

Assessment of hospitals of potential concern (excluding central London)

1. This paper provides a description of our current assessment of which private hospitals give rise to potential local competition concerns outside of central London due to unilateral market power. This paper focuses on competitive constraints currently provided by private hospitals on each other in the various local areas and does not address barriers to entry and expansion. The assessment of private hospitals in central London is described in a separate paper, which will be published shortly. This paper follows on from our annotated issues statement (AIS) published on the 28 February 2013 and should be read in conjunction with that document as many of the terms used, for example LOCI and 16 common specialties, are explained in the AIS.

2. In our AIS, we used filters based on two measures of local concentration, the network LOCI and the fascia count, to identify which private hospitals were considered to potentially raise competition concerns (defined as ‘hospitals of potential concern’). As a result of using these filters, we found that 144 private hospitals were hospitals of potential concern¹ for the following reasons:
 - (a) 116 private hospitals raise concerns because their patient network LOCI is below 0.6;
 - (b) 3 private hospitals raise concerns because their revenue LOCI is below 0.6;
 - (c) 19 private hospitals raise concerns because their fascia count for the basket of 16 common specialties is below 2; and
 - (d) 6 private hospitals raise concerns because their fascia count for oncology is below 2.

¹ Note that the number of hospitals of potential concern referred to in the AIS was 147. Following a subsequent review of our data and analysis the number reduced to 144.

3. We have now conducted a detailed assessment of the 140 private hospitals located outside central London and identified as being of potential concern on the basis of the filters. In order to assess the extent of any competition faced by each of these hospitals, we have taken into consideration each private hospital's individual characteristics as well as the characteristics of any nearby private hospitals (either competitor hospitals or hospitals under the same ownership); features of the local area in which the hospital is situated; and documentary evidence submitted by the parties.

4. In particular, in respect of each private hospital and any nearby private hospitals, we have assessed the factors listed below
 - (a) range of specialties offered and availability and type of ICU coverage;
 - (b) hospital size by total admissions, inpatient admissions, total revenue and inpatient revenue;
 - (c) hospital's shares of admissions accounted for by insured, self-pay, and NHS patients;
 - (d) size of the 80 per cent catchment area;²
 - (e) maps of 80 per cent catchment areas and population density by local authority;
 - (f) fascia count in the catchment area;³
 - (g) network LOCI;⁴
 - (h) network effect, defined as the difference between network and individual LOCI⁵;
 - (i) closest competitors by distance;

² 80 per cent catchment area, as defined in the AIS, is the area over which the hospital draws the 80% of its insured patients located closest to the hospital site.

³ Fascia count, as defined in the AIS, refers to the number of competitor hospitals located within the hospital's 80 per cent catchment area. Hospitals under common ownership are counted as one fascia. Two fascia counts have been used: one for the set of 16 common specialties and one for oncology only.

⁴ LOCI, as defined in the AIS, is a measure of local concentration based on weighted average market shares. The network LOCI, which we used as a filter, takes into account the common ownership of several hospitals by the same operator in the calculation of market shares (ie market shares are calculated at hospital operator level). The individual LOCI, on the contrary, is based on market shares calculated at hospital level.

⁵ The difference between network LOCI and individual LOCI provides an indication of the effect that the common ownership of hospitals has on each individual hospital's LOCI.

- (j) internal documents from the hospital operators (so far for hospitals with LOCI close to the 0.6 threshold, but the review is on-going); and
- (k) internal documents from insurers.

5. When assessing each hospital identified as being of potential concern on the basis of the filters, we have adopted the approach set out below:

(a) Solus hospitals have been considered to potentially raise competition concerns.

We have defined solus hospitals as hospitals which face no or very limited competition from other hospitals. When defining these hospitals we have taken account of competition from outside a particular town or city where relevant.

(b) We have described local areas with only two hospital operators as local duopolies. In some cases, the two operators may impose a similar competitive constraint on each other as they have similar characteristics and are of a similar size. We have classified these 'symmetric' duopolies as hospitals of potential concern but have noted them separately as we recognize that under some circumstances competition in a symmetric duopoly may provide an adequate constraint. In other cases, only one of the two operators may impose a significant constraint on the other operator. In these 'asymmetric' duopolies, the operator that faces weaker constraints (eg the operator offering more services and /or the larger operator) has been considered to potentially raise competition concerns, while the constrained operator has not.

(c) In large urban areas (eg Manchester and Birmingham), patients are considered to be more likely to travel inwards (from outside towards the inner city) than outwards, which could be related to work and/or the social attractions that urban areas offer. The relatively larger catchment areas that we observe for hospitals located in the centre of large urban areas provide evidence of this. This greater propensity to travel into urban areas together with the characteristics of the hospitals located in urban areas may suggest that hospitals in urban areas

impose a competitive constraint on hospitals in non-urban 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 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 and travel patterns.
- (e) Common ownership of several hospitals by the same operator in nearby local areas tends to undermine the constraint from other operators in a local area. If patients were to look for alternative hospitals in the area (or possibly in nearby areas), they would find that a number of these hospitals are actually owned by the same operator (we refer to this point as the 'diversion ratio' argument).
- (f) In some cases, two hospitals located at a considerable distance from each other may still impose a constraint on each other. 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 catchment areas may help to assess the extent of this constraint. We have not restricted our analysis to hospitals within the same catchment area but have considered overlaps of

catchment areas and the location and density of population. The overlap between catchment areas must be substantial and cover densely populated areas for us to consider that there is likely to be a sufficient constraint.

(g) A number of private hospitals utilise 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 utilisation 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 prioritise 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.

6. As a result of this detailed assessment, we have identified a number of private hospitals that the evidence suggests are subject to insufficient competitive constraints. These hospitals allow us to identify local areas where there could potentially exist an adverse effect on competition. Our initial list of hospitals identified as being of potential concern on the basis of the filters has consequently been reviewed. Out of 140 hospitals outside central London that were initially identified as hospitals of potential concern in the AIS, after our detailed assessment:

(a) 98 hospitals are retained as of potential concern because they are insufficiently constrained:

(i) 27 of them are in a multi-provider environment;

(ii) 24 of them are in a symmetric duopoly;

(iii) 17 of them are in an asymmetric duopoly; and

(iv) 30 of them are solus hospitals.

(b) 42 hospitals are no longer considered to be of potential concern because they appear to face sufficient competitive constraints.

7. After our detailed assessment, 3 hospitals, which were not initially identified as hospitals of potential concern in the AIS on the basis of the filters, have been added to the list of hospitals of potential concern. All these 3 hospitals are in symmetric duopolies.

8. We are in contact with those operators of the hospitals which have been identified as of potential concern following this analysis, to ascertain whether they remain of potential concern. We are also seeking views from the two largest private medical insurers, BUPA Health & Wellbeing and AXA PPP, on our assessment. If you wish to submit any comments these should be submitted to the Inquiry Manager by noon on Friday 7th June 200 by email to private-healthcare@cc.gsi.gov.uk.

9. If you consider that further information is required in order to enable you to comment on our analysis, please contact the Inquiry Manager by email on christiane.kent@cc.gsi.gov.uk at the latest by 5pm on 24th May setting out the reasons for your request.