

## AXA PPP'S RESPONSE TO HCA'S SUBMISSION

HCA's reply, 22 February 2013

### 1. Introduction

- 1.1 AXA PPP has made a further (undated) submission to the CC responding to HCA's submission of 31 July 2012 on the CC's Issues Statement.
- 1.2 In HCA's view, AXA PPP's submission (i) makes a number of wrong or misleading assertions, and (ii) fails to address many of the issues which HCA has raised concerning PMI strategies and their adverse effects.
- 1.3 HCA's detailed response to the CC's market questionnaire has already dealt with many of the points raised in AXA PPP's submission. However, HCA comments as follows on aspects of the submission, with reference to the headings used by AXA PPP in its submission in the order in which they are set out.

### 2. Section A : innovation and efficiency

#### ***AXA PPP submission***

- 2.1 AXA PPP points out that HCA has "*a successful track record of investment*" which contradicts HCA's assertions that PMIs have held up investment. AXA PPP claims that there is "*no instance in which AXA PPP has stifled HCA investments which are proven to improve patient outcomes*".

#### ***HCA reply***

- 2.2 HCA welcomes AXA PPP's acknowledgment that HCA has demonstrated consistent, long-term investment in new facilities, clinical procedures and technologies. Many of these are referred to in HCA's response to the Issues Statement and to the CC's market questionnaire. Innovation in new services and treatment pathways has revolutionised the way that treatment is delivered, e.g. through the improved diagnosis of complex conditions, minimally invasive procedures and through new, non-interventionist procedures which avoid the need for surgery altogether.
- 2.3 Accordingly, HCA places a strong emphasis on continuing to offer a high-quality offering and in order to support this goal it must continually invest in its hospitals, clinical infrastructure and support staff. A recent OFT merger decision noted that investment by hospitals to improve the quality and delivery of clinical services is one of the key dimensions of competition in healthcare markets.<sup>1</sup>
- 2.4 HCA has already provided evidence to the CC that PMIs have resisted new treatments and technologies and delayed or refused recognition of new clinical services. HCA believes that this has harmed investment in new facilities and the scope and quality of care available to private healthcare patients.

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<sup>1</sup> OFT ME/5351/12 *Anticipated merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital Foundation Trust*, 7 February 2013.

2.5 Whilst many of these instances have involved BUPA, there are also cases in which AXA PPP has failed to support new, innovative technologies that have proven patient benefits:

- ✂
- ✂
- ✂
- ✂

All of these innovations are supported by medical evidence as to their clinical benefits. Innovation by its very nature involves developing new products and services, the full potential and benefits of which may take time to be realised, and PMIs have an important role to play in encouraging this type of investment.

2.6 By way of example, the [✂] procedure, which AXA PPP has so far refused to recognise on the basis that it is still experimental:

- ✂
- ✂
- ✂
- ✂
- ✂.

2.7 A further example is the [✂] procedure, which AXA PPP has similarly refused to recognise on the basis that it is not proven to be effective. This is an [✂], which does not require bone work and results in minimal scarring. This means post-operative recovery is much more rapid, as is the return to work and resumption of normal daily activities. There is a reduced length of stay when compared to the alternative procedure.

2.8 When HCA sought recognition from AXA PPP for its [✂], AXA PPP declined and stated that it would review the position when [✂] becomes standard practice. HCA often encounters this type of response. HCA's positioning in the market as a high quality provider of tertiary care constantly requires it to adopt new technology and innovation, once it has been proven in the world setting. In addition to competition in the UK, HCA faces competitive pressure from hospitals in rival international medical centres seeking to gain a competitive advantage over the UK as the top-end destination for healthcare. Quite often, such procedures are already the recognised "standard" in other countries. For example, the CyberKnife treatment was already in widespread use in US, Europe and Asia at the time that HCA became the UK's first hospital operator to offer this service. CyberKnife has also now become the new standard of care for a number of procedures in the NHS, attracting NHS referrals from far afield.

2.9 AXA PPP's reluctance to recognise new procedures tends to rely on two flawed arguments. The first is that such a procedure is not currently standard practice, [✂]. This position leads to a chicken and egg situation, whereby PMIs will not recognise innovative treatments because they are not in widespread use, but without backing from the large PMIs, this is unlikely to occur. This clearly has the effect of stifling investment and innovation in the UK. The deadlock may sometimes only be broken once the treatment is eventually

commissioned for use in the NHS, which can mean highly effective treatments that might be appropriate to patients with specific clinical conditions (i.e. an inoperable tumour) will be unnecessarily delayed, particularly as the NHS' rate of technological adoption is also influenced by the objective of rationalising resources to provide healthcare services to the wider population. The second argument used by AXA PPP is that there is already a sufficient number of existing interventions for the treatment of a disease. HCA would have hoped for a more forward-thinking and flexible position, whereby the case-by-case clinical benefits are taken into account in the light of the patient's best interests.

- 2.10 As a result, PMIs such as AXA PPP are sluggishly "reactive" to treatment innovations – only seeking to recognise new treatments once it feels suitably pressed to do so by its members, rather than pro-actively engaging with hospital operators. An example of this is AXA PPP's manoeuvring on the [redacted]. HCA writes to PMIs to introduce important new technologies, providing information on, among other things, how the technology works, the benefits and evidence supporting its use, the suggested charge whilst a CCSD code is agreed and where it is already adopted. For the [redacted], an introductory letter was sent to AXA PPP in February 2010. AXA PPP did not at that time recognise this technology. Over two years later, in August 2012, AXA PPP wrote to HCA stating: *"I recall sometime ago that HCA introduced the [redacted] our previous view was that AXA PPP would not at that time be in a position to agree funding due to the experimental nature of the treatment. We recently had a request for the use of [redacted], the AXA PPP Clinical Centre are in the process of agreeing that this treatment can proceed. Therefore, I am keen to ensure that we agree to the cost of this service as soon as possible."* In a dramatic u-turn, AXA PPP switched from a position of non-recognition to wanting to agree the specific cost of service "as soon as possible". Fortunately for AXA PPP's member, HCA had already decided to accept a low return and invest in this technology due to the clear patient benefits. HCA was therefore able to respond to AXA PPP's unexpected request. Nonetheless, this example highlights the reactive approach to innovation adopted by larger insurers, and demonstrates the power that insurers have in dictating when and where new procedures are made available to their members.
- 2.11 Sections 33.28-33.37 of HCA's response to the CC's market questionnaire provides further details together with supporting evidence about the stance of BUPA and AXA PPP to new, innovative treatments. There is strong clinical evidence that these new procedures are of considerable benefit to patients, in many cases allowing patients to avoid the need for inpatient surgery which (particularly for older and more vulnerable patient groups) can be very risky. In many cases such treatment technologies are already recognised, established standards of care in the US, Europe and Asia, yet in the UK insurers often refuse to cover new procedures or insist on covering only the cost of the older form of treatment, leaving HCA to write off the excess or consider charging the patient. HCA considers that AXA PPP's refusal to support these treatments is not clinically justified and is based solely on cost considerations.
- 2.12 HCA has indeed proceeded to invest in new technologies notwithstanding that PMI recognition has not been obtained, but it should be noted that:
- Approximately [redacted] of HCA's business is based on overseas patients and investment in innovation is vital to attract these patients to London
  - the reluctance of PMIs to recognise new treatments may well have a greater "chilling" effect on other hospital operators which are even more dependent than HCA on PMI revenue and have less overseas business

- the reluctance of BUPA and, in some cases, AXA PPP to support new treatments has the effect of dampening the pace at which new treatment technologies are implemented in the private sector.

2.13 Furthermore, AXA PPP's ability to decline to recognise these new, innovative treatments which HCA brings to market attests to AXA PPP's leverage over HCA and other hospital operators, and its ability to dictate (on financial grounds) what clinical treatments may be made available to its subscribers. AXA PPP states "*We would like providers to engage with us before they make investments in expensive new technology.*" HCA welcomes discussion and dialogue with any of the PMIs but these examples demonstrate that PMIs need to be more open to considering the clinical evidence behind new products and services which deliver tangible benefits to patients and cost savings to PMIs. It is not clear that PMIs with profit maximising incentives would necessarily support innovations that improve quality and deliver patient benefits if they do not also deliver short-term cost savings. HCA also notes that there is an inconsistency in AXA PPP's cover in different jurisdictions [3<] was recently informed that AXA PPP in France would fully cover all cancer treatments (including CyberKnife) which the consultant recommends or authorises, whereas its policy in the UK is more restrictive.

2.14 The prompt recognition of new medical procedures that offer, in some cases life-saving, benefits to patients relies upon a competitive and dynamic PMI market, whereby rival PMI providers recognise new procedures more readily than their rivals in order to differentiate their PMI offering to customers and capture a higher share of the PMI market. In contrast, the UK PMI market is actually concentrated and stagnant, with smaller PMI providers unable to overcome the barriers to expansion thereby preserving the market position of a few dominant PMIs. In its recent submission to the CC, WPA registered its concern over "*the monopoly position of the largest insurers*" and how this was being enhanced by their managed care strategies.<sup>2</sup>

#### **AXA PPP submission**

2.15 AXA PPP argues that investment and innovation is not delivering "*cost efficiency*" by way of lowering costs and that this is "*indicative of a competitive failing*" in the market.

#### **HCA reply**

2.16 Technological innovation, particularly in the area of high acuity, tertiary care, delivers major clinical benefits to patients. Innovation in diagnostic imaging and tests such as molecular imaging leads to improved diagnosis of complex conditions, saving lives and improving the effectiveness of treatments. The development of new, non-interventionist procedures such as targeted radiation therapy enables cancer patients to be treated in fewer sessions (for example, interoperative radiotherapy (IORT) for breast cancer patients) or in outpatient settings, avoiding high-risk surgery. Similarly, the creation of new cardiovascular procedures such as TAVI (transcatheter aortic valve implantation) allows high risk patients, who would not be able to undergo conventional open-heart surgery, to be treated without lengthy inpatient stays. All of these developments are unquestionably improving clinical outcomes, often making a profound difference to the quality of care and patients' prospects.

2.17 As HCA has submitted in section 22 of its responses to the CC's market questionnaire, the cost impact of new technology is complex and subject to a number of factors:

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<sup>2</sup> WPA submission to CC, 5 February 2013.

- (i) New technology has undoubtedly shortened hospital stays and enabled many procedures which previously required lengthy stays in hospital to be delivered in outpatient facilities thus reducing the unit cost of a treatment (examples are provided below). Indeed, more cases are done on a day case basis each year, resulting in a PMI saving of around £[<] per year.<sup>3</sup> Hospital lengths of stay have also significantly declined, with estimated PMI savings of at least £[<] per year.
- (ii) Minimally-invasive or non-invasive procedures can lower the risk of post-operative care or even critical care admission, for example, caused by adverse side effects or infection, which may lower the overall cost of the patient's treatment pathway. HCA has some of the lowest infection rates in the industry.
- (iii) New technology is often more effective at treating a medical condition, thereby reducing the likelihood of that patient returning to hospital and needing to claim under their PMI policy again - a "counterfactual" cost saving that is not recognised by PMIs such as AXA PPP, who instead myopically focus on the unit cost. For example, the CyberKnife system provides a targeted high-dose treatment which minimises exposure to surrounding healthy tissue. AXA PPP has previously refused to reimburse the use of CyberKnife to treat cancer in particular parts of the body, including the prostate, on the basis that standard radiotherapy options are available at a lower cost. This position has been taken despite the benefit of CyberKnife being able to treat a patient with fewer fractions (i.e. episodes). It has been shown that for cancers, such as prostate cancer, fewer fractions and a higher dose produce better patient outcomes. In contrast, the standard fractionation can be up to 37 fractions of treatment for prostate cancer. As the PMI is charged per fraction, the total cost is greater with standard fractionation than with CyberKnife. The same principle applies in the case of Intraoperative Radiotherapy (IORT) which HCA has also invested in and has similarly experienced recognition difficulties with PMIs. CyberKnife for the prostate is the standard of care in many US centres of excellence and in locations across Europe and Asia. Indeed, even on the Royal Marsden Hospital website it makes specific reference to CyberKnife being used for prostate cancer:
 

*"Because of its pinpoint accuracy CyberKnife allows larger fractions (doses) of radiotherapy to be delivered, meaning that the patient requires fewer hospital visits. For example, visits for lung cancer patients could be reduced from 30 to three; for prostate cancer patients visits could potentially be reduced from 37 to five and visits for palliative radiotherapy could be reduced from ten to one."*<sup>4</sup>
- (iv) That said, new technology can require more expensive consumables or more skilled staff which can increase costs e.g. in patient preparation time and replacement products, but these costs need to be considered against the wider benefits to the patient and counterfactual cost that might arise.
- (v) Furthermore, new procedures, while potentially lowering the overall cost of treatment, may well increase the availability and use of the procedure because of the wider benefits it produces for patients and thus lead to an overall increase in expenditure. HCA has previously provided the example of arthroscopy, which allows keyhole surgery on joints and enables many patients to obtain treatment without the need for surgery. This has inevitably led to a substantial increase in the treatment of joints.

<sup>3</sup> In terms of the split of daycase vs 1 night procedure episodes: In 2002, [<] of procedures were conducted as a day case procedures (with [<] as a 1 night procedure), in 2012 the proportion of day case procedure was [<] (with [<] performed as a 1 night procedure).

<sup>4</sup> <http://www.royalmarsden.nhs.uk/diagnosis-treatment/treatment/radiotherapy/pages/cyberknife.aspx>

New procedures may also provide patients that were previously inoperable with a viable treatment option. The MitraClip system is used to treat a cardiac condition in which the patient's mitral valve does not function properly. It has been used on patients with co-morbidities and other high-risk factors that would deem them unsuitable for conventional surgery. This newer procedure therefore offers a potential treatment, where none existed before, in addition to faster recovery times. The system was successfully applied by Imperial College Hospital, which at the time claimed to be the only Trust in the country to offer both MitraClip therapy and the TAVI procedure.<sup>5</sup> [§].

- (vi) Equally, although the initial costs of new technology may be high, greater availability and use – as in the case of the TAVI procedure – will often bring unit costs down in the longer term. PMIs need to adopt a longer-term perspective when it comes to innovative treatments and recognise that it is in their interests to allow new technologies to proliferate and mature as the new, most cost effective standard for treatment.

2.18 HCA data shows that the average charge for its most common procedures has reduced, driven by a number of factors such as shorter lengths of stay and improvements in anaesthetic management. By way of example, in the period 2008 – 2012, the unit price. [§] declined by than [§] for the following common procedures:

- [§]
- [§]
- [§]
- [§]
- [§]
- [§]

2.19 These issues affect the NHS and private healthcare equally. The combination of an aging population, together with higher expectations about healthcare needs, is fuelling greater demands for healthcare which in the longer term is increasing public and private healthcare costs. Innovation and improvement in clinical technologies and procedures are vital in order to address evolving healthcare demands and achieve patient benefits.

2.20 AXA PPP is therefore wholly wrong in its claim that there is a "competitive failing" in the market. The pace of innovation is itself a feature of a lively, dynamic competitive market. HCA invests in new technologies in order to effectively compete in the market for both patients and consultants. Innovation greatly enhances patient outcomes. It often produces cost efficiencies in individual treatment episodes, but does not necessarily lower overall healthcare costs by increasing the availability and use of innovative technologies.

**AXA PPP submission**

2.21 In relation to CyberKnife, AXA PPP claims: "*There was no consultation AXA PPP about how we would view this technology prior to HCA deciding to invest*" and that "*it was only close to*

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<sup>5</sup> [http://www.imperial.nhs.uk/aboutus/news/news\\_019026](http://www.imperial.nhs.uk/aboutus/news/news_019026)

*the installation of the machine and the machine becoming operational that HCA and the specialists asked for our view".*

**HCA reply**

- 2.22 AXA PPP's statement is untrue and highly misleading. HCA's CyberKnife Centre opened in February 2009. HCA's then Commercial Director initiated prior discussions regarding CyberKnife with PMIs in summer 2008, including the submission of an extensive dossier incorporating a large number of supporting clinical studies. In addition, insurers were invited to see a CyberKnife facility in operation in Lille. HCA has a record of discussions with AXA PPP commencing in 2008 and into 2009 regarding CyberKnife, including a visit by AXA PPP staff to the Harley Street Clinic in December 2008 where discussions took place about the clinical benefits of CyberKnife. At the time of these discussions, AXA PPP did not suggest that it had not been given adequate notice.
- 2.23 HCA always welcomes a constructive, upfront dialogue with PMIs about the development and implementation of innovative treatment technologies. Indeed, HCA has a long-running record of writing to insurers to request their views on new technologies and often finds itself chasing insurers for a response several months later (as was the case when seeking recognition for the [X]).
- 2.24 Furthermore, as noted in section 33 of HCA's response to the CC's market questionnaire, large PMIs will not engage in a constructive discussion about the recognition of new treatment technologies until investments have already been sunk and equipment is ready to produce quality auditing data.
- 2.25 In short, the lack of openness and general resistance toward recognising proven medical technologies emanates from insurers such as AXA PPP, rather than from HCA, who, in contrast to AXA PPP, is under constant competitive pressure to improve the scope and quality of care offered to patients.

**AXA PPP submission**

- 2.26 AXA PPP makes a claim that HCA consultants are financially incentivised to use new technologies rather than alternative services offering "*higher quality or better value for money*".

**HCA reply**

- 2.27 This is a serious allegation which is wholly unsupported by any evidence. It is an unjustified calumny on the individual consultants concerned who are dedicated professionals and leaders in their clinical fields. HCA challenges AXA PPP to provide it with any instances in which doctors have recommended inappropriate treatments using new technology because of any conflicts of interest.
- 2.28 HCA has fully set out for the CC the limited number of joint ventures with consultants relating to outpatient facilities.
- 2.29 A group of consultants has a minority equity interest ([X]) in the Robotic Radiosurgery LLP which relates to the development and operation of the CyberKnife treatment facility based at the Harley Street Clinic. The vast majority of doctors that refer to the CyberKnife facility are not members of the partnership. A copy of the joint venture (JV) Agreement has been provided to the CC. It will be noted that:

- There is no requirement or obligation on consultants to refer or treat patients at the facility (unlike other hospital providers which do impose restrictions of this nature).
- The JV Agreement requires consultant members to exercise clinical judgement in the selection of appropriate treatments for patients and reminds them to ensure that their clinical decisions are not influenced by the JV Agreement and that they always act in the best interests of the patient.

2.30 HCA places paramount importance on good clinical practice and has instituted clinical governance measures to achieve this end. In the case of the CyberKnife centre, patient referrals will be initially screened by a medical director and clinical research fellow. Following this, patient cases deemed appropriate for CyberKnife treatment will be reviewed before the centre's Multi Disciplinary Team ("MDT"). The MDT convenes every two weeks to assess, in detail, whether admission to the CyberKnife centre would be in the patient's best interests based on clinical criteria. The MDT comprises consultant oncologists, neurosurgeons, surgeons and radiologists who have successfully completed specialist training and maintain competencies in stereotactic radiotherapy or radiosurgery, as well as staff connected to the CyberKnife unit. The majority of the MDT will not comprise members of the JV. Prior to the meeting, the referring clinician must submit a clinical justification case plus supporting evidence, including all necessary clinical details and diagnostic imaging. In the case of highly complex cases, further approval may be required from specialist surgeons. The patient will not be accepted for treatment until all clinical criteria are positively met.

2.31 The MDT can and does issue refusal decisions. For example, from Jan – July 2012, of the [3<] patients presented to the MDT, the number of patients accepted for treatment was [3<], and the number actually treated was [3<] [~46%]. Refusal decisions can be based on a host of factors, such as another treatment being considered more appropriate or disease progression. The number of patients actually treated may be lower still because of PMI funding decisions, availability delays, changes in the patient's condition, or if the patient decides not to proceed with treatment. BUPA has attended such MDT meetings and HCA would similarly welcome AXA PPP to attend these clinical meetings to observe the rigorous clinical governance adopted by consultants at HCA hospitals. Indeed, HCA invited AXA PPP's medical officer on 3 February 2009 to observe an MDT meeting to provide assurance that "*all other clinical options are being considered*" prior to the treatment.

2.32 The consultants are also subject to the professional duties set out in the GMC's Guidance on Good Medical Practice which includes a duty to declare financial and commercial interests in transactions and to ensure that financial commercial interests do not affect the way that they treat or refer patients.

2.33 Unless AXA PPP can particularise its allegation, providing specific evidence of specific instances of inappropriate use of CyberKnife treatment, its claim is groundless and vigorously rejected.

2.34 It is, in fact, AXA PPP rather than the consultants which has a fundamental conflict of interest in relation to new technology. AXA PPP's approach to innovation and new technology is determined primarily by cost considerations. PMIs are not benevolent public health regulators. AXA PPP's primary commercial interest is to limit claims costs as far as possible. It therefore has little incentive to promote and encourage hospital providers to innovate and improve patient outcomes where those innovations may not directly lead to PMI cost savings in the short-run.



- 2.35 Two [§<] episodes illustrate AXA PPP's preoccupation with cost over clinical quality.
- 2.36 The CyberKnife team was preparing to receive an AXA PPP funded patient for treatment. It transpired that this patient had initially been turned down by AXA PPP for Cyberknife treatment. It is understood that the patient vigorously protested and threatened to take further action against the insurer, and that AXA PPP eventually consented to the treatment. As noted above, AXA PPP's position is irrational even on cost grounds, as the CyberKnife treatment is more cost effective than standard external beam radiotherapy, as the patient requires fewer overall fractions, yet the centre's team hear of such incidents time and time again from patients.
- 2.37 [§<] AXA PPP refused to fund or even partially reimburse CyberKnife treatment for a [§<], which in itself is a very unusual position for it to take as CyberKnife is routinely used [§<]. The patient had been through the MDT clinical governance process and deemed appropriate for CyberKnife treatment. However, AXA PPP submitted that Gamma Knife should be used instead as it was cheaper and just as good. [§<] sought to challenge AXA PPP. In addition, the CyberKnife unit's research fellow wrote a supporting letter in which she clearly argued the case for CyberKnife fractionation, referring to the fact that the patient's own expert oncologist had not recommended Gamma Knife for this patient. Indeed, the use of Gamma Knife would have heightened the risk of post-fractionation swelling [§<], potentially endangering the patient. AXA PPP eventually agreed to cover the patient for CyberKnife treatment. In other cases, the patient may simply give up.
- 2.38 These examples are indicative of the resistance patients face from PMIs in obtaining the treatment they require due to cost considerations taking priority over patients' needs. AXA PPP changed its mind in both cases due to patients protesting, which obviously indicates that there was no genuine clinical reason to deny the treatment in either case.
- 2.39 Many more examples can be shared with the CC, including countless occasions where the patient has to cover (or HCA has had to write off) part of the cost for treatment because an insurer refuses to fully reimburse the recommended treatment. A further and considerably more serious consequence of such PMI delaying practices in approving funding is that the patient's condition is allowed to further deteriorate, and in cases where the disease has significantly progressed (for example, [§<] can develop very quickly), the patient may be untreatable under the CyberKnife system, resulting in cancellation of a treatment which represented the patient's last treatment option, solely because of the delay caused by an insurer.

### **3. Section B : recession and hospital revenues**

#### ***AXA PPP submission***

- 3.1 This section sets out some desultory and disjointed arguments but AXA PPP's claim *au fond* is that the PMI sector has declined, but private healthcare has shown resilience and in fact has expanded. AXA PPP argues that this is somehow evidence of higher relative competitive strength.

#### ***HCA's reply***

- 3.2 There are numerous inaccuracies in this section.

- 3.3 PMI is a mature market and has been affected by the weak economy, although in addition the inter-relationship between PMI demand and NHS waiting times (which have reduced in the last few years) also needs to be taken into account in understanding the trends in demand.
- 3.4 HCA would point out that there continue to be significant rises in PMI premiums: Table 3.8, page 178 of Laing's Healthcare Market Review 2011-2012 charts the growth in average prices for private medical cover 1995-2010. Even after 2008, there have continued to be significant increases in real prices for both company-paid and individual-paid policies. The Mintel report on Private Medical Insurance and Healthcare Cash Plans (September 2012), also points to a disparity between a drop in PMI subscribers and gross earned premium which suggests that rising prices, on average, have helped to limit any reduction in PMIs' earnings. Indeed, Mintel forecasts that PMIs' gross earned premium and sales volumes will rise over the next five years. These factors, HCA would suggest, evidence the lack of competitiveness in the PMI market, the high barriers to entry which protect the existing PMI operators, and the lack of new entry.
- 3.5 Indeed, AXA PPP's Interim Results for 2012 show that it has continued to perform relatively well with AXA PPP Healthcare reporting 6% insurance revenue growth and the UK and Ireland Group Chief Executive, Paul Evans, has stated that "... AXA PPP healthcare has continued to deliver strong growth in customer numbers, both in the UK and overseas markets."<sup>6</sup> The 2011 published statutory accounts for AXA PPP Healthcare also show a £303m increase in net insurance premium revenue between the years ended 31 December 2010 and 2011, accompanied by a £58m decline in net insurance claims. The Directors' Report also refers to the fact that, "*In a challenging environment, the Company has continued to achieve growth in revenue and customer numbers*".
- 3.6 Despite AXA's "*strong growth*" in customer numbers, the number of AXA PPP inpatient and day case admissions at HCA's six hospitals fell by [x] from 2011 to 2012. Furthermore, for the top 4 PMIs (which accounts for over 80% of the market), net revenue at HCA's six London hospitals has grown by around £[x] from 2010 – 2012 (i.e. an average of 3.5% per year). Taking inflation into account, HCA has experienced negligible growth in PMI revenue at its hospitals over this period.
- 3.7 AXA PPP refers to the growth in private acute healthcare over the last 30 years. Again, it fails to underline the factors which are driving growth in healthcare spending generally, in the public and private sector and worldwide:
- an increasingly aging population requiring ever greater healthcare needs
  - higher patient expectations regarding clinical treatments
  - new clinical services and treatments which are bringing the fruits of R&D to patients and increasing the availability and accessibility of procedures, often in outpatient settings
  - an increase in the use and demand for drugs (including high cost drugs)
  - rapidly rising costs of medical staff.

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<sup>6</sup> Source: <http://newsroom.axa.co.uk/media-releases/2012/interim-results-2012-strong-broker-led-revenue-growth/>

3.8 AXA PPP's attempt to contrast the contraction in PMI with the rise in private healthcare costs is profoundly misleading.

3.9 In reality, private healthcare providers continue to face a variety of economic challenges in a challenging marketplace. BMI, which operates the UK's largest hospital chain, including the operation of hospitals in Central London, is reported to be facing a number of financial challenges at present.<sup>7</sup> HCA must similarly navigate the economic challenges that affect the domestic and international market for patients.

#### **AXA PPP submission**

3.10 AXA PPP then argues that Central London hospital prices are "*substantially above national prices*" and that HCA's strategy to improve clinical outcomes is "*underpinned by revenue maximisation*".

#### **HCA reply**

3.11 The table in paragraph 47 is redacted and therefore it is not clear what prices AXA PPP is seeking to compare and whether these are on a "like for like" basis. It is hardly surprising that in general Central London hospital prices are higher than in the regions:

- Central London hospitals carry out a far higher proportion of high acuity, tertiary procedures than hospitals in other regions. This is because London has developed in to a world-leading centre for tertiary care, based on the presence of its major NHS teaching and research hospitals, eminent specialists at the top of their clinical field, and its large patient population. High acuity, tertiary procedures are generally more expensive, requiring more specialised consultants, staff and equipment than other procedure types. A straight comparison between Central London and national prices is therefore meaningless.
- There have been significant increases in the costs of medical staff in London compared to the regions. This is also true for the NHS. The London NHS Trusts such as UCLH receive 25%-30% higher reimbursement under the Market Forces Factor ("MFF")<sup>8</sup> than the national average to reflect higher salary and other costs and the MFF in London ranges from 100 to 149.
- There are also significantly higher property costs and travel costs in London compared to other parts of the country.

3.12 AXA PPP also makes a totally unsubstantiated claim that HCA's market strength is borne out by "*excessive levels of profit for some treatments*", which is a claim unsupported by any evidence or reference to HCA's cost structure.

3.13 As AXA PPP will be aware, price levels for specific treatments have been based on historical agreement between the parties rather than based on a separate, objective price negotiation for each procedure. During such negotiations, the parties have often adjusted the price levels of different procedures in order to reflect an overall discount level agreed between the parties. As a result of this pattern of historical negotiations, it is clearly not appropriate to

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<sup>7</sup> Sunday Times (Business section), 10 February 2013, *Private hospital giant in crisis talks on £2bn debt*.

<sup>8</sup> The MFF is a cost percentage that is added to the NHS national tariff based upon the variations in the provision of healthcare costs relating to the local area, e.g. property values and staffing costs.

single out the price for particular treatments as this would present a biased picture to the CC. Rather, the overall discount structure must be taken into account, as some procedures may be more heavily discounted than others. [X] are considerably lower than for other PMIs [X]. By way of example:

- X
- X
- X
- X

- 3.14 With regard to its comment that HCA's strategy to improve clinical outcomes is "*underpinned by revenue maximisation*",<sup>9</sup> it appears that AXA PPP has, quite frankly, failed to understand HCA's submission. It is precisely *because* HCA's rigorously pursues the objective of improving clinical outcomes that consultants and patients are drawn to its facilities and it is this continuing aspiration that drives its business forward.
- 3.15 It is telling that AXA PPP does not refer to the quality of care or patient outcomes in its analysis of HCA prices, highlighting the PMI's preoccupation with cost over quality. AXA PPP merely refers to HCA's hospitals being "*elite private hospitals*", which does not sit well with its earlier claim that "*measuring the quality of healthcare is elusive*".<sup>10</sup>
- 3.16 HCA is a high quality provider offering a range of services including high acuity and complex procedures. The absolute level of cost paid to HCA is determined by a range of factors, including the number of patient referrals to consultants practising at HCA's facilities and the type and complexity of treatments provided. Therefore, HCA considers that any analysis comparing the absolute cost paid to HCA based on its number of facilities compared to other providers is otiose.
- 3.17 HCA can point to several instances in which AXA PPP has departed from the complexity level classification designated by CCSD in order to lower the price it pays for treatments. CCSD is an industry wide body with representatives from PMIs, including AXA PPP and BUPA, and healthcare providers, which convenes to classify procedures and their associated complexity levels. As part of this process, PMI representatives approve the complexity level of a given procedure before it is formally adopted. Despite being involved in this process, AXA PPP has departed from the suggested CCSD complexity level and designated a lower complexity level as part of its own recognised schedule of procedures, thereby lowering the amount of reimbursement for such procedures. HCA can provide the CC with a significant number of such departures.
- 3.18 Furthermore, AXA PPP often unilaterally decides not to reimburse new technology procedures (see section 2 above) above the price paid for the previous standard procedure, despite evidence put to it regarding the clear medical benefits of the new procedure.
- 3.19 AXA PPP states that HCA/St. Martin's aligns its self-pay prices across its London hospitals. This is wrong – see section 20 of HCA's response to the CC's market questionnaire. HCA's self-pay prices have historically been determined at a hospital rather than a group level. Self-

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<sup>9</sup> Paragraph 23 of AXA PPP's submission.

<sup>10</sup> AXA PPP submission to the CC dated 20 July 2012.

pay patients can, and do, obtain quotes from different HCA hospitals and its competitors and negotiate over charges (often via the consultant).

- 3.20 HCA accepts that self-pay prices should be more transparent and, as explained to the CC, it is indeed taking steps to publicise self-pay pricing on the hospitals' websites.

#### 4. Section C : consultants

##### ***AXA PPP submission***

- 4.1 This section is difficult to follow, making somewhat vague and generalised criticisms about consultants practising at HCA hospitals. Once again, AXA PPP's rhetoric is unsubstantiated with any specific evidence.

##### ***HCA reply***

- 4.2 HCA has fully explained to the CC the type of agreements it has with its consultants and the nature of any financial terms. For reasons which have been fully set out in previous submissions, HCA wholly rejects the allegation that there are any "referral incentives" which contravene GMC rules.
- 4.3 AXA PPP refers to the Medical Billing Company. HCA imposes no requirements and has no direct involvement in the billing of consultant fees – these are entirely a matter for the consultants concerned. If consultants choose to use an intermediary company, they are free to do so.
- 4.4 AXA PPP complains about a lack of transparency in disclosure of consultants' financial interests, but HCA would point out that HCA's Code of Conduct requires consultants to comply with GMC requirements, including as to disclosure, and that this is a matter for the individual consultants concerned. HCA fully supports the principle of transparency of any commercial interests which consultants may have.
- 4.5 HCA's relationship with FIPO and the Private Patients Forum is also highlighted, but it is unclear precisely what criticism is being levelled against HCA. HCA supports the attempts by numerous organisations that represent consultants to make patients aware of recent PMI managed care initiatives such as Open Referral. Inexplicably, AXA PPP seems to object to the fact that "*FIPO has issued a newsletter for patients ...*". AXA PPP demands greater transparency in relation to consultants' financial interests, but objects to greater transparency about PMI practices. HCA believes that patients should be entitled to make an *informed* choice about where to go for treatment, based on full information. Consultants are entitled to spell out to their patients the restrictions which PMIs are imposing in their policies.
- 4.6 When looking at the range of consultant submissions put forward to the CC (from individuals to representative bodies), it is PMI practices adopted by larger PMIs that are routinely identified as the source of harm in the market. HCA noted in its submission that there was a risk that such practices would eventually risk undermining the incentive to supply services into the private healthcare market.<sup>11</sup> A recent NAO report has highlighted the fact that there are lower numbers of consultants going into private practice, and PMI managed care initiatives can only exacerbate this trend.<sup>12</sup>

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<sup>11</sup> See section 9 of HCA's submission.

<sup>12</sup> National Audit Office, Department of Health, *Managing NHS hospital consultants*, 6 February 2013.

## 5. Section D : competition

### ***AXA PPP submission***

5.1 AXA PPP has described who it believes are HCA's competitors in London. Unfortunately, much of this section is redacted and therefore the analysis of competitors is unclear.

### ***HCA reply***

5.2 HCA points to the detailed submissions it has already made to the CC regarding the breadth of competitive constraints it faces in and around London:

- 6 independent providers in Central London alone
- substantial private hospitals such as BMI Clementine Churchill and Spire Bushey in Greater London
- 16 NHS PPUs in Central London and 20 PPUs across the Greater London region.
- leading hospitals outside London in the South East.

5.3 The competitive constraints in London are growing:

- As AXA PPP itself acknowledges (see further below) there is a wave of PPU expansion and many London NHS Trusts are gearing up to expand private provision over the next few years. A recent example of this is the appointment by Barts Health NHS Trust of Parkside to develop and operate a new, dedicated PPU on the St. Bartholomew's Hospital site. A further example is the Royal National Orthopaedic Hospital in Stanmore which is undergoing a major new redevelopment which includes the building of a new private patient facility. Please refer to HCA's previous submissions for numerous other examples.
- It is understood that the BUPA Cromwell has received planning permission for a new advanced cancer diagnostics centre in London which will see it invest more than £30 million into this area of care.
- A major new hospital, the London International, is due to open next year.
- HCA has also cited numerous new outpatient facilities in London, e.g. involving BMI clinics.

5.4 HCA has also pointed out the competitive constraint afforded by the NHS, including a number of internationally renowned teaching hospitals based in London that are able to offer cutting-edge tertiary care.<sup>13</sup>

5.5 HCA refers to section 12 of its response to the CC's market questionnaire, together with Exhibit 12.2 which provides a commentary on each of its competitor hospitals.

5.6 HCA faces vigorous competition across the full range of its clinical services. These include its high acuity, tertiary service lines in areas such as cardiac, cancer and neurosurgery where it can point to a significant number of competitors – not least in Central London but also across the Greater London region – which compete directly for PMI and self-pay patients. If HCA's services are seen as high quality, or even 'elite', that is the result of it

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<sup>13</sup> See section 7 of HCA's submission.

competing successfully in a market where providers invest to improve their offer and to introduce new products and services for the benefit of patients.

- 5.7 AXA PPP refers to HCA's acquisition of St. Martin's Healthcare, which gave rise to its current ownership interests. HCA would point out that this acquisition was cleared by the OFT, and that, following this acquisition, HCA has raised the standards and quality of these healthcare facilities through continued investment, and has done so in the face of considerable market risk.

**AXA PPP submission**

- 5.8 AXA PPP claims that HCA "*overstates the catchment area over which its hospitals compete*".

**HCA reply**

- 5.9 HCA has provided the CC with detailed catchment area analysis for each of its hospitals indicating where it draws 80% of its patients. As set out in HCA's response to the CC's Market Questionnaire, the locational analysis undertaken was based on individual patient records from HCA's customer database. This analysis demonstrates broad catchments covering patients in and around London and into the home counties.

- 5.10 As HCA has already stated to the CC, the catchment areas surrounding a facility are not necessarily the same as the relevant geographic market in which the facility operates and in some cases represent a lower bound to the geographic market. This is because the catchment areas only identify where patients travel from and not directly the alternative options they may have. Patients on the boundary of the catchment area isochrone may have alternative options at a distance as far as their chosen facility. Therefore, in principle the geographic market could be twice as large as the catchment area.

- 5.11 AXA PPP contends that, while there are other facilities (outside London) located in the South-East, from which HCA draws patients, "*in our experience this does not happen in reverse*." This misses the point about the extent to which facilities outside London exercise competitive constraints on HCA hospitals. HCA competes with non-London providers to attract patients into London who otherwise have locally available facilities. HCA has given the example of the new Kent Institute of Medicine and Surgery, a new private tertiary care hospital being constructed in Maidstone, Kent, which is targeting patients who would otherwise travel into London for complex procedures. HCA is therefore competing directly with major providers outside London for patients in local catchment areas. The fact that "*this does not happen in reverse*" (i.e. residents in Central London travelling to Kent for treatment) is wholly beside the point.

**AXA PPP submission**

- 5.12 AXA PPP argues that PPU's are not direct competitors with HCA, although AXA PPP concedes that with the lifting of the private patient income cap, they will become "*credible alternative suppliers*" in the future.

**HCA reply**

- 5.13 AXA PPP's claim that PPU's in London are not *currently* significant competitors does not bear scrutiny.

- 5.14 They are not "small" facilities. The 16 PPUs in London include substantial facilities such as the Royal Marsden (69 beds), Royal Brompton & Harefield (43 beds), Royal Free (52 beds) and St. Mary's (43 beds). They individually match the size and capacity of many other independent providers in London. Many earn substantial private patient revenues, e.g. Royal Marsden reported earnings of £51 million for 2011 (up 11.8% from the previous year), and Imperial has earnings of £28.6 million (2011/12).
- 5.15 HCA understands that all the major PPUs in London are recognised by BUPA and AXA PPP, which itself demonstrates that AXA PPP regards PPUs as competitive alternatives for its subscribers. Furthermore, some PMIs have exclusive PPU networks: Aviva has the Trust Care network, and SimplyHealth has recently established a network with the Imperial hospitals. Furthermore, BUPA currently only recognises PPUs for the supply of TAVI procedures (as part of its new TAVI network). Despite putting forward a very competitive tender,<sup>14</sup> none of HCA's hospitals were accepted onto the network. BUPA's network composition for this complex procedure demonstrates that PPUs are not only credible suppliers but also *preferred* alternative suppliers. This undermines AXA PPP's submission that London PPUs are not currently credible alternative suppliers.
- 5.16 AXA PPP's claim that many "*offer little more than a private room in an NHS environment*" is simply untrue. Royal Marsden, Imperial, Royal Brompton, Great Ormond Street, Royal Free, Guy's and St. Thomas', and King's are all examples of separate, distinct facilities which offer the same patient experience as independent hospitals. Indeed, the prevailing PPU business model is to build a purpose-built *de facto* private hospital, and position this alongside the NHS site in order to provide convenience to the Trust's top consultants.
- 5.17 AXA PPP suggests that a number are "*highly specialised for example Moorfield Eye Hospital*". Many (e.g. Imperial, King's, Guy's and St. Thomas', and Chelsea and Westminster) are not specialised and offer a broad range of secondary and tertiary specialisms. Some are specialist, but nevertheless offer competition in the clinical treatments for which they are world renowned. The Royal Marsden, for example, is a world-leading cancer centre with substantial facilities offering a full care pathway for cancer patients and has recently seen significant investment in facilities and services. It is not clear what point AXA PPP is making, since AXA PPP also claims that HCA is specialised in "*complex care e.g. cancer treatment and cardiology*" – areas where it competes directly with several London PPUs.
- 5.18 AXA PPP notes that some PPUs "*share key facilities ... with the NHS*" which could create capacity constraints, but as AXA PPP concedes, PPUs are about to embark on a wave of expansion following the lifting of the caps. It should also be noted that the co-location of NHS infrastructure makes PPUs particularly strong competitors in tertiary services where their reliance on state-of-the-art NHS technology and services provides them with a strong advantage.
- 5.19 This strong advantage also provides PPUs with a platform to attract overseas patient activity, a significant component of HCA's customer base. By way of example, Imperial College Healthcare Trust reported its highest growth segment as the overseas patient base, with revenues from this segment more than doubling (£5.1m revenues in 2010/2011, up from

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<sup>14</sup> See section 43 of HCA's response to the CC's Market Questionnaire for further details of HCA's tender submission to BUPA.



£3.3m in 2009/10). Similarly, University College London and Barts both reportedly doubled their revenues from foreign nationals from 2010 to 2011.

5.20 AXA PPP makes no mention in its submission of the competitive constraints afforded by NHS public hospitals, particularly in areas of high acute tertiary care such as cancer, cardiology and neurosurgery where the NHS is often seen as the "preferred environment" for complex treatment.

5.21 AXA PPP also ignores the significant competitive advantages which London PPUs enjoy by virtue of being part of the NHS "family". HCA has noted the use of contractual ties by NHS Trusts to mandate consultants to spend a proportion of their private practice time in the Trust's own PPU. For example, the Royal Marsden has instituted a new consultant contract that has this effect and it is believed other Trusts will follow suit. Section 7 of HCA's Response to the CC's Issues Statement highlights the competitive advantages London PPUs benefit from.

#### ***AXA PPP submission***

5.22 AXA PPP refers to HCA's recent agreement with Guy's and St. Thomas' to develop a new cancer-focused PPU.

#### ***HCA's reply***

5.23 HCA struggles to understand why AXA PPP objects to the development of a new state-of-the-art cancer centre which will provide further options for cancer patients and increase capacity in London (particularly in view of AXA PPP's concern that PPUs are currently capacity-constrained). This is exactly the kind of investment which PMIs should be encouraging and incentivising. AXA PPP states that "*This would have the impact of increasing Guy's and St. Thomas' share*" but this is simply not true. Guy's and St. Thomas' PPU does not currently offer private cancer care and the arrangement relates to development of new capacity rather than the consolidation of existing activities. The OFT has cleared this transaction specifically finding that it does not involve any acquisition of the Trust's existing services or any diminution of competition. The OFT's clearance decision has rejected AXA PPP's objections as groundless. The transaction increases rather than reduces choice in London.

#### ***AXA PPP submission***

5.24 AXA PPP refers to HCA's alleged "*breadth of ownership*" in healthcare although it does not identify and substantiate the precise adverse effects this creates.

#### ***HCA reply***

5.25 HCA has provided the CC with full information regarding the facilities it operates, including its main hospitals, PPUs, outpatient diagnostic centres and primary care facilities. HCA does not consider that there are adverse effects on competition arising from its operation of a range of facilities.

5.26 By contrast, there is an inordinate influence exerted by the larger PMIs over the private healthcare market. For example, controlling and limiting the rate of expansion and investment by hospital operators, restricting the range of medical procedures offered, adopting detailed and often excessive pre-authorisation procedures prior to inpatient admission, day case procedures, MRI scans and other services a patient may require,

vetoing funding for particular procedures, and through managed care initiatives, exercising control over the entire patient pathway. Examples of such practices are provided in section 5 of HCA's response to the Market Questionnaire.

5.27 AXA PPP also conveniently ignores PMI vertical integration including:

- BUPA's ownership of the Cromwell and BUPA's primary care interests
- AXA PPP undertakes, as part of its Health Services division, a range of healthcare activities, including clinically-led employee health and wellbeing services, which are specifically tailored around the employer's corporate PMI scheme. In addition to a range of occupational health services, AXA PPP also offers employers an Employee Health Gateway product, the aim of which is to engage employees in a fully personalised and constantly evolving health agenda, highlight health issues and suggest courses of action for employees.

5.28 AXA PPP refers to HealthTrust Europe ("HTE") which has recently established a procurement hub for the purchasing of goods and services for member organisations. AXA PPP alleges that HCA will "*gain significant cost advantage through leveraging its purchasing volumes ...*". However, the HTE procurement hub procures on behalf of member organisations in both the public and private sectors. In the private healthcare context, certain HTE goods and services can be purchased both by HCA and other competing organisations, including for example the [X]. It is not exclusive to HCA.

5.29 NHS PUs have for many years been able to benefit from NHS procurement hubs and obtain economies in purchasing drugs and consumables. HTE is in fact opening up opportunities for independent providers to access similar purchasing economies.

## 6. Section E : PMI market structure

### ***AXA PPP submission***

6.1 It is claimed that, while the PMI market is highly concentrated, the same is also true of the hospital providers.

### ***HCA reply***

6.2 HCA has already set out its views in its submissions concerning the lack of competitiveness in the PMI market and the adverse effects this has on supply of private healthcare.<sup>15</sup>

6.3 HCA will simply point out in terms of the comparison of PMI and private healthcare:

- There has been no new entry or expansion in PMI. This may be contrasted with the examples of new entry and expansion in private healthcare, both in London and in the UK as a whole.
- The PMI market is characterised by substantial entry barriers which protect the position of the major incumbent providers.
- PMI recognition represents the most important single barrier to entry for private hospitals which provides the PMIs with substantial bargaining power.

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<sup>15</sup> See, in that regard, sections 6 and 11 of HCA's submission.

- There are few examples of innovation in PMI. By contrast, AXA PPP has conceded, there are numerous examples of new investment and innovation by private hospitals such as HCA which attests to a competitive private healthcare market.

6.4 HCA has already commented on the PMI market and AXA PPP's financial position in section 3 of this submission and in its response to the CC's Issues Statement.

## 7. Section F : switching

### **AXA PPP Submission**

7.1 AXA PPP accepts that switching PMI policies for individual policyholders is prevented by PMI providers as a result of the policyholder's pre-existing conditions, and that this cohort of policyholders represents 25% of the market. AXA PPP states that it is "*commercially unrealistic to expect insurers to behave differently*".

7.2 AXA PPP further notes that "*customers who have claimed experience lower premiums through pooling with their existing insurer and are commercially unattractive to a new insurer*" and that by continuing to provide coverage to existing policyholders the existing insurer is effectively "*accepting poorer risk business at standard rates*".

### **HCA reply**

7.3 HCA welcomes AXA PPP's recognition that policy portability is an issue faced by its policyholders. Referring to HCA's submission (paras 6.16 – 6.20), HCA did not comment on the commercial feasibility of permitting seamless switching between PMI policies, but did remark that the lack of PMI portability is nonetheless a significant feature of the PMI market that represents a barrier to entry and expansion for rival PMI providers. As noted above, this feature of the PMI market is not refuted by AXA PPP.

7.4 WPA, a PMI provider in the UK, described in its submission to the CC<sup>16</sup> the detrimental effect on smaller insurers, and the PMI market as a whole, that results from larger PMIs wielding excessive bargaining power in their dealings with consultants and hospital operators. WPA noted that this effect entrenches the market power of larger PMIs. WPA further noted that this effect is "*is further exacerbated by the fact that many privately insured individuals will find it difficult to move insurers due to pre-existing medical conditions and the underwriting terms which would be applied*".

7.5 The CC has also previously commented that the lack of PMI portability "*limits the ability and willingness of personal subscribers... to switch between PMI providers in response to price signals*".

7.6 It is HCA's view that when this portability issue exists **together** with a highly concentrated PMI market (in which BUPA and AXA PPP have held their current market positions as the leading PMI providers for decades) characterised by major barriers to entry, this combination of factors gives rise to significant competition concerns for both the PMI market and for hospital operators in the private healthcare market.

7.7 In terms of the implications for hospital operators, HCA submitted that a dynamic PMI market with low barriers to entry encourages prospective PMI entrants to challenge incumbent

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<sup>16</sup> Submission dated 6 February 2013.

providers by adopting innovative policies and recognition practices that would encourage and facilitate innovation in medical treatments and the expansion of healthcare facilities. As noted above, the lack of portability is one of the many factors inherent to the PMI market that gives rise to a barrier to entry for rival PMI providers.

- 7.8 The lack of PMI portability promotes and reinforces the buyer power of PMI providers over hospital operators and consultants. When faced with the threat of delisting by a PMI (as BMI experienced in 2011/12 with BUPA), the hospital operator or consultant will be keenly aware that no matter how good the quality of care it provides to the market, a significant base of that PMI's customers will be unable to switch to a rival PMI policy in order to continue their care with them. This "lock-in" effect is exacerbated by the concentrated nature of the PMI market, where very large PMIs, in effect, hold captive a large section of the PMI patient population.
- 7.9 As to AXA PPP's assertion that by continuing to provide PMI coverage on standard terms to existing PMI policyholders it is, in effect, "*accepting poorer risk business at standard rates*", the implicit suggestion is that AXA PPP not only fails to profit from the locked-in status of its individual policyholders but must also "endure" such customers. On that note, HCA would urge the CC to probe the relative profitability of individual policyholders over corporate policyholders. In particular, to determine whether individual PMI customers pay a significantly higher "loading" margin (i.e. total premium/total benefits paid out) compared to other customer cohorts.
- 7.10 In the light of the pervasive role played by PMIs through the patient pathway process, and the importance of a properly functioning PMI market for consultant and private healthcare markets, serious consideration ought to be applied to how best to empower UK PMI policyholders with the opportunity to switch PMI provider. One such innovation may be the formation of "affinity groups", i.e. purchasing consortia of individual customers, to represent the group's collective interests.

## **8. Section G : leader - follower**

### ***AXA PPP submission***

- 8.1 AXA PPP argues that it does not merely "follow" BUPA's strategy but in fact competes vigorously with BUPA.

### ***HCA reply***

- 8.2 HCA has already submitted substantial evidence to the CC that BUPA and AXA PPP have embarked on fundamentally the same market strategies and that there is little sign of the major PMIs offering competitive alternatives:<sup>17</sup>
- Both insurers have adopted similar network strategies, including the creation of general networks as well as specialist networks (e.g. MRI; ophthalmology).
  - Both PMIs have adopted "fixed fee schedules". Both PMIs impose this on all new consultants and are rolling this out to established consultants in the same way.

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<sup>17</sup> See section 6 of HCA's submission.

- The BUPA Benefit Maxima have traditionally served as the benchmark for reimbursements by other insurers such as AXA PPP. Both BUPA and AXA PPP have recently been making significant downward adjustments to the reimbursement rates for various procedures and treatments.
- BUPA and AXA PPP have enjoyed stable market shares for many years, occupying the number 1 and 2 positions in the PMI market for over 65 years, with little evidence of effective competition between them. In contrast, the private healthcare market has shown considerably more dynamism and entry in the market over an equivalent period.
- Both insurers have adopted Open Referral policies. The essential difference is that BUPA's policy is mandatory whereas AXA PPP's policy is simply one of several product offerings and is not imposed on subscribers.
- Both PMIs are aggressively de-listing consultants without providing clear criteria or reasons – this is amply illustrated in the many third party submissions which the CC has received from consultants.
- Both insurers have vertically integrated into primary healthcare, although AXA PPP claims that its primary care interests are less extensive than BUPA's.
- There is remarkable similarity in the way in which both insurers approach issues such as the recognition of new treatments, their involvement in setting clinical pathways, and the policy restrictions which they impose governing the way in which healthcare is provided within hospitals.

8.3 AXA PPP follows BUPA's lead in many important respects. There is therefore little evidence of a "distinctive strategy" by which AXA PPP significantly differentiates itself from BUPA and offers different products or services to its subscribers.

## 9. Section L : Open Referral

### ***AXA PPP submission***

9.1 AXA PPP argues that while it has launched an Open Referral product, this differs from BUPA in that it is not mandatory and is an optional product.

### ***HCA reply***

9.2 HCA acknowledges that the key difference between the BUPA and AXA PPP product is that BUPA has sought to introduce a *mandatory* product which requires corporate customers to ensure Open Referral where BUPA selects the consultants and hospital. By contrast, AXA PPP simply offers the Open Referral product as an option, allowing customers to choose. This is likely to be less distortive of competition.

9.3 It remains the case that, whether the product is mandatory or voluntary, PMIs have the ability to introduce these types of products in order to divert patients to lower costs providers. AXA PPP even carries out the booking of the consultant for the patient, giving it complete control over the decision as to where the patient is treated. This increases PMI bargaining power and provides the PMIs with additional leverage over hospitals in any pricing negotiations.

Products of this nature form part of the "outside options" available to PMI to contain healthcare costs.

- 9.4 HCA notes AXA PPP's acknowledgement that "*our networks are central to our competitive ability to negotiate advantageous price terms....*" HCA agrees. The use of networks indeed provides PMIs with a negotiating advantage and the ability to minimise costs.

## **10. Section M : international business**

### ***AXA PPP submission***

- 10.1 AXA PPP notes that international patients coming to London for treatment are unlikely to be price sensitive.

### ***HCA reply***

- 10.2 Competition for international patients is not merely on price but also on key competition parameters such as quality, innovation and customer service. For example, HCA places a strong emphasis on continuously improving its customer service levels, for example, by offering concierge services, highly trained nursing staff, broader catering options, interpreter services and patient leisure facilities, in order to compete to attract international patients to British hospitals.
- 10.3 International patients will, by definition, consider wider private healthcare options internationally before choosing a UK hospital for treatment. As HCA has set out in its response to question 12 of the CC's market questionnaire, HCA competes internationally for patients with a range of competitors in Germany, the US, Bangkok and Singapore, as well as other UK providers. Many of the type of overseas patients which HCA seeks to attract will generally require "high-end" tertiary care e.g. neurosurgery. They will typically consider a range of alternative options in jurisdictions such as the US, Germany, and Singapore. For these types of treatments, the reputation of the consultants, the quality of care, the availability of "cutting-edge" technology as well as price are all key factors in attracting these patients. This in turn incentivises Central London providers such as HCA to innovate in order to be in a position where they can compete with major facilities in the UK and around the world. International business therefore contributes to driving competition in innovation.

## **11. Section N : relative bargaining power**

### ***AXA PPP submission***

- 11.1 AXA PPP claims that HCA would remain viable if it lost AXA PPP work.

### ***HCA reply***

- 11.2 HCA has already explained its reliance on business from the major PMI providers:<sup>18</sup>
- HCA derives [x] of its revenue ([y] of its PMI revenue) from AXA PPP. HCA is a high fixed cost business which offers a full spectrum of treatments. No business could

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<sup>18</sup> See section 6 and 10 of HCA's submission.

survive with the sudden loss of this proportion of revenue without having a substantial impact on the way in which the business can continue.

- HCA has already explained that, because of what Laing & Buisson describes as the "consultant drag effect", the loss of business from one major insurer (for example, AXA PPP) would quickly lead to consultants taking their insured business to other hospitals and thus HCA would quickly lose BUPA, Aviva, etc. revenue as a result (compounding the loss of revenue from AXA PPP).
- There would also be significant reputational damage from the loss of a major insurer which no hospital provider – least of all a high-quality, tertiary provider such as HCA – could allow to happen.
- HCA has provided examples of where PMIs, including AXA PPP, have secured significant discounts by dint of the threat to remove HCA from a particular network.

11.3 Due to the redacting of AXA PPP's submission HCA is not able to review and comment in detail on their modelling of the scenario where HCA and AXA PPP do not trade. However, for the reasons set out above, HCA does not consider that this would be a viable situation for HCA. Furthermore, whilst HCA may have a greater proportion of international patients than other UK PH providers, this business still only accounts for around [X] of HCA's revenues and HCA competes internationally for these patients so would not easily be able to increase the revenues of these patients to fill any spare capacity as a result of AXA PPP (or indeed any other PMI provider) delisting HCA facilities.

11.4 Thus, AXA PPP's claim that HCA would have alternative "outside options" is simply not credible.

## 12. Section P : London choice

### ***AXA PPP submission***

12.1 AXA PPP refers to its lower-cost London networks which it offers to subscribers as an alternative option.

### ***HCA reply***

12.2 AXA PPP confirms that in relation to its network products: "*The rationale behind this was to try to draw customers away from the high cost, Central London providers towards the lower-costs, Outer London providers.*" HCA has always submitted that this forms one of the strategies available to PMI operators such as BUPA and AXA PPP to contain costs and increases their bargaining position.

12.3 AXA PPP claims that network products "*may be acceptable to a small sub-set of customers*" only but HCA would query this. It does not have information about the numbers of subscribers under different PMI products. However, HCA believes that both BUPA and AXA PPP has significant lower-cost network products which are increasingly diverting business away from London providers. Indeed, HCA notes BUPA's comments in its response to the CC's Issues Statement: "*At the present time networks remain the most effective means of managing costs and therefore need to be supported.*"

### 13. Section T : recognition

#### ***AXA PPP submission***

- 13.1 It is argued here that the withdrawal of PMI policies covering caesarean sections would not have had much impact and therefore would not have contributed to the closure of the St. John's and St. Elizabeth's maternity unit since the target market would have been self-pay rather than PMI patients.

#### ***HCA reply***

- 13.2 As HCA presented in its response to the CC's Issues Statement, it believes that the closure of the maternity unit was due to both the PMI policy restrictions which significantly narrowed the market to only self-pay patients, and to the growing competitive constraint of the NHS. In HCA's case, [X] of revenues at the maternity unit of the Portland Hospital are from PMIs. BUPA's recent action in withdrawing caesarean cover save in cases where the mother's life is in danger has had a direct impact on activity at HCA's Portland Hospital. Specifically, there has been a reduction of [X] in BUPA patient admissions and a fall in revenue attributable to BUPA patients of [X] from 2011 to 2012. It is therefore not at all fanciful to suggest that PMI actions in withdrawing cover have contributed to the closure of the St. John and St. Elizabeth maternity unit. In the case of the Portland Hospital, there has been a significant detrimental impact, with the closure of maternity beds.

### 14. Section U : relative bargaining power

#### ***AXA PPP submission***

- 14.1 AXA PPP further claims that *"that the fact that HCA is not recognised for our value proposition has nothing to do with AXA PPP's bargaining power. In May 2011 we invited HCA to participate in our competitive tender for our new Health on Line value proposition aimed at growing the PMI market by creating new product provision targeted at price sensitive customers."*

#### ***HCA reply***

- 14.2 AXA PPP concedes that HCA is not recognised on its "Health on Line" network product. This supports HCA's contention that it does not have the market power to compel PMIs to accept its hospitals on all of their product networks. This is evidenced by HCA's exclusion from a range of network products sold by AXA PPP (including its corporate plan pathways product which recognises BMI and the London Clinic but not HCA hospitals) as well as from other PMI providers' networks which have instead recognised HCA's competitors (including products sold by BUPA, Aviva and PruHealth).

### 15. Section V : incentives

#### ***AXA PPP submission***

- 15.1 AXA PPP alleges various *"inducements"* offered by HCA to consultants and believes that these create incentives to increase cost and distort referral pathways.



### **HCA reply**

- 15.2 Once again, AXA PPP is misinformed about the terms of HCA's relationships with its consultants. These have been fully described in various previous submissions to the CC. The CC has seen all the model agreements which HCA entered into with consultants. The list of alleged "inducements" is wrong, and the allegations are groundless.
- 15.3 Without wishing to repeat the extensive submissions which have already been made,<sup>19</sup> HCA points out that:
- There are no referral obligations on HCA consultants.
  - There are specific obligations on consultants to act in the patients' best interests and, as discussed above, there are "peer review" processes which monitor this.
  - There are specific GMC requirements which consultants must meet to avoid conflicts of interest.
- 15.4 AXA PPP has not provided any evidence whatsoever that any alleged incentives increase costs or alter referral pathways. Again, HCA challenges AXA PPP to support its sweeping generalisations with specific examples which can be investigated by HCA.
- 15.5 HCA challenges AXA PPP over its statement that any of the consultant agreements in the UK have "*been made illegal in the US*". That is simply not the case. The US investigations are wholly unrelated to any aspects of HCA's UK business or its agreements with consultants. It is disgraceful for AXA PPP to make serious allegations in a public document, including allegations of fraud, which it is unable to substantiate. AXA PPP's description of the US investigations is strongly rejected, but since these matters are irrelevant to any of HCA's consultant agreements in the UK, HCA sees no purpose in providing a detailed rebuttal of the comments in this section.
- 15.6 If AXA PPP is concerned about the behaviour of consultants, the appropriate course of action is to raise the matter with the GMC which has the appropriate regulatory powers to enforce its code of practice.

## **16. Section W : pricing transparency**

### ***AXA PPP submission***

- 16.1 AXA PPP alleges "*excessive pricing*" in relation to pathology charges.

### ***HCA response***

- 16.2 The data submitted by AXA PPP has been redacted and therefore it is not possible to comment, but the following points may be made:
- This is not a HCA specific matter. It is widely acknowledged that, in general, pricing in London is higher because of the higher acuity, tertiary treatments which are being provided and therefore a straight comparison with alternative providers is not meaningful.

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<sup>19</sup> See section 13 of HCA's submission.

- A comparison with NHS laboratory charges is also meaningless. The NHS is able to achieve substantial economies of scale. Moreover, for reasons which have been fully set out in HCA's previous submissions, the NHS is not charging a genuine, commercial rate since its services are heavily subsidised within the NHS.
- HCA's pricing with any PMI provider involves numerous different elements and it is impossible to look at the pricing of any one particular service line in isolation from the total pricing package which is agreed between the parties. HCA could equally point to other service lines at which HCA's prices to AXA PPP do not meet its underlying costs. The issue of pathology charges has been specifically discussed with AXA PPP in the context of the total "pricing envelope" and HCA offered to re-balance its charges having regard to the pricing of other service lines. Indeed, AXA PPP discussed this very point during its contract renewal negotiations for 1 October 2012. [§].
- Healthcare costs are generally higher in London – even in the NHS, NHS London providers receive significantly higher levels of reimbursement than the national average through the Market Focus Mechanism.

**22 February 2013**