

Private Healthcare Market Investigation AXA PPP response to HCA submission

Further to our submission to the CC of 20 July 2012 and our responses to the CC's various questionnaires, this submission provides further input in response to the non-confidential version of HCA International's (HCA's) Response to the Competition Commission's Issues Statement dated 31 July 2012 (the "HCA Submission"), available on the CC's website.

This paper is structured as an executive summary followed by more detailed points which, for convenience, follow the same structure as the HCA submission, with the inclusion of additional sub-headings A-W according to the themes of comments made and to assist with navigation. Numbered references are to the relevant sections of the HCA submission.

Executive Summary

Introduction

1. In AXA PPP's view, the HCA submission contains a large number of assertions that do not conform with our experience, in particular with respect to the characteristics and operation of the Central London market, the use and effect of specialist incentives, and the role and influence of PMI providers.
2. This paper seeks to build on our submissions to the CC during the site visit on 13 July 2012, our response to the CC's issues statement of 20 July 2012 and our responses to the CC's market questionnaire submitted during September 2012.

Competition in Central London

3. The HCA submission seeks to portray London as a highly competitive market. Our experience, which is supported by analysis of our claims expenditure, is that HCA's pricing stands at \times relative to other providers nationally, having steadily increased since 2000. We believe that since HCA was permitted to acquire St Martin's Healthcare in 2001, HCA has had the ability and incentive to exert significant market power in the Central London area for elite hospital services.
4. HCA owns six of the elite private hospitals in Central London, which face limited constraint from the other facilities to which HCA refers in its submission. Our analysis illustrates that over \times of complex procedures performed in Central London are performed in HCA facilities. As highlighted in our previous submissions, the features of Central London are distinct in that certain facilities (notably those owned by HCA) and consultants have a reputational draw, the fact the new technology will tend to be introduced in London before other locations, the importance of Central London facilities to large corporate customers, and the fact that many customers living both within and outside London prefer to be treated in Central London. Many of these features are acknowledged by HCA in its submission, and its assertions with respect to other facilities are therefore overstated.
5. HCA further claims that private patient units (PPUs) within NHS facilities represent a significant competitive constraint. We do not believe this to be the case today for many PPUs given their small size and the fact that many PPUs are located within facilities that, even with investment, are unlikely to be strong providers with a high reputation across a broad range of specialisms.

6. However we do believe that some NHS facilities, because of their reputation and expertise, have the potential to provide such competition. A clear example of this is the development of the PPU at Guy's and St Thomas. We believe it to be logical for HCA to compete vigorously to acquire the lease for this PPU. Given their dominant position in central London it is no surprise to us that they were able to offer more favourable terms than other bidders.
 7. On 30 October 2012 the OFT decided that this acquisition did not qualify as a relevant merger situation under the Enterprise Act 2002. The inability of the OFT to review this acquisition underlines the importance of the CC's role in considering what other measures may be necessary to prevent anti-competitive outcomes arising from HCA's growing position.
 8. HCA is also strengthening its position by acquiring or entering into partnerships in relation to a range of primary care facilities. This increased vertical integration (which HCA itself raises as a cause for concern in respect of Bupa's ownership of the Cromwell Hospital) enables HCA to channel patients to its hospitals.
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9. Ultimately we consider that HCA's market position is of such strength that it operates with little regard to its competitors or customers. This is borne out by excessive levels of profit for some treatments to the detriment of patients. We believe therefore that HCA's market position in Central London, which is being further strengthened via the acquisition of primary care facilities and PPUs, results in an adverse effect on competition via higher prices which is detrimental to patients.

Specialist incentives

10. Our previous submissions include detailed commentary relating to specialist incentives, and the concerns that we have in relation to such incentives which we believe influence professional judgement, distort competition and raise barriers to entry. We disagree with HCA that specialist incentives in the private healthcare sector are pro-competitive.
11. We have concerns that HCA frequently offers incentives to consultants in the form of providing consultants with: free or discounted consulting rooms, equipment and/or administrative support; participation in joint ventures; ownership of primary care facilities which facilitate or protect referral into hospitals; commission payments to doctors; profit shares and equity ownership arrangements.

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12. We support enhanced regulation in this area especially given the high level of trust placed in the practice of private healthcare by prospective and current patients. We would recommend that such regulation should encompass operating practices, disclosure rules and 'fit and proper persons' tests in respect of the ownership or management of private healthcare facilities.

Role and influence of PMI providers

13. HCA's submission makes a number of comments about the PMI market and the activities of the PMI providers, including AXA PPP, claiming that PMI providers have "very strong bargaining power which constrains the way in which hospital operators deliver private healthcare services." In particular it asserts that PMI providers have a range of potential strategies to adopt should they fail to reach an agreement with HCA; that PMI providers can

stifle investment in new facilities, limit the scope of care available to patients and harm the quality of care; and that strategies such as network policies, open referrals, fee capping and delisting consultants are limiting competition and reducing patient choice. HCA also contends that Bupa and AXA PPP are engaged in a “leader-follower” relationship.

14. These assertions are unfounded and misleading. The concentration levels in the PMI provider market are similar to those in the PH provider market on a national basis, but the PH provider market is more concentrated in local markets and in particular in the Central London market pertinent to the assessment of bargaining power with HCA, as described above. Nor is it the case that AXA PPP follows Bupa’s strategy – we adopt and implement different strategies and initiatives. We compete vigorously with all insurers, including Bupa.
15. We disagree that PMI providers can “stifle investment in new facilities”, and note that this suggestion is in any event contradicted by HCA’s own evidence on this topic set out in sections 3 and 4 of its submission. We are supportive of innovation and investment, but we expect these to result in improved outcomes for patients and/or to result in greater cost efficiency. We therefore assess new treatments carefully before agreeing to reimburse them, in order to protect the interests of our customers. We cannot think of an example where HCA has made an investment proven to improve patient outcomes where we have refused payment. Nor can we think of an example where HCA has developed a service which has resulted in decreased charges (or other efficiencies) to us.
16. As discussed previously, it is simply not the case that we have a range of alternative strategies should we decide to delist HCA. If we were to pursue such a course of action we consider that HCA would remain viable with business from Bupa and other insurers and overseas patients (we consider that AXA PPP accounts for less than 2% of HCA’s revenues).
2%
17. Finally, we do not accept that strategies such as network policies, open referrals or fee arrangements with consultants operate to reduce patient choice or limit competition. As set out in previous submissions, our fee arrangements are designed to provide greater certainty for our customers, our price capping affects only a small proportion of consultants, and our new consultant agreements have had no discernible impact on the number of consultants entering the market. We believe that network policies and open referrals similarly work to ensure efficiency and choice for our customers, and in no way disadvantage HCA.

SECTIONS 3 and 4: HCA and Private Healthcare

A. Innovation and efficiency

18. As detailed in section 3 of the HCA submission, HCA owns, or has ownership stakes in, a wide range of facilities in the UK, primarily in the London area, encompassing six of the elite private hospitals in Central London, a range of outpatient and diagnostic centres, primary care interests via the ownership of three private GP practice groups, a number of partnerships with NHS trusts of which three partnerships are focused on the treatment of cancer, and other related procurement and research facilities.
19. HCA claims in its Executive Summary in section B p5 that ‘PMI providers can stifle investment in new facilities’. However, this is at odds with HCA’s own activities since its acquisition of St Martins Healthcare in 2001 and further since HCA was acquired in 2006 (see paragraph 2 below).

20. In particular, we note the apparently contradictory comments in the HCA submission which seek to demonstrate HCA's successful track record of investment. In Section 4.33 reference is made to 'HCA's high level of capital investment and R&D spending', as a proportion of turnover and also relative to other industries. HCA also says in section 3.14 that 'it continually invests in its facilities in line with medical advances'.
21. As regards efficiency, in Section 4.5 and further in section 4.29, HCA refers to the 'impetus for hospital operators to maximise efficiency and continuously innovate in order to remain competitive and ensure they have adequate funding to continue to invest'.
22. HCA quotes a number of examples of innovation in section 4.32 to illustrate the introduction of a new robotic systems and procedures for patients who would otherwise be required to have open surgery; these are targeted at better clinical outcomes but also imply greater efficiency due to new capability to avoid/reduce inpatient stays.
23. We note the absence in HCA's submission of any reference to 'cost efficiency' or lowering cost. While we don't doubt that HCA's strategy includes the improvement of clinical outcomes, we believe this strategy is underpinned by revenue maximisation rather than cost efficiency. As discussed in Sections 3 and 4 - B below, HCA's pricing is significantly higher than that of other private healthcare providers.
24. More specifically on HCA's spend on new facilities, we are aware, from the financial accounts of HCA International Limited and St Martins Healthcare Limited which comprise c£476m of HCA's 2010 UK revenues, that for this subset of the business HCA has invested in fixed asset additions of c £24m and £37m in each of 2009 and 2010 respectively, as well as £7.5m and £12m on investment acquisitions in each of those years.
25. The Laing & Buisson report 'Laing's Healthcare Market Review 2011-12' p64 further indicates the financial strength of the group and lists a continuing series of substantial investments in the UK. It refers to the acquisition of the HCA group in 2006 by a private consortium for £17 billion 'in the largest ever private equity transaction', and notes that the consortium 'reportedly set aside £2 billion for investment and development, some earmarked for its UK operation'.
26. The report highlights a number of large investments in the UK as follows:
 - 'a £9 million extension at the London Bridge Hospital' - 2006
 - '£4 million for a new standalone private outpatient clinic in the City of London' - 2006
 - new 'satellite diagnostics and outpatient clinic in North London' - 2007
 - launch of the new London Breast Institute at the Princess Grace Hospital - 2007
 - opening of a new Cyber knife Centre at HCA @ Harley St Clinic as part of a £15 million development - 2008
 - Installation of new rapid radiotherapy machines (RapidArc) at the Harley St Clinic - 2009
 - New molecular imaging centre at the Harley St Clinic - 2010
 - New outpatient centre opened on the King's Road in Chelsea as a satellite to the Lister Hospital - 2010: 'this was part of a large-scale (£20 million plus) investment programme at the Lister Hospital since 2006, which also developed the Chelsea Consulting Rooms and doubled the size of the Lister Fertility Centre'
 - Opening of new £22 million medical centre at the Wellington Hospital which includes a 12 bed day surgery unit and a 10 bed chemotherapy suite in partnership with Leaders in Oncology Care
 - HCA has also invested in developing its private healthcare services in partnership with the NHS, including:

- managing a 16 bed cancer unit for Barking, Havering and Redbridge University Hospitals Trust- 2010
- a new contract with the University College of London Hospitals to manage cancer care for teenagers at the Trust's expanded PPU. HCA also became the first tenant of a new cancer centre developed by the Trust in 2012
- partnership with the Christie Clinic in Manchester, a 34 bed private cancer centre. 'HCA invested £14 million to develop the facility'.

HCA's submission lists a number of other interests. These include the acquisition of outpatient and diagnostic centres and private GP facilities including Rood Lane, Blossoms Healthcare and GenMed in the above period.

We are also aware that in 2011 HCA acquired Health Trust Europe, a procurement services provider for NHS West Midlands, Luton and London – with the stated aim of transitioning 'over the next three years into a major global procurement provider' – source: Healthtrust Europe Supplier Handbook.

Most recently HCA has been awarded the contract to operate a new cancer unit at Guy's and St Thomas' Hospital.

27. We believe that:

- a) HCA has continued to invest unimpeded by insurers and in such a way as to protect and expand its dominant and profitable position; and
- b) the absence of cost reducing initiatives is indicative of a competitive failing in the market for health provision.

28. In respect of hospitals' investment in innovation, from AXA PPP's perspective:

- a) It is important for AXA PPP that private treatment offers the most effective treatment possible for our customers
- b) It is also important that medical interventions develop to increase efficiency and result in lower costs and premiums for our customers.

29. When providers wish us to reimburse for a new treatment, our policy is to pay for it provided that there is sufficient evidence (either in the UK or internationally, often in the US) to show that the treatment is of patient benefit. We consider that providers have a duty to demonstrate that the treatments they offer are proven to work. Indeed we believe that providers have a duty to do this whether customers are paying directly for health care or indirectly via insurance premiums.

30. Ideally we would like providers to engage with us before they make investments in expensive new technology. This would allow them to engage with us to better understand the evidence of effectiveness of a proposed treatment and our view on this. However in most instances providers do not do this. Instead they make significant capital investments and establish a service, only at this point engaging with us regarding eligibility. It is our view that they do this in the belief that if they provide a service and market it sufficiently that will be enough to generate demand and hence force our payment, regardless of the actual scientific evidence.

31. The development of HCA's Cyber knife facility to which they refer is a good example. There was no consultation with AXA PPP about how we would view this technology prior to HCA

deciding to invest. Instead it was only close to the installation of the machine and the machine becoming operational that HCA and the specialists asked for our view.

- 32. Evaluation of technology is a highly skilled activity in which AXA PPP has significant experience. We reviewed the evidence regarding proven value and concluded that there were specific conditions where the Cyber knife was useful, for example for head and neck cancers and spinal tumours and as noted below, we paid claims for this treatment from the month of its introduction.
- 33. However it was also clear to us that specialists wanted to use the technology for other conditions. Our approach was to say that we would consider these, but that we would require evidence of effectiveness and a rationale for using it in the individual case. For example we were aware that one of the main uses of this technology in the USA is in treating prostate cancer. However there was insufficient evidence in favour of its use in this condition at the time. HCA would have been aware that US insurers pay for use in certain cancers but not others, including regarding use in cancer of the prostate as unproven. Indeed at least one of the largest US insurers (Blue Cross) continues to regard use as unproven and not eligible for reimbursement. See: <http://blue.regence.com/trgmedpol/surgery/sur16.html>
- 34. Determining whether there is sufficient evidence to prove effectiveness of treatments often involves judgment and interpretation. It is of great concern to us that the doctors involved in deciding whether or not to use this technology had a financial interest in its provision. This financial interest was not declared to us and we became aware of it only recently – source: Robotic Radiosurgery LLP Report and Accounts for the year ended 31 December 2011 and Annual Return. We believe that there is strong evidence that such arrangements incentivise over-use, are directly contrary to GMC guidance on conflict of interest and also that such referral would be illegal under US legislation.
- 35. Below is a table of amounts that we have paid to HCA and specialists for use of Cyber knife. The first invoice charged to us was in the month of introduction and total cost has increased substantially in the period since implementation as follows. ✂

- 36. At no point did we refuse to pay for this treatment when proven to deliver patient benefit.
- 37. Indeed we can think of no other example where HCA has made an investment proven to improve patient outcomes, where we have refused payment.
- 38. In terms of cost efficiency through investment we can think of no example where HCA has developed a service which has resulted in decreased charges to us. ✂

39. In summary we contend that:

- a) The fact that HCA's prices are significantly higher than its competitors, and that the costs we pay continue to increase relative to HCA's competitors (see further below in Sections 3 and 4 – B), provide no indication that HCA is acting to improve cost efficiency through investment, which in turn we believe is due to a failure in price competition;
- b) HCA's investments to achieve improved clinical outcomes are in large part aimed at increasing patient throughput and in particular revenue per patient;
- c) HCA's strategy of providing physicians with shares or other forms of incentive is likely both to lower the threshold for the use of the technology and to provide a powerful incentive for those doctors not to use alternative provision which might offer higher quality or better value for money. We believe that such arrangements are in direct contravention of GMC guidance on conflicts of interest; and
- d) We can think of no instance in which AXA PPP has 'stifled' HCA investments which are proven to improve patient outcomes. Indeed HCA can be seen to have a significant track record of continued substantial investment in the UK, with a succession of innovation and development projects as well as corporate acquisitions and trading agreements which continue to protect and strengthen HCA's dominant position. We are supportive of investment and innovation, but we are concerned when such investment comes at a higher price to insurers (and ultimately to patients) without providing a proven better clinical outcome, or where cost reductions arising from new procedures are not passed through the supply chain.

B. Recession and hospital revenues

- 40. In Section 4.11 HCA acknowledges that 'the PMI sector has been vulnerable to the economic cycle and the economic downturn has affected demand for PMI policies, which has in turn impacted PMI funded cases in hospitals.
- 41. We would highlight that in contrast, private healthcare provision appears to be less affected – and for HCA there appears to be no change in strategy in pricing (see further below in Section 12 – U) or investment - see section 5.25 of HCA's submission where HCA concludes its views on the London market by saying that 'there has been a significant level of capital spending and investment in new, enhanced facilities...there is no evidence of this trend abating'.
- 42. The volume of demand for UK PMI cover (representing PMI subscribers) fell by 5.8% in 2010 to reach a total of 3,238,000 subscribers, following a dip of 4.7% in 2009. The total market has been very flat in volume terms for at least the last 15 years since 1995 when insured subscriber numbers were 3,434,000 in total.
- 43. Over that period however the market for provision of private healthcare has benefited from growth in the number of self pay customers, which has increased from 124,000 to 724,000 - see table 3.1 on p170 of Laing's Healthcare Market Review 2011-12, referenced by HCA.
- 44. The same report includes on p.39 a table of real price increases after deflation by RPI which shows average annual growth of 8.8% in private acute healthcare over the last 30 years. Over this period, as an indicator of volume, the number of beds in independent acute

49. We also believe that HCA benefits in particular from overseas self pay customers, who are not subject to the same price sensitivity as other income streams, as discussed in Section 8 - M.
50. We would therefore highlight the higher relative competitive strength of HCA versus AXA PPP in the context of:
- a) the trend of continued contraction in the PMI market and recession
 - b) the continued expansion of the market for private healthcare provision
 - c) the particular resilience of the central London hospital market and self-pay UK and international revenue streams.
51. We are also concerned that both the lack of price competition in the elite hospital market and the lack of pricing transparency, serve to reduce competition between hospitals based not only on reputation and quality, but also on price, particularly in the central London elite market discussed below in Section 5 – D.

C. Consultants

52. In Sections 4.19 and 4.20 HCA acknowledges that hospital operators compete vigorously to attract and retain consultants.
53. We are aware that such competition includes a range of financial incentives as discussed more fully in our submission dated 20 July 2012 and further below in respect of section 13 - V.

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- a) introduction to the Medical Billing Company (MBC) – a company that promotes itself by advertising that it can increase billing amounts for consultants by 30% (or 25% after its own percentage fee) through its ‘expertise in both medical codes and the nuances of each insurer as to how the codes should be used’ which ‘ensures that the billing revenue is maximised for each client’. Further this company is remunerated as a percentage of amounts invoiced and collected.
 - b) a lack of transparency in disclosure of consultants’ financial interests both in giving advice or on the face of documentation, including billing.
 - c) insistence on strong confidentiality concerning the goodwill and reputation of HCA
- ✂
- d) the growing supply chain being acquired rapidly by HCA - from procurement through to primary care as detailed in Section 5 - D below.
 - e) use of closely linked organisations, to which HCA provides significant proportions of their funding either directly or indirectly - being the Federation of Independent Practitioners (FIPO) and the Private Patients Forum (PPF) - which purport to be independent organisations representing consultant and patient interests respectively, ✂. We note also that the Chairman of FIPO, Geoffrey Glazer, is the Medical Director of HCA’s Wellington Hospital.

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54. We are aware that the impact of such arrangements has given rise to:

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- a) substantial increases in billing for some consultants - ✂
- b) A lack of clarity in billing – failure to disclose incentives or existence of ownership/exclusive referral relationships
- c) indirect lobbying – eg. FIPO has issued a newsletter for patients asking them to complain about Bupa’s open referral initiative on the PPF website blog. PPF’s statements on twitter mirror those of FIPO. We believe the lack of transparency over the relationship with HCA is misleading, given the nature of these organisations.

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55. We consider that HCA’s statements in sections 4.19 and 4.20 of their submission illustrate their strong motivation toward referral incentives (as discussed in Section 13 - V) but that this extends to a range of other restrictive practices, such as the examples provided above, which we consider are in direct contravention of the GMC’s guidance on conflicts of interest, undermine the market for objective medical advice and unfairly impact competition to the detriment of patients. We are supportive of strengthened regulation in this area concerning operating practices, disclosure of interests and ‘fit and proper’ tests for those who operate and own private healthcare facilities.

56. These examples suggest that some of HCA’s practices result from a position of significant market power enabling it to respond to threats to that commercial position, not only by competition for business but also by additional measures (e.g. incentivising consultants, control of the referral chain, the response to the ✂ PPU) associated with use of market power to reduce or dilute competitive pressures and instances of being unresponsive to legitimate concerns from major customers (like AXA PPP).

SECTION 5: Private Healthcare in London

D. Competition

57. In Sections 5.1 - 5.10 HCA seeks to illustrate a highly competitive market in London. Our view is that there is a very distinct central London market for elite hospital care provision. We have very different views from those expressed by HCA in terms of:
- a) Our analysis of the pertinent market
 - b) HCA's share
 - c) Our view of the importance of PPU's
 - d) The impact of HCA's expansion within certain key PPU's.
58. As previously represented, 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. These latter features are acknowledged by HCA in section 5.1(v) of its submission.
59. In response to high cost and hence to contain premium increases, we undertook some specific analysis of competition in the London area in an effort to determine an alternative provider strategy.
60. Our analysis is based purely on the treatment of AXA PPP PMI customers and is focused on inpatient and day case treatment in acute and rehabilitation hospitals. We are not able to perform similar analysis of outpatient treatment data since this is invoiced by consultants who often do not identify the hospital location of treatment.
61. AXA PPP's claims experience shows that for UK PMI members treated in London, ~~are~~ treated within the HCA hospitals.
- ~~are~~
62. We have since developed our analysis at a procedure level. Even if we widen our definition to include other large facilities, we have determined significant concentration as described below.
63. If we include those private healthcare facilities in central London which we believe offer the strongest professional reputation for a broad range of treatments and which we believe are more important for our clients, though not necessarily 'must have', we would define the market as follows: ~~are~~

In our view HCA overstates the constraint imposed by other providers. We agree that there is a number of other facilities in London that compete to a certain degree with HCA. ~~are~~

64. HCA also overstates the catchment area over which its hospitals compete. Patients in Central London frequently wish to be treated near their work or home, and the availability of

transport links to other facilities is of little consequence, particularly as (as HCA acknowledges) specialists are often unwilling to split their lists and travel between hospitals. We do not consider any of the facilities listed in ~~to~~ compete effectively with HCA predominantly because of location and the range of services offered by these facilities.

65. In Section 5.9 HCA implies that a number of other facilities located in the south east offer a level of competition. There is evidence that HCA draws patients to its facilities from this catchment area but in our experience this does not happen in reverse.

66. Based on defining the ~~the~~ central London market according to the hospitals shown in the above table, we note that ~~that~~ of all the treatment in inner London for patients living in inner London occurs in these ~~the~~ hospitals. ~~the~~ the treatment in the ~~the~~ hospitals occurs in HCA hospitals.

67. In addition our analysis indicates that complex treatment is more prevalent in HCA hospitals than other ~~the~~ London hospitals. Of the patients living in inner London having treatment in the ~~the~~ hospitals, ~~the~~ % of the complex "stays" occur in an HCA facility.

68. The associated distribution of costs of treatment demonstrates the disparity of hospital revenues according to complexity and the skew of HCA's revenues toward high priced complex care e.g. cancer treatment and cardiology.

69. In summary:

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70. The focus of our analysis has been on UK based PMI. However for the purpose of contract negotiations, the volume of international business having treatment in HCA hospitals also has an influence. A significant proportion of our international policy members return to the UK for their treatment. For AXA PPP's international business ~~the~~ of the total value of claims is paid to HCA; this equates to approximately ~~the~~.

71. Of the International business having inpatient or day case treatment in the UK, ~~the~~ of the "stays" occur in an HCA hospital. When looking at London in particular ~~the~~ have treatment in an HCA hospital.

72. Our analysis illustrates:

- Nearly ~~the~~ of inner London claimant residents attend an HCA hospital
- Over ~~the~~ of complex procedures performed in central London are performed in HCA facilities
- HCA's activity is skewed toward higher revenue complex treatments.

73. We consider that this analysis supports our experience of HCA's strong concentration in central London, which underpins its disproportionate bargaining power in our negotiations for competitive provision of private healthcare.

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PPUs

74. In section 5.10 HCA states that its competitors include many PPUs. We do not believe this to be the case today, as:

- even in aggregate, the total number of patients and beds in PPUs is small;
- rules within the NHS have precluded the PPUs from expanding from their current size; and
- most PPUs are located within facilities that, even with investment, are unlikely to be strong providers with a high reputation across a broad range of specialties.

75. There are 16 NHS PPUs in central London, of differing sizes. A number of them are highly specialised, for example Moorfields Eye Hospital, and do not therefore offer realistic competition in London, other than in a very narrow specialism.

76. Most of the units are small and share key clinical facilities, such as theatres and radiology, with the NHS. This can mean that private patients' theatre lists have to wait behind NHS patients with higher clinical priorities and private surgery can get cancelled as a result. Investment in these facilities is highly variable, meaning that many of them offer little more than a private room in an NHS environment, while others offer facilities that are more directly comparable with private hospitals. These units, whilst they may be in large hospitals, are small and historically have not been seen as core business to the NHS hospital. We are also aware that specialists have a bias towards avoiding treating their private patients in the NHS facility they work in.

77. Recent changes following the House of Lords' approval to relax the cap that limits the amount that Foundation Hospitals can earn from non-NHS income, however give rise to the opportunity for potential expansion of individual PPUs.

78. Whilst we do not have access to the specific plans of the hospitals, we believe their intention will be to increase significantly the size of the PPU facilities and, therefore, there is potential for a limited number of current PPUs, notably those linked to prestigious hospitals, to remain or become significant competitors in the inner London 'elite' market in the future. HCA currently owns Harley St @UCH and is actively looking to expand its ownership of PPUs, notably with Guy's and St Thomas where it has been awarded a contract for the development of cancer care facilities.

79. While some PPUs are managed by the NHS Trust to which they belong, the ownership and/or management of a number of them has been outsourced to private providers. It is our view that the NHS Trusts who outsource management of their private facilities are attracted to bidders who are likely to generate the most income for the Trust. These tend to be the high cost providers, and we are of course concerned that HCA is now managing a number of these units, and expecting prices at the units to be on a par with their own private sites. We consider that this also means that HCA will inevitably win such tenders where it wishes to.

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80. The south east quadrant of London represents the pertinent market for those of our customers living in the central and south east London boroughs and extending out to Kent and Sussex.

81. We believe that the London Bridge and Guy's and St Thomas hospitals are of particular importance to our customers who work in the city area of London.

82. On this basis we calculated that HCA has a current share and Guy's and St Thomas PPU has a share of the south east quadrant of London elite private facilities for cancer care.

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83. Our expectation is that the development of the new cancer centre at Guy's will increase capacity to at least three times the current provision. This would have the impact of increasing Guy's and St Thomas' share of the above defined south east quadrant market to ~~thereby increasing HCA's share to some~~

84. It is our view that:

- a) HCA has a dominant share of the ~~hospital~~ market in central London and is actively seeking to strengthen and protect this position
 - b) We believe that a number of PPUs, whilst not significant in the current market, have the potential to become far more credible alternative suppliers in the critical central London ~~health provision~~ market
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HCA's breadth of ownership

85. In section 5.14 HCA refers in brief to other ambulatory care and day case facilities. We would like to highlight the broad range of facilities which we believe are owned by HCA in the UK in addition to its major London hospitals, as shown below.

86. HCA owns, or has ownership stakes in, a wide range of facilities in the UK, primarily in the London area, encompassing six of the 'must have' elite private hospitals in Central London plus a range of outpatient and diagnostic centres, primary care interests via the ownership of three private GP practice groups, a number of partnerships with NHS trusts including three partnerships focused on the treatment of cancer, and other related procurement and research facilities. These include:

PPUs

- Harley St @ UCH PPU
- London Gamma Knife Centre - joint venture with St Barts
- Guy's and St Thomas Trust

Referral

- Outreach outpatient and diagnostic centres referring to HCA hospitals e.g. Golders Green, Canary Wharf, Devonshire St, Chelsea
- Leaders in Oncology

Primary care

- Rood Lane – primary care, 26 GPs
- shareholding in Blossoms Inn – only significant competitor to Rood Lane
- GenMed 10 GP practices (Medicentres)

Other

- Sarah Cannon Research Institute SCRI – cancer drug development programme

Outside London

- Christie – Manchester
- Harley St @ Queens, Romford and outreach centres at Sevenoaks, New Malden and Brentwood
- Health Trust Europe (HTE) – procurement services provider.

87. We have commented previously that HCA's vertical expansion and contractual arrangements reinforce HCA's strategy to maximise profits, as they enable HCA to gain control over the patient pathway and direct patients to its own facilities.

88. In respect of the latter acquisition into procurement services, Health Trust Europe, we highlight that this company works across a number of industries including health. It is currently employed by 47 NHS trusts with c£2bn of purchasing which it reported to aim to increase to £5bn in five years.

See <http://www.healthinvestor.co.uk/ShowArticleNews.aspx?ID=2106>

89. HTE's supplier handbook page 9 states the following:

'Best Market Pricing

The focus of HealthTrust Europe is very much on the delivery of benefits. We offer a simple pledge to all our customers - "You cannot buy better". Our commitment is provide our customers with the best pricing in the market. We benchmark our prices monthly and report back to our customers. This demonstrates transparency and the value of being a HealthTrust Europe customer. Benchmarking of pricing between NHS organisations across England has already demonstrated that our contract prices are 13% less than those of NHS organisations that are members of other collaborative procurement arrangements or who directly source their products and services. However, over time HealthTrust Europe will also draw on innovative sourcing solutions such as global sourcing and direct from manufacturer procurement to drive greater levels of savings for the NHS

90. We believe there is opportunity for HCA to gain significant cost advantage through leveraging its purchasing volumes, for example in some of the complex areas in which it already specialises. By way of example we believe that private hospitals purchase DES (drug eluting stents) at about ¾. The rates at which the NHS purchases them in London are a matter of public record as below and are £480-£650, see:

<http://www.lpp.nhs.uk/page.asp?fldArea=2&fldMenu=5&fldSubMenu=4&fldKey=36>

Our pricing agreement with HCA includes a mark-up on the manufacturers' list price from 1 October 2012 of ¾.

91. We are concerned that:

- a) HCA's rapid horizontal and vertical expansion, together with its acknowledged use of incentive practices, are increasing the already significant dominance of HCA in central London
- b) the acquisition of health-related procurement services is likely to give HCA significant cost advantage compared to other hospitals/groups for drugs and consumables
- c) this extra margin is channelled to further extend HCA's dominant position or to benefit its shareholders. We highlight that this is not to the benefit of the consumer and arises through failure of price competition.

SECTION 6: Private Medical Insurance

E. Market structure

92. The HCA submission makes a number of comments about the structure of the PMI market. In particular, in Section 4.2 HCA refers to the 'oligopolistic structure' of the PMI market, whereas in section 6.10 HCA makes reference to "the increasing dominance of the leading two insurers, BUPA and AXA PPP".

93. In our view, allegations of dominance or oligopolistic behaviour are unfounded, for the following reasons:

- a) ✂ As noted above in Section 4 - B, the size of the PMI market has been largely unchanged in volume terms. The volume of demand for UK PMI cover (representing PMI subscribers) fell by 5.8% in 2010 to reach a total of 3,238,000 subscribers, following a reduction of 4.7% in 2009. The total market has been very flat in volume terms for at least the last 15 years since 1995 when insured subscriber numbers were 3,434,000 in total.

In section 6.7 HCA refers to the Herfindahl-Hirschmann Index (HH) for gauging market concentration and references a concentration index of 2,553 in 2010 as indicative of a highly concentrated market, which we note is driven mainly by Bupa's market share. However, the same is arguably true of the largest hospital providers which are also significantly concentrated in the UK, with the top 5 hospital groups accounting for 77% of the market as follows.

National PH market shares by value (2010)	Share
GHG	24.4%
Spire	18.2%
HCA	14.3%
Nuffield	11.4%
Ramsay	8.8%
Other	22.9%
	100.0%
Top 5	77.1%

Source: Table 6.1 OFT study December 2011 p78

We would highlight that the market shares shown above are those calculated on a national basis. In our view there are much higher concentrations in local areas, the most significant of which is the Central London market.

- b) If the Central London elite market is considered (as shown in paragraph ✂), concentration levels are higher still given HCA's significant market position, as discussed in Section 5 – D. As discussed in Section 10 - N prices are set by bargaining. ✂

- c) HCA's submission (Executive Summary section A p4) also states that 'PMI patients account for over half of private hospital income in the UK', which indicates other substantial revenue streams including international and self-pay patients
- d) Based on HCA's quoted UK revenues of 'over £600m' (section 3.3), AXA PPP's share of HCA revenues is relatively minor at 2%.

94. We would highlight that AXA PPP competes vigorously against all the major insurers. We discuss this and HCA's comments with respect to Bupa and AXA PPP having a "leader follower" relationship in further detail in Section 6 - G below.

F. Switching

95. Both FIPPO and HCA (in sections 6.16 to 6.21) refer to a so called "lock in effect" with regard to individual PMI customers. It should be noted that these represent only 25% of the market (with the remainder comprising corporate customers). In HCA's view, customer switching between PMI providers is prevented because medical conditions that a policyholder develops during the course of holding a PMI policy would not be covered by a rival provider if they attempted to switch, as the condition would be considered "pre-existing". However, the commercial reality is as follows:

- a) Insurers are required under regulation to set out in clear terms the nature of the cover in their policies in the sales process. This is policed by the FSA, and any insurer that failed to satisfy the regulatory requirements would be the subject of regulatory action.
- b) It is not plausible to assert that PMI customers could be easily exploited or misled. They represent a sophisticated minority of consumers from the top end of the socio-economic spectrum.
- c) Private medical insurance in the UK is voluntary. Individual customers decide whether to take out the product based on the range of benefits and the premium cost. Insurers will exclude existing conditions from cover. If they did not do this customers would only take out cover at the point they needed treatment.
- d) PMI is a sector that has performed well in terms of FOS complaints with a low average number of complaints over the past five years, and as a proportion of the total market size as follows.

New complaints referred to FOS

	<i>Note</i>	2008	2009	2010	2011	2012	<i>Average no.</i>
PMI	1	369	514	652	506	513	511
Market size ('000)	2	6,293	6,038	5,687	5,569	na	
% of complaints		0.01%	0.01%	0.01%	0.01%	na	

Notes

1. Source: Financial Ombudsman Service – complaints data shown in Annual Reviews for years ended 31 March
2. Source: e - Laing's Health Cover UK Market Report 2012 - people covered, for years ended 31 December
3. e - Laing's Health Cover UK Market Report 2012 - people covered, for years ended 31 December

- a) Once a subscriber begins to claim there is a very high probability that they will continue to do so. The table below shows the 2011 performance of those who had treatment in 2010.



- b) On an annual basis these customers decide whether they wish to renew or not. In calculating premiums insurers group together the people on plans pooling the claims experience of claimers and non-claimers. This means that even though people who have made claims are at much greater risk of future claims, their premiums do not take account of this because of the pooling. Thus customers who have claimed experience lower premiums through pooling with their existing insurer and are commercially unattractive to a new insurer.
- c) It is market practice in PMI for insurers to guarantee renewal, and not to impose specific policy terms or price changes on claiming customers. The only exception is a pre-defined No Claims Discount scale that most insurers introduced in response to customer demand.
- d) As a result of these market practices, which are very unusual within the wider general insurance market, insurers will make material losses in the future on customers who have claimed in the past. It is inaccurate to describe this as a “lock in”, rather the insurer is accepting poorer risk business at standard rates.

- e) It is implied that a subscriber should be allowed to switch insurer should, having claimed, they discover that their cover is not to their liking. This suggestion is analogous to a home owner, upon discovering that their house is on fire, seeking to increase his current and/or prospective insurance cover for fire. It is hard to see why any insurer should accept such a proposal.
- f) Were such switching allowed, consumers would rationally buy a cheap limited policy at the outset, and then upgrade when they need to claim. Insurers offering low cost products would therefore see high profits and insurers offering fully comprehensive products would see very large losses. This would lead to a strong downward pressure on the cover available.
- g) We are not aware of any market where such a system applies, as it would be unworkable. However, we are aware of some markets in which PMI represents a key element of the overall social delivery of healthcare. Characteristics of such markets (such as Australia) are:
 - The Government sets out a minimum level of coverage which all policies must provide.
 - In return, the Government offers tax relief of 30-50% on health insurance to encourage opt out from the state system.
 - In some cases regulations exist to facilitate switching. However, these only apply to existing benefits. Policy holders are not allowed to switch policies in order to extend current and/or prospective cover whilst avoiding further underwriting, as this is an unworkable system.

96. In our view it is therefore commercially unrealistic to expect insurers to behave differently.

97. In respect of the corporate market and switching:

- a) Corporates are not precluded by considerations of underwriting limitations from switching.
- b) It is reasonable for employers to choose the level of cover they are prepared to fund.
- c) At present the corporate market does tend to offer full cover. Insofar as employers have chosen to reduce cost, for example by excluding dependents from cover, insurers have sought to make available top ups which allow individual employees to add to their cover. If there were demand for more of such products then insurers would develop them.

Customer's ability to switch provider

98. We would counter that in practice there is a significant "lock in" effect between customers and the provider of healthcare they have been seeing. Once a relationship between the customer and their doctor and treating hospital has been established it is very difficult to change providers. This can be seen in patients' unwillingness to discuss fees with specialists or change when they are made aware of these charges. <This is discussed further in Section 10 – N.

G. Leader-follower

99. HCA has asserted that there is a “leader-follower” relationship in the market, with Bupa acting as the leader (section 6.49).

Networks

100. The first point that HCA makes to support this is that “network type” policies were first introduced by Bupa in the mid-1990s, with AXA and Aviva later copying their approach.

101. To the best of our knowledge, there have always been products which offer differential access to hospitals. For example, in the 1980s products offered by AXA PPP placed each hospital into one of four bands (A-D), based on the cost of care at those hospitals. There were negotiations between insurers and hospital groups, with the latter seeking to gain the broadest recognition and the former seeking to trade this for lower prices.

102. In the mid-1990s AXA PPP initiated a review of hospital access for customers with a view to testing an alternative strategy. The intention was to create a two-tiered approach based on direct local tendering. The result was a new two band approach, which in practice meant that most customers saw an improvement in hospital access at a lower price. This being the case, the policy was implemented.

103. AXA PPP introduced its network of hospitals towards the end of the 1990’s. This network and that of Bupa’s were looked at by the OFT who concluded: “The development of hospital networks has been a reasonable response to relatively static demand for PMI coupled with rising costs and overcapacity in the PMS market”. They went on to say “Hospital networks have been successful in encouraging hospitals to compete on price and quality and the evidence so far suggests that consumers are benefiting from these improved efficiencies through wider choice of lower cost PMI”.

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104. It should be noted that the greatest winners in terms of broader access to the customer base were in fact central London hospitals, with HCA in the vanguard.

Benefit maxima

105. AXA PPP is of the view that it is perfectly reasonable for an insurer to set out the maximum it will pay under its policies so that consumers can be clear as to the extent of their cover. ✂However, as noted in previous submissions:

a) AXA PPP is very flexible in its application of fee limits.

b) ✂Newly recognised specialists agree to accept our fees as full reimbursement as a condition of recognition. This is discussed in our previous submission. Our view is that this approach increases the choice for customers allowing them access to more specialists without incurring top up fees, whilst controlling costs.

106. ✂Until 2008/2009 AXA PPP relied on a “usual and customary” approach. However, this was replaced by a more specific fee schedule, for the following reasons:

- a) Advice regarding legal and regulatory changes indicated that a non-specific contract term of the type being used was becoming less sustainable.
- b) Such a rule frustrates any real attempt to limit liability. For example, if an insurer sought to reduce its liability by lowering what it will pay, it would be unable to do so since limits would, by definition, be set by reference to recent experience.



Open referrals policies

107. It is asserted that Bupa's Open Referral Policy, launched in 2011, is being copied by others. It should be noted that:
- a) AXA PPP developed its first Open Referral product in late 2009, two years before Bupa – HCA is aware of this fact as the product launch was used to generate a dispute with AXA PPP at that time.
 - b) Our understanding is that Standard Life (now Prudential Health) also had such a product which was in place several years prior to AXA PPP's launch.
 - c) Open Referral products, whilst relatively new in the UK are well established in other markets such as the US.
108. Our view is that, in the light of economic circumstances, it is not at all surprising that insurers have launched new products designed to improve cost efficiency for their customers

Other issues

109. HCA fails to note a number of instances where the strategies of Bupa and AXA PPP cannot be characterised as similar at all:
- a) Bupa has consistently been involved in the provider market, ranging from hospitals to health screening, wellbeing centres and long term care. AXA PPP's activity in this area has never been extensive and, since joining the AXA Group more than 10 years ago, such vertical integration has been explicitly excluded from consideration.
 - b) Bupa has consistently followed a high profile brand strategy designed to maintain its position as a recognised name in the sector. Marketing expenditure by AXA PPP has been much more new business acquisition orientated
 - c) Where Bupa has had disputes with HCA, AXA PPP has assessed and then followed its own commercial strategy
 - d) ✂Bupa has recently announced its withdrawal from the intermediated market for Individual PMI – not something we have considered. ✂
110. AXA PPP competes actively against Bupa and the other PMI companies, which follow their own distinctive strategies such as Aviva's strong focus on claims management by areas of clinical expertise and PruHealth's growth through acquisition of Standard Life and policy of full refund of specialist fees. Simplyhealth is focussed on integrating and expanding its PMI business, building on its cash plan heritage. We believe that providers are acutely aware of

the strong competition between PMI companies and use this to their advantage by offering selective discounts to different insurers for particular plans or initiatives, as discussed above.

H. Complaints to FOS

111. In section 6.67 HCA notes that ‘there have been a number of complaints to the Financial Ombudsman Service...regarding... experimental procedures such as laser treatment used during larynx surgery, key hole surgery for bladder problems and new spinal treatments which minimise side effects, which insurers have refused to fund. The FOS has ruled, in a number of cases, that insurers should pay for these procedures and that it is unfair for insurers to turn down claims for newer forms of treatment.’
112. Also in section 6.67 HCA notes that the FOS upheld a complaint relating to insurer recognition of a new form of varicose vein surgery, which had been standard practice in the US for several years’.
113. In section 6.68 HCA states that the FOS has reported a ‘significant increase in the percentage of ‘health insurance’ complaints that are upheld from 31% (2009) to 43% (2011), which represented the highest increase out of all insurance categories’.
114. In section 6.69 HCA states that ‘FOS has been limited to overturning insurer decisions regarding policies in which experimental treatments are not specifically stated in the policy as being excluded’.
115. Section 6.70 refers to emerging treatments as ‘limiting customer choice and slowing the pace of medical developments’
116. We would highlight that as outlined further above in Section 6 – F, the total number of complaints referred to FOS in respect of PMI is very low (at c. 500 complaints per year) and low relative to other forms of insurance.
117. Relating to experimental treatments, our policy wording is clear that unproven/experimental procedures are not eligible for reimbursement. However we do look at such requests on an individual basis. We will support customers wishing to participate in clinical trials providing benefit up to the level we would have paid for the “usual treatment”. We will also pay, up to the limit we would have paid for an established treatment, when customers want to have a new unproven treatment, provided that it is clear that there is an established treatment that they would have had.
118. We do have concerns regarding this issue. Whilst it may be appropriate to other forms of insurance, such as replacing an item following a burglary, health insurance is much more complicated. In particular in health it is the provider of care who most often determines the need. As mentioned further below in Section 13 - V, it is of concern to us when doctors who are deciding on care have direct financial incentives in providing that care. Experimental treatments are those that have insufficient evidence of effectiveness but are often promoted as being the latest treatment. Furthermore experimental treatments, as discussed in Sections 3 and 4 – B, are used to enhance the position of providers. It is our view that when experimental treatments are offered, and insurers meet the cost of the conventional treatment, no top up should be sought from patients by the providers.

J. Relationship with HCA – AXA PPP decision to divest hospital ownership

119. In Section 6.81 HCA says that when Bupa sold 37 of its hospitals ‘BUPA was aware of the trend toward greater PMI control over hospital operators’ and that ‘the major PMI providers have adopted an increasingly aggressive negotiating stance towards hospital operators’. It fails to mention the OFT ruling in 2000 that Bupa could not acquire Community Hospitals Group.
120. It says ‘BUPA is unlikely to have divested these facilities if it felt such a move would materially reduce its bargaining power over hospital operators’. Specifically in relation AXA PPP it says ‘the same can be said about AXA PPP’s decision to sell its stake in the hospitals jointly owned with HCA.
121. We wish to clarify that following PPP’s acquisition by AXA, there was a change in strategic direction to divest of our hospital investments, since:
- they were not deemed to be a core expertise; and
 - it was believed that there was greater market clarity for AXA PPP to be seen to be independent from its providers, in order to be able to more clearly demonstrate patient choice.
122. Further we would highlight that when we sold our joint venture hospital holdings to HCA, this was prior to the OFT permitting HCA’s acquisition of St Martins Healthcare. Thus at the time of our divestment we believed that there was a sufficiently wide choice of competition in central London provision.
123. We note that Bupa re-entered hospital ownership through its purchase of the Cromwell hospital. We consider this reflects the desire to have a more cost effective provision in central London for international, self-pay and insured customers.
124. We note also that HCA is critical of both Bupa’s sale of its hospitals but also of its purchase of the Cromwell hospital. It is also critical of Bupa’s vertical integration between PMI and its ownership of hospital and primary care provision. We would highlight the inconsistency of these arguments and the extensive ownership (including horizontal and vertical integration) of HCA in the UK as shown in Section 5 – D.

K. Recognition of new facilities

125. In section 6.92 HCA claims that PMI providers ‘hold up’ hospital operators by not recognising new or developed facilities until they are operational. HCA asserts that this ‘can dampen investment and growth in the private healthcare sector.

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126. We have set out in response to the CC’s Market Questionnaire a summary and example documents concerning our general and consistent approach in respect of our commercial decision-making as to whether or not to recognise a new facility, as part of a tender exercise or otherwise. Our view of the factors inherent in such decisions is also set out more fully in section 2 of our response to the OFT’s General information request dated 11 April 2011 concerning:

- price – fees and charges levied by the hospital and consultants
 - range of specialisms and treatments undertaken at the facility
 - extent of the provider’s national, regional or local coverage
 - quality of the treatments offered
 - number and quality of consultants
 - the form that these facilities take e.g. private hospital, PPU, day care centre etc.
 - geographical location of the facilities
 - capacity.
127. In assessing these factors we carry out physical due diligence of the available facilities and commercial assessment of the required provision, taking into account our existing facilities in the area.

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128. We consider that our networks are central to our competitive ability to negotiate advantageous price terms to the benefit of our customers.

L. Open referral

129. In section 6.99 HCA raises a number of concerns with respect to ‘managed care’ strategies, with particular focus on Bupa’s open referral policy under which, according to HCA, ‘BUPA retains the exclusive right to define the choice of consultant and hospital for the customer’s treatment. The GP is not entitled to recommend either the consultant, hospital or other healthcare provider for treatment. There are no exceptions, and customers who do not follow the Open Referral claims process lose their entitlement to reimbursement. The patient cannot express a wish or preference to be seen by a particular provider or pay a “top-up” fee to go to the provider of his choice’.
130. In Section 6.100 HCA says ‘Open Referral demonstrates BUPA’s complete control over the patient referral pathway. In that respect, the claims made by BUPA in its policy are highly misleading to its customers. BUPA alleges that the policy offers “a greater choice of consultants and hospitals”, when quite clearly BUPA is reducing the choice of provider by directing patients to a more limited pool of consultants and hospitals. The policy also claims “access to better levels of care”, but this flatly contradicts the OFT’s findings in its report that PMI providers do not possess sufficiently detailed information on quality of care to be able to advise patients’.
131. Whilst HCA does not raise particular concerns with respect to AXA PPP in this context, as the CC is aware, AXA PPP also has a small number of Open Referral policies which it has had since 2008 when it first introduced an Open Referral product on a pilot basis to a small number of individuals living in London.
132. In January 2010 AXA PPP launched a new Open Referral policy for the corporate market in partnership with BMI. The key product features required members making a claim to obtain an open referral from their GP in the event that they require secondary care and that they receive treatment in a BMI hospital if they live within 20 miles of a facility outside London and within 10 miles inside London.
133. Following pre-authorisation with AXA PPP confirming that the treatment was eligible, the member was passed to BMI to find a suitable consultant and arrange diagnosis and treatment where required for members in their catchment areas. For members who did not

live in or require treatment in a BMI catchment area, AXA PPP sourced a specialist using our own internal database of specialists. ✕

134. AXA PPP has information on specialists' interests, location and hospital usage. In addition to the information in the GP referral about the treating specialist, this enables AXA PPP to refer members to a specialist for their required treatment. In booking appointments we also ensure that the patient can be seen in a timely manner. We do not claim to have information on outcomes or specialists' results because, as has been stated in the OFT's findings, no such data is produced for PMI companies or GPs to access. We therefore do not claim to be able to identify which specialists represent better quality than their peers. However we believe we are in no worse a position, and in many cases better, than GPs who currently make referrals. As an example we offer the customer choice of location - close to home or work. His/her local GP is unlikely to be able to name an appropriate specialist in a different geographical area.
135. This product has now been updated and has been re-launched to the corporate market for 1 January 2013 renewals. The product still requires the member to obtain an open referral from their GP. We have expanded the hospitals included in the network to give a national proposition. In addition to BMI the network now includes Nuffield (added earlier in 2012), Aspen, London Clinic and others and has 120 hospitals. AXA PPP will in all instances select a specialist for the member based on the same criteria as described above (the speciality communicated by the GP, the patient's preferred treatment location and our database of specialists). We aim where possible to give the patient a choice of three specialists and will offer to contact the chosen specialist to make an appointment on behalf of the member, which is a further way of ensuring that the specialist to whom we are referring the member does provide the services required.
136. This product is planned to be promoted to all corporate renewals from 1 January 2013 as an option to their existing products, both to our own and to competitors' clients.
137. We have been already providing this service (finding a specialist and making appointments) for certain of our members in 2012. AXA PPP receives a number (around ✕of total referrals) of open referrals routinely – where the GP who has seen the member does not refer to a specific (named) specialist. We believe that the number of open referrals has been gradually and naturally increasing over time, although we have not carried out any research to verify this. We are aware that the practice of open referral to a hospital rather than a named specialist is now standard practice in many parts of the NHS and is becoming preferred practice e.g. NHS Choices. We believe that GPs often do not know the specific names of specialists, particularly when the patient wants to be treated near to work rather than home.
138. In addition to this we do not believe that patients typically have access to a vast choice when identifying a specialist. The majority of patients we believe will accept the suggestion of their GP of who they should see. However GPs do not have access to information about specialists to enable them to make highly informed decisions. In common with everyone else they do not have access to quality or outcome data as this is not published. Generally, AXA PPP will have better information, certainly at a national level, about specialists' services and sub specialisms.
139. Even if a patient tries independently to gather information about the specialist they should see for their particular condition, they will not be able to gather any comparative information (because none exists) to help inform their decision, either on the quality or cost of a particular specialist. This means that the patient may ask to be referred to a specialist

whose fees an insurer might not meet in full, or in the situation of a GP referral, be referred by their GP to a specialist whose fees will not be met in full and then feel 'obliged' to continue to see the specialist identified by the GP out of loyalty or an often erroneous assumption that the GP knows best.

140. AXA PPP therefore does not accept HCA's position that an insurer which makes open referrals and chooses the consultant (bearing in mind that where possible AXA PPP will give a choice) limits patients' choices. We believe that our way of handling open referrals, where we also make the appointment for the patient if that is what they want, gives the patient choice, ensures timely treatment through referral to the chosen specialist, enables us to guarantee a full refund and enhances the patient's experience.
141. Whereas BUPA has sought to mandate that corporate customers switch to open referral products at renewal, AXA PPP continues to offer these types of products as an option. We believe in offering our customers a choice and that open referrals offer customers benefits of increased choice and options. As noted above this also enables us to find a specialist able to provide the required treatment and whose costs we will be able to meet in full. AXA PPP does not claim to have information about the quality of one specialist over another because as far as AXA PPP is aware, this information does not exist – either for patients, GPs or insurers. AXA PPP does believe that having published, accurate, comparable information on quality and outcomes for specialists would enhance the proposition we are able to offer customers.

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142. Further we do not believe that FIPO is able to substantiate its views that some consultants should be preferred over others (that is, that we should prefer consultants other than those we select) on a meaningful basis of benefit to consumers. Indeed it should be noted that referrals made by us are to consultants who are used regularly by many GPs. It therefore appears illogical to infer that the specialists we select are of lower quality and would not be recommended by a GP.

SECTION 8: Theory of harm: Market power of hospital operators in certain local areas

M. International business

Price sensitivity

143. In Section 8.8 HCA says that ‘International patients can choose from a number of medical centres of excellence around the world, of which London is just one. Health attachés, for instance, are in a position to redirect their embassy patients to rival facilities to source more competitive deals’.
144. We find this statement surprising and do not believe that the multi-national market is particularly price sensitive - especially for the central London elite market.
145. Our experience is that London is normally seen in the International PMI market as one of the more expensive cities in the world in which to receive treatment. We consider that London is viewed as a centre of excellence and this is the main reason why patients travel to the facilities and Consultants in London, as well as other local amenities such as shopping. It is for example popular with Middle Eastern nationals (UAE/Saudi/Qatar etc.) who tend to live outside the Gulf during the hottest summer months, moving to their London residences and whilst staying in the UK they arrange any healthcare requirements. A similar situation exists for Russian nationals with residences in the UK.
146. The importance of location relative to price sensitivity of wealthy foreign patients can be supported by the significant financial failure of The Golden Jubilee National Hospital which was built by Health Care International in 1994 in Clydebank, Glasgow, as a large new private 260 bed hospital, together with 168 bed hotel and conference facilities. The Abu-Dhabi Investment Company took over ownership out of receivership and re-launched it as HCI International Medical Centre in 1995 aimed at attracting foreign patients with accommodation for relatives. The initial cost was reported to be £180m but the venture proved unsuccessful and the hospital was purchased for the NHS, at a reported cost of £37.5m in 2002 (see: <http://www.scottish-places.info/features/featurefirst11978.html> and <http://www.heraldscotland.com/sport/spl/aberdeen/louis-james-wiczai-1.375040>).
147. ✂ In our experience of negotiating with the hospitals, there has been long and robust aversion in the London provider market to procedure/package pricing and limited public display of pricing, ✂
148. The ‘concierge’ services offered by HCA are designed to help attract this type of business as noted below (see <http://www.londonbridgehospital.com/LBH/private-patients/international-patients/>) in respect of International patients.

‘Our International Team takes pride in looking after overseas patients and their relatives, making them feel at home

The service begins from the moment a medical report is received and passed to the appropriate specialist for a medical opinion. This gives both the patient and, if applicable, the sponsor an opinion of what surgery or treatment is required

If the patient decides to come to London for treatment, the International Team will make all the necessary arrangements for the patient and their relatives, including accomodation, consultation and/or admission, and transportation (ambulance or air ambulance as required)

Once a patient has been welcomed to the hospital, a full range of services is provided, including translations and all daily requitremets during their stay.' (sic)



SECTION 10: Theory of harm: Market power of hospital operators during national negotiations with insurers

N. Relative bargaining power

149. HCA and AXA PPP agree pricing and other key contract terms through bargaining. In Section 10.4 HCA says that ‘the standard economic theory used to assess relative bargaining strength in negotiations posits that the relative strength of each party's "outside option" will determine the balance of bargaining power between the parties.’
150. We believe that the bargaining outcome is also affected by the ability of one party to make credible "take it or leave it" offers.

Outside option analysis of HCA and AXA PPP

151. We have considered a scenario where HCA and AXA PPP do not trade. Note: we are not considering what happens if HCA do not trade with both of BUPA and AXA PPP.
152. We consider that HCA would remain viable, even if less profitable, with business from Bupa and other insurers, overseas patients, and if it lost AXA PPP work - short term capacity filling. Indeed we believe that the HCA hospitals, in part because of their international clientele, are much less dependent on UK PMI business than other private hospital chains.



O. Switching to another hospital provider

153. Section 10.16 ‘HCA operates in a highly competitive market in which it vigorously competes with a large number of independent hospital operators and PPU's. Further, there has been a demonstrable record of new entry and expansion in London over the last five years’.
154. In section 10.17 HCA says that ‘In the event that a facility does not offer a comparable treatment, hospital operators with the necessary clinical infrastructure and finances are in a position to switch the healthcare services they provide within a reasonable time frame’
155. We believe that both statements are indicative of surplus capacity and financial resources in the private hospital market, which we would expect to see manifest themselves in greater price competition.

P. London choice – AXA PPP

156. In section 10.24 HCA uses as an example, a copy of a 2011 AXA PPP network proposal to demonstrate ‘the significant choice available to PMI providers in London. This document clearly illustrates how a major insurer considers there to be a plethora of private healthcare options within different geographic segmentations of the market. It also demonstrates a willingness on the part of the insurer to leverage this choice in its favour as part of a bargaining scenario for network inclusion’
157. In the tender referred to by HCA, we detailed in Appendix 2 the regions and areas of the country, the hospitals in each area, and the likely number of hospitals to be included in our value proposition.

158. The London “region” as drawn for this purpose was a large area, significantly wider than any market definition of London. The rationale behind this was to try to draw customers away from the high cost, central London providers towards the lower cost, outer London providers. We divided the London “region” into four quarters to facilitate this process.
159. The Health on Line value proposition is a low-cost, entry level product offering a restricted list of providers designed for the Individual and SME markets. It is our experience that, while a network that excludes the prestigious London private facilities may be acceptable to a small subset of customers for such a product, it is not acceptable to purchasers of standard PMI products. To say that our tender is evidence that we consider there to be “a plethora of private healthcare options” in London is highly misleading.

Q. Client ability to switch

160. In section 10.27 HCA says that ‘The cost impact on PMI providers of delisting a hospital operator's facility is significantly diminished by the customer lock-in effect which features in the PMI market’.
161. We comment on the adverse financial implications of Individual client claimants who are less likely to switch in Section 6 - G. In the same section we make the case that it is reasonable for employers to choose the level of cover they are willing to fund.



162. We do not regard claimant customers’ propensity to renew as a mitigation within our analysis of a potential decision to de-list. Rather the opposite: we are aware that we are likely to retain Individual customers with a higher loss ratio whilst those likely to be of higher risk of lapsing are the more profitable non-claimants who have less concern over pre-existing condition policy terms or current treatment.

R. Hospital strategies in negotiation

163. In section 10.42 HCA claims that ‘By contrast, in the event that a PMI delists a hospital operator or unilaterally implements a policy which reduces demand for that hospital operator's services, the potential strategies for hospital operators are highly limited in number and scope’.



S. Suggested additional theory of harm – buyer power of insurers in national negotiations

164. In sections 10.68 to 10.96 HCA is advocating an additional theory of harm. HCA believes that:
- a) section 10.68: In testing this theory, “the CC should adopt the analytical framework set out above in the context of our discussion of theory of harm 3’.
 - b) section 10.70: the buyer power of the major PMI providers is capable of, and has in fact, harmed:
 - investment in new facilities;
 - the scope of care available to private healthcare patients; and

- the quality of care available to private healthcare patients.
165. We note that HCA is a substantial business in the UK with stated 2010 revenues of over £600m (section 3.3) and net assets of more than £413m (being those of the HCA International Limited and St Martins Healthcare Limited entities only).
166. Further as noted in Section 4 - B, HCA has continued to make substantial investments in fixed asset additions (buildings and equipment, furniture and fittings), and is expanding rapidly through investment in acquisitions and financial arrangements with consultants, including acquisition of premises and provision of services.
167. AXA PPP refutes the comments made by HCA that we have harmed its investment plans, and the scope and quality of care available to our customers. We comment in section 6 – M on our Open Referral products which we consider provide enhanced choice and benefits to our customers at more affordable cost. Indeed it is hard to imagine the higher levels of investment HCA may have in mind.

T. Recognition

168. In Section 10.61 HCA discusses the closure of the maternity unit at the Hospital of St John and St Elizabeth, making the suggestion that this was due, at least in part, to PMI provider actions. Our comments are as follows:

- ✂
- a) The majority of PMI policies only provide benefit for emergency Caesarean sections. Because of the nature of the patients accepted at the unit, the incidence of emergency Caesarean sections could be expected to be low. Over the last six years that the unit was open, we paid for an average of 6 Caesarean sections per year, with total annual payments for these procedures averaging ✂.
 - b) It is our view that the target market for this unit was not mothers covered by PMI, but rather those willing to self-pay for facilities offering a low tech, natural birth. Any restrictions or changes to PMI maternity cover can therefore have had little impact on the unit's viability.
 - c) We believe that this target market was simply too small to sustain the unit and that customers have been attracted to NHS private units such as St Mary's Lindo Wing and the Chelsea & Westminster, as well as by higher tech private units such as HCA's Portland Hospital for Women & Children.
 - d) At the time of closing, the Hospital of St John & St Elizabeth made a statement which said:

“Last year we made considerable effort to both refurbish and promote our unit in the face of the current challenging economic situation and increased competition. Sadly it's become clear that the unit isn't financially viable in the long term, leaving us with no choice but to close it and use the space to meet increased demands for other hospital services.”
 - e) At no point were we advised that the closure was due to any action by us.

SECTION 12: Theory of harm: Barriers to entry resulting from national bargaining between insurers and hospital operators

U. Relative bargaining power

169. In Section 12.4 HCA says that ‘ there are a number of instances in which insurers have placed some but not all of HCA's facilities on their network which further evidences their strong bargaining position and the inability of HCA to dictate the terms of recognition:
- BUPA has previously withheld recognition for a number of HCA's new outpatient facilities
 - HCA's facilities outside London are not included on BUPA's new low-cost budget product for hospitals outside the North/South Circular
 - AXA PPP has not recognised HCA's facilities on its new low-cost network under the "Health Select" and "Health on Line" brands
 - HCA is not recognised on AXA PPP's speciality oral/dental network
 - Aviva has excluded HCA hospitals from its key hospitals network list.
170. We would like to correct the statement above concerning AXA PPP, as in fact HCA is recognised by us for our standard network Health Select product.
171. Further we would add that the fact that HCA is not recognised for our value proposition has nothing to do with AXA PPP's bargaining power. In May 2011 we invited HCA to participate in our competitive tender for our new Health on Line value proposition aimed at growing the PMI market by creating new product provision targeted at price sensitive customers.

✂

SECTION 13: Theory of harm: Barrier to entry resulting from hospital operator, consultant or GP relationships

V. Incentives

172. In section 13.8 HCA states that it 'does not consider that its own terms of engagement with consultants give rise to any potential foreclosure effects on new entrants or on other hospital operators' existence of incentives'.
173. In section 13.10 – HCA says that it 'has partnership arrangements with a number of consultants, which are characterised by the fact that HCA has made significant capital investment in the creation of new clinical facilities, equipment or services' – the examples are redacted.
174. HCA claims in section 13.13 that 'these types of terms, which reward consultants for establishing and developing new facilities, have strong pro-competitive effects and efficiencies'.
175. We have set out in sections 13.5 and 17-20 of our submission dated 20 July 2012 our particular concerns about the effects of these incentives which appear endemic in the operation of the UK market, notably in London.
176. These incentives are in direct contravention of clear GMC ethical guidance on conflicts of interest, the specific terms of which we have submitted previously.
177. We note the article published on 25 October 2012 by The Guardian concerning the cessation of partnership agreements between 300 GPs and Virgin Care over their possible conflict of interest. See:
<http://www.guardian.co.uk/society/2012/oct/24/doctors-virgin-partnership-conflict-of-interest>

GPs end Virgin link over conflict of interest

More than 300 GPs ended their partnership with Virgin Care to provide healthcare services yesterday, following criticism that arrangements could see doctors profit from sending patients to clinics they part-own under the Government's NHS reforms. The Guardian (Randeep Ramesh) writes that Virgin had set up two dozen local provider companies, which sought to make money by being paid by the NHS to offer community services such as dermatology, physiotherapy and rheumatology to patients. All were run as partnerships with GPs, but Virgin has admitted that the Government's decision to force GPs to commission health services put them in a position of possible conflict of interest. As a result, Virgin has taken over the provider companies

178. We are aware that inducements offered by HCA include the following:
- Free or discounted rooms
 - Purchase of property leases from doctors, possibly up to £100k pa
 - Use of free or discounted equipment which doctors bill for
 - Transfer of doctor's staff to hospital payroll
 - Joint ventures set up between consultants and HCA, funded by HCA loans
 - Free administrative services such as web design and marketing
 - Introduction to a billing agencies, one of which publicises that it will increase specialist income by 30%
 - Purchase of facilities to facilitate or protect referral into hospitals
 - Payment to doctors for each blood or scan they order
 - 'Profit shares' (for increased billing and exclusivity)
 - Equity shares.

179. We note that Nuffield comments in its submission dated 20 July 2012 on 'rent-seeking behaviour' which we believe is being driven by HCA based on precedents in the US. In section 4.15 Nuffield says 'Where consultants and/or consultant groups have market power, this can be used to engage in 'rent-seeking behaviour'. In this case, consultants typically threaten to withdraw their activity in order to force the hospital to agree to:
- a. Higher fees and/or
 - b. Higher financial incentives'.
180. In section 4.25 it says 'Nuffield Health believes that such 'rent-seeking behaviour' is as much a result of local market power as it is a result of the fact that financial incentive schemes are allowed, and therefore provide consultants with the ability to engage in such behaviour.'
181. We believe that these initiatives create inappropriate incentives to increase cost and alter referral pathways which distort competition and raise barriers to entry. Further we contend that such payments are made in direct opposition to several specific areas of GMC guidance for doctors relating to conflicts of interest.
182. We have highlighted that many of the types of incentive that we have become aware of have been made illegal in the US, where large fines have been levied for healthcare fraud and where the violation of public trust in healthcare providers through such fraud, has been particularly underlined.
183. We have noted that HCA has admitted several such instances in the US and has paid substantial fines over a number of years. In 2003 HCA paid the US government \$1.7bn, of which \$900m related to illegal kickbacks to doctors. Despite this considerable sum, HCA has continued to operate incentive schemes.
184. Recently HCA agreed to pay \$16.5m in order to settle alleged violations relating to incentive arrangements over an extended period from 2007-2011. On 19 September 2012 it was reported that 'HCA, through its subsidiaries Parkridge and HCA Physician Services (HCAPS), entered into a series of financial transactions with a physician group, Diagnostic Associates of Chattanooga, through which it provided financial benefits intended to induce the physician members of Diagnostic to refer patients to HCA facilities...."We will not allow hospitals to provide financial incentives to induce physicians to steer patients their way," said Derrick L. Jackson, Special Agent in Charge, HHS-OIG in Atlanta. "These arrangements can corrupt medical decision-making and may result in unnecessary diagnostic testing and hospital admissions."

[Source:http://www.wrcbtv.com/story/19584753/hca-to-pay-165-million-to-resolve-health-care-fraud-charges?clienttype=printable](http://www.wrcbtv.com/story/19584753/hca-to-pay-165-million-to-resolve-health-care-fraud-charges?clienttype=printable)



185. We note that HCA is also the subject of current investigations into alleged over-treatment in the US and are concerned that there is a strong motivation on the part of providers to recoup the cost of investments in new equipment through increased utilisation which may not be in the best interests of the patient and which serves to increase costs. This is all the more likely for less invasive tests such as blood tests, as noted by Professor Malcolm Sparrow in his book entitled 'License to Steal – How Fraud Bleeds America's Health Care System'.

186. This is supported by early research – see ‘Association between Physician Billing and Cardiac Stress Testing Patterns following Coronary Revascularization’ -JAMA November 9, 2011- Volume 306, No,18. The study concluded ‘Physicians who billed for both technical and professional components of nuclear and echocardiographic stress imaging studies were significantly more likely to perform such tests compared with those not billing for any component of the test. We consider there is much scope for manipulation in particular where a test is simple and harmless or where the use of the treatment is one where a degree of discretion or judgment is needed’.
187. The above study is of a significant size, comprising nearly 18,000 patients with the insurer United Health in the USA. It shows that a clear increase in the incidence of tests being ordered compared to the baseline (where the doctor has no interest at all), to where he can claim fees for interpretation and again, to where he also bills for the facility.

For stress echocardiography the increasing likelihood of tests being ordered was as follows:

- 7.1 x more likely if the doctor also charged for interpretation
 - 12.8 x more likely if the doctor charged for the facility as well.
188. We support the need for enhanced regulation to reinforce the GMC guidance to doctors on conflicts of interest, and to act as a point of escalation and arbitration of conflicts in the case of dispute. We believe that such regulation should encompass, operating methodologies, disclosure rules and ‘fit and proper persons’.

SECTION 16: Theory of harm: Limited information availability

W. Pricing transparency

189. In Section 16.14 HCA says that it 'accepts the need for price transparency, particularly for self-pay patients and agrees that providers should give consumers clear pricing information, spelling out what is included or excluded (prosthesis, surgeons' and anaesthetists' fees for example)'.
190. We consider that the market for private healthcare provision is particularly opaque for the following main reasons:
- a) the absence of comparable data between the hospital groups e.g. differences in approach to procedure/package definitions and adoption
 - b) the lack of clarity over discounts being achieved on supply prices and therefore margins
 - c) the absence of comparable data relating to self-pay, where periodically we are advised by our customers that they can achieve better prices.
 - d) the negotiation stance by hospital groups to protect total income earned from AXA PPP. We have described this in our previous submissions as a 'basket of goods' approach, such that annual price renewal discussions often give rise to reallocation of price differentials for treatments where we are able to show obvious anomalies, where proposed prices are grossly disproportionate to the underlying cost or relative to other hospital groups, which for the reasons noted above are not easy for us to analyse.
191. As a result of the above we have developed over the years highly prescriptive price schedules, aimed at achieving as much clarity as possible between the parties. Where possible, and for more regular, less complex treatments, we have, to differing levels of extent, agreed procedure/package prices which we consider have been successful in reducing administration and disputes and should act to contain cost through constraining the utilisation of consumables to expected norms.



Procedure/package pricing

192. We believe that the provision of such prices is more prevalent in the self-pay market where these will typically include specialist, as well as hospital charges to provide an inclusive view of likely total cost, which is clearly helpful to the consumer. However they are not often published.
193. ✂ In section 6.72 HCA comments that 'PMI policies only reimburse the cost of treatment provided by consultants and not by other doctors or clinical staff...HCA invests significant sums in these support figures out of its own pocket because such staff comprises important components in the delivery of high-quality care to patients'. The examples they give are redacted. We confirm that we do not pay for items that we deem included within other fees (e.g. accommodation as part of procedure fees, interpretation of a scan within the fee for a scan, pathologist report within a pathology test fee) and consider that HCA's comment is a clear indication of its preferred strategy to unbundle costs in order to maximise income. The fact that we seek to be clear in our contracts that we do not pay for these services is to protect ourselves from this strategy.

Excessive pricing

194. We have reason to believe that in some instances HCA realises extremely high profits relative to their underlying costs. In the case of pathology we believe that HCA pathology charges are some 30 to 50 times the underlying cost of providing the tests, based on an NHS laboratory of similar size, details of which have been obtained on a confidential basis.
195. In addition the prices we pay to HCA for these tests are up to six times HCA's own laboratory price list. This is compared to our contracted rates, where we are told that we receive a 'discount' of 80%.
196. For this exercise we selected the following common tests which we believe probably comprise 80% by value of blood tests ordered.
1. Full blood count (which itself comprises haemoglobin, haematocrit, white cell count, differential, platelet count, MCV MCH MCHC)
 2. Electrolytes (urea creatinine sodium potassium)
 3. Liver function tests (bilirubin alkaline phosphatase AST ALT Gamma GT Protein, albumin, globulin)
 4. Bone profile (calcium, phosphate, albumin, alkaline phosphatase)
 5. Iron and TIBC (UIBC)
- 80%
197. We conclude that for these tests:
- HCA is likely to be earning excessive profits on certain treatments including pathology
 - AXA PPP as an insurer is being charged substantially more than HCA's 80% for self pay clients
 - These tests are of a nature that lend themselves to multiple use.
198. We believe that the large margins in these types of tests permit HCA to pay incentives to consultants, and that such incentive structures are also proven to drive increased use. This practice is contrary to GMC guidance on conflicts of interest and builds in additional cost to the market.

Self pay

199. HCA comments on its self pay offering on a number of its websites, for an example at the London Bridge hospital, see:
- <http://www.londonbridgehospital.com/LBH/private-patients/selfpay-patients/>
- where it says that it has '600 procedures where we can give you a guide price at the outset – this includes accommodation, nursing, theatre fees, drugs and dressings'. These prices are not published and treatment is stated to be dependent on a pre- assessment.
200. We note that HCA has recently published 16 self pay prices on its Galen Health Partners website. We believe this publication is for the first time. See:
- <http://www.galenhealthpartners.com/hca-selfpay.html?ref=www.theprincessgracehospital.com>

201. We are uncertain as to why HCA has chosen this site which we believe is not obvious to an uninformed patient, as it is not particularly easy to find. The site states that the exact components of the package will be disclosed to the patient prior to admission. This means that we cannot be sure which of the following are included:

1. Consultations
2. The doctors' fees
3. Investigations and tests to determine diagnosis
4. Investigations and tests to determine fitness for anaesthesia
5. The extent to which routine follow up is included

We are therefore unable to make any meaningful comparison of prices against those that we are charged for.

202. In addition we note HCA's intent to pull the customer into the patient pathway through an early stage consultation, after which we believe it will be harder for the patient to withdraw in order to choose another competitive offering.

203. It is also very difficult for us to determine more generally how the self pay market prices compare to the prices we pay, for HCA or more widely.

204. We can see examples of procedures where the prices we pay are vastly in excess of the published prices, where we would expect to benefit from our purchase volumes, however we are also aware of instances where different parts of the treatment are charged to us separately.

205. ✂ We are aware that many hospitals use 'spot rates' at marginal prices, where they have available capacity such as a free slot in an existing surgical list; this also creates variation in the self pay prices that customers communicate to us.

✂
206. Note: in 6.54 HCA says 'PMI patients tend to present relatively higher margins than NHS patients'. We believe that this statement implies acknowledgment of markedly differential pricing for different segments of business.

Other

✂ We are aware that HCA has been fined in the US for fraudulent billing practices including increasing the complexity of treatments and other means of inflating costs. ✂

207. In summary we would welcome much greater clarity on pricing which we believe would drive more effective competition. Specifically, and accepting the expectation of normal competitive confidentiality:

a) we would expect greater clarity of pricing transparency/strategy (headline prices notwithstanding confidential levels of discount) between business lines to extend to insurers:

- we are concerned about higher prices to insurers compared to self-pay, where we believe that hospitals are seeking to cover high fixed costs from insurers in the

first instance and where we might reasonably expect to benefit from volume arrangements

- we are concerned about potential price discrimination between international and UK patients

- b) whilst we object strongly to the practice of incentives as being unacceptable from a moral and GMC guidance perspective, we would as a minimum expect clear transparency to customers of their existence to aid fair choice, e.g. concerning ownership structures, exclusive trading agreements and referral income.
- c) we believe the protection of total income, whilst an understandable negotiation tactic, significantly undermines competition where this is achieved through the disproportionate negotiating power held by HCA.