consultants have small-scale private practices suggesting that the cost of professional indemnity

⁸ Bupa response to IS paragraphs 4.24 et seq; Bupa response to AIS paragraphs 2.66 et seq; AXA PPP response to IS.

⁹ Bupa response to AIS paragraph 4.27.

¹⁰ See further paragraphs 2.7 and 3.54. A recent BMA survey of 1,319 consultants in early 2013 did not show a material change in the number of consultants in private practice in the UK between 2005 and 2013 even though the proportion of consultants in private practice has reduced from 60 per cent to 40 per cent: <http://bma.org.uk/news-views-analysis/news/2013/april/doctors-fees-increasingly-threatened-by-insurance-companies>. This is due to an increase in the overall number of consultants.

¹¹ The BMA estimated that the number of consultants increased by 3 per cent a year throughout the UK.

<http://bma.org.uk/working-for-change/nhs-watch-how-many-doctors-work-in-the-uk>. Laing & Buisson Private Acute Medical Care (PAMC) 2012, p123, estimated that the average annual increase in England alone was around 5 per cent.

insurance is not a significant barrier, since even small-scale private practice appears to be viable.

- (d) As described in paragraph 4.8, there is overcapacity in private hospitals and we have not received evidence that consultants are having difficulties obtaining practising privileges at private hospitals or accessing consulting rooms or theatre slots.
- (e) We have not received evidence that recognition by PMIs for consultants newly entering or re-entering private practice is an issue, subject to such consultants agreeing to the relevant PMI's recognition criteria. We consider further below the key difficulty raised by consultants in relation to recognition, namely the relatively new requirement introduced by some of the largest PMIs for new consultants to agree not to charge above the relevant PMIs reimbursement levels.

7.6 In relation to individual consultants, no local areas were identified by the OFT or parties as local areas where individual consultants had local market power or where there were shortages of consultants in private practice due to in particular barriers to entry. The evidence that we have received and reviewed does not indicate that there were any issues around the quality of consultant services. Whilst some PMIs expressed concern at consultant charging behaviour in general, the evidence submitted by such PMIs did not indicate significant increases in consultant charges, and indeed PMIs have confirmed that their reimbursement rates have until very recently not been updated for some considerable time.¹² An initial analysis we

¹² The larger PMIs confirmed that their reimbursement fee schedules had not increased since the 1990s and for some procedures had decreased (this is particularly the case with Bupa's reimbursement fee schedule more recently). Bupa's analysis of average consultant earnings net of practice expenses in 2005 compared with 2010 showed that for the ten most common specialisms earnings remained robust. FIPO submitted evidence that established consultants' income from private practice had been broadly stable or declining over the three years 2009 to 2011 whilst costs had been increasing. [FIPO response to AIS, paragraph 5.1](#)

undertook showed in many specialties a real-term decline in revenues in particular since 2008/09 depending on specialty.¹³

7.7 Given (a) this insufficiency of evidence received, (b) the factors listed in paragraph 7.5 suggesting that most consultants in most areas are unlikely to have market power and (c) the highly fragmented and differentiated nature of the provision of consultant services, we have not focused on investigating ToH2 in relation to individual consultants any further. We have therefore not made a provisional finding of an AEC in any local market in relation to individual consultants for any specialty in the UK. However, we refer to Section 8 in relation to clinician incentives and to Section 9 in relation to the lack of information and information asymmetries in relation to consultants in particular.

Consultant groups

7.8 In relation to consultant groups, a number of such groups were identified by parties as of potential concern. Anaesthetist groups were in particular highlighted by the OFT in its decision to refer as consultant groups whose formation may in particular give rise to competitive harm. The referral patterns for anaesthetists are different to other consultants in that in the vast majority of cases the surgical consultant will chose the anaesthetist.¹⁴

7.9 Our survey of consultants¹⁵ showed that whilst 76 per cent of consultants overall told us that they did not belong to a consultant grouping, anaesthetists were twice as likely to belong to a group as non-anaesthetists, with 39 per cent saying that they belonged to a group compared with 20 per cent for non-anaesthetists. In accordance

¹³ Trauma and orthopaedics was the largest specialty by revenue by a significant margin and it was the only specialty to have seen a significant increase in revenues between 2006 and 2011. However, this appeared from our initial analysis to have levelled off since 2009. See Appendix 7.2 for further details on this analysis.

¹⁴ See footnote in paragraph 7.3(c).

¹⁵ Table E2 CC [GP and consultant survey](#).

with our survey, anaesthetists were also more likely to set their fees in relation to the group's guidelines or at levels specified by the group than non-anaesthetists: 60 per cent of anaesthetists in a group set fees at the level determined by the group or set them with reference to group guidelines compared with 51 per cent of non-anaesthetists in a consultant group.¹⁶

7.10 We therefore focused our analysis of consultant groups on anaesthetist groups. The following section summarizes our analysis of (a) the impact of anaesthetist groups on prices and (b) any entry barriers created by anaesthetist groups to individual anaesthetists, and the results of that analysis. Finally, we also consider other consultant groups below.

Anaesthetist groups

7.11 This section summarizes our analysis of (a) the impact of anaesthetist groups on prices and (b) any entry barriers created by anaesthetist groups to individual anaesthetists, and the results of that analysis. Full details of our analysis and results are presented in Appendix 7.1 to which we refer throughout this section.

Analysis

7.12 Several PMIs told us that some anaesthetists had formed groups that collectively set prices and shared revenue. They added that in some cases these groups accounted for a very large proportion of anaesthetic treatments in one or more hospitals. This, according to several PMIs, resulted in higher prices set by anaesthetist groups compared with independent anaesthetists, and in turn, to higher average prices set by anaesthetists. On the other hand, anaesthetist groups and the Association of Anaesthetists of Great Britain & Ireland (AAGBI) argued that group formation helped in delivering higher quality of service. Some parties argued that consultants forming

¹⁶ Table E3 CC [GP and consultant survey](#).

groups, as opposed to operating on a solus basis, are problematic from a competition and consumer choice perspective. We consider that there is no such general presumption. Indeed, there may be a significant number of benefits to consumers in such groups. AAGBI and several anaesthetist groups in particular have highlighted the patient benefits of anaesthetist groups including the provision of emergency cover 24 hours a day, 7 days a week, cross-dissemination of best practice and single points of contact and administration for patients. The parties' views on anaesthetist groups and consultant groups more generally are in Annex A of Appendix 7.1.

7.13 Table 7.1 shows a relatively higher rate of anaesthetist groups being formed between 1981 and 1990 and another spike between 2001 and 2010. This is based on a sample of 45 anaesthetist groups who provided full responses to our questionnaire. Around five out of the 26 anaesthetist groups established between 1960 and 2000, either changed from loose associations to formal legal structures or moved to collective price-setting between 2001 and 2010.

TABLE 7.1 Establishment of anaesthetist groups over time

<i>Time Period</i>	<i>Number of anaesthetist groups established</i>
1960–1970	1
1971–1980	7
1981–1990	13
1991–2000	5
2001–2010	19
Total	45

Source: CC analysis.

7.14 We did not have enough information on the anaesthetist groups' presence and membership across UK hospitals to test systematically their possible impact on average fees charged by anaesthetists.¹⁷ Therefore, our analysis covered only a

¹⁷ AAGBI provided some information about anaesthetists groups derived from a survey undertaken in conjunction with Enventure Research between December 2012 and February 2013 (AAGBI Submission, April 2013) but did not provide details on anaesthetists groups and their membership. We requested information from the PMLs and private hospital operators on the existence of anaesthetist groups (as well as other consultant groups) that they were aware of. This information together with the limited information provided by AAGBI and more general research carried out by the CC identified over 150 potential

certain number of local geographic areas, and anaesthetist groups active in these areas, that PMIs complained about, or mentioned specifically (ie 11 groups in total), as these were likely to be among the most problematic ones.

7.15 A key aspect of the analysis of each local area and anaesthetist group was to find an appropriate control group that allowed us to compare the fees for treatments administered by consultants that belong to anaesthetist group(s) with the fees of the control group (see paragraph 10 of Appendix 7.1). The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely that any difference in prices can be attributed to the presence of the anaesthetist group. As our control groups will not in general capture all other factors, there is some uncertainty associated with the results from our analysis. We controlled for the mix effect of different treatments performed in the different local areas by looking at six¹⁸ of the ten most common treatments in the UK under general anaesthesia (see paragraph 11 of Appendix 7.1).¹⁹

7.16 Where data was available, we conducted the analysis for each of the six treatments, as follows:

(a) First, we conducted price analysis at the national level to give an overview on the UK anaesthetist market (see paragraph 12(a) of Appendix 7.1).

(b) Then, we focused our price analysis on local geographic areas, where PMIs complained specifically about the presence of anaesthetist groups. Based on the 11 areas identified by PMIs we conducted regional analysis and individual case studies (see paragraphs 12(b) and 12(c) of Appendix 7.1).

anaesthetists groups in the UK. Contact details were obtained for approximately 100 such groups which were sent the questionnaire.

¹⁸ Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (w8500); Arthroscopic meniscectomy (including debridement) (w8200); Phakoemulsification of lens with implant—unilateral (c7122); Hysteroscopy including biopsy, dilatation, curettage and polypectomy with/without mirena coil insertion (Q1800); Diagnostic endoscopic examination of bladder (including any biopsy) (m4510); Surgical removal of impacted/buried tooth/teeth (f0910).

¹⁹ These account for around 18 per cent and 19 per cent of observations with non-missing CCSD codes by volume and by value, respectively.

- 7.17 In relation to our national and regional analyses, we note that, even for each specific treatment, we observe substantial price variation in anaesthetist fees across areas of the UK. Therefore, any difference between the average fees set by members of group(s) and non-members of groups²⁰ showed by our national and regional analyses could be explained by factors other than the presence of a group. We have taken this into consideration while interpreting the results of these analyses.
- 7.18 The individual case studies provide more detailed analyses that aim at better controlling for geographical variations. The analysis of price changes pre- and post-formation of the groups, or change of their legal status, is the most useful (in what follows we will refer to this analysis as pre- and post-event). The difference between the groups' prices pre- and post-event and those of non-groups, particularly in the same region, represents a good comparator as the only (observable) feature is the group formation. However, this could only be applied to three case studies as for the other case studies the group was formed before our period of analysis (2006–2012, part year). The second best comparator is independents working in the same hospitals, which was applied to four case studies. In theory comparing average fees between group members and independents in the same hospital is a good comparator as the only (observable) feature that differentiate them is that they are not part of a group. However, one possible disadvantage of this approach is that independents may choose to follow the prices set by the groups. The third best comparator is comparisons with nearby hospitals, which was applied in three case studies. We had difficulty conducting this analysis because of lack of data and

²⁰Note that non-members include independents or members of groups who are not identified in our database.

information about the presence and/or size of anaesthetist groups in nearby hospital.²¹

Results

7.19 Our national and regional analyses²² generally suggest that anaesthetist groups may charge higher prices compared with independent anaesthetists (see paragraphs 16 to 18 of Appendix 7.1). However, as noted in paragraph 6 of Appendix 7.1, these analyses do not control for geographical differences in anaesthetist charges.

7.20 In relation to the individual case studies, the results can be summarized as follows:

(a) We did not have enough observations to conduct individual case studies for five out of the 11 anaesthetist groups.

(b) The evidence on half of the individual case studies undertaken (three out of six) does not suggest that the presence of the anaesthetist groups, and especially their collective price-setting, leads to higher prices. However, for these case studies we were unable to carry out what we regard as the strongest piece of analysis—the pre- and post-event price analysis.²³

(c) For the other three case studies, where we could conduct the pre- and post-event price analysis, the evidence that the presence of the anaesthetist groups, and especially their collective price-setting, may have led to higher prices was, to some extent, mixed. The summary results of our analyses, as described in paragraph 19(a) of Appendix 7.1 for each of these case studies are set out below.

²¹ We note that, in our case studies, we have also compared prices of anaesthetist groups with regional averages on an annual basis (see paragraph 12(c)(i) of Appendix 7.1). Similar considerations to those made in relation to our national and regional analysis in paragraph 7 also apply to this analysis.

²² Including comparison carried out within each case study.

²³ This compares the percentage change in the price charged by anaesthetist groups pre- and post-event with the percentage change in a regional average price over the same period.

- 7.21 For Case Study A, the pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for five of the six treatments. For two out of the five treatments, the differences in price rises were three percentage points or lower. For the other three treatments, the differences in price rises were between four and 13 percentage points. For the sixth treatment, the price rise after the formation of the anaesthetist group was lower than that for the region. The comparison with independents working in the same hospitals could only be carried out for two out of six treatments and the comparison with nearby hospitals for three out of six treatments (see paragraphs 21(d) and (e) of Appendix 7.1).
- 7.22 For Case Study B, the pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the five treatments we had data to analyze. For one out of the four treatments, the difference in price rises was one percentage point. For the other three treatments, the differences in price rises were between eight and 19 percentage points. For the fifth treatment, the price rise after the group changed from a loose association to a formal partnership was lower than that for the region. For this case study, we could not carry out the comparison with independents working in the same hospitals, or the comparison with nearby hospitals.
- 7.23 For Case Study C, the pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the four treatments we had data to analyze. The differences in price rises were between eight and 29 percentage points. For this case study, we could only carry out the comparison with independents working in the same hospitals and this could only be carried out for three treatments (see paragraph 25(c) of Appendix 7.1).

- 7.24 Based on the results of our analyses at paragraphs 15 *et seq* of Appendix 7.1, we have concluded that the evidence available to us does not show that anaesthetists groups have an effect on prices for anaesthetist consultant services. In particular, although the national and regional analyses generally suggest a price effect of anaesthetists groups, we have placed less weight on these analyses as they do not control for geographical differences. In relation to the individual case studies, the evidence of a price effect of anaesthetist groups was mixed. In three of the six case studies undertaken, the evidence does not suggest that the presence of anaesthetists groups leads to higher prices. For the other three case studies, there was evidence of some price effect; however, this was not consistent across all treatments analyzed. Finally, we note that, due to data limitations, we could not carry out all the analyses set out in our methodology for all treatments for all case studies.
- 7.25 We also considered whether there were barriers to being an anaesthetist outside an anaesthetist group. We believe that barriers are low: we found no evidence of any anaesthetist groups having exclusivity arrangements with private hospitals; and individual anaesthetists broadly account for between 10 and 50 per cent of anaesthetist services at the main hospitals where the 11 groups operate.²⁴
- 7.26 On balance, we consider that the evidence we have received and reviewed does not demonstrate an AEC resulting from anaesthetists groups in any local areas.

Other consultant groups

- 7.27 A BMA survey of consultant members in 2011²⁵ provided to the CC as part of our investigation indicated that the majority of respondents (79 per cent) operate as sole traders in the private healthcare sector. Of the remainder, roughly half said that they

²⁴ 11 per cent in case study A, 38 per cent in case study B and 45 per cent in case study C.

²⁵ BMA survey of consultant income, May 2011.

traded as a member of a limited liability company, one-quarter that they were a member of an equity partnership and one-quarter that they were a member of a limited liability partnership.

7.28 A number of parties identified particular groupings involving consultants in specialties other than anaesthetics (other consultant groups) of concern. Each such grouping was very specific in terms of the nature of the membership, the structure of the group, the specialty(ies), whether there were any fee-setting structures in place and the local area of operation. In relation to these groups we did not receive evidence of widespread concerns across many local areas or in particular specialties as we did for anaesthetist groups.

7.29 As noted above in paragraph 7.12, we do not consider that there is a general presumption of competitive harm in professionals forming groups, and indeed, there may be a significant number of benefits to consumers in such groups similar to those identified in Appendix 7.1 in relation to anaesthetist groups.²⁶ Given the evidence received and the results of our pricing analysis of anaesthetists groups (which, for the reasons set out in paragraphs 7.9 and 7.10, were a particular cause for concern) we did not investigate further other consultant groups. We consider that the evidence available to use does not show an AEC relating to other consultant groups in any local areas.

ToH 4—countervailing power of PMIs

7.30 As summarized in paragraph 7.1 above, our ToH4 hypothesized that PMIs may have buyer power in relation to consultants which may be used to suppress consultant fees to a level below those which would prevail in a competitive market. If this were the case, this could lead to a reduction in the quality of service provided by

²⁶ See Appendix 7.1, paragraphs 7 and 10.

consultants to patients and affect the incentives to innovate. We also highlighted that PMIs may distort competition between consultants if caps on the reimbursement of fees were applied to some consultants and not others.

- 7.31 A number of the factors highlighted in paragraph 7.3 above may lead to consultants or consultant groups having local market power as a result of patients generally not being sensitive to price in determining their choice of consultant or treatment. In particular, GPs and other consultants will advise patients on the most appropriate consultant generally without regard to, or indeed knowledge of, a consultant's fees.²⁷ Similarly, a consultant will advise on a course of treatment generally without regard to cost considerations. This is particularly true for insured patients given that it is the PMI who is primarily responsible for funding treatment rather than the patient²⁸ where there would not appear to be effective constraints on consultants' fees apart from those imposed by the PMIs themselves.
- 7.32 We describe in more detail the lack of information and information asymmetries relevant to these issues in Section 9. In this section we focus on the ways in which PMIs have sought to constrain consultant fees and whether these are having an adverse effect on the provision of consultant services. Finally, we also describe other concerns raised by consultants and their trade associations in relation to the behavior of PMIs.

²⁷ In our [GP and consultant survey](#), less than 10 per cent of GPs stated that the consultants fees were an important factor in recommending a consultant to patients (table E6 CC GP and consultant survey). Only 15 per cent of GPs in the survey said that they would discuss or provide information on consultant fees (Table H2) and 86 per cent of GPs surveyed said that they did not have enough information on consultants' fees. The OFT's survey had similar results. www.of.gov.uk/shared_of/market-studies/Final-Survey-Report-08-2011.pdf.

²⁸ See further paragraphs 4.9–4.12 on the role of PMIs.

PMIs constraining consultant fees

- 7.33 Clinician fees (which are primarily consultant fees) account for approximately 25 per cent²⁹ of PMIs' claims expenditure. The larger PMIs' strategy towards consultants, and in particular fees, appears in recent years to have been driven by, on the one hand, a desire to cover consultants' fees so that policyholders do not have to pay any additional fees to the consultant and on the other hand a desire to manage claims costs so far as possible by limiting consultants' fees where possible.
- 7.34 All the PMIs publish fee schedules or guidance setting out the level of consultant fees they will reimburse under their policies. The fee schedules use a set of agreed clinical codes known as CCSD codes with each insurer deciding their fee levels independently. These procedure codes were developed by the Clinical Coding and Schedule Development Group (CCSD)³⁰ and were first introduced in 2006 to provide a consistent coding system across the industry. Bupa's fee schedule has approximately 2,000 separately listed procedures. Each procedure covered in Bupa's Schedule of Procedures has a code, appropriate narrative and complexity rating. There are 25 complexity ratings, which sit under five broad categories: Minor, Inter, Major, Major Plus and Complex Major (CMO). Under each category, there are sub-categories ranging from 1 to 5 (eg Minor 1 to Minor 5). Minor 1 is the least complex (and had a reimbursement rate of £91 in August 2012) while CMO5 is the most complex (and had a reimbursement rate of £2,030 at the end of August 2012).
- 7.35 Bupa's fee schedule, also known as Bupa Benefit Maxima, is regarded as the industry standard and consultants and PMIs have submitted that it is generally perceived as having the lowest reimbursement rates of the PMIs. Until recently, it

²⁹ Laing & Buisson PAMC 2012.

³⁰ Established by Bupa, AXA PPP, Aviva, WPA and Cigna. Current members are Bupa, AXA PPP, Aviva, PruHealth and Simplyhealth.

had not been materially revised since the introduction of CCSD codes in 2006.³¹

Over time, therefore, the Bupa Benefit Maxima has become the benchmark for consultant fees, acting effectively as a minimum fee schedule for consultants in the private healthcare sector.³² AXA PPP confirmed that the level of a consultant's fees will be influenced by the PMI's schedule and that Bupa's Benefit Maxima represented a minimum level of charging. AXA PPP submitted evidence showing that a significant proportion of consultants charge in line with or above the Bupa Benefit Maxima.³³

7.36 Bupa has said that under 50 per cent of their spend on consultant fees in 2011 was on treatments covered by the Benefit Maxima.³⁴ Aviva similarly indicated that its fee schedule only covered approximately 65 per cent of fees paid to consultants.³⁵ Fees for diagnostics³⁶ and outpatient consultations are the main fees not covered by the PMI fee schedules or fee guidance. PMIs generally agree, for example, consultation fees and diagnostic fees individually with consultants and include annual limits on the reimbursement of outpatient procedures. This is a major mechanism for controlling such fees.³⁷

7.37 PMIs, in particular the largest, Bupa and AXA PPP, have embarked in recent years on a number of initiatives to seek to control their costs in relation to consultant fees, whilst also seeking to reduce the need for policyholders to pay additional fees to the consultant. Such initiatives have included:

(a) In order to provide greater clarity to policyholders, in 2011 AXA PPP published a fee schedule similar to Bupa's Benefit Maxima, whereas its policies had

³¹ However, many consultants and their trade associations submitted that in reality there had been no increase in reimbursement rates at least since the mid-1990s.

³² 58 per cent of consultants in our survey set their fees at the same reimbursement level as Bupa and 32 per cent at AXA PPPs (Table E10 CC [GP and consultant survey](#)).

³³ [AXA PPP response to IS paragraph, 15.3.](#)

³⁴ [Bupa response to IS paragraph, 1.84.](#)

³⁵ [Aviva response to AIS paragraph, 2.4.](#)

³⁶ Generally, diagnostics and outpatient consultations are not covered by the PMIs' fee schedules as opposed to surgical procedures.

³⁷ [Bupa response to IS.](#)

previously reimbursed on the basis of ‘reasonable and customary fees charged in the market’.³⁸

- (b) Bupa has been carrying out full reviews of their fee schedules, and Aviva carry out a rolling review of their fee schedules, prioritizing procedures according to the degree of the problem.³⁹
- (c) Some PMIs have introduced a requirement on policyholders under some PMI policies to obtain guided referrals. Under a guided referral the referring clinician does not name the consultant (and/or hospital) but merely specifies the nature of the condition, enabling the PMI to seek to direct policyholders to consultants (and hospitals) whose fees are the lowest.
- (d) Bupa and AXA PPP have introduced new consultant contracts under which newly recognized consultants cannot charge above the PMI’s fee schedule thus making the PMI’s fee schedule the maximum amount such consultants can charge for their services.

7.38 We describe below key aspects of each of these initiatives.

Review of PMI fee schedules

7.39 As noted above, AXA PPP introduced a schedule of fees in 2011 for its policyholders. The fee schedule was set at a level that AXA PPP considered to be the mode of consultant fees for each procedure broadly in line with Bupa’s Benefit Maxima.⁴⁰

³⁸ AXA PPP response to IS paragraph, 15.3.

³⁹ Aviva response to IS paragraph, 5.5.14.

⁴⁰ AXA PPP response to IS paragraph, 15.3.

- 7.40 Between January 2011 and July 2012, Aviva reviewed 128 codes, 63 per cent of which were adjusted upwards and only 11 per cent of which were adjusted downwards.⁴¹
- 7.41 However, it is Bupa's review of its Benefit Maxima which has had a visible impact on consultant fees given that it is regarded as the industry standard, as described in paragraph 7.35 above. By June 2012, of those procedures reviewed,⁴² 49 saw increases in rates of on average 19 per cent, but 184 were reduced by an average of 32 per cent. Some procedures had significant changes in reimbursement rates, including cataract surgery fees. Bupa stated that its previous fee represented an approximate hourly rate in excess of £2,000. As of July 2012, the fixed rate was £567.⁴³
- 7.42 This review has been carried out by Bupa's in-house team of clinicians and analysts with input from external specialists who do not treat Bupa patients. Bupa explained that they do not generally consult on or otherwise discuss their Benefit Maxima levels with their recognized consultants in advance of final adoption, or with consultant representative trade bodies.⁴⁴
- 7.43 In addition to reviewing the level of reimbursement for individual procedures, the PMIs have also reviewed the circumstances in which they will reimburse consultants for multiple procedures under the same anaesthetic. For example, from 1 July 2012, Aviva no longer reimburses for more than three procedures in one theatre session in line with the other PMIs.⁴⁵

⁴¹ [Aviva response to IS paragraph, 5.5.15.](#)

⁴² Such procedures reviewed by June 2012 included procedures in the following specialisms: [X]

⁴³ We have received a number of complaints both from consultants and from patients with regard to Bupa's reduction in the level of cataract reimbursement in particular.

⁴⁴ Bupa told us that in 2013, it had a consultation period with consultants in Plastics and Radiotherapy.

⁴⁵ www.aviva.co.uk/health-insurance/.

Consultant fee capping

7.44 As noted in paragraph 7.37(d), Bupa and AXA PPP have introduced new recognition criteria for new consultants. Bupa and AXA PPP⁴⁶ said that these new criteria were aimed at addressing what they term shortfalls. Where a consultant's fees are in excess of a PMI's reimbursement rate, a consultant generally may charge the patient the difference, assuming the PMI does not meet the difference. This difference between the PMI's reimbursement rate and the consultant's fee will be termed a top up fee if the patient is aware of and agrees to pay the difference in advance of treatment. However, if the consultant for whatever reason⁴⁷ has not made the patient aware of this potential difference in advance of treatment, the difference is termed by the PMI as a shortfall.

7.45 According to the PMIs, shortfalls are identified by policyholders as a key concern. Bupa stated that for [✂] surgical procedures and [✂] anaesthetic procedures, the consultant's fees were higher than Bupa's Benefit Maxima.⁴⁸ Aviva stated that in 2010 approximately 17 per cent of consultants invoiced for fees exceeding its fee schedule⁴⁹ and that approximately 5 per cent of its policyholders might have an additional fee to pay to consultants as a result of Aviva not reimbursing in full the consultant's invoiced fees.⁵⁰ PruHealth estimated that between 5 and 10 per cent of consultants charged in excess of its fee schedule.⁵¹ Several PMIs explained that they frequently reimburse consultant fees in full over and above their fee schedules in particular where the patient is not aware of the likelihood of a differential. PMIs have

⁴⁶ [Bupa response to IS, paragraphs 6.74 et seq.](#) [AXA PPP response to AIS.](#)

⁴⁷ Such reasons may include insufficient knowledge of the patients' PMI policy, not being aware of changes to the PMIs reimbursement rates, treatments requiring multiple procedures and unforeseen treatments/complications. As noted elsewhere, we have been provided with evidence that this is particularly an issue in relation to anaesthetists' fees as the anaesthetists may only meet the patient on the day of surgery and it is generally the consultant surgeon who selects the anaesthetist for their theatre list and may not consider the anaesthetist's fees or the patient's particular PMI policy in doing so.

⁴⁸ [Bupa response to AIS, paragraph 2.84.](#)

⁴⁹ [Aviva response to AIS, paragraph 2.4.](#)

⁵⁰ However, Aviva indicated that this did not necessarily mean that the policyholder will pay the difference as consultants might invoice the PMI for a higher fee and then not seek to charge the differential in reimbursement to the policyholder. Bupa and AXA PPP similarly told us that they could not confirm final consultant charges as they did not generally know unless their policyholder raised the matter with them whether the consultant invoiced the patient directly or for how much.

⁵¹ PruHealth indicated that in such cases PruHealth would challenge the fee and seek to negotiate with the relevant consultant. This is usually successful. Policyholders will not need to pay any differential as PruHealth told us that they would always pay consultant fees in full, to ensure that its customers did not suffer a shortfall in benefit.

therefore sought ways to guarantee that their policyholders will not experience any shortfalls in relation to consultant fees as well as reducing their claims costs in covering such differentials.

7.46 Under the AXA PPP scheme introduced in 2008, AXA PPP required all newly recognized consultants, who were also largely newly qualified, to sign up to an agreement whereby in order to be recognized by AXA PPP they must only charge AXA PPP insured patients fees set within AXA PPP's fee schedule and agree not to charge AXA PPP insured patients any top-up fees (the CC refer to such consultants as fee-capped consultants).⁵² For such consultants therefore AXA PPP's reimbursement rate is the maximum fee that the consultant can charge for their services. AXA PPP told us that around [redacted] per cent of their 23,000 recognized consultants are subject to this contract.⁵³ AXA PPP also told us that they have not signed up any of their previously recognized consultants (ie those recognized prior to 2008) to the new contract and have not seen any decrease in the number of new consultants applying for recognition since the introduction of the new contract.

7.47 In addition to the [redacted] per cent of consultants who are fee-capped, approximately [redacted] per cent of AXA PPP's recognized consultants are fee-assured based on a 'usual and customary approach'. There is no contract in place between AXA PPP and these consultants but they have historically charged within reimbursement levels deemed acceptable by AXA PPP. However, if such a consultant were to routinely charge AXA PPP policyholders significantly higher fees than they previously had, AXA PPP would review their charges and practice. If, after discussion with AXA PPP, this charging practice were to continue the consultant would then be told that they are no longer on AXA PPP's list of fee-assured consultants, and their fees would be capped and

⁵² AXA PPP response to IS, Section E. AXA PPP response to AIS, paragraphs 5.20 et seq.

⁵³ AXA PPP response to IS, Table 6.

limited to the published schedule. This means that AXA PPP will not recommend such consultants to policyholders, and when a policyholder seeks pre-authorization to seek a non-fee-assured consultant AXA PPP will inform the policyholder that they may be liable for additional fees. However, AXA PPP policyholder's can use their benefits to see such consultants and are free to pay top-up fees.

7.48 Although newly recognized consultants from 2008 must adhere to AXA PPP's fee schedule, AXA PPP told us that it closely monitors the number of fee-capped and fee-assured consultants that it recognizes to ensure its policyholders have adequate choice. AXA PPP has also confirmed that it will keep under review the level at which fees are capped as those fee-capped consultants become more experienced⁵⁴ in order to keep the proportion of fee-assured and fee-capped consultants at over [X] per cent of its recognized consultants. This means that after a number of years, some consultants who are contractually obliged to charge within AXA PPP's fee schedule may be able to increase their fees.

7.49 Prior to 2010, Bupa ran a voluntary scheme under which, if a consultant agreed to charge within Bupa's reimbursement rates for all treatments covered by the Benefit Maxima, Bupa would pay a retrospective annual bonus of [X] of the consultants' charges (excluding consultation fees). Consultants on the scheme, some [X] as at June 2010, were advised to policyholders as fee assured. In June 2010, Bupa closed the voluntary scheme to new members and introduced a new mandatory consultant contract, which sets out the terms of recognition between Bupa and consultants who are newly recognized from that June 2010. Like AXA PPP, as a condition of recognition under the terms of Bupa's new contract, consultants are required, among other things, to charge Bupa policyholders in accordance with the fees set by Bupa.⁵⁵

⁵⁴ AXA PPP response to AIS, paragraph 5.20 et seq.

⁵⁵ Terms for Bupa Recognised Consultants (newly recognised from 2010)

They are not permitted to charge Bupa insured patients any amount over and above the Bupa agreed fees, even if this has been discussed with the patient in advance of treatment.⁵⁶ Bupa's scheme appears to be more stringent than AXA PPP's.⁵⁷ AXA PPP told us that it continues to recognize consultants even if such consultants are what AXA PPP regarded as systematically high chargers.⁵⁸ However, all consultants, whether fee-capped or not risk being de-recognized by Bupa and unable to treat any Bupa patients if they cannot provide objective justification as to why they are charging more than Bupa's Benefit Maxima.

7.50 If a consultant was already recognized by Bupa in June 2010, they were not required to sign up to the new contract. However, Bupa has said that in June 2012, it had signed up [redacted] previously recognized consultants to its new fee-capping contract⁵⁹ and that it intended to initiate a consultation with all currently recognized consultants (ie those consultants who were recognized prior to the introduction of the 2010 contract and who were not fee-capped) about how Bupa can 'work differently with them in the future'⁶⁰ [redacted].⁶¹

7.51 Bupa told us (as at March 2013) that approximately [redacted] consultants who had not previously been recognized by Bupa had signed up to the new contract since June 2010. Bupa also explained that while the new contract requires that consultants only

⁵⁶ Bupa told us that some procedures can involve unexpected complications which may not be reflected in the complexity ratings. In such cases, consultants can request uplift payments. All uplift decisions are reviewed by Bupa's Medical Directors and funding is approved where requests are medically justified.

⁵⁷ See the footnote in paragraph 9.7.50 on the number of consultants in our [GP and consultant survey](#) who had agreements to charge within a PMI's fee schedule. Bupa provided the CC with a Bupa consultant benchmark fee report which states that Bupa works with 12,000 consultants in the UK who have agreed to charge within its published benefit maxima reimbursement rates and those consultants treat the majority of its policyholders.

⁵⁸ [AXA PPP response to IS, section 15.4.](#)

⁵⁹ We understand that such consultants are termed 'Premier Consultants Partners' and such consultants have higher rankings under Bupa's Open Referral criteria.

⁶⁰ [Bupa response to IS, paragraph 6.82.](#) See also www.bupa.co.uk/jahia/webdav/site/bupacouk/shared/Documents/PDFs/healthcare-professionals/recognition/consultant/bupa-recognition-qanda.pdf.

⁶¹ 36 per cent of consultants in our survey stated that they had agreements with Bupa to charge in line with Bupa's fee schedule compared with only 13 per cent for AXA PPP. Table E12 [GP and consultant survey](#).

charge the fees that it has set (rendering these consultants fee-capped⁶²), policyholders retain the freedom to see the consultant of their choice. Should a patient request Bupa authorization to see a consultant who is not fee-assured, Bupa told us that they would grant the request—indeed, they did not prevent patients from going to see consultants who might charge a top-up fee provided the consultant was a recognized Bupa consultant.⁶³ However, Bupa would guide all policyholders towards consultants who had agreed to charge within their Benefit Maxima, whether fee-capped or under its previous voluntary scheme.⁶⁴ It did this (a) through Open Referral, (b) by prioritizing in their consultant rankings those consultants that were fee-assured so that patients were more likely to select such consultants when seeking authorization from Bupa whether on an Open Referral policy or not and (c) by advising policyholders at pre-authorization that should they select a consultant who was not fee-assured they risked being charged top-up fees and would recommend other fee-assured consultants.

7.52 Neither Aviva nor PruHealth are proposing to introduce similar consultant fee-capping contracts. PruHealth has stated that it did not direct patients to providers as it saw treatment as being clinically rather than insurance led.

Guided referral

7.53 Bupa, AXA PPP and Aviva have introduced PMI policies in the corporate sector under which the policyholder is required to obtain a guided referral from their GP or other referring clinician. Under this guided referral process, the referring clinician does not name the consultant (and/or hospital) but specifies the specialty or sub-specialty. The policyholder will then contact their PMI and depending on the PMI and

⁶² Bupa refers to fee-capped consultants and those consultants that are on its previous voluntary scheme as fee-assured consultants. AXA PPP defines fee-assured as including those consultants who are not fee-capped but who customarily charge within its reimbursement levels.

⁶³ We understand this includes consultants who are part of Bupa's voluntary scheme as well as fee-capped consultants.

⁶⁴ When a policyholder uses the online search tool to find a consultant, the 'fee-assured' consultants are listed first.

the terms of the policy, the PMI will advise the patient on the appropriate consultant.⁶⁵

- 7.54 Bupa initially launched its Open Referral policies in 2011 (in a pilot stage with two corporate clients). Open Referral was offered to all corporate customers from January 2012. Bupa has been actively encouraging all its policyholders, whether under an Open Referral policy or not, to obtain a guided referral.⁶⁶ Bupa has confirmed that it currently intends to launch policies with mandatory guided referral requirements to personal customers in the second half of 2013.⁶⁷
- 7.55 Bupa considers that guided referral policies enable it to constrain claims costs by directing its policyholders to those fee-assured consultants. Bupa also argued that guided referral enables it to direct its policyholders away from those consultants which it considers might over-test or over-treat patients. Unlike GPs, who in Bupa's view often refer patients to consultants 'with little or no objective data about a consultant's care practices or charges', Bupa had stated that it had a 'comprehensive database' giving it an 'insight into which consultants provide higher quality care'.⁶⁸
- 7.56 Policyholders are encouraged to bring Bupa's standard Open Referral form to their GP appointment and the GP will specify the policyholder's symptoms and clinical requirements (clinical specialty, sub-specialty and whether an appointment is needed urgently). Bupa then gives the policyholder a choice of generally two or more consultants. The choice of consultants provided by Bupa depends on several factors. For example, Bupa considers the location of the policyholder and the specialty required. However, Bupa's consultant scoring criteria also include cost criteria such

⁶⁵ As indicated in Section 6. In that section, guided referrals may also apply in relation to the hospital provider and not just the consultant.

⁶⁶ www.bupa.co.uk/.

⁶⁷ These policies will exist alongside policies without such requirements and therefore, customers will continue to have a choice.

⁶⁸ www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bupa-updates-archive/open-referral-news/Open-referral-letter.

as [redacted] and whether the consultant is fee-assured (see above, paragraphs 7.49 to 7.51).⁶⁹

7.57 AXA PPP started to offer policies to corporate customers requiring guided referral in May 2010 although this was limited to 70 BMI facilities. In January 2013, AXA PPP launched its Healthcare Pathway policy (Pathways) which covers a network of 120 facilities.⁷⁰ Like the Bupa policy, Pathways is also directed at corporate customers and is very similar to Bupa's in requiring policyholders to obtain a guided referral from their GP (both in terms of hospital and consultant). Policyholders are provided with a choice of up to three consultants from AXA PPP's list of fee-capped and fee-assured consultants. AXA PPP also offers a Fast Track appointment booking service under which it makes the bookings for first appointments.⁷¹ Policyholders not on mandatory guided referral products can also obtain guided referrals and use AXA PPP's services such as the Fast Track appointment service.⁷² However, AXA PPP does not at present, as actively as Bupa, encourage personal policyholders to obtain guided referrals.

7.58 Aviva recently launched a similar scheme (Guidewell) for large corporate customers under which members will be required to obtain guided referrals both in relation to the consultant and the hospital. In addition under such policies musculoskeletal problems will be managed through Aviva's BacktoBetter rehabilitation service which enables policyholders to bypass the need for a GP referral at all.⁷³

7.59 We have received a large number of submissions from consultants and their representative bodies critical of these initiatives and the way in which in particular

⁶⁹ Bupa's consultant scoring system has [redacted].

⁷⁰ BMI told us that it offered AXA PPP a deep discount of [redacted] per cent to contract by way of guided referral and that it insisted that discounts be used to support lower costs to the consumer of the Pathways product.

⁷¹ www.axapphealthcare.co.uk/.

⁷² AXA PPP response to AIS, paragraph 5.29.

⁷³ www.aviva.co.uk/healthcarezone/about-us/news/latest-news/guidewell-sustainable-and-affordable-pmi/.

Bupa and to a lesser extent AXA PPP engage with consultants more generally.

Whilst the submissions we have received are not necessarily representative of the views of all consultants, several of the trade associations have been relatively strong in their criticisms of the behavior of some of the PMIs and some PMIs have themselves expressed concern at some of the initiatives being adopted and/or the manner of their adoption, [REDACTED].⁷⁴

Analysis of key potential concerns regarding PMIs' buyer power

7.60 In light of the above we focused our investigation on two key issues relating to consultants fees: PMI reimbursement rates and PMI restrictions on top-up fees. In doing so we make two general observations. First, in the context of consultant fees, the consultant is the supplier of a service and the PMI is the payor and can therefore be characterized as the buyer of services. Strong buyers generally lead to increased competition and lower prices for consumers. As noted above in paragraph 7.31, in the absence of the PMIs constraining consultants' fees, it is unclear how such fees would be constrained. Second, consultants are critical to the PMI's business. The key perceived benefits of privately-funded healthcare are treatment by a consultant of choice and treatment at a time and place convenient to the patient.⁷⁵ Moreover, patients' experience of privately-funded healthcare will, in the main, be driven by the consultant. PMIs therefore depend for their business on a supply of high quality widely located and available consultants for their policyholders.

PMI reimbursement rates

7.61 Bupa told us that its Benefit Maxima were key in constraining consultants' charges. Without the PMIs, in Bupa's view consultants would not have any constraints on their

⁷⁴ [REDACTED] expressed specific concern in regards to the severe restriction of consultants' fees and linking consultant recognition to such restricted fees.

⁷⁵ 76 per cent of respondents to our patient survey stated that the main reason for going private was reduced waiting times, 52 per cent availability of appointment times, 39 per cent ability to chose a specific consultant, 38 per cent better quality of care, 25 per cent better after care, 25 per cent better clinical care, 23 per cent ability to in the top highest ranking reasons for selecting PMI (Table B1 [CC patient survey](#)).

fees. It provided analysis comparing consultant reimbursement per member by Bupa between 2007 to 2011 for outpatient consultations, which are not subject to the Benefit Maxima, and for surgical procedures which are subject to the Benefit Maxima. Bupa's analysis showed that spend per member for consultant consultations grew at a significantly faster rate than for surgical procedure spend per member and general inflation (RPI).

7.62 Bupa did not consider that its Benefit Maxima should be automatically increased each year. In its view the size of the PMI market is similar to that in the mid-1990s but the number of consultants available for private work has increased over the period. Moreover, in its view, improvements in technology have reduced the complexity of, and the skill and time required for, a number of treatments.

7.63 AXA PPP made similar observations regarding the lack of constraints on consultants' fees.⁷⁶ In particular AXA PPP stated that newly qualified consultants charged less than the average consultant per procedure and had lower episode costs. Like Bupa, AXA PPP also said that it had no evidence that consultants who charged above its reimbursement levels were of higher quality. AXA PPP also compared its reimbursement rates with those available in the NHS. For example, according to AXA PPP, NHS Trusts paid approximately £120 per hour for additional work by a consultant compared with an hourly rate in excess of £450 in the private sector.⁷⁷

7.64 As set out in Appendix 7.2 our preliminary analysis and the evidence submitted by parties on consultants' fees did not suggest that consultants' fees were either increasing or decreasing significantly. The extremely wide variation in the levels of consultant earnings and costs depending on specialty, locality and size of practice would have made any profitability analysis extremely difficult, resource intensive and

⁷⁶ AXA PPP response to IS and AXA PPP response to AIS.

⁷⁷ AXA PPP response to AIS, paragraph 5.21.

inconclusive. Appendix 7.2 contains further analysis by Stanbridge Associated Limited which suggests that net average incomes⁷⁸ for ten key specialties between 2005 and 2010 have been relatively stable over time. A number of factors have impacted on consultant fee income in recent years independent of the PMIs, including a decline in demand both from insured⁷⁹ and self-pay patients, decreased NHS waiting times, improved NHS consultant remuneration, greater NHS commitment requirements, and an increase in the number of consultants.⁸⁰

7.65 In addition, on the basis of the information we received, we are not able to ascertain whether the level of PMI reimbursement rates mean that consultants' charges are being constrained by the PMIs at a level which is more or less appropriate compared with the charges previously made. It is evident that the PMIs' strategies in relation to consultants' fees over the last few years is tending to constrain consultants' fees. This has combined with the PMIs' increasing role in determining the choice of consultant for particular treatments/referral journeys through the use of guided referral and other specialist referral schemes⁸¹ increasing the impact of the PMIs' steps to lower their reimbursement rates for many procedures.

7.66 However, we have not seen evidence to indicate that the PMIs' reimbursement rates are leading to lower quality of services, to lower incentives to innovate or are dissuading consultants from entering or remaining in private practice in sufficient numbers to affect consumer choice or cause long-term detriment. Further, it is in the

⁷⁸ Income after accounting for practice costs including staff costs, consulting room hire, professional indemnity.

⁷⁹ See paragraph 3.75.

⁸⁰ BMA survey of consultants reported that the most common explanations for consultant earnings being flat or declining were a decline in the self-pay market (64 per cent), decreased NHS waiting times (58 per cent) and an increase in the number of consultants (46 per cent).

⁸¹ Such as Aviva's musculoskeletal (MSK) rehabilitation service under which a GP referral is not required and Aviva directs customers to their strategic clinical partners who advise on treatment and the choice of provider. Bupa has a Specialist Eye Care process enabling optometrists to refer directly to Bupa's team. Policyholders with muscle, bone or joint conditions have the option not to obtain a GP referral, and instead to contact Bupa direct, which will then arrange a physiotherapist assessment to provide advice and refer the policyholder if necessary.

PMIs' own commercial interests⁸² to carefully balance their desire to constrain consultant fees (the benefits of which can be passed on to their policyholders in the form of lower premiums) and their need to ensure that their policyholders have full access to high quality, appropriately located and available consultants—such access is fundamental to their business as PMIs. Thus, it would not be in the PMIs' own interest to drive consultant charges so low that quality and innovation is negatively affected—and PMIs are, therefore, unlikely to do so. We make a few observations below at paragraph 7.77 in relation to information provided to policyholders in particular with regard to these matters.

Top-up fees

7.67 Bupa and AXA PPP argue that their new consultant contracts enables them to offer their policyholders the assurance that consultants' fees will be fully covered, with 'no surprises'. They also argued that price was not necessarily an indicator of quality.⁸³

7.68 Consultants and some of their trade associations⁸⁴ have argued that:

- (a) Bupa and AXA PPP represent a significant proportion of the market for consultants and through requiring consultants only to charge up to their reimbursement rates are determining the maximum fees a consultant may charge.
- (b) Consultants can no longer set their fees based on their experience, their specialist knowledge, the local market in which they operate and the quality of the service they provide but purely by reference to the standard rates that AXA PPP and BUPA are willing to reimburse. In addition, consultants' fees will vary

⁸² [AXA PPP response to IS, Section E](#). Indeed, most of the PMIs commented on the importance of consultants to their businesses. We also refer to the footnote in paragraph 7.60 above on the results of the [CC patient survey](#) and the reasons for choosing privately-funded healthcare.

⁸³ [AXA PPP response to IS, Section E](#).

⁸⁴ [FIPO response to IS](#).

depending on the patients' PMI rather than the consultants' own costs or the treatment provided.

- (c) AXA PPP and Bupa's reimbursement rates do not take into account differentials between consultants in terms of experience, expertise or location in the country. For example, the reimbursement rate for a consultant in central London, who will have higher costs, is the same as for a consultant located in Torquay. Similarly, the reimbursement rate for a consultant with 15 years' experience may be the same as for a newly qualified consultant.
- (d) The codes are relatively rigid and do not take into account the level of variation within different procedures, co-morbidities and associated factors.

7.69 There is clear disparity in organizational size between an individual consultant (and indeed most consultant groups) and a PMI. In addition, we find the argument that Bupa recognition and AXA PPP is critical to many consultants persuasive, given Bupa and AXA PPP's share of private patients. Furthermore, a consultant who is not recognized by Bupa and/or AXA PPP or who loses a significant proportion of Bupa referrals because they refuse to agree to be fee-capped could well find it uneconomic to run a private practice. A consultant may be willing to charge in accordance with the PMI's fee schedule but not be willing to enter into a contract under which they would be fee-capped, and could still find that they lose significant numbers of referrals. We note the BMA's recent survey of consultants found that the number of consultants threatened with de-recognition by PMIs has risen from 11 per cent in 2011 to 34 per cent in 2012.⁸⁵ Bupa's Benefit Maxima, as the industry standard, in particular clearly operates in practice for many consultants as both a maximum and minimum fee schedule. Moreover, Bupa's new contract also caps fees for outpatient consultations, unlike Bupa's Benefit Maxima and therefore the impact of Bupa's strategy on consultant fees and incomes is potentially very significant. We consider, therefore,

⁸⁵ <http://bma.org.uk/>.

that at the very least Bupa and AXA PPP have buyer power in relation to consultants. Consequently, Bupa and AXA PPPs action in relation in particular to capping some consultant fees has the potential to distort competition between consultants.

7.70 If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice. Fee-capping (and de-recognition of consultants who do not agree to abide by the PMI's fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions. This distortion may potentially be increased the greater the number of insured patients on policies that require guided referrals from GPs.

7.71 However, we have not received evidence that Bupa's and AXA PPP's contracts with new consultants are leading to the number of new consultants being recognized reducing annually since their introduction.⁸⁶ We also do not have evidence that the number of consultants in private practice as a whole is being adversely affected by the actions of the PMIs nor that, as a result of the fee-capping of some consultants, consultant fees are being constrained to such a level that this is adversely impacting on consumer choice or quality, discouraging innovation or otherwise causing long-term consumer detriment.

7.72 As noted at paragraph 7.48, AXA PPP will monitor closely the number of fee-capped and fee-assured consultants, and will keep under review the level at which fees are capped.

⁸⁶ For example, AXA PPP said that prior to the introduction of fee capping contracts it had 22,500 recognized consultants and 1,300 were recognized in 2007. In early 2011 it had 23,000 recognized consultants and 1,300 were newly recognized in that year. AXA PPP also said that it monitored carefully the impact of the fee-capping contract to ensure that it maintains adequate choice of consultant for its policyholders. [AIS response, paragraphs 5.2 et seq.](#) Similarly, Bupa has confirmed that it has continued to recognize approximately 1,200 new consultants a year since June 2010.

7.73 There are clear benefits to policyholders in the PMIs' promoting lower cost consultants which should be passed on to consumers. We also recognize that whilst the PMIs encourage policyholders to see fee-capped or fee-assured consultants, policyholders can pay top-up fees under the terms of their policies if they wish to see a non-fee capped (in the case of Bupa) or non-fee capped or assured consultant (in the case of AXA PPP). Whilst policies that require guided referral are a standard option for Bupa corporate policies (although not all corporate policies have guided referral) and Bupa intends to offer such policies to personal customers, policyholders will continue to be able to choose between policies offered by Bupa and other PMIs where guided referral is not mandatory and under which policyholders are able to and are not prevented from paying top-up fees if they so choose.

7.74 We also refer to our comments below with regard to the nature of information provided to policyholders and the potential this may have to distort competition between consultants and limit patient choice causing long-term detriment.

Other issues with regard to PMIs and consultants

7.75 The other main criticisms of PMIs' conduct fall into the following categories:

- (a) providing misleading information to patients on the status of consultants and/or their level of charges;
- (b) misleading patients over the reasons for redirecting patients from one consultant to another and the basis on which the PMI recommends one consultant rather than another;
- (c) lack of transparency to both patients and consultants as to the PMI's criteria for recommending particular consultants over other consultants;
- (d) arbitrary 'de-listing' of consultants and a lack of transparency in PMIs' handling of such matters;

- (e) without notice or consultation imposing additional obligations on consultants to continue to be recognized;⁸⁷
- (f) inappropriate clinical referrals by PMIs to consultants for certain procedures;
- (g) using staff that lack appropriate medical qualifications to review proposed treatments or provide advice on medical matters;
- (h) requiring particular courses of treatment, for example that all musculoskeletal cases be referred to a physiotherapist in the first instance rather than a consultant irrespective of GP referral or requiring the consultant's proposed course of treatment to be reviewed by the PMI prior to authorization; and
- (i) changing benefits of policyholders mid-term or withdrawing authorization mid-treatment.

7.76 Appendix 7.3 sets out in more detail the key themes emerging from the submissions we have received from consultants. Most of the complaints that we have received relate to Bupa, with some relating to AXA PPP and other PMIs. This is unsurprising given Bupa's leading position as a PMI provider, the fact that its reimbursement rates are generally regarded as the benchmark for consultant charges and that it has been at the forefront of a number of these initiatives in particular the review of its reimbursement levels, fee-capping of outpatient consultations as well as surgical procedures and guided referral. As noted elsewhere, Bupa is also intending to extend these initiatives in the near future, in the case of Open Referral, to personal customers and, in the case of fee-capping, to more consultants.⁸⁸

7.77 We have not received persuasive evidence that these issues indicate a competition problem in the provision of consultant services. However, we do consider that they raise matters of importance. As PMIs increasingly determine not only fee levels but

⁸⁷ Bupa told us that recently, it had ceased to require that the appraiser be in the same speciality.

⁸⁸ See paragraphs 7.50 and 7.54 above.

also which consultants a patient may see and, depending on how rigidly and extensively they do so, given in particular Bupa and AXA PPP's buyer power in relation to consultants, there is a risk that competition between consultants will become distorted. If patients are provided by the PMIs with inaccurate or misleading information regarding a consultant's fee levels or the quality of the services a consultant provides, this will distort competition. We have received some evidence that some of the language used by PMIs in distinguishing between consultants who are recognized but not fee-capped may suggest to patients that a consultant who is not fee-capped overcharges for their services. Similarly, we have received some evidence to suggest that some patients understand that quality rather than primarily cost (together with location and specialty) are the driving factors for the PMIs' recommendations and that a consultant to whom a patient has been referred but who is not fee assured may provide a lower quality of care than one who is recommended.

- 7.78 To the extent to which initiatives like guided referral achieve the PMI's objectives of lowering costs and these are passed on to policyholders in the form of lower premiums, this will be beneficial to consumers. If they are unsuccessful in reducing premiums, we have no evidence to suggest that in particular the corporate sector, where many of these initiatives have been launched, will not respond accordingly.
- 7.79 In respect of the concerns that PMIs are changing benefits of policyholders mid-term or withdrawing authorization mid-treatment, this is a concern, but a matter for the Financial Ombudsman Service (FOS) to address.
- 7.80 Whilst outside of our terms of reference, it is in relation to this issue that we received the most complaints from policyholders. It is clearly important that policyholders understand the terms of their policies at purchase and renewal. This includes being

made aware and fully informed about changes to reimbursement rates and the recognition of consultants which will have a direct impact on the nature of and value of benefits available under their policies (see Appendix 7.4 on information availability on PMIs).

Summary of our findings on consultants

- 7.81 We have found that there are factors which would indicate that some individual consultants and some consultant groups in some local markets may have market power. However, the evidence we have received and reviewed does not show that any such local market power by individual consultants is giving rise to competitive harm. Therefore, on the basis of the evidence available to us, we did not make a provisional finding of an AEC relating to individual consultants in any local market for any specialty in the UK. However, we refer to Section 8 in relation to clinician incentives and to Section 9 in relation to the lack of information and information asymmetries in relation to consultants in particular.
- 7.82 In relation to anaesthetist groups, on balance, even for the three case studies where the evidence of some price effect was strongest, we found this evidence to be mixed and we were, therefore, not persuaded that the presence of the anaesthetist groups led to higher prices. The same conclusion applies for the other three case studies, and, given that we focused our analysis on the more problematic areas highlighted by PMIs, we expect the same applies for the other regions in the UK.
- 7.83 In relation to other consultant groups, we did not receive evidence of widespread concerns across many local areas or in particular specialties as we did for anaesthetist groups. There is no general presumption of competitive harm in professionals forming groups and indeed there may be a significant number of benefits to consumers in such groupings. Our pricing analysis of anaesthetist groups

did not suggest that other consultant groups should become a focus for our investigation. Given these factors overall we did not focus on investigating ToH2 in relation to other consultant groups. We therefore consider that evidence before us on this point does not support an AEC relating to any other consultant groups in any local areas.

- 7.84 The two largest PMIs at least, Bupa and AXA PPP, have buyer power in relation to consultants but we have found no evidence to suggest that it is being exercised in such a way as to harm competition, for example, by leading to a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, the incentive is on PMIs to promote competition among consultants and maintain innovation and quality to protect and indeed improve demand for PMI.
- 7.85 In relation to fee-capping specifically, we consider that, on balance, the evidence we have received does not demonstrate that, at present, Bupa—or indeed any other PMI—is distorting competition between consultants through fee-capping of some consultants.
- 7.86 Whilst we have not received persuasive evidence that the other issues raised by consultants and trade associations in relation to PMIs indicate a current competition problem in the provision of consultant services, we consider that PMIs, and in particular Bupa, as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about consultants and the reasons for recommending some consultants or for advising against the use of particular consultants. The availability of information to patients on the performance of consultants and their fees is considered further in Section 9.

8. Hospital competition for clinician referrals

Introduction

- 8.1 One of the ways that private hospitals attract business is by encouraging consultants to treat private patients at their facilities. As most patients are referred to consultants by GPs, hospitals may also try to encourage GPs to refer patients to consultants who use their facilities.
- 8.2 In doing so, private hospitals can be expected to take account of the GMC rules and guidance. As we describe in Section 2, the GMC is the independent regulator for doctors in the UK and is responsible for keeping registers of qualified doctors. It is responsible for fostering good medical practice, including regulating the conduct of doctors treating patients privately and potential commercial conflicts of interest. Its rules are set out in its *Good Medical Practice*¹ and associated guidance. In Section 9 we examine information availability; there is some overlap between that section and this (in particular the discussion of ‘choosing a treatment option’ at paragraphs 9.20–9.48).
- 8.3 Private hospitals encourage consultants to use their facilities in a variety of ways. They promote themselves to consultants (or GPs) in communications or at events, where they describe the quality of their staff and the facilities and equipment that they have invested in. They commonly offer access to resources which will make using their facilities more convenient for a clinician by, for example, making consulting rooms or secretarial services available. They may also operate schemes which provide financial benefits to consultants using their facilities.
- 8.4 The purpose of this section is to set out the various schemes adopted by private hospital operators which provide incentives to clinicians, and consultants in

¹ [Good Medical Practice](#), GMC, 2013.

particular, to use their facilities and to consider whether any or all of these schemes may distort competition between private hospital operators.

Schemes adopted by the main hospital groups

- 8.5 Our market questionnaire asked private hospital operators what schemes they operated to encourage consultants to undertake work at their facilities or to GPs to refer patients to consultants who practised there. We asked for details of these schemes including when they operated, the cost of operating them and who benefited from them. We reviewed internal documents setting out the objectives and benefits of these schemes and in the case of equity partnership arrangements or joint ventures we examined the obligations of the parties as set out in the legal agreements giving effect to them. In addition, as part of the research for our case studies in Bath, Edinburgh and central London, we looked at the use of such schemes during episodes of entry and expansion.
- 8.6 We invited the views of PMIs and consultants' and GPs' representative and professional bodies on such schemes and the effect that they had on competition between hospitals. In addition, in our survey of consultants we asked questions relating to their knowledge and experience of such schemes.
- 8.7 We reviewed the regulatory framework within which these schemes operate in the UK, principally the Guide to Good Medical Practice published by the GMC² and its associated guidance. We also reviewed, but not extensively, the regulatory framework governing clinician incentives in the USA.
- 8.8 We describe below current or recent schemes adopted by the main hospital groups to encourage referrals by GPs to consultants practising at their hospitals and to

² GMC, [Good Medical Practice \(2013\)](#).

encourage consultants to undertake private work at their hospitals. We then go on to describe schemes operated by some of the smaller hospital operators, details of which were either collected during the research for our case studies on market entry or from submissions made by the parties.

BMI

GPs

- 8.9 BMI told us that, currently, it only made payments to GPs for private GP services provided in its hospitals, ie BMI subcontracted services to GPs and paid them for those services. It said that it had considered GP incentive schemes in the past but had decided not to implement these proposals following legal review. Among the schemes it considered implementing was one which it proposed to pilot in Bath.
- 8.10 BMI did operate a pilot scheme in Bath, commencing in 2010, whereby it made payments to GPs for preoperative assessments on BMI patients. It told us that the programme was designed to increase patient referrals through improved patient service by making pre-assessment more convenient. Under the terms of the scheme, where patients were referred to the Bath Clinic for an outpatient consultation and it was determined that surgery was necessary, a preoperative 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.
- 8.11 We asked BMI whether it had, in the last six years, any arrangements in place whereby GPs or other primary care providers would prioritize referrals to their facilities. BMI told us that it previously had in place an arrangement with [REDACTED].
- 8.12 It told us that it also had in place an arrangement, no longer active, with [REDACTED].

8.13 BMI told us that it had operated the BMI Syon Clinic as a corporate joint venture (ie a separate company) with Sentosa, a company comprising primarily consultants and GP shareholders. The Syon Clinic offers diagnostic and outpatient facilities provided by the consultants based there. [REDACTED], Sentosa consultants at the Syon Clinic refer all their patients from the Syon Clinic requiring in-patient care to BMI facilities and, where tests could not be undertaken at the clinic, to a BMI facility, subject to the GMC rules on *Good Medical Practice*. BMI told us that the corporate joint venture with Sentosa, which had established the BMI Syon Clinic, had helped move work from [REDACTED].

8.14 We asked BMI (and other private hospital operators) for details of any assets that it owned or rented where GPs or other primary care providers practised. BMI gave us examples of such arrangements, mainly operated at its hospitals, and told us that, in addition, it had some BMI outpatient facilities in GP surgeries.

Consultants

8.15 BMI told us that in early 2012, before the OFT's MIR decision, it had considered its position in relation to consultant incentive schemes. It wished to ensure that it was not engaging in schemes that could make the company vulnerable to media or regulator criticism, notwithstanding the eventual view that the CC took on the merits or demerits of these schemes. It decided to stop direct financial incentive schemes and profit-share arrangements other than where these related to joint investment or similar between the consultant and the hospital and including the 'consultant loyalty' schemes we describe below. Nonetheless, BMI told us that in an environment where competition for consultants was fierce and consultants represented a significant source of work, legitimate grounds arguably did exist for payments to consultants by hospitals. It noted that it had not withdrawn from consultant arrangements that

directly supported investment in particular joint ventures or co-investment vehicles.³

BMI said that it did not consider these to be ‘incentives’ at all; rather, they were necessary pro-competitive terms to support hospital investment and to bring into existence a shared desire between consultants and hospitals to develop new and enhanced patient services.

- 8.16 BMI supplied the CC with a review of what it described as ‘Consultant Loyalty Schemes’ that it said had been prepared as part of its business operations [REDACTED].
- 8.17 BMI group management considered consultant loyalty schemes in 2007 as part of its strategic response to increased competition from other hospital operators, including Circle. A board paper of April 2007, a month after Circle obtained planning permission for its Bath hospital, assessed the severity of the competitive threat to each of its hospitals. [REDACTED] Bath were considered to be exposed to the highest risks and, accordingly, were proposed as the first hospitals where consultant loyalty schemes would be set up.
- 8.18 The ‘Mark 1’ scheme combined profit sharing and ‘virtual equity’ elements which aimed to engage and motivate current and future consultants [REDACTED]. The scheme was designed in part to mimic an equity share plan [REDACTED].
- 8.19 The scheme covered a six-year period and entitled consultants to a share of the Bath Clinic’s profits, the size of their entitlement being determined by the amount of revenue that a consultant brought to the hospital.⁴ [REDACTED]

³ For example, it told us that BMI Beardwood invested in a new cancer treatment centre through a joint venture with a number of consultants [REDACTED].

⁴ [REDACTED]

8.20 As well as the rolling share of the Clinic's profits and the long-term payment referred to above, consultants would be entitled, depending upon their level of membership, to receive some or all of: [redacted].

8.21 In addition to these benefits, if a member were to introduce a new consultant to the clinic who subsequently went on to enter into a similar agreement, then the introducing member/consultant would be entitled to [redacted].

8.22 The 'Mark 1' scheme was contractual. [redacted]

8.23 Consultants were also required to agree that they would not enter into any form of agreement or contract with any competitor relating to operation of a private medical practice including acquiring any financial interest in such a competitor, although they could retain practising privileges elsewhere.

8.24 The Mark 2 scheme was adopted in 2010 and [redacted].

8.25 There was, unlike Mark 1, no formal contract with consultants [redacted]. The Mark 2 scheme also differed from Mark 1 in that there were no bars to participation, [redacted].

Cost of the schemes

8.26 We show below the payouts from the [redacted] and Bath Clinic schemes.

TABLE 8.1 Consultant loyalty scheme payouts at [redacted] and Bath clinic

	£		
	FY10	FY11	FY12 est
[redacted]*	[redacted]	[redacted]	[redacted]
Bath			
Mk1	[redacted]	[redacted]	[redacted]
Mk2	[redacted]	[redacted]	
Total	[redacted]	[redacted]	[redacted]

Source: BMI.

*A breakdown between the Mk 1 and 2 schemes at [redacted] was not available.

Spire

GPs

8.27 Spire told us that several Spire hospitals had agreements with GPs for the provision of services of various sorts, including advising on marketing to GPs and health screening, room rental for consultants visiting GP practices and facilities for advertising the relevant Spire hospital. Spire provided us with a list of these services and where they have been put in place. Generally, the value of these arrangements to GPs was a few thousand pounds a year.

Consultants

- 8.28 Spire told us that it had no schemes providing incentives to consultants as it would define such schemes, either at a national or at individual hospital level, and to the extent that arrangements might exist which might be considered as offering such incentives these would have been negotiated between the consultant and the relevant hospital director, may have arisen out of custom and practice and may not necessarily be recorded in writing.
- 8.29 Spire noted that arrangements with consultants could also sometimes take the form of joint ventures to introduce or expand a new procedure, service practice area or, as in the case of Spire Brighton, extend to the establishment of a new hospital.
- 8.30 It told us that Spire Brighton (the Montefiore Hospital) would be operated by a joint venture company (Montefiore House Limited). Spire had subscribed £[redacted] in equity in return for which it had received a [redacted] per cent share of Montefiore and the group of orthopaedic consultants and physiotherapists had subscribed £[redacted] in equity in return for which they would receive a [redacted] per cent share of Montefiore. The shareholders agreement would commit the consultants to the hospital for five years.

- 8.31 Spire listed the schemes that it operated and told us that most of them involved discounted consulting room rental or secretarial fees which it said were not linked to the volume or value of business that the consultant brought to the hospital nor to the proportion of their work that was undertaken at a Spire hospital.
- 8.32 We examined the arrangements that Spire set out in its submission. At Spire's [redacted] hospital, for example, the majority of the arrangements listed related to discounted room rentals and secretarial services. Some, however, involved quite significant payments to consultants.
- 8.33 Under one, the hospital paid the medical defence organization (MDO) costs of a surgeon as well as providing the surgeon with free medical secretarial services and consulting rooms. The payment of the consultant's MDO costs, Spire told us, was in return for them committing their practice and referrals to the hospital, subject to the clinical interests of the patient, compliance with applicable codes of practice of the BMA and GMC and other than where a patient's insurer does not recognize the Spire hospital for care, diagnosis or treatment. Spire told us that the annual value of payments to this consultant between 2009 and 2012 had amounted to £[redacted].
- 8.34 Another scheme [redacted] paid three consultants a proportion of the profit made by the hospital from cardiology tests referred to the hospital by the consultants. In 2011 this scheme paid out just over £[redacted] to each of the consultants. Spire told us that this arrangement pre-dated its ownership of the hospital [redacted].
- 8.35 Spire told us that in a small number of cases a consultant or small group of consultants had agreed to base their private practice exclusively at a particular Spire

hospital. At its [X] hospital, for example, it had established the [X],⁵ equipped with outpatient consulting rooms, a CT scanning and MRI suite and two operating theatres with laminar flow. Spire pays the [X] a fee based on the revenue generated by the [X] consultants. It told us that its total payments since January 2009 to [X] amounted to £[X].

8.36 Spire told us that the agreement with the consultants provided carve-outs for them to treat patients elsewhere if so required by the GMC guidelines or if the patient expressly wished to be treated elsewhere.

8.37 Similarly, it told us that it had acquired the orthopaedic surgery practice of [X] whose private practice work was now exclusive to [X] and who now referred private patients to the hospital 'subject to the patient's clinical best interests'. Between 2010 and the first half of 2012 payments to [X] amounted to just less than £[X] based on the share of the revenue generated by his practice and that of his colleague in the [X] unit [X].

HCA

GPs

8.38 HCA provided us with a description of the arrangements each of its hospitals has with GPs where these exist.

8.39 HCA told us that it had a three-year Fully Managed Practice (FMP)⁶ agreement with [X] to provide professional medical services at its Wellington Hospital in return for which he was paid £[X] also has an equity stake in the Wellington Diagnostic and

⁵ The [X] consultants operate outpatient clinics at the [X] and the [X] hospitals.

⁶ We explain FMPs and the other agreements used by HCA more fully in our discussion of HCA's arrangements with consultants.

Outpatient Centre (WDOC) JV in Golders Green.⁷ HCA told us that the payments to [redacted] represented fair market value for the services that he provided to the WDOC.

- 8.40 Also at the Wellington Hospital, HCA has a recruitment agreement with [redacted] for the establishment of a private GP practice at the Wellington Hospital. HCA offered [redacted] an income guarantee in the form of a loan to facilitate switching [redacted] practice to the Wellington Hospital's Platinum Medical Centre. In the event, since [redacted] income has not fallen below the guaranteed level, this facility has not been drawn down.
- 8.41 The Harley Street Clinic pays a retainer of £[redacted] per year to [redacted] under a Professional Services Agreement in [redacted] capacity as [redacted] New Malden Diagnostic Centre.
- 8.42 HCA told us that although these types of arrangements originally included obligations upon doctors to use their best endeavours to refer patients to HCA facilities, following a review in 2011/12 contracts have been reworded so as to remove this obligation and make clear that doctors, having signed a Professional Services Agreement (PSA) for example, 'shall be under no obligation to refer patients to any [HCA] hospital'.
- 8.43 In addition to these arrangements HCA has a number of Consulting Room Licence Agreements (CRLAs) with GPs who operate their practices at HCA facilities. It told us that consulting rooms were licensed out at the WDOC and Platinum Medical Centre and that consulting rooms were licensed to two GPs at the Harley Street Clinic Diagnostic Centre. The Lister Hospital owns two facilities where it licenses consulting rooms to GPs (the Chelsea Consulting Rooms and the Chelsea Medical Centre), the London Bridge Hospital provides facilities for two GPs at its Medical Centre in

⁷ Twenty-five private GPs operate from the WDOC, www.wellingtondiagnosticscentre.com/.

Sevenoaks and for one at the City of London Medical Centre and the Princess Grace Hospital provides facilities for four GPs in a facility located in front of the hospital.

Consultants

- 8.44 HCA told us that it had six types of agreement that it could offer consultants. Under its CRLA, which had a maximum term of one year and a one-month notice period on either side, consultants were provided with consulting rooms at HCA facilities for which the consultant paid a 'fair market value' other than in circumstances such as a consultant coming new to HCA in which case the fee might be waived for up to six months. It said that less than half of the 3,000 consultants with practising privileges at HCA facilities had CRLAs, which, it noted, contained no obligations on consultants to refer patients to HCA facilities.
- 8.45 FMP agreements, it said, related to clinical units which HCA wished to establish, develop or strengthen. Consultants were paid a fixed annual fee for their services and, though HCA and the consultants might agree certain growth targets for the unit, no bonuses were payable if they were met. Under the current contract, consultants were not obliged to refer patients to HCA facilities but must always refer on the basis of the patient's best interests and, in line with the draft FMP Handbook, must disclose their financial interests to patients. HCA told us that it had entered into 28 FMPs covering around 130 consultants and 21 of the 28 agreements contained growth plans.
- 8.46 Professional service agreements (PSAs) are agreements between HCA and a consultant for the provision of clinical services, for example a medical directorship at an HCA hospital. Consultants are paid a fixed annual fee for their services based on an hourly rate and the number of hours that the consultant is expected to devote to the work involved. Again, under the current contract consultants are not required to refer patients to HCA hospitals. HCA gave an example of this type of agreement

whereby a consultant was to supply neurology services at the Harley Street Clinic with an annual growth target of 10 per cent in new outpatients. HCA has entered into 141 PSAs covering around 170 consultants.

- 8.47 Recruitment agreements (RAs) have the objective of attracting consultants to an HCA facility. The consultant is expected to work with HCA to manage and grow their practice at an HCA hospital. HCA told us that these agreements might be offered to consultants relocating their practices and thus facing increased costs or risking losing patients, consultants in their first year of private practice and consultants wishing to reduce their NHS workload in favour of private practice. Under these agreements HCA may offer the consultant an income guarantee or a loan to cover start-up expenditure. Only ten such agreements are in place and HCA told us that it was in the process of phasing them out.
- 8.48 Recruiting agreements are different from 'recruitment agreements' and provide consultants who already have an FMP with additional resources to attract new or junior consultants to assist the consultant in developing the unit concerned. HCA may provide the consultant with a loan which he or she may use to fund an income guarantee for the new consultant, for example. HCA has 12 such agreements in place.
- 8.49 Galen consultant agreements (GCAs) are agreements between Galen Health Partners (a wholly-owned subsidiary of HCA) and consultants or a company of consultants under which Galen procures certain support services on behalf of consultants such as practice management, practice marketing and financial services. HCA currently has 143 Galen agreements in place.

8.50 The number and cost of these various arrangements was set out in HCA's 2012 business plan (2011). In total these costs amounted to around £5 million a year.

FIGURE 8.1

HCA's consultant engagement schemes

[✂]

Source: HCA.

8.51 HCA told us that in 2011/12 it reviewed its contracts with consultants for compliance with the Bribery Act and GMC guidelines. It told us that these (original) contracts obliged consultants to use their best endeavours to refer patients to HCA facilities but always subject to the clinical needs and best interests of the patient.

8.52 However, HCA told us that it wished to remove any potential conflict of interest and so reworded its contracts to state explicitly that consultants party to the agreements we have just summarized were under no obligation to refer patients to HCA hospitals. Letters to doctors explaining the need for the changed wording and also obliging doctors to disclose to patients their financial interest in the unit were sent out in the first half of 2012.

8.53 HCA told us that in addition to these arrangements it had entered into a number of JV agreements with consultants for certain outpatient facilities. The model for these JVs was that HCA would obtain a suitable site for the clinic and sublet it to the limited liability partnership (LLP). HCA would provide management services to the LLP in return for a fee of [✂] and the LLP would charge consultants a fee for the use of consulting rooms. In all cases, HCA was the majority owner of the LLP with shares ranging from 51.5 per cent (the Chelsea Outpatient Centre) to 90.4 per cent (the LOC Partnership LLP), with the remainder being owned by consultants practising at the facility.

- 8.54 The original agreements underlying these arrangements included obligations as regarded referrals to HCA hospitals, though with caveats with reference to patients' best interests.
- 8.55 The 2011 LLP agreement for the LOC obliged members to use their reasonable endeavours to refer their own patients who were seen at the LOC and who required inpatient care to HCA facilities, 'subject always to the patient's clinical needs and best interests'.
- 8.56 The LLP agreement relating to the Chelsea Outpatient Centre LLP, similarly obliged members to 'use best endeavours to refer all patients of the Member, who are seen at the Centre and who require in-patient treatment to an HCA hospital subject always to the clinical and best needs of the patient'.
- 8.57 HCA told us that just as it had reviewed its service agreements for compliance with the Bribery Act and GMC guidelines, it did so for its JV agreements. As a result of this review, the 'best endeavours' obligation to use HCA facilities wording was changed so that members undertook not to be influenced by the terms or the existence of the JV agreement in their choice of treatment or treatment facility recommended to patients.
- 8.58 We note that the varied agreement does include an undertaking that the member will 'use his reasonable endeavours to utilise the facilities of the Centre for the purpose of developing his private practice' again though 'subject always to the patient's clinical needs and best interests'. Members thus have, subject to the 'patients best interests' caveat, an obligation to use the relevant centre operated by the JV, in which they have an equity stake, but not to refer patients on to facilities operated by HCA.

8.59 HCA pointed out that these JV agreements in some cases incorporated non-compete obligations, for example that governing the CyberKnife treatment facility which prevents a consultant member of the JV holding an ownership interest in another business engaged in radiosurgery or other services provided at the CyberKnife centre. HCA pointed out that this clause did not limit the right of the consultant to practise at another private or NHS facility. It told us that, in the light of the substantial investments made and market risks faced by HCA, it considered these non-compete obligations to be entirely reasonable, proportionate and necessary. We note that 'non-compete' terms are contained in the LOC LLP agreement whereby member consultants are precluded from offering outpatient (though not inpatient or day-case) services at rival facilities within a 10-mile radius.

Nuffield Health

GPs

8.60 Nuffield told us that it had not in the last six years and did not currently have any arrangements in place with individual GPs, GP practices or other primary care organizations to prioritize referrals into its facilities and nor did it have any plans to do so in the future.

8.61 Nuffield provided us with details of premises that it owned where GPs currently practised and the terms on which these were provided. It told us that GPs practised at its Bournemouth, Brentford, Bristol, Derby, Guildford, Haywards Heath, Leeds, Oxford and Woking hospitals. It said that arrangements varied but that the most common was that facilities were not provided free and the hospital took a share of the fees generated by the GPs concerned.

Consultants

8.62 Nuffield told us that in 2009 it introduced a national reward programme for consultants called Practice Privileges Plus (PP⁺). It said that the paramount aim of the scheme was patient care, that consultants were not precluded from working elsewhere and that the scheme was intended to be funded from economies of scale arising from increased business growth. Payments under the scheme were calculated on the amount of revenue that the consultant had generated and revenue growth in the current year. Thus the more revenue a consultant had generated previously, the more they could earn from the scheme, and the greater the growth on the prior year, the bigger the payout, up to a maximum of 3.5 per cent of the gross value of the consultant's earnings for the hospital the year previously. The grid for payments is reproduced in Figure 8.2.

FIGURE 8.2

Nuffield's PP+ scheme payout grid

		Activity Growth Categories					
		£0 - £49k	£50k - £99k	£100k - £149k	£150k - £199k	£200k - £249k	> £250k
Loyalty Categories	£0k - £249k	0.00%	0.35%	0.70%	1.05%	1.40%	1.75%
	£250k - £499k	0.35%	0.70%	1.05%	1.40%	1.75%	2.10%
	£500k - £749k	0.70%	1.05%	1.40%	1.75%	2.10%	2.45%
	£750k - £999k	1.05%	1.40%	1.75%	2.10%	2.45%	2.80%
	£1,000k - £1,249k	1.40%	1.75%	2.10%	2.45%	2.80%	3.15%
	£1,250k - £1,299k	1.75%	2.10%	2.45%	2.80%	3.15%	3.50%
	£1,300k - £1,349k	2.10%	2.45%	2.80%	3.15%	3.50%	
	£1,350k - £1,399k	2.45%	2.80%	3.15%	3.50%		
	£1,400k - £1,499k	2.80%	3.15%	3.50%			
	£1,450k - £1,499k	3.15%	3.50%				
>£1,500k	3.50%						

Source: Nuffield.

8.63 In 2012, Nuffield decided to close the scheme. It told us that the scheme had been designed so that additional incentives would not be required. However, hospitals were continuing to provide free consulting rooms, free telephone use, secretarial services etc on top of the benefits of the PP⁺. It said that these practices varied by hospital so was not easy to quantify and also risked negating the model rewards as those who did not earn a financial reward could receive benefits in other ways. It said

that, in addition, doctor groups were being formed and in some cases engaging with management companies to negotiate on their behalf and therefore individual deals were being struck outside the PP⁺ contract.

8.64 The document setting out Nuffield's analysis of the scheme indicated that the current regulatory intervention may have contributed to the decision to review and cease the PP⁺ scheme. The report concluded:

However, the current climate emanating from the OFT investigation indicates that continuation of the PP⁺ programme is not sustainable. Nuffield Health has stated publicly that 'We would like a ban to be considered on any form of financial incentive to consultants and GPs from private healthcare organisations. We believe this will help improve the service consumers receive by providing greater choice and easier access to the right healthcare professionals to suit their needs.' Nuffield Health has established a position on such incentives. A decision to delay the removal of PP⁺ would be counter to this positive stance and create the appearance that any decision to remove PP⁺ in the future was reactive to any future announcement by the OFT or the Competition Commission (CC).

The recommendation is that PP⁺ contract termination is served soon as possible to meet the likely announcements regarding such incentive packages by the OFT or CC and in line with David Mobb's [group CEO] statement to the Times on 24th February 2012; with the effect of our maintaining our ethical stance on the subject and raising the spotlight on competitor practices.

Ramsay

GPs

- 8.65 Ramsay told us that it did not agree with offering direct financial incentives to GPs or other providers of primary care and did not make such incentives available. However, it regarded the role of GPs as sources of patient referrals as very important and that strong relationships with GPs were critical to its business success. It said that each of its hospitals employed a GP Liaison Officer who would regularly visit GP practices, inform practitioners about developments at Ramsay hospitals, introduce GPs to Ramsay consultants, discuss any issues with previous referrals and get feedback from GPs. It said that the only payments that it made to GPs were in return for services provided in attendance at its neurological rehabilitation units.
- 8.66 Ramsay told us that private GPs operated out of some of its hospital facilities. At its Springfield hospital, for example, a group of private GPs rented two consulting rooms, an office plus reception and waiting area. The hospital charged the GPs £[REDACTED] per month for the use of these facilities which included the cost of employing two reception staff. Ramsay said that save for a free room provided at its West Midlands Hospital to support the NHS Abdominal Aortic Aneurysm screening programme, it did not provide any free or subsidized accommodation or services to GPs.
- 8.67 Ramsay told us that it strongly believed in the importance of GP education and training and that its hospitals regularly hosted 'lunch and learn' events at GP practices at which a consultant with relevant expertise would present on a topic of interest to GPs. In addition to these events, Ramsay told us that it organized educational seminars and workshops for GPs and practice employees and provided literature and reports, including information on the quality of the services at each of its hospitals.

Consultants

- 8.68 Ramsay told us that it had operated just two financial incentive schemes in the previous three years and that these were offered at its Berkshire Independent Hospital. It said that both had now been terminated.
- 8.69 Ramsay told us that between January 2009 and June 2011 it operated a consultant revenue share scheme under which consultants received a payment equivalent to [X] per cent of the outpatient revenues they had generated for the hospital and [X] per cent of the inpatient revenues they had generated for the hospital in each quarter. At the same time as it introduced this scheme it also ceased subsidizing medical secretarial services which, from then on, had to be paid for on a full recovery basis. Ramsay told us that the scheme had been introduced by the then Regional Director without approval from Ramsay's executive team, that it was not a contractual scheme and that a total of £[X] had been paid out to consultants under it.
- 8.70 Ramsay said that urology consultants, operating as Reading Urology Partnership, had a separate but similar scheme which operated from January 2008 to June 2011 (when the partnership moved its practice elsewhere). Under the scheme, which was non-contractual and initial discussions over which had taken place prior to Ramsay's acquisition of Capiro in November 2007, the partnership received a total of £[X] in payouts.
- 8.71 Ramsay told us that there were various 'support/benefit' arrangements in place at its hospitals, for example room rental and secretarial services, but that it was for each hospital to determine the appropriate charge for these. It said that in the majority of Ramsay hospitals consultants paid the standard (non-discounted) room rental fee but that some of its hospitals discounted room rental or provided the consulting room free of charge for consultants who generated a high level of revenue for the hospital.

Other private hospital operators

8.72 We examined the schemes adopted by some smaller private hospital operators as part of our research into episodes of market entry or expansion in Bath, central London and Edinburgh (see Section 6).

Circle

8.73 As we set out in our case study on Bath (see Appendix 6.1), Circle differs from some of its competitors in that it offers consultants who commit to undertake a given proportion of their work at a Circle hospital an equity stake in the business.

8.74 Circle Health Limited, the parent company of the Circle operating group, is 50.1 per cent owned by Circle Holdings plc and 49.9 per cent owned by Circle Partnership Limited. Circle Holdings is the entity through which capital is raised to fund the growth of Circle's activities and Circle Partnership is the entity through which clinicians and employees are granted share ownership in Circle.

GPs

8.75 Circle told us that in 2006/07 it had attempted to attract GPs to the partnership with a view to developing an integrated care model as practised in the USA. It said that the attempt was abandoned once it was clear that it was not appropriate for GPs to have a substantial role in Circle's partnership as this would pose inherent provider–commissioner conflicts. It said that a relatively small number of GPs remained in the Circle practice but were not active.

Consultants

8.76 Circle told us that when it identified a particular market that it believed was viable, it met with consultants in the area. In exchange for building a new hospital in the area, consultants were asked to commit a certain proportion of their private work, usually

around 50 to 60 per cent, to the hospital but could terminate this contract with 12 months' notice after the first anniversary of the hospital's opening. Upon entering into this agreement the consultant typically received a small grant of Circle Partnership shares. Shares were offered to consultants at 'fair market value' determined annually by an independent valuer, though participants did not need to pay for them at the time of acceptance but only when they came to sell the shares.

- 8.77 Circle told us that consultants working at its facilities were encouraged to take responsibility for both the quality and the cost of care they provided through participation in the facility's executive board, which reviewed operational, clinical and financial performance and comprised clinical leads who were responsible to the board.

Bupa Cromwell Hospital

GPs

- 8.78 We included BCH in our case study of TLC's expansion of its cancer treatment facilities in central London.
- 8.79 BCH told us that its hospital site encompassed mews buildings, some of which were rented out to consultants and GPs. It said that there were [X] private GP practices operating out of the mews with lease agreements. It said that the rental for this accommodation had previously been dependent on the value of referrals made to BCH under agreements reached prior to Bupa's ownership of BCH. BCH confirmed that it had removed the direct link in these arrangements between the office rental value and referral fees.

Consultants

- 8.80 BCH told us that it had operated schemes which provided consultants direct financial incentives to refer patients to the hospital. These included a volume-related financial

incentive scheme to encourage consultants to refer patients for [redacted] and [redacted], which has now ceased, where consultants received payment for referrals.

8.81 BCH told us that, as with GPs, it had been the practice at the hospital to subsidize rates at which consultants were provided with consulting rooms. Figures supplied to us indicate that these subsidies were valued at just over £[redacted] a year.

8.82 BCH said that since acquiring the hospital it had sought to rationalize and standardize its approach to consultant reimbursement but that currently, using incentives was unavoidable to remain competitive in London if other hospitals were permitted to use them. However, it also expressed concerns regarding an ‘arms race’ developing between hospitals which, it said, would lead to the hospitals with the deepest pockets entrenching the relationships with consultants. It said that it had itself experienced the challenges of entering new services because it could not match the incentives offered by other large hospital operators in London.

The London Clinic

GPs

8.83 We asked TLC for details of any arrangements it had with GPs and consultants. TLC did not provide us with details of any arrangements with GPs.

Consultants

8.84 In our case study on TLC’s Cancer Centre, we reported an episode in which two consultants, [redacted]⁸ at the Clinic, were contemplating transferring their practice to another hospital, believed by TLC management to be HCA’s Platinum Centre at the Wellington Hospital. The Board of Trustees gave its ‘exceptional’⁹ permission to the

⁸ In excess of £[redacted].

⁹ TLC told us that it was a ‘one-off, defensive’ arrangement.

management to come to an arrangement with the two consultants that would retain them.

8.85 The terms agreed included that the consultants concerned were under the following obligation: they should:

use best endeavours to procure that all referrals and diagnosis requiring other treatments are carried out at the Hospital and not at any other institution including, without limitation, the London Oncology Centre (LOC) and HCA hospitals. This requirement will not apply if it is concluded by the Contractor or the Consultant that, for clinical reasons, it is in the best interests of the relevant patient for treatment to take place elsewhere.

8.86 We also reported in the case study that TLC had an agreement with the LOC which it had signed in 2005 which obliged the LOC, in exchange for a £[redacted] loan from TLC, to refer patients to TLC. These obligations were quite extensive. Members were obliged to refer to TLC, and to use their best endeavours to cause all consultants working at the LOC to refer to TLC all new patients requiring inpatient admission and all outpatient and day-case patients who could not be treated at the LOC. Similar obligations applied to the referral of patients for general radiology, ultrasound and CT/MRI and, when TLC was able to provide these services, PET scanning, all radiotherapy and nuclear medicine imaging. In addition, the LOC was entitled to a £70 fee for each MRI scan undertaken by TLC arising from LOC referrals. These obligations were, however, subject to the 'patients' best clinical interests' caveat and subject to the GMC rules on *Good Medical Practice*.

Aspen

8.87 Aspen became the owner and operator of the Edinburgh Clinic in 2011. The entry of the Edinburgh Clinic under its previous ownership into the Edinburgh market was the subject of our Edinburgh case study.

Consultants

8.88 Aspen made a submission to us on the relationship between hospital operators and consultants, and specifically equity based JVs. It said that, as it was US owned and by way of its close operational ties with United Surgical Partners International, it conformed to a number of US federal regulations intended to govern the illegal remuneration of physicians in the USA that was also translatable to consultants within the UK. It told us that there were a number of safe harbour provisions in the US Anti-Kickback statute which it sought to comply with in the UK. It said that the US regulations were more prescriptive than any current regulation within the UK and that by taking this stance it would avoid any ethical issues in relation to long-term equity investment models.

8.89 Aspen told us that it had a small number of equity-based JVs but that its strategy was not based entirely around consultant partnerships. It said that in most cases these took the form of an LLP which leased an Aspen-owned hospital and operated it. Consultants would then invest cash in return for an equity interest in the LLP. However, it said that it also had facilities which were originally owned by a group of consultants which Aspen had bought into by acquiring shares. It said that in all these arrangements it maintained managerial, operational and clinical control by owning more than 50 per cent of any interests or shares in the JV entity.

8.90 Aspen told us that the invitation to participate in a JV was extended to consultants already practising at an Aspen facility, rather than to attract new consultants to practise there, and that its agreements were based on five key principles:

- Consultants invest their own cash for a minority equity interest alongside Aspen and the price per equity unit is based on fair market value. No consultant was ever ‘awarded’ equity or received equity at less than market value in consideration of a commitment to make referrals.
- Financial returns to consultants are derived from the profits of the JV and the return to each consultant is based on and proportionate to the level of the consultant’s equity investment and not on the number of patients that the consultant treats at or refers to the facility.
- The JV agreement requires the consultant to exercise clinical judgement when deciding on treatments or venues for patients and always to act in the patient’s best interests.
- The arrangement is transparent to patients, the JV agreement requiring the consultant to inform their patient of their stakeholding.
- JV member consultants have the ability to sell their equity stake at any time.

Views of the parties

Hospital operators’ views

8.91 Private hospital operators, in their submissions on this issue, (generally) argued that in some parts of the country the practice of offering incentives to consultants had become commonplace since it was necessary to do so in order to attract key consultants and that competition for consultants was intense.¹⁰ Some said that they would welcome clarification from us on the merits and de-merits of various types of scheme.

¹⁰ See, for example, [General Healthcare Group’s response to the issues statement](#), paragraph 2.3b.

8.92 We have cited above hospital operators' comments provided to us in response to our questions about their schemes. Some of the hospital operators also provided views and comment in response to our annotated issues statement. Our annotated issues statement raised the question as to whether incentive schemes gave rise to barriers to entry and some of the responses received (most notably that from HCA) focused on that issue.

BMI

8.93 In response to the annotated issues statement BMI made limited additional comments. It noted the importance of competition for consultants and that this competition 'drives hospitals to meet the existing and future needs of patients as effectively and efficiently as possible'. It said that it 'welcomes the role of the CC with respect to defining the boundaries of useful and pro-competitive interaction between consultants and PHPs'.

HCA

8.94 In response to the annotated issues statement HCA said that this had 'not presented any evidence that hospital/consultant agreements are creating foreclosure effects in local healthcare markets, or specifically any evidence of foreclosure in London'¹¹ and that, overall, the 'evidence discussed in Appendix E does not bear out the concerns that these [agreements] constitute barriers to entry or expansion'.¹² HCA also said that, in the light of the CC's and OFT's consultant survey evidence which HCA said revealed the relatively low number of consultants that were aware of or had been offered incentives/benefits by private hospitals,¹³ it was 'difficult to see how incentive arrangements can create material barriers to entry where they involve such a relatively small group of consultants'. With respect to London, HCA said that 'there is

¹¹ [HCA response to AIS](#), paragraph 7.32.

¹² *Ibid.*

¹³ [HCA response to AIS](#), paragraph 7.33.

a relatively large pool of NHS consultants (over 7,500) which ensures that new entrants have ready access to consultants which need to undertake a private practice. In these circumstances, it is inconceivable that any the types of schemes described in Appendix E are likely to have material foreclosure effects in the London market'.¹⁴

8.95 HCA noted that 'new entrants are able to compete to attract consultants on exactly the same terms and conditions as incumbent hospital operators. The incumbent enjoys no inherent advantages' and that 'there is no reason why new entrants are not able to offer the same incentives in order to attract consultants to a facility'.¹⁵ In that regard, HCA pointed to Circle's consultant incentive model which HCA said had 'allowed Circle to attract consultants in a relatively short space of time, and thereby attract significant volumes of business, which has served as Circle's route to market'.¹⁶ HCA submitted that hospital/consultant collaborative agreements provide a means for providers to establish new facilities or expand existing ones by attracting consultants and creating new innovative types of ventures and motivating consultants to develop new services.¹⁷ HCA drew our attention to recent GMC guidance that it said 'acknowledges that consultants may have financial or commercial interests in healthcare facilities provided they do not allow conflicts of interest to arise and disclose these interests to their patients'.¹⁸

8.96 HCA also wrote to us commenting on AXA PPP's response to the annotated issues statement. HCA strongly disagreed with AXA PPP's claim that HCA incentivized consultants to use new technologies rather than better value-for-money alternatives.

¹⁴ [HCA response to AIS](#), paragraph 7.40.

¹⁵ [HCA response IS](#), paragraph 13.24. HCA made reference to the European Commission's guidelines on abuse of exclusionary conduct: "If competitors can compete on equal terms for each individual customer's entire demand, exclusive purchasing obligations are generally unlikely to hamper effective competition unless the switching of supplier by customers is rendered difficult due to the duration of the exclusive purchasing obligation."

¹⁶ [HCA response to AIS](#), paragraph 7.39.

¹⁷ [HCA response to IS](#), paragraph 13.14.

¹⁸ [HCA response to AIS](#), paragraph 7.41.

HCA told us it places paramount importance on good clinical practice and has instituted clinical governance measures to achieve this, providing examples of these measures. HCA argued that AXA PPP, rather than the consultants, has a fundamental conflict of interest in relation to new technology. HCA said that AXA PPP's approach to innovation and new technology was determined primarily by cost considerations and therefore it had little incentive to promote and encourage hospital providers to innovate and improve patient outcomes where those innovations may not directly lead to cost savings for AXA PPP in the short-run.

Nuffield

- 8.97 In response to the annotated issues statement Nuffield identified consultant incentive schemes as a 'key barrier to entry'. Nuffield said that it 'believes hospitals should compete for consultants on the quality of service they provide to patients, not the quantum of (direct or indirect) incentives offered to their doctors'.

Ramsay

- 8.98 In response to the annotated issues statement Ramsay said that it did not then have any such incentive schemes with either consultants or GPs. It also said

Ramsay considers that the issue of incentive schemes goes beyond barriers to entry and that such schemes raise serious ethical issues. It is Ramsay's view that consultants and GPs must be free to provide patients with the most appropriate treatment and that clinical judgment should be inviolable. Financial incentives to refer patients to certain hospitals potentially interfere with that clinical judgment and therefore are unethical. Other jurisdictions have recognized that such incentive schemes raise ethical issues and accordingly they are not permitted (see, for example, the USA and Australia).

Spire

- 8.99 In response to the annotated issues statement Spire said that it ‘does not believe that it is appropriate for hospital operators or insurers to offer GPs incentives in return for referring patients to a particular private hospital operator or alternative healthcare provider’.
- 8.100 Spire suggested that problems that may be caused by incentive schemes could be addressed by a ‘bar on arrangements that could risk distorting consultant referral patterns, such as volume and revenue incentives; and full disclosure of all other consultant arrangements’.
- 8.101 Spire also said that ‘If the CC were minded to restrict, or even prohibit, consultant arrangements, [redacted].’¹⁹
- 8.102 Spire did, however, warn that an outright ban on consultant incentives might have unintended consequences, of which it gave two examples. First, it could raise the costs of consultants entering private practice to a prohibitive level. Second, it could result in a ban on co-investment by consultants in facilities and services, and as a result certain new services might not be introduced to the market.²⁰
- 8.103 Spire was concerned by statements in the annotated issues statement that implied that over-treatment or over-diagnosis might be occurring. It said that
- ‘Spire has clinical governance systems in place to protect against both over- and under-treatment. In a case where Spire found evidence of either over- or under-treatment by a consultant at one of its hospitals, it would not hesitate to refer that consultant to the GMC. It appears that the PMIs have raised over-treatment as a concern with the CC. Spire

¹⁹ [redacted]

²⁰ [Spire response to AIS](#), paragraph 6.4.

engages in regular discussions with all of the major PMIs in the UK on a wide variety of topics relating to its business and the PMIs have not raised over-treatment as a concern. If over-treatment were an issue in Spire hospitals, Spire would expect the PMIs to raise it during these discussions. No PMI has done so during the period in which Spire has owned the hospitals.²¹

8.104 Spire also said that the level of treatment available in the NHS may not be an appropriate point of comparison for the level of treatment available in private facilities in light of significant objective evidence of under-treatment in the UK. It said ‘the fact that certain diagnostic tests and treatments may be more widely available and more frequently provided in private facilities than in the NHS does not therefore reflect over-provision in the private sector.’²²

PMIs’ views

8.105 The PMIs generally condemned incentive schemes for consultants, expressing concerns about both medical and competitive effects. Bupa and AXA PPP both made extensive submissions on the subject.

8.106 In its response to our issues statement Bupa included an annex²³ that discussed ‘unwarranted variation’ in healthcare, referring to variation ‘that cannot be explained by clinical needs, patient preference or the capacity of the health system’. It argued that unwarranted variation was driven by conflicts of interest facing the clinician, the fee-for-service reimbursement model, information asymmetries, a lack of effective competition between clinicians, and a lack of credible oversight and sanction.

²¹ [Spire response to AIS](#), paragraph 7.4.

²² [Spire response to AIS](#), paragraphs 7.5-7.6.

²³ [BUPA response to IS](#), Annex E.

8.107 Bupa provided five case studies relating to different types of treatment.²⁴ Two of the case studies indicated that Bupa's patients were much more likely to receive certain treatments²⁵ for these conditions than patients of the English NHS. Bupa noted that the NHS (England) was not a perfect benchmark, but said that the extent of private treatment, which was in some instances three or four times greater than in the NHS (England), raised significant concerns as to whether all interventions were required. Two case studies²⁶ indicated there was significant variation between clinicians within private practice into the way treatments were delivered, for example some private clinicians continued to use treatment practices that were out of line with evidence-based medical guidelines. The fifth case study indicated that patients who were referred by their GP to a cardiology consultant who did not have appropriate skills to serve their specific condition faced significantly greater number of tests, costs and delay before receiving the required treatment.

8.108 Bupa also described medical review processes that it launched for two procedures in 2011. These medical reviews required the consultant to explain in a short form why proposed treatment was necessary and in line with best practice medical guidelines before funding was authorized. Bupa told us that it had observed an immediate, significant and sustained reduction in the number of procedures ordered by consultants. Bupa said that this indicated that some consultants did not believe they had sufficient medical grounds to justify the procedure.

8.109 AXA PPP considered that the practice represented an additional theory of harm. It argued that consultant incentives to refer patients and/or commissioning excessive treatment had a distortive effect. It said that while medical specialists endeavoured as part of their professional ethical obligations to act in the best interests of patients,

²⁴ Four of these were in the [BUPA response to IS](#), Annex E. A fifth was provided in a response to our market questionnaire.

²⁵ Knee arthroscopy and shoulder repair.

²⁶ Wisdom teeth and hysterectomy.

consultants were far from immune to responding rationally (if often subconsciously) to financial incentives that in this case distorted competition by raising entry barriers and leading to cost inflation.²⁷

8.110 AXA PPP provided several examples of instances which demonstrated, in AXA PPP's view, inappropriate and at times unethical practice. AXA PPP also drew our attention to a paper²⁸ from the USA. This, it said, showed a clear increase in the incidence of tests being ordered when they could claim fees for interpretation and again, when they also billed for the facility. For stress echocardiography the increasing likelihood of tests being ordered was 7.1 times more likely if the doctor also charged fees for interpretation and 12.8 times more likely if the doctor charged fees for the use of the facility as well.^{29,30}

The GMC

8.111 The GMC told us that it had a legal power to give advice to the profession on standards of professional conduct and medical ethics but that its guidance (*Good Medical Practice*) did not have the force of a statutory code of practice. However, the GMC told us that it provided the framework for the GMC's fitness to practise procedures and that serious or persistent failure to follow its guidance would put a doctor's registration at risk.

Clinicians' representatives

8.112 We received few comments from bodies representing doctors on the issue of incentives to clinicians offered by private hospital owners.

²⁷ AXA PPP response to AIS, paragraph 1.3.

²⁸ 'Association between Physician Billing and Cardiac Stress Testing Patterns following Coronary Revascularization', *JAMA*, November 9, 2011, Volume 306, No, 18.

²⁹ AXA PPP response to AIS, paragraph 3.5.

³⁰ HCA strongly disagreed with parts of AXA PPP's response to the AIS. See paragraph 8.96.

- 8.113 The BMA said that the CC should consider whether consultant incentives could serve to raise barriers to entry. It noted, however, that since indirect incentives such as free or discounted consulting rooms were widespread, they were unlikely to act as a barrier to entry. The BMA also said that GP referrals should be based on clinical decisions, not financial incentives, and that GP incentives raised ethical issues and would be contrary to GMC guidance.³¹
- 8.114 The AAGBI said that it opposed consultant incentives provided by private hospital operators, as described in the OFT's report, but drew our attention to the practice of private hospital operators paying surgeons higher hourly rates than anaesthetists when operating on NHS patients in private hospitals. It said that this represented a covert incentive to induce surgeons to bring privately-funded patients to private hospital facilities.³²
- 8.115 FIPO said that it was in principle opposed to all forms of clinician incentives which might lead to foreclosure, although it also said that incentivization of consultants could not be considered independently of an analysis of the economics of running a consultant's practice. It said that under circumstances where fee schedules were inflexible, prices had not increased in 18 years, PMIs were unilaterally implementing reduction in the reimbursement rates and patients were not able to decide on co-payments and top-ups, then some form of incentivization could be pro-competitive. FIPO said that it had no objection to equity partnerships between doctors and hospital operators provided that they were not linked to any specific anticompetitive agreement but that the overriding consideration in looking at incentive schemes was that they should be compliant with the GMC Good Medical Practice guidelines.³³

³¹ BMA initial submission.

³² AAGBI initial submission.

³³ FIPO initial submission.

Provisional conclusions

8.116 We found that schemes to attract business by encouraging clinicians to refer patients to or treat patients at private hospital operators' facilities were widespread. We found that these were much more commonly directed at consultants than at GPs.

8.117 We found that such schemes were not confined to particular geographic areas or hospital types: some independent private hospitals as well as all of the main private hospital groups had, to a greater or lesser extent, adopted them.³⁴ However, there was some evidence that schemes which directly rewarded consultants for referrals were most likely to be adopted during periods, in geographic areas and in medical specialisms where hospital competition for consultants was evident.³⁵

8.118 The schemes differed in nature, value and sophistication and could provide benefits either in kind or in cash. They ranged from seminars for GPs and consultants providing information and training on particular illnesses and/or treatments,³⁶ through relatively low value, non-cash benefits to clinicians such as free or subsidised secretarial services, to schemes entitling consultants to, potentially, substantial financial rewards. We distinguish in our analysis between promotional activities, such as seminars or marketing communications, and incentive schemes, which we provisionally conclude on below.

8.119 Incentive schemes differed as to whether or not the size of the benefit to which the clinician was entitled varied with the amount of business brought to the hospital. Incentives which entitled clinicians to benefits based on the volume or value of

³⁴ As described above, Ramsay's adoption of such schemes has been very limited.

³⁵ See paragraph 8.16 above in relation to BMI's [§<] schemes and to Appendices 6.1 and 6.3, for the Bath and London case studies.

³⁶ In many cases, these seminars can count towards the continuing professional development requirements of clinicians. They also allow hospitals to promote their facilities and the consultants who practise at them.

business they brought to the hospital became less common from 2011, coincident with the OFT's market study and, subsequently, our market investigation.

8.120 There are two main types of advice given to patients, namely advice as to the choice of provider (ie consultants and hospitals) and advice as to the nature and level of diagnostic tests or treatments. We discuss both below.

8.121 Before doing so, we note that the fee-for-service model on which remuneration in the private health market is based provides an inherent form of incentive in respect of treatments, rather than hospital, recommended. When consultants recommend a treatment they will generally undertake it themselves and receive a fee for doing so—indeed that is their primary source of income in private practice. The fee-for-service model on its own, on the other hand, is unlikely to provide a consultant with an incentive to treat a patient at one hospital rather than another.

8.122 Patients rely to a large extent on the advice of GPs and consultants and are rarely in a position to question their recommendations. Any arrangement by which the economic benefit to the adviser varies according to the advice given and which reinforces the incentives inherent in the fee-for-service model and exploits the information asymmetry between patient and clinician therefore has the potential to distort competition.

Consultants' advice on choice of hospital

8.123 There are both direct and indirect incentives that can apply where consultants advise patients on the choice of hospital. Direct incentives can be in the form of rewards for referrals, either in cash or equity, or in the form of subsidized consulting rooms, nurses, administrative support etc, the provision of which is explicitly or implicitly linked to hospital income generated. Indirect incentives usually take the form of

equity or some other form of profit-sharing where the incentive effect arises from the fact that directing a patient to a particular hospital is likely to increase the profits of that hospital in the longer term. These incentives are likely to have less effect on behaviour than referral fees or their equivalents because the percentage share of total profit accruing to an individual consultant is usually low and the financial benefit is, in any case, less immediate. Moreover there are pro-competitive effects associated with consultants taking equity shares in new hospitals—not many new private hospitals have been built in the last five years, but a feature of many of those that have been built, or are planned to be built, is a high level of consultant equity participation. We have found that consultant equity participation can be an effective way of incentivizing them to commit in advance to working at a new hospital, which may take several years to build and equip. Such commitments strengthen the viability of a business plan and the ability to obtain financing. They can thus be an important way of lowering a barrier to entry, as described in Section 6.

8.124 The competitive harm that arises from consultant incentives on choice of hospitals is that they might incline consultants to refer patients to or treat patients at a hospital that they would not have chosen on grounds of either quality or of price and that hospital operators may therefore choose to compete over rewards to consultants rather than on the basis of the quality or price of their facilities.

8.125 We consider that hospital operators would only enter into and continue to invest in these incentive schemes if they believed them to be effective in attracting business. It is therefore our view that patient choices are being affected by these schemes in a way that would not occur in a well-functioning market. By affecting the outcomes of competition between hospital operators these incentives can distort the market, although in the case of equity-type incentives the competitive benefit of lowering barriers to entry may be sufficient to outweigh any such distortion.

8.126 There are some considerations that mitigate the effects of incentive schemes. With regard to the appropriateness of the recommended hospital, we recognize that consultants are under ethical and regulatory³⁷ constraints to act in the patient's best interest. With regard to the cost of a hospital we note that for self-pay patients, hospital price information is generally available. In the case of insured patients the cost of a hospital will often not be relevant to the patient, although we recognize that under certain circumstances (such as co-payment schemes) it may be.

Consultants' advice on diagnostic tests and treatment

8.127 The second type of advice to patients is in regard to diagnostic tests and subsequent treatment, where consultants are generally the most influential if not the sole source of advice.

8.128 PMIs have told us that they believe that over-treatment and over-diagnosis occurs. Bupa has cited analyses of variation in treatments in support of this view, however, we note that comparisons with the NHS in England provide limited support as the NHS in England might tend to under-treat or under-diagnose. Research from the USA suggests that financial incentives can lead to over-treatment. Hospital operators strongly dispute that there is any relevant evidence of over-treatment or over-diagnosis and point to their governance arrangements as a check on such activity.

8.129 As regards advice on treatment, we expect the ethical and regulatory constraints on behaviour to offset to a substantial extent any economic incentive for a consultant to offer advice that was otherwise than in the patient's best interests. We would not rule out that on some occasions, some consultants might be influenced by economic incentives so as to over-treat, but we think such incidents are likely to be few and far between.

³⁷ In this context 'regulatory constraint' refers to the potential for disciplinary action by the GMC.

8.130 In respect of advice on diagnostic tests (blood tests, scans etc) and outpatient consultations, our view is that the ethical and regulatory considerations are less likely to affect decisions. These considerations apply differently to diagnostic tests and treatment, since some diagnostic tests, such as extra analyses of bloods already taken, are completely non-invasive and others minimally so. Incentives to conduct unnecessary diagnostic tests or consultations are therefore likely to have more effect on consultants' behaviour than incentives to over-treat. In our view for some (probably very few) consultants, on some occasions, economic incentives are likely to result in unnecessary diagnostic tests or consultations.

8.131 We note that schemes which reward consultants in proportion to the volume or value of tests or treatments that they conduct are, now, relatively uncommon. However, we are aware of schemes through which consultants share the profit from use of a single piece of equipment, such as an MRI scanner or a cyberknife (see paragraph 3.19). In this case the incentive properties are closer to those of a referral fee than those of a more dilute share in the profit from a wide range of health activities, such as a whole general hospital. It is less clear that any benefits that may arise from such schemes, such as encouraging investment in new equipment, outweigh their adverse effects.

8.132 The competitive harm that arises from these incentives is likely to be greater than the incentives related to hospital choice. In the hospital choice case the harm relates to the facility at which the healthcare activity will be undertaken, whereas in the case of over-treatment or overuse of diagnostic tests wasteful activity occurs which leads to higher costs for self-pay patients and to higher premiums for insured patients.

Provisional conclusion

8.133 We provisionally concluded that incentive schemes do affect consultant behaviour. We believe that an intention of these schemes is to affect consultants' referral

decisions and that the schemes have this effect. We also found that, on balance, the evidence indicates that incentive schemes are likely to lead to excessive diagnostic tests or consultations. Whilst the evidence also suggests that they may lead to over-treatment, having regard to ethical and regulatory constraints we think the competition effects are likely to be minimal.

8.134 We therefore provisionally concluded that the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities, whether in cash or kind and whether related to the value of referrals or not, are a feature of the market that gives rise to an adverse effect on competition. We also concluded that equity ownership by consultants of private health facilities is a feature that gives rise to harmful effects on competition, except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.

9. Information availability

Introduction

- 9.1 In our overview of the private healthcare industry (see Section 2) we described various consumer ‘pathways’ to privately funded healthcare. At certain points on these pathways the consumer has to make choices: which consultant to see, which treatment option to follow and at which hospital to be treated. If the consumer lacks the necessary information to make these choices, or if information asymmetries exist, it is possible that market distortions may arise.
- 9.2 As the OFT pointed out in its Market Study:
- accessible, standardized and comparable information is vital for ensuring that consumers can exercise informed choice so that markets work well. Information asymmetries, where suppliers have better information about the quality and price of a product than consumers, can dampen competition between suppliers and result in poor outcomes for consumers in terms of price, quality, innovation and productivity.¹
- 9.3 In our AIS we posited (ToH6) that the privately funded healthcare industry was characterized by both a lack of information and information asymmetries and that these, together with the industry’s fee-for-service model, could give rise to incentives on the part of PHPs to, for example, refer patients to particular facilities on the basis of non-clinical factors or for unnecessary or more elaborate tests.
- 9.4 In addition, we said that we would be concerned if we identified financial or other incentives designed to capitalize or exploit any asymmetry, for example by private hospital operators offering incentives to consultants to refer patients to or use their

¹ www.of.gov.uk/shared_of/market-studies/OFT1396_Private_healthcare.pdf.

facilities. We deal separately in Section 8 with incentives offered by private hospital operators to clinicians.²

9.5 We set out here the evidence we have examined, the analysis we have undertaken and our provisional conclusions on information availability and asymmetry in the following contexts:

- (a) choosing a consultant;
- (b) choosing a treatment option; and
- (c) choosing a private hospital.

Choosing a consultant

9.6 In this section we consider what information is available to patients when choosing a consultant or, more commonly, considering the appropriateness of the consultant or consultants recommended to them by a GP (or their PMI). We look at (a) the current availability of information on consultants' professional qualifications, areas of clinical expertise and fees and (b) the future availability of information on consultant performance based on clinical outcome data. We begin by setting out what the parties told us about the process of choosing a consultant.

What the parties told us

PMIs

9.7 Bupa said that it had significant concerns that consultants (and hospitals) in private practice had failed to produce and make available data that allowed patients, GPs and insurers to evaluate and compare the quality of the treatments they performed and the care they offered, as well as the cost. It said that this gap in information put patients at risk and also created the perverse outcome that patients sometimes incorrectly assumed that price was a sign of quality. It told us that greater

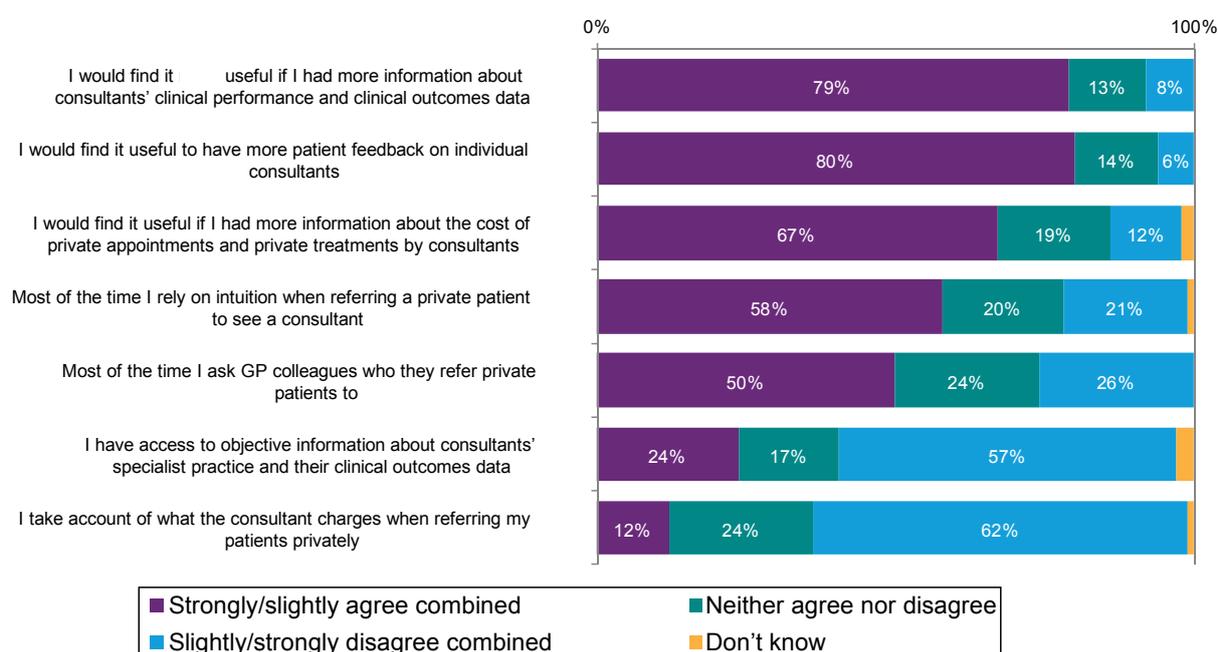
² www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603_hospital_competition.pdf.

transparency of information was fundamental to empowering patients (and the commissioners of care on their behalf).

9.8 Bupa provided us with the results of a survey that it had conducted among GPs. This indicated that GPs would like more information about consultant performance and clinical outcomes, with half of those responding saying that they either relied on intuition when making a referral or asked a colleague for a recommendation.

FIGURE 9.1

Bupa GP survey findings



Source: Bupa (KantarHealth Survey, December 2011/January 2012).

Note: Base: 397 GPs.

9.9 Aviva also said that there was 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. It said that this asymmetry restricted the patient's (as well as the GP's and the PMI's) ability to make an informed choice about the most appropriate hospital/consultant. It said that while it recognized that healthcare information was often complex it was possible to provide information that patients

could use and would find useful. It cited, for example, outcome and process measures relating to treatment conducted.

- 9.10 Aviva noted the importance of the GP in the early referral process and that the majority of patients followed the GP's recommendation. However, it said that it was concerned that GPs were not well informed about the quality of consultants. A survey of GPs which it had conducted indicated that more GPs recommended a consultant on the basis of his or her reputation (77 per cent) than on the basis of their quality (7 per cent).

Private hospital operators

- 9.11 Private hospital operators did not, generally, comment in detail on ToH6. Ramsay, however, said that it thought that information asymmetries were not as extreme as depicted by the CC and that current initiatives, for example the Private Healthcare Information Network (PHIN) project³ (see further paragraph 9.53) would, in any case, solve the issue. It said that the surveys undertaken by the OFT indicated that patients and GPs were not as concerned by a lack of information as the CC had suggested.
- 9.12 Ramsay quoted the OFT's patient survey which had explored patient attitudes to, for example, the number of procedures that a clinician had carried out or mortality rates among a consultant's patients: 'most [patients] did not feel equipped to assess such information and did not think it was necessary for the GP to provide this level of detail.'

³ www.phin.org.uk/About.aspx.

Our surveys

- 9.13 Our survey of patients⁴ indicated that clinical expertise and reputation were the two most common reasons that respondents gave for choosing a consultant, specified by 38 per cent and 36 per cent of respondents respectively. Whether the PMI would cover their fees came reasonably close behind (29 per cent), though after the GP's recommendation (32 per cent) and the length of time the patient would have to wait for an appointment (32 per cent).
- 9.14 Roughly 60 per cent of patients did not know which consultant to see before they visited their GP. Just under one-third of respondents had sought information about a consultant's reputation or expertise and about half of these would have liked to have had more information but did not identify any specific information gaps.

Current and future information availability on consultants

- 9.15 General information about consultants, such as where they practise, their specialties, qualifications and professional memberships is easily obtainable from portals such as Dr Foster,⁵ PMI websites,⁶ hospital websites⁷ or consultants' own websites. Some consultants include information on their fees for an initial and/or follow-up outpatient consultation on their personal websites, although they do not generally provide information on the price of treatments or surgery.⁸
- 9.16 Performance/outcome data for individual consultants is not generally available to patients and GPs in the UK.⁹ Only the Society for Cardiothoracic Surgery in Great

⁴ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey_patients_report.pptx.

⁵ www.drfoosterhealth.co.uk/consultant-guide/.

⁶ For example, <http://finder.bupa.co.uk/>.

⁷ For example, www.hcahospitals.co.uk/our-specialists/.

⁸ However, package prices for self-pay patients, including consultant fees and hospital charges, can be found on the websites of hospitals participating in the PHIN project for a range of common treatments.

⁹ [Where are we with transparency over performance of doctors and institutions?/by Aniket Tavare BMJ 2012 345 \(published 3 July 2012\)](#).

Britain and Northern Ireland publishes such data.¹⁰ Other than this, little information has been available to patients or GPs on individual consultants as regards clinical outcomes or the extent of their experience with particular procedures, for example the number they have undertaken.¹¹

9.17 Plans to disclose data on individual NHS consultant's performance in ten specialties¹² were announced in 2012 for implementation in England in the summer of 2013.¹³ This programme is intended to encompass activity, clinical quality measures and survival rates for every consultant practising in the specialties concerned.¹⁴ As and when implemented, this would represent a significant increase in the information available to GPs and patients, both private¹⁵ and NHS.

9.18 At the time of writing (August 2013) consultant performance information based on outcome data is available for cardiothoracic surgeons in England. The NHS in Scotland, Wales and Northern Ireland currently have no plans to publish comparable data.

Assessment—choosing a consultant

9.19 As set out above, patients have ready access to information on consultants' areas of expertise, qualifications and professional memberships, although information on consultant fees remains more limited. Information on the performance of consultants (at least in their NHS practice) is increasingly available for patients in England, although not in the other Nations.

¹⁰ www.scts.org/patients/.

¹¹ [Can patients really make an informed choice: an evaluation of the availability of online information about consultant surgeons in the United Kingdom/by Sarkhell Saadi Radha et al, BMJ Open Access Medical Research, 20 March 2012.](#)

¹² Nine surgical specialities plus interventional cardiology.

¹³ www.england.nhs.uk/wp-content/uploads/2013/06/con-clin-outcome.pdf.

¹⁴ [Everyone Counts: Planning for Patients, 2013–2014.](#) The specialties are: adult cardiac surgery, interventional cardiology, vascular surgery, upper gastro-intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.

¹⁵ The vast majority of consultants working privately also work in the NHS.

Choosing a treatment option

Overview

- 9.20 Information asymmetry is inherent in the consultant/patient relationship as it is in any professional/client relationship: consumers instruct professionals to perform tasks that they could not undertake themselves because they do not have the qualifications or experience to do so (see paragraph 8.106). Patients are entitled to expect, however, that their consultant, as their agent, will act in their, the principal's, best interests.
- 9.21 It was put to us by PMIs that, irrespective of the incentive schemes that hospital operators may adopt to encourage consultants to use their facilities (these are discussed in Section 8 and there is some overlap between that section and this one in regard to arguments related to over-treatment), the private medical sector's fee-for-service model may in itself create a tension between the consultant's duty to act in the patient's best clinical interest and their, the consultant's own, financial interest. Consultants and some of the private hospital operators, on the other hand, have argued that the PMIs incentives operate in the opposite direction and that PMIs have an incentive to, in effect, 'under treat' patients.
- 9.22 In either circumstance the patient may wish to test the advice that they have been given and will therefore need to seek information. We examine below whether information is available to patients that would enable them to do so.
- 9.23 We first set out the views that were put to us regarding clinical incentives arising from the fee-for-service model of private healthcare and how these might give rise to what have been described as 'unwarranted variations in treatment'.

What the parties told us

The PMIs

- 9.24 Bupa told us that variation in treatments could signal market malfunction. It said that while variations in treatment could be clinically justified or explained by patient preference, it had observed wide variations in the way consultants and hospitals treated specific conditions in UK private healthcare, some of which amounted to 'unwarranted variation'. It said that such variation could harm patients, placing them at risk of unnecessary complications or death, and also affecting the cost of healthcare.
- 9.25 Bupa submitted a number of case studies which it said illustrated unwarranted treatment, one of which dealt with shoulder repair. It said that it had observed high levels of variation in two types of shoulder surgery to repair the rotator cuff muscle: arthroscopic acromioclavicular decompression and extensive open repair of rotator cuff muscles. Bupa told us that its members were [redacted] per cent more likely to receive the first treatment and [redacted] per cent more likely to receive the second treatment than comparable patients using the NHS. Bupa cited published articles advocating that initial treatment for rotator cuff damage should, in general, be non-surgical and quoted the American Academy of Orthopaedic Surgeons to the effect that patients with rotator cuff-related symptoms, in the absence of full thickness tear, should be initially treated non-operatively, using exercise and/or non-steroidal anti-inflammatory drugs.
- 9.26 AXA PPP submitted details of academic research undertaken in the USA, demonstrating that physicians were substantially more likely to order tests for patients if they received a fee for interpreting the test and/or a fee for using the testing facility.

Hospital operators

- 9.27 Hospital operators generally argued that PMIs, where they had introduced guidance into their processes, were at least partially influenced by commercial considerations. HCA, for example, drew our attention to the many submissions made to us by individual consultants which raised concerns about managed care in general and Bupa's open referral process in particular. It said that these contained many specific complaints that, although a particular consultant had been recommended on clinical grounds to treat a particular patient, the PMI had redirected patients to lower-cost providers.
- 9.28 Spire told us that arguments to the effect that private healthcare providers had an incentive to 'over-treat' patients, using comparisons of practice in the NHS and the private healthcare sector, could be misleading. It told us that there was a risk that publicly-funded capitation models such as the NHS in the UK faced incentives to 'under-treat' and that the level of treatment available in the NHS may not be an appropriate point of comparison for the level of treatment available in private facilities. Spire also highlighted that it had extensive clinical governance structures in place to prevent either over- or under-treatment by consultants.

Clinicians

- 9.29 The British Medical Association told us that managed care initiatives disrupted traditional, clinically proven referral processes and treatment pathways. It said that decisions were often based on what was deemed cost-effective, or what was allowed under the patient's insurance policy, rather than what was clinically appropriate.
- 9.30 The British Orthopaedic Association made a similar submission to HCA's, citing in particular Bupa reviews of consultant decisions, which it said were entirely motivated by commercial objectives and which were causing severe patient detriment.

- 9.31 FIPO too made similar points, again in the context of musculoskeletal conditions. It cited the Bupa by You's option of an initial consultation for a patient with back pain with a physiotherapist as indicating that such modifications to the referral mechanism may not be dictated by the patient's best interest.
- 9.32 As noted above, we received many letters from individual consultants which included references to PMI managed care processes suggesting that they may result in inappropriate treatment for patients. We present a summary of these letters in Appendix 7.3.

Information available on treatment options

- 9.33 We review here information sources on treatment options which, while they are mainly provided by the NHS, are also available to private patients.

National Institute for Health and Care Excellence clinical guidelines

- 9.34 NICE produces clinical guidelines with recommendations on the appropriate treatment and care of people with specific diseases and conditions. They are based on available evidence and developed in association with the Royal Medical, Nursing and Midwifery Colleges. In general, healthcare workers in the NHS in England and Wales are expected to follow NICE's clinical guidelines. The Scottish Intercollegiate Guidelines Network (SIGN) is responsible for developing evidence based clinical practice guidelines for the NHS in Scotland. NICE and SIGN have signed a Memorandum of Understanding, setting out how they work together.¹⁶ In Northern Ireland, the Department for Health Social Services and Public Safety has a formal link with NICE under which the latter's guidance is reviewed for its applicability to

¹⁶ www.sign.ac.uk/about/niceandsign.html.

Northern Ireland and, where found to be applicable, is endorsed by the Department.¹⁷

- 9.35 NICE has produced 168 clinical guidelines and more than 60 guidelines are in development. Topics are referred to NICE by the DoH. Topics are selected on the basis of a number of factors, including the burden of disease, the impact on resources and whether there is inappropriate variation in practice across the country.¹⁸
- 9.36 Most guidelines aim to support clinicians but NICE also produces versions of its clinical guidance written for the public to help patients make informed decisions. These versions summarize the recommendations that NICE makes using suitable language for people without specialist medical knowledge: for example, a NICE guideline describes the various options for patients with prostate cancer together with questions the patient should consider themselves or ask their doctor.¹⁹

NHS Choices

- 9.37 NHS Choices is funded by the DoH and describes itself as ‘the UK’s biggest health website’²⁰ receiving, in the first quarter of 2013, an average of over 25 million visits a month.²¹ NHS Choices includes detailed information about common diseases and conditions and treatments on its publicly available website and contains links to other relevant NHS sites such as Choose and Book, as well as NICE Guidance and a range of other sources of information and support for patients.²²

¹⁷ www.dhsspsni.gov.uk/sqsd-guidance-nice-guidance;

www.dhsspsni.gov.uk/circular_hsc_sqsd_04_11_nice_guidelines_8211_new_process.pdf.

¹⁸ A list of published clinical guidelines can be found at <http://guidance.nice.org.uk/CG/Published>.

¹⁹ www.nice.org.uk/nicemedia/live/11924/39526/39526.pdf.

²⁰ www.nhs.uk/aboutNHSChoices/Pages/NHSChoicesintroduction.aspx.

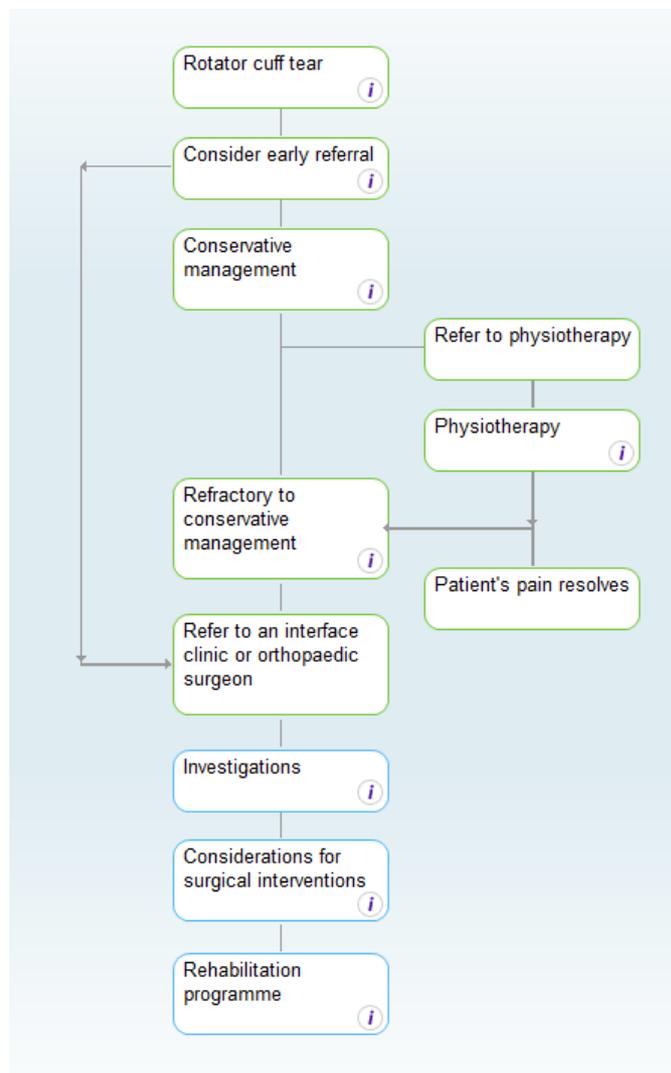
²¹ www.nhs.uk/aboutNHSChoices/professionals/developments/Pages/Preformancestatistics.aspx.

²² These include links to various charities which provide information and support to those suffering from various illnesses, such as Macmillan cancer support, and specialist colleges and institutes, such as the Chartered Society of Physiotherapy.

9.38 The website also contains openly accessible advice to clinicians, through ‘maps of medicine’. We show below the ‘map’ for shoulder pain where the clinician considers this may arise from rotator cuff damage.

FIGURE 9.2

Map of medicine for shoulder pain



Source: NHS Choices.

Patient decision aids

9.39 Patient decision aids are similar to clinical guidelines, in that they are based on research evidence, but they are designed not just to inform patients, but to help them think about what the different options might mean for them and to reach an informed

preference. They are also designed to emphasize the principle that there should be 'no decision about me, without me'.²³

9.40 Patient decision aids take a variety of forms, spanning everything from simple one-page sheets outlining the choices, through more detailed leaflets or computer programmes, to DVDs or interactive websites that include filmed interviews with patients and professionals, enabling the viewer to delve into as much or as little detail as they want.²⁴

9.41 Decision aids for 38 conditions were developed by the Right Care Programme, a workstream of the DoH's Quality, Innovation, Productivity and Prevention (QIPP) programme for the NHS in England.²⁵ These decision aids are available on the Right Care website²⁶ and mimic the exchanges between clinician and patient that would take place through a process of shared decision making (SDM).²⁷ The guides take a patient through various stages of the decision process, enabling them, for example, to access additional information at various stages if they wish to do so.

9.42 The Health Foundation, an independent charity with the mission of improving the quality of healthcare in the UK, is sponsoring the Making Good Decisions In Collaboration (MAGIC) project which is exploring how SDM can be embedded into mainstream clinical practice. Initial trials of the programme are being undertaken in NHS hospitals in Newcastle and Cardiff.²⁸

²³ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

²⁴ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

²⁵ NHS Scotland has included shared decision making as a goal in its Healthcare Quality Strategy published in May 2010. See www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf.

²⁶ <http://sdm.rightcare.nhs.uk/pda>.

²⁷ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

²⁸ www.bmj.com/content/341/bmj.c5146; www.health.org.uk/areas-of-work/programmes/shared-decision-making/.

PMIs websites

9.43 Most of the larger PMIs provide a range of information to patients on their websites, or via call centres. Bupa's website has a directory of over 600 healthcare topics, which provide information ranging from general lifestyle advice, to detailed descriptions of illnesses and treatment options.²⁹ In addition, Bupa operates a 'Treatment Options Service', which is a call centre staffed by qualified nurses, who discuss the various treatment options that may be available to Bupa policyholders following their diagnosis.³⁰ Similarly, AXA PPP's website provides factsheets on a broad range of medical conditions, the information for which is supplied by NHS Choices. AXA PPP policyholders also have access to its panel of medical experts, to whom they are able to submit questions via the website.³¹

Private hospitals' websites

9.44 Patients are also able to access some information on the most common treatments from the websites of the private hospitals. For example, BMI's website provides information on what a specific procedure involves, what a patient should expect before, during and after surgery, the potential complications associated with a treatment as well as potential alternative treatments which may be appropriate for a given illness.³² Spire, Nuffield, Ramsay and HCA provide similar information on their websites, although in some cases the information is limited to a description of the procedure and the recovery, rather than a fuller discussion of treatment options.³³

²⁹ See: www.bupa.co.uk/individuals/health-information/directory/b/hi-breast-cancer?#textBlock192475.

Aviva also offers a variety of health and treatment information to patients, see: www.aviva.co.uk/health-insurance/home-of-health/.

³⁰ www.bupa.co.uk/members/members-health-insurance/members-treatment/treatment-options-service.

³¹ www.axapphealthcare.co.uk/health-information/meet-the-experts/.

³² www.bmihealthcare.co.uk/treatment/treatmentsdetail?p_treatment_name=Hip%20replacement%20surgery&p_treatment_id=304.

³³ www.spirehealthcare.com/our-treatments/body-map-and-a-z/a-z-treatments/; www.nuffieldhealth.com/hospitals/tests-and-treatments/treatments; www.ramsayhealth.co.uk/system-pages/treatments.aspx; <http://www.hcahospitals.co.uk/treatments/a-z-of-services-and-treatments/>.

Assessment—choosing a treatment option

- 9.45 PMIs put it to us that the incentives inherent in the private healthcare's fee-for-service model, coupled with the patient's lack of information on treatment options gave rise to over-treatment. Clinicians, and some private hospital operators, told us that PMIs, by adopting open referral processes, were making it more probable that under-treatment would result.
- 9.46 We think that it would be extremely hard to quantify the extent of over- (or under-) treatment in privately funded healthcare not least given, for example, the difficulty of identifying an appropriate benchmark.
- 9.47 Some of the evidence put to us made comparisons between practice in the NHS and in private healthcare, for example. However, we do not consider that NHS practice is, necessarily an appropriate benchmark since its fee per capita model³⁴ provides an incentive to minimize the cost of treatment. Certain procedures might rarely be performed under general anaesthetic within the NHS on cost grounds, for example, even if patients would prefer this. Our (albeit limited) review suggests that patients have access to significant quantities of information to help them understand the treatment options available to them, which should allow them to engage in an informed discussion with their consultant regarding these options. However, we note that this type of information does not fully eliminate the information asymmetry between the patient and consultant. The patient will necessarily remain reliant on the consultant for the diagnosis of his/her specific condition. For example, in the case of a torn rotator cuff, a patient has access to information indicating that for a mild tear physiotherapy may be recommended, whereas for a more serious tear surgery may be necessary. However, the patient must rely on his or her consultant to diagnose the severity of his/her rotator cuff tear.

³⁴ A remuneration scheme which is on a per capita of the population served basis rather than a payment per service delivered.

9.48 Furthermore, we recognize that, while a significant quantity of information on treatment options may be available to patients, they may not currently be making use of it. Our survey indicated that only 9 per cent of patients had sought information on the procedure or treatment that they received. This implies that a large proportion of patients rely on their consultant's recommendation regarding treatment options.

Choosing a hospital

9.49 We now look at what information is available to consumers on the cost, facilities and service quality of private hospitals.

Information available currently

9.50 Information on the facilities provided by private hospitals, including the treatments they offer, the consultants they use and the facilities they provide, is readily available from their websites. Equally, and particularly since the PHIN initiative discussed below, the cost of their services is reasonably transparent for self-pay patients. However, information on hospital performance is less readily available.

9.51 Private hospital operators have, historically, provided a limited amount of information on their hospitals' performance on portals such as Dr Foster and NHS Choices as well as their own websites. This has included statistics on patient satisfaction and MRSA and C. Difficile infection rates, for example.

9.52 In addition to information provided by the private hospital operators, patients are also able to access information on hospital quality from the healthcare regulators in England, Wales, Scotland and Northern Ireland. These are the Care Quality Commission (CQC), Healthcare Inspectorate Wales, Healthcare Improvement Scotland and the Regulation and Quality Improvement Authority, respectively. These regulators inspect all hospitals, both NHS and private, and evaluate them against a

range of criteria, from infection control procedures to respecting patients' dignity and human rights.³⁵ Each regulator uses slightly different criteria, although there is significant overlap in the quality measures taken into account. During the course of our investigation, private hospital operators launched a new initiative to make information on private hospitals available to patients. PHIN, a not-for-profit member organization open to all independent hospital operators, superseded the collaborative Hellenic Project begun in 2009 by the main hospital groups,³⁶ with, it told us, improved resources, governance and breadth of participation. PHIN told us that it intends to publish standardized and directly comparable information which will allow patients and doctors to search for local hospitals by procedure and to compare how they perform based on treatment data of more than 1 million patients a year. The website³⁷ launched at the end of April 2013 with information including, for example, the frequency with which particular procedures were undertaken at the hospital concerned.

9.53 PHIN told us that it aimed, within a planned timetable, to collect and publish information relating to the treatment of all patients (private and NHS-funded) at all independent hospitals in the UK, benchmarked against the NHS wherever possible. PHIN told us that it currently publishes data from 11 provider organizations comprising 194 hospitals, with seven more providers at various stages of joining. Publication of data is based on PHES (Private Hospital Episode Statistics) collected by PHIN from its members, with the intention that this dataset be equivalent to the HES data collected in England by HSIC on all NHS patients whether they are treated at a private or an NHS hospital. PHIN combines PHES and relevant HES data to

³⁵ For an example of an inspection report for the London Bridge Hospital, see www.cqc.org.uk/directory/1-126955902. For an example of an inspection report for Spire Yale, see www.hiw.org.uk/Documents/477/Inspection%20Report%20Spire%20Yale%20English%202010.pdf.

³⁶ Including BMI, HCA, Spire, Ramsay and Nuffield.

³⁷ <http://www.phin.org.uk/About.aspx>

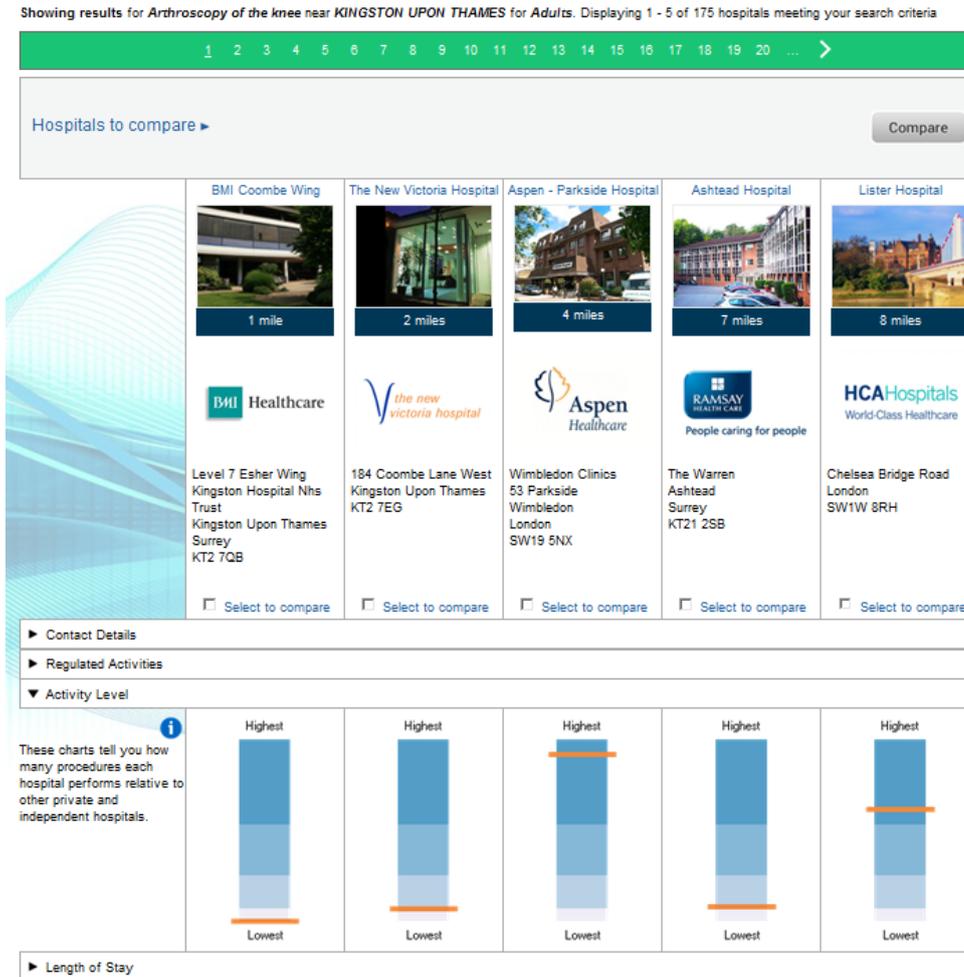
produce IHES (Independent Hospital Episode Statistics) to give a picture of the quality of service available in private hospitals.³⁸

- 9.54 HSIC also collects, again solely in England, patient reported outcome measures (PROMS) for hip and knee surgery. PHIN told us that it would publish PROMS data relating to private patients from its member organizations that currently collected it.
- 9.55 We show in Figure 9.3 below the first page results of a sample search, for hospitals offering knee arthroscopy centered on Kingston, Surrey. This shows how frequently the procedure is carried out at the identified hospitals which are rank ordered by distance from the postcode used in the search. It can also display the number of nights a patient could expect to be in hospital for this procedure though only the BMI PPU involves an overnight stay.

³⁸ PHIN told us that it collects and publishes data from other NHS and private sources beyond IHES data, including PROMs, the NHS Friends and Family Test, the National Joint Registry and infections data from Public Health England.

FIGURE 9.3

PHIN sample search results



Source: PHIN.

9.56 PHIN told us that it intends to increase the range of information on the website significantly, and has a program in place to publish more extensive data relating to a greater number of comparators over the next three months to one year. PHIN told us that in addition to launching further clinical quality indicators, it intends to introduce an IHES analytical tool for members aimed at improving use of information, and to publish reports looking at specialty areas such as cancer services and cosmetic surgery services in detail.

Hospital operators' views

9.57 The hospital operators did not comment extensively on ToH 6. However, Ramsay said it believed that the PHIN project would, in the very near future, deliver information on private hospitals equivalent to, if not more comprehensive than, that available on NHS hospitals. In addition Ramsay noted that the private hospitals participating in PHIN had engaged in a process by which each operator would publish indicative tariffs for a set of self-pay procedures in a format that was consistent and comparable. This was launched in early June 2013. Spire told the CC that it was supportive of current initiatives to provide additional quality information to patients, both via PHIN and through its own website, highlighting its recent publication of PROMs data, as well as readmission rates and a number of other quality benchmarks.

PMIs' views

- 9.58 There was general agreement among the PMIs that more information on private hospital quality and performance would be desirable.
- 9.59 Bupa said that, like the CC, it saw no reason why performance and outcome data on private hospitals should not be comparable with that available for NHS hospitals. Aviva set out additional information that it would like to see published and explained the use that it would make of it. The information it would wish to see available included safety data (for example, concerning the incidence of MRSA), access information (whether the patient was given a choice of dates) and information on the patient experience (for example last-minute cancellations). Assessment—choosing a hospital.
- 9.60 In some parts of the UK patients have little or no choice of private hospital. Even where patients have had a choice, however, there has been little consistent and

readily comparable data on performance on anything like the range of indicators and metrics available for NHS hospitals. Nor have private hospitals collected or reported to the CQC (or other regulators in the nations) HES data,³⁹ other than in respect of NHS patients that they treat at their hospitals. Such data could provide an input to and help prioritize the CQC's (and other regulators in the nations) risk-based inspection programme or possible hospital rating system.

9.61 The PHIN project aims to address the lack of a consistent and comprehensive dataset on private hospital performance, and PHIN has told us that it aims to deliver performance information comparable to that collected and published for NHS hospitals using a phased-in approach. In order to make the data comparable to NHS and international benchmarks, it may be necessary for the industry as a whole to standardize certain aspects of data collection, for example the coding of activity and impairment data. In this respect, we note that a recent contract signed between HCA and Bupa stated that [redacted].⁴⁰

Provisional conclusions

9.62 We considered information availability and asymmetry in three contexts:

- (a) choosing a consultant;
- (b) choosing a treatment option; and
- (c) choosing a private hospital.

Choosing a consultant

9.63 We took the view that for competition between consultants to function well, patients would need to know, in addition to the consultant's fee structure, information about the consultant's qualifications, areas of expertise and performance.

³⁹ www.hscic.gov.uk/hes.

⁴⁰ A description of the ICD 10 coding system is set out on the World Health Organisation website: <http://www.who.int/classifications/icd/en/>.

- 9.64 We found that information on the qualifications and specialisms of consultants was readily available across the UK via private and NHS hospital websites, portals such as Dr Foster and the consultants' own websites, although information on consultant fees remains more limited.
- 9.65 In England, initiatives are underway, though not yet complete, to disclose individual consultant performance data in ten specialisms. We understand that no equivalent programmes to disclose consultant performance information are envisaged for the rest of the UK.
- 9.66 We could not be sure when or whether the remaining consultant performance data which it is envisaged will be disclosed in England will appear nor whether plans to disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. We therefore provisionally conclude that a lack of sufficient publicly available performance and fee information on consultants prevents the proper functioning of competition between consultants and is a feature of the private healthcare market giving rise to an AEC.

Choosing a treatment option

- 9.67 Whilst we acknowledged that information asymmetry between consultant and patient was inevitable, we consider that, in order for competition between consultants and between consultants and alternative healthcare pathways to function properly, patients should have access to information on the comparative benefits of different treatment options.
- 9.68 We found that patient information on treatment options was readily available across the UK. Our provisional conclusion is, therefore, that a lack of patient information on

treatment options is *not* a feature of the private healthcare market giving rise to an AEC.

Choosing a private hospital

9.69 Information on the performance of private hospitals has been poor in the past and certainly below the standard of the information available on NHS hospitals. During the course of our investigation a fresh initiative (PHIN) was launched to improve the quality of information that is available to patients.

9.70 Whilst this information is expected to improve in terms of hospital coverage and range of indicators, we provisionally conclude that, at present, it is insufficient to promote competition between private hospitals. We therefore provisionally conclude that the lack of publicly available information on private hospital performance is a feature of this market giving rise to an AEC.

10. Provisional findings

- 10.1 As described in paragraph 1.1, on 4 April 2012, the OFT made a market investigation reference to the CC under sections 131 and 133 of the Act regarding the supply or acquisition of privately funded healthcare services in the UK. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of goods or services in the United Kingdom or a part of the United Kingdom’. If that proves to be the case, under the Act, this constitutes an AEC.
- 10.2 For the reasons given in Sections 6, 8 and 9, we identified that there are a number of structural and conduct features that either individually or in combination give rise to AECs in the supply and/or acquisition of privately funded healthcare services in the UK.
- 10.3 We identified two structural features¹ in the provision of privately funded healthcare by hospitals:
- (a) high barriers to entry for full service hospitals; and
 - (b) weak competitive constraints in many local markets including central London.
- Together these features give rise to AECs in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with insurers.
- 10.4 We identified the operation of incentive schemes by private hospital operators to encourage patient referrals for treatment at their facilities as a conduct feature in the provision of privately funded healthcare by private hospitals. This feature gives rise to

¹ See paragraph 6.294.

an AEC due to the distortion of referral decisions to particular hospitals and the distortion of patient choice of diagnosis and treatment options.²

10.5 We identified the lack of sufficient publicly available performance information on private hospital performance as a conduct feature in the provision of privately funded healthcare by hospitals.³ This feature gives rise to an AEC due to the distortion of competition between private hospital operators by preventing patients from exercising effective choice in selecting the private hospitals at which to be treated. This reduces competition between private hospital operators on the basis of quality and price.

10.6 We identified the lack of sufficient publicly available performance and fee information on consultants as a conduct feature in the provision of privately funded healthcare by consultants.⁴ This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.

10.7 We have produced an initial estimate of the consumer detriment resulting from the market power of three largest private hospital operators (BMI, HCA and Spire) using the profitability analysis. This analysis was based on the private hospital activities of the relevant firms,⁵ including their provision of services to NHS patients. As NHS services are outside the scope of our reference, we have sought to exclude them from our estimate of detriment. Our estimate apportions EBIT and capital employed between NHS and private work in proportion to the revenue earned from each

² See paragraph 8.132.

³ See paragraph 9.69.

⁴ See paragraph 9.63.

⁵ These are: Bupa Cromwell Hospital, BMI, HCA, Nuffield, Ramsay, Spire and TLC.

source. We then calculate the difference between the ROCE and the cost of capital (taken to be 10 per cent).

10.8 On this basis, our initial estimate of the consumer detriment resulting from the three largest private hospital operators is between £173 million and £193 million per year between 2009 and 2011, which is equivalent to around 10 to 11 per cent of the total private revenues of these firms (BMI, HCA and Spire). We consider that this represents a conservative estimate of the consumer detriment for the following reasons:

- (a) NHS revenue generates a lower margin than private revenue, hence a larger proportion of EBIT will relate to private patients than we have estimated in our analysis;
- (b) we have used a cost of capital of 10 per cent, which is above the upper end of our range of 7.2 to 9.9 per cent, reducing the overall estimate of detriment as compared with a figure based on the mid-point of 8.6 per cent;
- (c) the analysis does not take into account the efficiency of the operators. To the extent that less efficient operators are making a lower ROCE, this inefficiency will not be reflected in our estimate of detriment; and
- (d) we believe that our profitability estimate may be reduced by the economic recession in the UK.

10.9 The figures shown in Table 10.1 are for the three largest private hospital operators combined, BMI, HCA and Spire. Together these firms account for 53 per cent of the privately funded healthcare market.

TABLE 10.1 **Estimated detriment**

<i>Total detriment</i>	<i>All providers, £ million</i>				
	<i>FY07</i>	<i>FY08</i>	<i>FY09</i>	<i>FY10</i>	<i>FY11</i>
Detriment	94	146	173	193	190
% of private revenue	6.8	9.4	10.7	11.3	10.5

Source: CC analysis.

10.10 In our view it is not practical to quantify the detriment arising from incentive schemes (10.4) or from lack of information (10.5 and 10.6) although these features may increase the profitability of hospital operators and therefore be reflected to some extent in the estimates set out in 10.9.