

Response of



General Healthcare Group

to

Issues Statement dated 22 June 2012

23 July 2012
(Non-Confidential)

1. INTRODUCTION

- 1.1 This market investigation is complex and unusually wide-ranging. This response document focuses on the key points that General Healthcare Group ("GHG") would like the CC to have in mind at this stage when considering the Issues Statement.¹ It is not intended to be a complete review of GHG's position in respect of all the points raised by the Issues Statement.

2. HEADLINE POINTS

- 2.1 GHG appreciates the work the CC has done since the start of the Inquiry to broaden and refine the OFT's work. Nevertheless, as is perhaps to be expected at this early stage, the Issues Statement still significantly reflects the OFT's Report.
- 2.2 In some respects the OFT Report is a reasonable starting point for the Inquiry and understanding the markets. However there are some important mistakes and omissions. The CC will need to fully appreciate these in order to understand the features of the market under investigation.
- 2.3 GHG considers that the key points, many of which are missing from the OFT Report, that the CC should keep in mind are:
- (a) Hospitals are one component part of the private healthcare 'ecosystem'. Although the hospital's role is understood in the context of a typical private patient journey, it appears not to be fully reflected in identification of the possible features (for example in the analysis of hospital networks). Hospitals are not responsible for (and have no control over) the majority of the patient journey(ies): consultants, insurers, GPs, NHS commissioning, drug or prosthesis suppliers, etc.
 - (b) Consultants are a critical input for private healthcare ("PH") providers. The CC recognises that consultants are a key asset for hospitals and that they play a major role in bringing patients into a hospital.² As a result, private hospitals compete intensively to attract consultants. This process of rivalry - as much or more so than competition for funders (including PMI providers) - is what drives hospitals to meet the existing and future needs of patients as effectively and efficiently as possible.
 - (c) The OFT excluded PMI from scope of its study. This was an unfortunate decision that appeared to reflect both the demands of the complainants that had contacted the OFT to press for a market study in

¹ GHG's hospital business operates under the brand name BMI Healthcare ("BMI"). This response refers to GHG and BMI throughout. GHG is typically used in respect of the corporate group and BMI in any discussion of hospital or operational issues.

² Issues Statement, paragraph 45.

the first place and administrative realities.³ The Issues Statement includes *"investigating how competition in the privately funded healthcare sector is affected by the conduct of [PMIs] although we do not anticipate investigating how competition functions in the private medical insurance market."*⁴ GHG thinks it is a mistake not to investigate the PMI market in full and that the CC should consult now on a request to vary the terms of reference so that it is included. As with the recent Movies in Pay TV Investigation, it is likely to prove difficult for the CC to identify and understand the effect of market features on competition (still less define proportionate and effective remedies should that be necessary) when constrained by the terms of the reference to one part, particularly an upstream component part, of the consumer offering.

- (d) The OFT did not consider the significant structural challenges unrelated to competition that hospitals face, including: (i) declining number of insured lives; (ii) a shift from inpatient to day case/WIWO⁵ work; (iii) reduction in acuity and length of stay as result of medical advancement; (iv) declining real prices across the customer base (particularly but not limited to NHS and PMI); and (v) spare capacity against high fixed cost estates.
- (e) The Issues Statement states that currently procedures funded by the NHS but privately provided are outside the terms of reference. However, the Issues Statement also recognises that the NHS is significant to PH providers through both its commissioning and provision and that this is in a state of flux. The competitive significance of the NHS is absolutely crucial to this Inquiry and the CC will need to be very careful to ensure that its impact is fully considered even to the extent that it is outside the formal terms of reference. Specific instances of this are noted in the commentary on the Theories of Harm below.
- (f) There was no analysis of a number of key areas, including profitability. GHG is clear that it does not make super-normal profits.

3. MARKET DEFINITION

- 3.1 As the CC acknowledges, the role of the NHS is pervasive and significant. GHG agrees with the ways in which the NHS might impact on the market

³ *"The OFT does not propose to focus directly on PMI... This is to ensure that the OFT can deliver both a suitably targeted market study in a timely manner and one which reflects the OFT's focus on provision of PH treatments and services"* OFT Private Healthcare - Final Statement of Scope March 2011, paragraph 3.35.

⁴ Issues Statement, paragraph 3.

⁵ WIWO refers to "Walk In Walk Out"; which is a hospital procedure that does not require an overnight stay and can be undertaken without an allocated hospital bed. Endoscopy is a typical example.

noted in paragraph 14 of the Issues Statement. The impact of the NHS in all these guises must be a focus of the Inquiry.

- 3.2 GHG also agrees with the CC's intention to "*understand the extent to which PPU's represent a competitive constraint on hospital operators or whether the NHS represents a material competitive constraint on privately-funded healthcare services*".⁶
- 3.3 Although both these elements (NHS-operated PPU's and the NHS more generally) are relevant; it is clearly the case that NHS-operated PPU's represent a competitive constraint on hospital operators. NHS-operated PPU's are differentiated from standard NHS facilities and made available to private patients on a full-time basis. They sit on the site of an NHS acute hospital trust and, to a greater or lesser extent, share the facilities of the trust.
- 3.4 The Health and Social Care Act 2012 further blurs the line between private and public healthcare *provision* in particular through:
- (a) removal of private patient income cap: PPU's expanding or being created through partnering arrangements; and
 - (b) "Any Qualified Provider" and CCGs: private hospitals have the ability to undertake more NHS work.
- 3.5 [~~X~~], the recency, significance and scope of the changes taking place in the NHS as a result of the Health & Social Care Act 2012, means that particular care needs to be taken that the effects of change are not unduly discounted or misrepresented.
- 3.6 GHG notes the questions that the CC has identified at paragraph 17 of the Issues Statement relating to demand and supply side substitutability by treatment and specialty. Demand side substitutability, at least between medical procedures and specialties, is unlikely to be particularly helpful in determining the "*framework for the assessment of the effects on competition of features of a market*".⁷ Medical procedures prescribed or recommended by a consultant are typically not substitutable from the patient's (i.e. demand) perspective. In any event, the vast majority of patients do not pay directly for their treatment so would not be expected to switch in response to a SSNIP even if there were functional substitutes. Definition of the relevant product markets and analytical framework is therefore likely to look more to supply side substitutability and then the appropriateness of aggregating product markets into clusters for analysis of market features.
- 3.7 In GHG's view the PH product market is characterised by competing hospitals able to adjust their "product range" using common assets (theatres, beds, nurses, consultants, etc.) to meet competition. The vast majority of hospitals

⁶ Issues Statement, paragraph 17(e).

⁷ See Draft Guidelines for Market Investigations; their role, assessment, remedies and procedures, June 2012, paragraph 131.

are able to (and do) offer the vast majority of procedures that are typically undertaken in private hospitals. The presence of asymmetric constraints, (including the example given by the CC of a diagnostic centre versus a hospital), are relevant but should not be overstated. GHG looks forward to helping the CC consider this issue in the context of the market questionnaires and future working papers.

Geographic market definition

- 3.8 GHG agrees that the CC needs to consider both local and non-local factors when considering the relevant geographic market(s).
- 3.9 Negotiation between PMI and PH providers takes place at national level. Prices and other terms of trade (mainly quality and safety standards) are agreed upon in a single negotiation that covers the whole United Kingdom.⁸ Pricing for most NHS work is also fixed nationally via the tariff system.
- 3.10 Local competition is clearly a factor in insurer funded, self-pay and NHS work, although it operates differently for each. For insurer funded work, local competition occurs overwhelmingly on non-price metrics – particularly quality and attracting consultants. Price competition is limited to self-pay and some spot purchase NHS contracts.
- 3.11 GHG looks forward to considering the appropriate local market definition in the context of the market questionnaires and future working papers.
- 3.12 GHG does not consider that there is a regional (as opposed to local) dimension to competition. No purchasing occurs on a regional basis and other key parameters of competition (e.g. quality, choice of consultants, timeliness of treatment, etc.) are related to a hospital's catchment area (i.e. local market).

4. THEORY OF HARM 1: LOCAL MARKET POWER

- 4.1 The CC has identified three sources of local market power, repeated in bold below. The following points are relevant to the investigation of each of these.
- 4.2 **Limited number of rival hospitals nearby:** This might be a plausible source of local market power, although the CC will need to understand *why* there may be a limited number of hospitals in a particular location and whether there is any evidence of effects consistent with market power.
- 4.3 **Limited number of rival hospitals nearby that offer or specialise in a particular treatment:** This is an unlikely source of market power for a number of reasons.
 - (a) First, as the CC identifies, at paragraph 17 of the Issues Statement, most procedures although differentiated on the demand side are characterised by significant supply side substitutability. Hospitals are

⁸ [redacted].

able to perform a wide variety of procedures using common assets (imaging, theatres, rooms, pharmacy, specialised consultants with existing privileges, nursing staff, etc.). Relevant barriers to supply side substitutability are discussed below.

- (b) Second, for procedures which can be performed at one hospital but not the nearest local competitors, the CC also notes that willingness to travel is likely to be different (Issues Statement, paragraph 18(b)). For example, there is only one gamma knife (a sophisticated piece of equipment for brain surgery) at a private hospital outside London. Patients requiring this equipment therefore can be expected to be referred from across the country or into the NHS (see below).
- (c) Third, the more specialised or acute treatment becomes, the more the NHS (whether free or as a private provider) becomes the most relevant alternative provider. For example, very few private hospitals have ICU facilities that are able to treat patients requiring ICU Level 3 advanced respiratory support for longer than 24 hours, or support for 2 major organs at all.⁹ Patients that require, or may require, such care are either not treated in private hospital or will be transferred into the NHS – whether as a free or private patient.

4.4 **Limited number of hospitals nearby with significant spare capacity:** This is very unlikely to be a widespread problem. The CC will be collecting capacity data and GHG anticipates that this will quickly demonstrate that capacity constraints cannot be a source of a market power across the industry as a whole. By way of illustration, GHG also notes that Bupa was recently able to de-list 37 BMI hospitals.

5. **THEORY OF HARM 3: MARKET POWER DURING NATIONAL NEGOTIATIONS BETWEEN INSURERS AND HOSPITAL OPERATORS**

5.1 Both PMI and PH providers are mostly large concerns with teams of staff involved on each side in negotiating complex terms of trade. No two negotiations are the same and vary considerably in the style of negotiation adopted. Some negotiations are collaborative focussing on mutually beneficial outcomes and characterised by a good degree of mutual trust and partnership working. Each party's walk away position is likely to be referred to, but the negotiation is not characterised by adversarial threats and counter threats relating to each party's alternative to an agreement. In GHG's experience PH/PMI provider relationships like this are the most effective at supporting innovation, delivering service improvements, and efficiencies as well as price reductions.

5.2 Alternatively some negotiations are purely "transactional", characterised by each party seeking to extract the maximum concession from the other for the short term. These negotiations are often adversarial, characterised by

⁹ The Intensive Care Society; "Levels of Critical Care for Adult Patients: Standards and Guidelines", 2009.

recurring threats and ultimatums relating to each party's best alternative to a negotiated solution.

- 5.3 In either case, CC must be very careful not to confuse strategic positioning for future negotiations with useful evidence of actual behaviour or intent. Not all threats in a negotiation will turn out to be credible. This risk of strategic gaming is particularly acute when (as is the case now), competition between PMI providers is not within the terms of the reference – as a result of which the PMIs do not risk creating 'hostages to fortune' in respect of negotiations with their own customers.
- 5.4 In paragraph 31, the CC indicates that a hospital operator may derive market power in national negotiations with insurers from "*local market power and/or the scale of its network*". As a terminology point, and to reduce confusion GHG suggests that the term "network" is reserved for groups of hospitals approved for use by a given PMI policy rather than a chain of private hospitals. GHG owns and operates a chain of hospitals but this is not usually described as a "network" in the industry and in GHG's terminology is the PH's "portfolio".
- 5.5 GHG does not believe it has local market power. However, for the purposes of this discussion, even if it did there would be no ability to leverage such local market power in the manner suggested by ToH3. GHG will provide further submissions on this important point, but for present purposes notes the following:
- (a) Insurers do not need "full" coverage. Bupa and other insurers have even recently de-listed BMI hospitals that are the only hospitals serving a given local market (solus hospitals).
 - (b) As an empirical matter, BMI does not negotiate on the "one in all in" basis anticipated at paragraph 31(b). Insurers are not "required" to take all hospitals in order to access the ones they want. Rather negotiation is focussed on increased volume to mitigate fixed costs.
 - (c) In any event, it is far from clear that "one in all in" negotiations would be a credible threat in an insurer negotiation. There are a large number of insurance products (and PMI networks supporting such products) that recognise a sub-set of available hospitals. Bupa Essential Access, AXAPPP Pathways, Aviva Trustcare are all examples.
 - (d) Even if "one in all in" were to be used successfully, it is not clear what the negative effects would be. No PMI network has volume commitments and very few have any other exclusive characteristics, hence a recognised hospital merely becomes a choice available to local patients and consultants. In this respect most networks are open rather than closed. The mere presence of a consumer choice in a given market cannot of itself be considered to be a feature which distorts the competitive process.

- (e) "Must have" facilities were very poorly defined and understood by OFT. While hospitals are more or less attractive to patients, consultants, etc. it is far from clear which hospitals are "must haves" in any empirical sense. BMI in its most recent negotiation with Bupa for example found that Bupa was prepared (and did in fact) de-list hospitals that BMI had previously considered were amongst its strongest units.
 - (f) Solus facilities are in areas of low demand and account for a small proportion of the addressable PMI market.
- 5.6 GHG commends the CC for recognising the dependency of ToH3 on PMI providers being in a weak bargaining position. This is just not the case.
- 5.7 The power of PMI providers in the patient journey and in negotiations with PH providers is seen by virtually all market participants to be of critical importance -- as the initial submissions to the CC have revealed.
- 5.8 In the context of PMI/PH provider negotiations, insurers are able to threaten, do in fact threaten and do in fact carry out threats to de-list hospitals. The threat to de-list hospitals in price negotiations is rightly and rationally seen by PH providers as a demonstrably credible one.
- 5.9 PMI providers have developed, and are increasingly developing, insurance products that give themselves far greater capacity to influence patients' choice of hospital. This trend has been reflected in a large number of the initial submissions from consultants, particularly in respect of Bupa. Open referral products are explicitly designed to give insurers control over where patients are treated, reducing choice but also allowing insurers a far subtler tool to direct volumes to or away from hospitals.
- 6. THEORY OF HARM 5: BARRIERS TO ENTRY**
- 6.1 GHG notes that the most significant barriers to *de novo* greenfield entry in PH are inherent to any high fixed cost business run from real property assets. The key ones are noted at ToH 5(c), in particular:
- (a) high capital and recurring fixed costs;
 - (b) planning constraints; and
 - (c) availability of suitable land.
- 6.2 There are additional barriers specific to PH providers. These are chiefly attracting consultants, obtaining PMI network recognition, becoming accredited to treat NHS patients and obtaining CQC regulatory approval. None of these are controlled by PH providers.
- 6.3 GHG also notes that the relative lack of *de novo* entry (although there has been some), is not of itself evidence of the existence of barriers. There are significant structural challenges unrelated to barriers to entry which have nonetheless deterred entry, including: (i) declining number of insured lives; (ii) a shift from inpatient to day case/WIWO work; (iii) reduction in acuity and

length of stay as result of medical advancement; (iv) declining real prices paid by NHS and insurers; and (v) spare capacity against high fixed cost estates.

- 6.4 Notwithstanding the above, there is significant threat of new entry/expansion should a market opportunity arise. The most plausible entry/expansion routes are those that minimise the barriers noted in 6.1 above, in particular by reducing capital and land requirements: (i) PPU partnering agreements; (ii) JVs with consultants and other healthcare providers; (iii) consulting and diagnostic "outreach" suites (e.g. BMI Brighton Consulting Rooms); and (iv) consulting day case surgical centres (e.g. Spire Shawfair Park, BMI Weymouth Clinic, BMI Southend Private Hospital).

5(a) Barriers to entry resulting from national bargaining between insurers and hospital operators

- 6.5 This theory of harm supposes that vertical agreements between PMI and PH providers include restrictive terms that foreclose entry. In particular terms that create foreclosure effects in the PH market by preventing a PMI provider from "recognising the hospitals of new entrants"; and further that these restrictive terms are the result of "pressure" on PMI providers by PH providers.
- 6.6 Before considering whether such "pressure" exists, it is worth considering the appropriate framework for determining foreclosure effects.
- 6.7 In this regard, GHG would encourage the CC to look to the analytical framework applicable to vertical agreements under Article 101 TFEU, particularly the European Commission's Guidelines on Vertical Restraints (the Vertical Guidelines). Notwithstanding the procedural limitations on the CC's ability to apply Art 101 (and Chapter 1 CA 1998) the analytical framework will be highly instructive as it is designed specifically to understand foreclosure effects in vertical agreements such as network agreements between PMI and PH providers.
- 6.8 A restriction that prevented the recognition of a new entrant would be characterised in the Vertical Guidelines as a single branding or non-compete obligation.¹⁰ In commercial terms, such restrictions are commonly described as exclusivity. We do not present a full analysis under the Vertical Guidelines but set out below what the approach to identifying foreclosure effects for a single branding restraint such as this would be under Article 101 TFEU.
- (a) The starting point is that, if the market positions of the PH provider and PMI provider are both less than 30% and the restriction lasted less than five years, then *prima facie* the restriction would benefit from the Vertical Agreements Block Exemption (i.e. be regarded as complying with Art 101 TFEU automatically without further analysis). As the CC is aware, negotiations between insurers and hospital operators take place

¹⁰ Commission Notice, *Guidelines on Vertical Restraints*, OJ (2010/C/ 130/1), paragraph 129.

at a national level and on this basis no PH provider has a share of 30% and only one PMI provider does (Bupa).

- (b) For present purposes, leaving the Block Exemption thresholds to one side, the next stage of the analysis would look to the extent of the tied market share – i.e. that proportion of the market affected by the restriction and to the length of the agreement. The greater the tied market share and the longer the agreement the greater the foreclosure effect was likely to be.
- (c) Next the market position of the supplier (i.e. the PH provider's) competitors is assessed. Other than in a cumulative effect situation (see below), foreclosure is "*not very likely where they have similar market positions and can offer similarly attractive products*".¹¹ GHG believes this is the case in any local area where a PMI network excludes an actual or potential competitor; but it is particularly true in those "competitive areas" where the PH provider is trying to "*use the market power derived in local areas to seek to achieve recognition of their hospitals in competitive areas*".¹²
- (d) Next the countervailing power of buyers is considered. The Vertical Guidelines state that, "*powerful buyers will not easily allow themselves to be cut off from the supply of competing goods or services*".¹³ The role of buyers is considered below when discussing whether such clauses come about due to "pressure" from PH providers.
- (e) The Vertical Guidelines would go on to consider the cumulative effect of such agreements – i.e. if the industry was characterised by such agreements the foreclosure effect cannot be understood in the context of a single agreement. At the intermediate level of supply (i.e. not final sale to customers) as is in the case in PMI network agreements, the Vertical Guidelines state that "*a cumulative anticompetitive effect is unlikely to arise as long as less than 50% of the market is tied*".¹⁴

6.9 [X].

6.10 As this analytical structure shows, the competitive effect of the agreement (or restrictive terms in the agreement) depends on factors that are predominately in the full control of the PMI providers. It is up to a PMI provider to determine how often to tender its network admission and how much of their business they wish to commit to a particular network product. It is also up to a PMI provider to decide whether they wish to use exclusivity in its tendering to create scarcity of network slots and drive competition between PH providers.

¹¹ *Ibid*, paragraph 134.

¹² Issues Statement, paragraph 42.

¹³ Vertical Guidelines; paragraph 137.

¹⁴ *Ibid*, paragraph 138.

- 6.11 If such exclusivity was the result of "pressure" from PH providers, we would expect to observe a number of features suggesting this. The smallest providers with the least bargaining strength would be most likely to offer exclusive networks. This is not the case. [REDACTED].
- 6.12 We would also expect to observe that exclusivity benefited the strongest hospital groups. This is not the case. Nuffield, is excluded from the [REDACTED] network in a number of its locations despite Nuffield being for a long time at least the second largest PH provider. As the OFT Report shows, Nuffield's decline from this position has occurred steadily over the past 5-7 years, although exclusion from [REDACTED] exclusive network, [REDACTED] pre-dates this.¹⁵ Conversely single site independent hospitals such as the New Victoria Hospital, Kingston are listed in the same [REDACTED] network while the local BMI facility is excluded.
- 6.13 We would also expect to see PMI providers acting quickly and firmly to ensure that exclusivity once agreed under "pressure" from PH providers would be rigorously enforced – as a result of the same pressure. This is also not the case. [REDACTED] had granted [REDACTED] exclusivity in its [REDACTED] network in the [REDACTED] area - but despite this [REDACTED] has now recognised [REDACTED] as well - with no deterioration in the terms offered to [REDACTED] by BMI.
- 6.14 Lastly, GHG notes that the OFT referred to "alleged pricing threats" in its Report¹⁶. This referred to PH providers using threats of increased pricing to prevent PMI providers from recognising other hospitals. As we and others have pointed out¹⁷ this analysis is badly flawed. If a PH provider prices its offer on the basis that it will be an exclusive provider, and will therefore have greater certainty over expected volume, why would that PH provider maintain that price when the PMI provider subsequently breaks the exclusivity on which it is based?

ENDS

¹⁵ See OFT Report Figure 6.1. [REDACTED].

¹⁶ *Ibid*, paragraph 8.24 through to 8.29.

¹⁷ For example, see section 3 of Submission Prior to the Issues Statement submitted by Ashurst LLP on behalf of Ramsay Healthcare Limited.