

Private healthcare market investigation

Submission and response to Issues Statement: Nuffield Health

20 July 2012

REDACTED VERSION

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Introduction

0.1 Nuffield Health welcomes the opportunity to respond to the Competition Commission's (CC) Issues Statement. We hope that our comments will prove helpful for the CC and look forward to engaging with the CC regarding these issues throughout the investigation.

0.2 Overall, we believe the Issues Statement succeeds in highlighting the key areas that should form part of this investigation.

- However, we do believe that certain issues in the market have been overlooked, such as the need for competitive neutrality and the adverse effects of vertical integration¹
- We welcome the fact that the CC has identified the need to investigate the impact of insurers on the private healthcare market and believe this should constitute a key focus going forward

0.1 In this response we set out our views in relation to the key issues raised in the Issues Statement, and refer to evidence and analysis where this has been readily available.

- Where we do not address a particular issue raised by the CC, or do not provide supporting evidence, this should not be taken to mean that Nuffield Health agrees with the suggestion set out in the Issues Statement

0.4 Nuffield Health agrees with the CC's overall summary (paragraphs 8 – 15) of characteristics of the private healthcare market. We agree that the market for privately-funded healthcare services has a number of underlying, complex, and often inter-related characteristics that are particularly relevant when assessing competition in the sector.

0.5 To capture this in our response letter we have set out two broad sections:

- Nuffield Health's views on the market, its characteristics and the basis upon which to assess competition (Sections 1 and 2)
- Nuffield Health's views in relation to the 'theories of harm' identified in the Issues Statement (Sections 3 to 8)

¹ See Section 5 and Section 7 respectively for more detail on our views regarding these issues

1. Market Fundamentals

1.1 We attempt to explain the complexities of the private healthcare market by walking through the important characteristics of the market, looking at:

- (i) The consumers of private healthcare and their 'patient journey'
- (ii) An overview of the private healthcare market, including the relationships and competitive dynamics between industry players

(i) Consumers of private healthcare and their 'patient journey'

1.2 Nuffield Health feels it is important to reiterate that, despite the adverse features of the market which do not always act in the interests of those funding and benefiting from private healthcare, the quality of private healthcare provision in the UK remains of an extremely high standard.

1.3 The provision of private healthcare is distinguishable from public, NHS healthcare through the level of service provision that private patients obtain. Nuffield Health believes that these superior characteristics that private patients should expect to receive are:

- Fast access to diagnosis and treatment
- Continuity of care with a named consultant of their choice
- Bespoke care to address their individual needs
- High standards of medical equipment and facilities as well as highly responsive and skilled staff at all levels
- Excellent customer care, information and follow-up services

1.4 Given the different funding sources that exist to access private healthcare, several different 'types' of private healthcare consumer exist, as listed below:

- *Self-pay patients*, who pay in full the cost of their private medical treatment, represent c.20% of patients in total²
- *Insured patients*, who's private medical treatment costs are covered by an insurance policy³, represent c.80% of patients in total²

1.5 As the CC highlighted, this implies that for the majority of treatments, there is a distinction between the funder and consumer. For a majority of insured patients, their Private Medical Insurance (PMI) policy is purchased by their employer, as opposed to self-funded⁴.

- Employers generally purchase a corporate PMI policy or invest in employee health trusts (generally Third Party Administered (TPA) funds managed by an insurer).

² In 2011, the breakdown of privately-funded healthcare revenues was: 77.9% insured patients, 18.5% self-pay, 3.6% overseas patients (Laing & Buisson Healthcare Market Review 2011-12)

³ PMI policy or Third Party Administered (TPA) Fund by an insurer

⁴ In 2011, the breakdown of insured patients was: 74.4% corporate, 25.6% individuals (Laing & Buisson Healthcare Market Review 2011-12)

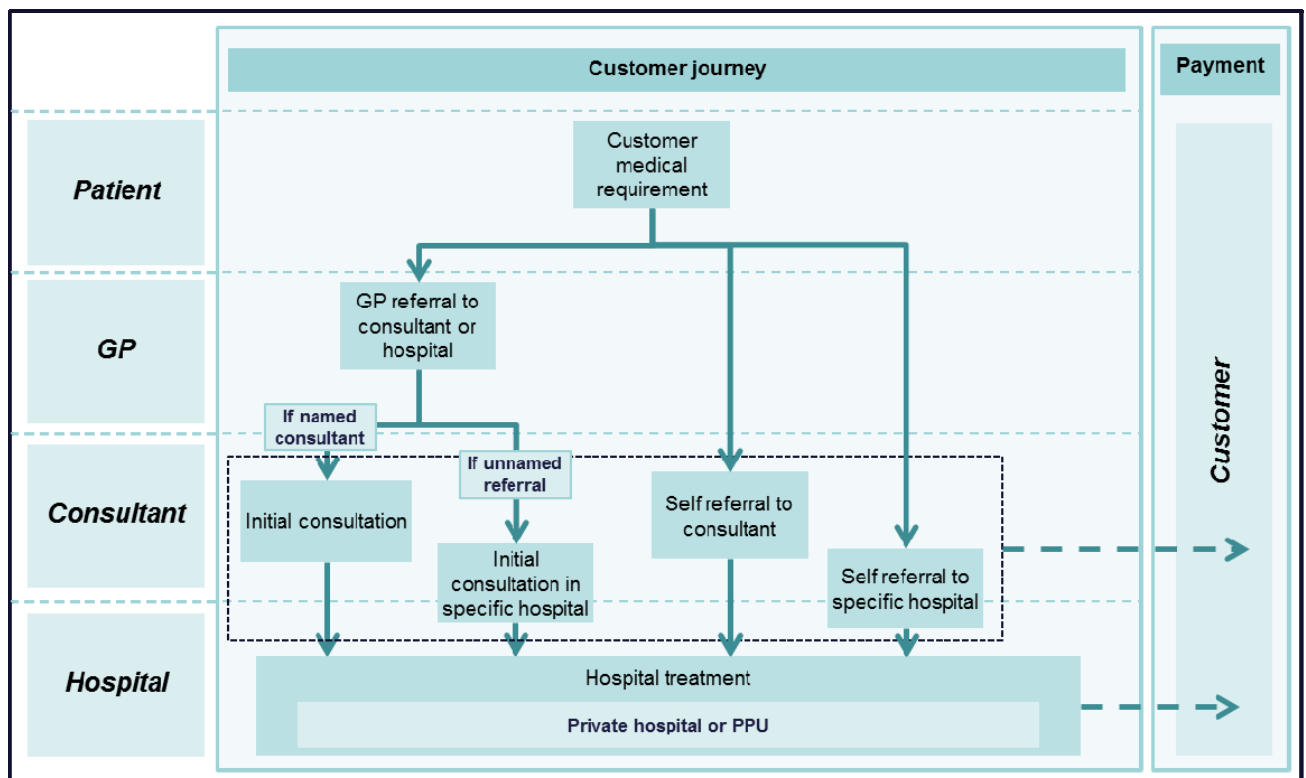
1.6 As the largest customer base for insurers, corporates are important in defining the dynamics of the market (See Section 3 of this letter). Indeed, insurers must focus their efforts towards creating PMI products that correspond to corporate employers' needs. This generally means:

- Having sufficient geographical coverage to provide cover in all of a corporates locations and/or the main business centres in the UK
- Enabling corporates, as policy payors or healthcare trust investors, to keep increasing healthcare costs under control

1.7 The characteristics that differentiate private provision from public provision, mentioned in 1.3, mean that private patients effectively have a different 'patient journey'⁵, offering more choice than that of public patients.

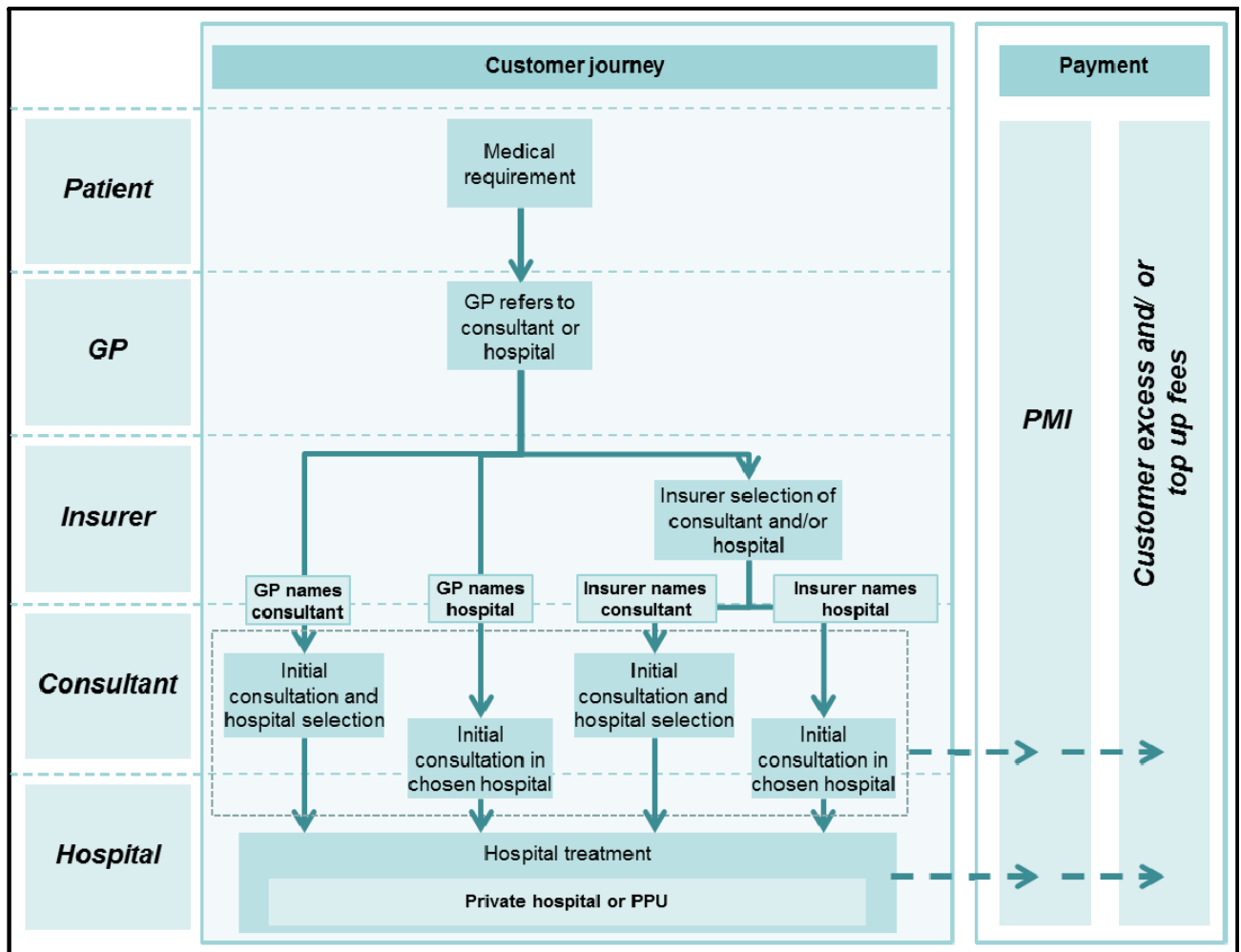
- Figures 1.1 and 1.2 show the typical patient journey for both self-pay and insured patients. These are broadly similar, though a patient's insurer may influence their patient journey to different degrees depending on their policy.

Figure 1.1: Typical patient journey for a self-pay patient



⁵ Also referred to as the 'Patient Pathway'

Figure 1.2: Typical patient journey for an insured patient



1.8 For both patient types, it is typically the GP who determines the best course of action for a patient by referring to a consultant, who in turn will choose the most appropriate hospital operator for that patient to use.

1.9 Certain insured patients will have policies that allow their insurer to restrict their patient journey. The most common instances of this of such restrictions are:

- Requiring an 'open referral' from GPs, so that the insurer may direct to a consultant of their choice
- Refusing named referrals from GPs for consultants that charge above the insurer's maximum reimbursement rate, or forcing patients to pay a fee 'shortfall' in order to keep that named referral
- Restricting the number of hospital operators a patient may have access to for inpatient or day case treatment. In contrast, there are generally limited restrictions for outpatient and diagnostics treatment, which creates confusion and disrupts the care pathway for patients

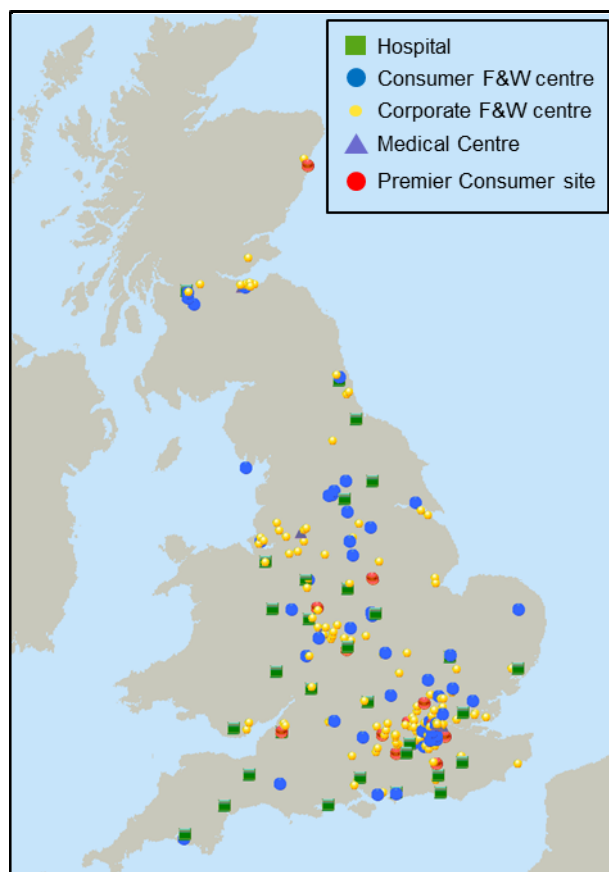
(ii) Overview of the private healthcare market, including the relationships and competitive dynamics between industry players

- 1.10 In the following section we seek to provide the CC with an overview of the private healthcare market, its main players and their relationships. We run through:
- a. An overview of Nuffield Health
 - b. An overview of industry players, their relationships and competitive dynamics

(ii.a) Overview of Nuffield Health

- 1.11 Nuffield Health was established in 1957 as the Nuffield Nursing Homes Charitable Trust and is now the largest independent trading healthcare charity in the UK. Our group has income in excess of £500m and employs over 6,500 employees. We seek to offer one complete healthcare service through a network of over 200 facilities, including 31 hospitals as well as Clinics, Fitness and Wellbeing Centres, Corporate Wellbeing Centres and diagnostics units across the UK (see Figure 1.3)

Figure 1.3: Nuffield Health facilities across the UK, by type



- 1.12 Our charitable purposes are to advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of every kind, all for the public benefit. We believe that these charitable purposes are most likely to be achieved through provision in an open, competitive and efficient market place.

- For more information on our charitable status and the implications this has for our activity, please see Appendix I submitted with this letter

- 1.13 Our long term strategic direction as a group is the creation of the “Nuffield Health and Wellbeing ‘system’”, whereby we will be the first organisation to unite services to improve and maintain health, to contain the risk of illness and disease, and to provide diagnosis and treatment when it’s needed.⁶
- 1.14 As we have tried to set out later in this response, this strategy has been in part driven by some of the theories of harm identified in the CC’s Issues Statement. Originally a hospital provider, Nuffield Health was forced to diversify and rethink its strategy when confronted with the issues of the private hospital market. This resulted in:
- An expansion into consumer fitness and corporate wellbeing services with the purchase of Sona in 2005, Cannons Gyms in 2007 and Bladerunner corporate fitness in 2010
 - The disposal of ten hospitals⁷ in 2008, primarily driven by the effects of the theories of harm discussed further in this letter⁸

(ii.b) Overview of industry players, their relationships and competitive dynamics

Key industry players: Hospital operators

- 1.15 Nuffield Health is one of five large hospital operator groups providing services to the UK private healthcare market.
- 1.16 The hospital operator market is highly consolidated with the five largest groups occupying c.70% market share in 2011. Other providers include smaller hospital groups (e.g. Aspen), NHS PPU⁹, individual hospitals and/or clinics, and represent c.20% of the market.

Figure 1.4: Hospital operator market shares (Source: Laing& Buisson 2011)

Hospital operator	2010 market share	
1 General Healthcare Group	21.5%	Top 5 providers 70.3%
2 Spire Healthcare	16.6%	
3 HCA	12.6%	
4 Nuffield Health	10.1%	
5 Ramsay Health Care UK	9.0%	
6 Care UK	3.7%	Top 10 providers 82.4%
7 Trustees of the London Clinic	3.0%	
8 Circle	2.0%	
9 Bupa's Cromwell Hospital	1.7%	
10 Aspen Healthcare	1.7%	
Other providers	17.6%	

⁶ Nuffield Health Prospectus, 2007

⁷ Nine hospitals were sold to BMI and one hospital was sold to the NHS (Hull)

⁸ See Section 3 of this letter

⁹ See 1.17 for detail on PPUs (Private Patient Units)

1.17 The NHS also provides private healthcare services alongside private hospital operators, generally through Private Patient Units (PPUs). These are typically separate wards within a Trust reserved for fee paying patients. Currently the level of private provision a Trust may supply is capped, generally at c.2% of revenues¹⁰.

- The 2012 Health and Social Care Act raised the cap of private work a Trust may undertake to 49% of revenues

1.18 Over the past decade the market's hospital supply has undergone significant consolidation, particularly amongst the two largest providers, Spire and BMI. Successive acquisitions and organic growth have allowed these two players to gain national coverage of the UK, which awards them significant bargaining power with insurers (See Section 3).

- Spire consolidated their initial portfolio of ex BUPA hospitals with the acquisition of Classic hospital group in 2008.
- BMI bought a portfolio of nine hospitals disposed of by Nuffield Health in 2008.

Key industry players: Insurers

1.19 Insurers play a key role in the market. As is explained in 1.4, they represent the funding source for c.80% of private patients¹¹ and as such represent the largest group of (direct) purchasers of hospital services. Insurers effectively constitute the 'buyer' market of private healthcare.

1.20 Like the hospital operator market, this buyer market is also consolidated. BUPA and AXA, the two largest insurers, represent c.65% of the Private Medical Insurance (PMI) market¹².

- BUPA, the single largest insurer, has a c.40% market share alone⁹

1.21 As a result of this consolidation, hospital operators are heavily reliant on these two insurers (BUPA and AXA) in order to secure a majority of possible insured patient referrals.

- As we discuss in points 1.31 –1.33, the viability of a hospital is entirely dependent on securing referrals from at least one, BUPA, if not both largest insurers

Relationships between market participants

1.22 As described in Figures 1.1 and 1.2, a multitude of market players are involved along the patient journey. In order to ensure the patient's continuity of care, hospital operators must therefore interact with:

- a. GPs and/or consumers

¹⁰Cap levels currently vary by Trust, based on their proportion of private revenues in 2002. The cap level may range between c.1% and c.30%

¹¹ In 2011, the breakdown of privately-funded healthcare revenues was: 77.9% insured patients, 18.5% self-pay, 3.6% overseas patients (Laing & Buisson Healthcare Market Review 2011-12)

¹² Laing & Buisson 2011

- b. Consultants
- c. Insurers

GP and consumer relationships

1.23 In order to drive patient referrals locally, hospital operators market their hospital to local GPs, and in some instances directly to consumers, for self-pay.

- The levels of information currently available to GP and consumers at this stage of the patient journey are generally limited to marketing materials. Given the lack of comparability between hospital operators, this does not generally constitute adequate information (see Section 6)

1.24 Hospitals therefore compete on a local level in order to attract self-pay referrals. This is typically done through promotion activities amongst primary care professionals and consumers in the local area.

Key role of consultant relationships

1.25 Given the consultant's key role in directing patients to a hospital, the relationship between a hospital operator and its consultants is extremely important. Hospitals seek to become the primary location of a consultant's private practice. Typically, individual consultants chose their hospital operator of choice based on a number of characteristics, including:

- Location,
- Facilities,
- Theatre and specialism related assets,
- Theatre staff and scheduling availability,
- Nursing and patient support staff,
- Consultant support services, and
- Insurer network recognition of a hospital

1.26 However, this is changing, due to the fact that:

- Consultants are increasingly grouping their practices together, forming consultant groups of a particular speciality in order to negotiate with hospital providers (see Section 4)
- It is now not uncommon practice for hospitals to use financial incentive schemes in order to attract and 'lock in' consultants. (See Sections 4 and 8)
- There is a trend towards directional products which require the GP to provide an unnamed consultant referral so that insurers may directly select the consultant and hospital used¹³

¹³ Unnamed, direct referrals to hospitals have also come to exist through the NHS Choice booking system, which did not provide named consultant choices (though we understand this is now changing)

1.27 At a local level, hospital operators compete in order to attract consultants, and their patient referrals, to their hospitals. Beyond the attributes listed in 1.25, hospitals use a number of other means to differentiate themselves from competitors and secure consultants' practices, including:

- Free services to support consultants in their private practice, such as consulting rooms, secretarial services, marketing services, etc.
- Investment in specialist equipment of a consultant's particular preference
- Providing financial benefits in exchange for a consultant's loyalty to their hospital

Importance of networks in insurer relationships

1.28 In order to treat a given insurer's policyholders, a hospital must be included on that insurer's list of approved network hospitals. Hospital operators therefore negotiate for their hospitals to be recognised on insurer networks. Generally this is done at a portfolio level, with a fixed price charged per procedure across all hospitals. The price charged by hospitals will be dependent on the network in question (e.g. if it is 'exclusive'¹⁴). There are broadly three types of network:

- *Main 'geographic' networks:* Insurers initially tendered general acute networks geographically, typically tendering for provision in a number of individual regions in order to provide coverage across the UK. We discuss the evolution of these networks in 1.29
- *Product networks:* More recently, insurers started to tender 'procedure' networks, where a hospital was awarded the right to perform a given procedure for their patients. To date insurers have only gained traction for diagnostics and cataract procedure networks.
- *Low cost networks:* The recent trend is for insurers to tender networks specific to their 'low cost' policy products, where the consumer elects to access a restricted set of hospitals for a limited range of procedures. Hospitals must agree a discount price to gain inclusion on these networks.

1.29 At their inception, insurers' main 'acute' networks were designed to drive down hospital operator costs, in exchange for providing access to the hospital operator's portfolio. Both main insurers, BUPA and AXA, operate a main (acute) hospital network.

- BUPA's main network allows all hospital operators to compete for inclusion, provided they meet the required price and quality criteria set by BUPA for each different hospital operator
- AXA's acute network was let out on an 'exclusive' basis, with given hospitals enjoying exclusivity in competed areas. In Nuffield Health's view, this network has effectively not been re-tendered on a clear and transparent basis since its

¹⁴ 'Exclusive' networks award recognition exclusively to a single hospital operator in local markets where more than one hospital operator competes.

inception in 1997¹⁵. Approved hospitals have therefore benefited from exclusive access to AXA patient volumes for over fifteen years

- 1.30 The main hospital operator groups compete to provide national coverage to insurers. Currently only the two largest players (BMI and Spire) are able to compete on a national basis, with other smaller operators providing coverage across certain regions.
- This type of contracting has given hospital operators an incentive to acquire and expand in order to maximise the coverage of their portfolio, and effectively to compete on scale¹⁶ rather than price and/or quality to gain negotiating power over insurers.

Considerations when entering the market

- 1.31 As the CC has correctly highlighted in its Issues Statement, there are high barriers to entry for hospital operators in the private healthcare market. This is suggested by the fact that there have been few new entries into the market in the last decade (e.g. Circle), with only changes in hospital ownership bringing in new players.
- 1.32 When entering a new market and/or developing new services in an existing market, a hospital operator must take into account a number of key considerations beyond demand levels, including:
- *Network recognition:* The viability of a potential hospital is heavily dependent on its ability to treat insured patients, particularly from the two largest insurers BUPA and AXA, as they represent c.65% of potential insured patients
 - *Consultant 'buy-in':* It is crucial for a new hospital to be able to secure support from local consultants to bring their practice to that hospital once it is built
- 1.33 These two barriers to entry are significant, particularly when compounded with the largest ability of the incumbent hospital operators' to use their market power by influencing network inclusion/exclusion and locking-in consultants (through the 'consultant drag effect'). We discuss this further in Sections 3 to 5.

(iii) The market has reached a 'tipping point' due to gradual changes in these relationships

- 1.34 Over the last decade, incremental changes in supply and demand trends in private healthcare have had a cumulative effect, leading us to reach a 'tipping point', beyond which the adverse impacts of competitive distortions will be long lasting and significantly undermine the value proposition to the consumer.
- 1.35 We believe the incremental progression towards this 'tipping point' has been created by a series of interrelated trends:
- a. Demand side consolidation (of insurers)
 - b. Supply side consolidation (of both hospitals and consultants)
 - c. Government intervention in the private healthcare market

¹⁵ The first tender phase of AXA's main acute network started in 1997

¹⁶ The largest hospital operators compete on overall scale, coverage of strategic insurer markets and ownership of 'must have' hospitals. We explain this in detail in Section 3.

(iii.a) Demand side consolidation

- 1.36 In the face of a stagnating PMI market, insurers have sought to grow by gaining market share, rather than growing the market. This has resulted in a heavily consolidated PMI market, with AXA and BUPA occupying c.65% of the market. (See 1.20)
- 1.37 This consolidation combined with insurers' need to reduce costs in order to maintain subscriber levels has had considerable implications for their interactions and negotiations with:
- Consultants and, more materially,
 - Hospitals
- 1.38 As insurers have looked to cut costs throughout the supply chain they have sought to minimise consultant fees. In order to reduce costs, insurers have resorted to keeping consultant fee limits unchanged, reclassifying procedures to reduce their complexity (and therefore remuneration) and pushing for composite billing¹⁷ of services to push fee negotiations on hospital operators wherever possible.
- 1.39 For hospitals, insurers created networks to ensure corporate clients would have national hospital access at a suitable price (see 1.28-29). Where these networks have been 'exclusive' this has channelled volumes preferentially through certain hospitals, contributing to the largest hospital operators' (who already had market power) ability to further reinforce their dominant position (see Section 3).
- 1.40 The combination of a consolidated PMI and hospital markets has led to significant issues in hospital operator – insurer negotiations, leading to 'dead lock' situations which do not enable either suppliers or customers to drive efficiencies in the market. These distortions are caused by the fact that:
- *Only the largest insurers have countervailing buyer power with the largest hospital operators:* We believe BUPA is the only insurer that is able to apply material buyer power; other insurer's networks have effectively been 'seized' by the largest hospital operators (see Section 3)
 - *The largest insurers have considerable buyer power over smaller hospital operators:* Smaller operators without market power are unable to exercise any seller power in negotiations and are therefore often subject to excessive price pressure from insurers

(iii.b) Supply side consolidation

Hospitals

- 1.41 As mentioned in 1.18, the changes in insurer contracting dynamics and expectations have pushed hospital operators to acquire and expand to achieve national coverage, in order to gain negotiating power.

¹⁷ Composite billing: Full cost of medical treatment (including consultants' fees) are billed by the hospital to the insurer. This is the case, for example, for diagnostics.

- A result of this is that the market is heavily consolidated, with the top five players in the market representing a c.70% market share¹⁸. There has also been limited change in hospital operators' market shares since 2008.

1.42 We understand that BMI and Spire, due to their leveraged capital structure, have come under considerable pressure to:

- Grow enterprise value in a stagnant or low growth market, and have both pursued consolidation and scale strategies to this effect
- Achieve a given level of profitability in order to service their high levels of debt and maintain their covenants created by their capital structure

1.43 We believe that in a stagnant, low growth market the pressure to meet these financial requirements may increase the potential for anti-competitive behaviour

Consultants

1.44 The increased pressure from insurers for consultants to decrease fees and move towards composite billing has pushed consultants to consolidate into groups. Dealing with insurers at a group level enables consultants to have increased weight in negotiations (See Section 3).

(iii.c) Government intervention in the private healthcare market

1.45 Further pressure on the changing dynamics hospital operators face will be created by the 2012 Health and Social Care Act, which is likely to produce an influx of NHS private beds (generally PPUs).

- This is likely to create distortions in the market due to a lack of competitive neutrality between public and private providers¹⁹. PPUs are currently able to under-price thanks to NHS cross-subsidisation. We discuss this further in Section 5

1.46 The government's decision to remove tax relief on PMI will also indirectly impact the market.

A 'tipping point' has been reached

1.47 The increment of the dynamics mentioned in points 1.36 – 1.45, which are inter-related and create adverse effects on competition, has served to lead us to a 'tipping point' beyond which the path dependent nature of these interrelated effects will create long lasting harm for consumers.

¹⁸ Laing & Buisson 2011

¹⁹ We discuss the implications of our charitable status on competitive neutrality in Appendix I

(i)

2. Considerations around market definition and the correct basis on which to assess competition

2.1 When considering how to define the market in this investigation, we believe the CC needs to be aware of considerations beyond those referred to in its issues statement for the:

- (i) Scope of the investigation
- (ii) Geographic market definition
- (iii) Product market definition

(i) Scope of the investigation

2.2 We agree with the CC's suggestion that PPUs should form part of this investigation, as they represent a competitive constraint on private hospital operators.

- Nuffield Health's experience indicates that PPUs are credible competitors in the market. More broadly, within our analysis presented in Section 3, we consider that the PPUs included on the largest insurer networks²⁰ are genuine substitute providers of private healthcare
- Issues around competitive neutrality also mean it is essential to 'future proof' the market, by including the current and future impact of NHS provision of private services as part of this investigation (See Section 5 of this letter)

2.3 As part of this investigation, the CC should also consider carefully the implications of the consolidated nature of the PMI market and the impact of the largest insurers' (BUPA and AXA) dominance on market dynamics.

2.4 Nuffield Health also believes the CC should increase its focus on the impact of consultant supply dynamics, namely the impact of consultant groups on the market. From a hospital operator's point of view, this is a particular area of concern going forward.

(ii) Geographic market definition

2.5 The CC must not only carefully consider the method it uses to define geographic hospital markets, but also take into account other important factors that affect geographic competition dynamics in the private hospital market. In particular, we believe that the CC should:

- a. Base its definition of local hospital markets on empirical data
- b. Investigate the London hospital market separately to other markets
- c. Consider the importance of geographic 'insurer' markets on competition

2.6 In past investigations, patients differing propensities to travel have led to a definition of local hospital markets based on drive times from a hospital's location

²⁰ We include PPUs recognised under AXA's acute network, which is less restrictive in PPU inclusion than BUPA's main network

- Should the CC choose to use a similar method, we believe it is important to realise that the relevant drive time definitions are likely to vary dependent on a hospital's location (e.g. in a rural areas vs. an urban area)

2.7 The London hospital market cannot be defined using the same criteria as other UK hospital markets. As a market, it has a number of distinct features to take into account:

- Patient travel dynamics, which differ due to London's extensive urban area, reliance on public transport and levels of congestion
- The level of corporate activity in London, acting as a daily hub of privately insured consumers in the central London area
- The concentration in value of the London market within the central London area
- The market's product mix, which includes much higher levels of self-pay, international and tertiary work than the rest of the UK

2.8 We agree with point 18.(a).(ii) in the CC's Issues Statement that the geographic market definition must also take into account non-local aspects that arise as a result of negotiations between insurers and hospital operators at a national level.

2.9 In particular, we believe it is crucial to investigate 'insurer' markets, which we define as the markets in which insurers aim to provide policy coverage, based on the locations of insured patient demand and supply.

- Understanding 'insurer' markets is of great importance as these define insurer purchasing behaviour in negotiations with hospital operators

2.10 Certain insurer markets must be included in the coverage of an insurer's policy in order to have a credible corporate product to offer to market. Defining strategic insurer markets is key in understanding hospital operators' competitive dynamics. We attempt to identify these based on whether markets are: *(See Section 3 for more detail)*

- Necessary to create national coverage
- High PMI penetration markets
- High corporate activity markets
- NHS teaching or tertiary service hospital locations²¹

2.11 We believe that the CC must consider both hospital markets and insurer markets simultaneously, in order to highlight hospitals that award substantial power in hospital operator negotiations with insurers.²²

²¹ NHS teaching hospitals dictate the level and specialty breadth of consultant supply in a local area

²² We label such hospitals 'must have' hospitals (See Section 3 for more detail)

(iii) Product market definition

2.12 Nuffield Health broadly agrees with the CC's stated approach in defining the relevant product markets in private healthcare. We would add that the need to take into account the fact that specialties and treatments are increasingly differentiated

- In our opinion the market is increasingly competitive at sub-specialty levels, with certain specialised providers electing to provide services in a single sub-specialty

3. Market power of hospital operators (Theories of harm 1 and 3)

Summary: CC and Nuffield Health position

3.1 In its Issues Statement, the CC considers the market power of hospital operators and its effects under three separate theories of harm. In particular it considers whether:

- Hospital operators may have market power in certain local areas (*Theory of harm 1*)
- Hospital operators may have market power during national negotiations with insurers (*Theory of harm 3*)
- Market power in national negotiations with insurers results in barriers to entry for new hospital operators (*Theory of harm 5(a)*)

3.2 In the CC's view, the market power of hospital operators may create adverse effects for consumers, including:

- Higher prices: higher costs of self-pay treatments locally (*Theory of harm 1*) and higher premiums for insured patients nationally (*Theory of harm 3*)
- Lower quality of service: hospitals with market power may have limited incentives to provide high quality services, furthermore network recognition may not reflect the competitive strengths of individual hospitals locally (*Theories of harm 1 and 3*)
- Reduced patient choice: patients face restricted hospital access due to the network exclusion of existing providers and potential new entrants (*Theories of harm 3 and 5*)

3.3 Nuffield Health agrees that the market power of certain hospital operators adversely affects competition in the private healthcare market and welcomes the CC's acknowledgement that certain hospital operators may have market power in national negotiations with insurers. In our view the most material adverse impacts on effective competition and consumer choice are a result of these national negotiations, where operators use their market power to:

- Secure network inclusion for all or most of the hospital operator's hospitals, termed 'one in, all in' negotiations
- Maintain the network exclusion of competitor hospital operators (creating a beneficial associated 'consultant drag effect')
- Command higher prices
- Create or maintain barriers to entry for new and incumbent operators

3.4 We aim to aid the CC's considerations in assessing market power by demonstrating through our analysis and case studies that:

- (i) The largest hospital operators have acquired market power

- (ii) Market power is leveraged in national insurer negotiations, raising barriers to entry and creating adverse effects for consumers
- (iii) Hospital operators with market power have a self-reinforcing dominant position

(i) The largest hospital operators have acquired market power

3.5 In point 31.(a) of the Issues Statement, the CC hypothesises that hospital operators may own hospitals which confer local market power, so that the insurer has little or no choice but to contract with the hospital operator and recognise such hospitals if it is to offer an insurance policy to consumers living or working in that area

3.6 We agree with the CC that certain hospitals confer bargaining power to hospital operators in their negotiations with insurers. Given that insurers have little or no choice but to include these on their network, we term such hospitals 'must-have' hospitals.

3.7 More broadly, we believe that hospital market power in national negotiations with insurers is determined by:

- *Overall scale and national coverage:* overall scale of an operator's portfolio defines it as a fundamental building block of any national insurer network
- *Coverage of 'strategic' insurer markets²³:* the level of strategic market coverage reflects the importance of a hospital operators portfolio for insurers
- *Number and proportion of 'must-have' hospitals:* each 'must-have' hospital in an operator's portfolio awards it incremental degrees of negotiating power with insurers

3.8 We believe the CC should be cautious in identifying 'must-have' hospitals solely on the basis of a standard measure of local market power. In our opinion, the strategic importance to insurers of the markets in which hospitals are located must be taken into consideration when identifying 'must-haves'.

3.9 Nuffield Health has attempted to identify factors that award market power to hospital operators in national insurer negotiations through the following four stage process:

- a. *Identify insurer markets:* markets where insurers aim to provide policy coverage
- b. *Identify 'strategic' insurer markets:* markets that are of strategic importance to insurers in order to provide a viable product to market
- c. *Identify 'must-have' hospitals:* hospitals which, because of a number of characteristics, insurers 'must' recognise on their network
- d. *Identify operators with market power:* identifying providers which, as a result of their coverage of strategic markets and number of 'must-have' hospitals, have negotiating power over insurers

(i.a) Identifying Insurer markets

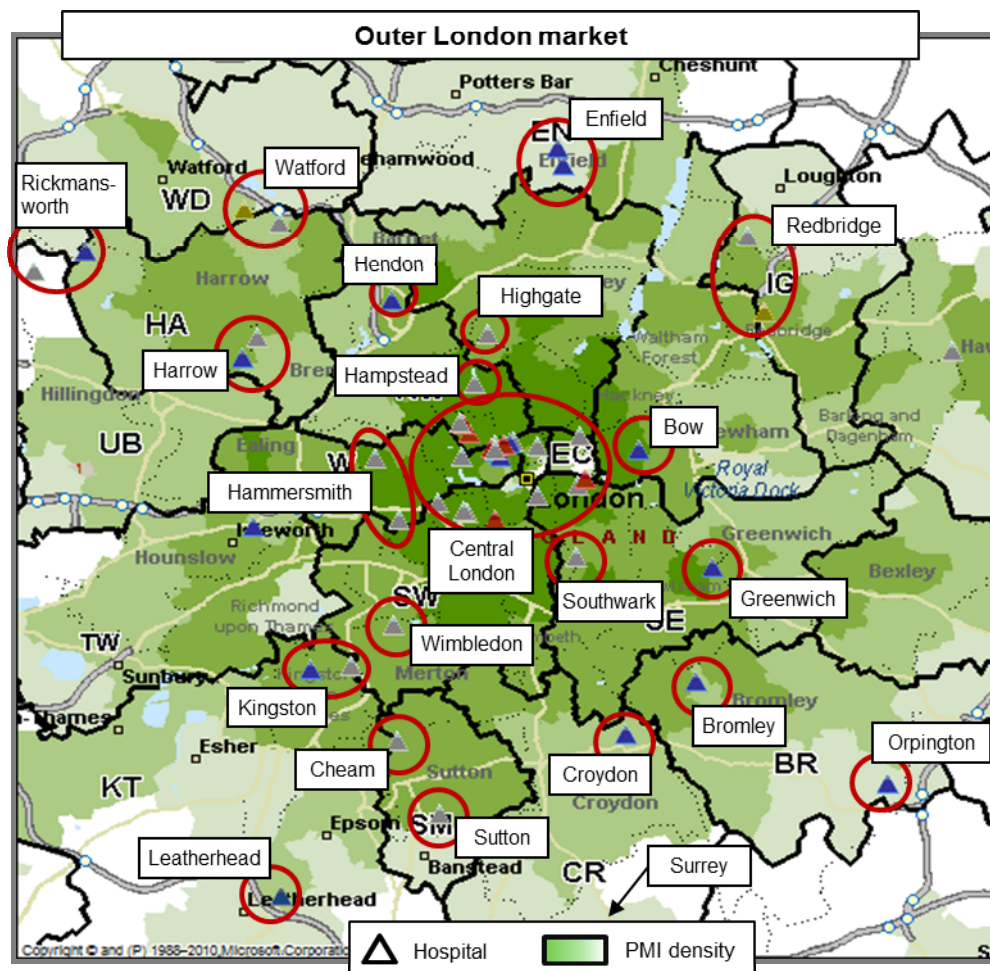
²³ We define and identify strategic insurer markets in point (i.b) below

- 3.10 In our opinion hospital markets are distinct from the markets where insurers aim to provide policy coverage:
- Hospital markets are traditionally defined as areas delimited by a 30 minute drive time from a hospital's location
 - Insurer markets are based on locations of insured private healthcare demand and supply
- 3.11 Although the standard '30 minute drive time' definition of a hospital's local market remains a good starting point to assess competition, we believe this does not necessarily reflect or indicate the (wider) insurer market that a hospital serves and competes for.
- 3.12 We broadly determine an insurer market by locating: – supply, by identifying clusters of hospitals; and – demand, by identifying areas of high PMI penetration and high self-pay demographics in the proximity of hospital locations.
- Using this approach, we estimate that there are 147 distinct insurer markets served by 212 private hospitals
 - Nuffield Health acknowledges that defining insurer markets is not an exact science
- 3.13 Nuffield Health believes the CC should validate these definitions further, and should be able to do so by obtaining information from the largest insurers, requesting they provide the necessary information to understand their approach to building their networks with national coverage.
- 3.14 As discussed in Section 1, the dynamics of the London market need to be considered separately given the large number of characteristics that differentiate it from other insurer markets in the UK, including:
- Geographically: the commuter and large city dynamics of London differentiate it from other UK insurer markets
 - Its product mix: London providers carry out a larger proportion of self-pay, overseas and complex procedures
 - Its NHS private provision: London providers also face effective competition from high quality PPUs
 - Its value: The Greater London area represents £1.3bn of the total £4.2bn UK private healthcare market²⁴. Inner London alone represents c.65% of the Greater London area.
- 3.15 When looking to establish hospital coverage, we believe insurers draw an important distinction between the Inner and Greater London markets. Given this, we define the London market by grouping the individual markets around the periphery of the 'Inner London' market as the 'Outer London market' (See Figure 3.1 on the next page)

²⁴ Laing & Buisson Healthcare Market Review 2009-10

- The Inner London market contains the highest proportion of the Greater London market's value
- The Outer London market comprises 21 individual insurer markets in the vicinity of London

Figure 3.1: The Inner and Outer London insurer markets



(i.b) Identifying 'strategic' insurer markets

3.16 Certain insurer markets must be included in the coverage of an insurer's policies in order to have credible products to offer to market. We term these 'strategic insurer markets' as they are of strategic importance to insurers. Insurers should be able to provide insight regarding these markets to the CC, however Nuffield Health has attempted to identify these based on whether they are:

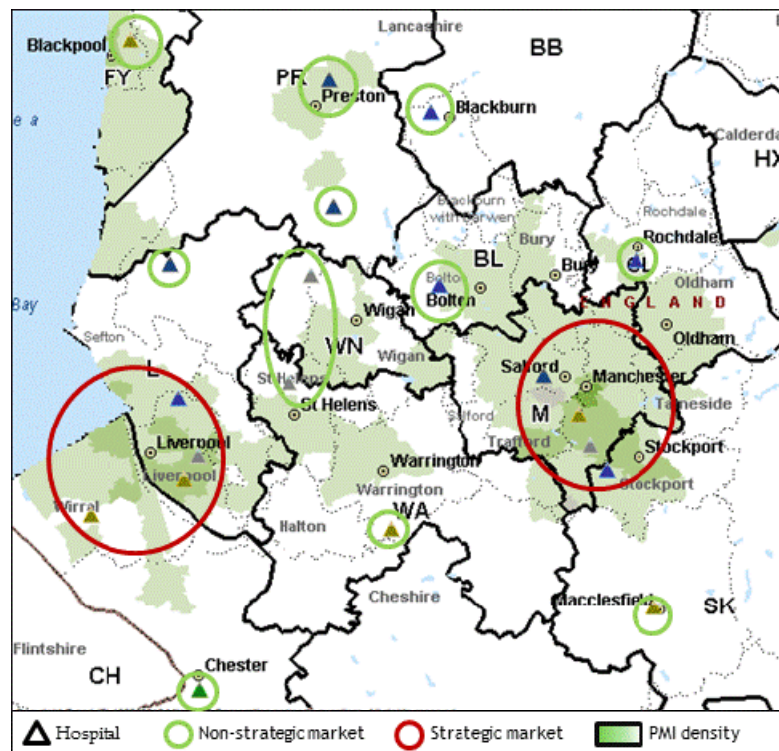
- Markets that are necessary to create effective national coverage
- Markets with high levels of PMI penetration
- Markets with high levels of corporate activity

- Markets with NHS teaching or tertiary service hospital locations²⁵

3.17 By way of demonstration of Nuffield Health’s methodology outside London, in the North West, Manchester and Liverpool stand out as strategic insurer markets due to their high PMI demand, high levels of corporate demand and the presence of teaching hospitals. (See Figure 3.2 on the next page)

- A number of markets in surrounding areas that do not satisfy these criteria have been classified as non-strategic markets (e.g. Blackburn)

Figure 3.2: North West Insurer markets



3.18 Given the extremely high levels of PMI penetration in the Greater London area, the Inner London market and all Outer London markets are classified as strategic insurer markets.

3.19 Using the above methodology, we identify 49 strategic insurer markets out of the 147 insurer markets in the UK²⁶:

- 1 Inner London strategic market
- 21 Outer London strategic markets
- 27 Strategic markets outside the London region

(i.c) Identifying ‘must-have’ hospitals

²⁵ NHS teaching/tertiary hospitals dictate the level and specialty breadth of consultant supply in a local area

²⁶ Excluding Northern Ireland

3.20 A 'must-have' hospital is a hospital that insurers have little or no choice but to recognise on their network if they are to offer a credible policy to corporates and/or individuals. They therefore only exist in strategic insurer markets.

3.21 In our opinion whether a hospital is 'must-have' is determined by:

- High market share²⁷ in that strategic insurer market
- Offer a breadth of specialities or unique particular specialities in the market
- Any relationship to another, typically adjacent, strategic market (this is particularly important in considering the specifics of the London market)

3.22 Using the above criteria, we estimate there are 55 'must-have' hospitals in the UK:

- 20 outside of the London area, owned by three hospital operators (BMI, Spire and Nuffield Health)
- 7 in the Inner London area, all owned by HCA
- In addition, there are 28 hospitals located in the key strategic outer London markets, owned by six hospital operators including BMI, Spire, Ramsey, Aspen and others

(i.d) Identifying operators with market power

3.23 As mentioned in 3.6, 'must-have' hospitals provide significant bargaining power in national insurer negotiations. We therefore believe that market power in national negotiations with insurers is determined by:

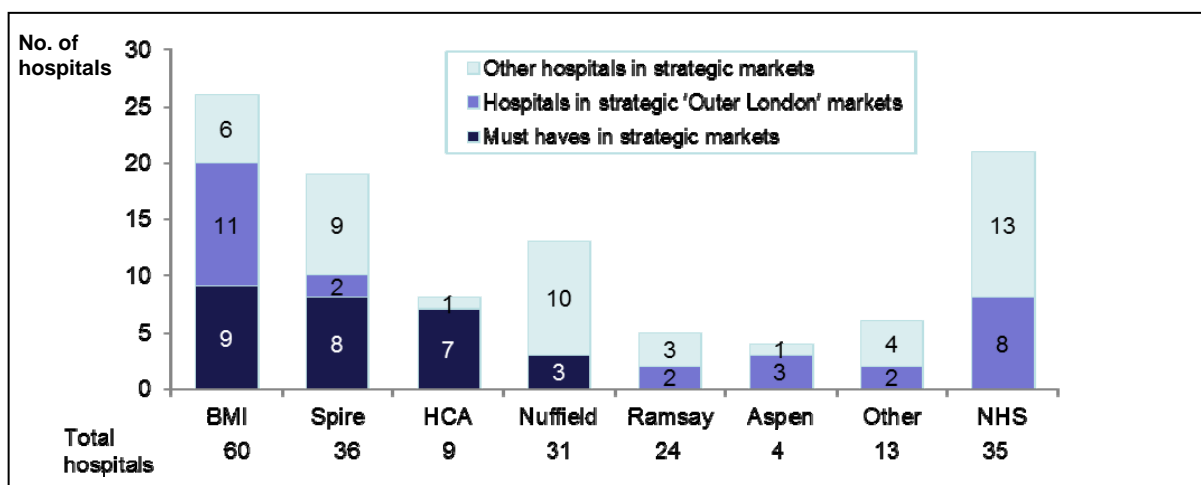
- *Overall scale and national coverage:* overall scale of an operator's portfolio defines it as a fundamental building block of any national insurer network
- *Coverage of strategic insurer markets:* the level of strategic market coverage reflects the importance of a hospital operator's portfolio for insurers
- *Number and proportion of 'must-have' hospitals:* each 'must-have' hospital in a hospital operator's portfolio awards it incremental degrees of negotiating power with insurers

3.24 Figure 3.3 on the next page shows the number of hospitals that are 'must-have' and/or in strategic markets by hospital operator by identifying out of each operators total number of hospitals:

- The number of 'must-have' hospitals in strategic markets
- The number of hospitals in strategic outer London markets
- The number of hospitals in strategic markets in the rest of the UK

²⁷ For further information regarding our method of calculating market share, please refer to our supplementary model guide

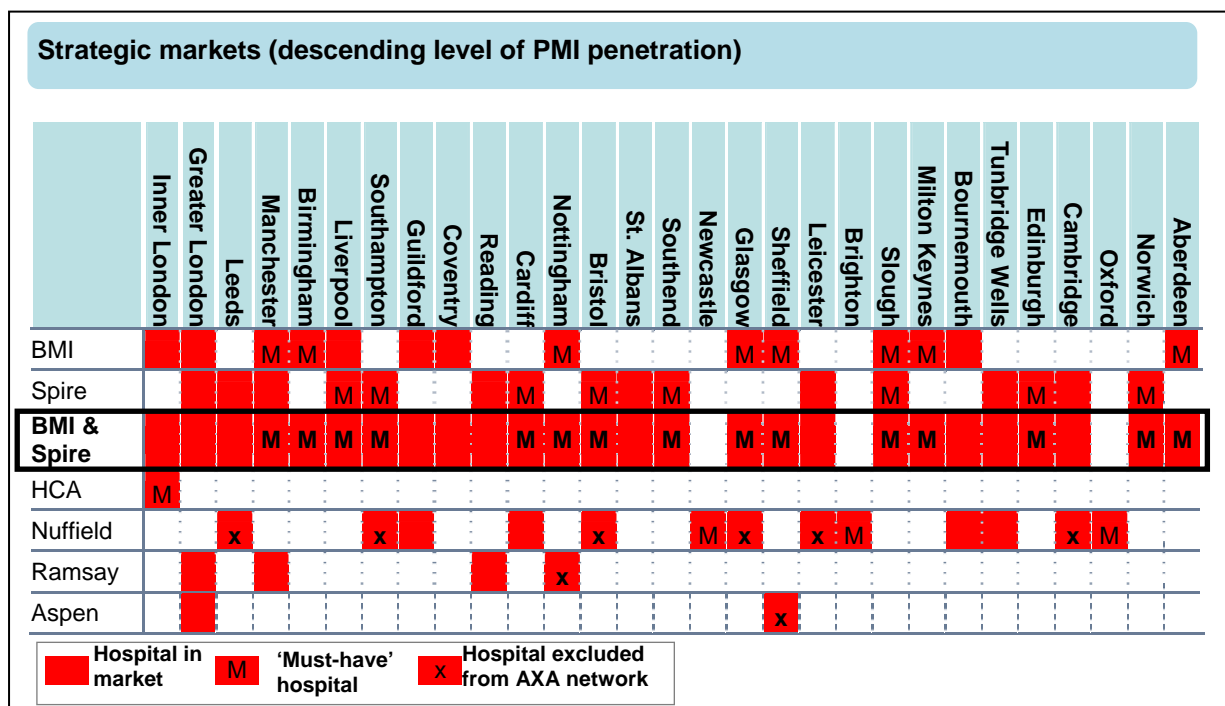
Figure 3.3: Hospitals by type by hospital operator



3.25 BMI, Spire and HCA control 89% of 'must-have' hospitals in the UK. BMI also controls 50% of the strategic Outer London hospitals

3.26 Figure 3.4 shows operators' coverage of strategic insurer markets with both 'must-have' and non 'must-have' hospitals.

Figure 3.4: Strategic market coverage of hospital operators



3.27 In our opinion, Figures 3.3 and 3.4 strongly indicate that Spire and BMI have market power in national negotiations with insurers. Indeed, both combined and individually they have the most 'must-have' hospitals and a disproportionate amount of strategic insurer market coverage.

- Their scale and strength of coverage means that insurers must essentially build their national network by starting with the BMI and Spire portfolios, subsequently adding other operator hospitals in areas lacking coverage
 - Both BMI and Spire have full AXA acute network inclusion across their hospitals in strategic markets
- 3.28 Other hospital operators, such as Nuffield Health and Ramsay, do not have market power as their strategic market coverage and number of 'must-haves' is much lower. Unlike BMI and Spire, they do not have full AXA acute network inclusion across their hospitals.
- 3.29 Figures 3.3 and 3.4 also strongly indicate that HCA also has market power in its negotiations with insurers²⁸. Unlike BMI or Spire, this is not due to national coverage but because of the fact that all its hospitals in Inner London, which represent >50% of the largest PMI (sub) market in the UK²⁹, are 'must-have'.
- In order to ensure London coverage, essential to any corporate policy, insurers are forced to contract with HCA
- 3.30 We feel it is important to dispel the false notion in the OFT's report that all 'solus' hospitals³⁰ award bargaining power to the operators that own them. Whether these hospitals do award any negotiating power will depend on whether they are located in a strategic PMI market (and therefore most likely, 'must-have').
- Nuffield Health has no evidence to suggest that 'solus' hospitals in non-strategic locations award any market power. An analysis of self-pay prices across Nuffield Health's portfolio indicates no correlation between 'solus' status and prices charged, nor any inverse relationship between 'solus' status and quality (measured by patient satisfaction).

(ii) Market power is leveraged in national insurer negotiations raising barriers to entry for existing and new entrants

- 3.31 BMI and Spire use their market power in order to dictate the terms of negotiation with insurers at a national level and distort hospital networks, by:
- a. *'One-in, all-in' negotiation*: Ensuring the network inclusion of all hospitals in their portfolio, independent of their local price or quality merits over competition
 - b. *Excluding competitors*: Enforcing network exclusions of local competitors, and benefiting from the associated 'consultant drag effect' from being an 'exclusive' provider
 - c. *Raising prices*: Ensuring higher prices across their portfolio than would be the case with locally competed price levels
 - d. *Raising Barriers to Entry*: Ensuring through 'one-in, all-in' and exclusion methods that existing or new entrant hospital operators are unable to gain network recognition

²⁸ Nuffield notes that this view is seconded by most other hospital operators as well as insurers in their initial submissions as part of the investigation

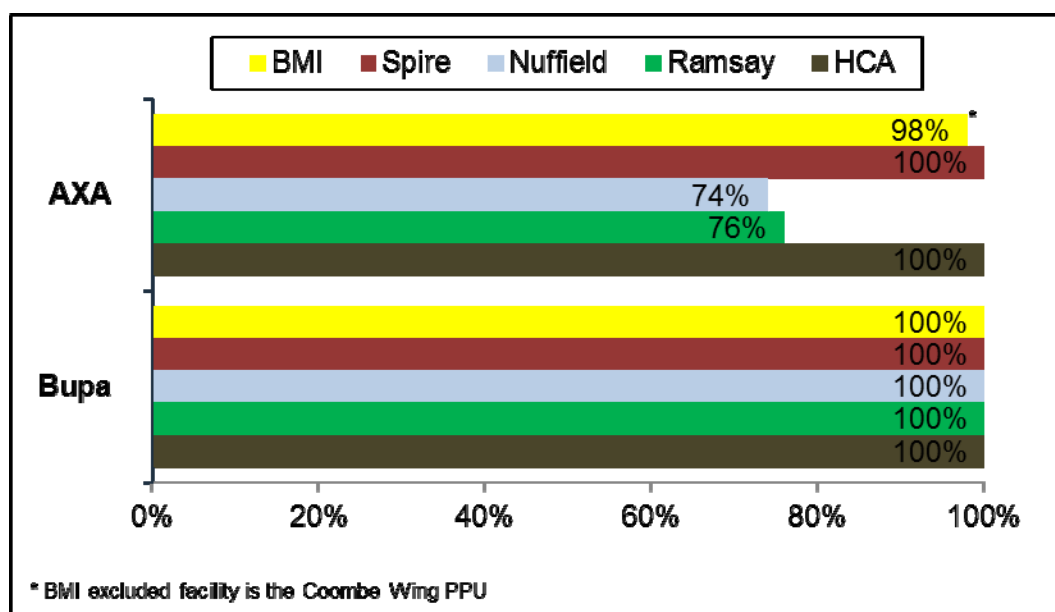
²⁹ The Inner London market serves the largest PMI population in the UK

³⁰ 'Solus' hospitals are defined by the OFT as hospitals without competing hospitals within a 30 minute drive time

(ii.a) & (ii.b) 'One-in, all-in' negotiation and excluding competitors

- 3.32 As discussed in Section 1, certain insurers restrict their hospital networks by including certain hospitals on an 'exclusivity' basis and excluding others.
- Of the two main insurers, BUPA and AXA, which account for c.65% of the UK market, this is the case for AXA's main ('acute') hospital network
 - Some smaller insurers, e.g. [REDACTED], have also operated their hospital networks on this basis in past negotiations with Nuffield Health
- 3.33 Where insurer hospital networks are operated on an 'exclusivity' basis, hospital operators with market power (BMI and Spire) are able to distort these by influencing inclusion and/or exclusion decisions in their favour
- Due to insurers' obligation to include their 'must-have' hospitals on their network, BMI and Spire use 'one-in, all-in' negotiations to ensure all or most of their portfolio is included, often regardless of price and quality metrics. (See Figure 3.5)
 - BMI and Spire are also able to ensure that insurers continue to exclude competitors, irrespective of their price and quality merits (See Figure 3.5)

Figure 3.5: Inclusion of operator hospitals on key insurer networks



- 3.34 BMI and Spire's ability to gain 'automatic' network inclusion of hospitals has been further evidenced through a change in network approval status of acquired previously excluded hospitals
- Of the AXA excluded hospitals Nuffield Health disposed of in 2008, all those subsequently acquired by BMI and Spire gained immediate network inclusion upon change of ownership³¹. On the other hand, the one hospital

³¹ Excluded hospitals acquired by BMI were: Nuffield Birmingham, Huddersfield, Enfield and Gerrards Cross. The Gerrards Cross hospital was subsequently sold by BMI to Spire in a back to back deal. Nuffield strongly recommends

subsequently acquired by Ramsay (Nuffield Nottingham) was unable to secure AXA network inclusion and remains excluded today

3.35 Where the hospitals of smaller hospital operators are excluded from the network, as is the case for Nuffield Health, exclusion cannot be justified through price or quality merits. In a number of instances, AXA network recognition does not reflect the competitive strength of a hospital in a given local area.

- The starkest example of this is Nuffield Health's hospital in Leeds³², which, despite being an acclaimed 'state of the art' hospital in which Nuffield Health has substantially invested, has been unable to secure AXA network inclusion
- Nuffield Health is also currently undertaking a substantial refurbishment of its Bristol hospital, to date this has been without guarantee or any indication from AXA that its excluded status will be reversed. As a result of this, investment has been tailored to provide a niche, boutique service, limiting the capacity and choice of services that will be available to patients

3.36 Nuffield Health is also able to provide evidence of certain elements in negotiations with AXA and other insurers around network inclusion that suggest BMI and Spire are able to influence exclusions/inclusions in their local markets. Contracts and correspondence relating to these negotiations may be made available to the CC upon request.

- [REDACTED]
- [REDACTED]
- [REDACTED]

3.37 The impact of the network exclusion on excluded competitor hospitals is compounded by the 'consultant drag effect': consultants strongly prefer to treat all their patients at a single hospital³³, and therefore hospitals with an 'exclusive' status benefit from a disproportionate volume uplift due to the exclusion of other hospitals in the local market.

- [REDACTED]

that the CC investigate the terms of this sale as we believe the price negotiated reflected BMI's revision of the excluded status of the hospital with AXA.

³² For more detail on Nuffield's Leeds hospital we refer the CC to Nuffield's presentation at the CC's site visit.

³³ OFT market investigation report

Figure 3.6: [REDACTED]

3.38 As discussed in (iii.d) the strong consultant drag effect ‘exclusive’ hospitals benefit from, particularly when combined with financial incentives that aim to lock in consultant practice, create high barriers to entry for both new and existing players in the local market.

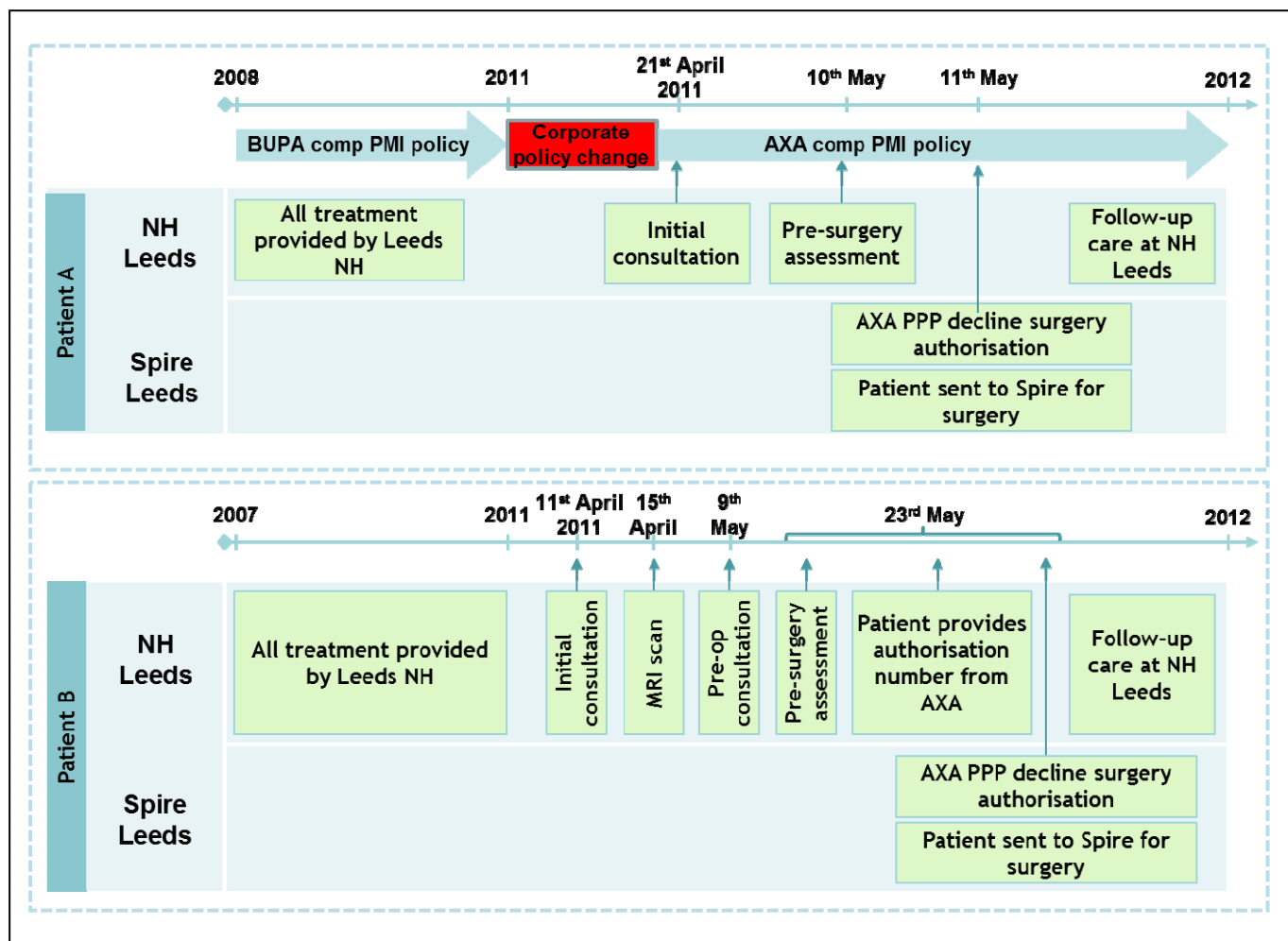
- [REDACTED]

3.39 The manipulation of insurer network negotiations by hospital operators with market power creates significant adverse effects for consumers. We believe these are:

- *Restriction of patient choice:* insured patients with policies that exclude certain hospitals are restricted in their choice of hospital. Nuffield Health has numerous examples³⁴ of patients’ continuity of care being compromised due to network exclusion. It may also restrict consultant choice due to the consultant drag effect favouring ‘exclusive’ hospitals. (See Figure 3.7 on the next page)
- *Lower service quality:* – hospitals that are excluded have less investment capability, hampering their possibility of competing in the long term; –hospital operators with market power have limited incentives to compete on quality or to innovate
- *Higher prices:* The control operators with market power have over the network inclusion/exclusion may mean that the best value hospital is not recognised on networks

Figure 3.7: Case Studies demonstrating of patient journey restriction (Nuffield Leeds Hospital)

³⁴ Correspondence available upon request



(ii.c) Raising prices

- 3.40 We believe that where hospital operators cannot manipulate network exclusion, as is the case for the BUPA network, which does not operate on an exclusive basis, operators with market power (BMI, Spire and HCA) are able to command higher prices across their portfolio.
- 3.41 Though Nuffield Health does not have access to PMI pricing data for other hospital operators, anecdotal evidence obtained during our disposal of hospitals in 2008 indicates that BMI prices were at a significant premium to Nuffield Health's.
- [REDACTED]
- 3.42 In London, we believe that HCA is able to charge higher prices as a result of its market power: it is the 'must have' operator for insurers in the Inner London area.
- 3.43 Nuffield Health strongly encourages the CC to investigate insured work pricing levels across all hospital operators.
- Data recorded through Healthcode, the system that registers the majority of billing transactions between hospital operators and insurers, should provide the CC with price data by procedure and by hospital.

- Although pricing methods are not uniform across the industry we believe the CC should be able to acquire comparable average total costs per procedure³⁵ by hospital operator using retrospective insurer data.

3.44 Higher hospital prices is a considerable adverse effect of operator market power on consumers. Higher hospital prices will increase the cost of care for self-pay patients and in the longer term, raise premiums for insured patients.

(ii.d) Raising Barriers to Entry

3.45 We agree with the CC's Theory of harm 5(a) that the practices highlighted in (ii.a) and (ii.b) raise barriers to entry for new entrants by making it difficult for new hospital operators to gain insurer recognition for new hospitals. We also believe that they raise barriers to entry for existing hospital operators in these local markets. They also limit investment possibilities for incumbent, excluded operators.

3.46 As described in the Section 1 of this letter and the OFT's market investigation report, network recognition, particularly from the two largest insurers (BUPA and AXA), is key in determining the viability of an investment case for a new hospital build.

- [REDACTED]

Figure 3.8: [REDACTED]

3.47 Hospital operators with market power are not only able to protect their 'exclusive' position on certain networks, but also able to protect their dominant position on all networks by preventing the network inclusion of any new hospitals in their portfolio locations. The OFT's market reports suggests this is done by:

- Using contract provisions that oblige insurers to consult them on any decisions regarding the potential addition of any new hospitals in their network
- Using price threats across their portfolio in order to render it un-economical for insurers to recognise new hospitals on their network

3.48 Hospitals with an 'exclusive' network status also raise barriers to entry for existing market providers by:

- Benefiting from the associated 'consultant drag effect' of exclusions, and thus raising barriers to entry for existing local hospitals in creating new, competing service lines due to their inability to attract consultants
- Diminishing the business case for investment in equipment and facilities at excluded hospitals

3.49 In London, we believe that HCA uses its market power and consultant incentives to create extremely high barriers to entry in the Inner London market, where new entries have been very limited in the last decade.

3.50 The principle adverse effects of these artificially high barriers to entry on consumers are:

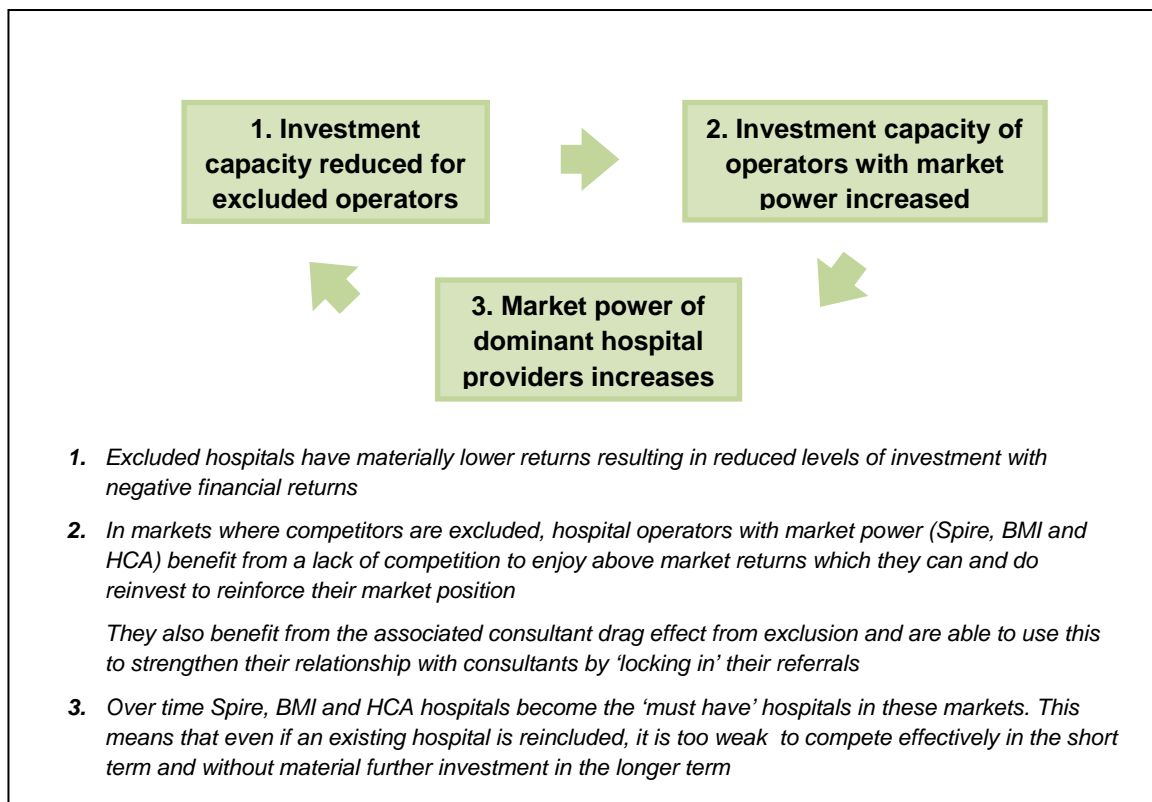
³⁵ Including any follow up and/or additional charges

- *Decreased patient choice:* Preventing new entrants or new service lines from entering the market decreases the choice of hospital operators available to patients
- *Higher prices:* By excluding new entrants, players with market power are able to limit competition and therefore, we believe, charge higher prices

(iii) Hospital operators with market power have a self-reinforcing dominant position

- 3.51 The drivers behind the lowering of quality mentioned in 3.40 mean that the dominant position of players with market power is self-reinforcing. *(See Figure 3.9 on the next page)*
- 3.52 This cyclical effect emphasises the importance for the CC to address the market power that BMI, Spire and HCA have acquired. If left unaddressed, as has been the case in previous OFT merger investigations, the adverse effects discussed in *(ii)* will become further ingrained in the industry, to the detriment of consumers and the market.

Figure 3.9: Self-reinforcement of dominant position of hospital operators with market power



4. Market power of consultant groups (Theory of harm 2)

Summary: CC and Nuffield Health position

- 4.1 The CC hypothesises that consultants or consultant groups in certain local areas have local market power over their patients, caused by several factors, including:
- A limited number of consultants in a particular local area for specific treatments/ specialities
 - The way referrals are made and consultants selected (historic referral pathways potentially becoming entrenched)
 - The joint setting of prices [REDACTED]
- 4.2 The CC believes that this is likely to result in patients facing high charges and a reduced quality of service for both self-pay and insured patients³⁶.
- 4.3 Nuffield Health agrees that consultant and/or consultant groups have market power in certain localities and specialities. In our experience, certain consultants and/or consultant groups have market power over local hospital operators as well as patients, since they are instrumental in bringing patient referral volumes to hospitals.
- 4.4 We agree that the main driver of this market power is the limited consultant supply of a given specialty in local areas. In our opinion, the formation of consultant groups has significantly contributed to this by consolidating consultant supply in certain local areas.
- 4.5 In broad agreement with the CC, we believe the adverse effects of this market power are:
- *An increased cost of care for no consequent quality increase* – as consultants with market power drive up fees and/or incentive payments
 - *Reduced patient choice of hospital facility*– as consultants channel all volumes through specific hospitals
 - *(Potentially) reduced quality of service for patients*– as consultants with local market power have little incentive to innovate or compete on the quality of their services.
- 4.6 In order to aid the CC's thinking around this theory of harm we have set out our thoughts and evidence around the following framework:
- (i) Factors that award consultants and/or consultant groups market power over hospital operators (as well as patients)
 - (ii) How consultant market power is leveraged through 'rent-seeking behaviours'
 - (iii) The adverse effects of consultant market power

³⁶ Insured patients may have to make additional payments or may face higher insurance premiums in the long term

(i) Consultant and/or consultant groups market power over hospital operators

4.7 Despite highlighting the reasons for consultant market power over patients, we believe the CC has overlooked the market power that consultants may have over local hospital operators. We believe that this is driven by the fact that consultants have influence over patient hospital treatment.

- As discussed in our description of the patient journey³⁷, consultants play a key role in determining a patients' choice of hospital. As such they possess a degree of negotiating power with hospital operators, who are dependent on being able to attract and retain consultants at their hospital in order to secure patient volumes

4.8 Where the local supply of consultants is restricted, we agree with the CC that consultants or consultant groups are likely to have market power.

- Individual consultants with high revenues and high local market share are likely to have a strong hold over local hospitals, because of the hospital's reliance on that consultant for referrals and revenues
- Consultant groups with a majority local market share either in a particular area of medical specialisation or generally, have collective control over a large proportion of patient referral volumes and revenues, also giving them a stronghold over hospital operators

4.9 We agree with the CC that consultant market power within a local market is driven by limited supply of consultants in a given speciality locally. In particular we agree that market power is driven by:

- Certain local areas having a limited supply of consultants and/or consultant groups
- The growing trend for consultants to specialise in sub-specialties, which creates a limited number of experts available to provide services
- Consultants increasingly consolidating local supply by forming consultant groups

4.10 The number of consultants that are part of a consultant group has grown materially. Although the OFT's report focuses on anaesthetic groups, our research shows that these groups exist across all specialties (See Figure 4.1 on the next page).

- The number of consultant groups grew by 110% from July 2006 to November 2009. Currently, of the 15,000 consultants that have a private practice, 8,750 practice as individuals and 6,250 practice as part of a group³⁸

³⁷ See upfront description of referral pathway (Figures 1.1 & 1.2)

³⁸ Independent Nuffield Health research (2010), can be made available on request

Figure 4.1: Growth in consultant groups, 2006 - 2009

	Jul-06	Jul-07	Nov-09	Growth
Anaesthetists	22	27	40	82%
Orthopaedics	17	30	38	124%
"other"	11	15	32	191%
Radiology	8	9	14	75%
Colorectal	5	8	8	60%
Urology	5	7	11	120%
Gynaecology	5	6	8	60%
ENT	4	9	9	125%
Ophthalmology	4	6	10	150%
Total	81	117	170	110%

4.11 We believe the current trend of consultants forming groups is likely to continue, due to pressures from

- Insurers attempting to reduce consultants' fees, and
- Rising consultant practice costs such as medical malpractice indemnity fees

4.12 Figure 4.1 shows that consultant groups are increasingly common across all specialties. Although these groups are typically set up for a particular specialty in a local area, some are nationwide and/or multi-disciplinary. [REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]

4.13 We feel that it is important to highlight that in our experience, it is more often consultant groups rather than individual consultants that possess and leverage such market power.

(ii) Consultant market power is leveraged through 'rent-seeking behaviours'

4.14 Nuffield Health recognises that there are benefits for consultants in forming groups such as sharing overheads, marketing costs etc. However, we believe that the increase in the number and size of consultant groups has served to consolidate consultant supply in certain local markets.

- In our opinion, this raises concerns that such consolidations of supply may lead to an increase in consultants' market power. Where consultant groups are able to exert significant market power, there is a risk that this may be applied in ways that are likely to give rise to adverse effects for consumers.

4.15 Where consultants and/or consultant groups have market power, this can be used to engage in 'rent-seeking behaviour'. In this case, consultants typically threaten to withdraw their activity in order to force the hospital to agree to:

- a. Higher fees and/or
- b. Higher financial incentives

(ii.a) Higher fees

- 4.16 Hospital operators usually have visibility of consultant fees for self-pay work and in certain specialities for insured work (as they do not typically bill for consultant services). Where this is the case, Nuffield Health will bill a total cost of treatment, including consultant fees.
- For insured patients, this is the case for certain specialities, for example Radiology and Histopathology
 - For self-pay patients, Nuffield Health puts forward a packaged price (including consultant fees) to market. In this case, however, consultant fees are simply 'pass through' revenue
- 4.17 Where we negotiate on fees, Nuffield Health is able to provide numerous examples, across both our insured and self-pay activity, where we have been forced to raise or maintain fees as result of local consultant market power. We include the most significant examples of this in points 4.18 – 4.20 below.
- 4.18 For our self-pay work, we face instances where groups have insisted on raising their fees, putting pressure on our ability to quote market rate prices and compete in the market [REDACTED]
- 4.19 [REDACTED]
- [REDACTED]
 - [REDACTED]
- 4.20 Regarding Anaesthetists, though we do not generally administer their fees (except for self-pay), we are aware of issues between insurers and anaesthetist groups with fee negotiations.
- In some instances, we have evidence that this results in patients of certain local areas being systematically charged top up fees
 - We are also aware the anaesthetist fees are on occasion not discussed until late in the referral process, leaving patients little choice but to pay any top up fees

Figure 4.2: [REDACTED]

- 4.21 Although not direct examples of raising fees, Nuffield Health has often been confronted with difficulties in readjusting consultant fees in response to insurer reimbursement rate changes. We believe this is also an example of consultant groups using their market power to maintain prices higher than the insured market demand would otherwise sustain.
- [REDACTED]
 - [REDACTED]

(ii.b) Higher financial incentives

4.22 Given the small proportion of work for which we include consultant fees, it is more often the case that Nuffield Health faces pressure from consultant groups with market power to increase their incentive package in order to retain their patient volumes.

- This increases hospital costs and, ultimately is likely to feed in to higher hospital prices. [REDACTED]

4.23 [REDACTED]

- [REDACTED]
- [REDACTED]

4.24 Though Nuffield Health does not pass on the cost of consultant incentives to its customers, in the long run we believe that this 'rent-seeking behaviour' would force hospital operators to reduce investment due to diminishing resources, or to raise prices.

4.25 Nuffield Health believes that such 'rent-seeking behaviour' is as much a result of local market power as it is a result of the fact that financial incentive schemes are allowed, and therefore provide consultants with the ability to engage in such behaviour.

(iii) The adverse effects of consultant market power

4.26 In these situations a hospital's ability to retain a specialty and/or a majority of consultants of a specialty is unrelated to its quality or price of service, but rather based on its willingness to pay high incentives to consultants to attract volumes.

- In addition, where a hospital is excluded from a major insurer network, this is compounded by the fact that it is extremely difficult to compete on such a basis, since excluded hospitals are forced to offer much higher revenue shares across a smaller pool of insurer activity³⁹

4.27 More specifically, Nuffield Health believe the adverse effects of consultant market power to be:

- An increased cost of care
- (Potentially) reduced quality of service for patients
- Reduced patient choice of hospital facility

4.28 We believe that the 'rent-seeking behaviour' of negotiating additional incentives contributes to higher costs for patients and, in the longer term, may affect the quality of hospital services.

- Where hospitals are effectively forced to compete on financial incentives packages provided to consultants, this is likely to result, in the long run, in higher hospital prices [REDACTED]

³⁹ For more information on the impact of network exclusion see Section 3; for more information on Barriers to Entry see Section 8

- If hospitals compete primarily on incentive schemes to attract consultants with market power, both their focus on innovation and resources allocated to providing the highest quality services are likely to decline
- 4.29 Consultant market power is also likely to result in higher consultant fees and a declining level of care quality.
- Where consultant fees are increased this is likely to result in higher self-pay prices, and higher 'top up fees' and/or insurance premiums for insured patients [REDACTED]
 - Consultants with local market power may have little or no need to compete on the quality of their services. In the long term this may lead to lower quality services
- 4.30 Where the behaviours of consultant groups leads to a consolidation of services and/or specialties in single hospitals, this is likely to restrict a patient's choice of hospital for a given type of treatment.
- [REDACTED]
- 4.31 Where consultant groups are able to negotiate 'open referral' contracts directly with insurers in national contracts, this reduces patient choice of consultant.

5. Competitive Neutrality / Influence of the NHS

5.1 The CC notes in paragraph 14 of its issues statement that the private healthcare market is a relatively small part of the wider UK healthcare sector, most of which is public through the NHS. The CC acknowledges that the NHS interacts in a number of ways with the privately-funded healthcare sector, in particular highlighting that it is

- A customer of the (private) hospital operators
- Supplier of privately funded healthcare services through PPUs
- A partner with certain hospital operators (e.g. through PPUs)
- A supplier of national health services, representing an alternative to privately-funded healthcare

5.2 The CC also notes that it will also need to understand the extent to which PPUs represent a competitive constraint on hospital operators, and more broadly whether the NHS represents a material competitive constraint on privately-funded healthcare services.

5.3 Nuffield Health is pleased that the CC recognises that the NHS may have a large influence on the dynamics of the private healthcare market. We are, however, disappointed that the issues around the co-existence of publicly and privately owned hospital operators have not been incorporated under a separate theory of harm.

5.4 Nuffield Health believes that there is a lack of competitive neutrality between publicly owned providers (Trusts⁴⁰) and privately owned providers (Hospital operators and/or clinics)⁴¹ that is large enough to distort the market.

- The NHS is not only able to influence the services that are provided in the private healthcare market, it also benefits from substantial advantages as a supplier of privately-funded healthcare services.

5.5 We believe that in its issues statement, the CC has failed to understand the changes the private healthcare market is facing as a result of government policies affecting the NHS. These stand to substantially further the role of the NHS in the provision of services to private patients. Indeed, there are already indications that this will be the case today

- The Health and Social Care Act raises the cap of private work Trusts may perform to 49% of their total income. As a direct result of this policy, an increasing number of Trusts are investing in new PPUs to expand their private work. Currently, we know that at least 10 Trusts are planning investments in new or existing PPUs by 2013.
- This Act and the current budget cuts that the NHS is facing are pushing Trusts to think about maximising patient revenue, and is already affecting the way Trusts allocate services, for example by encouraging certain 'non-essential' procedures to be done privately by restricting NHS supply.

⁴⁰ Trust private revenues include 'Top up fees' and private work in PPUs and/or NHS beds

⁴¹ For additional information regarding the implications of our charity status with regard to competitive neutrality, please see Appendix I

5.6 As such, we believe that a discussion around competitive neutrality should form part of this investigation, not only to ensure healthy ongoing competition in the market, but also because we believe that competition issues are likely to emerge in the future if the status-quo remains

5.7 In order to aid the CC's thinking around the intrinsic advantages that the NHS possesses and their potential adverse impact on the market, we have structured our thoughts along the following framework:

(i) *Intrinsic NHS advantages:*

- a. Material cross-subsidisation of 'private' NHS services
- b. Advantages as a monopsony employer of consultants
- c. Advantages as a monopoly or majority share provider of certain services

(ii) *Potential adverse effects:*

- a. Risks around predatory pricing in the medium to long term
- b. Restriction in consultant supply to private hospital operators

(i) Intrinsic advantages

(i.a) Material cross subsidisation of 'private' NHS services

5.8 As explained in Section 1, the NHS provides private services primarily through Private Patient Units (PPUs) but also through other services charged out as private work or 'top up' charges by the Trust.

- Many other services are also billed directly out of Trusts, from full procedures in NHS theatres / wards, to 'ancillary' services such as radiology, pathology etc.
- 'Top up' charges allow patients following NHS treatment to elect to pay for additional add-on services (e.g. certain drugs that are unavailable on the NHS)

5.9 We consider that the 41 of 73 PPUs in the UK that are included on the main insurer networks are relevant competition to hospital operators in the context of this investigation

5.10 In our experience PPUs are able to price below market rates, probably even below the price floor that a 'fully efficient' private hospital operator could charge. We attribute this to the cross-subsidisation of their running costs, rather than any intrinsic competitive advantages. In particular, we believe that NHS 'private services' benefit from the cross-subsidisation of:

- a. Financing costs (e.g. Pension and/or Tax advantages)
- b. Capital costs
- c. Equipment costs

d. Ancillary service costs

- 5.11 Unlike private hospital operators, Trusts and PPUs do not have to account for any pension liability shortfalls, as these any NHS pension deficits are borne entirely by the public purse. We believe this is a substantial cost advantage that is derived from a PPUs public ownership.
- 5.12 Nuffield Health has substantial anecdotal evidence of private work charged out of Trusts and/or out of PPUs at prices that cannot be accounting for the use of equipment, instances where NHS capital budgets fund PPU capital costs, and other factors. *(See points 5.14)*
- 5.13 We also suspect that it is common practice in NHS Trusts for private work to have free access to any ancillary services required for treatment. In contrast, where private hospital operators require such services, often from the NHS Trust, this is provided at charge.
- 5.14 We include a number of examples which we believe exemplify the existence of this cross subsidisation.
- We are aware that the Leeds NHS £220m investment in the Bexley Wing Oncology unit was for a mixed public and private unit
 - [REDACTED]
 - [REDACTED]
 - We believe private IVF facilities located within NHS buildings are allowed full, free usage of NHS labs
 - We also believe that 24 hour medical cover is provided free of charge for NHS private beds, whilst this represents a material cost for private hospital operators

(i.b) Advantages as a monopsony employer of consultants

- 5.15 As the only significant employer of secondary care consultant grade medical staff in the UK healthcare market (public and private), the NHS has a status of monopsony employer. This has a number of implications for the private market, given that the NHS may
- a. Dictate the geographic location of consultant supply in the UK
 - b. Control consultant supply available to the private hospital operators
- 5.16 Private hospitals are only able to set up practice in locations where both the required patient demand and consultant supply exist. The supply of consultants of a certain speciality in a given local area is broadly dictated by the services provided locally by an NHS Trust
- Where the NHS only provides secondary care services, this limits the specialities that a private hospital operator can provide
 - Any service closures at local NHS Trusts have a direct impact on services and specialties that a private hospital operator can provide

5.17 As monopsony employers of consultants, NHS Trusts have a significant position of power in dictating their terms of employment. In particular, they are able to influence or dictate the terms of their private practice

- In 2009, the Cooperation and Competition Panel [CCP]⁴² noted that a majority of Trusts placed some form of restriction on consultants' ability to work out of contract hours, using a number of mechanisms including refusing them the right to work for other providers and/or coercing them into joining covenants to not work elsewhere
- In our opinion, because of its position, the NHS is able to select and quantify the number of hours (both public and private) that their consultants work. We believe certain consultant contracts go as far as to restrict consultants to offer their first 4 hours of non-NHS work back to their Trust.

(i.c) Advantages as a monopoly or majority share provider of certain services

5.18 As mentioned in point 5.6, the NHS provides certain 'ancillary' healthcare services to the private healthcare sector such as radiology, pathology and other lab services. For certain services and/or in certain localities the NHS is a dominant provider either through a monopoly or a position of market power for these services

- Where the NHS is a dominant supplier, it may abuse of this position. This is something that Nuffield Health has been subject to in more than one of its markets

5.19 For instance, the NHS is the monopoly provider market of emergency blood supplies, which are a legal requirement for private hospital operators.

- Most notably, it is able to use this in order to tie the purchase of this service to other services that the Trust provides. This has occurred in Nuffield Health's negotiations with the NHS, which we explain in further detail in 5.20. We believe that product tying in such a manner is a clear abuse of dominant position by the NHS

5.20 From c.2000, Nuffield Health engaged in a process aiming to reduce its expenditure on pathology services by replacing these, where possible, by internal provision. In 2004, Nuffield Lincoln⁴³ therefore attempted to withdraw its pathology services from the local Trust. This was met with substantial opposition, which culminated in the Trust threatening to withdraw its emergency blood services if Nuffield Health were not to reconsider.

- Nuffield Health is able to provide correspondence covering the detail of these negotiations demonstrating such behaviour

5.21 The NHS is also the monopoly provider of A&E services in the market. The NHS is able to take advantage of this position in order to increase referrals to its private practice⁴⁴.

- Nuffield Health has come across anecdotal evidence that in some Trusts patients are asked upon their arrival at A&E whether they have a PMI policy, in order to refer them directly to the Trust's PPU

⁴² http://www.ccp-panel.org.uk/content/cases/nhs-consultants-non-contracted-hours/CCP_report_on_NCH_restrictions.pdf

⁴³ Nuffield Lincoln was sold to BMI in 2008 and is therefore not part of the current Nuffield portfolio

⁴⁴ The NHS is also able to increase internal referrals through its triage of private patients in outpatient departments

- We discuss this practice and its adverse effects further in Section 7 of this letter

(ii) Potential adverse effects

(ii.a) Risks around predatory pricing in the medium to long term

- 5.22 As the private work cap for Trusts is raised, PPUs' ability to undercut the prices of other players in the market may allow them to aggressively increase their market share. In the long term, such low prices will prevent private hospital from offering certain services, or drive them out of the market or them. In such a situation, PPUs would find themselves in a position without competition, where they would be heavily incentivised to raise prices, which would suggest their current actions amount to de facto 'predatory pricing'.
- 5.23 The CC should carefully consider the implications of the issues discussed in points (i) – (iii) in the current market context. Indeed, as the Health and Social Care Act raises the private work cap, it is likely to substantially change the dynamics of the private healthcare market.
- 5.24 Though it is unlikely all Trusts will take-up the provision of services up to the 49% cap, which could create as many as 80,000 beds in NHS run private units (vs. c.11,000 total private market beds today⁴⁵), there are significant indications⁴⁶ that Trusts will expand their private activity aggressively now the cap has been raised. For example,
- The Cambridge University Hospitals NHS Foundation Trust has submitted plans to develop 'The Forum', a 35,000 square metre education centre, private hospital and commercial hotel. This will materially increase the Trusts current share of private revenues of 1.5%
 - The North Bristol Trust is planning a PPU partnership for build start in 2014. The Trust expects this PPU, built on the Southmead Hospital⁴⁷ site and with access to its main theatres, to generate £8m – £20m per year
 - We are aware of over ten other Trusts known to be considering PPU expansion plans
- 5.25 Given this, PPUs current ability to compete on un-level terms with private hospital operators is likely to significantly distort and reduce competition in the private healthcare market in the long run
- As discussed in 5.22, PPUs are likely to be able to acquire a majority market share, and in such a situation will be heavily incentivised to raise prices, suggesting their current actions amount to de facto 'predatory pricing'.

(ii.b) Restriction of consultant supply to private hospital operators

- 5.26 As described in the OFT report, consultants must generally have an NHS practice in order to secure insurer recognition for private work. Given that the overwhelming majority of consultants with a private practice are employed by the NHS, its ability to restrict and/or influence their private practice has a significant impact on private hospital operators.

⁴⁵ Across both private hospital operators and NHS private provision

⁴⁶ Press article: NHS hospitals plan expansion of private patient services – Health Insurance & Protection

⁴⁷ Southmead Hospital is a £430m, 800 bed NHS PFI hospital

- 5.27 The NHS's ability to abuse its position of power over consultant employment terms, if practiced on a large scale as the NHS becomes a material competitor in any local market, could lead to substantial adverse effects by effectively restricting consultant supply to private hospital operators in the market.

6. Limited information availability (Theory of harm 6)

6.1 Nuffield Health agrees with the CC that there is limited accessible, standardised and comparable information available to assist patients and their advocates⁴⁸ to select the most suitable consultant and/or hospital that best meets their requirements

- We agree that there is currently limited comparable information on either price or quality that self-pay patients may use
- Whilst we acknowledge that insured patients are less likely to focus on price due to the separation of those paying for and receiving care, we still believe that insured patients do not possess adequate price, as well as quality criteria, to make informed judgements

6.2 Nuffield Health agrees that these information shortages and the information asymmetries they create may distort competition. In particular we agree that this is likely to compromise the patient's ability to choose the best hospital/consultant or their condition

6.3 In order to aid the CC's thinking around this theory of harm we structure our thoughts and evidence around the following framework:

- (i) The information shortages that exist in the market
- (ii) Impact of these information shortages on competition
- (iii) The benefits of increased transparency and information availability
- (iv) How the CC should seek to remedy the market's limited information availability

(i) Information shortages in the market

(i.a) Quality information

6.4 Both self-pay and insured patients and/or their advocates do not possess the necessary clear and transparent quality information in order to make informed decisions with regard to their choice of hospital provider, and/or consultant

Hospital quality

6.5 Though hospital operators currently provide their own quality measures and satisfaction surveys for marketing purposes, these are generally not useful in helping patients make decisions regarding their choice of hospital because the metrics used are not comparable across providers

- Project Hellenic was set up in an attempt to address this issue, however this has seen limited progress to date. In its current form Hellenic seeks to replicate the metrics used in NHS Choices, but hospital operators have been unable so far to agree on a common set of metrics.

⁴⁸(GPs, insurers, and consultants in the case of hospital selection)

Consultant quality

6.6 Patients do not currently have access to any information regarding the quality of consultants in the market. In part because of this, their choice of consultant is principally dictated by their GP's referral decision. In turn the GP cannot refer on the basis of transparent, up to date information.

- OFT research⁴⁹ indicates that GPs typically base their referral decisions on informal or reputational information and relationships (which do not necessarily provide a true reflection of the quality of the consultant)
- In fact, this research further suggests that GPs do not generally consider that their information needs regarding key consultant performance variables are met

(i.b) Price information

6.7 It is our view that both self-pay and insured patients face a lack of, and would benefit from more, information on their cost of care. In particular, we believe that:

- a. Self-pay patients should be able to compare like for like prices for procedures across providers
- b. Insured patients and/or their policy buyers should be able to determine whether they are getting the value for money from their policy; this is of particular importance to corporates with employee health trust funds⁵⁰.

6.8 For self-pay patients, hospital operators typically quote a packaged price that includes consultant fees for a procedure. Though these packaged prices aim to be straightforward and understandable, in reality, patients do not have access to clear and comparable prices across different providers

- Providers tend to use different packaged price models, and so prices quoted for a procedure typically exclude varying degrees of additional charges such as non-standard prosthetics, follow -up consultations, ancillary services, etc.
- This issue was highlighted in the OFT's report which suggested developing a form of self-pay price comparison tool

6.9 In contrast to most providers, Nuffield Health's self-pay pricing policy is to charge a fixed, fully inclusive episodal packaged price whereby patients face zero risk of additional charges

- We think that this model is both attractive and of benefit to self-pay consumers, and believe that the current lack of clarity in self-pay price information prevents consumers from fully perceiving its benefits

6.10 In the case of insured patients, we believe that policyholders and/or the buyers of these policies do not currently have and would benefit from additional price information to aid them in their decisions when seeking treatment or when looking to purchase a policy

⁴⁹ "Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants" – GHK, 2011

⁵⁰ Often Third Party Administered (TPA) Funds, administered by insurers

- When choosing their consultant, insured patients do not currently have access to clear information about the level of top up fees they are likely to face from that consultant. This issue was clearly outlined in the OFT's market report⁵¹.
- Policyholders and/or their corporate policy buyers are currently unable to understand whether their choice of hospital is at a higher charge than other local hospitals covered by their policy. We believe this information would be of interest, particularly for corporate buyers of PMI policies and/or users of employee health trust funds seeking to maintain or reduce premiums to an affordable level

(ii) Insurer restrictions on choice

6.11 More broadly, Nuffield Health believes the information asymmetries in the market stem not only from a lack of consistent information provided by hospital operators, but also from a lack of transparency and clarity in PMI policy information provided by insurers.

- (i) As a prospective policy buyer, it is extremely difficult to understand from available information (e.g. websites) which hospitals are included on an insurer's network, and how this might differ between different policies

6.12 From its interactions with patients Nuffield Health is also conscious that policyholders are often unaware of any restrictions their policy places on consultant and/or hospital choice

- In its AXA excluded hospitals, Nuffield Health is often made aware of instances where patients are extremely disappointed to discover (often having started treatment at Nuffield) that their AXA policy does not entitle them to further treatment at a Nuffield Health hospital⁵².
- Nuffield Health is also aware of situations in which patients, having already selected their consultant of choice (either through GP advice, past experience or friendly recommendations), are subsequently redirected to a consultant imposed by their insurer.

(iii) Impact of these information shortages on competition

6.13 As mentioned in 6.2, Nuffield Health agrees that the information asymmetries in the market and the limited information available to patients distort competition.

6.14 Market actors (patients or their advocates) are unable to drive competition in the market by using information to discriminate which providers (hospitals or consultants) are best to treat their condition. Ultimately we believe that this results in:

- a. GPs relying on informal information upon which to base their decisions, potentially leading to higher prices and lower quality of services
- b. Reduced incentives and ability for hospital operators and consultants to compete aggressively on the basis of either price or quality

⁵¹ Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants" – GHK, 2011

⁵² Examples of correspondence letters can be made available upon request

- c. Reduced incentives for insurers to base policy restrictions such as 'open referrals' or hospital networks on value rather than price criteria alone
 - d. Higher search costs for patients and GPs
- 6.15 GPs rely on informal information in order to advise patients regarding consultant and hospital choice. This means there is no guarantee or way of verifying that GP recommendations reflect the best quality of service available in the market.
- The reliance on informal information is likely to strengthen the position of incumbents and raise barriers to entry to new providers, which is likely to lead to consumers paying higher prices or receiving lower quality services.
- 6.16 Given the lack of information available to patients and their intermediaries, hospital operators and consultants are unlikely to compete aggressively on quality or price. As discussed in Sections 3 and 4 of this letter, this effectively serves to hide the inefficiencies of the market and drive higher prices and/or lower quality.
- In particular, we believe it obscures the fact that hospital operators with market power in national insurer negotiations are able to sustain prices above levels that hospitals of similar quality would command in competitive markets
 - We also believe this obscures the fact that national insurance premiums effectively subsidise the higher prices charged in the London area
- 6.17 As policyholders are unable to judge the quality and/or value of hospitals and consultants included in their policy, insurers are likely to base policy restrictions such as open referrals and hospital networks principally on price criteria in order to drive down costs.

(iv) The benefits of increased transparency and information availability

Self-pay patients

- 6.18 Clear and comparable quality and price information for self-pay patients will enable patients to drive competition in this market.
- 6.19 Nuffield Health's experience in elective (self-pay only) procedure markets, where better information is available, has shown that patients use available quality and price information to discriminate amongst providers
- In the laser eye surgery and cosmetic surgery markets, though prices may not be directly comparable across providers, patients make significant use of the available information to 'shop around' before choosing their provider

Insured patients

- 6.20 In the case of insured patients, we believe that improved policy information using clear price and quality criteria from hospitals and consultants would allow policyholders to drive competition in the PMI market and therefore in the private healthcare market
- 6.21 Our research around the past experiences of certain international health care markets and other academic papers available indicates that where increased transparent information is provided, this is beneficial for both consumers and market participants.

6.22 We believe that should corporate healthcare buyers (either of PMI policies or TPA funds) have access to transparent information on hospital prices from their insurers, this would be used and would drive efficiencies in the market

- In the immediate to medium term, corporates, who have been facing rising healthcare costs, are well placed to counter inefficiencies in the market (such as network recognition not reflecting price or quality merits), by using the best value hospital operators

(v) How the CC should seek to remedy the market's limited information availability

6.23 In our opinion, the CC should aim to understand the following when looking to improve the quality information available in the market:

- a. The appropriate scope and metrics of quality information
- b. For whom this information should be designed (e.g. patients vs. GPs)
- c. Through which channels this information should be diffused

6.24 In order to do this, the CC should:

- Seek to establish the relevant metrics in coordination with relevant industry partners
- Learn from examples and knowledge from other markets and academic research
- Consider the role insurers may play in diffusing this information

6.25 In establishing quality metrics for the industry, the CC must remain vigilant not to select quality metrics based on what is easily measurable, but focus on what is important in driving competition between providers. Falling short of this may incentivise hospital operators and/or consultants to compete in order to maximise their 'metric scores' rather than patient value.

6.26 We have a limited view on what the appropriate metrics should be for consultant quality information, but suggest that the CC should seek to establish these in coordination with the relevant Royal Colleges (by specialty)

6.27 We believe the appropriate scope and metrics of quality information for hospital operators must go a lot further than currently planned under the Hellenic project

- These metrics should not simply aim to replicate NHS Choice type information but seek to reflect patient information needs that are specific to the private healthcare market

6.28 The CC should also consider the channels that are most relevant to diffuse certain this information. The CC should pay particular attention to the important role that insurers are able to play in better informing the consumers of this market

- Our research has highlighted certain international, privately insured, health care markets where insurers provide substantial price and quality information to their policyholders. In the United States, for example, Anthem provides

quality and cost information for many common procedures through its care comparison tool to its policy holders.

- The CC should consider the prominence and transparency of information that insurers should provide to prospective customers at the point of sale, particularly in relation to the restriction on choice of consultant and/or hospitals and any potential fee shortfalls

6.29 We believe the CC should carry out an extensive review of existing market examples and academic research in order to understand the number and relevance of possible solutions to this issue of information shortage in the market.

7. Vertical integration (Theory of harm 7)

7.1 The CC addresses the subject of vertical integration in Theory of Harm 7 of the Issues Statement. In particular, it mentions insurer ownership of hospital and/or primary care facilities, but does not believe (at this stage) that these vertical linkages are likely to lead to significant harm to competition.

7.2 Nuffield Health acknowledges BUPA's ownership of the Cromwell hospital as an example of vertical integration, but believes that the CC has overlooked many other instances in which vertical integration exists in the market and the potential adverse effects these may have.

7.3 Currently, vertical integration occurs at various different levels of the market supply chain. In our opinion, the instances in which this may result in adverse effects for consumers (namely restriction of choice), are:

- (i) The vertical integration of services in the NHS
- (ii) Hospital ownership of triage centres and/or primary care services
- (iii) The integration of primary and secondary care through equity ownership
- (iv) Insurer ownership of medical service providers⁵³

7.4 We discuss the adverse effects of these vertical integrations in (v), points 7.19 – 7.20.

(i) Vertical integration of services in the NHS

7.5 The NHS provides a large breadth of services that are, to different extents, vertically integrated. A number of these services are likely to generate referrals for private healthcare which PPU's and the wider NHS stand to benefit from, at the expense of private operators in the market.

7.6 We believe that a number of NHS services in both primary and secondary care are likely to generate referrals that will be preferentially directed towards PPU's or NHS private practice. In particular, this is likely to be the case for:

- *GP services*: GPs may refer preferentially to NHS services (e.g. PPU's), or to their own private service offerings
- *Secondary care triage services*: triage centres and, for example, A&E can be used as points of referral for private patients to NHS services

7.7 As discussed in Section 3 of this letter, both the current climate and government policies heavily incentivise NHS Trusts to maximise their sources of private patient income. In turn, this is likely to push Trusts to make use of their position to influence private referrals.

- Plans under the Health and Social Care Act to provide GPs with commissioning powers and budgets are likely to give rise to certain conflicts

⁵³ Including the provision of internal triage and clinical advice services, traditionally carried out in the patient journey by GPs

of interest. Trusts may incentivise GPs to preferentially refer private patients to PPUs in order to 'safeguard' budgets

7.8 Nuffield Health already has had evidence, anecdotally, of NHS Trusts preferentially referring work to NHS PPUs and/or services, [REDACTED]

- In these instances, GPs, triage services (e.g. A&E) and consultants are heavily incentivised to refer directly to local Trust PPU / private services. Such un-competed referrals effectively remove patient choice of hospital

(ii) Hospital ownership of triage centres and/or primary care services

7.9 As they have come under financial pressure, due to spare capacity amongst other factors, hospital operators have increasingly sought to integrate their services further along the care pathway in order to capture referrals.

- Hospital operators have principally done this by acquiring primary care providers, including GP practices and/or triage centres

7.10 Although a joined-up care pathway has many benefits for patients, we believe that the ownership of primary care services by hospitals presents conflicts of interest that are likely to limit competition in the market and create adverse outcomes for patients.

- Where hospital operators own GP practices, patients are unlikely to gain access to objective advice about the best secondary care providers available for their particular condition
- Similarly, if private operators run triage centres, patients (both NHS and private) are likely to be directed exclusively to that provider's hospitals

7.11 Where a hospital operator has market power (e.g. HCA in London), vertical integration with a primary care provider is likely to consolidate this position of power further.

- [REDACTED]
- [REDACTED]
- [REDACTED]

7.12 [REDACTED]

(iii) The integration of primary and secondary care through equity ownership

7.13 Equity ownership models of hospitals have become more prevalent in the last decade. These arrangements typically provide practitioners (either consultants or GPs) with an equity stake in a particular hospital or hospital operator.

- [REDACTED]

7.14 Given that hospital operators must be able to get consultants 'on board' in order to build new hospitals, such ownership models do present some benefits. However, we believe that where these restrict consultants' practice, i.e. are used to 'lock-in' their referrals, they have an adverse effect on the local and wider market.

- In such arrangements GPs and/or consultants are not only heavily incentivised to refer to 'their' hospital, but in some instances, are contractually obliged to do so
- This reduces patient choice of hospital they normally have access to at each stage along the care pathway (GP to consultant referral and consultant to hospital referrals)

(iv) Insurer ownership of medical service providers

- 7.15 In order to keep the cost of claims down, insurers try to direct and control the patient journey. This is evidenced, for example, by the recent introduction of 'open referral' policies.
- 7.16 In order to control costs further, insurers may integrate vertically in order to attempt to drive savings. As the CC has highlighted, this is the case for BUPA, through:
- Hospital ownership (The Cromwell in London)
 - The ownership of medical service companies and professionals (BUPA Clinovia⁵⁴, Clinical advisory teams)
- 7.17 If insurers were to gain too much control over the patient journey through vertical integration, we believe this would be to the detriment of consumers.
- 7.18 It is our understanding that BUPA was forced to re-enter the Inner London strategic market in an attempt to counter HCA's dominance. However, operators in the London region are most likely better placed to comment on any adverse effects from BUPA's ownership of The Cromwell.

(v) Adverse effects

- 7.19 The ability to preferentially direct referrals to certain providers effectively means that the operator is able to have a stronghold on a private patient's journey. We are firmly of the opinion that this does not benefit the consumer, and that more broadly, the adverse effects of this practice, if widespread, will be:
- *A reduction in patient choice* : patients are effectively restricted along the care pathway
 - *Higher prices and lower quality*: providers that benefit from captured referrals have little incentive to compete on price or quality
- 7.20 Where a provider has market power (e.g. HCA in London), its ability to vertically integrate cements this dominant position, and raises barriers to entry even further for new entrants.

⁵⁴ BUPA Clinovia provides domiciliary chemotherapy nursing services for BUPA subscribers

8. Barriers to Entry (Theory of harm 5)

8.1 The CC hypothesises that there are a number of barriers to entry which reduce competition, either directly or by providing the necessary conditions for the other theories of harm to have effect.

8.2 Nuffield Health agrees with the CC that certain barriers to entry exist, either intrinsically, or as a result of the theories of harm discussed earlier in this letter. We believe those that are particularly high are:

- (i) *Barriers to entry resulting from national bargaining between insurers and hospital operators*: hospital operators require network recognition from the largest insurers in order to enter a market
- (ii) *Barriers to entry resulting from the relationships between hospital operators and consultants or GPs*: hospital operators rely on consultants to bring patient referrals to their hospitals

8.3 The adverse effect of barriers to entry are to reduce the levels of competition in the market, reinforcing hospital operator market power and adversely impacting consumers.

- High barriers to entry prevent both existing players from expanding and/or developing services and prevent new players entering the market
- A lack of new entrants and competition between incumbents mean that in the long term patients will face reduced choice, and potentially higher prices and/or lower quality

(i) Barriers to entry resulting from national bargaining power between insurers and hospital operators

8.4 As was discussed in Section 3 of this letter, the market power of hospital operators in national negotiations with insurers creates significant barriers to entry for new and existing entrants.

8.5 As network recognition is key in making a new hospital investment viable, an inability to gain recognition is likely to jeopardize an operator's plan to build a new hospital.

8.6 Hospital operators are likely to use their market power in order to disincentivise insurers from recognising new entrants or changing the status of existing network excluded players.

- Operators are effectively able to place pressure on insurers to continue to recognize all their hospitals and not those of new entrants. We discuss this in more detail in points 3.30 – 3.37

(ii) Barriers to entry resulting from the relationships between hospital operators and consultants or GPs

8.7 In order to gain referrals, hospital operators compete at a local level to attract consultants to practice at their hospital. In order to help new consultants set up their private practice, it is common practice within the industry to initially give certain services away for free (e.g. consulting room sessions, secretarial services). Over the past few years, however, there

has been a trend to provide greater benefits to consultants, including direct financial incentives.

- These financial reward schemes aim to incentivise consultants to concentrate their volumes within a single hospital
- In certain agreements, hospitals may provide large start-up loans which are required to be repaid from annual revenue incentives. This is a particularly effective method of locking consultants in to a specific hospital

8.8 Such incentive schemes act as a high barrier to entry to new and existing entrants in a local market.

- New entrants and incumbents seeking to develop new services rely on their ability to attract consultants at their new hospital. Where the local competitor has 'lock in' incentive schemes in place, consultants are unable to move or expand their practice at a new hospital. Operators using such schemes are therefore able to protect themselves from competition

8.9 Where such lock-in schemes are combined with the barriers to entry created by 'exclusive' network inclusion (e.g. on the AXA network), their effect is compounded.

- Local operators have an 'exclusive' network status and use 'lock in' incentive schemes to reinforce their dominant position in their local market. Indeed, excluded hospitals will struggle to attract consultants, or will need to do so at a high cost in order to compensate for the reduced number of patients consultants may treat at their hospital

8.10 Although non-'lock in' incentive agreements do not necessarily constitute a barrier to entry, as these imply that in order to attract consultants hospitals must pay higher and higher incentives. Accordingly, they too have adverse effects on the market.

- Higher incentive payments will, in the long term, contribute to an increased cost of care, without associated quality benefits (See point 4.28)

8.11 More formal 'lock in' agreements, such as Circle's equity incentive program for consultants also create clear barriers to entry.

- We have reason to believe that Circle has contracts with consultants (and GPs) that award equity in return for a guaranteed percentage of their private work to be committed to their hospital⁵⁵

⁵⁵ The CC should investigate the types of contracts that Circle have with consultants further

Appendix I

[REDACTED]