

HCA **International**

Response to Competition Commission's Issues Statement

31 July 2012

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1 INTRODUCTION

- 1.1 HCA International Limited ("HCA") welcomes this opportunity to submit its comments and evidence on the issues which the Competition Commission ("CC") intends to consider in its investigation. These comments are not exhaustive, and HCA will complement its submission with further detailed argument and evidence as appropriate during the course of this inquiry in order to assist the CC with its provisional findings.
- 1.2 This submission attempts to deal with the core issues in relation to hospital operators. The fact that HCA does not expressly respond to a point in the Issues Statement does not necessarily imply that HCA agrees with it.
- 1.3 The HCA Group is the largest non-governmental healthcare organisation in the world. In the UK, HCA brings the perspective of a London-based private healthcare provider, owning and operating six world-class facilities in London. Its submission is primarily based on its experiences as a London provider. However, many of the key competitive dynamics which are discussed below – in particular, the power of the private medical insurers, and the competitive constraints on hospital operators – apply more broadly to the UK and are therefore of general relevance to the CC's inquiry.
- 1.4 This submission is structured as follows:
 - Section 2:** Executive summary
 - Section 3:** An overview of HCA and its activities
 - Section 4:** A brief description of private healthcare
 - Section 5:** The competitiveness of private healthcare in London where HCA's hospitals are based
 - Section 6:** An overview of the private medical insurance ("PMI") market and the strong bargaining position of the insurers
 - Section 7:** Some observations on market definition
 - Section 8 - 17:** HCA's comments on the theories of harm proposed in the Issues Statement
 - Section 18:** Conclusions
- 1.5 This submission contains confidential business secrets which should not be disclosed to third parties without HCA's consent. HCA will prepare and submit a non-confidential version of this submission for publication on the CC's website.

2 EXECUTIVE SUMMARY

The key themes highlighted in the submission, and HCA's high-level responses to the CC's theories of harm, are briefly outlined as follows:

A Key themes

Competitiveness of private healthcare

HCA's six London hospitals operate in one of the most competitive parts of the UK. HCA faces vigorous competition from a wide array of independent hospitals and NHS private patient units ("PPUs"), and its business is subject to strong competitive constraints. Competition, particularly over clinical quality, customer service and innovation, continues to deliver tangible benefits to consumers, such as access to pioneering treatments and a higher quality of care. Such competition also incentivises hospital operators to offer the highest quality service at the best possible value. In addition, the NHS, by offering a free alternative to patients, acts as a powerful constraint on private providers by constraining the extent to which patients opt for private healthcare.

New entry and expansion

There has been an impressive record of new entry and expansion, particularly in London, but also right across the UK and this trend looks set to continue. Investors have committed significant funds in new build hospitals, speciality clinics and outpatient facilities. The market is also witnessing new, innovative forms of clinician-led ventures. Furthermore, financial pressures on the NHS along with the removal of the "cap" on income that NHS Foundation Trusts are allowed to earn from private patient activities is paving the way for a further wave of PPU expansion which will also increase capacity in London.

The London market possesses unique characteristics that off-set the risk of market failure for new entrants. Specifically, London's economic resilience, its vast patient and consultant population, its position as a centre for healthcare research and development, and its transport infrastructure lower the risk associated with market entry compared to many other parts of the UK.

Innovation

The private healthcare sector is fast-moving and technological developments have led to exponential growth in the pace of innovation over the last few years. Innovation plays a critical role in private healthcare, particularly in high-acuity, tertiary care which is a strong feature of HCA's offering and of the provision of private healthcare in London.

HCA has positioned itself as an early adopter of cutting-edge technology and emerging clinical practices. To sustain this position, HCA has invested heavily in its facilities and clinical staff over the years, specifically, HCA currently reinvests over █████ of its profits in order to provide the highest quality care to patients. This is because HCA is committed to improving the quality of care in the long-term rather than focus on short-term profits. Innovation is also important when competing to attract the best consultants.

It is essential that hospital operators retain the commitment, confidence and incentive to innovate in new services and technologies, and strive to continually improve clinical outcomes. Investment in new equipment and technologies leads to increased treatment options and choice for consumers,

and ever improving clinical and quality of life outcomes. Furthermore, new technologies and best practices eventually proliferate throughout the private healthcare sector and the NHS, benefiting patients across the UK.

PMI power

Revenue from PMI patients accounts for over half of private hospital income in the UK. The PMI sector is highly concentrated and PMI providers exercise substantial bargaining power in a manner which constrains the way private healthcare is delivered to consumers. PMI recognition and access to PMI networks are amongst the most significant challenges for new entrants. The major PMI companies have in recent years consciously adopted a more aggressive stance towards hospital operators, and recent PMI "directional" strategies, such as BUPA's Open Referral and AXA PPP's fixed fee schedule, are creating significant distortions in supply. Some of BUPA's managed care initiatives, in particular, have focused on cost containment, which can be inconsistent with the patient's optimum clinical choice.

Transparency

HCA recognises the importance of improving transparency in pricing and quality. HCA's strategy has been, and remains, to provide high-acuity hospital services to the highest clinical and customer standards. HCA notes that the development of a coherent, objective and cross-sector quality framework is a challenge that has yet to be successfully overcome in any country. Notwithstanding this, the UK private healthcare sector has made good progress in developing a framework for measuring clinical outcomes. To that end, HCA has been in the vanguard of collaborative efforts by the major hospital groups to improve the scope, transparency, accuracy and usefulness of information on service quality for customers, clinicians, hospital managers and regulators. Moreover, HCA welcomes and supports further discussion on how the industry could work together to resolve any information asymmetries and improve the availability of price and clinical data to patients and GPs.

B Theories of harm

Theory of harm 1: market power of hospital operators

- Competition manifests itself in relation to quality, innovation, timeliness and price.
- HCA operates in a highly competitive market, and faces numerous independent and PPU rivals.
- The CC must take account of all the competitive constraints on hospital operators, including ease of entry and expansion and the constraints imposed by the NHS.
- Customers have the ability to choose amongst a range of competitive alternatives. In particular, PMI providers have very strong bargaining power which constrains the way in which hospital operators deliver private healthcare services and gives rise to theory of harm 3(b).

Theory of harm 2: market power of consultants

- Consultants are valuable partners for hospitals and in London there is fierce competition for the top clinicians.

- Consultants can switch easily between facilities and are forming new collaborative ventures, evidencing a lively and competitive market.
- PMI providers exercise powerful constraints over the activities of consultants and recent PMI initiatives may have an increasingly detrimental impact on the future of consultant private practice.

Theory of harm 3: market power of hospital operators in national negotiations with insurers

- When looking at the respective bargaining power of PMI providers and hospital operators, the CC needs to assess each party's "outside option".
- PMI providers have a range of potential strategies to adopt should they fail to reach an agreement with HCA – for example, there are a wide-range of alternative providers and there has been significant new entry and expansion.
- By contrast, HCA's alternative strategies are extremely limited. The two major insurers account for such a high level of business that HCA has no option but to agree terms which are largely dictated by the insurers.

Theory of harm 3(b): market power of hospital operators in national negotiations with insurers

- A separate theory of harm exists in respect of the insurers' market power and the harmful effect this has in the private healthcare sector.
- Specifically, PMI buyer power and the resulting conduct and practices that are used by PMI providers can stifle investment in new facilities, limit the scope of care available to patients and harm the quality of care. Further, in light of the lack of entry and consolidation occurring in the PMI market, these practices are likely to go unchecked over time.

Theory of harm 4: buyer power of insurers over consultants

- The PMI providers exercise substantial bargaining power over consultants.
- Recent PMI strategies, such as fee-capping and delisting consultants, are limiting competition between consultants and reducing patient choice.
- HCA is concerned about the long-term implications for the number of consultants who are willing to take up private practice in the future.

Theory of harm 5(a): barriers to entry resulting from national bargaining between insurers and hospital operators

- HCA does not have a national presence and does not negotiate at a national level.
- HCA's agreements with PMI providers do not prohibit new hospital operators entering the market.
- PMI bargaining power is attested by a broad range of evidence, including the fact that insurers have declined to list HCA facilities on PMI network products.
- In any event, the CC must also look at the impact of exclusive and restrictive PMI networks which often create or contribute to any foreclosure effects in local markets.

Theory of harm 5(b): barriers to entry resulting from relationships between hospitals, consultants or GPs.

- There is vigorous and healthy competition between hospitals for consultants – mainly around quality and location, but also on terms of engagement.
- For its part, HCA does not restrict or deter consultants from practising at rival hospitals.
- There is no evidence in London that consultant incentives such as equity investment foreclose competitors – on the contrary, there is significant evidence of new entry and expansion. Further, consultant/hospital partnerships have an important role in guiding investment decisions and shaping the future delivery of care.
- Rival hospitals and new entrants can and do compete by offering similar terms to recruit new consultants.

Theory of harm 5(c): other barriers

- There has been a significant level of new entry in recent years and there is no evidence that high capital costs are deterring new entry and expansion.
- Institutional investors, hospital groups and also clinicians have been prepared to invest where there are competitive opportunities.
- In HCA's experience, planning does not create any special barriers in private healthcare and there is no evidence that the existing planning regime deters new entrants.

Theory of harm 5(d): barriers to entry for consultants

- There is no evidence that there are significant barriers to entry for consultants.
- Consultants readily switch between hospitals at no material cost.

Theory of harm 6: information availability

- The industry has made great strides towards improving information on quality and clinical outcomes.
- There have been advances in the regulation of the clinical professions and of private and NHS hospitals, and the roles of the Care Quality Commission (CQC) and General Medical Council (GMC) continue to evolve to provide robust defences against the risks of low quality delivery of healthcare.
- Whilst comparing clinical outcomes across a range of providers is an extremely difficult task, there is a wide-range of quality metrics and registries which could allow for benchmarking.
- HCA accepts that the industry has further to go and welcomes a discussion on how more information can be made available for the benefit of both patients and GPs.

Theory of harm 7: vertical effects

- BUPA's vertical linkages and strong PMI market presence give it the ability and incentive to:
 - divert patients away from competing facilities based in London;

- utilise strategic information regarding other hospital operators that it generates from its PMI role to its advantage; and
- limit the pace of development of rival hospital operators.

3 HCA

Summary

- HCA operates six hospitals, 11 outpatient and diagnostic centres and four NHS partnerships.
- When HCA entered the UK market, it had a vision of transforming its hospital network through large-scale investment, expertise and diligence into centres of excellence equipped to deal with complex tertiary care.
- HCA has a philosophy of continuous investment and innovation and is dedicated to providing patients with the highest quality of care at the best possible value.
- HCA is proud of its international reputation and record on quality and welcomes initiatives to improve transparency over the quality of care.

3.1 This section provides an overview of HCA and its position within the market.

Introduction

3.2 The HCA Group is based in Nashville, Tennessee in the US. It was founded in 1968 and was one of the first hospital companies in the US. It has grown to become one of the largest private operators of healthcare facilities in the world, with total revenues of \$30 billion and 199,000 employees, serving 14 million patients a year. The HCA Group currently owns and operates 164 hospitals and 106 freestanding ambulatory care centres (akin to outpatient, day case and diagnostic centres) across the US and UK.

3.3 In the UK, HCA treats over 65,000 inpatients and over 420,000 outpatients annually and has total UK revenues of over £600 million.

3.4 HCA's core competency and focus across its whole business is the delivery of high quality healthcare in both inpatient and outpatient settings, which provides it with a deep understanding and knowledge of the healthcare markets in which it operates. Two of HCA's founders are physicians, and HCA's clinical focus provides the bedrock for HCA Group's success.

3.5 In the UK, HCA's activities span:

(i) Six private hospitals in London:

- The Wellington Hospital
- The Harley Street Clinic
- The Portland Hospital for Women and Children
- London Bridge Hospital
- The Princess Grace Hospital
- The Lister Hospital.

(ii) Eleven outpatient and diagnostic centres, which provide outpatient consultation, diagnostics, and private GP facilities. These include:¹

¹ In addition, HCA also has primary care interests, notably, the Rood Lane Medical Group and Blossoms Healthcare.

- 30 Devonshire Street
- 31 Old Broad Street
- Brentwood Medical Centre
- Chelsea Outpatient Centre
- City of London Medical Centre
- Docklands Healthcare
- The Harley Street Clinic Diagnostic Centre
- The New Malden Diagnostic Centre
- Platinum Medical Centre
- Sevenoaks Medical Centre
- Wellington Diagnostics and Outpatients Centre.

(iii) Four partnerships with NHS Trusts for the provision of private patient services:

- Harley Street at UCH: Providing services to UK and international private patients on a dedicated floor of University College London Hospital (part of University College London Hospital's NHS Foundation Trust):
- Harley Street at Queens: Delivering comprehensive cancer services to private patients from dedicated new facilities at Queen's Hospital in Romford (part of Barking, Havering & Redbridge University Hospital's NHS Foundation Trust);
- The Christie Clinic: Delivering comprehensive cancer services at the Christie Hospital (part of the Christie NHS Foundation Trust).
- The London Gamma Knife Centre:² a joint venture with the NHS at St. Bartholomew's Hospital in the City of London delivering treatment to both NHS and private patients.

(iv) Leaders on Oncology Care ("LOC"): founded in 2005 as a collaborative venture between leading oncology consultants and HCA. LOC has developed into a renowned institution for the medical treatment of cancer patients by bringing together specialist consultants into a form of "consultant chambers" which combines the skills of its members and supports a common vision to develop new clinical practices and improved services for cancer patients. This once novel model of consultant groups has been emulated by doctors working in other specialities.

(v) The Sarah Cannon Research Institute UK ("SCRUK"), a HCA subsidiary and affiliate of the Sarah Cannon Research Institute in the US. SCRUK has opened a cancer drug development programme in partnership with HCA and LOC. SCRUK is the Sarah Cannon Research Institute's first research program for clinical trials outside the US.

3.6 HCA's investment in the UK goes back several years. In 1996, a BMI joint venture sold the Harley Street Clinic, Portland, Princess Grace and Wellington Hospitals to HCA. BMI divested its London hospitals because of the high cost of operating in London and, accordingly, had projected increasingly lower margins across its range of low-acuity service lines. HCA acquired, as part of a joint venture with PPP Healthcare Limited, these four London facilities with a different vision which was modelled around its US experience. HCA believed that these

² The London Gamma Knife is run in partnership with HCA's Harley Street Clinic.

facilities could be transformed through large-scale investment, expertise and diligence into centres of excellence equipped to deal with complex tertiary care, an area that, at the time, was largely the remit of the NHS. In 2000, PPP sold its interest to HCA following its acquisition by AXA in the previous year, as this segment of its business was considered non-core.

... HCA believed that these facilities could be transformed through large-scale investment, expertise and diligence into centres of excellence ...

3.7 In 2001, HCA acquired St. Martin's Healthcare Limited from the Kuwait Investment Office which owned the London Bridge, the Lister and the Arrazi hospitals. The OFT reviewed and cleared this transaction.³ At the time, the London Bridge was considered an unattractive

and oddly located hospital (being south of the river Thames), however, following significant cumulative investment by HCA, has been transformed into one of the UK's best private hospitals and is able to compete on an international level with leading hospitals in the US, Germany, Singapore and Thailand. The Lister has similarly developed an international reputation for providing high quality private healthcare to patients across a wide range of specialties. The Arrazi was converted into an outpatient and diagnostic treatment centre.

3.8 These six hospitals comprise the portfolio of London hospitals which HCA operates to this day. The success of its hospitals was at no point inevitable; rather, HCA has striven, based on a philosophy of continuous investment and innovation, toward realising the potential of each of its facilities.

The success of its hospitals was at no point inevitable ...

3.9 Over the last few years, HCA has expanded its range of advanced outpatient and diagnostic centres, which is in line with recent clinical practice, whereby treatments conventionally delivered in hospitals are being increasingly delivered in local settings, thereby improving convenience for patients by offering care closer to the patient's home and making the delivery of care more cost effective.

Clinical specialisms

3.10 HCA offers a wide range of clinical services in its hospitals covering almost all of the main clinical specialisms and sub-specialisms, including:

- cancer
- heart
- ENT
- fertility
- gastro and bariatric
- general medicine
- general surgery
- hepato-biliary
- intensive care
- neurosciences
- maternity
- orthopaedics
- paediatrics
- rehabilitation
- urology
- women's health

³ Evaluation of the Competition Commission's past cases, Final report, Competition Commission, January 2008, para 2.38.

- 3.11 HCA has a strong focus on "tertiary" clinical specialisms, i.e. the treatment of serious and complex medical conditions, with high levels of acuity requiring specialised investigation, treatment and care in facilities with advanced equipment, highly trained staff and 24/7 life support back-up capabilities. Examples of tertiary care include cancer treatment, neurosurgery, cardiac surgery, advanced neonatal services and other complex medical and surgical interventions.⁴
- 3.12 HCA has invested heavily in diagnostic and treatment facilities and intensive care facilities which support high-acuity care in areas such as cancer, cardiac and neurosurgery. It also provides the clinical environment which can support higher levels of patient dependency, such as level-3 intensive care units. This investment, along with the support of highly qualified clinical staff, has attracted leading consultants from major London teaching hospitals.
- 3.13 HCA's hospitals are individual centres of excellence which offer some of the most advanced treatments in the UK (including the NHS) in numerous areas of medical practice. HCA hospitals have international reputations in key specialisms, for example:

HCA's international reputation	
Cancer:	Harley Street Clinic; Wellington; London Bridge; UCH; Christie Clinic
Cardiac:	Harley Street Clinic; London Bridge; Wellington
Neurosciences:	Harley Street Clinic; London Bridge; Wellington
Paediatrics:	Harley Street Clinic; Portland
Obstetrics:	Portland
Fertility:	Lister

Investment

- 3.14 HCA continually invests in its facilities in line with medical advances. It has a reputation for having some of the most advanced medical equipment in any private hospital in the UK. In the last four years alone, it has invested a total of [REDACTED] in new assets, equipment and treatment technologies. Annual capital investment (including R&D spending) represents [REDACTED] of HCA's turnover,⁵ or [REDACTED] of its profits. This level of investment is important if HCA is to remain competitive, continue to attract leading consultants and medical staff, and deliver high quality, cost-effective healthcare across the range of specialisms.
- 3.15 There are numerous examples of HCA investing in advanced medical equipment or technologies for the benefit of its patients and these include:

Annual capital investment... represents [REDACTED] of HCA's turnover, or [REDACTED] of its profits

⁴ By way of example, HCA's cancer care covers all modalities, including chemotherapy, radiotherapy and surgery and treatment for haematological cancers, and HCA's cardiac care includes cardiothoracic surgery.

⁵ Profit is earnings before interest and tax ("EBIT"). This percentage is based on the cumulative figures for the past four years (year end 2008 to 2011). During this period, HCA's total turnover was [REDACTED] and its EBIT was [REDACTED]. Investment was therefore [REDACTED] of turnover and [REDACTED] of EBIT, respectively.

CyberKnife

The Harley Street Clinic opened the UK's first revolutionary CyberKnife robotic radiosurgery machine. This is a compact linear accelerator mounted onto a robotic arm designed to deliver precision treatment of tumours anywhere in the body, including areas not possible to treat on more established radiosurgery platforms, by directing concentrated doses of radiation to a precise target (thereby minimising damage to surrounding healthy tissue). This technology was subsequently introduced, with cross-sector knowledge-sharing by HCA based consultants, in four competing facilities.

The Harley Street Clinic opened the UK's first revolutionary Cyberknife robotic radiosurgery machine...

NanoKnife

A pioneering new cancer treatment for inoperable tumours in the lungs, kidney, liver, breast, prostate or pancreas was made available to patients at the Princess Grace in 2012. This treatment destroys soft tissue tumours with an electric current, minimising the risk of damage to nearby organs or blood vessels. Over the last 20 years, patients with inoperable cancers have been given radiofrequency ablation therapy which uses heat to destroy cancer cells. However, this treatment has its limitations and is not suitable for patients with tumours near major blood vessels. NanoKnife circumvents these problems by using a 3,000 volt electric current rather than heat to destroy the cancer.

da Vinci robotic surgery

A computer-enhanced, robotic surgery system (first brought to the UK at the Princess Grace) which enables the surgeon to perform minimally invasive work in tricky or delicate areas whilst having a clearer 3D view of the nerves, blood vessels and muscles. The Wellington was the first UK private hospital to introduce the upgraded da Vinci SI surgery system – which offers enhanced high definition 3D vision, dual console capability to support training and collaboration during surgery and extensibility for digital operating theatre integration.

Extremity MRI

This scan uses a strong magnetic field and radio wave to create very high quality computer images of tissues, organs and structures inside the body.

Super low-dose CT

The London Bridge Hospital offers a super low-dose CT scanner, an imaging system that drastically reduces the radiation dose to patients and is especially beneficial to patients who may require multiple imaging tests, such as cancer patients.

Gamma Knife

This is an advanced radiosurgical system which is used to treat patients with certain brain conditions. It may be used as a replacement for conventional neurosurgery, but at other times it may be effective in situations where there is no conventional surgical alternative available. Radiation treatment is delivered with great precision to abnormal tissue within or around the brain, whilst at the same time minimising any dose to surrounding healthy tissue.

Image Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Rapid Arc

Radiotherapy systems which, using a tumour mapping system, target tumours with a greater degree of accuracy and far less damage to surrounding healthy tissue than linear accelerators without these systems.

Sensei: Robotic Catheter System

London Bridge Hospital was the first private hospital in the UK to offer the innovative first generation Sensei Robotic Catheter System (also known as the Hansen Robot) within the Cardiology Department. This system is designed to give surgeons accurate and stable control of catheter movement during complex cardiac procedures performed to diagnose patients suffering from abnormal heart rhythms or arrhythmias.

Breast intra operative radiation therapy (IORT)

From October 2011, the Princess Grace became the first private hospital in the UK to offer this pioneering form of radiotherapy that can be delivered in a single session, rather than over several weeks. Normally, women with breast cancer receive radiotherapy following surgery, typically over the course of three to six weeks, to prevent the risk of the cancer recurring. IORT can be delivered in a single dose, directly to the breast, immediately after the tumour is removed. IORT has been found to have similar success rates to conventional radiotherapy with fewer side effects.

Robotic Liver Surgery

On 20 June 2012, the CyberKnife Centre London began clinical trials of a new cancer treatment. The trial is open to patients with metastatic colorectal cancer that has spread to the liver. These are patients who are no longer responding to chemotherapy. The clinical trial involves treatment by CyberKnife and a new anti-cancer vaccine, Immodulon. The Centre has teamed up with SCRUK, a dedicated oncology clinical trials unit which is also based in Harley Street. Data on the effectiveness of the drug will be sent to the manufacturer of the vaccine and later published.

Vacuum assisted breast biopsy

This allows for the removal of breast lumps quickly and without a surgical operation, using the technology of the ENCOR breast biopsy system.

New life saving blood test

A team of specialists at London Bridge Hospital became the first in the UK to offer a new test to identify patients at risk of complications associated with blood thinning drugs given following heart surgery.

3.16 HCA also invests in technologies that support better clinical practice, such as:

PACS (picture archiving and communication system)

PACS replaced film-based diagnostic image display and storage with a digital system for processing and storing diagnostic images (such as X-ray, MRI and CT scans). The PACS system includes high resolution workstations enabling doctors to view and manipulate images to diagnose more effectively. PACS is being upgraded to process cardiac catheter-imaging, convert output into 3D multi-layered images (using Visage) and to facilitate remote access of imaging, for example, at the consultant's outpatient site.

Care Pathways

A software programme that enables a patient's care plan to be co-ordinated and monitored by nursing staff. The system provides prompts for each action required under an individualised care plan. Care Pathways adopts a multi-branch pathway which provides guidance to nurses that adapts to previous clinical decisions and to the patient's circumstances.

Physician and patient portals

PatientKeeper is a web-based physician portal to real-time patient data. Software can be downloaded to a remote desktop, mobile or iPad, allowing the consultant to remotely access information such as the patient's profile, key vital signs, administered treatments and drug history. MiHealth software is a web portal for patients to access their own clinical data, for example their latest lab results. It also integrates secure messaging between the patient and physician to discuss results or make appointments.

3.17 The above represent just a few examples of the kind of investments HCA has made that translate into more effective clinical practice, better quality of care and improved customer service.

3.18 HCA's investments bring about wider benefits in the healthcare sector. A few examples include:

- HCA supports research fellows at St. Bartholomew's Hospital in researching new applications of Gamma Knife technology, thereby generating knowledge and best practice that can be shared throughout the sector.
- HCA's CyberKnife Centre teamed up with SCRUK to identify patients (who are no longer responding to chemotherapy) to take part in a clinical trial involving treatment by CyberKnife and a new anti-cancer vaccine. The results will be openly published with the hope of new drug developments.
- SCRUK runs a dedicated drug development programme led by world-leading consultants. The centre has recently had success in identifying a new drug for treating melanoma and developing a companion diagnostic test. This is a major advance in care for patients with a potentially life-threatening condition and is

...HCA's investments bring about wider benefits in the healthcare sector...

...supporting and promoting medical research and education...

3.19 HCA has also set up the HCA International Foundation, a charity dedicated to supporting and promoting medical research and education. The Foundation provides scholarship opportunities for young consultants and specialist registrars to travel abroad or in the UK to enhance their training by studying advanced medical and surgical techniques which are not in common use but which would have important applications for their chosen area of practice. Successful candidates have opportunities to learn about and gain practical experience of cutting-edge clinical techniques and technologies and are encouraged to spread this knowledge to others in the medical profession so that the practice becomes progressively more widespread. There is no requirement for candidates to have any connection with HCA.⁶

3.20 [REDACTED] Advances in genetic science have opened up the possibility for making patient-specific diagnoses and assessing individual risk according to the patient's genetic profile, which, it is hoped, would lead to improvements in diagnoses (for example by distinguishing between different types of cancer) and patient-specific treatments.

...dedicated to providing the best possible quality of care...

Quality

3.21 HCA is dedicated to providing the best possible quality of care in terms of:

- clinical outcomes
- customer care
- navigating patients through the complexities of treatment options
- providing choices of treatments (subject to clinical need)
- providing choice of treatment time (by investing in sufficient capacity to enable flexibility)
- employing and training clinical staff to assist patients and work with consultants to deliver care to the very highest standards
- collaborating with consultants to shape the delivery of clinical services and guide investment decisions
- operating robust clinical audit, risk management and clinical governance arrangements.

3.22 Quality of care lies at the very heart of HCA's business ethos and underpins HCA's success. HCA is proud of its record on quality and has a transparent approach to reporting quality data and treatment outcomes. For instance, HCA provides a quality report on its website (HCAqualityreport.co.uk) detailing key statistics, e.g. waiting times, survival rates, hospital transfers, MRSA incidents, cleanliness inspections and certain patient & consultant satisfaction metrics. HCA also actively supports relevant national studies, audits registries and databases (see Annex 1), and allows open reporting of its outcomes on third party websites and in professional publications.

HCA welcomes initiatives to improve transparency...

3.23 HCA's accomplished record on quality includes:

⁶ www.hcainternationalfoundation.com

Record on quality

- (i) HCA's independently-run patient satisfaction surveys show that over 99% of patients rated HCA hospitals highly for overall quality of care (2011).
- (ii) A consultants' survey in 2010 showed that 95% of HCA consultants would recommend the hospitals to family and friends.
- (iii) HCA achieves consistently high patient survival rates. For example, an Intensive Care National Audit Research Centre ("ICNARC") study of survival rates in intensive care units in the UK found HCA hospitals to be in the top 10% of hospital operators.
- (iv) HCA has achieved 100% compliance with all CQC outcomes of care (2011).
- (v) HCA has won more quality awards and nominations than any other private hospital group including the Health Investor Award for Private Hospital Group of the Year (2012).
- (vi) HCA leads the way in breast care and quality tracking by recruiting leading clinicians and specialists to audit and improve the quality of HCA's cancer care offering.

3.24 HCA welcomes initiatives to improve transparency over the quality of care. HCA is well-used to its quality benchmarks being openly published, for example, in the US, care delivered to patients funded by the government (such as under a Medicare plan) is openly quality-benchmarked against HCA Group's competitors. HCA would welcome moves toward greater cross-sector transparency on the quality of care for UK consumers too.

4 PRIVATE HEALTHCARE

Summary

- There is vigorous competition between private healthcare providers at a number of different levels. HCA emphasizes the importance of innovation as a key parameter for competition in the private healthcare market.
- The CC cannot credibly evaluate PMI bargaining power and its effects on hospitals and consultants without taking account of competition in the PMI market and the powerful constraints imposed by the NHS.
- There has been significant new entry and expansion in private healthcare in the last few years which does not bear out the claims about market foreclosure.

4.1 This section sets out a broad, high level description of the provision of private acute healthcare, the way in which the market functions, its competitiveness and current market trends. This sets the scene for HCA's comments on the CC's proposed theories of harm.

Scope of reference

4.2 The CC's market investigation relates to the supply or acquisition of privately-funded healthcare services in the UK. There are a number of preliminary points to note about the scope of the investigation:

- (i) The term "privately-funded healthcare services" is broad and covers a range of services at varying levels of the chain of delivery. The OFT's report, and the CC's Issue Statement, focuses on acute secondary private healthcare, i.e. medical/surgical and diagnostic procedures provided in clinics and hospitals, rather than primary healthcare by GPs and private organisations delivered directly to the consumer.⁷ In line with the CC's scope, this submission similarly focuses on the provision of secondary healthcare.
- (ii) The reference relates to the "supply or acquisition" of privately-funded healthcare services. Since PMI providers are the predominant purchasers of private healthcare, the Issues Statement rightly notes that the investigation will need to consider the conduct of PMI companies. The CC suggests "*we do not anticipate investigating how competition functions in the private medical insurance market(s)*", but the CC cannot credibly evaluate PMI bargaining power and its effects on hospitals and consultants without a proper and in-depth understanding of competition in the PMI market. This requires consideration of issues such as the oligopolistic structure of the market, market power held by the major PMI providers, high barriers to entry, the lack of innovation, the inability of subscribers to switch policies, and the lack of transparency of PMI policies at the point of sale. This is discussed further in section 6 below.

⁷ It should be noted that acute secondary care is only one part of the treatment that an individual consumer may seek and/or receive during the course of investigation, treatment, support and aftercare. The biggest areas of physical ill health in the UK (and consequently healthcare interventions) are cancer and cardiac conditions and these conditions are rarely investigated and treated by acute secondary care alone. In addition, the terms of reference focus on acute (short-term) healthcare rather than on the treatment of long-term chronic conditions.

- (iii) The Issues Statement states that NHS-funded healthcare services fall outside the terms of reference. However, it is important for the CC to recognise that the NHS acts as a powerful constraint on private healthcare and can have a strong influence on competition in the private healthcare sector. This constraint affects both the demand for privately-funded healthcare services (by offering a free alternative) and the supply of such services (through its important relationship with almost all consultants in the UK). Moreover, NHS hospitals have embarked on offering "self-funding services" whereby patients pay cash for treatments, thereby making the NHS a direct competitor to independent hospital operators.⁸ The CC has previously acknowledged that the NHS provides an "element of price constraint".⁹ The CC again recognises this issue in its comments on market definition in the Issues Statement. This issue is discussed further in section 7 below.

NHS/private

- 4.3 The NHS is the predominant provider of healthcare services,¹⁰ which are free at the point of use, and forms an important backdrop to an understanding of the private sector and the interplay and crossovers between the NHS and private healthcare. These interplays are discussed further in section 7 below.

...NHS public healthcare provision acts as a powerful constraint on private healthcare

- 4.4 The NHS is facing rising long-term healthcare demand as people live longer. Consumer awareness and expectations of the NHS have also heightened.¹¹ In addition, other developments have increased the cost of supply, for example, costlier drugs and medical treatments, the need to upgrade technologies and clinical infrastructure, as well as staffing costs.¹² This rising cost curve and the consequent risk of a funding gap was highlighted as a key challenge facing the NHS, which would need to be addressed by improvements in

⁸ See, in that regard, the front page of the Sunday Times, July 8 2012, *Hospitals charge for NHS treatment*.

⁹ British United Provident Association Limited and Community Hospitals Group plc ("BUPA/CHG"), Competition Commission (2000), para 2.67.

¹⁰ The UK private acute healthcare sector has a total annual value of approximately £7.2 billion, which represents around 15% of total public/private elective surgery.

¹¹ Consumer awareness of the healthcare sector and the concept of exercising choice are growing. Influencing factors have been the government's initiatives to promote consumer choice within NHS-funded services (including the right to choose services being delivered by the private sector) and ability to access information through the internet.

¹² A study undertaken on behalf of the Nuffield Trust by the Institute for Fiscal Studies (Institute for Fiscal Studies, 2012, *NHS and social care funding: the outlook to 2021/22*) sought to quantify the financial challenge facing the NHS and social care system over the next 10 years. The study explained that "public spending on the UK NHS has increased faster than economy-wide inflation since the 1950s, with an average real growth rate of 4.0 per cent a year between 1949/50 and 2010/2011". The study further noted that "the fact that over the longer-term NHS spending has increased as a share of national income can be explained by a number of reasons: demographic changes have increased the proportion of elderly people in the population; there is a general propensity for society to spend a higher share of their income on health care as their income rises; and over time there has been a general increase in the range of health problems that can be managed by the health care system".

productivity, technology and management (the "Nicholson Challenge").¹³ A BUPA commissioned report suggested that the NHS's need for healthcare funding in the future is likely to rise at a rate greater than 4.5% per annum in real terms,¹⁴ and that failure to plug this gap could be detrimental to the quality of NHS care. The report noted: "*in the future the NHS may not be able to pay for every possible medical treatment in a country with an ageing population, demographic pressures, rising public expectations and increased possibilities of medical treatment for long-term therapies*".¹⁵

- 4.5 The private healthcare sector has faced similar market trends, that is, changes in patient demographics and expectations as well as rising costs of medical treatments, technology and labour. To that end, the present cost of private healthcare provision reflects the giant steps that have been taken by hospital operators over the years both in terms of the way patients are treated (e.g. technological improvements that enhance the accuracy of treatment) and the scope of care that private hospital operators are now able to deliver (e.g. expanding care into high-acuity tertiary cases, which requires a high standard of clinical infrastructure and staffing). These forces mean there is also an impetus on hospital operators to maximise efficiency and continuously innovate in order to remain competitive and ensure they have adequate funding to continue to invest.

...impetus on hospital operators to maximise efficiency and continuously innovate...

Clinical treatment pathways

- 4.6 It is important to commence with an understanding of the relationships between the various parties involved in the clinical treatment pathway which leads to the treatment of patients in acute healthcare facilities: patients; GPs; consultants; healthcare facilities; and PMI providers.
- 4.7 The conventional referral pathway which leads to inpatient and outpatient treatment in healthcare facilities involves the following players:

Patients

The vast majority of UK private patients are covered by PMI policies and their entitlement to private healthcare depends on the terms of their PMI policy. Across the UK market, the proportion of self-pay patients is relatively small (15%), and their numbers have been declining.¹⁶ HCA has a significant contingent of international patients accounting for approximately [REDACTED] of its total revenue.

GPs

GPs are traditionally the "gatekeepers" to secondary, acute healthcare (whether private or publicly funded). Most UK patients will initially consult a GP (NHS or private) who will refer

¹³ Referring to the challenge put forward by Sir David Nicholson to the entirety of the NHS to find efficiency savings to counteract economic forces that are projected to significantly increase the cost of care. The NHS is also undergoing significant internal reforms aimed at increasing competition and choice for patients.

¹⁴ *Mind the gap: sustaining improvements in the NHS beyond 2008*, a report for BUPA by Edward Bramley-Harker and Tim Booer (NERA Economic Consulting) et al.

¹⁵ *Ibid*, pg 23.

¹⁶ Laing's Healthcare Market Review (2011-12), figure 2.4, pg 43.

them to a recommended consultant with an appropriate clinical specialism. The vast majority of GPs are NHS, but there is a small pool of private GPs. Patients will typically rely on the GP's recommendation based on the GP's professional expertise and assessment of their clinical needs. In view of recent PMI practices (discussed below), GPs are finding it increasingly easier to refer patients to the NHS compared to private providers.

Consultants

Consultants are specialist senior doctors that provide secondary or tertiary care to patients. GPs conventionally refer their patients to a named consultant for secondary care, and in some cases the consultant may then refer patients to other more specialist consultants (e.g. for tertiary care). Virtually all consultants in private practice have an NHS post and treat private patients in their "non-contracted" time (i.e. outside of the minimum time they are required to work under their NHS contract) at one or more private hospitals.

Hospitals

Consultants have practising privileges – i.e. contractual "admitting rights" – at one or more private hospitals to carry out inpatient or outpatient treatments. Since most GP referrals are to named consultants (who may in turn refer the patient for more specialised treatment to another named consultant), it is generally the consultant who brings his or her patients to a given hospital and who therefore acts as the conduit for the referral of both insured and self-pay patients to a hospital. A hospital may, however, also attract some patients directly.

PMI providers

PMI providers, through the insurance policy, dictate the terms on which subscribers may access private healthcare. They also typically require pre-authorisation of the consultant and hospital prior to treatment. The PMI companies enter into contracts with hospitals, setting out the prices and terms on which subscribers may be treated. As discussed below, the major PMI companies are increasingly asserting their control at every stage of the treatment pathway, and BUPA's Open Referral policy has gone one step further in that the insurer, rather than the GP, chooses the patient's consultant and hospital, thus subverting conventional referral patterns based on the patient's clinical needs.

... PMI companies are increasingly asserting their control at every stage of the treatment pathway...

Hospital procedures

4.8 Secondary acute healthcare in hospitals or clinics involves:

- inpatient treatment, which requires at least one overnight stay;
- day case admission, where a procedure or operation can be performed without the need for an overnight stay; and
- outpatient treatment, which are minor procedures (e.g. under local anaesthetic) which do not generally require post-operative recovery time in hospital.

- 4.9 Improvements and advances in drugs and treatment technologies are impacting on the way in which patients are treated. Procedures which previously required inpatient treatment in hospital can now be performed as day cases or outpatient treatments. This is increasingly moving patients into ambulatory care settings and is driving growth in outpatient facilities. HCA has encouraged this trend by investing in new outpatient clinics which enable a more cost-effective means of delivering care whilst also improving convenience for local patients.

Sources of revenue

- 4.10 Hospital operators derive their business from:

- PMI providers
- self-pay patients
- overseas patients
- the NHS.

PMI

- 4.11 PMI providers are the most important purchasers of private healthcare and the main funding source for private acute hospitals. Private medical cover represents on average 59% of total hospital revenue and therefore the PMI providers account for a substantial share of hospital revenue streams. HCA derives around █████ of its revenues from PMI providers and is therefore highly dependant on this customer segment. The strong bargaining position of the major insurers is discussed below (see sections 6 and 10). 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 on PMI-funded cases in hospitals.

HCA derives around █████ of its revenues from PMI providers...

Self-pay

- 4.12 UK self-pay patients, who fund their treatment themselves, accounted for nearly 14% of private medical hospital income¹⁷. This has been on a downward trend over the last few years due to the impact of both (i) the economic downturn that has affected self-pay spending, and (ii) higher NHS spending and improvements in waiting times in recent years which have made NHS treatment more attractive and which tend to disincentivise patients from opting for private treatment. HCA derives approximately █████ of its revenues from UK self-pay patients.

Overseas

- 4.13 A significant number of overseas patients come to London for treatment. These are self-payers or funded by a third party such as embassies. Overseas patients account for approximately █████ of HCA's revenues and represent a key driver of HCA's business. HCA hospitals attract patients from countries such as the Kuwait, Saudi Arabia, United Arab Emirates, Qatar, Cyprus, Pakistan and Russia, and are in competition with leading hospitals in many other parts of the world including the US, Germany, Singapore and Thailand.

¹⁷ Laing's Healthcare Market Review (2011-12), pg. 49.

NHS

- 4.14 The NHS represents a major income source for other leading hospital groups: BMI, Ramsay, Spire and Nuffield. The NHS has contracted with private hospitals for the treatment of NHS patients at designated Independent Sector Treatment Centres operated by private providers or under the "Choose and Book" system which allows NHS patients to choose a private provider instead of an NHS hospital. NHS spending on private healthcare has doubled over the last five years. On the whole, HCA does not have a significant level of NHS activity and derived only [REDACTED] of its revenue from this source.
- 4.15 Notwithstanding the above, two of HCA's cancer surgery centres have a higher proportion of NHS work:
- At the CyberKnife Centre (based in the Harley Street Clinic), NHS patients account for around [REDACTED] of patients.
 - At the London Gamma Knife Centre (operated by the Harley Street Clinic and based at St. Bartholomew's Hospital), NHS patients account for around [REDACTED] of patients. In this case, treatment charges are set at the standard NHS tariff rate.

Competition between private healthcare providers

- 4.16 There is vigorous competition between private healthcare providers at a number of different levels.

PMI contracts and recognition

- 4.17 Hospitals compete fiercely for contracts with PMI providers. Since patients with PMI policies typically account for 59% of hospital revenues, it is essential for hospitals to secure recognition from major PMI providers and secure terms which allow subscribers to undergo treatment at the hospital. Hospitals are largely fixed cost businesses, and failing to be recognised by a PMI provider can be detrimental to the financial viability of a hospital. PMI recognition is a key barrier to entry and expansion for hospital operators and also affects a hospital's ability to attract consultants (in particular, recognition by BUPA is essential). In HCA's experience, PMI providers will not automatically grant recognition, and are often resistant to recognising new facilities where they perceive that there is already sufficient capacity in a given area. There is therefore competition between hospital operators to obtain terms of recognition with PMI providers.

There is vigorous competition between private healthcare providers...

PMI networks

- 4.18 Even if a hospital operator obtains PMI recognition, it may need to compete to secure a position on a PMI network. The concepts of recognition and networks should not be confused, since PMI recognition does not necessarily mean that a hospital is admitted onto the insurance company's network product. Both BUPA and AXA PPP have pursued a network strategy involving the creation of exclusive provider networks, whereby subscribers covered by lower cost policies will be directed to low-cost network providers only. There is therefore further competition by providers to secure admission onto PMI networks as admission is necessary to generate the patient volumes required for a facility's economic viability.

Consultants

4.19 Hospital operators also compete vigorously to attract and retain consultants. The OFT report noted (paragraph 3.17) that 85% of GP referrals of PMI funded patients are to named consultants, and not facilities, and therefore it is primarily the consultant who decides where a patient's treatment takes place. Hospitals therefore compete for the best consultants to take up practising privileges at their facilities and bring their patients for inpatient and outpatient treatment. This creates a further framework for competition between hospital operators. Key factors which attract consultants to a hospital include:

- quality and location of the hospital and its facilities;
- investment which a hospital is prepared to make in the latest generation technology;
- opportunity to work with other leading specialists in the field; and
- quality and experience of its clinical and support staff.

4.20 Indeed, there is fierce competition for consultants in London in particular. The major NHS teaching hospitals (Guy's and St. Thomas', St. Bartholomew's, King's College, UCH, the Royal Marsden etc.) boast leading practitioners in virtually every clinical field. Many of these have significant private practices and HCA invests heavily to provide the right high-quality clinical environment which motivates leading consultants to bring their private patients to its hospitals. It is easy for consultants to switch between private hospitals – there are no significant switching costs and moreover many consultants have practising privileges at two or more private hospitals – therefore hospital operators have to remain competitive in order to retain their top clinicians. This provides a further powerful incentive for hospital operators to continue to invest in their facilities and services, which benefits both patients and consultants.

It is easy for consultants to switch between private hospitals – there are no significant switching costs and moreover many consultants have practising privileges at two or more private hospitals

Patients

4.21 Hospitals also compete for insured and self-pay patients:

- (i) The majority of private patients are referred by GPs to a recommended, named consultant. However, the recommended consultant may practice at two or more different hospitals and the patient may have a choice of where to be treated.
- (ii) Alternatively, the GP may recommend a choice of different consultants in different hospitals at the patient's convenience.
- (iii) There may also be self-pay patients who contact hospitals directly and conduct their own research on potential treatment options.
- (iv) A significant number of overseas patients come to London for private treatment.

Under each patient pathway, there is vigorous competition between London providers for patients.

NHS

4.22 Hospital operators also compete for NHS contracts. These may include the management or operation of NHS Independent Sector Treatment Centres or NHS patient referrals under the

"Any Qualified Provider" scheme (formerly, "Any Willing Provider"). In recent years, NHS patient referrals have become a significant source of revenue for BMI, Ramsay and Spire. HCA does not carry out a significant level of NHS patient work.

4.23 Competition between hospital operators is over:

- quality of clinical treatment
- innovation/availability of leading-edge treatment options
- price
- customer care
- timeliness of access to care
- reputation of consultants
- comprehensiveness of services – both in terms of covering the pathway from diagnostics, treatment, care and follow-up and in terms of choice of treatment
- ease of access (location and transport links).

...the competitive market has delivered significant improvements in clinical services...

4.24 Competition incentivises providers to offer the highest quality product at the best possible value. In London, the competitive market has delivered significant improvement in clinical services through investment in new products, services, technologies and facilities (e.g. by creating "centres of excellence").

Innovation

4.25 Healthcare is constantly evolving with, among other things, demographic changes, patient morbidity and consumer expectations. The pace of change has accelerated in recent years because of the opportunities for innovation enabled by the technology revolution in almost every field of healthcare.

The incentives for hospital operators to invest in new technology are therefore of critical importance

4.26 HCA emphasizes the importance of innovation in any discussion of the features of the private healthcare market. Innovation is mentioned only fleetingly in the CC's Issues Statement and requires careful consideration in this market investigation. Investment by hospital operators in new services and technology is vital in order to ensure that the fruits of R&D into new drugs, equipment and treatment pathways are channelled into enhanced clinical outcomes for patients. The incentives for hospital operators to invest in new technology are therefore of critical importance.

4.27 The importance of R&D and innovation has been acknowledged in a number of CC precedents (see "Importance of R&D" below).

"... High R&D spending to sales ratio provide a clear indication that competition takes places through innovation."

Importance of R&D

- In a 2004 merger decision in the microscopy industry,¹⁸ the CC explained that “*firms have a strong incentive to invest in R&D, as the resulting product innovations can confer a significant advantage in the marketplace. In essence this process of competing through innovations is an important constraint on profits and maintains value for money to the customer.*”¹⁹
- The CC further noted that “*firms spend a high proportion of their income on R&D compared with the average, essentially competing using their R&D programmes to win market power on specific innovations. There is some price competition in these markets, for example through negotiations on specifications. Competition to introduce product innovations supplements this price competition in driving overall profit margins down.*”²⁰
- In a 2007 merger decision in the Mass spectrometry²¹ industry²² the CC acknowledged the importance of R&D in product development. The CC explained that “*product development appears to be an important driver of competition in this market. The importance of product development in providing a competitive advantage implies that suppliers need to invest in product and process R&D.*”²³ The CC set out in its decision the R&D-to-sales ratio for the merging parties.
- In a 2009 merger decision in the software industry,²⁴ the CC provided more detail as to what types of product development they would consider to be relevant to innovation. The CC again noted “*the importance of product development in providing a competitive advantage implies that suppliers need to invest in product and process innovation.*”²⁵ The CC further explained that: “*Innovation can occur on both core and non-core modules, and may entail a product development such as an upgrade or the introduction of a new product.*”²⁶
- In June 2012, the CC released for consultation a draft version of new Market Investigation Guidelines (“Consultation Guidelines”). In these guidelines,²⁷ the CC clarified that “*In assessing market power in high-technology industries, the CC will pay particular attention to the number of products and/or technologies that are being developed...High R&D spending to sales ratios provide a clear indication that competition takes place through innovation. Where R&D investment is high, market power may be vulnerable to future innovations by rivals or new entrants.*”²⁸

¹⁸ Competition Commission, *Carl Zeiss Jena GmbH and Bio-Rad Laboratories Inc: a report on the proposed acquisition of the microscope business of Bio-Rad Laboratories Inc*, May 2004.

¹⁹ *Ibid.*, para 4.4.

²⁰ *Ibid.*, para 5.57.

²¹ Mass spectrometry is an analytical technique used to measure the masses of individual molecules that have been converted into ions. It is a versatile technique which has uses in many areas of science and technology, such as life sciences, pharmaceuticals, environmental control, the nuclear industry, the oil industry, medicine, forensic science, earth sciences and planetary exploration.

²² Competition Commission, *Thermo Electron Manufacturing Limited and GV Instruments Limited merger inquiry*. A report on the completed acquisition of GV Instruments Limited by Thermo Electron Manufacturing Limited, May 2007.

²³ *Ibid.*, Main Report, para 5.26.

²⁴ Competition Commission, *Capita and IBS: a report on the completed acquisition by Capita Group plc of IBS OPEN Systems plc*, June 2009.

²⁵ ¹ *Ibid.*, Main Report, para 6.34.

²⁶ *Ibid.*, Main Report, para 6.35.

²⁷ Competition Commission, *Guidelines for Market Investigations – Draft for Public Consultation*, June 2012

²⁸ *ibid*, para 189.

4.28 The NHS has recently published a report entitled “Innovation, health and wealth” to explain why innovation is crucial in healthcare.²⁹ According to this report, innovation “*is about making a real and tangible difference to the lives of millions. Keyhole surgery has allowed faster recovery time, and made surgery possible for patients less fit for more invasive treatment. New medicines, medical technologies and informatics have transformed patient outcomes. Across the NHS, countless patients bear witness to the power of great ideas*”.³⁰ Across the report, the NHS highlighted a series of examples of innovation in public healthcare, and the benefits that flowed to patients.³¹

4.29 In the report, the NHS also explains the importance of innovation by explaining that “*given the demand and funding pressures the NHS now faces, it is widely accepted that more of the same will not do. More radical changes in the way services are delivered and how people work will be required. We need to plot a sustainable course of the future of the NHS. Innovation can help provide the route-map, improving quality at the same time as driving productivity and potential efficiency in a difficult financial environment*”.³²

4.30 In the private healthcare sector, hospital operators compete through the development and adoption of state-of-the-art equipment and facilities across several specialties. For example, increasingly sophisticated forms of radiotherapy (cancer radiation treatment), chemotherapy (cancer drugs) and surgery (e.g. cardiac surgery and interventional radiology), are enabling increased tailoring of treatment to each patient’s specific needs and with fewer side effects. Such advances benefit consumers and may lead to a widespread change in the market landscape, e.g. the adoption of minimally invasive surgical techniques or molecular profiling (so called “personalised medicine”). This capability is expected to be enhanced by the development of genetic profiling which would allow doctors to determine the likely efficacy of different treatment options for specific patients.

[REDACTED]

“... hospital operators compete through the development and adoption of state-of-the-art equipment and facilities...”

4.31 A competitive process driven by innovation naturally leads to a market dynamic in which new technologies are introduced by first-movers before becoming widely adopted. See “Competing to innovate” below.

4.32 In addition to new treatment technologies, HCA’s hospitals support consultant-led innovation in the form of new clinical practices and treatment techniques. For example, the London Neurosurgery Partnership (a team of eight consultant neurosurgeons practising at the Harley Street Clinic) introduced a new spinal surgery technique called Endoscopic Microdiscectomy in the UK. This procedure can be performed on patients who would otherwise have to endure open surgery, but are now able to have the whole procedure performed through a cut no

²⁹ Department of Health, *NHS Improvement & Efficiency Directorate, Innovation and Service Improvement, (2011), Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS.*

³⁰ *Ibid.*, pg 9.

³¹ For example, the reverse innovation applied to heart surgery, the redesign hip replacement, the finger-prick blood test device, home haemodialysis, development of cytosponge and e-consultation.

³² Department of Health, *NHS Improvement & Efficiency Directorate, Innovation and Service Improvement, (2011), Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS, pg 9.*

bigger than a needle puncture using an endoscope. HCA's network of hospitals and depth of clinical infrastructure fosters these sorts of consultant collaborations and group innovation.

Competing to innovate

- In 2009, Harley Street Clinic introduced the UK's first revolutionary CyberKnife robotic radiotherapy machine, a system designed to treat tumours anywhere in the body. Following the launch of HCA's CyberKnife Centre in early 2009, the London Clinic opened its own CyberKnife treatment clinic later in 2009. Following this, three further CyberKnife facilities were built at Mount Vernon, St. Bartholomew's Hospital and the Royal Marsden.
- In 2004, the Princess Grace was the first independent hospital to invest in the da Vinci robot surgery system. There are now 20 da Vinci surgery systems within 100 miles of London, of which three are based in independent hospitals (the Princess Grace, the Wellington and the London Clinic). The Royal Marsden became the first NHS hospital to adopt this technology in 2009.
- In 1998, the Cromwell Hospital opened the first Gamma Knife Centre in London. A further Gamma Knife centre was developed in 1999, which was later acquired by HCA and run by the Harley Street Clinic, before being moved to a new purpose-built site at St. Bartholomew's Hospital in 2009. Three further Gamma Knife treatment centres have opened in the UK: the Leeds Gamma Knife Centre at St. James's Hospital, the National Centre for Stereotactic Radiosurgery at the Royal Hallamshire Hospital, and the Thornbury Gamma Knife Centre at the BMI Thornbury Hospital.

4.33 Paragraph 3.14 referred to HCA's high level of capital investment and R&D spending, amounting to about [redacted] of its turnover on average for the years 2008 - 2011. In Annex 2 we compare this percentage to UK data from 41 sectors³³ taken from BIS's latest R&D Scoreboard.³⁴ We present total figures for R&D investment and capital expenditure for 2009 (the latest year for which data is available).³⁵

4.34 As shown in Annex 2, HCA ranks 14th, with levels of investment (as a proportion of sales, which is the methodology previously adopted by the CC)³⁶ higher than industries such as technology hardware and equipment, and aerospace and defence for example.

4.35 A significant proportion of the investment made by HCA is in employing experienced specialist medical teams to support its consultants.³⁷ These multi-disciplinary teams are necessary for the highly specialised tertiary care treatments delivered by HCA. This investment in specialist staff will not be reflected within typical R&D-to-sales ratios. For this reason, HCA's figure should be considered a conservative lower bound to its actual levels of investment, relative to other industries.

³³ Four out of these 41 sectors do not have sales figures available.

³⁴ Department for Business, Innovation and Skills, The 2010 R&D Scorecard.

³⁵ As Table 1 includes all types of capital expenditures, the ranking is led by industries relying heavily on infrastructure (e.g. mining), but not necessarily leaders in terms of R&D investment.

³⁶ Competition Commission, *Carl Zeiss Jena GmbH and Bio-Rad Laboratories Inc: a report on the proposed acquisition of the microscope business of Bio-Rad Laboratories Inc*, May 2004.

³⁷ See paragraph 6.74 for more details regarding the clinical staff employed by HCA

New entry and expansion

4.36 The CC proposes in its Issues Statement to investigate theories of harm relating to barriers to entry into the private healthcare market. The central theme in the OFT's report is that practices in the private healthcare market are creating barriers to entry and foreclosing new entrants.

4.37 However, there has in fact been significant new entry and expansion in private healthcare in the last few years which does not bear out the picture of market foreclosure. In section 5, a number of specific examples of new entry and expansion in London are identified. Outside of London, examples of entry and expansion include the following:

...there has in fact been significant new entry and expansion in private healthcare...

- (i) There have been four new-build, full-service hospitals in the past three years and two more are scheduled to open this year:
 - Edinburgh Clinic (2009)
 - Spire's Shawfair Park Hospital in Edinburgh (2010)
 - Vale Hospital in South Wales (2010)
 - Circle's hospital in Bath (2010)
 - Spire's The Montefiore Hospital in Brighton and Hove (opening later this year)
 - Circle's hospital in Reading (opening in August this year).

- (ii) There has been a steady stream of new small-scale specialist clinics entering the market, for example:
 - Eye surgery facilities such as the Prospect Eye Clinic which opened in Altrincham, Cheshire
 - New foot surgery clinics including a podiatric surgical unit in Dorking set up by the advanced footcare group
 - A private clinic in Manchester specialising in ear nose and throat conditions
 - CancerPartners UK has developed four radiotherapy centres in Portsmouth, Southampton, Hertfordshire and Birmingham.
 - Equipment supplier, Healthcare Technologies International ("HTI"), established Nova Healthcare as a private patient healthcare arm which provides a broad range of services for the diagnosis and treatment of cancer (including Gamma Knife) at a specialist cancer unit based in the St. James's Institute of Oncology in Leeds. Nova Healthcare has leveraged HTI's technological expertise as a basis for extending its services to other diagnostic and treatment modalities to forge a highly competitive offering.
 - Nuclear healthcare has opened a private gastroenterology day hospital in South Wales.
 - Circle clinic in Stratford-upon-Avon for minor surgery.
 - Circle clinic in Windsor, which was acquired as a specialist hand clinic, but expanded to include other services, such as skin and eye treatments.

- (iii) In addition, there are several new outpatient, diagnostic and day case centres, many of which have been set up by clinician-led partnerships. A typical example is the Clockhouse Medical Practice which opened in Epsom in 2007, a partnership of 14 local consultants offering day case and outpatient services. As stated above, changes in medical technology are driving growth in outpatient facilities, which can be set up at relatively low cost by groups of clinicians.

5 THE PROVISION OF PRIVATE HEALTHCARE IN LONDON

Summary

- London is one of the most competitive parts of the UK. There is a broad range of independent hospitals and PPUs and competition is vigorous and growing, with new entry and expansion into the capital.
- HCA's competitors in London include the UK's leading NHS PPUs based in major NHS teaching and research hospitals.
- Some of HCA's key competitors in London benefit from competitive advantages which are not available to HCA hospitals.
- London is a "cradle for healthcare innovation" and private healthcare providers in London play an important part in the development of innovative clinical practices.

5.1 In London, the provision of private acute healthcare is shaped by a number of factors:

- (i) Many of the major NHS teaching and research hospitals (e.g. Royal Marsden, UCH, King's College, Royal Free, St. Bartholomew's, Guy's & St. Thomas', and St. Mary's) are based in London and have contributed to London's position as a global medical centre of excellence with well-established tertiary care services.
- (ii) Many of these NHS Trusts have long-established PPUs attached to their NHS hospitals. The UK's eight largest NHS PPUs by revenue are in London and benefit from the prestigious reputations of the teaching hospitals to which they are attached. These compete directly with independent providers such as HCA.

The UK's eight largest NHS PPUs by revenue are in London
- (iii) There is a large pool (approximately 7,500) of NHS consultants in London including many eminent specialists at the top of their clinical field. Many NHS consultants also have private practices, either within the Trust's PPU and/or in one or more independent private hospitals. There is vigorous competition between providers to attract and retain these consultants.
- (iv) London's reputation as a major global centre of tertiary healthcare attracts a significant number of overseas private patients to the capital, particularly from the Middle East, Far East and the emerging economies.
- (v) Similarly, London hospitals offering specialist tertiary-based services attract UK patients from a broad catchment area. The travel time for a majority (■) of HCA's UK patients would be within ■ minutes by road or ■ minutes by public transport to visit an HCA hospital.³⁸

...The travel time for HCA's UK patients would be within ■ minutes by road or ■ minutes by public transport to visit an HCA hospital

³⁸ This is based on an analysis by KPMG of three million patient trips to HCA facilities covering the period 2001 - March 2012.

(vi) PMI penetration is higher in London and the South-East than in other parts of the UK, giving rise to a larger PMI covered population. In addition, with the larger presence of major corporates in the region, PMI corporate policies account for a higher share of PMI sales. BUPA's market share of corporate PMI policies is believed to be higher than its share of total PMI sales which compounds BUPA's market power in this region.

5.2 London has developed into a world-leading centre for tertiary care, based on the presence of its major NHS teaching and research hospitals and its large patient population. HCA and its major competitors have invested heavily in private tertiary-based services to contribute to London's established reputation as a centre of excellence. These services require a higher level of experience, expertise, infrastructure and resource to ensure delivery of high quality care in a more specialised environment which can deal with high-acuity conditions.

5.3 HCA's London hospitals compete vigorously at an international level (approximately [REDACTED] of HCA's revenues are from international patients) against a number of strong, well-financed independent competitors to attract this highly mobile and quality-sensitive patient group to London. By way of example, in the field of paediatric cardiology, the Harley Street Clinic competes with facilities in the US (such as the Mayo Clinic and the Cleveland Clinic) Germany, France and Singapore. It is often international competition that drives forward innovation and medical technology in the UK. HCA's hospitals have significantly contributed to London's profile as a centre of medical excellence. HCA won the Queen's Award for Enterprise (International Trade) in 2009 and 2003 in recognition of its ability to generate valuable trade for the UK.

HCA competes within a broad catchment area that extends across Greater London, into the Home Counties and even beyond the UK...

Competition in London

5.4 HCA competes across a broad catchment area that extends across Greater London, into the Home Counties and even beyond the UK.

5.5 London is one of the most competitive parts of the UK. There is a broad range of independent hospitals and PPUs that are densely packed within the city (with over 50 competing independent hospitals and PPUs across Greater London), and competition is vigorous and growing, with continuous entry and expansion. To that end, competition in London comes from for-profit and not-for-profit organisations, multi-specialty hospitals and single specialty hospitals, groups of consultants working together to deliver specific services from small scale facilities, from PPUs and from the NHS itself.³⁹

5.6 Moreover, it is possible to travel between almost any two locations within London within one hour. The availability of good transport links makes it easy for patients and consultants to travel to hospital operators in different locations.

³⁹ The NHS is free at the point of delivery. During periods of economic downturn and when waiting times are as low as they are now, patients who have PMI often choose to use the NHS. The NHS has seen an unprecedented level of investment over the last 10 years with many new hospital developments and an emphasis on reducing waiting times.

Independent providers

5.7 In London alone, there are numerous independent (i.e. private sector) competitors offering a broad range of clinical services:

- Cromwell Hospital (BUPA)
- Fitzroy Square Hospital (BMI)
- Highgate (Aspen)
- London Clinic
- London Independent (BMI)
- King Edward VII hospital
- Parkside (Aspen)
- Hospital of St. John and St. Elizabeth
- Weymouth Hospital (BMI)

5.8 In outer London there are numerous private hospitals operated by six different organisations. The independent hospitals in Greater London that compete with HCA hospitals include:

- Aspen's Holly House Hospital (Buckhurst Hill)
- BMI Bishops Wood (Northwood)
- BMI Blackheath
- BMI Chelsfield Park Hospital (Orpington)
- BMI Clementine Churchill (Harrow)
- BMI Shirley Oaks (Croydon)
- BMI Cavell (Enfield)
- BMI King's Oak (Enfield)
- BMI Sloane (Beckenham)
- BMI Garden (Hendon)
- New Victoria Hospital (Kingston)
- Ramsey's North Downs Hospital (Caterham)
- Spire Roding (Redbridge)
- Spire Bushey (Watford)
- St. Anthony's Hospital (Cheam)

5.9 In the south east (outside Greater London) there are a further 44 independent hospitals operated by seven different organisations. These providers primarily compete for local consumers who may choose a London provider as an alternative.

PPUs

5.10 HCA's competitors include many leading NHS PPUs. There are 16 PPUs in London and 20 PPUs across the Greater London region (accounting for around one-fifth of the total bed capacity). The OFT's report rightly acknowledges that the major PPUs "*that have strong reputations and ... support from the local consultants provide a competitive constraint on other PH providers.*" The eight largest PPUs by revenue are in London and include renowned institutions with global reputations such as the Royal Marsden, St. Mary's, Royal Brompton &

Harefield, Royal Free and King's College. London PPUs have large dedicated facilities, for example:

- Royal Marsden (69 beds)
- Royal Brompton & Harefield (43 beds)
- Guy's & St. Thomas' (48 beds)
- Great Ormond Street (34 beds)
- Royal Free (52 beds)
- St. Mary's (43 beds).

5.11 In the south east of England (outside Greater London) there are 12 PPUs operated by ten different NHS Trusts/Foundation Trusts. There is a bias toward supply of NHS private patient services in London and the South East, with more than two-thirds (69%) of PPU bed capacity located in London and the Home Counties.⁴⁰

5.12 The competitive constraints from PPUs are discussed further in section 7 below.

Some of HCA's key competitors in London benefit from competitive advantages which are not available to HCA hospitals.

Competitive advantages

5.13 Some of HCA's key competitors in London benefit from competitive advantages which are not available to HCA hospitals.

Advantages of Competitors

- A number, such as the London Clinic, St. John and St. Elizabeth, and King Edward VII are charitable hospitals and their charitable status provides them with significant tax benefits. These include the fact that they do not have to pay corporation tax, are not required to earn a return or pay dividends and have lower costs of capital.
- One of HCA's main competitors, the Cromwell hospital, is wholly-owned by BUPA. Vertical integration provides it with major advantages since BUPA is able to direct its policyholders to the Cromwell at the expense of other hospitals. BUPA's vertical integration is discussed in section 17 below.
- PPUs have a number of competitive advantages over independent providers, including the co-location of NHS infrastructure, the ability to use staff and equipment at marginal or zero cost, as well as significant financing and tax advantages. A Department of Health commissioned study⁴¹ quantified the distortive impact of these advantages: *"The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider. The pensions and cost of capital distortions are the most significant."* These competitive advantages and the resulting distortions are discussed in more detail in section 7 below.

Ambulatory and day case centres

5.14 In addition to inpatient units there are numerous ambulatory care and day case services being offered in stand-alone small scale facilities or within independent hospitals by private

⁴⁰ Laing's Healthcare Market Review (2011-12), pg 85.

⁴¹ See Health and Social Care Bill 2011, Impact Assessments, Department of Health (2011), at para B.55, citing the study KPMG Fair Playing Field Report, 2009, economic analysis commissioned by Department of Health.

healthcare organisations and groups of consultants across London. For example, the London Foot and Ankle Centre is a group of consultants who operate at three different private hospitals: the Cromwell Hospital, London Bridge Hospital and the Hospital of St. John and St. Elizabeth.

Innovation

- 5.15 A number of developments in the private healthcare sector, such as increasingly sophisticated forms of radiotherapy, chemotherapy and cardiac surgery are pioneered by consultants practising in London, and both national and international patients look to London in seeking out such leading-edge developments. To that end, London is a “cradle for healthcare innovation” and private healthcare providers play an important part in this by investing in and supporting the technologies which enable the development of new clinical practice. Over time, these developments are rolled out more widely to the benefit of ever greater numbers of patients across the UK.

London is a "cradle for healthcare innovation..."

New entry/expansion

- 5.16 London has seen a significant level of new entry and expansion in recent years, attesting to the dynamic nature of competition in this market and Laing's Healthcare Market Review 2011-2012 (p. 79) notes: *"Much development activity has been concentrated in London where the private healthcare market is particularly robust."*

Full service hospital entry/expansion in London and surrounding counties

- 5.17 Recent examples of new entry and expansion are as follows:
- April 2009: BMI acquired the Fitzroy Square Hospital (formerly St. Luke's Hospital). The hospital opened a new gynaecological unit in 2011 offering a comprehensive range of services for women's health.
 - December 2009: The London Clinic, which has been going through a period of expansion, opened its £80 million London Clinic Cancer Centre, a purpose-built state-of-the-art facility dedicated to cancer care, diagnosis and treatment.
 - August 2010: The BMI Weymouth Hospital opened offering 17 beds and providing a range of inpatient and day case procedures close to Harley Street. The hospital is a joint venture between BMI and the Phoenix Hospital Group.
 - 2008 – 2012: Following BUPA's acquisition of the Cromwell Hospital in 2008, BUPA is investing £30 million on refurbishing the hospital's infrastructure and on new equipment to develop its cancer care, neurosciences, diagnostics, paediatrics, family medicine, endoscopy and orthopaedics services. New equipment includes the Leksell Gammaknife Perfexion and Tomo Therapy High-Art Radiotherapy System.
 - Due to open in 2014: The London International Cancer, Heart and Brain Hospital is a new 150-bed acute private hospital under development in Ravenscourt Park (near Hammersmith) backed by investors C&C Alpha Group. Construction began in 2007 and

...significant level of new entry and expansion...

the hospital is due to open shortly with a total of investment of around £100 million. This hospital will be a significant competitor in specialist tertiary care.

5.18 HCA has itself invested considerably in the refurbishment and re-equipping of its hospitals.

5.19 Major new entrants and developments in the area surrounding London are anticipated to have an impact on the numbers of patients choosing to travel to London for private healthcare.

These include:

- August 2012: A new private hospital in Reading (Circle Reading) with 30 inpatient beds and 20 day case beds.
- Due to open in 2014: The Kent Institute of Medicine and Surgery, a new private hospital being planned in Maidstone, Kent. This is said to be the largest single clinician-led development, comprising a 100-bed full service hospital with a development cost of £80 million. There are around 100 clinicians investing in the project, with funding from Clydesdale Bank. It is believed that Spire will operate certain services within the hospital. The intention is to treat patients who would otherwise be transferred to London hospitals for complex procedures. The Institute has agreements with Guy's & St. Thomas' and King's College in London relating to the provision of NHS patients and surgeons.

NHS PPU entry/expansion

5.20 PPUs in London, which already comprise a significant competitor to private hospitals, represent a "sleeping giant" of potential competition that has yet to be fully realised, and which poses a serious threat to the continued existence of non-NHS private healthcare providers.⁴²

5.21 Several NHS Trusts and Foundation Trusts have recently upgraded their PPUs, for example:

- The Royal Marsden opened a new private care wing in 2011 following a £6 million expansion and refurbishment programme.
- The Chelsea and Westminster NHS Foundation Trust recently refurbished and expanded its birthing centre PPU which completed in 2011.
- St. Mary's Hospital, part of Imperial Healthcare NHS Foundation Trust, recently refurbished and expanded its PPU, the Lindo Wing which provides the highest quality of care for surgical, medical and obstetrics patients.

PPUs in London represent a "sleeping giant" of potential competition...

5.22 Many London NHS Trusts are gearing up to expand private provision over the next few years. Several Trusts have recently announced plans to develop PPUs either on their own or through partnering arrangements with the private sector. Examples include:

- Barts Health NHS Trust advertised in 2011 for a partner to develop and operate a new dedicated PPU on the St. Bartholomew's Hospital site.

⁴² As further set out in section 7 below, PPUs have a number of competitive advantages which enhance their ability to compete with private hospital operators.

- King's College Hospital NHS Trust advertised in 2011 for a partner to build and operate a new 60-bed PPU with dedicated theatres on the King's College Hospital site (21 bed PPU at present).
- St. George's Hospital NHS Trust has announced plans to partner with a private healthcare provider to develop a new dedicated PPU at the hospital site with the construction of a new three storey building
- Guy's & St. Thomas' tendered in April 2011 for a private healthcare firm to fit out and run a PPU at the trust's proposed new cancer treatment centre which is due to open in 2015 (and is negotiating with HCA as preferred bidder).
- The Royal National Orthopaedic Hospital NHS Trust intends to redevelop its hospital site with the development of a new PPU in partnership with a private healthcare provider (23 beds at present).
- West Middlesex Hospital NHS Trust advertised in 2011 for a partner to develop and operate a new PPU.
- West Hertfordshire Hospital NHS Trust is seeking a provider to create a PPU at Watford General Hospital (6-bedded maternity PPU at present).

Outpatient and ambulatory care centre entry/expansion

5.23 In addition, there have been several new outpatient and diagnostic centres across London, providing consumers with greater convenience and choice as well as providing a more cost-effective means of delivering care. Furthermore, barriers to entry in respect of such centres are typically very low. Recent examples of entry include the following:

- The Hospital of St. John and St. Elizabeth has recently invested £11 million in new services including an outpatient facility, a day case centre and a primary care centre.
- BMI has opened a number of diagnostics and outpatient centres including BMI City Medical in the city off Bishopsgate (Jan 2009), Bushey (Dec 2009), 9 Harley Street (Dec 2009), and BMI Syon Clinic which opened in mid-2010 with state-of-the-art diagnostics and a minor injuries treatment service.
- Aspen Healthcare opened "Parkside at Putney" providing outpatient consultations, diagnostics and minor procedures in February 2012.
- HCA has opened a number of outpatient and diagnostic centres, for instance, the £■■■■■■■■■■ Platinum Medical Centre in St. John's Wood (May 2011), the Chelsea Outpatient Centre (April 2010), the New Malden Diagnostic Centre (August 2011) and the Brentwood Medical Centre (2010) and Sevenoaks Medical Centre (2010).

Such consultant groups will pose an increasing competitive constraint on hospital operators...

Consultant groups

5.24 One further development is physician "groups" or chambers which involve consultants grouping together in partnerships or incorporated companies, such as Medical Chambers UK or the Fortius Clinic, to provide outpatient and diagnostic services that compete with similar facilities owned by hospital operators. It has been estimated that the number of consultant groups more than doubled from 2006 - 2009⁴³ and HCA believes that economic pressures on consultants will mean this trend will continue.

⁴³ This number is estimated by Dr. R. J. Stanbridge, an expert and commentator on the private healthcare market.

Such consultant groups will pose an increasing competitive constraint on hospital operators with outpatient and diagnostic facilities and provide PMI providers with a credible outside option.

Conclusion

5.25 There is therefore a demonstrable track record of continuing entry and expansion in the London market. There has been a significant level of capital spending and investment in new, enhanced facilities and this has brought on stream a significant level of new capacity across a broad range of clinical specialisms. Further, there is no evidence of this trend abating, with the prospect of further entry and expansion by both private and NHS competitors. In regards to the latter, the likely removal of the private patient cap currently imposed on NHS Foundation Trust facilities will generate significant opportunities for expansion. As far as London is concerned, the record of new entry and expansion flatly contradicts the concerns in the OFT's report about potential market foreclosure.

6 PMI

Summary

- PMI providers are the predominant acquirer of services offered by hospital operators, therefore the structure of the PMI market and behaviour of PMI providers must be closely examined.
- The PMI market has become increasingly consolidated with the top four major PMI providers strengthening their dominant position in the market.
- The major PMI providers have been able to restrict the scope and quality of private healthcare as well as hinder the rate of entry/expansion.
- A more dynamic PMI market with lower barriers to entry would encourage prospective PMI entrants to challenge incumbent providers and adopt PMI practices that foster greater growth and innovation in the private healthcare sector, thereby improving consumer choice.

- 6.1 The scope of the CC's investigation includes the "acquisition" of privately-funded healthcare services in the UK, and in that respect, the CC has stated that it seeks to "*understand the significance of the roles played by insurers*" in the provision of private healthcare services in its Issues Statement.
- 6.2 The role of PMI acquisition is of particular importance as PMI providers are the predominant acquirer (on behalf of their customers) of private healthcare services.⁴⁴
- 6.3 In order to understand the PMI role in shaping the provision of private healthcare, account must be taken of the structure of the PMI market and PMI practices and policies which directly or indirectly influence the scope, price, and quality of private healthcare, and affect the rate of entry/expansion in the private healthcare market.

Market structure

- 6.4 Market shares provide a useful indication of the market structure and of the relative importance of the various undertakings active on the market.
- 6.5 The PMI market is a highly concentrated oligopoly comprising four major PMI providers, namely (in order of size) BUPA, AXA PPP, Aviva and PruHealth.
- 6.6 These top four PMI providers accounted for 88% of the market (by value) in 2010 (see Figure 1 below).⁴⁵ This figure stood at 82% in 2005.⁴⁶ Therefore, the major PMI providers have consolidated their stronghold in the market over the five year period (as illustrated by Figure 2).
- 6.7 The Herfindahl–Hirschman Index ("HHI"), a common tool for gauging market concentration, calculated for the PMI market was 2,553 in 2010.⁴⁷ Within the South East of England, the HHI

⁴⁴ Laing's Healthcare Market Review (2011-12), Figure 2.4 (pg 43).

⁴⁵ The remaining 12% of the market is held by around 15 PMI providers, Laing's Healthcare Market Review (2011-12).

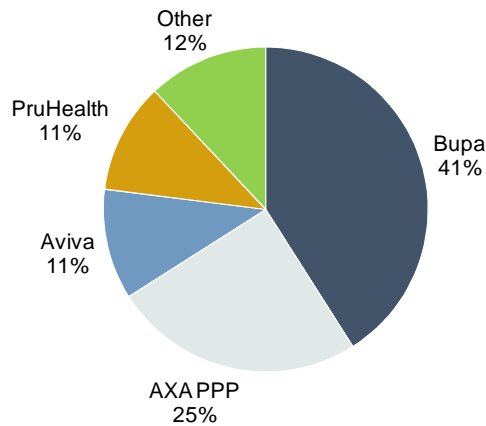
⁴⁶ Laing's Healthcare Market Review (2011- 12).

⁴⁷ Laing's Healthcare Market Review (2011- 12): The HHI calculation is based on market share data in 2010 on the top nine providers (comprising 96.5% of the market) in table 3.14 (pg 206).

is expected to be even higher. The OFT and CC's joint merger assessment guidelines note that a market with a HHI exceeding 2,000 should be considered "highly concentrated".

6.8 As illustrated in Figure 1, the largest PMI provider is BUPA, with a market share of 41% in 2010. BUPA's nearest competitor, AXA-PPP, held a market share of 25%. Therefore, the top two providers accounted for two-thirds of the total PMI market share by value.

Figure 1: PMI % market share by income UK (2010)



Source: Laing's Healthcare Market Review 2011 – 2012.

6.9 It is recognised that the higher a firm's market share, and the longer the period of time over which it is held, the more likely it is that the firm's market share indicates the existence of substantial market power.⁴⁸

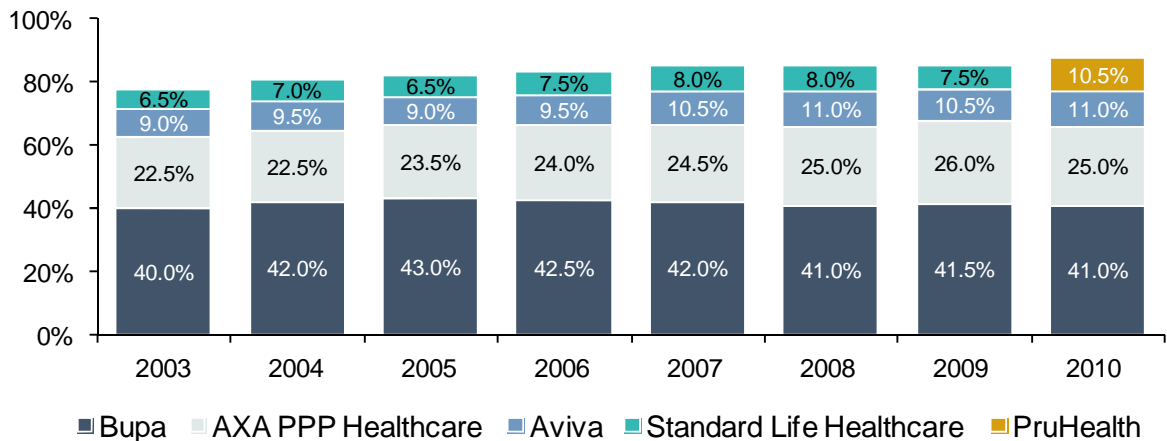
6.10 During the period 2003 – 2010, the top four PMI providers have consolidated their position (increasing their share from 82% to 88%). Over the same period, the market share of BUPA and AXA PPP remained relatively stable. Consolidation is therefore attributable to a cannibalisation of the fringe of smaller PMI providers. Indeed, as noted in Laing's Healthcare Market Review, the market share of insurers outside the top four has been "on a downward trend for much of the 2000s", in contrast to the "increasing dominance of the leading two insurers, BUPA and AXA PPP".⁴⁹

Top four PMI providers have consolidated their position...

⁴⁸ Guidance on its enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings (OJ C 45, 24.2.2009), para 15.

⁴⁹ Laing's Healthcare Market Review (2011–12). The competitor fringe comprises around 17 firms, none of whom hold a market share above 3% (pg 208).

Figure 2: PMI top-four market share over (2003 - 2010)⁵⁰



Source: Laing's Healthcare Market Review 2011 – 2012.

6.11 Going further back in time, the market share of the top two PMI providers, then BUPA and PPP, over the period 1995 - 1999, was at a similar level to 2010 levels, and remained relatively stable.⁵¹ Indeed, BUPA has had a stronghold over the PMI market for 65 years.

Entry barriers

6.12 Barriers to entry in a market can include specific advantages that are enjoyed by a dominant incumbent that are not available to a prospective entrant, for instance, economies of scale.⁵² The CC has previously considered there to be a number of barriers to entry in the PMI market.⁵³ These include:

Brand name and prior insurance experience

6.13 Possessing prior insurance experience and an established and respected brand name in the PMI market was considered by the CC to be particularly important. BUPA and AXA PPP have a considerable advantage over potential entrants as their respective brand names are virtually synonymous with PMI, and their long-established market leadership means they have amassed considerable experience.⁵⁴

BUPA has had a stronghold over the PMI market for 65 years

Selling and claims infrastructure

6.14 The CC has noted the importance of possessing a selling and claims infrastructure to achieve the distribution and support network necessary to deliver PMI products to consumers. To that

⁵⁰ In 2010 PruHealth acquired Standard Life Healthcare, thus becoming the fourth biggest PMI.

⁵¹ BUPA/CHG (2000), Ch 4.

⁵² Guidance on its enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings (OJ C 45, 24.2.2009), para 17.

⁵³ BUPA/CHG (2000). Ch 4.

⁵⁴ BUPA/CHG (2000), para 4.103

end, commercially viable entry on a national scale can require potentially heavy start-up costs, which represents another important barrier to entry in the PMI market.⁵⁵

- 6.15 The CC has further noted that a new entrant may expect to suffer losses during the initial years of commencing business until such time that a critical mass of customers is built up that can earn the PMI an economic level of profit given the necessary investment in marketing systems.⁵⁶

Lack of switching – portability of PMI policies

- 6.16 A further barrier to entry, previously acknowledged by the CC, is the customer lock-in effect which remains an inherent feature of underwriting in the PMI market for individual policyholders.
- 6.17 Lock-in arises because medical conditions that a policyholder develops during the course of holding a PMI policy would not be covered (or would only be covered at prohibitive cost) if they switched to a rival PMI provider, as these would be considered "pre-existing" conditions at the time of switching.
- 6.18 Alternatively, the rival PMI provider may require a switching customer to agree to a moratorium condition whereby cover is not provided for the customer's pre-existing conditions for a set period after the policy start date, for example, two years, provided no claim is made during that two-year period.
- 6.19 The result of these restrictions is that policyholders who have previously made claims for treatment find it difficult or impossible to switch. This effect is likely to be enhanced the longer the customer remains with that PMI provider.
- 6.20 As noted by the CC, this lock-in effect "*limits the ability and willingness of personal subscribers... to switch between PMI providers in response to price signals*".⁵⁷ This, in turn, significantly affects the likelihood of successful market penetration by a prospective PMI entrant. In addition, PMI providers seek to make up the lower margins obtained from corporate clients (where portability exists) by increasing prices for consumers who are unable or reluctant to switch.
- 6.21 Policy portability has been the subject of legislation in the USA. Measures introduced by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") were designed to limit the ability of a new employer's PMI plan excluding coverage for pre-existing conditions and prohibit discrimination against employees and their dependent family members based on any health factors they may have, such as prior medical conditions.

...policyholders who have previously made claims for treatment find it difficult or impossible to switch

⁵⁵ BUPA/CHG (2000), para 4.101 – 4.102.

⁵⁶ BUPA/CHG (2000), para 4.101.

⁵⁷ BUPA/CHG (2000), para 4.104.

Economies of scale – buyer discounts

- 6.22 A key aspect of a PMI provider's role is to negotiate with hospital operators over the pricing of private healthcare services.
- 6.23 The size of PMI provider is an important determinant of the scale of discounts off a hospital's "headline price" for hospital procedures. As noted by the CC, the effect is that "*larger PMI providers are able to operate at a lower cost base than the smaller, with regard to the largest area of claims costs*".⁵⁸
- 6.24 This remains the case to date and BUPA, in particular, has demonstrated an ability to leverage its scale and mass of locked-in customers to negotiate substantial discounts from hospital operators.
- 6.25 These cost advantages serve to further entrench the dominant market position of the leading PMI providers.⁵⁹

Impact of entry barriers

- 6.26 The existence of significant barriers to entry is corroborated by the absence of any new full-service PMI provider for over seven years, the last such entrant to make inroads in the PMI market being PruHealth, who entered the market in 2004.
- 6.27 Laing's Healthcare Market Review summed up the entry prospects for a new entrant:⁶⁰
- "Certainly, however, there is little chance that a new entrant could gain any significant market share"*
- 6.28 To that end, the proliferation of online selling as a mode of distribution has not substantially improved entry conditions into the PMI market, and the prospect of full-scale entry by large retail chains, such as the supermarkets and high street banks, in direct competition with the incumbent PMI providers, has not materialised in any lasting form.⁶¹
- 6.29 Rather, Laing's Healthcare Review notes that, in the absence of any significant entry into the market since PruHealth,⁶² the main market event from the second half of the 2000s has been consolidation with four key deals driving the upward consolidation trend:
- transfer of Legal and General's medical cover business to AXA PPP healthcare;
 - acquisition of FirstAssists medical cover business by Standard Life Healthcare;
 - acquisition of Clinicare by Groupama; and

...cost advantages serve to further entrench the dominant market position of the leading PMI providers

⁵⁸ BUPA/CHG (2000), para 4.103.

⁵⁹ Laing's Healthcare Market Review (2009-10).

⁶⁰ Laing's Healthcare Market Review (2011-12).

⁶¹ Laing's Healthcare Market Review (2011- 12), pg 209.

⁶² Laing's Healthcare Market Review (2011- 12), pg 207 – 209.

- acquisition of Standard Life Healthcare by PruHealth (August 2010).
- 6.30 It is submitted that the dearth of entry into the PMI sector has and will continue to have consequences for the delivery of private healthcare.
- 6.31 A dynamic PMI market with lower barriers to entry would encourage prospective PMI entrants to challenge incumbent providers by adopting innovative policies and recognition practices that, for example, lead to a broader or faster recognition of private healthcare facilities or provide reimbursement for a wider scope of emerging treatments. These new PMI providers would challenge the conservative approach to PMI recognition of facilities and treatments, which has arguably had the effect of hindering and slowing the pace of innovation in the private healthcare sector.

BUPA

- 6.32 Having participated in the PMI market since 1947 (pre-dating the NHS) and having had a considerable marketing budget at its disposal, the BUPA brand name is widely known and advertised and is generally considered to be synonymous with PMI.
- 6.33 BUPA's market share in 2010 based on share of PMI sales was 41%. Its PMI income in 2010 was £1,493 million,⁶³ which remained steady from 2009 despite demand for UK PMI cover falling by 3.8% in 2010.
- 6.34 BUPA's share of corporate PMI policies is higher still, and in London and the South East, where there is a higher proportion of PMI customers (of which the majority are corporate PMI policyholders)⁶⁴, BUPA wields significant bargaining power.
- 6.35 As noted above, BUPA's market share and scale in the market is such that it has preserved its market power over time. As noted in Laing's Healthcare Market Review (2011 - 2012):
- "... the competitive advantages of scale, enjoyed by BUPA and AXA PPP, significantly reduces their vulnerability to competition, all other things being equal."⁶⁵*
- 6.36 BUPA's capacity to leverage its scale in order to derive a competitive advantage over small rival PMI providers is one of the reasons BUPA has continued to dominate the PMI market, alongside its nearest competitor, AXA PPP. This trend was noted in Laing's Healthcare Market Review (2011 - 2012):
- "The market in 2010 continued to be dominated by BUPA and AXA PPP healthcare with a combined medical insurance market share in terms of premium incomes of two thirds..."*

...new PMI providers would challenge the conservative approach to recognition of facilities and treatments...

⁶³ Laing's Healthcare Market Review (2011- 12), table 3.14, pg 206.

⁶⁴ Laing's Healthcare Market Review (2011- 12), pg 175.

⁶⁵ Laing's Healthcare Market Review 2011- 12, Ch 3, for instance, see table 3.3.

Influence over consultants

- 6.37 BUPA's sizeable share of PMI customers, who may be locked-in to BUPA, provides BUPA with an inordinate influence over consultants, a key input for hospital operators.
- 6.38 Over the years, BUPA has demonstrated a capacity to wield significant influence over consultant reimbursement, for instance, the introduction of fixed fee schedules, restricting access to consultants who refuse to sign up to its fee structures, and the reclassification of surgical procedures in order to drive down consultant (and hospital) fees.

Vertical integration

- 6.39 Despite a major divestment of its hospitals in 2007, BUPA reacquired an ownership interest in the private healthcare sector through its £90 million acquisition of the Cromwell Hospital from Medical Services International in April 2008.

- 6.40 The 128-bed Cromwell Hospital is a major provider in London, a geographic area in which HCA competes alongside other private hospital operators and NHS PPUs.

- 6.41 BUPA's dominance in PMI's combined with its ownership of the Cromwell's provides it with a particularly strong position when negotiating with other London hospital operators. To appreciate the scale of BUPA's vertical integration, ownership of the Cromwell alone put BUPA in the top 10 hospital operators in the UK.⁶⁶

Whilst, nationally, the scale of vertical integration has diminished, this remains an acute issue within London

- 6.42 The CC has previously noted that BUPA's dual presence in the private healthcare and PMI markets afforded BUPA the opportunity to leverage its market power in the PMI market, and that a common concern was that such vertical integration presented further barriers to entry in the PMI market.
- 6.43 Whilst, nationally, the scale of vertical integration has diminished since the CC's review, this remains an acute issue within London, where BUPA has materially increased its dual presence. Specifically, BUPA's ownership of the Cromwell Hospital enhances BUPA's bargaining position vis-à-vis other London providers, as it has the ability and incentive to redirect patients to its own hospital offering. A further consequence of this is that BUPA is in a position to adopt an aggressive negotiating stance towards London providers.
- 6.44 BUPA is also active in the private primary care market through its BUPA Wellness subsidiary.
- 6.45 BUPA's 45 Wellness Centres located across the UK (five of which are in London) offer private GP services and this provides BUPA with the means to influence referral patterns to its preferred consultants and private healthcare facilities, further augmenting its bargaining power with hospital operators. BUPA's influence extends beyond its own customers, as its Wellness Centres accept any PMI patient.

⁶⁶ Based on acute medical/surgical income, Laing's Healthcare Market Review (2011 – 12), table 2.10, pg 70.

- 6.46 BUPA Home Healthcare, a BUPA subsidiary, is principally active in the supply of healthcare services to patients in their homes or other community settings. This includes offering chemotherapy treatment at home in return for cash payments and offering incentives to consultants to use BUPA's home healthcare service, which positions BUPA as a direct competitor with providers offering outpatient chemotherapy services.
- 6.47 BUPA's vertical integration into home healthcare enhances BUPA's capacity to redirect demand for private healthcare. BUPA itself expressed its confidence that its home healthcare service could impact demand in hospitals:⁶⁷

"The proposed changes in the health service, with the need to reduce costs, are expected to accelerate the desire to move patients out of hospital and into the home healthcare environment for the delivery of therapies. Whilst the external commercial environment is expected to remain competitive for the foreseeable future, the directors remain confident that the Company is well positioned to achieve its strategy of increasing public and private adoption of home healthcare and becoming the first choice provider in the UK."

AXA PPP

- 6.48 BUPA's nearest competitor, AXA PPP, is another long-established PMI firm, which in 2010 held a PMI market share of 25% (by income). In addition, AXA PPP steadily increased its market share year-on-year between 2004 – 2009.
- 6.49 Over the course of BUPA's and AXA PPP's prolonged period of market dominance, a leader-follower relationship has been established, whereby BUPA acts first and AXA PPP follows. This pattern is consistent with the notion that BUPA generally dictates the type and pace of change in the PMI sector.

...a leader-follower relationship has been established...

BUPA and AXA PPP: Leader Follower relationship

- BUPA's first introduced network policies in the mid-1990s. Two of its rivals, PPP and Norwich Union, later introduced network-type products.
- BUPA introduced its "Benefit Maxima" many years ago. This limited the level of fees that it was willing to pay consultants for any given procedure. The importance of BUPA's Benefit Maxima increased during the 1990s and eventually became the *de facto* standard adhered to by consultants and other PMI providers (including AXA PPP) as a set of national benchmark consultant rates. This continues to be the case. Indeed, the OFT noted in its final report: "*Given BUPA's share of the market for PMI, its published benefit maxima is often considered to be the industry standard in terms of reimbursement rates.*"⁶⁸
- BUPA's Open Referral policy, which appears to have already been implemented by other insurers in a "soft" form (by encouraging patients to visit particular facilities), looks likely to be adopted by other PMI providers.

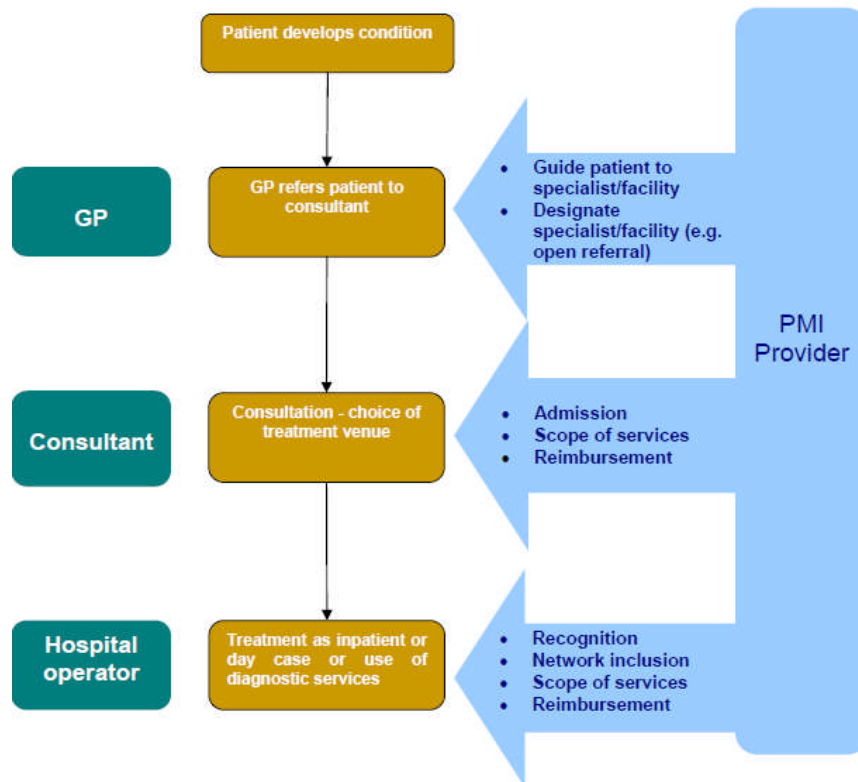
⁶⁷ BUPA Directors' report for the year ended 31 December 2011.

⁶⁸ Private Healthcare Market Study, Report on the market study and final decision to make a market investigation reference, April 2012, page 79, footnote 179.

Importance of PMI recognition

6.50 As illustrated in Figure 3, PMI providers have the opportunity to intervene at every step of the patient pathway and have demonstrated a capacity to exercise their influence (both financial and directional). Furthermore, when PMI providers do intervene, such as in the case of BUPA's Open Referral, such intervention is primarily predicated on cost containment rather than the best care available for patient.

Figure 3: The scope of PMI influence in the typical patient pathway⁶⁹



Source: HCA

6.51 Recognition by each of the major PMI providers is of critical importance to HCA and such PMI providers are, in effect, indispensable trading partners. In BUPA's case, recognition is tantamount to a "licence to operate".

Financial dependence

6.52 First, as noted above, there is a critical dependency on the revenue stream that the top four PMI providers are able to offer to hospital operators from their large pool of customers.

6.53 As noted above, the top four PMI providers account for close to 90% of the PMI market and this share has increased over the last decade. BUPA and AXA PPP, in themselves, accounted for two-thirds of the PMI market, and their bargaining power is commensurately higher.

⁶⁹ In addition to the steps set out in the diagram, a patient would typically arrange follow-up appointments and further outpatient sessions before and after the provision of treatment at a hospital facility.

- 6.54 In addition, PMI patients tend to present relatively higher margins than NHS patients that exercise their right to visit any qualified provider in the private healthcare sector.
- 6.55 In short, failing to be recognised by a top four PMI provider, particularly BUPA and AXA PPP, can threaten the financial viability of a facility by limiting the volume of patients that can be admitted for treatment. This effect is significantly multiplied by the consultant drag effect, whereby consultants prefer to treat their patients at a single facility, and faced with a split list, choose to exit that facility altogether, thus creating a vicious spiral which PMI providers can use to their advantage in a bargaining scenario. This means that there is a very strong incentive on hospitals to ensure that their consultants are able to treat the subscribers of as many of the PMI providers as possible. Indeed, HCA is not aware of any UK private hospital that is not recognised by at least one of BUPA or AXA PPP. This is explored in section 10 below.

Failing to be recognised by a top four PMI provider... can threaten the financial viability of a facility...

Reputational risk

- 6.56 In tandem with the above effect, failing to be recognised by any PMI provider represents a serious reputational risk for hospital operators.
- 6.57 Moreover, even if a hospital operator is generally recognised by a PMI provider, there is further reputational risk of not being included on a specific network product and the quality signal this may send to patients.⁷⁰
- 6.58 In that respect, HCA receives constant complaints from consultants and their patients regarding its omission from certain Aviva network products which include rival London facilities. Furthermore, the Princess Grace [REDACTED] [REDACTED] which occurred despite the hospital boasting state-of-the-art MRI facilities at the time ([REDACTED]).

- 6.59 A recent incident illustrates the way in which BUPA can exploit this power. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

In such a scenario, HCA is only left with the option of capitulating to BUPA's demands or face the severe reputational consequences of a BUPA delisting.



⁷⁰ The OFT noted in its Market Study report (para 5.2) that clinical procedures are typically experience or credence services where quality may not be directly observable by the patient. As a consequence, signalling plays a role with respect to both GPs and consumers when making decisions over facility recognition.

Attracting consultants

- 6.60 PMI recognition is vital to attracting new consultants to HCA hospitals and important in maintaining the attractiveness of HCA to consultants already practising in its facilities.
- 6.61 Consultants are drawn to HCA's facilities primarily because of the quality and range of support staff, HCA's dedicated approach to investment in the latest equipment and clinical infrastructure, and its open and collaborative managerial style with consultants.
- 6.62 Notwithstanding these important attributes, HCA would be confronted with significant consultant migration to rival facilities if it failed to secure recognition by one of the top four PMI providers. As indicated above, this would be exacerbated by the consultant drag effect, whereby consultants that are unwilling to split their lists would choose to relocate their practice to a rival hospital. This defection would be more pronounced the larger the PMI provider, as this would represent a higher proportion of that consultant's patient list. In the case of BUPA, which commands over 40% of the PMI market, failure to be recognised would amount to a "deal-breaker" between the consultant and hospital operator.
- 6.63 The reduction in demand following a PMI provider delisting of HCA facilities is capable of having a pronounced effect on the demand for highly specialised tertiary services, where the number of patients treated would be relatively smaller than for more routine private hospital treatments. There could, for instance, be a disproportionate reduction in demand for such services. As a consequence, consultants practising at HCA, particularly those that are actively contributing to the development of new healthcare practices and techniques in these highly-specialised areas of care, may decide to base their practice at a competing operator instead.

How PMI providers shape private healthcare services

- 6.64 PMI companies are in a position to determine the scale and scope of private healthcare and its mode of delivery to PMI subscribers.

Scope of treatment

- 6.65 PMI providers are able to restrict medical cover and in recent years have taken steps to limit cover in a number of clinical areas as a cost containment exercise. PMI reluctance to recognise new forms of treatment disincentivises hospitals to invest in emerging treatment technologies.
- 6.66 The most recent, clinically controversial, illustration has been BUPA's decision in 2012 to inform hospital operators that it does not cover obstetric procedures unless the insured mother's life is in danger, even where there is a risk to the foetus.
- 6.67 There have also been a number of complaints to the Financial Ombudsman Service ("FOS") regarding life saving experimental procedures such as laser treatment used during larynx surgery, keyhole 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. The FOS also upheld a complaint relating to insurer

PMI providers are able to restrict medical cover and in recent years have taken steps to reduce cover in a number of clinical areas as a cost containment exercise

recognition of a new form of varicose vein surgery, which had been standard practice in the US for several years.⁷¹

6.68 To that end, 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 relative increase out of all insurance categories.⁷² In relation to BUPA alone, the FOS reported that sixty per cent of complaints were upheld in the first six months of 2011.⁷³

6.69 FOS has been limited to overturning insurer decisions regarding policies in which experimental treatments are not specifically stated in the policy as being excluded, however, it appears to have been powerless where policies specifically exclude experimental treatments. In these latter cases, HCA submits that a dynamic PMI market with lower barriers to entry is required to foster PMI policy innovations that broaden the scope of cover to the benefit of consumers.

6.70 PMI providers have reportedly expressed their reluctance to provide cover for emerging treatments on the basis that customers will be claiming for procedures or drugs that have not been fully tested in the UK. However, in taking this position, they fail to recognise that emerging treatments are often relied upon when the conventional treatment pathway would not be appropriate or has previously been unsuccessful. This conservative position can have the effect of limiting customer choice and slowing the pace of medical developments.

HCA has consciously taken the decision to support its consultants with experienced specialist medical teams

6.71 It should also be noted that PMI policies do not traditionally recognise the wide range of types of care that are valid components in the treatment of long term, chronic conditions or mental health problems, and this similarly dampens the potential to create and grow a private market in these areas.

Clinical staff

6.72 PMI policies only reimburse the cost of treatment provided by consultants and not by other doctors or clinical staff. For example, clinical nurse specialists, a [REDACTED] [REDACTED] are not subject to PMI reimbursement. A further category that is not covered is "[REDACTED]"⁷⁴

HCA invests significant sums in these support figures out of its own pocket because it believes such staff comprise important components in the delivery of high-quality care to patients.

6.73 PMI policy restrictions affect the way healthcare is delivered in hospitals by limiting reimbursement to consultant provision only and providing no incentive for hospitals to engage non-consultant doctors to deliver services or invest in clinical teams to support consultants. As

⁷¹ Article, *Experimental ops can now be paid for*, Daily Mail, 22.2.2006.

⁷² Financial Ombudsman Service, Annual Review 2010/2011, www.financial-ombudsman.org.uk/publications/ar11/dealt.html#3

⁷³ www.hi-mag.com/health-insurance/product-area/pmi/article379236.ece

⁷⁴ [REDACTED]

these costs are not recognised by the insurers, they must be met through the hospital's own charges.

- 6.74 HCA has consciously taken the decision to support its consultants with experienced specialist medical teams, including highly-skilled resident medical officers ("RMOs") that can provide 24 hour on-site cover), nursing staff, radiologists, chemotherapists and a number of other healthcare professionals that contribute to the delivery of care. HCA is unusual in having a high level of support staff, which in HCA's case is necessary to treat high-acuity conditions. For example, the [REDACTED] [REDACTED] where most private hospitals have just one. This is a significant cost for the business and many of HCA's competitors do not provide the same depth of resource. This is therefore a further example of the way in which PMI practices disincentivise hospital operators from investing in clinical infrastructure which is in the patient's interest.

As these costs are not recognised by the insurers, they must be met through the hospital's own charges

Clinical pathways

- 6.75 At the most fundamental level, PMI policies govern the terms on which insurers are prepared to reimburse the policyholder, and therefore the PMI provider is, in effect, dictating the terms on which healthcare is provided to PMI-funded patients.

- 6.76 There is a growing PMI involvement in setting the clinical pathways for the delivery of healthcare within hospitals. BUPA is introducing a form of the Milliman Care Guidelines, developed in the US, which cover approximately 400 diagnoses in inpatient and surgical care and general recovery. The Guidelines specify in considerable detail whether a patient should be hospitalised, predict his daily progress, and determine how long a patient with a particular condition should stay in hospital. They demonstrate how insurers are increasingly applying care management techniques to determine the way in which hospitals deliver care to patients.

...BUPA's recent initiatives regarding managed care ... are not focused on the patient's best clinical interests in terms of quality, safety or value

- 6.77 HCA believes that BUPA's recent initiatives regarding managed care in general and clinical pathways in particular, have been dominated by a desire to contain costs, and are not focused on the patient's best clinical interests in terms of quality, safety or value. In the private healthcare sector, where innovation is key, these initiatives may also have the effect of limiting the development of emerging clinical practices to the detriment of consumers. Furthermore PMI providers are not subject to regulatory control to audit the quality and probity of their care management practices, therefore, hospital operators and consultants have no formal channel through which to express concerns over the impact of PMI practices that increasingly intrude into the sphere of clinical decision-making.
- 6.78 Policy restrictions on the scope and delivery of private healthcare can significantly impact on the hospital operator decision-making and investments, as they are dependent on PMI recognition for economic viability. Provided the PMI market is dynamic and keenly contested with new or expanding PMI providers willing to progress the boundaries of recognition for

treatments and care settings, the dependence on PMI providers is not necessarily problematic.

- 6.79 However, where substantial market power has been held by a few long-established PMI participants in a tightly held oligopoly, PMI policies instituted by such incumbents, that have the effect of stifling innovation, investment and quality in hospitals, can cause considerable harm to consumers.

PMI practices affecting bargaining power of hospital operators

- 6.80 From the 1990s, the bargaining relationship between PMI providers and hospital operators has followed a discernible trend toward PMI providers exerting a greater control and influence over the hospital operator's ability to invest and expand within the sector. This trend toward greater PMI control has been brought about by a number of strategies and practices by the major PMI providers which have, together, substantially weakened the bargaining position of hospital operators vis-à-vis PMI providers.
- 6.81 BUPA was aware of the trend toward greater PMI control over hospital operators when it undertook a major strategic decision in 2007 to divest 36 of its hospitals (around 20% of the market) for £1.45 billion in order to focus on its core PMI business. BUPA is unlikely to have divested these facilities if it felt such a move would materially reduce its bargaining power over hospital operators. The same can be said about AXA PPP's decision to sell its stake in the hospitals jointly owned with HCA. HCA submits that nothing has changed in the PMI market to alter that position, and if anything, the major PMI providers have adopted an increasingly aggressive negotiating stance towards hospital operators.

PMI networks

- 6.82 Both BUPA and AXA PPP have pursued a network strategy involving the creation of exclusive provider networks, whereby PMI customers covered by specific networks will only be entitled to reimbursement at the hospital operators forming part of that network.
- 6.83 Network products were intended to leverage the PMI provider's ample scope for supply side substitution in order to create a competitive tendering process whereby hospital operators bid for inclusion on different networks. The process inevitably results in the exclusion of certain hospital operators on particular networks.
- 6.84 Once the networks are created, PMI providers can make subsequent decisions to list new facilities or delist a hospital operator's existing facilities.
- 6.85 BUPA has demonstrated a capacity to credibly make a delisting threat following its confrontation with BMI in 2011/2012 as part of the parties' contractual negotiations. To that end, the recent BUPA/BMI negotiation provides a text book illustration of BUPA's power to use delisting, or the threat of delisting, as a tool to secure substantial discounts from hospital operators. The

Network products were intended to leverage the PMI provider's ample scope for supply side substitution in order to create a competitive tendering process

delisting was reportedly resolved following BMI's agreement to offer BUPA significant discounts as part of a three-year agreement.⁷⁵ The vast majority of BMI hospitals are now included on BUPA's recognised hospital list, however, BMI Gisburne Park Hospital, BMI The Lancaster Hospital and BMI Castle Consulting Centre remain out of the network. Therefore, even in the case of a large player such as BMI, it is clear where the balance of negotiating power actually lies between PMI provider and hospital operator.

- 6.86 BUPA's aggressive negotiating stance with BMI was by no means intended to be an isolated incident. A BUPA's published report⁷⁶ signalled a "more robust approach" in dealing with hospital operators going forward:

"Rising private hospital prices are of particular concern given the current weak economic climate and, in 2011, the business initiated a more robust approach to negotiation with private hospital groups to help drive better value care for its customers, which resulted in a new agreement with BMI Hospitals for the next three years"

Constraining hospital operator growth

- 6.87 PMI providers are also in a position to constrain how hospital operators expand and invest in the private healthcare sector. This can occur, for example, through the exercise of a recognition veto on facilities developed by HCA.

- 6.88 [REDACTED]
[REDACTED]
[REDACTED] This provides BUPA with the ability to dictate where, when and on what terms HCA expands [REDACTED]. [REDACTED]
[REDACTED]
[REDACTED]

- 6.89 HCA has had a number of difficulties and major delays in securing recognition of its recently opened facilities, [REDACTED]
[REDACTED]
[REDACTED] In the case of HCA's planned [REDACTED] HCA has been forced to suspend its planned investment [REDACTED]

- 6.90 HCA was therefore in no way able to secure automatic recognition from BUPA. [REDACTED]
[REDACTED]
[REDACTED]

- 6.91 [REDACTED]
[REDACTED] These examples aptly demonstrate BUPA's negotiating power and contradict the notion that hospital operators such as HCA are able to utilise their bargaining

⁷⁵ Article, *GHG takes cut in BUPA fees to ward off vulture funds*, Daily Telegraph, 30 January 2012.

⁷⁶ BUPA Preliminary results announcement for year ended 31 December 2011.

strength to behave unilaterally or achieve advantageous commercial terms. That has patently not been the case.

- 6.92 At the time that hospital operators make investment decisions in new facilities, PMI providers do not necessarily commit to recognition. In the case of BUPA, it claims it must conduct its quality assessments prior to granting recognition, which necessarily means that a hospital operator must invest in a facility and be operational prior to BUPA recognition. This sequence of events means that PMI providers are in a position to "hold-up" hospital operators that have sunk costs into developing facilities. Larger PMI providers have a greater capacity to hold-up hospital operators as they represent a significant revenue stream for the facility and recognition is required to attract consultants. This hold-up issue, when unresolved by an effective contracting solution, can dampen investment and growth in the private healthcare sector.

Managed care strategies

- 6.93 Managed care strategies extend the insurer's control over the entire patient referral pathway by designating the PMI provider as the "gatekeeper" at one or more key steps in the patient pathway. Managed care strategies therefore involve prescriptive requirements regarding the scope of treatments and facilities available to a customer, preauthorisation of treatment, designating the patient's length of stay, determining consultant recognition and intensive quality audits.
- 6.94 By way of example, in 2011, BUPA introduced a new medical review process for knee arthroscopy which meant that even where a consultant recommends treatment for a patient, BUPA will carry out a "second stage" medical review process before it will agree to reimbursement.
- 6.95 HCA believes that these managed care strategies are not, in practice, predicated on directing patient demand toward facilities that maximise customer convenience, quality and value, but, rather, part of a wider goal (in particular over the past three years) to protect margins whilst preparing for Solvency II.
- 6.96 In order to manage and redirect demand toward the NHS, PMI providers have also marketed policies with a "six weeks rule" or "cash-back incentives".
- The six-week rule: if after diagnosis it is determined that inpatient treatment, day patient treatment or any surgical procedure is required, a PMI customer will need to establish that treatment is not available on the NHS within six weeks of the date on which the treatment should be undertaken.
 - Cash-back incentives: PMI customer receives a cash payment if they elect to be treated by the NHS rather than exercise their entitlement for private healthcare.
- 6.97 Both of the above examples demonstrate a PMI provider's ability to leverage the availability of the NHS as a competitive constraint in order to redirect demand away from hospital operators.
- 6.98 More recently, BUPA has rolled out its Open Referral policy to both corporate and individual customers.⁷⁷ Open Referral entitles BUPA to dictate the choice of consultant and facility for

⁷⁷ We note that BUPA's website states that it has implemented Open Referral with "*retail customers*".

customers that are part of the scheme. This is currently being aggressively promoted by BUPA and HCA understands that it applies to around 40% of its group policies.

- 6.99 Under the terms of BUPA's Open Referral policy, 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/her choice.

... claims made by BUPA in its policy are highly misleading to its customers

- 6.100 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 (see e.g. paragraph 5.49).

- 6.101 In addition, Open Referral can distort hospital operator incentives in a way that harms quality for patients. Under a conventional GP referral pathway, patient referral decisions are made on the basis of the patient's clinical interests – that is, the "highest quality" offering. Accordingly, hospital operators have an incentive to invest in facilities based on a high-quality market proposition. However, where patient referrals are being driven by cost considerations, as is chiefly the case under Open Referral, this gives rise to an incentive in the medium term to compromise quality of healthcare over cost (a "race to the bottom").

... where patient referrals are being driven by cost considerations, as is chiefly the case under Open Referral, this gives rise to an incentive in the medium term to compromise quality of healthcare over cost (a "race to the bottom").

- 6.102 The OFT's market study acknowledged, but did not appreciate the full significance of, Open Referral and the way in which this has further strengthened BUPA's bargaining position. We urge the CC to give it due consideration as part of its investigation into the acquisition of private healthcare, particularly given the likelihood of other PMI providers imitating BUPA thereby establishing Open Referral as a pervasive feature of the PMI market.

7 MARKET DEFINITION

Summary

- There are no grounds to distinguish between PUs and independent operators in assessing the competitive structure of the market.
- PUs enjoy a number of significant competitive advantages over independent providers which place them in a particularly strong competitive position.
- NHS public provision plays an important role in shaping and determining the landscape of private healthcare provision.

7.1 In paras 16–18 of the Issues Statement, the CC has set out its methodology to identify relevant product and geographic markets in privately-funded healthcare services. At this stage, there are two specific issues on which the CC has invited comments and which HCA wishes to address in relation to market definition:

- (i) the extent to which PUs represent a competitive constraint on hospital operators; and
- (ii) whether the NHS represents a competitive constraint on privately-funded healthcare services.

HCA will take these issues in turn.

A PUs

7.2 NHS PUs compete closely with independent providers and provide direct competitive constraints. HCA sees no reason to distinguish between PUs and independent operators in assessing the competitive structure of the market. It has traditionally been held that PUs form part of the relevant product market alongside independent providers, and there is no reason to change this view. On the contrary, PUs in London are a significant force and are expanding, and competition from PUs will intensify over the next few years.

PPUs in London are a significant force and are expanding, and competition from PUs will intensify over the next few years.

7.3 PUs operate in direct competition with independent hospitals:

- (i) PUs are operated as separate, dedicated facilities reserved for private patients. They are either separate wings within the NHS hospital, or separate buildings on the hospital site. They can be distinguished from NHS "pay" beds which are typically beds in NHS wards which are used for private patients. There are no general distinctions to be drawn between PUs and independent providers in terms of the overall patient experience, clinical outcomes or quality of care.
- (ii) PUs, like independent hospitals, provide a platform for NHS consultants to undertake their private practices in their "non-contracted" time. The consultant holding an NHS post will take his/her private practice either to the Trust's own PPU, or to an independent hospital, or indeed to both (in London many consultants have practising privileges in two or more private facilities). The Trust's PPU is therefore in direct competition with independent providers such as HCA to attract the Trust's consultants with their private practices. Indeed, NHS Trusts provide financial incentives to consultants to expand their practice within the Trust's PPU facility and disincentives to treating patients elsewhere.

- (iii) In London, PPUs are typically recognised by the major PMI providers and are capable of treating BUPA and AXA PPP patients. Many also have significant self-pay and overseas patients.
- (iv) PPUs in London provide the same depth and breadth of clinical services as independent providers. To that end, there are highly specialised PPU facilities e.g. the Royal Marsden which provides cancer treatment, and the Royal Brompton and Harefield which is a leading private cardiac unit, as well as more general PPU facilities such as Guy's and St. Thomas' PPU which offers a broad range of clinical specialisms.
- (v) NHS Trusts such as the Royal Marsden, Imperial College, Royal Brompton and Harefield, Great Ormond Street, King's College, Guy's and St. Thomas', and the Royal Free, have major national and international reputations which benefit their PPUs. The "brands" associated with these leading NHS teaching and research institutions are highly respected worldwide. Like independent providers, these PPUs attract patients from a broad catchment, particularly for tertiary care.

- (vi) The leading PPUs in London are substantial facilities with significant bed and theatre capacity. They may be larger than many independent providers and earn significant revenues from private patients:

- Royal Marsden: £41.5 million.
- Imperial College: £31 million.
- Royal Brompton and Harefield: £22.2 million.
- Great Ormond Street: £21 million.
- Royal Free: £17.7 million.
- Guy's and St. Thomas': £17 million.
- King's College: £14.5 million.

PPUs enjoy a number of significant competitive advantages over independent providers...

Source: Laing's Healthcare Market Review 2011 - 2012

- (vii) A Trust's consultants often prefer for convenience to use the PPU on the Trust's site, and many leading, eminent consultants use PPUs as their primary location for their private practices.

7.4 PPUs enjoy a number of significant competitive advantages over independent providers which place them in a particularly strong competitive position:

- **Access to infrastructure:** Co-located PPUs have access to infrastructure, such as intensive care units, which may well be unavailable to independent providers in many areas.
- **Access to land:** NHS Trusts can readily access land within the NHS estate to develop or extend private patient services, whereas private operators may be faced with significant land and planning costs. This could be a significant advantage in London where land costs are higher.
- **Access to support staff:** NHS Trust staff providing clinical support services can be readily deployed for private patient activity at nil or marginal cost.
- **Consultant convenience:** PPUs offer convenience for consultants who can operate their NHS and private patient lists from the same hospital site without travelling very far and this convenience can be a significant influence on the consultant's choice of facility.

- **Consultant restrictions:** NHS Trusts in London have been able to restrict their consultants from carrying out private patient work other than within the Trust's own PPU through restricting the scheduling of consultant's NHS work (e.g. the management of consultants' "Programmed Activities") or incentivising consultants e.g. by giving discretionary merit awards to work at the PPU.
- **Opaque accounting:** The NHS can use its core NHS public facilities (infrastructure, equipment and staff) to support its PPUs at nil or marginal cost. There is insufficient transparency of accounting which enables third parties to monitor effectively whether or not the NHS is operating its PPUs on a genuinely stand-alone, commercial basis. To that end, the PPU can have a distortive impact in the private healthcare sector when it is able to operate on a "cash negative" basis.
- **Favourable pensions:** PPUs do not have to contribute to staff pension costs and can offer attractive NHS pensions without any cost to the commercial business. Furthermore, NHS pensions are often considerably more generous than those provided by commercial employers, creating a market distortion in the recruitment and retention of employees in specialist roles.
- **Pricing policies:** PPUs do not necessarily price services at a level that recovers income for reinvestment in facilities and services in the way that independent providers must do since they can use facilities which are part of a larger NHS estate.
- **Cost of capital:** NHS Trusts are able to raise capital at a considerably lower cost than private hospital operators, which, in a sector where investment is a key parameter for competition, and in an economic environment where access to capital can be limited, provides an important competitive advantage to the NHS.
- **Tax:** There are also significant tax advantages. The NHS pays no corporation tax. In addition, some input costs are exempt from tax or capable of being reclaimed by NHS providers but not private providers.
- **Volume:** The NHS can also obtain volume discounts on drugs, consumables and other supplies.

There is insufficient transparency of accounting which enables third parties to monitor effectively whether or not the NHS is operating its PPUs on a genuinely stand-alone, commercial basis

- 7.5 An independent investigation by the Health Service Journal found that PPUs were pricing at below cost (based on an examination of the costs and charges for 13 Foundation Trusts). The report concluded that the NHS is significantly subsidising private patients ("*Trusts in the dark over cost of private patients*", HSJ 28 May 2009).⁷⁸
- 7.6 A Department of Health commissioned study quantified the distortive impact of these advantages:⁷⁹

⁷⁸ The Health Service Journal examined the costs and charges for 4,142 private patients treated in 13 trusts in 2007-08. The trusts' data shows 1,238 of those patients were charged less than the hospital's average cost for providing the relevant type of treatment (see "*Patients by numbers*" box). Eleven of the 13 trusts undercharged by a gross total of £122,303.

⁷⁹ See Health and Social Care Bill 2011, Impact Assessments, Department of Health (2011), at para B.55, citing the study KPMG Fair Playing Field Report, 2009, economic analysis commissioned by Department of Health.

"The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider. The pensions and cost of capital distortions are the most significant."

- 7.7 The Secretary of State has requested Monitor, the independent regulator of NHS Foundation Trusts, to carry out an independent review of matters which may affect the ability of providers of NHS services to participate fully in providing such services. Monitor announced on 14 June 2012 its Fair Playing Field Review which will cover inter alia barriers to entry and incumbency advantages of NHS entities as against private providers. The outcome of this review will be relevant to the CC's understanding of PPU competitive advantages.
- 7.8 From 2003, NHS Foundation Trusts have been subject to a private patient income cap which prevented the Trust from earning a higher proportion of its total income from private charges than it derived in the financial year 2002 - 2003 (the year before the first Foundation Trusts were authorised). In other words, Foundation Trusts were limited to private provision in the 2002 - 2003 base line. However, section 165 of the Health and Social Care Act 2012 has removed the cap on private income. The removal of this restriction now paves the way for Foundation Trusts in London to significantly expand PPU provisions. Financial pressures within the NHS have also created an impetus for NHS Trusts that are not Foundation Trusts (and not previously subject to the cap) to expand their PPUs too.
- 7.9 Indeed, many London NHS Trusts are in the process of creating and expanding private provision. Numerous Trusts have announced plans to develop PPUs and have gone out to tender to appoint a private sector partner to operate and/or build/expand a PPU. HCA is aware of at least nine current plans for London PPU development. This will significantly increase new private provision over the next few years and lead to even further competition in the London market. Partnering with the private sector provides an opportunity to the Trusts to tap into and utilise the independent sector's commercial experience, management capability, and resources to manage and develop these new facilities and fully exploit the commercial opportunities which are available.

B NHS

- 7.10 NHS public provision plays an important role in shaping and determining the landscape of private healthcare provision. At the most basic level, the NHS funds the provision of general practitioner services and the training of consultants. There are, in addition, increasingly important interactions between public and private healthcare which affect private healthcare provision. Therefore, NHS public provision and private healthcare provision cannot be seen as mutually exclusive.
- 7.11 The role and behaviour of the NHS acts as a powerful constraint on private providers in three important respects:
- (i) The availability of NHS elective care, which is free at the point of use, constrains the extent to which patients opt for private healthcare.
 - (ii) The NHS controls the availability of consultants to the private sector.

...NHS public provision and private healthcare provision cannot be seen as mutually exclusive.

- (iii) The NHS is a major customer of private healthcare and through its procurement practices has significant influence in shaping the way private healthcare is delivered.

These three issues are examined in turn.

NHS elective care constrains private healthcare

7.12 The NHS offers a free service comprising 15 times the bed capacity of the private sector.

7.13 The NHS is widely viewed as the preferred environment for serious, complex high-acuity conditions. In London, the major NHS teaching and research hospitals have a very strong reputation in tertiary care and there will be many patients and GPs who perceive that the NHS, with the full back-up of intensive care and clinical support, is "better" for certain treatments. This *perception* will undoubtedly have some effect on the choices which patients make as to whether to elect for public or private treatment.

7.14 Therefore, while the NHS does not compete with the private sector on price (NHS treatment is free) it is capable of competing, and does compete, on quality and clinical outcomes which will have an important bearing on patient choice.

7.15 The Oxera paper on market definition prepared for the OFT concludes that public healthcare acts as a competitive constraint on private healthcare and states as follows:

"Second, the UK appears to be unique in that the public healthcare sector (NHS) exists alongside the PH market. NHS private patient units (PPUs) and the existence of a free public healthcare service and practice may provide a competitive constraint on private hospitals, at least with respect to self-pay private patients."⁸⁰

7.16 However, these constraints apply not only to self-pay patients (who have the choice whether to elect for free treatment as opposed to making a payment for that treatment) but also to insured patients.

7.17 A recent survey commissioned by HCA and carried out by Boston Consulting Group (Annex 3) shows that a substantial number of patients using NHS treatments are covered by PMI policies. In the survey, 28%

...a substantial number of patients using NHS treatments are covered by PMI policies...

of NHS patients in Greater London were insured but nevertheless elected for NHS rather than private treatment.⁸¹ While in some cases this will be due to the fact that the treatment was for emergency care (where the patient is generally taken directly to an NHS hospital) or that the PMI policy did not cover the particular treatment, in a number of cases the reasons cited included the fact that the GP did not offer or suggest a private option or suggested that the NHS would be better for a particular treatment. This survey

⁸⁰ *Techniques for defining markets for private healthcare in the UK*, Oxera, November 2011, pg 29.

⁸¹ It has been estimated that NHS-funded care to PMI customers is likely to exceed £2 billion/year based on analysis undertaken by Boston Consulting Group using data sourced from a Key Note *Private Healthcare Services Report* (2007). The analysis shows that in Greater London alone there were 240,000 elective admissions (in a single year) which were funded by the NHS, but which could have been funded under PMI. Given costing discrepancies in the NHS, there is clearly ample scope for NHS public provision to affect demand and give rise to material distortions within the private healthcare sector.

demonstrates that there is direct competition between the NHS and private sector even for those patients covered by private policies. There will continue to be many insured patients who consciously elect for NHS public treatment. This puts the onus on private hospital operators such as HCA to compete on quality and investment.

- 7.18 There is a clear correlation between NHS waiting times and private healthcare demand. While this interaction is particularly important for the self-pay market, waiting times are also important for insured patients and can influence:
- (i) an insured patient's choice whether or not to elect for NHS or private treatment under the PMI policy; and
 - (ii) the consumer's decision whether or not to pay for a PMI policy.
- 7.19 HCA has noted that waiting times for NHS open heart surgery is positively correlated with HCA's self-pay and PMI demand (see Annex 4). Specifically, a significant reduction in NHS waiting time was associated with a reduction in demand for the equivalent privately offered service. Furthermore, over the years, NHS hospital facilities have been upgraded, and newly developed facilities have enhanced the attractiveness of the NHS vis-à-vis private hospitals. By way of example, Maidstone and Tunbridge Wells NHS Trust recently opened a new hospital in Pembury, Kent (2011) which became the first NHS hospital to provide a separate room to every inpatient.
- 7.20 Laing's Healthcare Market Review 2011 – 2012 notes (page 51) as follows: *"A key factor determining private self-pay demand going forward is likely to be the performance of NHS services under the coalition Government, in particular shifts in average wait for acute hospital treatment. ...it remains to be seen how NHS performance evolves under its plans, but any significant upward shift in waiting across hospital treatments, whether localised or a national trend, is expected to energise demand for self-pay private healthcare."* The report charts an increase in average median waiting times across a range of specialisms in 2010/2011 and on this basis projects a modest recovery in self-pay private volumes.
- 7.21 Laing's Healthcare Market Review also notes the link between the decline in individual PMI policies from 2004/2005 with improvements in NHS services, notably reduced patient waiting times across most treatments in this period. The willingness to pay for individual PMI cover is likely to be heavily influenced by an individual's perception of NHS performance and the "value added" which the PMI policy provides over NHS treatment.
- 7.22 Furthermore, the Government is promoting an open, competitive market within the NHS and thus patients have increasing choice with regard to the NHS or private facility providing NHS-funded treatment. This has the effect of changing the nature of any perceived "differential" between public and private healthcare. Patients needing routine elective care in England are able to choose between any NHS or independent sector provider that is willing to provide services at the NHS tariff to NHS standards ("Any Qualified Provider" or "AQP", formerly "Any Willing Provider"). The ability of patients to request the consultant and hospital of their choice via AQP (including within a private hospital) opens up much greater potential for competition between the NHS and the private sector.

AQP... opens up much greater potential for competition between the NHS and the private sector

- 7.23 A recent report of the NHS Co-operation and Competition Panel ("Review of the operation of 'Any Willing Provider' for the provision of routine elective care", 20 July 2011) found that an increasing number of patients are exercising their right of choice and selecting providers other than their local NHS provider, and that the number of NHS procedures undertaken in the private sector has grown by 10% per month to around £500 million per year. The introduction of greater competition with the NHS, and the availability of greater patient choice, undoubtedly impacts on the consumer's willingness either to self-pay or to pay for PMI.
- 7.24 The provision of privately funded healthcare services to NHS patients within private facilities (via AQP or via independent sector treatment centres ("ISTC") services) serves to further blur the lines between the NHS and private provision of healthcare. Private providers which also treat NHS patients are acutely aware that this is increasingly eroding the differential between public and private healthcare. In that regard, a recent newspaper article refers to extracts of a letter sent by the Executive Director of the The Meriden Hospital (BMI) to the hospital's consultants, which indicated the hospital's concerns *"regarding the lack of differentiation between NHS and private patients"* and the negative effect on the hospital's private patient referrals.⁸²
- 7.25 In addition to the above, there have been reports of NHS hospitals actively marketing "self-funding services" whereby patients pay cash to have treatments within the NHS.⁸³ In the case of Homerton University Hospital NHS Foundation Trust in east London, its infertility website stated: *"Self-funding NHS patients are those patients who have to pay us for their treatment... The price list... is very competitive in comparison to the private option."* Such practices, which are reportedly being driven by the need to generate greater revenues, place the NHS as a whole in direct competition with services offered by private operators. This direct competition is subject to the NHS/private market distortions discussed in paragraph 7.6. HCA is unsurprised by the Trust's ability to be *"very competitive"* on pricing in comparison to private options. Pressures on NHS funding are likely to see an expansion of such self-funding treatments rather than a contraction.
- 7.26 PMI strategies are actively encouraging patients to go to the NHS for treatment:
- (i) Some PMI companies operate a "six-week rule" whereby if inpatient, day case or outpatient treatment is required, patients are only covered for private treatment if they can establish the treatment is not available on the NHS within six weeks of the date on which the treatment should be undertaken. This is offered in return for a reduced insurance premium, which has been attractive to patients in more challenging economic times. As NHS waiting times have fallen, more activity that would otherwise have been undertaken in private provider facilities has been undertaken in NHS facilities.
 - (ii) Insurers are offering "no claims bonus" discounts to patients which has the effect of creating a financial incentive for customers to use the NHS rather than private healthcare.
 - (iii) In addition, some insurers offer cash incentives through "cash back" schemes to patients to opt for NHS care rather than using their PMI policy.

Pressures on NHS funding are likely to see an expansion of such self-funding treatments rather than a contraction

⁸² The Independent, Saturday 4 July 2012, *Private hospital told doctors to delay NHS work to boost profits*.

⁸³ See, in that regard, the front page of the Sunday Times, July 8 2012, *Hospitals charge for NHS treatment*.

7.27 These strategies provide compelling evidence that PMI providers perceive NHS public treatment to be, in some circumstances, an alternative venue to private healthcare for their customers.

7.28 The OFT's report referred to the European Commission's decision in *Capio* which noted.⁸⁴

"Private acute hospitals also differentiate themselves from public acute hospitals in terms of the overall patient experience, waiting lists, clinical outcomes and physical comfort" which led the Commission to define a separate market for private acute hospitals in the UK.

7.29 However, in view of the issues set out above, the differentials and distinctions referred to in *Capio* are becoming increasingly blurred.

NHS controls the availability of consultants

7.30 The NHS also determines and controls the availability of consultants to the private sector.

7.31 The vast majority of consultants in private practice also have an NHS post. The NHS consultant contracts agreed in 2003 place consultants on either a full-time or part-time basis and stipulate the minimum number of fixed NHS sessions which the consultant must undertake. These contracts therefore determine the extent to which NHS consultants can devote their time to private practice. The 2003 contract reduced the time available for private practice.

...the NHS determines and controls the availability of a key resource – consultants

7.32 The NHS is also in a position to incentivise or pressure consultants to ensure that any time over and above their contracted hours is made available to the NHS rather than private providers. Laing's Healthcare Market Review 2011-2012 states (page 137): *"All consultants, working over and above core contractual hours (full-time, 40 hours per week) are encouraged to offer these additional hours of employment to the NHS in the first instance."* HCA has been told that some consultant NHS contracts stipulate that the first one or two sessions beyond NHS commitments must first be offered to the Trust before the consultant considers work at other providers.

7.33 HCA understands that a number of NHS Trusts expect or even require the consultants to take all their private patients to the Trust's own PPU.

7.34 NHS organisations also control access to substantial research funding and funds held in trust, which can be exploited to influence consultants' decisions about where they practise.

7.35 Thus, the NHS determines and controls the availability of a key resource – consultants – to the private sector which places a direct constraint on the extent to which private healthcare services can be provided.

⁸⁴ Case No COMP/M.4367 APW / APSA / Nordic Capital / Capio.

NHS as customer of private healthcare

- 7.36 The NHS is also an increasingly important customer for private hospitals. There has been a strong increase in NHS-funded contracts and the NHS represents nearly 25% of funding for private acute hospitals, reflecting the growth in central commissioning of ISTC provision and local procurement by NHS Trusts, driven by the Government's choice initiative.
- 7.37 The top four leading hospital operators all have a significant NHS business:
- 60% of Ramsay's UK patient admissions are NHS-funded.
 - 25% of Spire's admissions are NHS patients.
 - Similarly, 25% of BMI's admissions are NHS-funded.
 - Nuffield has also reported significant increases in NHS patient volumes.
- 7.38 As an important customer for private healthcare, the NHS is in a strong position to influence the size and scope of private healthcare, the degree to which private healthcare can expand and grow, and the incentives for private providers to invest in clinical services.
- 7.39 Furthermore, the NHS' engagement in private healthcare activities (PPUs, pay-beds and consultant relationships) means that it is highly informed about private sector healthcare provision.

Conclusion

- 7.40 HCA believes that it is an opportune time, in this market investigation, to re-appraise the inter-relationships between public and private healthcare. In London in particular, NHS public healthcare has a deeply constraining effect on the shape of private healthcare provision and the Government's reforms serve to erode the distinctions which were previously drawn between these two sectors.

8 THEORY OF HARM 1: MARKET POWER OF HOSPITAL OPERATORS IN CERTAIN LOCAL AREAS

Summary

- Competition manifests itself in relation to quality, innovation, timeliness and price.
- HCA operates in a highly competitive market, and faces numerous independent operators and PPU rivals.
- The CC must take account of all the competitive constraints on hospital operators, including ease of entry and expansion and the constraints imposed by the NHS.
- Customers all have the ability to choose amongst a range of competitive alternatives. In particular, PMI providers have very strong bargaining power which constrains the way in which hospital operators deliver private healthcare services and gives rise to theory of harm 3(b).

- 8.1 The CC's first hypothesis is that hospital operators may have market power in certain local areas.
- 8.2 The CC states (paragraph 23) that there may be local market power where there are only "a limited number" of local competitors. However, in HCA's view, an assessment of local market power must take account of all the potential competitive constraints on the hospital operator and not only the number of rival hospitals in the relevant catchment area.

Competitors

- 8.3 Clearly, there needs to be a case-by-case assessment of competitiveness in the local geographic market. In HCA's case, as it has indicated above, HCA operates in a highly competitive and fragmented market and faces competition from:
- 9 independent hospitals and 16 PPUs in London (in some cases, located in close proximity to HCA hospitals)
 - numerous hospitals and PPUs in Greater London and further afield in the South-East.
- 8.4 However, the CC's assessment must include not simply the *number* of rival hospitals but also their *strengths*. As indicated above, HCA's main competitors all enjoy significant competitive advantages which are not available to HCA:
- charitable hospitals such as the London Clinic, St. John and St. Elizabeth, and King Edward VII have significant tax benefits.
 - PPUs derive benefits from their association with NHS Trusts.
 - the Cromwell Hospital, a key London competitor, is vertically-integrated with BUPA.
- 8.5 Consequently, HCA faces huge competitive constraints from numerous competitors (in some cases, within walking distance from HCA hospitals) and there is considerable competition and choice of provider for PMI companies, PMI-insured patients, and self-pay patients.
- 8.6 Furthermore, it is not sufficient for the CC to consider, in isolation, the absolute number of competitors in a given market. For instance, the number of firms in a market may depend

....HCA operates in a highly competitive and fragmented market

on the level of demand. Furthermore, a higher level of market concentration may create the economies of scale and scope necessary to fund and incentivise research and development expenditure in a period when medical technologies and practices may be rendered obsolete in a fast-moving market.

Customer purchasing power

- 8.7 HCA's range of customers, including international, UK self-pay and PMI providers, each have a number of alternative choices for treatment.
- 8.8 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.
- 8.9 UK self-pay patients in the South East are similarly presented with a vast range of competing facilities comprising a broad spectrum of market offerings based on each hospital's scope of care, consultant base, quality proposition and clinical infrastructure.
- 8.10 The major PMI companies exercise considerable purchasing power. As discussed in section 6 above, PMI recognition is necessary for a hospital's viability. PMI bargaining power represents a substantial competitive constraint on a hospital, irrespective of the hospital's relevant market share in the local area. The insurers can exploit their bargaining power in national negotiations with hospital groups to secure substantial price concessions across the hospital operator's entire network of hospitals. This is discussed further under theory of harm 3 (section 10 below).

Barriers to entry

- 8.11 A further factor in terms of the assessment of market power is the relative ease of entry and expansion in the local market and the competitive constraints provided by new entrants. PMI recognition is a key barrier to entry, but where PMI contracts are secured, there is ample evidence of new entry and expansion.
- 8.12 As outlined in section 5 above, there has been significant new entry in London including new build, full service hospitals, specialist clinics, and outpatient facilities, as well as established hospital operators commencing new clinical treatments. There is considerable further growth projected with the establishment of new PUs over the next few years.

... there has been significant new entry in London including new build, full service hospitals, specialist clinics, and outpatient facilities, as well as established hospital operators commencing new clinical treatments
- 8.13 Similarly, ease of entry is evidenced by new facilities in other parts of the UK (see section 4 above). The threat of new entry creates further competitive pressures on hospitals in local markets.

Competitive constraint of the NHS

- 8.14 The CC's analysis also needs to take account of the constraints arising from the NHS. Within London, there are 20 acute NHS Trusts and nine acute Foundation Trusts (some of which have more than one acute hospital site). The major NHS teaching hospitals (Guy's

and St. Thomas', St. Bartholomew's, King's College, UCH, Royal Marsden etc.) house leading consultants from every clinical field, and many NHS facilities possess high-quality clinical environments (with back-up critical care support) that compete with private hospital operators on quality of care and to attract leading consultants.

- 8.15 As noted in section 7, there is a clear correlation between NHS waiting times and private healthcare demand. HCA has noted that a significant reduction in waiting times for NHS open heart surgery has correlated with a significant drop in HCA's self-pay and PMI volumes (see Annex 4).

Effects

- 8.16 The CC states that limited competition in an area may lead to higher prices and/or a lower quality of service. HCA believes that the competitive constraints imposed on hospital operators drives the sector toward better value for money, greater innovation and higher quality. To that end, quality and innovation represent two major parameters for competition in the private healthcare sector.

...quality and innovation represent two major parameters for competition...

- 8.17 Competition to innovate in the private healthcare sector is a dynamic process. Therefore, at any one point in time there will naturally be a smaller number of first movers adopting the latest and most sophisticated treatments, however, as new technology matures, these innovations tend to be more widely adopted.
- 8.18 Hospital operators, and, in particular, HCA, whose market proposition is predicated on a high-quality offering, are therefore strongly incentivised to invest in new equipment, facilities and service lines in order to attract patients and consultants. This competitive dynamic results in continuous improvements in clinical outcomes for patients and expands consultant know-how and expertise. It also leads to more widespread adoption of new technology in the private sector and NHS.

9 THEORIES OF HARM 2: MARKET POWER OF INDIVIDUAL CONSULTANTS AND/OR CONSULTANT GROUPS IN CERTAIN LOCAL AREAS

Summary

- Consultants are valuable partners for hospitals and in London there is fierce competition for the top clinicians.
- Consultants can switch easily between facilities and are forming new collaborative ventures, evidencing a lively and competitive market.
- PMI providers exercise powerful constraints over the activities of consultants and recent PMI initiatives may have an increasingly detrimental impact on the future of consultant private practice.

- 9.1 HCA does not consider that any market power which consultants may have operates to the detriment of either insured or self-pay patients.
- 9.2 It is relatively easy for consultants to switch between competing facilities. Further, consultants are increasingly forming new collaborative ventures, e.g. in the form of new outpatient facilities and consultant chambers which, HCA suggests, evidences a competitive and dynamic market.
- 9.3 Consultants are undoubtedly valuable partners to hospital operators, and hospitals compete to attract and retain consultants who will bring their private patients, develop new units and services and improve patient care.
- 9.4 In London, there is a relatively large pool (approximately 7,500) of consultants, a large proportion of whom have a private practice. Hospitals compete fiercely for leading consultants who have well-established practices and strong reputations. In the healthcare market, which is driven by innovation, there are inevitably some highly specialised areas of practice with a more limited number of top clinicians. These consultants, whilst limited in number, tend to play a key role in the establishment of newly emerging forms of care.
- 9.5 The PMI companies exercise powerful constraints on consultants and these are discussed in section below. PMI reimbursement rates have steadily declined in real terms, while the cost of private practice has increased. PMI providers are also increasingly "capping" consultants and restricting consultants from charging shortfalls. HCA is concerned that in view of these trends, private practice may be becoming increasingly unattractive, particularly for new younger consultants, and this could have significant implications going forward for both insured and self-pay patients. To that end, PMI practices which have the effect of limiting the supply of consultants in private practice would constrain growth and inhibit entry in the private healthcare sector.
- 9.6 HCA supports greater transparency of consultant charges and clinical data to facilitate competition and patient choice. Further, HCA believes it is important that PMI providers and consultants continue to work together to develop a communication mechanism limiting the risk of PMI customers being unexpectedly faced with a shortfall payment for their care.

The PMI companies exercise powerful constraints on consultants...

10 THEORY OF HARM 3: MARKET POWER OF HOSPITAL OPERATORS DURING NATIONAL NEGOTIATIONS WITH INSURERS

Summary

- When looking at the respective bargaining power of PMI providers and hospital operators, the CC needs to assess each party's "outside option".
- PMI providers have a range of potential strategies to adopt should they fail to reach agreement with HCA – for example, there are a wide-range of alternative providers and there has been significant new entry and expansion.
- By contrast, HCA's alternative strategies are extremely limited. The two major insurers account for such a high level of business that HCA has no option but to agree terms which are largely dictated by the insurers.
- A separate theory of harm exists in respect of the insurers' market power and the harmful effect this has in the private healthcare sector.
- Specifically, PMI buyer power and the resulting conduct and practices that are used by PMI providers can stifle investment in new facilities, limit the scope of care available to patients and harm the quality of care. Further, in light of the lack of entry and consolidation occurring in the retail PMI market these practices are likely to go unchecked over time.

The CC's approach

- 10.1 The CC's framework for this theory of harm focuses almost exclusively on one party, starting from the position that the market power resides with the hospital operator, so that PMI providers have "little or no choice"⁸⁵ in their negotiations. Consideration of the bargaining power of PMI providers is limited to whether they have "countervailing buyer power" to mitigate the hospital operator's market power.
- 10.2 This theory of harm is presented as a substantially "one sided test", where an assessment of the existence of any market power held by the hospitals is followed by a consideration that PMI providers may have some leverage against the (assumed) strong position of the hospitals. We believe this approach has significant shortcomings as a framework to assess the relative strength of hospital operators and PMI providers.
- 10.3 The CC should instead jointly consider the most profitable alternative each party has to reach an agreement with a contracting counterparty and evaluate their relative strength jointly. The best alternative for the PMI provider and for the hospital operator would be that counterparty's "outside option".

... the relative strength of each party's "outside option" will determine the balance of bargaining power...

⁸⁵ Paragraph 31 of Issues Statement

A bargaining approach

- 10.4 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.⁸⁶
- 10.5 The worse the consequences associated with not reaching an agreement with the contracting counterparty, the more willing that party will be to make concessions in order to strike a deal.
- 10.6 This implies that in order for the CC to assess whether any hospital operators have any market power vis-à-vis PMI providers it will have to consider the PMI providers' outside option relative to the hospital operators' and vice versa.

Key elements for assessing hospital operators and PMI providers' bargaining power

- 10.7 As part of this framework, it is necessary to consider the potential value, cost and time associated with each potential strategy should a hypothetical negotiation fail. That is, an outside option is not as strong a threat to the other party if a significant cost needs to be incurred relative to the value generated. For instance, a hospital operator (delisted by a major PMI) could switch the treatments provided with the aim of increasing the proportion of international self-pay patients, or of NHS patients, but the required investment may be too high relative to the increment and/or the revenue generated may be too low. Therefore, it is the value (i.e. potential benefits compared to costs) of each party's outside option which will determine the balance of bargaining power.
- 10.8 In addition, the longer it takes to implement the alternative strategy, the lower the value of that outside option (since profits would be realised at a later stage than in a scenario under which the best strategy was more readily implementable). The level of each party's financial reserves and ability to get funding will also determine whether they would be able to afford not to reach agreement, given the time needed to implement the alternative strategy.
- 10.9 The CC should also take into account any asymmetry in the level of uncertainty faced by the bargaining parties and the potential for investment hold-up in the bargaining process.
- 10.10 The outside option would relate to either the best individual strategy or the best combination of strategies (as such strategies need not be mutually exclusive).

Assessing the PMI provider's outside option

- 10.11 Ultimately any bargaining power held by hospital operators is derived from the degree to which the PMI would suffer in its downstream (retail) market, if an agreement is not reached and that operator's facility is delisted. This may include, for example, the PMI

⁸⁶ See, for instance, Muthoo, A. (1999), *Bargaining Theory with Applications*, Cambridge University Press; Inderst, R. and Shaffer, G. (2008), *Buyer Power in Merger Control*, Chapter for the ABA Antitrust Section Handbook, Issues in Competition Law and Policy, W.D. Collins, ed., 2008; Inderst, R. and Mazzarotto, N. (2008), *Buyer Power in Distribution*, Chapter for the ABA Antitrust Section Handbook, Issues in Competition Law and Policy, W.D. Collins, ed., 2008.

provider selling fewer policies, and/or having to reduce its insurance premiums, as a result of removing that hospital facility from its network, which will ultimately depend on the degree to which the PMI's customers are likely to respond to any changes in the PMI's network.

10.12 The creation of PMI networks means that PMI providers are not necessarily limited to recognising all of a hospital operator's facilities or none at all. A PMI provider can, for instance, make a number of credible threats as part of the bargaining process. The first is to delist a hospital operator entirely from all of its networks (effectively, to cease recognition altogether), the second is to exclude a hospital operator from some of its network products, and the third is to delist particular hospitals from some or all of its networks.

10.13 From the perspective of a PMI provider, three alternative viable strategies are identified below:

Strategy 1 – switch to another hospital operator

10.14 The most readily available strategy for a PMI provider is to substitute the delisted facility with another hospital operator's facility which offers comparable treatments.

10.15 The extent to which hospital operators are considered alternative providers is largely influenced by the breadth, quality and capacity of alternatives to the delisted facility in a geographic area.

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.

10.17 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 (see, in that regard, paragraph 4.31 above).

10.18 As noted in section 7, NHS PPU's comprise formidable competitors to HCA's hospitals. With an onsite supply of highly-accomplished consultants and the availability of clinical support infrastructure, whether in the form of nursing and clinical staff or critical care units, PPU's represent effective supply-side substitutes for PMI providers.

10.19 As acknowledged by the OFT in its market study (paragraph 4.24), those NHS PPU's based in London, which is where HCA's six hospitals are based, are the most likely to pose a direct competitive constraint:

"The OFT notes that some PPU's do, however, seem to compete effectively with other PH providers and are considered by PMI providers to be viable alternatives. These PPU's tend to be based in London or other large metropolitan areas and attached to NHS facilities with strong established reputations and/or teaching hospital status. Eight of the top 10 NHS trusts with the highest private patient revenue are based in central London."

- 10.20 With the removal of the private patient cap on NHS Foundation Trusts and financial pressures in the NHS leading to Trusts seeking additional income rather than having to cut costs, PPU's are a growing and attractive option for PMI providers going forward.
- 10.21 On the whole, from a PMI provider's perspective, the London and the South East private healthcare market is both highly competitive and dynamic and there is significant choice of alternative providers should a decision be made to delist facilities in this area.
- 10.22 BUPA recently demonstrated its ability to exercise this option when delisting BMI, a major hospital operator.
- 10.23 HCA is not in a position to leverage its existing hospital operations to compel PMI providers to include all of its facilities on each of their product networks. As an illustration of the fact that PMI providers can turn to alternatives in London, Aviva's Key List network product incorporated the King Edward VII, the BUPA Cromwell, the London Clinic and St. John and St. Elizabeth hospitals (all of whom are close competitors to HCA), but excluded every HCA hospital. Similarly, Aviva's Trust Care list includes HCA's Manchester PPU, the Christie Clinic, but Aviva decided not to include HCA's London-based PPUs: Harley Street at Queen's Hospital and Harley Street at UCH (whereas other London PPUs were included).
- 10.24 To appreciate the significant choice available to PMI providers in London, a copy of a 2011 AXA PPP network proposal document is attached (Annex 5). 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.
- HCA has experienced instances of major insurers excluding their facilities from its network products*
- 10.25 In addition, we note that BUPA [REDACTED] [REDACTED] not to recognise this facility despite earlier assurances by BUPA to the contrary. [REDACTED]
- 10.26 In short, PMI providers have historically demonstrated a willingness to exclude HCA facilities in favour of competing hospital operators. Indeed, the very rationale behind long-established hospital networks is to leverage the scope for supply side substitution (as part of a competitive tendering process) between hospital operators and select certain hospital operators over others.
- 10.27 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 (see section 6 above). PMI customers who may have otherwise defected to a rival PMI provider (following a facility delisting) would be reluctant or unable to do so because medical conditions acquired whilst holding their existing policy would, at the time of switching, be treated as pre-existing conditions by the rival PMI provider and potentially not covered. Furthermore, subscribers in a corporate policy do not have any choice of PMI provider since this is dictated by their employer, and this also limits the extent to which customer switching takes place. Finally there is a general cost and effort required by customers to

switch PMI policy. The customer lock-in effect therefore mitigates the cost impact of delisting and enhances the PMI provider's credibility of a delisting threat during the bargaining process.

Strategy 2 – managed care initiatives

- 10.28 Where negotiations with a specific hospital operator break down, managed care initiatives provide the PMI with an ability to influence the patient journey (that is, the patient's choice of consultant and healthcare facility) in order to effectively manage any loss of a hospital facility from its network by redirecting patients in such a way that demand for PMI policies and its profits is not significantly affected.
- 10.29 As noted above in section 6 of this submission, these initiatives can occur through a number of mechanisms such as Open Referral policies, low-cost policy networks, managed care pathways, policy restrictions such as the "six-week rule" or customer incentives such as cash back for using (free) NHS services rather than a private hospital operator.⁸⁷
- 10.30 In addition, these managed care initiatives may be relatively simple to implement and can be targeted toward specific specialisms that are practised at facilities the PMI is looking to delist.

Strategy 3 – sponsor entry or vertical integration

- 10.31 A third potential strategy available to a PMI provider is to sponsor entry (or expansion) of a new hospital operator into the market, or enter into the PMI market itself.
- 10.32 The sponsorship of entry or expansion does not necessarily have to take the form of financial assistance. It may, for example, involve assurances of recognition or at least a greater willingness to expeditiously recognise that hospital operator's facilities.
- 10.33 In light of BUPA's size and presence in the PMI market, an assurance by BUPA would represent access to a substantial proportion of the PMI market and embolden any entrant. It would also enable the provider to bring consultants (who are generally reluctant to split their lists between different hospitals) on board. Exercise of this sponsorship option would benefit all PMI providers as it would promote greater supply-side substitutability for all PMI providers.
- 10.34 A further strategy available for a PMI provider is to vertically integrate as a hospital operator.
- 10.35 BUPA, through its acquisition of the Cromwell Hospital, demonstrated both a willingness and capacity to exercise this option in 2008. Moreover, it did so by acquiring a competitor to HCA. Indeed, ownership of the Cromwell Hospital alone put BUPA among the top 10 hospital operators in the UK in terms of revenue.⁸⁸

⁸⁷ The CC recognised some of these possibilities at paragraph 32(b) of the Issues Statement.

⁸⁸ Laing's Healthcare Market Review 2011 – 12.

- 10.36 BUPA's ownership of the Cromwell Hospital also provided it with a "demonstration capability", whereby it could practically test how its PMI initiatives would play out in the market and with consultants before launching similar initiatives across the sector.
- 10.37 Notwithstanding any harm that could arise from such vertical integration (see section 17), BUPA's acquisition further enhanced its bargaining power with respect to other private healthcare facilities, particularly in respect of those hospital operators based in London.
- 10.38 As noted above, BUPA is also embarking on a substantial investment programme at the Cromwell, which will further enhance its standing vis-à-vis HCA and the other London-based hospital operators.
- 10.39 BUPA has also vertically integrated into private healthcare through its BUPA Home Healthcare subsidiary, which supplies healthcare products and services to patients in their homes or community settings.
- 10.40 The home healthcare service, which includes services also provided by hospital operators, such as chemotherapy for cancer patients,⁸⁹ is intended to compete directly with hospital provision. An extract from the company's directors' report for the year ended 31 December 2011 ("the Report"):
- "The proposed changes in the health service, with the need to reduce costs, are expected to accelerate the desire to move patients out of hospital and into the home healthcare environment for the delivery of therapies. Whilst the external commercial environment is expected to remain competitive for the foreseeable future, the directors remain confident that the Company is well positioned to achieve its strategy of increasing public and private adoption of home healthcare and becoming the first choice provider in the UK."*
- 10.41 HCA welcomes the CC's decision to assess vertical integration of PMI providers into the private healthcare market as a potential theory of harm, which is addressed separately in section 17.

Assessing the outside option for hospital operators

- 10.42 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.
- 10.43 This is in part due to the heavy financial dependence on large PMI incumbents, and also partly due to the fact that most of the hospital operator's alternative strategies would require a long timeframe to be implemented.

⁸⁹ To that end, the BUPA home chemotherapy team includes specialist oncology nurses, pharmacists and technicians who visit patients' homes to provide treatment.

Financial implications

10.44 The financial implications of being delisted by an insurer can be highly detrimental to the continuing viability of the hospital facility.

...the potential strategies for hospital operators are limited in number and scope

10.45 In HCA's case, BUPA accounts for █████ of total revenue and █████ of its PMI revenue. BUPA and AXA PPP collectively account for █████ of total revenue and █████ of PMI revenue. There is, therefore, a substantial revenue dependence on BUPA and AXA PPP.

Reputational cost

10.46 In addition, hospital operators face the prospect of a significant reputational cost in the event of delisting by a PMI provider.

10.47 As noted by the OFT in its Market Study report (paragraph 5.2) clinical procedures are typically experience or credence services where quality may not be directly observable by the patient. As a consequence, signalling plays a role with respect to both GPs and consumers when making decisions over facility recognition.

10.48 A publicised delisting event can therefore signal poor quality to customers or GPs rather than reflect the outcome of failed negotiations between a PMI provider and hospital operator.

Consultant drag

10.49 The consultant drag effect exacerbates the effect of delisting by a major insurer. PMI business is crucial for consultants and therefore a hospital wishing to compete to attract and retain consultants has a strong incentive, and in the case of the major insurers, an absolute need, to secure recognition, even if this means agreeing entirely to the PMI provider's contractual terms.

With respect to other insurers, there are still material financial, reputational and consultant-drag implications that can provide PMI companies with substantial bargaining power.

10.50 Failure to be recognised by an insurer, even outside of the top four, may result in a consultant being required to split his/her list, which may, in turn, cause that consultant to defect and base their practice out of another hospital operator's hospital (which is recognised by that delisting insurer). In addition, if an insurer delisting led to a disproportionate impact on demand for highly specialised areas of care (where the total number of patients treated in a year may be relatively small), consultants may decide to move their practice for professional reasons.

10.51 The consultant drag effect therefore further enhances PMI bargaining power.

10.52 The two major PMI providers are unavoidable trading partners which can exploit their bargaining position in the contractual pricing negotiations. [REDACTED]. With respect to other insurers, there are still material financial, reputational and consultant-drag implications that can provide PMI companies with substantial bargaining power.

10.53 The viability of the four alternative strategies which may in principle be available to hospital operators is explored below.

Strategy 1 – switch to alternative PMI provider

10.54 The CC would need to consider the degree to which a hospital operator can replace the lost demand through increased referrals from another PMI provider. This clearly depends on the nature and on the degree of competition in the retail PMI market.

10.55 As set out in section 6 above, the PMI market is a highly concentrated oligopoly in which the leading four PMI players have consolidated their stronghold in the market over the last 10 years. Further to this, there has not been a significant entrant in the PMI market since 2004 (being PruHealth), and the entry prospects for a viable PMI entrant are low.

Strategy 2 – new entry

10.56 The degree to which a hospital operator can replace the lost demand from derecognition through new entry into the PMI market will be affected by any barriers to entry in the PMI market. HCA submits that major barriers to entry exist in the PMI market and that these barriers themselves harm innovation and development in the private healthcare market (see theory of harm 3(b) below).

Strategy 3 – replace demand with non-PMI customers

10.57 A hospital operator could theoretically replace lost PMI demand from being delisted with self-pay or international patients. However, this is unlikely to be a feasible strategy. [REDACTED]

10.58 This strategy also depends on the degree to which insured patients are likely to switch to self-pay following a change in the network coverage of their PMI. This will depend on how sensitive insured patients (and the PMI's corporate customers) are to price, quality and choice of healthcare services. Moreover, this will again be affected by the level of competition in the retail PMI market, which HCA submits is not functioning effectively.

10.59 The degree to which a hospital operator can increase the proportion of NHS-funded patients raises a number of issues. First, there can be higher transaction costs for undertaking NHS work, and second, this strategy would not be effective in mitigating the

hospital operator's lost demand [REDACTED]
[REDACTED]
[REDACTED]

A hospital operator could theoretically replace lost PMI demand from being delisted with self-pay or international patients. However, this is unlikely to be a feasible strategy

Strategy 4 – scale down facilities or exit the market

10.60 The degree to which a hospital operator can scale down its facilities and services, to reflect a lower patient throughput, without a significant adverse impact on its margin may not be possible in the short-term given the significant fixed cost element to the private healthcare business.

10.61 This leaves the option of hospital operators exiting the market by withdrawing particular facilities or service lines. Indeed, such exits, which can reduce consumer choice and dampen competition, have been noticeable in the private healthcare sector. For example, the Hospital of St. John and St. Elizabeth recently announced the closure of its well-regarded maternity unit. It is believed this decision was driven by two factors, (i) PMI policy restrictions which significantly narrowed the potential market to those mothers prepared to self-pay and (ii) a growing competitive constraint from the NHS which had improved the quality of its offering to prospective mothers, thus diminishing the pool of self-pay mothers.

10.62 HCA has also felt the brunt of PMI recognition practices.

- [REDACTED] threatened the ongoing viability of these facilities. The facilities were taken over in October 2010, [REDACTED] not formally recognise the facilities until [REDACTED].
- Despite earlier informal assurances that it would recognise [REDACTED]
[REDACTED]
[REDACTED]
- [REDACTED] this project has been put on hold.

10.63 These instances are set out in further detail below.

Concluding remarks

10.64 A sound economic analysis based on the above framework should inform the CC that the balance of power during negotiations between hospital operators and PMI providers is inconsistent with theory of harm 3, and in fact, that an alternative theory of harm exists with respect to PMI bargaining power.

10.65 The CC itself noted that it may need to consider an alternative theory of harm focusing on the buyer power that PMI providers have over hospital operators.⁹⁰ To that end, we urge the CC to both:

⁹⁰ Paragraph 34 of the Issues Statement

- adopt a sound analytical framework in its assessment of the relative bargaining strengths of PMI providers and hospital operators, as outlined above; and
- consider an additional, alternative theory of harm 3(b): “buyer power of insurers during national negotiations with hospital operators”.

10.66 While HCA is aware that the OFT has not referred the PMI retail market to the CC, it would be impossible for the CC to evaluate the relative bargaining strength of hospital operators and PMI providers without consideration of the retail PMI market. This is because PMI providers hold considerable sway in shaping the provision of private healthcare services in the UK.

10.67 HCA notes that considering both theory of harm 3 and theory of harm 3(b) would be consistent with the approach followed by the CC in the context of theory of harm 2 and theory of harm 4, where mutually exclusive hypotheses are set out for further analysis during the inquiry.

Theory of harm 3(b): buyer power of insurers during national negotiations with hospital operators

10.68 HCA believes that, as mentioned by the CC in paragraph 34 of the Issues Statement, a separate theory of harm focusing on “market power of insurers during national negotiations with hospital operators” is relevant. Such a theory of harm would recognise that a PMI provider may have buyer power which is not offset by the bargaining power of the hospital operator. In testing Theory 3(b), the CC should adopt the analytical framework set out above in the context of our discussion of theory of harm 3.

10.69 The consequences of PMI providers over-exerting their buyer power over hospital operators may include a number of potentially harmful effects. For instance, as noted by the CC, “*insurers may exert too much pressure on the price paid to the hospital operator. As a result hospital operators may reduce investment in facilities and equipment*”.⁹¹ This reduction in investment can, in turn, harm the future quality of care for patients.

10.70 HCA submits that 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.

Buyer power stifling investment in new facilities

10.71 The structure and timing of the bargaining process for facility recognition places the hospital operator at a disadvantage with respect to PMI providers.

10.72 Typically, prior to the development or expansion of a facility, a hospital operator will gauge the level of interest among the major

...creates the potential for an investment hold-up...

⁹¹ Paragraph 34 of the Issues Statement

PMI providers for such a facility, particularly as their recognition decision can make or break a facility.

10.73 However, once the investment is made, a PMI provider may refuse to recognise the newly developed facility unless substantial discounts are offered either at the new facility or in respect of other facilities (or simply refuse recognition altogether). This scenario creates the potential for an investment hold-up, whereby the hospital operator must capitulate to the PMI provider's demands or risk significant losses on its investment.

10.74 The hold-up issue is enabled by the level of concentration in the PMI market, whereby the major PMI providers are aware of their revenue-generating and reputational importance and therefore hold more sway.

10.75 To deal with this issue, HCA has, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

10.76 However, BUPA still requires comprehensive quality assessment checks, beyond the CQC's requirements, which can only be met once the facility is up and running. Indeed, BUPA's assessment sometimes goes beyond reasonable quality audits. Further, there is a lack of transparency about BUPA's requirements which can often be arbitrary. Given BUPA's market power, it should be required to publish fair and reasonable criteria governing its quality assessments, particularly as BUPA is in a position to significantly delay or prolong its recognition decision.

10.77 [REDACTED] BUPA has demonstrated an ability to significantly delay recognition of a facility taken over by HCA. [REDACTED]
[REDACTED] has demonstrated its capacity to hold up and stifle investment. Prominent examples include:

[REDACTED]

10.78 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

10.79 Following the failure to have this centre recognised by BUPA, a number of consultants decided they would not practise at the new facility (due to the "consultant drag effect"). This example clearly shows the level of uncertainty and additional costs faced by hospital operators in dealing with PMI providers. The facility was eventually recognised [REDACTED]
[REDACTED]

[REDACTED]

10.80 HCA took over and refurbished the [REDACTED]
[REDACTED]
[REDACTED]

...two weeks before the centre opened, BUPA informed HCA that there was sufficient MRI capacity in that area, and that therefore it would not recognise the new centre

10.81 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

10.82 Further delays followed as BUPA consistently failed to provide HCA with a "provider number". A provider number is required in order to process facility bills through the usual electronic billing system.

10.83 As a consequence of the delays, there was a substantial backlog of unpaid bills by BUPA, as the facility had continued to treat BUPA patients.

10.84 [REDACTED] HCA has been forced to suspend its planned investment [REDACTED]. A clear example of [REDACTED] to stifle investment in new services and facilities which may otherwise have improved the quality of care and convenience for patients in this area.

[REDACTED]

10.85 In [REDACTED], BUPA alleged a number of clinical issues in relation to [REDACTED]
[REDACTED]

10.86 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

subsequently determined unfounded by HCA, but HCA was nonetheless obliged to comply with BUPA's unreasonable demands

10.87 This example also shows the level of uncertainty hospital operators face when setting up a facility or investing in new equipment or technology and the extent to which BUPA is willing to interfere with a hospital operator's clinical practice.

Buyer power harming the scope of treatments available

10.88 Hospital operators are unlikely to commence (or maintain) offering treatments that are not recognised by PMI providers. By way of example, the Hospital of St. John and St.

Elizabeth recently stopped offering obstetrics services following BUPA's decision to clarify that PMI cover would not be covered in instances where the foetus' life was in danger. These decisions, by their very nature, reduce the scope of treatments in the private healthcare market.

10.89 The Sarah Cannon Research Institute ("SCRI") launched a UK arm, SCRUK in 2011. SCRUK is a partnership between SCRI, Leaders in Oncology Care and HCA International, which runs a cancer drug development program that provides access to Phase I clinical trials for patients. [REDACTED]

10.90 In 2010, HCA established a new specialist PPU at the Harley Street at Queens, in collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust at Queens Hospital in Romford. The new facility provides medical and surgical cancer treatments, general surgery, neuro-surgery, and treatments for haematological disorders. BUPA initially refused to recognise the new facility. [REDACTED]

10.91 Hospital operators will be less likely to innovate in new medical technological advances, where they are less confident that any innovative treatments or drugs will be reimbursed (and in a timely fashion) under PMI policies.

10.92 Given the potential reduction in patient numbers from a particular PMI, hospital operators may be compelled to stop offering specialised tertiary care services,⁹² which need a significant catchment population from which to draw potential patients to be financially and operationally viable.

10.93 Also, PMI providers limit the recognition of care to the conventional hospital/consultant setting and institute bureaucratic and largely unnecessary recognition procedures which have the effect of slowing the pace of innovation of new treatments and alternative care settings in the private healthcare sector.

Buyer power harming quality of care

10.94 The implementation of managed care policies, which direct patients to providers chosen by the insurer, are intended to maximise PMI margins rather than offer customers the most convenient and high-quality option. This can have two harmful effects for consumers:

- (i) The immediate impact is on quality, that is, by substituting cost-considerations in place of the best clinical option, the quality of care received by patients is harmed.

⁹² The National Health Service defines specialised services as those services with planning populations of more than one million people. See: Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements (England) Regulations 2002.

- (ii) Such policies shift the focus of competition in the private healthcare market on price and cost reduction rather than incentivising hospital operators to compete on innovation and quality parameters.

10.95 The implementation of consultant fixed fee schedules, and the practice of delisting consultants who refuse to align themselves to fixed fee schedules, limits the choice of consultants for PMI patients in the short-run. In the medium to long-run, PMI restrictions on consultant reimbursement can hinder the future growth of the consultant profession in private practice.

Concluding remarks

10.96 HCA therefore urges the CC to consider the potential adverse effects on consumers that result from the use of PMI bargaining power when dealing with hospital operators, including harm to the level and rate of investment and innovation and to the quality of care.

11 THEORY OF HARM 4: BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS

Summary

- The PMI providers exercise substantial bargaining power over consultants.
- Recent PMI strategies, such as fee-capping and delisting consultants, are limiting competition between consultants and reducing patient choice.
- HCA is concerned about the long-term implications for the number of consultants who are willing to take up private practice in the future.

11.1 HCA welcomes the CC's intention to consider as a separate theory of harm PMI buyer power over consultants and the implications for competition, patient choice and quality. Consultants who are not recognised by BUPA and AXA PPP are unlikely to have a viable private practice. PMI recognition is as important for consultants as it is for hospitals.

HCA supports the calls by some consultants for insurers, and particularly BUPA, to publish clear, transparent criteria for recognition

11.2 In recent years, the major PMI companies have embarked on a series of initiatives which have significant adverse effects on consultants and which the CC should consider carefully.

Delisting

11.3 There has been a growing number of reported instances of insurers delisting consultants so that they are no longer recognised to deliver treatment to PMI subscribers. There may well be cases where delisting is justified, e.g. on grounds of fraud or negligence. However, there are undoubtedly cases in which the insurer does not have a reasonable justification for withdrawing recognition. HCA supports the calls by some consultants for insurers, and particularly BUPA, to publish clear, transparent criteria for recognition and for an appeal/arbitration mechanism in which consultants can seek review of an insurer's decision to withdraw recognition. At present, there appears to be nothing to prevent insurers from taking decisions on wholly arbitrary grounds without giving any explanation. The summary termination of a consultant could have a serious impact on his or her livelihood and threaten the continuity of care provided to a patient.

Reimbursement rates

11.4 BUPA's reimbursement rates for consultants (its benefits maxima) serve as a standard fee schedule which are followed by other insurers.

11.5 BUPA's reimbursement levels have not been increased for many years and, taking into account inflation, have fallen in real terms.

11.6 Allied to this, BUPA has also reduced the reimbursement rate in a number of clinical specialities, such as ENT, gastroenterology, dermatology, urology, gynaecology, and orthopaedics.

- 11.7 Consultants are therefore caught by (i) an overall reduction in PMI reimbursement rates, coupled with (ii) an increase in the cost of practice e.g. indemnity cover, room rentals, etc. HCA is concerned that these trends are putting increasing financial pressure on consultants and are making private practice increasingly unattractive. Laing's Healthcare Market Review 2011 - 2012 (p. 136) cites a BMA report (March 2009) and states that "*its survey showed that fewer than 10% of new consultants were practising privately.*" This may well suggest that more recently qualified consultants are not being sufficiently incentivised to engage in private practice, which could have serious consequences in the longer term, such as choking off the supply of new and potentially innovation-yielding consultants to PMI customers.

Fixed fee schedules

- 11.8 Both BUPA and AXA PPP have introduced fixed fee schedules for new consultants. HCA's understanding of these is that they commit the consultant to charging fees set out in the schedule and **prohibit** consultants from seeking a higher fee, with the shortfall being met by the individual subscriber. HCA's understanding is that these fee schedules are being imposed, on a mandatory basis, on all new consultants and are being gradually extended to cover other, established consultants.
- 11.9 The concept of the fixed fee schedule takes away the consultant's freedom to set his or her own fee rates. Traditionally, if a subscriber wished to see a consultant whose fees were higher than the insurer's reimbursement rate, the subscriber had the choice to make an additional payment, the shortfall. The fixed fee schedule prevents the consultant from seeking any additional charges from the patient. In effect, the imposition of a fixed fee denies the PMI subscriber the right to "top-up" his or her insurance cover to see the consultant of his or her choice.
- 11.10 Fixed fee schedules are likely to have the impact of restricting competition and patient choice. HCA is aware of a number of consultants who have refused to accept fixed fee schedules, since it restricts their fees, and therefore are no longer available to the insurer's subscribers. It could also remove the incentive for consultants to develop and deliver innovation. The fixed fee schedule is an unwarranted restriction on the consultant's right to set his or her own charges, and the patient's right to pay a shortfall to see a consultant of his or her choice. HCA wholeheartedly agrees with the OFT's report that "*In general, price or fee caps are capable of distorting supply in markets.*" In principle, top-ups should be allowed so that patients can elect to pay higher fees in return for higher quality treatment, if that is their choice. It is hoped that the CC will look at the distortive effects of fixed fee requirements.

... a fixed fee denies the PMI subscriber the right to "top-up" his or her insurance cover to see the consultant of his or her choice

Fee caps

- 11.11 Associated with the introduction of fixed fee schedules, some PMI insurers have also been "capping" individual consultants. Consultants have expressed concern that this is being undertaken on an arbitrary and discriminatory basis, with some consultants free to set their charges, and other consultants subject to the maximum fee cap. Again, there does not appear to be very much transparency about why insurers have taken these decisions

or about the criteria for deciding whether a consultant should be capped. This is a further aspect which the CC should consider carefully.

Networks

- 11.12 As in the case of hospitals, insurers are also seeking to create provider networks of consultants.
- 11.13 Under BUPA's Premier Consultant Partnership Scheme, consultants who sign up and agree a specific consultation fee are given a prominent position in BUPA's consultant guide and are promoted to BUPA members. They qualify for a fee bonus where they limit their charges to the BUPA maxima.
- 11.14 BUPA has attempted to launch an ophthalmology network of consultants and is also beginning to direct patients to networks for physiotherapy and mental health. These initiatives evidence an increasingly directional strategy whereby BUPA is seeking to control referrals to consultants. That BUPA has been able to achieve these steps is a further illustration of its market power in private healthcare.

Package pricing

- 11.15 BUPA has also been following a strategy of negotiating package or bundled prices with groups of consultants which either (i) "bundle" the consultant's fee together with the hospital or (ii) create a package of operation fees and post-operative consultation and treatment. These packages, in effect, create a risk of a reimbursement shortfall for consultants (and hospital operators), who may be subject to cases of varying levels of high-acuity (and therefore cost).

Effects

- 11.16 The reduction in reimbursement rates and the introduction of fee caps, which take away consultants' freedom to set their own fees and are offered on a "take it or leave it"⁹³ basis by BUPA, could result in:
- (i) payment shortfalls for PMI customers;
 - (ii) consultants being disincentivised from engaging in private practice which could reduce the number of consultants in the longer term;
 - (iii) reduction in competition and patient choice, since the pool of available consultants which subscribers can go to will be severely restricted;
 - (iv) consequences for quality and clinical outcomes; and
 - (v) driving consultants towards forming groups or legal entities which allows them to collectively bargain in order to counteract PMI bargaining strength.

12 THEORY OF HARM 5(A): BARRIERS TO ENTRY INTO PRIVATELY-FUNDED HEALTHCARE RESULTING FROM NATIONAL BARGAINING BETWEEN INSURERS AND HOSPITAL OPERATORS

Summary

- HCA does not have a national presence and does not negotiate at a national level.
- HCA's agreements with PMI providers do not prohibit new hospital operators entering the market.
- PMI bargaining power is attested by a broad range of evidence, including the fact that insurers have declined to list HCA facilities on PMI network products.
- In any event, the CC must also look at the impact of exclusive and restrictive PMI networks which often create or contribute to any foreclosure effects in local markets.

12.1 This theory of harm tests the hypothesis that, in national negotiations with insurers, hospital operators which have a national presence can leverage their market power in one or more local markets (i) to achieve recognition of their hospitals across the whole network and/or (ii) to prevent insurers from recognising new entrants.

12.2 HCA's six major facilities are in London which, as discussed above, is a highly competitive market. Indeed, each of HCA's hospitals has at least one competing hospital operator within very close proximity. HCA does not have a national presence, and unlike BMI, Spire, Nuffield and Ramsay, is not involved in negotiating at a national level.

12.3 The underlying premise, that hospital operators enjoy market power over insurers, is unfounded for the reasons set out in section 10. The context for the negotiations between insurers and hospital operators is that the insurers have a strong bargaining position and can bring considerable pressure to bear. The large insurers have successfully used recognition protocols and rolled-out PMI networks to control and limit the number of hospitals that are available to their PMI customers.

Instances in which insurers have placed some but not all of HCA's facilities on their network... further evidences their strong bargaining position and the inability of HCA to dictate the terms of recognition

12.4 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 ([REDACTED]).
- [REDACTED]
- 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 Online" brands.
- HCA is not recognised on AXA PPP's speciality oral/dental network.
- Aviva has excluded HCA hospitals from its key hospitals network list.

- 12.5 Even if, for the sake of argument, a hospital operator with a national network were to adopt a negotiating strategy of seeking recognition for all its hospitals, it does not necessarily follow that this creates barriers to entry for new providers. Where a PMI network is non-exclusive and admits all providers that are willing to accept the insurer's prices and terms, without providing any guarantee of volume, a hospital operator would not necessarily be displacing any competitors. It is the exclusive or restrictive nature of the PMI network strategy which may create or contribute to foreclosure effects for new entrants.

13 THEORY OF HARM 5(B): BARRIERS TO ENTRY INTO PRIVATELY FUNDED HEALTHCARE SERVICES RESULTING FROM THE RELATIONSHIPS BETWEEN HOSPITAL OPERATORS, CONSULTANTS OR GPs

Summary

- There is vigorous and healthy competition between hospitals for consultants – mainly around quality and location, but also on terms of engagement.
- For its part, HCA does not restrict or deter consultants from practising at rival hospitals.
- There is no evidence in London that consultant incentives such as equity investment foreclose competitors – on the contrary, there is significant evidence of new entry and expansion. Further, consultant/hospital partnerships have an important role in guiding investment decisions and shaping the future delivery of care.
- Rival hospitals and new entrants can and do compete by offering similar terms to recruit new consultants.

13.1 The CC's hypothesis relates to the impact of "incentives", to consultants and to GPs, and the concern that these incentives potentially raise barriers to entry.

13.2 The OFT's report highlighted the issue of consultant incentives in particular and suggested that these could make it difficult for new entrants to attract consultants and therefore could have foreclosure effects.

HCA does not see cause for concern that consultant incentives create barriers to entry and foreclose new entrants

13.3 The CC will need to consider what it means by "incentives". The OFT loosely uses the term "incentives" without seeking to define it, and there is some confusion in the report about what this term encompasses, and also what the OFT means by "financial" as opposed to "non-financial" incentives or by "direct" as opposed to "indirect" incentives, and precisely what the incentive effect of these schemes may be. However, the OFT appears primarily concerned with provisions which prevent, restrict or discourage consultants from treating patients at competing facilities (which the OFT describes as provisions conferring "consultant exclusivity or loyalty ... drawing consultants away from new contracts or other PH providers"). Similarly, the Issues Statement refers to incentives which deter consultants from switching to new entrants

13.4 HCA does not see cause for concern that consultant incentives of the type referred to in the OFT's report create barriers to entry and foreclose new entrants:

- Hospital operators compete for consultants, and competition in relation to terms and conditions of engagement benefits consultants and patients alike.
- This form of competition can encourage new market entry and expansion by creating new types of collaborative ventures between hospital operators and consultants for the delivery of clinical services.
- For its own part, HCA does not restrict or deter consultants from practising at rival hospitals. In contrast, HCA understands that the BUPA Cromwell Hospital expressly requires consultants to treat their patients only at the Cromwell other than in exceptional circumstances.

- HCA has entered into [REDACTED] but these are designed to invest in new or enhanced clinical facilities or services.
- HCA has seen no evidence in London that these types of consultant incentives foreclose competitors – on the contrary, there is significant evidence of new entry and expansion. New entrants can and do compete by offering similar terms to recruit consultants.
- Providers and consultants are in any event subject to professional obligations to ensure that they act in a patient's best clinical interests.

Competition for consultants

13.5 Hospitals compete vigorously to attract and retain top-quality consultants. As discussed above, this is a further important dimension to competition. The hospital provides the platform – i.e. the equipment, facilities, clinical infrastructure and environment – within which consultants may bring their patients for treatment. Under the conventional referral pathway, patients are referred by GPs to consultants, and it is therefore the consultants who largely determine where their patients will be treated. In London, experienced, well-established consultants who are leaders in their clinical fields enjoy a strong reputation and are likely to be significant revenue drivers for any hospital.

13.6 For consultants, there is considerable ease in switching from one facility to another:

- They must meet the new provider's practising privileges criteria, which typically require the consultant to be on the GMC's specialist register and to hold an NHS post. In any event many consultants have practising privileges at multiple private hospitals and can therefore readily switch their practices with immediate effect.
- There are no capital costs or investments required to take up practising privileges in a different hospital.
- Since consultants can easily take their patients to a rival facility, hospitals have to compete to retain and motivate them to admit their patients to the hospital.

13.7 The factors which attract consultants to a hospital and which form the basis on which hospitals compete are:

Location

The convenience of the facility's location, its proximity to the NHS hospital where the consultant is based, and travel times to and from home are important factors. NHS PUs which are co-located with the main NHS hospital have an advantage from this point of view.

...there is considerable ease in switching from one facility to another

Educational opportunities

The opportunity to participate in a range of educational initiatives as part of a collegiate network of physicians has been highlighted as a significant draw for consultants. For example, consultants have expressed a keen interest in [REDACTED]

Quality and innovation

A key factor is the quality of the hospital and its facilities including:

- the level of investment in the facilities, including intensive care facilities;
- the availability of new equipment and treatment technologies and the presence of critical care facilities;
- the opportunity to work with other colleagues and leading specialists in the field;
- the strength and depth of clinical teams, including Resident Medical Officers and nursing staff; and
- the hospital's clinical record and reputation.

Terms and conditions

Hospital operators also compete on the terms and conditions on which practising privileges are offered to consultants. The OFT correctly notes that location and quality are particularly important factors. Competition in relation to the terms on which practising privileges are granted is simply one, and only one, facet of competition between hospitals.

HCA's terms with consultants

13.8 HCA 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.

13.9 HCA does not prevent or restrict consultants from practising at other hospitals. On the contrary, HCA stipulates that consultants must always act in the best interests of patients and in accordance with its Code of Conduct and relevant GMC obligations. HCA has not withdrawn, or threatened to withdraw, practising privileges if consultants use other facilities. Similarly, [REDACTED]

13.10 HCA has partnership arrangements with a number of consultants, which are characterised by the fact that HCA has made a significant capital investment in the creation of new clinical facilities, equipment or services:

- (i) [REDACTED]
- (ii) [REDACTED]
- (iii) [REDACTED]

13.11 These are, typically speaking, collaborative arrangements between HCA and the consultants concerned, which involve a significant investment by HCA to create or expand a new clinical unit. [REDACTED]

[REDACTED] It is expressly stated that consultants are required to act in the patient's best interests in line with their professional obligations. [REDACTED]

13.12 HCA provides support and assistance to some consultants. [REDACTED]

Pro competitive effects

13.13 These types of terms, which reward consultants for establishing and developing new facilities, have strong pro-competitive effects and efficiencies.

13.14 The provision of these incentives [REDACTED]

[REDACTED] They encourage providers to innovate and consider new forms of partnering with consultants for the delivery of clinical services e.g. through joint venture arrangements and other forms of collaboration. They provide a means for providers to establish new facilities or expand existing ones by attracting consultants and creating new innovative types of ventures and motivating consultants to develop new services.

13.15 Circle has successfully entered the private healthcare market on the basis of an equity ownership model which commits investor clinicians to treat a high proportion of their patients at Circle's hospitals. Circle has opened a new hospital in Bath and has plans to open hospitals in Reading and Manchester. It has reportedly raised £120 million of private equity investment to fund its ambitious growth plans. The Circle model is controversial, and not without its critics, but it provides a text-book example of how a new entrant has successfully used consultant incentives to attract a critical mass of clinicians to invest in new facilities.

13.16 There have also been numerous new clinician-led partnerships which have entered the market in recent years, backed either by private investors or by major hospital groups. These typically involve some form of ownership or tie-in of consultants to the facility. For example, the Oxford Clinic for Specialist Surgery involves a joint venture between consultant-founding partners and BMI. In addition, the proposed new Kent Institute of Medicine and Surgery will be one of the largest clinician-led developments, and it is reported there are around 250 clinicians involved in the project which have agreed to transfer a proportion of their private practice to the new hospital.

HCA's partnerships with consultants have allowed for the creation of new clinical services

13.17 Similarly, HCA's partnerships with consultants have allowed for the creation of new clinical services. An illustration is the LOC based at Harley Street, which has attracted four leading clinical oncologists as founder partners, to establish, run and develop a world-class oncology unit with state-of-the-art facilities in cancer care. Often, these partnerships arise because consultants approach HCA with proposals and ideas for ventures which they wish to establish in conjunction with the hospital.

13.18 These collaborative ventures create significant pro-competitive benefits for consultants and patients alike. They create new opportunities for consultants in the delivery of services. They provide for new facilities and services, enhancing competition and choice available to patients. It is likely that any limitations on the ability of providers to compete for consultants may well dampen competition and lead to poorer outcomes for consumers. HCA believes that restricting or prohibiting providers from offering incentives could well have deleterious effects by making it more rather than less difficult for new providers to enter the market with innovative business structures, which ultimately deliver improvements in clinical care to patients.

Lack of foreclosure effects

13.19 The OFT fails in its report to explain why it believes that incentive schemes have the potential to foreclose competition. Indeed, there is a fundamental contradiction at the heart of the OFT's findings on this issue.

13.20 The OFT rightly observes that consultants generally, and for the most part, prefer to practise at a single facility (see in particular paragraph 8.14 of the report). At footnote 240, the OFT notes as follows:

"This is supported by evidence from the OFT consultants' survey which shows that approximately 40% of consultants report that they only have admission rights to a single PH facility. Additionally, 52% of consultants report that, in a typical month, they would only admit to or treat at a single PH facility. Of those consultants who indicated that they would usually treat patients at two different PH facilities, there was a strong tendency to treat most of their patients at their main PH facility – more than 60% of consultants said that they would treat between 70% and 100% of patients there."

13.21 In HCA's experience, while it is indeed the case in London that consultants often "multi-home" and have practising privileges in more than one hospital, consultants have a strong preference for the convenience of treating most of their patients in one facility (the so-called "consultant drag effect").

13.22 In this context, competition between hospitals for consultants generally occurs at the outset, that is, hospital operators compete for a consultant and, thus, for most or all of the business which the consultant can bring. A new entrant would be seeking to secure all or most of a consultant's private patient lists. Hospitals do not, in the main, compete for a marginal proportion of a consultant's practice. It is therefore difficult to understand why the OFT considered that incentives – even, in the most extreme case, an absolute exclusivity provision which commits the consultant to a single facility - would prevent other hospital operators from competing for consultants on the same terms.

13.23 It is acknowledged that in the case of a supplier with market power, incentive schemes can have foreclosure effects in markets where the supplier's competitors are competing

for a proportion of sales. However, as stated in the European Commission's guidelines on abuse of exclusionary conduct: *"If competitors can compete on equal terms for each individual customer's entire demand, exclusive purchasing obligations are generally unlikely to hamper effective competition unless the switching of supplier by customers is rendered difficult due to the duration of the exclusive purchasing obligation."*

13.24 It is submitted that new entrants are able to compete to attract consultants on exactly the same terms and conditions as incumbent hospital operators. The incumbent enjoys no inherent advantages. There is no reason why new entrants are not able to offer the same incentives, such as an equity stake, in order to attract consultants to a facility. This is precisely what, for example, Circle has done by offering consultants an opportunity to invest in new build hospitals through an equity ownership structure which has attracted consultants from other hospitals. Even if a consultant is incentivised to commit his or her practice to a single facility, the consultant can readily and without significant switching costs "jump ship" to a rival operator.

New entry

13.25 As already described above (see section 5), there are numerous examples of new entry and expansion in London and there is no evidence that incentives schemes of any description have hindered new entrants.

13.26 There has been a significant level of new capacity in recent years. The growth plans of many PPU's indicate there will be further new capacity coming onstream over the next few years facilitated by the new Health and Social Care Act which has lifted the "cap" on how much private revenue Trusts may raise. The impetus to do so has also been heightened by added financial pressure on NHS Trusts. In each case, providers are competing effectively to attract consultants and their private patients to new or refurbished facilities.

There is no reason why new entrants are not able to offer the same incentives...

13.27 HCA would again argue that incentives such as equity participation have had a pro-competitive effect in London and have facilitated new entry by allowing providers to set up new ventures and attract consultants to them.

Legal requirements

13.28 Providers are in any event subject to various legal requirements in relation to incentive schemes:

- (i) The Bribery Act 2010 creates new criminal offences relating to bribery which extend to the provision of financial and other advantages. All providers are now required to ensure that their incentive schemes are Bribery Act-compliant.
- (ii) All doctors registered with the GMC are subject to professional duties set out in the GMC's guidance on Good Medical Practice. There is a duty to *"declare any relevant financial or commercial interest that you or your family may have in the transaction"* (guideline 73). In addition, financial commercial interests *"must not affect the way you prescribe for, treat, or refer patients"* (guideline 75).
- (iii) Any restrictive provisions, such as exclusivity clauses, are always subject to the Competition Act 1998 and must comply with the normal requirements of competition law.

14 THEORY OF HARM 5(C): OTHER BARRIERS TO ENTRY INTO THE PROVISION OF PRIVATELY-FUNDED HEALTHCARE SERVICES

Summary

- There has been a significant level of new entry in recent years and there is no evidence that high capital costs are deterring new entry and expansion.
- Institutional investors, hospital groups and also clinicians have been prepared to invest where there are competitive opportunities.
- In HCA's experience, planning does not create any special barriers in private healthcare and there is no evidence that the existing planning regime deters new entrants.

14.1 The CC refers to the potential barriers to entry which arise from (i) capital costs, and (ii) planning consents.

Capital costs

14.2 It is very difficult to generalise about the capital costs of entry. These will depend on the scale and nature of the facility and will differ for:

- new build, full service hospitals
- new units within an existing hospital
- specialist clinics
- outpatient facilities.

There has been a significant level of entry in recent years and there is no evidence that high capital costs are deterring new entry and expansion

14.3 There has been a significant level of entry in recent years and there is no evidence that high capital costs are deterring new entry and expansion:

- There are numerous recent examples of new-build hospitals e.g. the London Independent in London and Circle's new hospitals in Bath and Reading.
- There is substantial evidence of development activity within existing hospitals to create new clinical units e.g. the London Clinic's new cancer treatment centre and BMI Fitzroy Square's new gynaecological unit.
- There has been a spate of new, specialist clinics in specialisms such as cosmetic surgery, bariatrics, eye surgery, fertility, dermatology and gastroenterology.
- There are also numerous examples of new outpatient facilities, either within the existing hospitals or as new, stand-alone premises. As discussed above, medical advances are increasingly moving patients into outpatient settings which are characterised by lower barriers to entry.

14.4 There has been a high degree of interest on the part of investors in funding new healthcare projects:

- Private equity investors continue to be active. For example, the London International Hospital involves a £90 million private equity investment led by C&C Alpha Group.
- There has also been bank funding, e.g. Clydesdale Bank is providing the £34 million debt financing to build the new Kent Institute of Medicine and Surgery.
- Institutional investors are also investing and it was recently reported that Circle has raised a further £47.5 million through a share placing on the stock market. Also, in 2010, Circle

secured £50 million in development funds from Ropemaker Properties, the direct real estate investment arm of the BP Pension Fund, to build its new Reading hospital.

- As discussed above, there had been new clinician-led ventures in which groups of consultants have invested equity capital in new hospitals, clinics and outpatient facilities.
- Incumbent hospital groups such as BMI and Spire have also been prepared to make very significant investment in their hospitals.
- International medical groups, such as Japan's Tokushukai group have expressed an interest in typing up with the Cambridge biomedical campus to develop new UK medical facilities as part of a joint venture.
- PPU expansion and development is also attracting a significant amount of private sector interest, with private providers bidding keenly to establish or expand PPU facilities. The competitive advantages enjoyed by PPUs, such as the lower cost of capital to fund expansion, has already been discussed above.

14.5 The capital costs of entry cannot be viewed in isolation. Investors look to the potential returns on investments. The business case will be influenced by a wide range of factors, most importantly the ability to get PMI recognition (a key barrier to entry), but also the opportunity to attract a sufficient volume of consultants (to be clinically viable and provide opportunities for innovation and growth) and medical staff, the extent and predictability of local self-pay and NHS demand, and the competitive opportunities within the local market, since these are all factors which influence the number of firms investing in a local market.

14.6 The development activity in London has already been discussed above (see section 5). New build projects such as the London International and the Kent Institute of Medicine and Surgery attest to the appetite of funders to invest in new clinical capacity and services.

Planning

14.7 There is a range of potential planning related consents required for health facilities, depending on the size and nature of the development. These include planning permissions and listed building and conservation area consents. Developers have permitted development rights for certain hospital buildings, provided they meet certain prescribed limitations.

HCA does not consider that planning creates any special barriers to entry for private hospitals in particular

14.8 For a local planning authority ("LPA") to grant planning permission, the application for planning permission must conform with the development plan for that area, and national planning policies unless other material considerations indicate otherwise. The development plan may specify particular areas or sites where new medical facilities are to be provided.

14.9 At present, the planning regime treats private hospital developments in the same way as other commercial projects. Therefore, HCA does not consider that planning creates any special barriers to entry for private hospitals in particular.

14.10 Planning authorities are generally sympathetic to NHS developments because of the perceived social benefits which they create. This is a factor which provides a further competitive advantage to PPUs and other NHS facilities that impose a competitive

constraint on HCA. In contrast, these perceived social benefits are not considered to apply in the case of private hospital developments, despite private hospitals still performing an important function in serving patients in local communities as well as easing pressure on NHS facilities.

- 14.11 Planning authorities do tend to be more open to the idea of developments near major NHS sites or established areas of medical practice such as in and around Harley Street. Specifically, where there are established NHS sites, planning authorities recognise the benefits of consultants and NHS ITU facilities being nearby. Local planning authorities consider planning applications by reference to the local development plan which may identify the extent of need for health facilities.
- 14.12 Some local authorities are resistant to a change in use from residential/commercial to medical but this depends on the local development framework for the area. When HCA developed its outpatient centre in Golders Green, the planning authorities considered the implications of conversion from business use to medical use within the context of the Barnet Local Development Framework policy, but local lobbying by the community in favour of development was a persuasive factor.
- 14.13 A hospital is within use Class C2 of the Town and Country Planning (Use Classes) Order 1986, along with nursing homes. Clinics are within Class D1. Where a site has pre-existing medical use permission, an extension to an existing facility (an example is HCA's application process for an extension of the Wellington Hospital) is generally straightforward.
- 14.14 It is not HCA's experience that the planning process leads to significant delays or that it is used tactically by incumbent operators against new entrants. The entire process lasts around three to five months (or longer if there are serious objections), and if an application is refused there is a right of appeal to the Secretary of State. There tends to be little external engagement in the planning process, other than perhaps residential lobbying resisting change.

15 THEORY OF HARM 5(D): BARRIERS TO ENTRY INTO THE PROVISION OF CONSULTANT SERVICES IN PRIVATE PRACTICE

Summary

- There is no evidence that there are significant barriers to entry for consultants.
- Consultants readily switch between hospitals at no material cost.

15.1 In HCA's view, there are no significant barriers to entry which limit the extent to which consultants can take up practising privileges at new hospitals.

15.2 As already explained, it is easy for consultants to switch their private practices to rival hospitals:

- practising privileges would normally be granted on the recommendation of the Medical Advisory Committee ("MAC"), the group of consultants advising the hospital;
- the admissions criteria, which typically require the consultant to be on the GMC's specialists register and hold an NHS post, are not problematic and are unlikely to create any barriers for consultants;
- there are no significant costs arising from switching between facilities. There are no additional fees which the consultant needs to pay other than the renting of rooms and secretarial assistance.

15.3 There is indeed a significant degree of mobility of consultants in London

16 THEORY OF HARM 6: LIMITED INFORMATION AVAILABILITY

Summary

- The industry has made great strides towards improving information on quality and clinical outcomes.
- There have been advances in the regulation of the clinical professions and of private and NHS hospitals, and the roles of the CQC and GMC continue to evolve to provide robust defences against the risks of low quality delivery of healthcare.
- Whilst comparing clinical outcomes across a range of providers is an extremely difficult task, there is a wide-range of quality metrics and registries which could allow for benchmarking.
- HCA accepts that the industry has further to go and welcomes a discussion on how more information can be made available for the benefit of both patients and GPs.

16.1 HCA supports initiatives to improve the provision of information relating to the quality and pricing of private healthcare. HCA believes that it has already made good strides towards these objectives and would support further moves towards greater transparency for the benefit of GPs and patients.

Private healthcare quality initiatives

16.2 The private healthcare sector has a statutory duty to deliver high quality care. All providers are registered with and regulated by the Care Quality Commission ("CQC") to 28 outcomes defined in the Essential Standards of Quality and Safety under the Health and Social Care Act 2008, each reflecting a specific regulation. Providers are required to provide statistics for a number of clinical KPIs relating to:

- hospital mortality
- unplanned re-admissions
- unplanned returns to the operating theatre
- unplanned transfers out
- surgical site infections for hip and knee arthroplasty
- incidents of MRSA bacteraemia and MRSA
- statutory CQC notifications as defined in Outcome 20, Regulation 18.

16.3 The results of compliance inspections are publicly available on the CQC website. The NHS is similarly regulated but to only 16 core quality and safety standards.

16.4 Hospital operators have made substantial progress towards the provision of clinical data relating to private acute facilities. It must be emphasized that the capture of valid, clinically-rich data which allows for relevant risk adjustment is labour intensive and requires significant organisational efforts. HCA has made considerable investment in staff whose function is to capture, validate and submit data in order to improve the information available to patients.

16.5 There are a number of registries such as the National Joint Registry, which collects information on all hip, knee and ankle replacement operations, and the Regional Cancer Registry, although these do not benchmark processes or outcomes as such. There are also some professionally-led databases, e.g. the Central Cardiac Audit database ("CCAD") which comprises nine national heart disease audits and allows professionals to

continually measure and improve care by comparing their work to specific standards and national trends (and includes e.g. actual survival rates). It is an independent publicly-available website which is designed to help patients make choices about their care and treatment. HCA agrees that similar databases in other specialisms could provide meaningful information guiding patient choice. That said, international experience has shown that publication without intelligent commentary can lead to unintended consequences and may be misleading.

HCA quality information

16.6 In addition, HCA submits data to the Intensive Care National Audit Research Centre ("ICNARC") study which fosters improvement in critical care. The ICNARC carries out audits through the provision of comparative data and allows for actual and predicted survival rates to be derived. This comparative survival information has been provided to HCA patients for a number of years. HCA point out that it wished to publicise the fact that the ICNARC study showed that HCA has the [REDACTED] in the country, but was prevented from doing so by the Department of Health.

16.7 HCA provides quality metrics and information about its facilities in an accessible and understandable format. HCA's quality report which is regularly updated is published on its website (see HCAqualityreport.co.uk). This provides key statistics including:

- waiting times
- cardiac surgery survival rates
- experience in clinical trials
- unplanned transfers to other hospitals
- unplanned returns to the operating theatre
- hospital acquired MRSA incidence
- cleanliness inspections
- IVF success rates
- quality accreditations
- patient and consultant satisfaction surveys
- awards.

HCA believes that it leads the way in the high level of transparency which it has achieved within its hospitals

16.8 HCA actively supports relevant national studies, audits, registries and databases and allows open reporting of its outcomes on third party websites and in professional publications. HCA believes that it leads the way in the high level of transparency which it has achieved within its hospitals. In a competitive market place, quality can be a key differentiator and a unique selling point. Hospital operators compete on quality and it makes commercial sense to promote a hospital's record in areas such as waiting times, cleanliness, survival rates and quality accreditations. HCA therefore supports robust, benchmarked quality matrixes and outcomes. Indeed, in a competitive market quality can be a key differentiator between competing hospitals.

Comparability

- 16.9 There are variations in the way in which providers publish their data. This sector is not homogenous and service provision varies from small units carrying out simple procedures through to large hospitals providing tertiary care for a host of complex conditions. There is scope to improve comparability but crude indicators may be misleading, e.g. mortality rates at treatment centres carrying out simple day case procedures will always be zero. However, one approach would be for providers to select indicators which are reflective of the particular services which they provide.
- 16.10 There is also a role for third parties to develop information tools providing information on private healthcare options. By way of example, there is a commercial website, www.privatehealthcare.co.uk, run by Intuition Communication which provides detailed information about clinical treatments available at different private hospitals together with prices. The website referred to above (www.privatehealthcare.co.uk) allows consumers to apply for an indicative cost for treatment and this is forwarded to three private providers for a quote.
- 16.11 HCA is prepared to discuss with other providers how the Hellenic project can be further developed to improve the information available to patients and GPs.

Consultant quality

- 16.12 Practising privileges are only granted to those holding substantive NHS consultant appointments or who can demonstrate equivalent experience. This in itself indicates a level of professional achievement and experience. Robust clinical governance processes ensure that clinical performance is strictly monitored and action taken with immediacy should an unexpected outcome occur. Nevertheless, HCA would support initiatives to improve clinical data for consultants in conjunction with the relevant medical organisations.
- 16.13 HCA also calls for greater openness and transparency from BUPA with respect to the consultant selection criteria used in its Open Referral product. BUPA has informed HCA that it does not publish the criteria for its consultant search tool as these are commercially confidential to BUPA. However, it would benefit consumers to determine whether the BUPA criteria for consultant selection matches their own. Furthermore, consultants and hospital operators would benefit from such transparency by working towards meeting the standards set by BUPA.

Hospital pricing

- 16.14 HCA 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).
- 16.15 A provider which is not sufficiently transparent is likely to be at a competitive disadvantage. HCA's experience is that it has a better track record of [REDACTED]
[REDACTED]
[REDACTED] Accordingly, HCA is making good strides toward improving transparency in

other facilities. This is an example of how competition between providers is improving transparency. The Institute for Public Policy Research noted in 2008:

"The information gap suffered by individual self-paying patients is improving, with increasing amounts of information and providers of self-pay brokerage."⁹⁴

Consultant pricing

16.16 HCA also agrees that consultation charges should be clearly indicated in advance of the initial consultation and that clear estimates and charging structures are provided in advance of the diagnostic and treatment procedures. There may be some urgent cases where this is impracticable, but as a general rule consultants should adopt a practice of informing patients in advance of the likely costs of treatment. Consultants should also be encouraged to inform the patient of the anaesthetist's charges. These are matters which can be discussed further with the appropriate consultant bodies.

16.17 In addition, the issue of shortfalls is something which needs to be addressed by the insurers. There are some insurers (notably WPA) which do not have any problems with shortfalls. There are others, particularly BUPA and AXA PPP, which have a poor track record. HCA's experience is that AXA PPP may change its benefit maxima to consultants without prior notice which exacerbates the problem. The question whether a shortfall arises depends entirely on the insurer's reimbursement rates which vary between insurers and indeed between policies, and the level of excess, which is not something which the consultant will necessarily know. HCA welcomes the fact that the OFT has raised this with the FSA with a view to ensuring that insurers are more transparent with their subscribers about the possibility of shortfalls arising.

Further initiatives

16.18 The industry is making good progress towards transparency. However, HCA would be supportive of initiatives to improve the availability and accessibility of clinical data, building on the Hellenic project, as well as greater transparency of pricing information for self-pay patients and would welcome further discussions as to how this is best achieved.

⁹⁴ *Private Spending on Healthcare*, June 2008

17 THEORY OF HARM 7: VERTICAL EFFECTS

Summary

- BUPA's vertical linkages and strong PMI market presence give it the ability and incentive to:
- Divert patients away from competing facilities based in London.
- Utilise strategic information regarding other hospital operators that it generates from its PMI role to its advantage.
- Limit the pace of development of rival hospital operators.

- 17.1 The CC states in its Issues Statement that, whilst it does not believe that the vertical linkages of PMI providers are likely to lead to significant harm to competition it is "keeping an open mind to any potential vertical theory of harm". In particular, the CC queries whether such harm could take the form of higher prices or privately-funded healthcare services that may be less suited to patients' needs, reduced service quality, reduced choices of service and supplier and reduced innovation.

...these vertical linkages do have the potential to harm competition for private healthcare in London

- 17.2 The CC has in the past raised a number of concerns with BUPA's vertical integration, particularly when considered in tandem with its substantial PMI buyer power.⁹⁵ The CC stated:

"As regards links between the BUPA businesses, our view is that BUPA is able to exploit its PMI buyer power to extract benefit from other [hospital operators] whilst using its own PMS business to its strategic benefit. It is able to exert leverage between BUPA [as a hospital operator] and BUPA PMI by the non-transparent and subjective process it uses to select hospitals for its network; through its pricing strategy, in particular by offering preferential discounts to BUPA PMI at BUPA hospitals; by the management of the [Consultant Partnership Scheme]... and by the imposition of stringent conditions on [hospital operators] (as a result of which highly confidential information about their businesses is made available to BUPA)."

- 17.3 BUPA's dominance in PMI, combined with its ownership of a major London hospital, invites careful review.

BUPA's vertical linkages

Hospital operator

- 17.4 In 2006, BUPA undertook a complete divestment of its hospitals. However, in 2008 BUPA re-entered the market as a hospital operator through its acquisition in 2008 of the Cromwell Hospital from Medical Services International. The 128-bed Cromwell Hospital is a major hospital operator in London, one of the areas in which HCA closely competes alongside other private PMS providers, PPUs and the NHS. HCA understands that the

⁹⁵ BUPA/CHG (2000), para 2.161.

Cromwell Hospital expressly requires consultants to treat their patients only at the Cromwell other than in exceptional circumstances.

Primary care

- 17.5 BUPA has a growing level of involvement in private primary care through its BUPA Wellness subsidiary which operates 45 Wellness Centres offering private primary care services (of which five are based in London). BUPA Home Healthcare is a BUPA subsidiary whose principal activity is to supply healthcare products and services to patients in their homes or community settings.
- 17.6 The home healthcare service, which includes services also provided by hospital operators, such as chemotherapy for cancer patients,⁹⁶ is intended to compete directly with hospital provision. An extract from the company's directors' report for the year ended 31 December 2011 states:
- "The proposed changes in the health service, with the need to reduce costs, are expected to accelerate the desire to move patients out of hospital and into the home healthcare environment for the delivery of therapies. Whilst the external commercial environment is expected to remain competitive for the foreseeable future, the directors remain confident that the Company is well positioned to achieve its strategy of increasing public and private adoption of home healthcare and becoming the first choice provider in the UK."*
- 17.7 Moreover, BUPA has vertically integrated (through its BUPA Health Assessments business line) into patient health screening. For instance, BUPA has an agreement with Spire for the provision of health screening services which give BUPA national reach and provides another means for BUPA to influence the patient pathway.
- 17.8 HCA submits that BUPA's vertical linkages provide BUPA with the incentive and ability to harm competition for private healthcare services.

Diversion of patients to the BUPA Cromwell

- 17.9 The ownership of the Cromwell Hospital, when viewed together with BUPA's ownership of primary care facilities and its implementation of managed care initiatives (see section 6 of this submission) which allow BUPA to control the referral pathway, creates a conflict of interest. BUPA is incentivised to direct patients to the Cromwell Hospital irrespective of the most clinically and personally appropriate option for patients.
- 17.10 Further, BUPA has invested considerable sums in upgrading and expanding the range of care at the Cromwell Hospital, therefore this incentive, and its ability to execute such directional strategies, has increased over time.

⁹⁶ To that end, the BUPA home chemotherapy team includes specialist oncology nurses, pharmacists and technicians who visit patients' homes to provide treatment.

Sharing strategic information about rival hospital operators

- 17.11 BUPA, in its PMI provider capacity, undertakes a number of quality and cost assessment procedures with HCA's hospitals and with other rival hospital operators. These measures tend to be particularly onerous to comply with and can duplicate or even go beyond the strict CQC requirements already in place for such developments.
- 17.12 In addition, BUPA has recognition protocols in place for emerging treatments and new technologies that hospital operators are seeking to deploy. Similarly, BUPA has recognition protocols in place for new facilities that are being developed by hospital operators.
- 17.13 BUPA's quality and recognition protocols are pursuant to the terms of BUPA's contractual arrangements with HCA and must be strictly adhered to in order for treatments to be reimbursed. Furthermore, they are prospective and therefore concern future services and facilities.
- 17.14 The information shared by HCA with BUPA comprises detailed future strategic information concerning proposed investments in technologies and new facilities, emerging treatments and medical practice as well as pricing and discounts.
- 17.15 Notwithstanding any business line separations that may exist internally within BUPA, there is a clear incentive for this sensitive strategic information to be shared with the Cromwell Hospital, which as noted above, is a close competitor with HCA. The dissemination of that information would significantly undermine HCA's ability to compete and affect its incentive to invest. The effect would be particularly acute for HCA, as one of HCA's key competition parameters is investment and innovation in the market.

Limit the pace of investment

- 17.16 HCA has experienced significant delays obtaining BUPA recognition of newly developed facilities, including but not limited to:
- [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
- 17.17 BUPA has an incentive to delay or withhold recognition of HCA's outpatient facilities as consultants using these facilities may also hold practising privileges at HCA's hospitals and therefore refer their outpatients to HCA facilities for inpatient treatment.
- 17.18 In addition, BUPA has an incentive to make the quality assessment procedures in place for rival hospitals more rigorous and more time-consuming than for its own hospitals. For instance, HCA has often experienced delays in obtaining responses to its queries during recognition discussions.

17.19 BUPA has also demonstrated a capacity and willingness to challenge clinical practice at HCA's facilities. [REDACTED] It has a clear incentive to direct such challenges towards services that are only offered at competing hospital operators.

Benchmarking

17.20 BUPA's quality assessment procedures rely on benchmarked statistics. Ownership of the Cromwell Hospital provides BUPA with an incentive to calibrate those benchmarks in a manner that minimises any prejudice to its own hospital.

Conclusion

17.21 In summary, HCA submits that BUPA's vertical linkages in the private healthcare sector provide BUPA with both the incentive and the ability to harm competition for private healthcare services.

18 CONCLUSIONS

- 18.1 The market for private healthcare is highly competitive. The level of new entry and expansion, and the scale of investment in facilities and technologies, bespeaks a lively, dynamic and evolving market. Private healthcare has delivered positive outcomes for consumers in terms of quality of clinical care and innovation. In HCA's submission, the CC's potential theories of harm relating to concentration and market foreclosure in private healthcare are therefore unfounded.
- 18.2 HCA has highlighted in this submission PMI practices which create cause for concern. The major PMI providers – and BUPA in particular - have engaged in increasingly aggressive, confrontational and directional strategies under the banner of "managed care" which have the potential to distort competition, deter new entrants and reduce consumer choice in private healthcare. It is important for the CC to consider the long term implications of these strategies for the development of the private healthcare market and for the incentives for hospital operators to invest in quality and innovation.
- 18.3 This market inquiry is also an opportune time for the CC to take stock of the growing role and influence of the NHS in private healthcare, as the traditional boundaries between public and private healthcare become increasingly fluid.
- 18.4 HCA believes that the private healthcare sector can be justly proud of its record in raising quality, improving clinical outcomes and investing in innovative treatments and procedures. As discussed above, there is more to be done in preparing and publishing comparative clinical data for the benefit of patients and GPs and HCA would be delighted to discuss with the CC ways in which transparency may be improved.
- 18.5 HCA hopes that these comments have been helpful and looks forward to engaging with the CC on these issues as the inquiry progresses.