

PRIVATE HEALTHCARE MARKET INVESTIGATION

Private healthcare in central London: horizontal competitive constraints

1. This paper sets out our analysis of the competitive conditions in the provision of private healthcare in London, and in particular in central London, relevant to the assessment of horizontal competitive constraints. The paper is structured as follows:
 - (a) Part 1 considers characteristics of healthcare in London that distinguish it from many other parts of the country.
 - (b) In light of the characteristics of healthcare in London identified in Part 1, we reviewed the results of our filter analysis (LOCI) in central London and carried out further analysis of hospital operators in central London. Part 2 reviews the share of supply represented by each operator in Greater and central London. Shares of supply have been computed based on number of inpatient and total admissions, inpatient and total revenue. Shares have also been analysed specifically for complex specialties, tertiary treatments and intensive care services. We also look at shares of capacity. This shows that there is a significant degree of concentration, particularly within central London and for high acuity and complex treatments.
 - (c) The appendix sets out the views of hospital operators and insurers regarding the nature of competition in London and competitive constraints faced by HCA in particular.

Characteristics of healthcare in London

2. This section considers a number of characteristics of healthcare in central and Greater London which impact on competition between hospital operators. For the purpose of our analysis, we refer to central London as being the area inside the North and South Circular Roads and Greater London as the Government Office Region as defined by the Office for National Statistics (ONS). We also use the term

outer London to refer to hospitals and patients outside Greater London but still on the periphery—for example, commuter towns in counties that border London.

The CC 2000 Bupa/CHG merger decision

3. In the CC merger decision that followed the purchase of Community Hospital Group (CHG) by Bupa (2000), the CC viewed market conditions in the London region as differing markedly from those prevailing elsewhere in the UK and has considered that London should be regarded as a distinct market segment in itself.¹ The special features of the London market it cited in this context include:
- (a) the presence of the UK's main teaching hospitals;
 - (b) the availability of eminent, including world-ranking, consultants;
 - (c) PPU's appeared to be a more effective competitive force than in other parts of the country;
 - (d) a large number of self-pay patients, including from overseas;
 - (e) in many cases hospital prices were well above the average for the UK;
 - (f) different travel patterns in London and higher disposable income; and
 - (g) the four main national hospital operators at the time having their hospitals located almost exclusively outside of London.

London hospitals

4. There are 28 private hospitals and PPU's in central London and 46 outside central London but within Greater London:
- (a) HCA has the largest presence in central London measured by number of in-patient facilities, including six hospitals it owns and one PPU it manages. It also manages one PPU in Greater London.
 - (b) BMI owns four hospitals in central London and six hospitals in Greater London, it also manages three PPU's in Greater London.

¹ www.competition-commission.org.uk/rep_pub/reports/2000/449bupa.htm#full, paragraphs 4.68 & 2.71.

- (c) Nuffield, Ramsey and Spire have no hospitals in central London. They have hospitals just outside Greater London: Nuffield Brentwood; Ramsay Ashted and North Downs; and Spire Bushey and Hartswood.
- (d) Aspen has one hospital in central London (the Highgate Hospital) and one hospital in Greater London (the Parkside Hospital).
- (e) There are a number of independent private hospitals in central London: the Bupa Cromwell Hospital, the Hospital of St John and St Elizabeth, the King Edward VII's Hospital Sister Agnes and The London Clinic (TLC). There are two independent private hospitals in Greater London: the New Victoria Hospital and St Anthony's Hospital.
- (f) There are 11 PPUs in central London (excluding those operated by HCA and BMI). There are four PPUs in Greater London (excluding those operated by the above hospital operators).

The size of London

5. The London area (including Greater and central London) has a population of around 8.2 million,² 4.9 million of whom live outside central London and 3.2 million live within central London. In addition, a unique aspect of working patterns in the capital is that a further 1 million people commute into central London on a daily basis for work.³
6. The London area has a particularly high level of PMI penetration. The last known accurate measure suggested that London had a PMI penetration rate of 17.5 per cent. This compares to a UK wide rate of 12 per cent, but with a number of other parts of the country exhibiting much lower penetration, many as low as 5 to 10 per cent. Only the South-East has a higher PMI penetration rate at 18.5 per cent.⁴ AXA,

² All demographic data has been sourced from the ONS and is based on the 2011 census: www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-284349.

³ <http://londontransportdata.wordpress.com/>.

⁴ Source: L&B UK Health Cover 2012, estimated from the Family Resource Survey 2004–2005 (DWP), after applying UK growth rates (persons covered) 2004–2006 to all regions.

for example, estimates that approximately [X] per cent of its insured policyholders live in London.

7. Private hospitals in central London generated revenue of around £[X] in 2011, and around £[X] if all the hospitals in Greater London are included. As can be seen from Table 1, central London alone represents nearly a third of UK private hospital revenues, or close to 40 per cent if Greater London is included. In terms of inpatient revenue, the Greater London area represents 43 per cent of UK private hospital inpatient revenue. Bupa also noted that central London accounted for over [X] per cent of its annual hospital spend in 2011, with the rest of Greater London contributing a further [X] per cent.

TABLE 1 London as a proportion of national private hospital revenue

	<i>London as % of total hospital revenue</i>	<i>London as % of inpatient revenue</i>	<i>London as % of insured revenue</i>	<i>London as % of self-pay revenue</i>
Central London	32	37	30	29
Including Greater London	38	43	37	35

Source: CC analysis.

8. The largest hospital group in central London is HCA which had London revenues of around £[X] in 2011, followed by TLC, which had an annual revenue of £124 million in 2011. Private hospital revenue in both Greater and central London has been growing at around 8 per cent a year since 2009.

Where do patients treated in London come from?

9. The CC's catchment area analysis did not reveal that London hospitals (including both Greater and central London) had a significantly larger catchment area than other areas of the UK on average.⁵ However, there are a number of hospitals in more rural parts of the UK where patients will have little choice but to travel some distance

⁵ The average catchment in London was 15 miles, which compares to a national average of 17. This, however, disguises a wide variation: the smallest catchment in London was 5 miles, whereas the largest was 41 miles.

to receive treatment, and this may explain the size of the average catchment area across the UK.

10. It is clear that a significant number of patients are prepared to travel into central London to be treated. Bupa reported in minutes of a board meeting that [X] per cent of members who received treatment in a central London hospital did not live in a central London location. For this reason there would be potential benefits if its policyholders could be encouraged to have treatment outside central London, closer to their home, in hospitals that were lower cost to Bupa.
11. Bupa has also analysed where policyholders with its largest corporate customers treated in HCA's central London hospitals live. Bupa's analysis indicates that patients are located across the South-East, with smaller numbers travelling from further afield, as shown in Figure 1.

FIGURE 1

Bupa analysis of where HCA corporate patients live

[X]

Source: Bupa.

12. HCA has also carried out internal research to understand the catchment areas where it draws most of its patients. According to HCA's analysis, its catchment area is influenced both by where there is demand for the services it offers and by the location of the hospitals, particularly their positioning with respect to transport corridors and infrastructure. HCA's map (see Figure 2) shows where HCA draws most of its patients from for all its services (inpatient and day-case admissions), with the darker colours representing a higher number of patients coming from that area (the legend indicates the number of patients per 10,000 population). HCA identifies what it calls its 'core' catchment area as having at least ten treatments per 1,000 population and

its 'wider catchment' area as the areas with more than five treatments per 10,000 population (see shading on legend).⁶ HCA stated that the area shown accounted for over 90 per cent of HCA's UK admissions. HCA noted that the effect of transport corridors was evident by the areas of high treatment radiating outward from central London in south-easterly, north-westerly and south-westerly directions.

13. HCA stated that using its patient data, it found that, on average, the catchment area for 80 per cent of patients to get to an HCA facility would be equivalent to a travel time of [redacted] minutes by road or [redacted] minutes by public transport.⁷ By looking at the location of UK patients travelling to HCA's full hospitals, HCA concluded that the catchment areas of patients to each of its facilities extends to at least the perimeter of the M25, with many patients coming from beyond Greater London, such as from the Home Counties.

FIGURE 2

HCA catchment area analysis

[redacted]

Source: HCA.

14. Internally, HCA has also analysed where its patients originate on a hospital by hospital basis. The hospital with the broadest catchment area would appear to be [redacted], shown in Figure 3. The red dot on the left-hand map represents a postcode where an HCA patient lives and the second map colour codes different areas based on revenue deriving from each area. The importance of the location of the hospital, and transport links into London, can be seen when this map is contrasted with the same analysis for the [redacted], which draws more of its patients from those located [redacted] (Figure 4).

⁶ The catchment area was defined by analysis of patient postcodes in HCA's billing data based on admitted patient activity (inpatients and day-cases) and excludes outpatient activity.

⁷ This is based on an analysis by KPMG of 3 million patient trips to HCA facilities covering the period 2001–March 2012.

FIGURE 3

HCA analysis of [redacted] catchment

[redacted]

Source: HCA.

FIGURE 4

HCA analysis of [redacted] catchment

[redacted]

Source: HCA.

15. Although the results above suggest that central London hospitals (at least HCA hospitals) draw patients from a relatively wide area including Greater London and outer London, this does not necessarily mean that hospitals located outside central London represent a strong constraint on central London hospitals.

16. Given that almost all hospital admissions start with a referral to a consultant by a GP, looking at GP referral patterns should provide an insight into the patient journey that is leading patients to be treated in central London. [redacted]⁸ We do not know what proportion of referrals this group represents, but the study also notes (see Figure 5) that a relatively small proportion of GPs are responsible for a disproportionately high number of HCA referrals (~65 GP practices make up [redacted] per cent of referrals) suggesting that referrals from this group of [redacted] GPs are likely to reflect an important source of referrals and provides a relevant insight into to the most common referral route to HCA hospitals.

⁸ HCA claimed that this analysis was subject to error and should not be relied on due to (a) the data not covering all patient records, (b) the fact that it included overseas patients, who may be more likely to use central London GPs, (c) the fact that the exercise manually matched GP names to GP practices and so could be prone to error, and (d) the analysis used data that was assumed to represent a referral rather than being based on actual referrals. We note these criticisms and that the analysis is not a precise reflection of actual referrals. However, we think the analysis is still likely to be indicative of referral patterns and the criticisms become less relevant when considering only the top 10 GP practices, which according to this list each make [redacted] referrals to HCA hospitals per year.

17. Several parties have suggested that some patients who commute into London for work end up being treated in central London because, for convenience, they wanted to have their consultations in central London.⁹ This may also apply to the initial GP appointment.

FIGURE 5

BCG analysis for HCA on GP referrals



Source: HCA.

FIGURE 6

Top private GPs referring to HCA



Source: HCA.

FIGURE 7

Top NHS GPs referring to HCA



Source: HCA.

18. Although Figures 2 to 4 clearly suggest that patients are drawn from Greater London and outer London into central London, they also suggest that a significant proportion of patients are central London residents. Internal analysis conducted by Bupa (Figure 8), based on the claims spend of its [redacted], offers a similar pattern, with the majority of patient visits seemingly deriving from its policyholders resident in central London.¹⁰ Bupa noted that it was unclear whether these were all home rather than work addresses, but even if some are work addresses this would still support a conclusion that a significant proportion of patients treated in central London are either residents or are tied to central London through work.

⁹ See comments in the [appendix](#) by [redacted] and [redacted] about [redacted] in London ([redacted]). Also comments by Bupa ([redacted]).

¹⁰ Bubble size indicates the number of Bupa members treated at HCA hospitals in 2011.

FIGURE 8

Bupa analysis showing where HCA patients are resident



Source: Bupa.

19. While there does seem to be evidence of patients travelling into central London for treatment, what we have not found is any evidence which suggests that a significant number of patients living in central London move out to the periphery for treatment, suggesting that there may be a significant cohort of patients resident in central London who are largely captive to central London providers. For example, in the CC patient survey, residents of Greater London reported a similar 'actual' travel time from home to the consultant to patients on average (just below 30 minutes compared with just above 30 minutes on average), suggesting that central London residents would tend to seek treatment within the capital.¹¹

The attraction of London

20. We understand that many patients treated in central London are attracted by a perception that quality of care is high in the capital.
21. For example, when asked why patients choose to be treated in London, TLC stated that there was a perception among patients that standards in London were generally higher:

But on the whole people who live or work in London perceive the best will be offered in London and therefore look to London for their treatment ... think in terms of the investment in the facilities and the scope of back-up that you can provide, it's much greater. A lot of people are not well informed, because they don't access private healthcare until

¹¹ CC patient survey: QE1A, Slide 48, see [Private healthcare market investigation | Our work | Competition Commission](#).

something goes wrong, and therefore you look to your local hospital.

But for those who search the internet and really look into their condition,

it is probable that you will find yourself being drawn into central London.

22. HCA also commented that London was regarded as a global centre of excellence, especially for 'high end' tertiary care, which attracted patients from around the world.
23. The Federation of Independent Practitioner Organisations (FIPO) was of the view that patients were attracted to London due its international reputation and the high quality of consultants.
24. It seems that the reputation for high-quality services that London has is, at least in part, a reflection of the significant proportion of highly-regarded NHS teaching hospitals which attract skilled consultants. HCA commented that London's teaching hospitals (Guy's and St Thomas', St Bartholomew's, King's College, University College Hospital, Royal Marsden etc) boasted a strong global reputation and had contributed to London's position as a global medical centre of excellence with well-established tertiary care services. Similarly, FIPO referred to the 'gilded London teaching hospitals'. TLC noted that nearly all of its consultants worked at London teaching hospitals.
25. HCA suggested that a distinguishing feature of London was the large pool (approximately 7,500) of NHS consultants, including many eminent specialists at the top of their field. It argued that London had developed into a world-leading centre for tertiary care, based on the presence of its major NHS teaching and research hospitals and its large patient population.

26. HCA said that it had a strong focus in 'tertiary' clinical specialisms, which it described as the treatment of serious complex medical conditions with a high level of acuity requiring specialist investigation, treatment and care in facilities with advanced equipment, highly-trained staff and 24/7 life support back-up capabilities. HCA suggested that examples of tertiary care included cancer treatment, neurosurgery, cardiac surgery, advanced neonatal services and other complex medical and surgical interventions.

27. HCA also commented that it had invested heavily in diagnostic and treatment facilities and intensive care facilities to support this focus on tertiary/high acuity services. It also noted that it provided the clinical environment which could support higher levels of patient dependency, such as level 3 intensive care units. It said that this investment had attracted leading consultants from major London teaching hospitals.

28. Using the number of critical care beds as a proxy for the ability to do more complex or specialized tertiary treatment, there is certainly more potential for high acuity work to take place in private London hospitals generally. Two hundred and fifty-seven (75 per cent) of the 344 critical care level 3 beds are in London, 225 (65 per cent) of which are in central London. This may exaggerate the number of private critical care beds, as a number of these are at NHS private patient units (PPUs), which are not necessarily dedicated to private patients. However, London (central and Greater London) also accounts for 95 (66 per cent) of 145 critical care level 3 beds in UK private hospitals, of which 81 (56 per cent) are in central London. It may therefore be that there are some more complex treatments performed privately in central London that cannot be done privately, or are less accessible, in many other parts of the country.

29. AXA also argued that patients were attracted to seek treatment in central London, due to a 'Harley Street effect', a point that was separately made by FIPO.
30. The CC patient survey found that patients treated at Greater and central London hospitals¹² were more likely to say that they chose private treatment to access the expertise of private hospitals/private consultants (27 per cent compared with 7 per cent on average).¹³ Patients in London were also more likely to say that the most important reasons for choosing the private consultant were the consultant's reputation (46 per cent compared with 36 per cent on average), the consultant's clinical expertise (43 per cent compared with 38 per cent on average) and the geographic location of the consultant (32 per cent compared with 25 per cent on average).¹⁴
31. The CC patient survey also showed that patients in London were more likely to have engaged in some research ahead of their treatment. Patients in London were more likely than average to have looked up any information online (63 per cent compared with 47 per cent on average), and in particular more likely to have looked up the websites of private consultants (41 per cent compared with 25 per cent on average), of private hospitals/PPUs (36 per cent compared with 24 per cent on average) and other websites (eg Google search) (20 per cent compared with 12 per cent on average).¹⁵

NHS PPUs in London

32. It appears that PPUs in London are larger than they are elsewhere in the country. Nine of the ten trusts with the highest revenue from private patients are located in

¹² Sample size 118 patients.

¹³ <http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/surveys>, CC patient survey: QB1, Slide 25, Table B1.

¹⁴ <http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/surveys>, CC patient survey: QC6, Slide 32, Table C6.

¹⁵ <http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/surveys>, CC patient survey: QF1, Slide 63, Table 133.

London.¹⁶ London also has 526 (44 per cent) of the UK's dedicated private patient beds.¹⁷

33. HCA highlighted that some PPUs in London had large dedicated facilities, for example:

- (a) Royal Marsden (69 beds);
- (b) Royal Brompton & Harefield (43 beds);
- (c) Guy's & St Thomas' (48 beds);
- (d) Great Ormond Street (34 beds);
- (e) Royal Free (52 beds); and
- (f) St Mary's (43 beds).

34. HCA also noted that NHS Trusts such as the Royal Marsden, Imperial College, Royal Brompton and Harefield, Great Ormond Street, King's College, Guy's and St Thomas' and the Royal Free had major national and international reputations which benefited their PPUs.

Large number of corporate PMI customers based in London

35. One of the issues identified by parties was the significant number of corporate customers located in London, or corporate customers that made regular use of central London hospitals (see [appendix](#), paragraphs 42 to 48). In 2011, approximately 60 per cent of insurers' hospital expenditure was incurred by policyholders that were members of a corporate scheme.¹⁸ However, this may

¹⁶ Lang & Buisson, Private Acute Medical Care UK Market Report 2012, Table 4.2.

¹⁷ Lang & Buisson, Private Acute Medical Care UK Market Report 2012, Table 4.3.

¹⁸ CC analysis.

understate their importance from an insurer's perspective as close to 75 per cent of policyholders belonged to a corporate scheme of some kind.¹⁹

36. HCA also noted that the larger presence of major corporates in the London region meant that PMI corporate policies accounted for a higher share of PMI sales.
37. We have not been able to identify the overall size of the corporate market in London from an insurer's perspective or how this compares nationally. Only Bupa provided data at a sufficiently disaggregated level to allow us to isolate and estimate its corporate expenditure at central London hospitals (see Table 2). This suggests that close to [redacted] of its expenditure by corporate customers was in central London. However, an even larger proportion of its personal customers use central London hospitals.

TABLE 2 **Bupa hospital expenditure—by customer type**

	<i>Corporate policyholders*</i>	<i>Individual policyholders</i>
Central London expenditure† (£m)	[redacted]	[redacted]
UK expenditure (£m)	[redacted]	[redacted]
Central London (%)	[redacted]	[redacted]

Source: Bupa.

*[redacted]
†[redacted]²⁰

Competitive conditions in central London

competition filters in central London

38. As explained in the annotated issues statement,²¹ we have created filters for the purpose of identifying hospitals which appear to face relatively limited competition ('hospitals of potential concern'). We are conducting a detailed competitive assessment of these hospitals.

¹⁹ Lang & Buisson Health Cover UK Market Report 2012, Table 1.2.

²⁰ [redacted]

²¹ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130228_final_ais.pdf.

39. Our filter analysis identified four hospitals with a revenue network LOCI below 0.6 in central London—three HCA hospitals (Lister, Portland and Wellington) and one BMI hospital (Blackheath).
40. HCA operates seven hospitals²² in central London, including one PPU joint venture. In addition, HCA also operates a number of other specialized, diagnostic and out-patient centres, such as the London Gamma Knife centre at St Bartholomew's Hospital, the Chelsea Outpatient Centre and the London Oncology Centre (a separate brand which provides oncology services at HCA hospitals across London). For HCA hospitals which were not below the threshold, three (Harley Street Clinic, London Bridge and Princess Grace) were at or just above the threshold ([§]). We did not have data for the other two HCA hospitals. With the exception of NHS Ventures UCLH (the PPU managed by HCA), each of HCA's hospitals had more than [§] private admissions and more than [§] private inpatients in 2011. The relative sizes of HCA's hospitals compared with other private hospitals in central and Greater London are discussed in paragraphs 49 to 52.
41. BMI has four hospitals in central London (Blackheath, Fitzroy Square, London Independent and Weymouth). With the exception of Blackheath, BMI's hospitals were over our threshold, two substantially so (between 0.65 and 0.8). Two of its hospitals are small compared with other private hospitals in London (Weymouth and Fitzroy square). Blackheath and London Independent each had [§] private admissions in 2011.
42. We have looked at the LOCI results for central London hospitals in more detail. Due to the wider geographic footprint of hospitals in central London compared with hospitals across the UK, the LOCI associated with London hospitals tends to be higher

²² One of these hospitals is an NHS PPU which HCA manages and another is the London Oncology Clinic specialized on oncology.

than the LOCI for non-London hospitals. In particular, the wider geographic coverage of hospitals in central London means that these hospitals are attracting patients from a wider number of sub-markets, including sub-markets outside central London where there are other hospitals that most patients living in that area may use. This in turn results in a higher LOCI for central London hospitals.

43. In addition, as discussed in the previous section, London, and in particular central London, appears to have some distinctive characteristics that in combination suggest that central London is somewhat different from other parts of the UK (although we recognize that some of these characteristics may be also present in other large conurbations across the UK). On the demand side, patients are prepared to travel into central London from Greater London and outer London to seek treatment. This can be explained by convenience (especially if they work in central London) and the high reputation of private consultants and private hospitals in central London. On the supply side, private consultants and private hospitals are highly specialized and provide high acuity/complex treatments alongside more routine ones. This expertise is partly related to the presence in central London of a number of highly renowned NHS trusts. All this suggests that there are asymmetric constraints between hospitals in central London and hospitals in Greater London (and possibly outer London), in that hospitals in central London exert a constraint on hospitals located in Greater London (and possibly outer London), but the reverse may not be true, or may be true to a much less extent.
44. Furthermore, many insurers, Nuffield and TLC have expressed serious concerns about the lack of competition in central London, and in particular about the strong position of HCA (see the [appendix](#) for a review of the insurer and hospital operator views).

45. Taking all these factors together—the LOCI results, the reasons for the LOCI results being generally higher in central London than in other local areas, the characteristics of central London, the likely existence of asymmetric constraints and the serious concerns expressed by a number of parties—we have decided to carry out a detailed assessment of competition in central London.

Competitive assessment in central London—overview

46. This section presents our analysis of competition in relation to hospitals located in London. In particular, we consider:
- (a) the degree of concentration as measured by hospital operators' shares of supply in two different geographic segments, specifically central London and Greater London;
 - (b) the degree of concentration as measured by hospital operators' shares of supply in various product segments, including complex specialties/treatments as well as particular specialties; and
 - (c) the capacity available at the various hospitals.
47. The analysis in (b) and (c) relates to hospitals located in central London, although we also provide some relevant figures for Greater London for comparison.
48. We note that the focus of our competitive assessment in central London is mainly on the relative positions of the various hospital operators in aggregate rather than in terms of their individual hospitals. We have taken this approach as focusing on individual hospitals alone may underestimate any market power held by hospital operators. We have adopted a similar approach for our detailed assessment of the hospitals of potential concern across the UK. [X] This more detailed assessment of BMI Blackheath has been done as part of our analysis of local competition outside central London in conjunction with the other BMI hospitals located near Blackheath

(Sloane, Shirley Oaks, Chelsfield Park and Fawkham Manor) which are located outside central London.

Shares of supply—by geographic segment

49. This analysis looks at the degree of concentration across all specialties and all treatments by calculating the share of supply of each hospital operator for patients that choose to be treated in Greater London and central London hospitals. Figures 9 and 10 show shares of supply in terms of inpatient admissions and inpatient revenue in central London and Greater London respectively. Tables 3 and 4 provide the same information in a table format. Similar results hold for inpatient and day patient together. Figures 11 and 12 show the shares of supply in terms of total revenue in central London and Greater London respectively. Tables 5 and 6 provide this in table format.²³

TABLE 3 Hospital operators' shares of supply by inpatient admissions and inpatient revenue—central London, 2011

	<i>% share of central London admissions</i>	<i>% share of central London revenue</i>
HCA	40-50	[X]
TLC	10-20	[X]
BMI	0-10	[X]
The Bupa Cromwell	0-10	[X]
Aspen	0-10	[X]
Hospital of St John & St Elizabeth	0-10	[X]
King Edward VII Hospital	0-10	[X]
Royal Marsden	0-10	[X]
Other PPU's	10-20	[X]

Source: CC analysis.

²³ Based on the data submitted by the parties.

TABLE 4 Hospital operators' shares of supply by inpatient admissions and inpatient revenue—Greater London, 2011

	<i>% share of Greater London admissions</i>	<i>% share of Greater London revenue</i>
HCA	30-40	[X]
BMI	20-30	[X]
The London Clinic	0-10	[X]
Aspen	0-10	[X]
The Bupa Cromwell	0-10	[X]
St Anthony's	0-10	[X]
Hospital of St John & St Elizabeth	0-10	[X]
Other private hospitals (3)	0-10	[X]
The Royal Marsden	0-10	[X]
Other PPU's (7)	0-10	[X]

Source: CC analysis.

TABLE 5 Hospital operators' shares of supply by total admissions and total revenue—central London, 2011

	<i>% share of central London admissions</i>	<i>% share of central London revenue</i>
HCA	40-50	[X]
TLC	10-20	[X]
BMI	0-10	[X]
The Bupa Cromwell	0-10	[X]
Aspen	0-10	[X]
Hospital of St John & St Elizabeth	0-10	[X]
King Edward VII Hospital	0-10	[X]
Royal Marsden	0-10	[X]
Other PPU's	0-10	[X]

Source: CC analysis.

TABLE 6 Hospital operators' shares of supply by total admissions and total revenue—Greater London, 2011

	<i>% share of Greater London admissions</i>	<i>% share of Greater London revenue</i>
HCA	30-40	[X]
BMI	20-30	[X]
The London Clinic	0-10	[X]
Aspen	0-10	[X]
The Bupa Cromwell	0-10	[X]
St Anthony's	0-10	[X]
Hospital of St John & St Elizabeth	0-10	[X]
Other private hospitals (3)	0-10	[X]
The Royal Marsden	0-10	[X]
Other PPU's (7)	0-10	[X]

Source: CC analysis.

FIGURE 9

Hospital operators' shares of supply by inpatient admissions and inpatient revenue—central London, 2011

[X]

Source: CC analysis.

Note: Inpatient revenue data not available for Royal Brompton and Harefield NHS Foundation Trust and for The Royal Marsden NHS Foundation Trust.

FIGURE 10

Hospital operators' shares of supply by inpatient admissions and inpatient revenue—Greater London, 2011

[✂]

Source: CC analysis.

Note: Inpatient revenue data not available for Royal Brompton and Harefield NHS Foundation Trust and for The Royal Marsden NHS Foundation Trust.

FIGURE 11

Hospital operators' shares of supply by total admissions and total revenue—central London, 2011

[✂]

Source: CC analysis.

FIGURE 12

Hospital operators' shares of supply by total admissions and total revenue—Greater London, 2011

[✂]

Source: CC analysis.

50. This analysis highlights that HCA has a very high share of supply when considering only central London ([✂] per cent of inpatient admissions, [✂] per cent of inpatient revenue, approximately [✂] per cent of total revenue). HCA shares of supply in central London are higher than its shares in Greater London, where, however, they remain high, especially in terms of revenue (approximately [✂] per cent of inpatient revenue and [✂] per cent of total revenue).

51. The only sizeable competitor to HCA in central London is TLC (which has shares of supply of approximately [✂] per cent by all measures). BMI in central London has smaller shares of supply (approximately [✂] per cent of inpatient admissions and below [✂] per cent of inpatient revenue and of total revenue).

52. In relation to insurers' own spend at HCA hospitals, Figure 13 shows how Bupa's hospital expenditure in central London, and HCA's share of this spend, has increased since 2007.

FIGURE 13

Bupa spend at HCA hospitals



Source: Bupa.

Shares of supply—by product segments

53. The second piece of analysis looks at the degree of concentration across a number of product segments, including complex treatments/specialties and individual specialties.
54. To capture these different product spaces we sought to analyse the following:
- (a) 'complex' specialties—cardiology, neurology, oncology, cardiothoracic surgery and neurosurgery (Tables 7 and 8);
 - (b) 'CCL3' capability—whether a hospital can provide the highest level of critical care. We use this as a proxy for identifying hospitals better positioned to attract consultants undertaking complex treatments (Figure 14);
 - (c) 'tertiary' treatments—those requiring a referral from a consultant to another consultant, which may be interpreted as more complex treatments (Figure 15);²⁴ and
 - (d) each specialty individually (Table 9).

Complex specialties

55. Table 7 shows the shares of supply for the five complex specialties together by admissions and total revenues in central London, by operator and weighted by the

²⁴ We recognize that it is difficult to define tightly what constitutes a 'tertiary' treatment. However, we also note that this is a category of treatment that central London providers have themselves tried to isolate in internal analysis (see paragraph 60). The procedures selected here were based on a list of CCSD codes provided by Spire which it stated were the tertiary procedures performed at its hospitals.

size of each specialty. Revenue shares for TLC are incomplete due to a lack of data on revenue by specialty, apart from oncology, hence the revenue shares of other operators are overestimated to a certain extent. Even taking account of this HCA has the highest share of both admissions and revenue for these specialties in central London.

TABLE 7 Hospital operators' shares of supply of the five complex specialties together—central London, 2011

Operator	per cent	
	Admissions share	Revenue share
BMI	[X]	[X]
Bupa Cromwell	[X]	[X]
HCA	[X]	[X]
TLC	[X]	[X]
Other private hospitals	[X]	[X]
The Royal Marsden	[X]	[X]
Other PPUs	[X]	[X]

Source: CC analysis.

Note: Revenue data for complex specialties not available for Royal Brompton and Harefield NHS Foundation Trust and for The Royal Marsden NHS Foundation Trust.

56. Table 8 shows the number of hospitals owned by different hospital providers, which offer one or more of the five complex specialties we identified. HCA owns six private hospitals and operates one PPU that offer one or more of the complex specialties, with four of its hospitals offering all five complex specialties. BMI has one private hospitals in central London that offers five complex specialties and one which offers four. It also operates nine hospitals in Greater London (including three PPUs), but some of these offer fewer complex specialties. Four independent hospitals and nine PPUs (excluding PPUs managed by the large operators) also offer one or more complex specialties. The two independent private hospitals that offer all five complex specialties are the Bupa Cromwell and TLC. Therefore HCA is the hospital operator with the largest number of such hospitals in central London. Although none of the PPUs provides all five of the complex specialties, five of these do provide four specialties. However, as can be seen from Table 7, this group only makes up less than 15 per cent of admissions and an even smaller share (less than 10 per cent) of revenue.

TABLE 8 Private hospitals/PPUs by number of complex specialties offered—central London, 2011

	One complex specialty	Two complex specialties	Three complex specialties	Four complex specialties	Five complex specialties	Total
BMI	0	0	0	1	1	2
HCA	0 (+1 PPU)	0	0	2	4	6 (+1 PPU)
Other private hospitals	0	1	0	1	2	4
Other PPUs	1	1	2	5	0	9

Source: CC analysis.

Intensive care critical level 3

57. Figure 14 shows inpatient admissions and inpatient revenue of hospitals in central London that offer intensive care at critical level 3. HCA runs most of the largest hospitals in central London with intensive care capacity at critical level 3 and so has a higher share than any other hospital operator.

FIGURE 14

Hospital operators' inpatient admissions and inpatient revenue for hospitals/PPUs with intensive care at critical level 3—central London, 2011



Source: CC analysis.

Note: Inpatient revenue data not available for Royal Brompton and Harefield NHS Foundation Trust and for The Royal Marsden NHS Foundation Trust.

Tertiary treatments

58. Finally, Figure 15 shows the revenue from tertiary treatments (based on Healthcode data) at hospitals in central London.²⁵ HCA is again the largest provider of tertiary treatments by revenue in Greater London. HCA also earns the highest proportion of its total revenue from this group of treatments.

FIGURE 15

Hospital operators' revenue of from tertiary treatments and as a proportion of total revenue—central London, 2011



Source: CC analysis.

²⁵ Only one hospital operator has provided a list of CCSD codes for tertiary treatments. This has been used as a basis for this analysis.

Summary: HCA's share of complex/specialist treatments

59. Tables 7 and 8 and Figures 14 and 15 highlight that HCA has a very high share of supply in the high complexity segment (by all measures considered) in central London. Its closest competitor in central London is TLC, which, however, is much smaller than HCA. BMI is the next largest competitor if Greater London is considered, but again it is much smaller than HCA by most measures.

60. HCA has also conducted research into how it can grow its revenue from specialized procedures. A 2010 report for HCA prepared by external consultants also analysed its market share on the basis of its share of patients in 'tertiary services' across Greater London. This noted that:

HCA's market share of all private sector tertiary activity across its entire catchment area is [%] per cent and [%] per cent within London. This figure is distorted, however, due to the high volume of [%] attendances in which HCA has a relatively low market share. The market share of inpatient activity is therefore likely to offer a better estimate of financial market here than the aggregate total. HCA has a significantly higher share of inpatient tertiary activity, providing between [%] per cent of all private sector inpatient tertiary treatments within its catchment area.

Within London this figure is even higher at [%] per cent.

Individual specialties

61. Looking at individual specialties, Table 9 shows shares of supply by specialty for HCA, TLC and all other providers in central London together. Shares have been calculated on the basis of total admissions by specialty (inpatient plus day patient) as reported by the parties. From the table, it can be seen that HCA has high shares of supply by admissions for individual specialties in central London. As HCA tends to have higher shares by revenue rather than by admissions, the figures in the table

may underestimate HCA's shares by revenue in each specialty.²⁶ In the three largest specialties that together account for more than a third of central London admissions, HCA's share is significantly above [redacted] per cent.

TABLE 9 Hospital operators' shares of admissions by specialty—central London, 2011

	<i>per cent</i>			
	<i>Shares of supply</i>			<i>Share of total admissions accounted for by each specialty</i>
	<i>HCA</i>	<i>TLC</i>	<i>Others</i>	
<i>Complex specialties</i>				
Oncology	[redacted]	[redacted]	[redacted]	[redacted]
Cardiology	[redacted]	[redacted]	[redacted]	[redacted]
Neurosurgery	[redacted]	[redacted]	[redacted]	[redacted]
Neurology	[redacted]	[redacted]	[redacted]	[redacted]
Cardiothoracic surgery	[redacted]	[redacted]	[redacted]	[redacted]
<i>Other specialties</i>				
Trauma and orthopaedics	[redacted]	[redacted]	[redacted]	[redacted]
Gastroenterology	[redacted]	[redacted]	[redacted]	[redacted]
General surgery	[redacted]	[redacted]	[redacted]	[redacted]
Obstetrics and gynaecology	[redacted]	[redacted]	[redacted]	[redacted]
Plastic surgery	[redacted]	[redacted]	[redacted]	[redacted]
Urology	[redacted]	[redacted]	[redacted]	[redacted]
Ophthalmology	[redacted]	[redacted]	[redacted]	[redacted]
Otolaryngology	[redacted]	[redacted]	[redacted]	[redacted]
General medicine	[redacted]	[redacted]	[redacted]	[redacted]
Oral & maxillofacial surgery	[redacted]	[redacted]	[redacted]	[redacted]
Anaesthetics	[redacted]	[redacted]	[redacted]	[redacted]
Clinical radiology	[redacted]	[redacted]	[redacted]	[redacted]
Dermatology	[redacted]	[redacted]	[redacted]	[redacted]
Rheumatology	[redacted]	[redacted]	[redacted]	[redacted]

Source: CC analysis.

Capacity available

62. Table 10 shows the capacity available at different hospitals located in central London and the hospitals' respective share of this capacity. As we do not have data on the capacity of PPUs which is dedicated to private patients, our analysis focuses on private hospitals only. Theatre, bed and consulting room capacity are used as a measure of the hospitals' overall capacity, while we also consider the number of hospitals able to perform more complex procedures by looking at those that have ICU at critical care level 3 or ICU at critical care level 2. As Table 10 shows, HCA has almost half of the theatres in private hospitals in central London and more than half of the overnight beds. A similar result is found if one looks at consulting rooms, with

²⁶ [redacted]

HCA owning 55 per cent of consulting rooms at private hospitals in central London. It is noticeable that all HCA hospitals have beds at critical care level 3 and level 2. Moreover, HCA has 57 beds at critical care level 3, representing more than 70 per cent of the total in London.

TABLE 10 Installed capacity in central London hospitals

	<i>Overnight beds</i>	<i>% overnight beds</i>	<i>Theatres</i>	<i>% theatres</i>	<i>Consulting rooms</i>	<i>% consulting rooms</i>	<i>Intensive care level</i>	<i>Critical care beds level 3</i>	<i>% critical care beds level 3</i>
<i>Aspen</i>									
Highgate Hospital	28	2.2	3	3.8	12	2.7	Level 2	0	0
<i>BMI</i>									
Blackheath	69	5.3	4	5.0	21	4.8	Level 2	0	0
Fitzroy Square	16	1.2	1	1.3	7	1.6	No	0	0
London Independent	58	4.5	4	5.0	10	2.3	Level 3	6	6.0
Weymouth	10	0.8	4	5.0	0	0	No	0	0
Total BMI	153	11.8	14	16.3	38	8.6		6	6.0
<i>HCA</i>									
Harley Street Clinic	104	8.0	4	5.0	51	11.6	Level 3	20	18.0
Lister Hospital	74	5.7	4	5.0	31	7.0	Level 3	2	6.0
London Bridge Hospital	111	8.6	7	8.8	56	12.7	Level 3	8	10.0
Portland Hospital	87	6.7	4	6.7	39	8.8	Level 3	3	7.0
Princess Grace Hospital	114	8.8	8	8.8	38	8.6	Level 3	4	7.0
Wellington Hospital	226	17.5	11	17.5	20	4.5	Level 3	20	24.0
Total HCA	716	55.3	38	47.5	235	55.8		57	72.0
St John & St Elizabeth	49	3.8	5	3.8	36	8.2	Level 2	0	0
King Edward VII's Sister Agnes	60	4.6	3	4.6	6	1.4	Level 3	0	4.0
The Bupa Cromwell	118	9.1	5	9.1	29	6.6	Level 3	7	7.0
The London Clinic	170	13.1	13	13.1	74	16.8	Level 3	11	11.0
Total	1,309		81		430			81	

Source: CC analysis.

Introduction and summary

1. In this section we consider the views of hospital operators and insurers regarding the nature of competition in central and Greater London and the competitive constraints faced by HCA in particular.
2. We have received representations from most insurers that there is a lack of competition in central London. Specifically, we are told that:
 - (a) HCA owns the most reputable hospitals in central London. Although there are a number of hospitals in Greater London and outside London, these do not provide a competitive constraint on HCA for patients that either live in central London or those that choose to travel into central London for treatment (see paragraphs 7 to 9). Nor do PPUs represent a viable alternative for most patients treated in central London (see paragraphs 10 to 14).
 - (b) Insurers face several constraints that mean that they would face difficulty in directing patients to alternative hospitals were they to have a dispute with HCA. These constraints include the limited capacity at comparable hospitals (see paragraphs 34 to 37) and a perception among customers, particularly corporate customers, that they must retain access to HCA's hospitals (see paragraphs 41 to 48).
 - (c) Given the above, any attempt to delist HCA hospitals would be very costly (see paragraphs 54 to 60).
 - (d) Furthermore HCA has certain contractual terms with some insurers that make it difficult to price their policies in such a way as to signal to their customers the higher cost associated with HCA hospitals (see paragraphs 68 to 73).
3. However, in response HCA argued that:

- (a) There were a large number of comparable private hospitals in and around London that competed strongly for patients and consultants. In addition, competition from PPUs was significant and growing (see paragraphs 15 to 31).
- (b) There was sufficient capacity around London to absorb HCA patients were an insurer to delist its hospitals (see paragraphs 38 to 40). There was little evidence to suggest that corporate policyholders required access to HCA hospitals under their PMI policies, but if there was a perception among customers that they must have access to HCA hospitals, this simply reflected the quality of the service it provided (see paragraphs 50 to 52).
- (c) The consequence of losing the recognition of an insurer would be much worse for HCA than for the insurer as it would lead to the loss of significant volumes of business and undermine the viability of its hospitals (see paragraphs 61 to 67).
- (d) A significant constraint faced by HCA was that insurers were able actively to encourage or redirect patients to attend cheaper hospitals. Many insurers had introduced policies that did not offer access to HCA hospitals (see paragraphs 76 to 79).

London's distinguishing features

- 4. In line with the analysis set out earlier in this paper, several parties argued that there were certain features that distinguished private healthcare in central London. AXA stated:

in our view Central London has the features of a distinct market given the reputational draw of certain facilities and consultants, the fact that new technology will tend to be introduced in London before other locations and/or may only be justified in London due to the concentration of population and specialist consultants, the importance of London facilities to large corporate customers, and the fact that many customers

living both within and outside London prefer to be treated within Central London.

5. TLC stated:

In The Clinics opinion the Central London Market for private healthcare has a number of features which distinguish it from private healthcare in other parts of the country. These include: a focus on acute care and complex and tertiary surgery (e.g. cardiac, neurosurgery and oncology services); world renowned consultants and facilities; a higher proportion of self-paying patients (including many overseas patients) and a patient population drawn from outside the local area; the presence of HCA and dominant local competitor; high capital and operating costs and limited opportunities for expansion in the immediate area.

Closeness of competition in London

Insurer views

6. Insurers argued that there was a relatively small cohort of close competitors in central London. In their view, hospitals outside central London, including Greater London and those on the fringes of London, did not provide enough of an alternative from their perspective to provide a constraint. PPU did not represent a close alternative.

Competition in central London

7. While accepting that other hospitals in London competed to some degree with HCA, AXA argued that HCA overstated this competition. AXA argued that hospitals in London could instead be split between 'elite' and 'non-elite' hospitals, elite hospitals being those that provided the strongest professional reputation for a broad range of treatments and which it believed were more important for its clients, though not

necessarily 'must have' (see paragraph 42 for AXA definition of 'must-have' hospitals in central London). AXA argued that the London hospitals could be divided along the following lines:

Elite London hospitals

Non-HCA

BMI Weymouth Street
BUPA Cromwell Hospital
Hospital of St John & St Elizabeth
King Edward VII's Hospital Sister Agnes
London Clinic
Parkside Hospital (Acute)
Royal Marsden Hospital²⁷

HCA

Harley Street @ UCLH²⁷
Harley Street Clinic
Lister Hospital
London Bridge Hospital
Portland Hospital
Princess Grace Hospital
Wellington Hospital

London non-elite

BMI Fitzroy Square Hospital
BMI London Independent Hospital
BMI The Blackheath Hospital
BMI The Garden Hospital
Highgate Private Hospital
London Day Surgery Centre
London Radiosurgical Centre
St Anthony's Hospital

8. AXA argued that for patients resident in Central London competition was closest between the elite hospitals on this list. Based on defining an elite central London market according to the hospitals shown above, 71.2 per cent of all the treatment in central London for patients living in central London occurred in these elite hospitals. 58.6 per cent of the treatment in the elite hospitals occurred in HCA hospitals.

Competition from hospitals outside central London

9. Bupa argued that the fact that a number of patients travelled into central London for treatment did not mean that central London hospitals faced strong competition for these patients from hospitals on the periphery:

Commuting patterns into Central London overstate the catchment areas over which Central London hospitals 'compete'. A significant number of insured customers travel into Central London every day to work. For

²⁷ PPU.

these customers it may appear that hospitals closer to their home postcodes are possible alternatives for inpatient treatment. However, for many their local hospital may continue to be a weak alternative because they will begin their treatment journey with a consultant located inside Central London who, being close to their place of work, is convenient to meet during the working day for the first consultation or diagnostic. Once the patient has met the consultant it becomes highly likely that they will receive inpatient care at a facility at which that consultant has practicing privileges. Therefore, while it appears that the patient has “chosen” to have inpatient care inside Central London (far away from their home postcode) this does not reflect the Central London hospital being superior but rather that the patient was seeking convenient outpatient/diagnostic care inside Central London.

Competition from PPU's

10. AXA argued that it did not consider most NHS PPU in London to be significant competitors currently, noting that investment in these facilities had been variable, with many being little more than a private room in an NHS environment while others offered facilities more directly comparable with a private hospital. Moreover, as they shared clinical resources, such as theatres, with the NHS, this could mean that private patients' theatre lists had to wait behind NHS patients with higher clinical priorities and private surgery could get cancelled as a result. AXA also suggested that specialists had a bias towards avoiding treating their private patients in the NHS facility they worked in. However, AXA also stated that there was potential for a limited number of PPU's, notably those linked to prestigious hospitals, to remain or become significant competitors in the inner London 'elite' market in the future (see paragraph 7 above for AXA's description of elite hospitals). These are:

Charing Cross Hospital
Chelsea & Westminster Hospital
Guy's and St Thomas'
Hammersmith Hospital
Harley St @ UCH
Kings College Hospital

Royal Brompton Hospital
Royal Free Hospital
Royal Marsden Hospital (Fulham)
St Bartholomew's Hospital
St Mary's—Lindo wing

11. AXA, however, excluded a number of PPUs with strong but limited areas of specialism (such as the Great Ormond Street Hospital, Moorfields Eye Hospital and The Heart Hospital) since it considered that, from an insurer's perspective, in order to provide an effective alternative to HCA they would, even taken together, need to provide a much broader range of specialism than they did today.
12. While AXA believed that these hospitals had the potential to develop as stronger competitors, it had particular concerns that HCA might inhibit this development by bidding to run the facilities itself. AXA noted that NHS Trusts which outsourced management of their private facilities were attracted to bidders who were likely to generate the most income for the Trust, which it suggested tended to be the high-cost providers such as HCA. It cited the example of HCA's plan to take over Guy's and St Thomas' PPU which could otherwise emerge as competitor to the London Bridge.
13. WPA noted that with the exception of hospitals such as the Royal Marsden, which were slightly unusual because they were world-renowned centres, it did not regard PPUs as viable alternatives to private hospitals. It also expressed a concern that when HCA took over the running of an NHS PPU they tended to be much more expensive.
14. Aviva also argued that PPUs were not currently a competitive constraint on private hospitals and often did not feel like a private hospital experience. It noted, however,

that this might change with the lifting of the private patient cap as hospitals might start to set them up differently.²⁸ The exception it noted in London was the good reputation of Guy's, which it thought HCA had expressed an interest in running. Aviva did also note that in the case of some complex surgery a consultant may recommend the use of a PPU due to the availability of NHS intensive care facilities.

Hospital views

15. HCA argued that London was one of the most competitive parts of the UK. There were a significant number of competitors in both central London and Greater London, including private hospitals and PPUs with a world-class reputation, which represented a competitive constraint.

Competition in central London

16. As regards its 'main competitors' in central London, HCA stated:

I think that in central London the private hospitals are, of course, London Clinic and Cromwell. They are probably the most formidable competitors that we face. We also have King Edward VII, St John and Lizzies and the BMI hospital, the London Independent. There are six of those private hospitals in the central London area that are our main competitors.
17. HCA also identified NHS PPUs as a second group of competitors in central London that it thought were very competitive.
18. TLC argued that, including itself, competition for private patient activity in central London was primarily concentrated within 11 central London private (ie non-NHS)

²⁸ Under the Health and Social Care Act 2012 NHS foundation trusts will be able to earn up to 49 per cent of their income from private patients, a significant increase from the current cap.

hospitals. This includes six HCA hospitals,²⁹ three charitable hospitals (TLC, the Hospital of St John and St Elizabeth and the King Edward VII's hospital) and two others (Bupa Crowell Hospital and BMI Weymouth Clinic).

19. However, [REDACTED].

Competition from hospitals outside central London

20. HCA argued that hospitals outside central London competed strongly for its patients. It suggested that there was a higher propensity to use public transport in and around London, and evidence from the National Transport Survey³⁰ showed that Londoners were prepared to travel longer for healthcare services than individuals in other parts of the country.

21. In addition to the hospitals in central London that HCA identified as its main competitors and central London NHS PPUs, HCA also identified hospitals around the edge of London as a third group of competitors. The final group of competitors HCA identified were international hospitals in other healthcare destinations such as Germany, the USA, Singapore and Thailand, which competed for international patients.

22. When discussing how effective a competitor it was, [REDACTED] noted that the extent it could compete with hospitals in central London had to be considered on a procedure-by-procedure basis. In this regard [REDACTED] stated:

We can credibly compete with the comparable offer in London and, where we have more complex offers in certain hospitals, [REDACTED], on those service lines we can effectively compete. We do not compete on a broad band basis at each of those individual hospitals for all of the services that the London hospitals offer.

²⁹ HCA 1. The Wellington 2. Harley Street Clinic 3. The Portland 4. Princess Grace 5. London Bridge Hospital 6. Lister Hospital.

³⁰ <https://www.gov.uk/government/organisations/department-for-transport/series/national-travel-survey-statistics>.

23. [X] noted that it considered HCA was a strong competitor as many patients who lived in the outer area of London opted to be treated in central London in HCA hospitals. It suggested that this was often commuters but also patients who were not regular commuters into London that chose to be treated in central London. [X] also noted that the OFT's view [X], was that analysis of patient postcodes suggested that HCA was a strong competitor in what might otherwise be regarded as these hospitals' primary catchment. [X] view was that this applied all the way around London.
24. [X] noted that it could not compete for patients located in central London that wanted to be treated in central London. However, it identified two other groups it was seeking to attract:
- In the kind of Greater London space there are about 5 million people. They have a choice to make. They can move out of London or into London and we would like to equip our hospitals on the periphery to be able to attract some of those. Then we have the 1.6 million commuters that come into London every day to work and then go back out. Many of them pass our [X] sites.'
25. However, [X] also noted that although patients would travel for surgery, they would not travel for a consultation and a lot of consultations happened 9 am to 8 pm Monday to Friday. [X]
26. [X] explained that it had tried to put outpatient consulting rooms in central London ([X]) as a way to attract patients to the [X]. However, this was not a success.
27. When asked why it thought insurers were not doing more to encourage patients to be treated in outer London facilities, Aspen noted that traditionally there had been an

aura around Harley Street. Also, the insurance companies had found it difficult to direct patients to outside central London: 'I suspect that it's not that easy for them to openly direct. They have tried via various networks etc, but have never been able to do it to any great extent, to our knowledge'.

28. HCA stated that it competed for patients located outside of London. It also stated that these hospitals primarily competed for local patients: 'in the south east (outside Greater London) there are 44 independent hospitals operated by seven different organisations. These providers primarily compete for local consumers who may choose a London provider as an alternative'.

Competition from PPUs

29. HCA argued that central London PPUs represented strong competitors. It noted that although some of these facilities were 'niche' players, these hospitals often had global reputations (eg the Royal Marsden and Great Ormond Street). HCA also stated that other hospitals, including, amongst others, the Royal Free and the cluster of PPUs operated by Imperial and Kings College Healthcare Foundation Trust, offered a broader range of services which overlapped with its own services. It noted that the most significant competitive threat came from PPU's expertise in high acuity tertiary specialties.
30. HCA also argued that PPUs in London, as well as already being a significant competitor to private hospitals, represented a 'sleeping giant' of potential competition that had yet to be fully realized, and which 'poses a serious threat to the continued existence of non-NHS private healthcare providers'. HCA commented that not all PPUs were as competitive as they might be. However, when it had gone into partnership with UCH, it had been able to increase its market share, suggesting that PPUs could be more formidable competitors. HCA said that it was looking for more partner-

ships, provided the proposed joint venture was consistent with HCA's objective and strategy. It noted that the fact that PPUs were now partnering with private providers was 'double edged', as on the one hand it represented an opportunity, but on the other a threat, if competitors partnered with the PPU. Although PPUs currently accounted for less than 10 per cent of inpatient and day-patient admissions in London, HCA's expectation was that this would [✂] over the next five years.

31. HCA also provided a comment on an Aviva comment, pointing out that a number of PPUs were included on Aviva's 'Key List' of hospitals, suggesting that Aviva must therefore regard these PPUs as directly competing alternatives. HCA also pointed out that Aviva sold a 'Trust Care' product, demonstrating that an insurer could develop a low-cost product based exclusively on PPUs. HCA also made the point that central London PPUs were included in policies sold by Bupa, AXA and PruHealth that did not include all HCA hospitals.

32. However, TLC argued that the London PPUs were not close competitors because they did not offer comparable services to central London private hospitals:

PPUs by definition operate as part of an NHS Hospital and thus are unable to accommodate consultants working for other NHS Trusts or private hospitals. The service they offer also falls below that expected at private hospitals both in terms of the 'customer experience' but also access to dedicated facilities on a timely basis. The weakness of competition from PPUs is most marked in relation to tertiary case of PMI funded patients (e.g. specialist oncology treatment) which is dominated by HCA with The Clinic and the other private hospitals taking a smaller share.

33. In response to questions about PPU capacity, Kings College Hospital NHS Foundation Trust noted that there are 18 theatres and 72 Level 3 critical care beds across the trust. Priority is given to NHS patients so that NHS care is not compromised. The PPU access to these facilities is flexed accordingly.

Constraints that could prevent insurers switching hospital provider—capacity

Insurer views

34. Insurers argued that one of the reasons they were in a weak position when negotiating with HCA was that they would need to find alternative capacity to absorb their patients were they to delist HCA.
35. AXA tried to estimate the impact of delisting HCA (see paragraph 56 below). This modelling assumed that redirecting treatment to other hospitals was feasible, but noted that it would need to redirect [redacted] patients and it did not know if there would be available capacity in practice.
36. We also find [redacted] evidence from Bupa internal documents to suggest that it had considered this. In preparing for its recent negotiation with HCA, Bupa discussed this issue:
- Removing HCA completely from the BHW networks would require alternative provision to be found elsewhere ...
- [redacted]
37. When planning for its negotiation with HCA in 2010, Bupa noted that HCA had a particularly strong position in some specialties in London, such as [redacted]. It also noted that HCA were able to attract and retain consultants who practised in [redacted], since there were few private patient alternatives available for these doctors to use. AXA

noted that of the patients living in inner London having treatment in the elite hospitals, [X] per cent of the 'complex stays' occurred in an HCA facility.

Hospital views

38. TLC also suggested that there might be capacity constraints that would stop an insurer delisting HCA:

I think the difficulty for insurance companies is if they were to exclude HCA from their network, it would be difficult for all of that work to be absorbed by any one or two other providers. So that makes it difficult. ... we need to be competitively priced in order to keep in those networks. So although we couldn't absorb all the work HCA do, if we were excluded from insurer networks they could absorb all the work that we do.

39. HCA noted that the number of competitors changed as acuity increased. However, it stated that hospitals did not necessarily require level 2 or level 3 critical care support to do high acuity work, due to the ability to transfer patients to the NHS if necessary.
40. When asked whether it considered that there would be enough capacity at rival hospitals were an insurer to exclude HCA for any reason, particularly for high acuity or specialist services, HCA responded that it thought that there would be. It did, however, note that this would depend on the 'elasticity of supply' at rival hospitals such as PPUs, which in the short term it recognized could be quite low. HCA noted that this was not something it had ever had to consider or put to the test.

Constraints that could prevent insurers switching hospital provider—customer demand

Insurer views

41. Insurers also suggested that one of the challenges they faced when negotiating with HCA was that it would be extremely difficult to delist HCA, even for a short time, due to the demands of customers, in particular corporate customers which wished to retain access for their policyholders.

42. AXA argued that a PMI policy purporting to offer a full network that only included one of the seven core London hospitals would not be seen as a credible policy. In its view, professional groups based in London required access to these hospitals in their PMI policies.

Within London, certain hospitals are clearly ‘must have’ for servicing Corporate Customers which have employees in the south-east. Another advantage is that senior decision-makers are often based in London and have a desire to achieve the ‘best’ access for themselves.

We defined the ‘must have’ private hospitals as comprising those healthcare facilities offering the strongest professional reputation for a broad range of treatments and those which we believe are a ‘must have’ for our large corporate clients. We believe there to be seven such facilities, six of which are owned by HCA in addition to the London Clinic.

43. Bupa emphasized that its [REDACTED].

44. Bupa argued that measures such as network LOCI would underestimate HCA’s market power [REDACTED].

45. Aviva also stressed that its largest corporate clients in London had all chosen products that allowed access to HCA facilities. It said that corporate clients regarded HCA hospitals as must have. It contrasted HCA's position with that of TLC, which would not be in the same position as HCA in a negotiation and offered lower prices accordingly (which meant it was listed on Aviva's standard 'Key' network). In practice, Aviva felt that its options in London were very limited and HCA had a monopoly over the areas it specialized in.

46. PruHealth noted that the corporate market was largely intermediated and brokers often insisted that their clients had access to HCA hospitals.

47. When planning for its ongoing negotiation with HCA, Bupa analysed demand for HCA services from corporate customers, noting that a number of large corporate customers had a strong preference for its services.

The majority of the spend with HCA comes from BHW corporate clients with [redacted] of their BHW revenue coming from [redacted] of BHW's corporate clients ...

[redacted]

48. Bupa also analysed the share of its corporate spending with different HCA hospitals (Figure A1). This suggested that the [redacted] accounted for a significant proportion of this.

FIGURE A1

Bupa spend at HCA hospitals

[redacted]

Source: Bupa.

49. Aviva argued that it could not tie back the prices charged by HCA to differentiated quality outcomes or service it provided to its customers. Documents prepared by Bupa for the purpose of preparing for negotiations with HCA noted that [REDACTED].

Hospital views

50. HCA argued that the CC survey of corporate PMI holders did not support the view that London corporate customers required access to HCA hospitals.
51. While HCA agreed that there was a high level of corporate penetration in London and the South-East, it suggested that this gave Bupa additional bargaining power as the Bupa share of corporate PMI policies was particularly high.
52. HCA also argued that any perception that its facilities were strongly demanded by PMI clients simply reflected the quality of the service HCA provided. HCA stressed that many of its hospitals were centres of excellence which offered some of the most advanced treatments in the UK (including the NHS) and international reputations in key specialisms. It suggested that this was accepted by BUPA:
- We ask them this question almost every time we meet now ... Why do you think that with 29 per cent of the beds we are getting more than 29 per cent of your customers coming in? Essentially, they say that it is because you run really good hospitals. We say that, yes, we think that that is how it should be.
53. [REDACTED] also noted that HCA had excellent quality hospitals which operated a high level of complexity.

The consequences of a dispute between HCA and an insurer

Insurer views

54. Insurers argued that the lack of alternatives and the various constraints on switching provider meant that it would be very costly were they to remove HCA from their network, leaving them in a weak negotiating position.
55. AXA provided analysis which purported to show the impact of delisting HCA on its business. AXA noted that it would make significant savings if it was able to direct patients to alternative facilities. However, it would face a significant price increase for any patients who continued to be treated at HCA facilities (which it estimated would be a [redacted] per cent increase if prices were increased to rack rate). AXA estimated that there would be at least [redacted] per cent of patients that it would not be able to redirect to other hospitals, even in the medium term.³¹ Based on a steady state (ie not taking into account increased lapses due to HCA being omitted from the network), AXA estimated that it would lose [redacted] in the first year, and would need to redirect [redacted] per cent of the treatment in future years to break even on an annual basis.
56. However, if HCA was excluded from the AXA network, AXA argued that it would need to reduce its premiums to retain business, particularly in the London region. AXA also believed that in practice it would lose a significant volume of customers to other insurers (many of which would continue to use HCA facilities). AXA provided the results of its modelling to show the effect on its business, depending on the extent of any reactions from corporate customers. As set out in Table A1, AXA argued that it would lose between £[redacted] and £[redacted] in the first year, [redacted].

³¹ 'For existing customers, given such a major change to our hospital listings, we do not believe we would be able to effect the change to the hospital list for the customer at least until they reached their renewal. Therefore for claimants, we would see a continuation of treatment in HCA after it has been "de-listed". This would also be applicable to in-flight claims (where patient treatment has commenced) occurring over the renewal date. Additionally there may be times that, due to medical necessity, an AXA PPP customer could use HCA facilities in the future (typically our "out-of-network" claims as a proportion of the total value of claims is [redacted] however given that we would be de-listing some elite hospitals it is likely that this would rise). Some of our products have an "out-of-network" policy provision, under which the customer can go to any hospital regardless of whether it was in the network, so they could still claim at HCA.'

TABLE A1 AXA analysis of cost of delisting HCA on its business

Scenario	Lapse rates (%)			Price discount (%)	Impact on P&L (£m)			
	Large corporate	SME	Individual		AXA PPP		HCA	
					Year 1	Year 2+	Year 1	Year 2+
A	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
B	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
C	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
D	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Stable state: Scenario A ~ No change in lapses or price discounts
 Optimistic scenario: Scenario B ~ impact on lapses and small price discount
 Realistic scenario: Scenario C ~ impact on lapses and price discount of [REDACTED]
 Pessimistic scenario: Scenario D ~ impact on lapses and price discount of [REDACTED]

Source: AXA.

Note: All scenarios assume the following business redirection rates:
 Months 0-3 Months 3-6 Months 6-12 Year 2+
 [REDACTED]

57. A 2010 internal Bupa document setting out internal thinking as it prepared for negotiations with HCA summarizes [REDACTED]:

[REDACTED]

58. Discussing upcoming negotiations with HCA, minutes from the Bupa board meeting cite Bupa Health and Wellbeing's then Managing Director explaining that [REDACTED]:

[REDACTED]

59. As can be seen in Figure A2, analysis conducted by Bupa's advisers helping it prepare to enter into its current round of negotiations suggest that Bupa thought it would be able to redirect [REDACTED].

FIGURE A2

Bupa analysis of delisting HCA

[REDACTED]

Source: Bupa.

FIGURE A3

Bupa analysis of delisting on corporate clients

[REDACTED]

Source: Bupa.

60. Figure A4 is another presentation prepared by Bupa's advisers to assist preparations for Bupa's most recent negotiations with HCA. This evaluates where demand for HCA services derives, and shows which Bupa clients spend the most at HCA. This also shows what proportion of the company's overall spend HCA represents. [✂]

FIGURE A4

Bupa 'top 20' corporate spend with HCA

[✂]

Source: Bupa.

Hospital view

61. HCA argued that insurers were in a strong bargaining position and the size of PMI provider was an important determinant of the scale of discounts it received, with Bupa in particular able negotiate significant discounts.
62. HCA argued that it faced a 'critical dependency' on the revenue stream of the top four insurers, which accounted for 90 per cent of the PMI market. Bupa and AXA, in themselves, accounted for two-thirds of the PMI market, and their bargaining power was commensurately higher. Bupa accounted for [✂] per cent of HCA's total revenue and Bupa and AXA collectively accounted for [✂] per cent of its total revenue. HCA stated:

In short, failing to be recognised by a top four PMI provider, particularly BUPA and AXA PPP, can threaten the financial viability of a facility by limiting the volume of patients that can be admitted for treatment. This effect is significantly multiplied by the consultant drag effect, whereby consultants prefer to treat their patients at a single facility, and faced with a split list, choose to exit that facility altogether.

63. HCA noted that its success was dependent on being recognized by the major insurers. While it thought the insurers could potentially live without HCA, it could not live without them.
64. HCA also argued that in tandem with the above effect, failing to be recognized by any PMI provider represented a serious reputational risk for hospital operators.
65. HCA stated that while it has a relatively high proportion of international patients, it would not easily be able to increase the revenues of these patients to fill any spare capacity as a result of AXA (or indeed any other PMI provider) delisting HCA facilities.
66. HCA also argued that even smaller insurers had been able to secure significant discounts from it, noting that Aviva was building an increasingly strong position with London corporate subscribers, and major corporate customers included [REDACTED]. In HCA's view, [REDACTED] had secured substantial discounts from itself, [REDACTED] which effectively extended [REDACTED] discount for large corporate clients to [REDACTED] per cent. These discounts were in recognition of [REDACTED] growth and increasingly important position in the London corporate market. As they grew even small insurers were able to get substantial discounts.
67. HCA also argued that aside from a threat to 'delist' its facilities there were other ways by which insurers asserted their leverage. For example, HCA noted that if insurers refused to approve new 'innovative' treatments, this could undermine investment in new equipment or procedures. HCA said that PMI providers were in a position to constrain how hospital operators expanded and invested in new facilities and were often resistant to recognizing new facilities where they perceived that there was

already sufficient capacity in a given area. HCA told us that the use of service line tenders was now a long-established tactic insurers used to drive down prices.

Redirection of policyholders away from HCA facilities

Insurer views

68. Insurers argued that it was difficult actively to direct policyholders away from HCA facilities towards cheaper facilities. Moreover, contractual clauses HCA had with [REDACTED] may make it more difficult to price insurance policies in such a way as to signal that HCA facilities were more expensive than other hospitals.
69. The clearest example of this type of clause was in the most recent contract with [REDACTED].³²
70. [REDACTED]
71. In setting out its objectives for the negotiation, [REDACTED] explained why it wanted to remove the clause: [REDACTED].
72. In further internal preparations for the negotiation, [REDACTED]. It stated that the ‘nub of the problem’ was that it wanted to be able to create networks which gave customers the choice over what they would pay for—and ensure that the price of the products reflected the underlying cost of provision. Customers could then exert pressure on providers to deliver value.
73. [REDACTED] Although it did not prevent [REDACTED] from introducing new policies, neither was it tied to how much [REDACTED] spent with HCA, but instead [REDACTED].

³² Defined as the area within the North and South Circular Roads.

74. Aviva currently only included HCA on its premium 'Extended' hospital list but not on its more widely-sold 'Key' hospital list. It noted that it priced its policies on a postcode by postcode basis with a focus on winning business in areas of the country where it felt it got competitive prices from hospitals. Aviva said that some years ago it tried to increase its volumes significantly in London and wrote policies for big corporates like [REDACTED] to increase its volume. However, it claimed that it did not see a notable difference in price with HCA, which continued to increase. At this stage it decided not to try compete for SME and individual policyholders in London and decided to separate HCA hospitals from the other London hospitals so it was clear to all of its customers that there was a premium for them, over and above the other hospital groups.
75. Aviva also noted that while it had not seen a significant number of its large corporate policyholders taking policies that did not include HCA, it was starting to have conversations with corporate customers about how they could reduce their spend in London.

Hospital view

76. HCA argued that the fact that Aviva sold a policy which included access to most of the central London independent hospitals, the main PPUs but not HCA was an example of how insurers could exercise real negotiating leverage. It noted that on Aviva's website the 'Key' hospital list was offered as the standard default option. HCA told us that Aviva had informed it that this accounted for [REDACTED] policyholders in London with a treatment value of £[REDACTED] million. , HCA suggested, was a real example of an insurer 'delisting' HCA on a mainstream PMI product.
77. [REDACTED]

78. HCA also questioned a comment made by AXA that AXA network products ‘may be acceptable to a small sub-set of customers’ only. HCA believed that both Bupa and AXA had significant lower-cost network products which were increasingly diverting business away from London providers.
79. HCA argued that all of the PMIs sold products that did not include HCA. It suggested that there was no shortage of consumer choice for a network product which was not HCA hospitals. However, HCA commented that when consumers were given a choice, they liked to go to its hospitals.
80. HCA stated that the clauses in its contract with [REDACTED], had not prevented [REDACTED] from introducing and marketing its [REDACTED] policies to corporate clients in London. Furthermore, HCA had not sought to enforce this clause to prevent or restrict [REDACTED] from launching [REDACTED] policies, such as its [REDACTED].
81. HCA said that the clause requiring [REDACTED]. However, this provision had never been enforced, nor had [REDACTED], rendering the provision redundant.
82. [REDACTED] explained that it had seen Bupa’s algorithms at work in its call centre and these did not appear to recommend that Bupa patients in London use its facilities. On this basis, [REDACTED] inferred that the reason for this must be some contractual restrictions that stopped certain insurers from referring or directing patients away from HCA. [REDACTED] also argued that there was a difference between creating an incentive for insurers to allocate or direct work to a hospital and any absolute prohibitions or restrictions on insurers’ ability to direct it anywhere else.