

Response of



to

the CC's Annotated Issues Statement

15 April 2013
(Non-Confidential)

1. **State of Play and Principal Concerns**

1.1 The CC's Annotated Issues Statement ("AIS") reflects a very early stage of the CC's analysis. It is clear from the errors of fact, inappropriate methodologies and procedural irregularities that many of the early conclusions reached are unsound. Given the administrative timetable, the CC is at real risk of taking these unsound early conclusions and embedding them in its provisional findings. The CC needs to review these early conclusions – on profitability, on the role of the NHS, on local market power, on negotiations between hospitals and insurers – and have the courage to accept that many of its early views are wrong.

Errors of fact

1.2 The CC has substantially erred in its understanding of BMI's profitability. On the CC's basis, in FY2011 BMI's EBIT was stated to be [x] million. This is wrong. It was in fact [x] million, even using the CC's methodology.¹ The CC has **overstated BMI's EBIT by some [x]% or [x] million.**

1.3 The CC has also dramatically understated BMI's capital employed, especially land and buildings. The conclusion that **BMI's hospitals are, on average, worth about [x] million, when modern equivalent assets have demonstrably cost between £30 million to £90 million** defies common sense. The DTZ Report is stated as not being a valuation but it is treated by the CC as one.

1.4 Consequently, the CC seriously overstates **BMI's ROCE** which, even on the CC's extremely conservative methodology was **only [x]% (2011)** rather than the supposed [x]%. This clearly demonstrates that BMI does not make excessive profits.

1.5 At the Hearing the CC seemed to believe that BMI uses 'one in, all in' negotiations and the BMI was not prepared to negotiate price on any basis other than nationally. As we advised at the hearing this is simply not the case.

1.6 Time and again negotiations show that BMI has very **little influence over network definition and is prepared to offer pricing on a narrower basis than national.**

1.7 The CC's analysis of exclusive or restrictive agreements is incorrect or incomplete. There is no assessment of the merits or demerits of such agreements: increasing volume and decreasing price versus foreclosure risk. Any agreements BMI has with insurers with restrictive or tight characteristics have limited, if any, foreclosure effect and are in return for deep volume discounts. The long run history of exclusive or restrictive agreements is that they are honoured in the breach by the insurer without recourse from BMI.

¹ [x].

- 1.8 The CC says PMIs are in the weaker position during negotiations. But this view is based on **material errors, overstatements and inaccuracies** in the assessment of the PMI's negotiating position and an almost complete lack of analysis of the PH provider's position. **PMIs do not consistently consider themselves to be in a weaker position opposite BMI.** For instance, AXA PPP says to the contrary.² Why is this? BMI notes that both the CC's Movies on Pay TV inquiry and the CAT judgment in *BSkyB v Ofcom*³ are recent reminders of how critically important it is to differentiate between commercial strategies presented under a guise of competition argument and persuasive evidence.
- 1.9 Constraint from the NHS has been limited to PPU's. This is wrong. The NHS acts as a powerful and specific constraint on BMI and likely to become more so. The CC has evidence of this.

Inappropriate methodologies

- 1.10 Land valuations: the DRC methodology is universally recognised as being a last resort where no other comparables are available. The CC has insisted on using DRC even though other evidence is available to assess current market value, including the actual costs of modern equivalent assets.
- 1.11 LOCI: the CC has used LOCI for a 'weighted average market share' approach, despite the fact that the methodology appears: (i) not to be widely used or accepted; and (ii) not to have (yet) been successfully through the peer review process. There is a clear consensus in the literature that the logit model (to which LOCI has very significant similarities) is **deeply problematic as a framework for thinking about substitution patterns and market power.** Dr Peter Davis has provided a detailed critique of LOCI at Annex 1.
- 1.12 Isolating outward postcode where a hospital has a high share does not tell the CC much about the actual choices that a person living in that area has. This is particularly so when the **CC's survey suggests patients travel up to 44 minutes** and "would consider travelling for just over an hour".
- 1.13 A sense check of the CC's conclusion that [x] out of BMIs 60 hospitals are 'of potential concern' shows it cannot be correct. Why is it that of the **37 hospitals Bupa delisted, [x] are 'of potential concern'**? How is the CC's LOCI filter providing helpful insight in the light of Bupa's decision that sufficient local alternatives existed for its members in these areas?

Procedural deficiencies

- 1.14 Contrary to the published Profitability Methodology, it is now clear from correspondence that the CC decided, in August 2012, that replacement cost was how it wanted to see land valued and that it chose a surveyor to validate that choice. In doing so, the CC chose a valuation team with that had *no*

² Appendix D to AIS, paragraph 30.

³ *British Sky Broadcasting and Ors v. Office of Communications* [2012] CAT 20, paragraph 29.

ability whatsoever to provide professional reliable valuation advice on private acute hospital land value, turnkey value or trading value.”⁴

- 1.15 The NHS plays a "key role", yet the CC has apparently **failed to obtain information from the NHS acute and foundation trusts** about their expansion plans for private healthcare, or even the extent of current revenues from private healthcare, and wrongly focused almost exclusively on PPUs.
- 1.16 The CC has **not considered the PH provider's perspective** in the negotiation. Specifically, what the best alternative to reaching an agreement with an insurer would be – still less the costs associated with that alternative for the PH provider.

External factors v. features that harm competition

- 1.17 The CC should distinguish between issues created by external factors and those created by defects (if any) in the process of rivalry between PH providers. In BMI's view, the problems of the private healthcare industry are largely **unrelated to competition between private hospitals:**
- (a) Thin demand;
 - (b) Consumer preference for local provision;
 - (c) PMI preference for local provision;
 - (d) Changes in hospital medical care;
 - (e) Improvement in and greater competition from the NHS;
 - (f) Low growth in the addressable market for private healthcare – particularly outside London;
 - (g) Choices, of Bupa in particular, not to support hospital rationalisation, private differentiation from the NHS, collaborative working with hospitals to support service innovation and real growth in insured lives;
 - (h) Factors together creating a large UK estate of relatively under-utilised private hospitals. Rationalisation of the estate is inevitable [§<].
- 1.18 Not every observed sub-optimal outcome in an industry or market necessarily reflects defective competition between the participants in that market. The CC should resist the intellectual temptation to characterise the issues it observes as competition issues leading to an identification of the 'features' that have caused this adverse effect on competition. **Many issues in private healthcare are a result of external factors which are unaffected by the intensity of competition between PH providers.**

⁴ Colliers' critique of the DTZ Report, paragraph 2.1.

- 1.19 BMI understands the group's interest in consumer issues and reassures the group that it has no objection to bolstering consumer protection, although notes that this is not the role of a market investigation.
- 1.20 As the Movies on pay TV inquiry also showed, it is critically important to keep abreast of on-going developments. [§<]. The CC will need to ensure parity of treatment with other parties as these circumstances continue to change/develop.
- 1.21 The CC is right that there are no material barriers to entry outside Central London. But the CC must also recognise that **entry is not always efficient**. Bath now has two underutilised hospitals [§<]. Circle's entry has merely divided the private healthcare market – there has been **no growth and NHS opportunities are insufficient to fill the gap**.
- 1.22 This is not merely a submission for the inquiry but a business reality. [§<].

2. Introduction

- 2.1 There is still – as the CC itself accepts – a long way to go before any conclusions can be drawn about features of the private healthcare market that may adversely affect competition. There are a large number of important areas where the AIS resembles the CC's former 'emerging thinking' documents and has not yet developed to the point typically seen in working papers. This may be the reason that the CC abandoned its original intention to issue the usual working papers and opt instead for an AIS plus appendices approach to disclosure.
- 2.2 BMI has provided extremely extensive information to the CC during the investigation, not all of which appears to have been digested. However, it has focused this response to those aspects of the AIS that are of most immediate concern to it and to which it is in a position to comment at this stage.

3. Progress of the Investigation to date

- 3.1 While BMI welcomes the transparency offered by the AIS and appendices, BMI's ability to comment on the AIS, and therefore the CC's thinking to date, is constrained by the fact that much of the CC's critical analysis is still at an early stage. This applies in particular (but not exclusively) to the LOCI analysis; the price correlation analysis; the discussion of certain non-structural barriers to entry - especially bargaining between the PMIs and PHPs and consultant incentive schemes; and the analysis of prices charged by PHPs to PMIs.
- 3.2 Given the CC's current timetable, the CC will not have time to finish work on and give the main parties an appropriate opportunity to comment on a large number of crucial areas ahead of the cut-off date, currently set for May, for parties' submissions before provisional findings. BMI does not believe that it is fair or appropriate for the CC to disclose to the main parties the case for an adverse effect on competition ('AEC') – if that is what it is to do – for the first time in the provisional findings. The CC's guidance and procedural practice in all previous market investigations has recognised this. Indeed, until 12 February 2013, this is not what the CC intended to do in this inquiry.⁵
- 3.3 BMI considers that it (together with the other PHPs) has a legitimate procedural expectation that the CC approach this case in a substantially similar way to the process adopted historically, foreseen in its procedural guidance and in earlier administrative timetables and correspondence in this inquiry. In particular adequate time and information must be provided for the main parties to assess the CC's workings and guide the thinking which informs the CC's provisional findings. The CC's recently issued procedural guidelines indicate that (in an 18 month investigation) parties could expect the publication of relevant working papers from about 5 months in, giving the

⁵ See letters from Christiane Kent to Catherine Vickery dated 21 December 2012 and 12 February 2013.

opportunity to review and comment on the CC's thinking well in advance of its provisional findings.⁶ At the outset of the investigation, it was clear from the CC's administrative timetable that it intended to follow the guidance and past practice with the publication of full working papers well in advance of the deadline for parties' responses before provisional findings.

- 3.4 The CC has since moved from this approach, contrary to the legitimate procedural expectations it has created. First, on 21 December 2012 the CC wrote to BMI, explaining "*it is not possible for us to make many of the working papers available in advance of all the hearings*" but that "*[t]his will not in any way preclude you from responding to the working papers after the hearing has taken place in the usual way*".⁷ A full 7 weeks subsequent to this, the CC wrote to BMI informing of its intention to abandon the publication of many of these: "*As for working papers, in the light of the fact that we shall be publishing a detailed annotated issues statement with appendices and presentation slides as described above, there is unlikely to be a large number of stand-alone working papers.*"⁸
- 3.5 Instead of publishing detailed working papers on its work to date, the CC has provided the parties with an AIS, with accompanying appendices and two working papers. This means that the CC has not presented the parties with the same level of detailed analysis that: (i) is typical at this stage of an investigation generally; and (ii) it led the parties to believe they would receive in this inquiry. Further to this, the CC has made no corresponding amendments to its plans to notify provisional findings and remedies notice (if relevant) in June, with the deadline for all responses and submissions required in April/May. Therefore, the parties are being given less developed analysis on which to comment, meaning there is less time to make an impression on the group's thinking. If there is insufficient time to facilitate the parties' legitimate procedural expectations in the current administrative timetable, then the provisional findings should to be delayed so as to allow sight of the CC's work before any excessively preliminary undeveloped and misdirected conclusions are further embedded in them.
- 3.6 The approach to the inquiry to date has already led to material avoidable errors in the AIS. BMI has been prepared to, and has offered to, engage with the CC on some key issues but the CC has refused to do so.

4. Characteristics of privately-funded healthcare

- 4.1 The CC has correctly described many of the characteristics of privately funded healthcare. However, there are important implications of these characteristics which are not yet well understood. It is important to consider

⁶ Guidelines for market investigations: Their role, procedures, assessment and remedies (April 2013), paragraph 55.

⁷ Letter from Christiane Kent to Catherine Vickery, dated 21 December 2012.

⁸ Letter from Christiane Kent to Catherine Vickery, dated 12 February 2012.

these issues before trying to 'fit' the characteristics observed in the market into the framework of 'features' that result in an adverse effect on competition.

The link between PH prices and demand for PMI policies

- 4.2 It is clear that the private healthcare sector faces challenges: capacity utilisation is low and growth is low or negative. However, these industry characteristics are not caused by 'a feature or combination of features that prevents restricts or distorts competition.' Rather BMI considers that problematic and inherent industry characteristics are a result of a series of factors that affect demand and pricing for private healthcare and which are unrelated to competition in PH. In particular, there are characteristics of both PMI and the NHS – the two principal financial intermediaries between patient demand and hospitals – that affect how PHPs grow volume through discount pricing to these intermediaries. We deal with these in turn below.

Characteristics of the PMI market

- 4.3 In BMI's view, there are a series of characteristics of the PMI market that define the operation of the PH market. These affect the way that a PHP negotiates with PMIs and seeks growth.
- (i) Demand is very thin. Of 10,500 GP practices in the UK, only [x] are within 30 minutes of a BMI hospital.⁹ PMI penetration is low and strongly correlated to factors extraneous to private hospitals, particularly professional employment and UK economic growth.
 - (ii) PMIs and consumers value choice and local provision very highly. These factors have resulted in the large number of private hospitals the UK has currently.¹⁰
 - (iii) Hospital charges make up only a portion of PMI costs so the benefit of PHP discounts can readily be diluted or diverted by PMIs. BMI is often unsure whether the discount is passed on. If so, in what proportion? To which customers (e.g. corporate/individuals)? To date PMIs have – as a general matter - been unable or unwilling to provide clarity on this point.
 - (iv) In respect of PMI policyholders, which make up the vast majority of BMI's private caseload, there is no direct financial relationship between PHPs and patients.¹¹ PHPs have the lead relationship in respect of supplying the service, but they are reliant on PMIs to grow demand for insured work, particularly through pricing.
 - (v) PMIs are not 'buyers' in the traditional sense of the word. They have an incentive to suppress demand for PH.

⁹ [x].

¹⁰ In the CC's patient survey, half (48%) of private hospital patients said that geographic location was an important part of their choice – the single most significant factor (PH Market Investigation, Survey of Patients November/December 2012, p 42).

¹¹ Outside of excesses, shortfalls and co-payments.

- (vi) PMI's have consistently chosen to adopt 'hold-up' strategies in negotiations with PHPs. The CC has looked at one of these being recognition of new facilities but there is also evidence of failure to offer hard volume commitments, failure to maintain exclusivity of networks whilst expecting pricing to remain constant, and failure to direct volume.
 - (vii) There is increasing evidence of Bupa and others working to suppress demand for PH services by offering enhanced cash benefit payments to actively incentivise PMI policy holders to access care in the free-at-point-of-use NHS.
 - (viii) The PMI market (and the PH market in respect of self-pay) is clearly constrained by the NHS – a free alternative, accessible to all, that virtually everyone is accustomed to using for many of their and their families healthcare requirements.
- 4.4 These characteristics have not been considered by the CC – although they should be. BMI recognises that the OFT did not refer the PMI market for investigation, we have always considered this a significant mistake and encouraged the CC to seek an amendment to its terms of reference in its response to the first Issues Statement.¹² The PMI role as financial intermediary between consumers and hospitals and the role it has in determining outcomes in PH services is not obvious, yet an accurate understanding is vital if the CC is to determine what the causes and effects of characteristics observed in the PH market might be. The CC has recognised this in the AIS: *'the way in which the privately funded healthcare sector is affected by conduct of and interaction with the private medical insurers'*. The CC rightly sees this as a *'key issue'*.¹³ Great care must now be taken in the short period left before the provisional findings to expand very significantly the focus on PMI – and in particular Bupa's behaviour in that market.

PMI incentives to suppress demand

- 4.5 In a conventional market, such as groceries, a retailer such as Tesco has a strong incentive to sell as much as it can of the products it buys from producers. There is a strong likelihood therefore that lower prices obtained from producers are passed onto consumers and retailers' sold volumes rise. Conversely, the PMIs are not retailers of PHP services. From a PMI's perspective, the ideal level of actual consumption of PH services is zero. In practice, this means as close to zero as is possible without undermining sales of PMI policies.
- 4.6 The CC recognises this although it also says it makes sense to consider PMIs as 'buyers'.¹⁴ While this is intuitive given the contractual frameworks in place, we must be very mindful of the limits of applying 'buyer' and 'seller' labels to

¹² BMI Response to the Issues Paper, paragraph 2.3 (c).

¹³ AIS, paragraph 3.

¹⁴ Appendix D to AIS, paragraph 8.

the PMIs and PHPs respectively, as it has implications for how a competition specialist may consider the merits or demerits of power on each side of the PHP/PMI bargain. Features of PMIs that distinguish them from typical buyers include:

- (i) In a normal market, 'retailers' who are able to price discriminate, would allocate discounts to marginal customers **most likely to consume more** of the good or service. Conversely, PMI providers have a strong incentive to allocate discounts provided by PHPs to policyholders who **are least likely to use PH services**.
- (ii) There is very little transparency around the rate of pass-through of discounts offered by BMI to insurers. There are exceptions to this amongst the more innovative PMIs, such as AXA PPP and Simplyhealth, where BMI discounts were used overtly to support lower prices to PMI policyholders. Nevertheless, BMI's rational starting position is that it needs to engage a PMI on pass through, as a typical PMI will not wish to see greater consumption of PH services and will instead seek to **suppress the volume of PH services consumed**.
- (iii) PMI incentives to suppress demand are readily evident in the patient journey where there are a large number of barriers to use of the service that patients have pre-paid for access to: GP referrals, pre-authorisations for each stage of treatment, PMI networks, policy exclusions (psychiatric, podiatry, cancer care, etc.), cash benefits for use of NHS facilities, no claims bonus, bars to treatment of pre-existing or chronic conditions, etc.
- (iv) Restrictions on pre-existing conditions are particularly important. Policyholders with pre-existing conditions are, almost by definition, highly likely both to use PH services and have higher co-morbidity and acuity rates than average, resulting in higher sales for PHPs. PMIs impose **extremely high switching barriers** on these patients (resulting in lowered demand). Whether these are appropriate or not within the market for PMI is a moot question. What is clear is that they exist and that these switching barriers reduce even further a PMI's incentive to attribute any cost savings it obtains from PHPs to these policyholders. Note in this context that Natalie-Jane McDonald (former Managing Director of Bupa Health and Well Being UK ('BHW')) regarded switching barriers for patients with pre-existing conditions to be so high that BMI's suggestion that such people could switch PMI was: **'misguided and ridiculous' given that insurers will not cover pre-existing conditions**.¹⁵

4.7 There are also features of PHPs such as BMI that clearly distinguish them from typical upstream 'producers':

¹⁵ Interview with *Health Insurance*, available at <http://www.hi-mag.com/health-insurance/product-area/pmi/article385126.ece?page=2>.

- (i) Unlike, say Associated British Foods or Nestle in a groceries model, BMI along with the consultant **provides the service *itself* to the end consumer** – not the PMI;
- (ii) BMI's hospitals are known to the end consumer. According to the CC's survey evidence, **79% of consumers know which hospital they want to go to before they are referred by a consultant**. The reality in the provision of private healthcare services is that, through direct interaction with patients which dictates their experience, a PHP will exercise a much greater influence over a customer's opinion of its 'product' than can a traditional producer; in doing so, the PHP carries out a role much more closely aligned to the provision of retailing services;¹⁶ and
- (iii) BMI competes across a wide range of dimensions to attract consumers to its PH service offering, either directly or through consultants and GPs.

4.8 Clearly then, in the context of the provision of private healthcare services, there are numerous important differences that demonstrate the traditional retailer-producer model is not an appropriate framework for the CC to adopt when conducting its analysis.

BMI's efforts to innovate and stimulate demand

4.9 As is evident from BMI's active engagement with open referral products such as AXA PPP Pathways; [redacted] to facilitate insurer open referral products and improve the patient pathway and BMI's shift towards sophisticated package pricing which accommodates co-morbidity measures and hence allows insurers greater precision on costs when underwriting individual policyholder risk profiles, BMI has endeavoured to work collaboratively with PMIs. This is not a new characteristic of BMI. [redacted].¹⁷

4.10 Two examples of BMI's effort to work collaboratively with insurers to stimulate demand are the AXA PPP Pathways product and the Simplyhealth trial MSK product. These were described in BMI's response to the Market Questionnaire but for illustrative purposes are briefly set out again below.

AXA PPP Pathways

4.11 Through Pathways, BMI sought to incentivise AXA PPP to place more volume with BMI via a deep discounting strategy and a directional (i.e. restricted) network. As AXA PPP noted in its response to the Issues Statement: "*BMI approached us, keen to innovate in the market by developing a lower cost proposition to offer to corporate customers, which would also guarantee no shortfalls to members by including the surgeons and anaesthetists fees for all procedures. BMI offered a [...] discount applicable to all corporate customers on a Pathways product treated at its facilities and to include the specialists'*

¹⁶ PH Market Investigation, Survey of Patients November/December 2012, p 17.

¹⁷ [redacted].

fees in its charges. BMI also undertook to sign specialists up to the proposition and to invoice on their behalf also with a [...] discount relative to average prices.”¹⁸

- 4.12 Pathways originally anticipated a narrow, BMI-only network (except where a patient was over 20 miles from a BMI hospital) with discounts off the usual network prices in return for directing patients to BMI. Pathways was distinct from the AXA PPP acute network in two main ways: (i) the patient has to obtain an open referral and will be directed to call [§<] who then manage the whole referral process for AXA PPP; and (ii) BMI offered – as a major selling point to AXA PPP – [§<].
- 4.13 [§<]. From 1 January 2013 the ‘Pathways’ open referral product has become the default offering for all large corporate schemes and corporate clients will have to ‘trade up’ if they wish to continue on a product offering traditional referral paths.
- 4.14 BMI is to remain the preferred provider in the ‘Pathways’ network although Nuffield will now also be participating as BMI's network is not wide enough on its own. We also understand AXA PPP has engaged [§<] to increase the network offering for Pathways in Central London as well as additional ‘gap fillers’ in the provinces. The new Pathways network now consists of around 120 hospitals – with BMI facilities accounting for approximately 50% of the hospitals in this network.
- 4.15 The Pathways product innovation has a major impact on the volumes that BMI undertakes for a given corporate customer, showing the ability of tight networks to increase volume, drive discounts and ultimately support industry rationalisation. Typically, BMI will see its share of an individual company’s acute healthcare spend [§<] after a switch to Pathways. BMI offered AXA PPP a deep discount of [§<] on top of the existing acute network discount to encourage AXA PPP to contract in this way. [§<]. BMI insisted that these discounts must be used to support lower costs to the consumer of the Pathways product – pass through to the ultimate consumer is critically important to support the economic rationale for the discount.¹⁹

Simplyhealth MSK trial

- 4.16 A second example of a collaborative approach between BMI and a PMI is the trial MSK product – developed between BMI and Simplyhealth at the start of 2012 – which was designed to change the care pathway and make the patient journey more efficient and seamless, and to offer a higher quality service to patients. The approach was completely different to the traditional patient journey and the open referral directional approaches adopted by other PMIs.²⁰

¹⁸ AXA PPP Response to the Issues Statement, paragraph 8.4.4.

¹⁹ [§<].

²⁰ [§<].

- 4.17 The product was designed to remove the need for GP referral, avoid duplication of information, minimise any reliance on patients to pass on information and reduce fragmented correspondence. It provides another example of the innovation potential that can be unlocked by collaborative working partnerships between the different complementary suppliers of final service to the consumer. In BMI's view, this model will deliver superior outcomes when compared to the aggressive use of a simple lowest cost procurement model preferred by Bupa. The new initiative went live on 1 April 2013 for two key corporate customers insured by Simplyhealth and initial feedback on the new referral pathway has been extremely positive.

The NHS

- 4.18 At paragraph 25 of the AIS, the CC lists ways in which the NHS interacts with PHPs. This list is unchanged since the Issues Statement. Again the CC has rightly acknowledged the 'key role' that the NHS plays in assessing competition in PH services, although, as with PMI, this requires significantly more development to understand fully. This is particularly the case with regard to:
- (i) Subsection (a) – free at point of use NHS;
 - (ii) Subsection (e) – the NHS's role as customer of the private hospital operators when NHS patients are treated in private hospitals; and
 - (iii) Subsection (c) – the NHS's role as supplier of privately-funded healthcare services through PPU's.

NHS as a customer

- 4.19 NHS-funded treatment is the most rapidly growing proportion of demand in the PH sector, yet pricing is primarily set independently of PHPs and by reference to NHS provider costs. Although NHS work makes a contribution to BMI's fixed costs, this contribution is not always proportionate to the share of revenue or volume undertaken as BMI has no control over the price of NHS work and often has to agree to take "bundles" of episodes from the NHS, so is not able to cherry pick the ones that it can undertake profitably. Taking increasing amounts of NHS work at lower average prices has helped to mitigate the capacity gap (seen in hospital utilisation rates) that has opened up as a result of shortening AVLOS²¹ and falling numbers of insured lives.
- 4.20 The requirement to serve NHS patients in PHP hospitals at fixed prices naturally has [§<] implications for pricing to PMIs. As PHPs have no way of influencing NHS pricing, they have to recoup the balance of their fixed costs from PMIs and self-pay patients. This has two consequences. The first is that the PHPs are correspondingly increasingly dependent on PMIs and self-pay. The second is that the NHS has a free riding benefit – which is unconnected to the existence or exercise of any market power by the PHPs.

²¹ Average Length of Stay – a measure of how long the average patient can expect to be in the hospital.

NHS as a supplier/competitor

- 4.21 BMI welcomes the CC's decision to include PUs (whether NHS managed or outsourced) in the competitive framework. This is quite obviously correct and consistent with BMI's earlier submissions, the OFT's decisional practice, PMIs network definition, the CC's survey evidence and the incentives created by the Health and Social Care Act 2012 on NHS trusts to further grow this source of revenue.
- 4.22 However, the CC also appears to underestimate the role of NHS as supplier of private healthcare (subsection (c)), as *including* but not limited to PUs. The NHS role as a competitor to PHs is not limited to PUs.
- 4.23 The CC has paid no attention so far to cash benefit policies that encourage PMI patients to use NHS facilities. For instance, the patient survey found that 73% of private patients chose to use private healthcare "because they had PMI" but the survey did not explore the extent to which these patients were offered cash benefits to stay in the NHS and as the survey population was recruited from patients attending private hospitals rather than PMI claimants, obviously did not include any individuals who had made such a choice. Cash benefits paid by insurers to PMI policyholders to encourage use of the NHS are a clear diversion from PH providers to the true NHS. Recent evidence suggests these cash benefits are being significantly enhanced to persuade PMI policyholders to access care in the NHS.²²
- 4.24 NHS provision is a **particularly important head to head competitor** to PHs in respect of **higher acuity or more complex work**. There is a considerable body of evidence already before the CC that demonstrates this. For example, when BMI decided to invest in an ICU at its Blackheath hospital, the investment case for this project stated that it would become the first private ICU between "*Blackheath and Brighton*". This is a large geographical area with a similarly large affluent population. It is not plausible that there was simply no demand for higher acuity PH services in this area. Far more likely is that patients with PMI or who were willing to self-pay and who needed high acuity healthcare services were either travelling or were being treated in the NHS. Again this is the usual NHS, not NHS-managed PUs. [X]

[X]²³

- 4.25 Competition is not just seen in respect of investment decisions, as evidence from BMI's Priory hospital demonstrates, but in NHS pricing for private episodes. [X].²⁴
- 4.26 [X]

²² This point is also highlighted by HCA in its paper "PMI buyer power – further recent initiatives".

²³ [X].

²⁴ [X].

[3<]

- 4.27 There are a number of reasons why privately funded patients find themselves being treated in the 'normal' NHS. The most obvious relates to consultant influence during the patient journey. A consultant will frequently want to see patients who are gravely ill, or whose surgery carries greater risks, in an environment where they have full access not just to ICU equipment but also to the critical care teams of nurses and junior doctors they are accustomed to working with in these higher risk situations.²⁵ There are significant additional advantages to a consultant in seeing high acuity patients in the NHS, in particular the fact that patients will be supervised around the clock by the consultant's team of junior doctors. In the private sector, this responsibility falls to the consultant him/herself.
- 4.28 It is also worth noting that professional indemnity for treatment of higher risk patients in the NHS – in NHS time – will be covered by the relevant trust, rather than under the professional indemnity cover funded by the consultant him/herself.
- 4.29 These advantages are noted by the NHS in marketing materials to private patients:

"Consultants who treat privately in NHS hospitals are there because it is their work base and this is where they have built up a specialist team. There is always back-up from a wide range of on-site expert care, including specialist nurses and therapists."²⁶

- 4.30 The CC appears to be contemplating a sharp division between "PPU" and "normal" NHS. This is not sustainable in practice. Private beds in a PPU are just that. The imaging, x-ray, path lab, theatre, recovery and ICU facilities on which the private ward depends are all 'normal' NHS. A private patient whose surgery requires a stay in an ICU may not actually use the PPU until they recover enough to be stepped down from ICU. Laing & Buisson recognise this referring throughout their report to "NHS private patient revenues" of £482m in 2012 rather than PPU revenues:

*"At mid-2012 Laing & Buisson estimates there to be 77 dedicated NHS private patient units PPUs in the UK with a total of 1,195 beds. Three of the units offer day care surgery only. **In addition there are believed to be around 1,500 non-dedicated beds used to treat private patients on an irregular basis, which have historically had private patient 'occupancies' of around 10%.**"²⁷ [emphasis added.]*

- 4.31 Indeed, not all private work requires a bed so this is likely to understate the level of activity. Of course, it is within the CC's capabilities to obtain

²⁵ Junior doctor in the sense of non-consultant doctors employed by the NHS, namely Foundation Doctors and Specialty Registrars.

²⁶ <http://www.michelham.com/ourcharges.html>

²⁷ L&B 2012, paragraph 4.2.

complete, accurate and current information on NHS private patient revenues by approaching the NHS acute and foundation trusts directly, and BMI would urge the CC to do this in order that it may more clearly understand both the extent of NHS private patient revenues and the competitive constraint the 'normal' NHS represents to PHPs.

- 4.32 BMI also notes that information obtained under Freedom of Information Act 2000 by Gareth Thomas MP (Lab; Harrow West) and reported in the Guardian in April 2013. This states that a large number of NHS foundation trusts had ambitious plans to grow their private work as the previous cap on private income is removed by the Health & Social Care Act 2012. Importantly this trend is not restricted to specialist centres of excellence in London:

"Beyond the centres of excellence, such as Great Ormond Street hospital, these trends have encouraged smaller trusts to seek extra funds. Ealing hospital in London – which is facing the closure of its A&E department – has budgeted for a 231% increase in private patient income in 2012-13 as against 2010-11, albeit from a low base. The Surrey and Sussex trust has budgeted for a 186% increase."

"Of the country's 146 foundation trusts – each of which has a significant degree of financial autonomy – 40 plan to open private patient units"²⁸

- 4.33 It might have been expected that the CC would have conducted its own investigation to elicit this information, particularly as the NHS "*play[s] a key role in assessing competition in the provision of privately-funded healthcare services*".²⁹ Obviously both actual entry in this way – and indeed the threat or risk of such entry – are an important, and as yet overlooked, dynamic.
- 4.34 The CC's survey also suggests at least a 12% diversion into the NHS for self pay patients if the chosen private hospital is unavailable, excluding "don't knows". This is not insignificant, particularly as the survey suggests that self pay patients are likely to be higher acuity or have higher co-morbidities³⁰ and therefore represent higher value to the hospital. Also this diversion is found in a survey population that had already completed their self-pay treatment in the private hospital. A similar question asked of the *potential* self-pay population (i.e. those who could have paid but did not) may well have elicited a much higher percentage.

Conclusion on characteristics of the market

- 4.35 The features of the industry and the pricing within it are primarily a function of the characteristics described above and not a lack of competition (not at least at the PH level). The consumer has historically chosen (at least as expressed through PMIs' strategic decisions) to have a large network of relatively

²⁸ <http://m.guardian.co.uk/society/2013/apr/06/nhs-hospitals-increase-private-patients>

²⁹ AIS, paragraph 26.

³⁰ Surveys of Patients, slide 15.

underutilised local provision. PH prices reflect the costs of the resulting thin demand that is financially intermediated by PMIs.

- 4.36 BMI believes that there is very strong evidence that, at least in its own case, pricing reflects costs and not excess profitability. BMI considers that a **proper evaluation** of profits together with a **true and fair valuation of its capital base** would demonstrate that it does **not generate 'excess profit'**.
- 4.37 The NHS is a relevant constraint and becoming more so. The **CC cannot take a static approach** and ignore the effect of the Health & Social Care Act 2012, particularly as there is very **recent evidence of significant expansion plans for NHS foundation trusts into PH services**.

5. Market Definition

Product Market (Appendix A)

- 5.1 BMI agrees with the CC that demand-side substitutability between different medical treatments is limited. This is consistent with its view submitted in response to the Issues Statement.³¹
- 5.2 BMI also agrees with the CC that the product market for the provision of hospital services is characterised by supply-side substitution. BMI notes that this statement is made more accurately in the Annex to Appendix A than in paragraph 3(c)(i) of Appendix A:

"To a large extent, the same production assets can be used for the provision of a wide range of treatments, hospital facilities, operating theatres, hospital staff."³²

- 5.3 BMI agrees with this description, which again is consistent with BMI's submission in its response to the Issues Statement.³³
- 5.4 However, BMI considers that the CC should bear in mind the following points in respect of its approach to analysing the following competitive constraints: (i) medical speciality; (ii) type of care; and (iii) high acuity.

Speciality Aggregation

- 5.5 The CC's competition rationale for limiting this to the top 16 specialities undertaken in hospitals that can offer inpatient care is unclear. The CC states that the "16 consultant specialties are offered by 80% or more of these 215 general private hospitals and PPUs providing inpatient care" and that these 16 specialities constitute "86% of patient admissions in these hospitals".³⁴ Given

³¹ GHG response to Issues Statement, paragraph 3.6.

³² AIS - Annex to Appendix A, slide 19.

³³ GHG response to the Issues Statement, paragraph 3.7.

³⁴ Appendix 1 Annex A Slides 26 and 27.

the CC's findings in respect of supply side substitutability between specialities, it is inappropriate to limit the competitor set to just 16 specialities, which account for just 86% of revenue, without considering the potential for supply-side substitutability.

- 5.6 As BMI has noted in its response to the market questionnaire, there are usually very low barriers to switching between specialities. A good way to illustrate this is to consider the CC's proposal to exclude vascular surgery. The only additional material characteristics which a hospital already undertaking general, gastro and orthopaedic surgery would require in order to undertake vascular surgery would be a vascular surgeon. Does the CC believe that the supply of vascular surgeons is constrained such that some hospitals that would be able to treat such patients cannot do so due to lack of access to consultants? If so, this would be surprising as none of this reasoning is visible from the AIS and appendices and it would anyway be inconsistent with the CC's apparent lack of concern about the supply of consultants generally.³⁵
- 5.7 BMI does not believe that there is a compelling case for Oncology to be separated out from the other specialities:
- (i) It is far from clear why it is appropriate to aggregate specialities at the level of 80% of 215 general hospitals, rather than 68%.
 - (ii) Oncology is a very broad field, which encompasses chemotherapy that can be delivered by nurses in the home; through to advanced radio and surgical therapies, such as the gamma knife where there are only a tiny number of private facilities in the country. There are therefore treatments within oncology that can only be carried out at a smaller number of hospitals – but this is the case for all specialities and its impact on market definition is discussed below.
 - (i) As BMI's evidence shows, entry into chemotherapy in particular is common and requires low investment (for example, at Goring Hall an initial investment of £2,000 was made to provide a chemotherapy unit at an existing hospital site.)³⁶ At BMI Beardwood, BMI entered into a joint venture with consultants to establish a new oncology practice at the hospital. BMI provided the necessary equipment and facilities and was able to establish the practice very quickly after the consultants were committed, and certainly in well under a year. Many surgical oncological treatments have similar requirements in terms of hospital equipment and nursing expertise as other surgical specialities. Hence the relevant [production] assets can be used by firms to supply oncology services and other PH services. Moreover, the [relevant firms] have the ability and incentive to quickly (generally within a year) to shift capacity between these services depending on demand for each.³⁷ There is no sensible basis to think that oncology is not also

³⁵ AIS, paragraph 107.

³⁶ [redacted].

³⁷ CC2 paragraph, 5.2.17.

affected by the wider supply side substitutability considerations noted in the CC's analysis. The fact that fewer inpatient private hospitals currently offer oncology is not sufficient justification for excluding it from the market definition.

Type of care (in-patient, day case and outpatient)

- 5.8 The CC's approach to segment in-patient, day case and out-patient work on the basis of asymmetric constraint except as between inpatient facilities is excessively static and risks focusing the CC's inquiry on an artificially narrow competitor set. Private healthcare has seen a long established trend of reducing average length of stay (AVLOS). Medical procedures that were previously in-patient have become day case procedures (e.g. hysterectomy), and day-case procedures are increasingly being performed in an outpatient setting (e.g. EVLT treatment of varicose veins). Advances in anaesthesia in particular have also significantly shortened the time a patient needs to recover from many surgical procedures.³⁸
- 5.9 The CC's recently issued guidance describes the role of market definition as follows:
- In defining the relevant market (see paragraph 26), the CC identifies the participating firms and customers and the traded products in the market(s) that are the subject of the reference. This enables the CC to focus on the sources of any market power and provides a framework for its assessment of the effects on competition of features of a market (see paragraph 31).³⁹*
- 5.10 Simply put, the CC's proposal to focus the inquiry on inpatient care will not assist in achieving this aim. Using inpatient care as the frame of reference instead reflects an outdated view of private health; a service characterised by patients lying in a hospital bed in a single en-suite room, for a number of nights, quietly convalescing and using the 'hotel' services of a private hospital. This view is at least ten, if not twenty, years out of date. It cannot give the CC a true picture of how competition in PH services operates. Inpatient, day case and outpatient care are all components of the private health offering and each often forms part of a single patient's journey through their treatment.
- 5.11 As hopefully demonstrated to the CC via site visits, modern private hospitals are places where the great majority of people treated are on an outpatient, day case and walk-in walk-out basis. Looking at inpatient work alone does not reflect the true nature of competition between hospitals along any dimension (whether price, quality, investment, consultants, patient experience or speed of treatment). BMI Albyn undertook [redacted] inpatient **and** day case episodes in 2012 – about [redacted] per calendar day. In the same year, it

³⁸ [redacted].

³⁹ Guidelines for market investigations: Their role, procedures, assessment and remedies (April 2013), paragraph 131.

undertook c. [redacted] outpatient appointments. Inpatient **and** day case episodes accounted for less than [redacted]% of its workload. BMI does not routinely manage its business on an IP only basis. Importantly, it would appear very unlikely that the fixed costs of running hospitals could be covered considering any particular subset of patients alone.

5.12 Inpatient, day case and outpatient are not fixed categories. Individual services and treatments move between them. As well as the longstanding trend of moving towards reduced AVLOS (i.e. moving from inpatient to day case and from day case to outpatient/"walk in walk out" – see next paragraph), there are also differences amongst the same procedures. An operation may be listed and priced as a day case but may involve an overnight stay if the patient needs longer to recover, faces a complication or was simply treated late in the day and is not ready to be discharged the same day.

5.13 The following graphs demonstrate the movement of BMI's case mix from inpatient to day cases and falling AVLOS – which has fallen by more than [redacted]% in FY12 to [redacted] days and is budgeted to fall further in FY13 to [redacted].⁴⁰

[redacted]

[redacted]

5.14 [redacted].

5.15 Negotiations with PMIs also do not provide any evidence of a separate market for episodes of differing lengths of stay. Inpatient pricing is not negotiated separately with PMIs. Subject to service line tenders, inpatient, day case and outpatient prices are negotiated together and each price is closely correlated to the other – to such an extent that the vast majority of PMI negotiations see the prices for each procedure type move together at the same time by exactly the same amount.

Critical care levels

5.16 As the CC has found, it is the case that many private hospitals do not have the facilities and staff to undertake elective inpatient work that may require critical care level 3, although most do provide care to level 2. BMI notes that the CC is not proposing to define a separate market for hospitals offering critical care level 3, but will consider these asymmetric constraints in the competitive assessment.⁴¹

5.17 Whilst BMI agrees that it is inappropriate to define markets based on critical care capability, it is nonetheless very important that the CC understands why relatively few private hospitals have full ICU / critical care level 3 capabilities when considering the implications of the potential "asymmetric constraints" for

⁴⁰ [redacted].

⁴¹ AIS - Annex to Appendix A, slide 32.

the competitive assessment. This characteristic of supply is a reflection of NHS competition – not the barriers to undertaking work at critical care level 3.

5.18 There are number of ways to illustrate this. See, for example, BMI's decision to invest in an ICU at its Blackheath hospital, which would become the first private ICU between Blackheath and Brighton (as discussed at paragraph 4.24 above).

5.19 BMI's [redacted] higher acuity work is **focused on attracting work from the NHS, not other private hospitals:**

[redacted]

5.20 Hospitals that do not have critical care level 3 can expand to undertake this work quickly (i.e. within 12-18 months)⁴² and there are examples of this occurring, for example the BMI Clementine Churchill and BMI Blackheath. Moreover, almost all PPUs would be able to 'expand' in this way, as each has existing access to the facilities of the host NHS trust.⁴³ It is notable that private hospitals in countries whose healthcare markets are not characterised by the NHS, will usually have ICU and critical care level 3 capabilities. Indeed in many jurisdictions, the private healthcare sector is where the highest acuity, most sophisticated, most highly specialised services are typically found. The fact that this is not the case in the UK (indeed in most local markets the reverse is largely true) is entirely a function of the NHS.

5.21 BMI does not recognise tertiary care as a relevant indicator of horizontal differentiation between private hospitals. It is not a term used by BMI to describe the capability of hospitals and refers instead to the nature of the referral. A tertiary referral is made by a consultant to another (typically more specialised) consultant. There is no necessary or useful correlation between the capabilities of the hospital at which the receiving consultant chooses to practice and the tertiary nature of the referral.

6. Profitability

6.1 BMI rejects completely [redacted] that it or GHG generates excess profits.

6.2 [redacted].⁴⁴

7. Theory of harm 1: market power of hospital operators in certain local areas

7.1 At this stage, with the disclosure that has been made available to date and before the data room process is complete, it is not possible to provide detailed feedback on the CC's work on local market concentration, or on the price concentration analysis. However, so as to assist the CC and in view of the

⁴² CC2 paragraph 5.8.11 entry within 2 years is considered timely.

⁴³ The only exceptions to this would be the small number of PPUs in NHS hospitals without an ICU.

⁴⁴ [redacted].

extremely compressed timeframe in which the current administrative timetable anticipates provisional findings, BMI has commissioned Compass Lexecon to prepare a short paper describing the methodological issues associated with using LOCI as a measure of local market concentration and the CC's work on price concentration which is attached at Annex 1. BMI will be commenting more substantively after the data room exercise. It therefore confines itself below to some key issues that are immediately apparent.

- 7.2 Following the BMI hearing, we hope that it is clear to the CC that LOCI is suggesting a filter with particularly large 'holes'. As such it is providing an extremely poor guide to local market power. [redacted] out of 61 BMI hospitals are caught by this filter. [redacted] of the 37 hospitals de-listed by Bupa are caught by the filter, as are many hospitals that face vigorous direct local competitors such as [redacted].
- 7.3 The LOCI filter is also inconsistent with a detailed econometric examination of effects. As Dr Peter Davis's paper illustrated, there was no compelling evidence of the exercise of market power, even when looking at a cohort of solus hospitals that faced far higher levels of local concentration than those caught in the 'hospitals of potential concern' filter.⁴⁵
- 7.4 Finally, the CC notes that the findings of market power in local areas is consistent with the fact that hospital groups are earning returns in excess of the cost of capital.⁴⁶ Neither BMI nor GHG earn excess profits and we refer here to our submission in response to the profitability working paper. Given this, BMI would expect the CC to draw the inverse conclusion – i.e. that lack of excess profitability is consistent with BMI not having (or not exercising) market power.

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

- 8.1 The CC acknowledges that the appropriate framework to consider is that of each side's best alternative to an agreement – in other words the 'outside option' available to both the PMI and the PHP.⁴⁷ The outcome of the negotiation (or a series of negotiations) might be expected to be determined by the relative attractiveness or otherwise of each side's outside option.
- 8.2 However, at this stage the CC has only considered the PMIs' outside option and the insurers' supposed difficulties in the negotiation. There is no consideration of the outside option open to the PHPs. For instance, the credibility of any threats made around access to hospitals and hospital pricing, the presence or absence of contract terms that reflect success of 'leveraging' strategies, the harm caused to individual hospitals and PHPs as a whole by

⁴⁵Do private healthcare providers have market power in solus hospital markets?' 3 January 2013, Peter Davis, Erik Langer and Stefano Trento, Compass Lexecon.

⁴⁶ AIS, paragraph 71.

⁴⁷ Appendix D to AIS, paragraph 9.

PMIs directing volume away (whether as a result of de-listing or otherwise), how long that harm might be expected to last, what strategies and effectiveness of such strategies the PHP has to mitigate such harm. Yet, despite this, the CC's emerging thinking is that "*considering the bilateral negotiations over the main contract in isolation, based on our review of documents provided by the parties, it does seem that insurers are often in a relatively weak position.*" .

8.3 Without undertaking the necessary analysis of the PHPs' position and thereafter considering the negotiations with a genuinely open mind, this thought cannot constitute an evidence-based finding. Furthermore, the evidence, at least in so far as it relates to BMI's negotiations, simply cannot support such a view. Much of the 'difficulty' cited by the CC has apparently just been repeated from the submissions of certain PMIs and does not bear scrutiny against either the passage of the actual negotiations or their outcomes. BMI notes in this regard that the CC states: "*It is clear from documents and submissions that **most insurers** feel that they rarely secure favourable terms through traditional bilateral contract negotiations with hospital operators*"[emphasis added]. Two points arise from this.

(a) The first is that **not all PMIs** consider this to be the case. This and the identity of the PMIs who do not is revealing in itself. As the CC notes, Bupa, as the dominant PMI provider, is in a "*significantly stronger*" position than everyone else, yet it supposedly considers itself as one of the insurers in this relatively weak position.⁴⁸ Therefore there must be smaller non-dominant PMIs who do consider that they get a good deal from hospital providers. Indeed, AXA PPP have acknowledged that they have sufficient bargaining power opposite BMI.⁴⁹ Why is this? Why are they able to obtain favourable terms yet Bupa (according to its submissions at least) is not?

(b) In a competition inquiry into relative bargaining strength such as this, the CC must recognise that each side has an incentive to present its position to the agency as the one of relative weakness. It is therefore surprising that not all insurers have presented their position as weak – simply as a tactical matter. There is no downside to doing so and potentially significant upsides – particularly if the CC can be persuaded to intervene to strengthen their relative position as is Bupa's apparent objective. The conclusion must be that some PMI's do not consider it credible for them to maintain that position.

8.4 In the remainder of this section, BMI considers the analysis of the negotiating position of the insurer using the structure of Appendix D; throughout we draw attention to the evidence of BMI's position in the negotiation which has not yet been considered.

⁴⁸ Bupa response to IS, paragraph 1.59.

⁴⁹ Appendix D to AIS, paragraph 30.

Part 1 A: The bargaining position of the hospital operators and insurers during their principal contract negotiations:

- 8.5 The CC rightly considers that a PMI's bargaining strength comes from its ability to switch its demand to other providers.⁵⁰ Part 1 considers a traditional mechanism for doing this, namely the insurers' ability to define hospital networks where their insured are treated. It is important to hold in mind however, that de-listing a hospital from such a network is only one mechanism for determining where patients are treated. The negotiation between a PMI and hospital provider cannot be reduced to network recognition alone – what matters is an insurers' ability to affect where insured patients are actually treated. Network recognition is only the start of understanding this.
- 8.6 The CC has considered two "*key difficulties*" that insurers face in threatening to de-list a hospital:
- (a) Cost to the insurer of de-listing; and
 - (b) Removing hospitals can harm an insurers' business and cause it to lose policyholders.
- 8.7 In reality these two difficulties are the same. The costs of de-listing can be expected to include the direct costs of doing so (a), as well as the strategic costs (b). The PHP also faces costs associated with de-listing which affect its response to a threat to de-list. These include direct costs (for the hospital concerned and the group as a whole) as well as strategic harm to the business over the longer term (consultant departures, changed GP/patient referral patterns and perceptions etc.). In particular, consultants may split their practice, treating patients claiming under a PMI product for which the BMI hospital has been delisted at a rival hospital. It is not uncommon for consultants to then continue to split their practice even after the hospital is re-listed. Again, the CC has not yet considered any evidence of the costs to the hospital but will obviously need to do so if it is to adopt a **fair** and **balanced** assessment.
- 8.8 In respect of the direct costs to an insurer of removing a hospital from its network BMI considers that these have been greatly overstated. We explain why using the headings at paragraph 23, Appendix D:

- (a) *"Insurers face a significant increase in the level of prices if out of contract with a hospital operator"*

It is important to recall a couple of key facts when considering this.

First, hospitals have high fixed costs in proportion to total cost. This makes profitability very sensitive to variation in patient volume, which in turn means PHPs are willing to offer discounts for volume.⁵¹ This

⁵⁰ AIS, paragraph 11.

⁵¹ The CC has acknowledged this at Appendix E to AIS, paragraph 36.

price/volume trade-off is at the heart of BMI's pricing and approach to insurer negotiations.

Second, an insurer never has a commitment to provide a hospital provider with any volume at all. The best position a hospital provider can expect is either that patient volume will simply be **available to its facilities to compete for** (as would be the case when negotiating access to a non-exclusive insurer network); or be **actively directed to its facilities** (as would be the case in an exclusive or restricted network). The choice as to which is for the insurer when designing its network strategy.

An "out of contract" situation can also refer to different things. It can mean that an insurer is saying to a hospital operator that it will use its best efforts to direct its patients away from the PHPs hospitals. We assume this is the "out of contract" scenario the CC is referring to and this was the case in the 2011 BMI/Bupa negotiation. In such a situation, the hospital provider can have no expectation of any volume from the insurer against which it can mitigate its fixed costs. The efficient response therefore is that the unit price offered to that insurer must rise to reflect lower volume over which to recover fixed cost and greater uncertainty as to the extent of the volume that will arrive at all - given the insurer's stated objective to direct it elsewhere.

Alternatively and more commonly "out of contract" can simply mean that there is no subsisting agreement between hospital and insurer – with no intent or threat by the insurer to direct volume away. This situation has historically been quite common and in some ways still characterises arrangements between BMI and certain insurers. Bupa and BMI operated "out of contract" from [redacted] right up until [redacted] ([redacted] years [redacted] months). Why would Bupa put itself in this position if it faced significant price increases simply for being "out of contract"?

Price negotiations continue in these situations against the usual price/volume trade off – often with pricing in the interim being set against a combination of continuing the previous contractual framework with forward looking discounts, inflationary rises and rebates for volumes achieved.

Crucially, in both "out of contract" situations, any **fair and balanced** assessment would take account of BMI's powerful incentive to continue to encourage the insurer to send volume to its hospitals. Hence, in the Bupa / BMI negotiation in 2011, **BMI's "out of contract" proposals offered Bupa [redacted]:**

[redacted]⁵²

In the same vein, BMI offered Bupa [redacted].

⁵² [redacted].

It is therefore misleading to say that insurers face a significant price increase if out of contract. Offered prices will have to rise if an insurer indicates that it is determined to direct volume away, but the evidence shows that in practice this has been mitigated by [§<]. This makes sense as the PHP still needs to attract the volume, particularly given that, across the portfolio, BMI's hospitals on average have significant spare capacity. The CC must consider this evidence in the round including from the hospitals perspective if its conclusions are to rest on **fair** and **balanced** foundations.

It is also important to remember that the negotiation does not take place in a vacuum. The PMI directing volume away from BMI can expect improved terms from the PHP to whom it directs the resulting volume (see below). As such, while it is unsurprising that the CC has seen evidence of PMI's evaluating the impact of changing price arrangements with hospital providers resulting from their negotiating strategies, however, taking a **fair** and **balanced** approach to the issue, net/net it is far from clear to BMI that insurers' actual costs rise significantly as a result of being out of contract with it.

(b) *"Insurers may face a delay before they can amend their network"*

This is factually wrong. PMI policy terms either already (or could if they wanted to) allow PMIs the freedom to amend their hospital lists immediately without needing to await their policyholders' renewal cycle:

- **Aviva**
The Aviva list states that "Our Hospital Lists are regularly updated and these details should be taken as an indication only."
- **WPA**
The WPA list states the WPA "reserve the right to withdraw or amend the hospital list without prior notice if necessary, in such a way we feel is reasonable and commercially necessary"
- **Pruhealth**
The Pruhealth list states: "This list is accurate at time of printing (January 2013) and is subject to change."
- **Bupa**
Bupa removed BMI swiftly by publishing a notice on its website with an accompanying Q&A.⁵³

(c) *Removing a hospital from an insurer's network may not be viable if the alternative is more expensive.*

⁵³ [§<].

The statement **ignores the hospital's position** in the negotiation, contrary to what is required of a fair and balanced assessment. What matters to the negotiation is the **credibility of the threat**. BMI has **no transparency as to the price terms of its competitors**. Hence BMI has no way of knowing whether a threat to use an alternative hospital would mean an increased price for that insurer.

Furthermore, **BMI has been approached by PMIs in this situation** and asked to offer deeper discounts if competitors are delisted, where such de-listing would result in BMI's volumes going up. [X]⁵⁴

Negotiations with insurers tend to be conducted on a national basis, hence in a given delisting scenario, if the services provided by an alternative hospital to the potentially delisted hospital are more expensive, it is highly unlikely that the inclusion of such a hospital could have the effect of making a PMI product as a whole "unviable". In any event, unless the CC has a sound appreciation, based on empirical data, of the margins of each PMI at the PMI product level, it is not open to the CC to come to this conclusion because it will not have based its understanding of the underlying economics on a fair and balanced consideration of appropriate evidence.

- (d) *"Removing a particular hospital operator may transfer pricing power to other hospital operators in parallel negotiations"*

This is factually wrong. In any parallel negotiation the hospital provider does not know what threats are being made to its competitor. In any event whether negotiations occur in parallel is within a PMI's control. In practice, PMIs will typically not negotiate in parallel – it is more efficient for both PMIs and PHPs for contract termination dates to settle over time so a single team of negotiators can deal with each settlement sequentially.

- (e) *"Planning for a delisting is time consuming and costly"*

There is no reason to think that the hospital provider puts less effort into preparing for the negotiation than the PMI. Notably, so far absolutely no consideration has been given to the costs the hospital provider would face in preparing for a potential delisting, which can obviously not constitute a fair and balanced approach to the question.

Although BMI cannot know the extent of insurer costs, it certainly faces high costs in preparing for these negotiations which hamper investment certainty, staffing recruitment and retention, harm marketing efforts and consistency of message to consultants, GPs and patients as well as take up very significant management time and resource.

8.9 The CC considered at paragraphs 24 through 28 the supposed indirect or strategic costs falling on an insurer from de-listing. The CC appears here to

⁵⁴ [X].

have adopted (rightly) a more sceptical view of these claims. For instance, the claim that hospital providers can have a material impact on the likelihood of switching by policyholders is pretty far-fetched. BMI has no means by which to even know, let alone to actually contact, the vast majority of policyholders. Remember that only a fraction of the relevant policyholders will have used a BMI facility in the past and so have given their contact details to BMI; and many of these will not have given data protection consent to use their details for marketing purposes.

- 8.10 BMI's comments during the Bupa negotiation which suggested Bupa members, who were disgruntled with Bupa's decision to remove access to certain BMI facilities, should consider shopping around for an alternative product. Bupa responded aggressively to this by saying in the media that it was "**misguided and ridiculous**" to suggest that any policyholder could switch insurer due to the restrictions on pre-existing conditions⁵⁵. [§<].⁵⁶
- 8.11 The scepticism the CC shows about harm to an insurers' reputation from a de-listing at paragraph 28 Appendix D is also well placed. Whilst BMI is unaware of the quantum of costs that fall on an insurer, it knows that the costs that fall on it are severe and long-lasting as discussed below.

Part 1 B: How insurers have used network recognition in negotiations

- 8.12 The CC refers here to Bupa's de-listing of 37 BMI hospitals as evidence that this threat is used but there is no developed discussion of the significance of this negotiation. BMI (and apparently BMI's competitors⁵⁷) consider this negotiation to be of central importance to the CC's investigation. BMI has explained in detail the context, progress and outcome of the Bupa negotiation and does not repeat those submissions here⁵⁸; the following key points however ought to be understood:
- (a) Bupa **actually did** de-list 37 BMI hospitals – including [§<] "hospitals of concern" on the LOCI methodology, 4 solus (as identified by the OFT) and 4 of Nuffield's supposedly hypothetical "must haves". Where a threat is actually carried out there can be no question that such a **threat is credible**.
 - (b) Bupa did not delist the hospitals temporarily. Bupa delisted them on 1 January and had started its patient and consultant communications well before this. Bupa also wrote to Netcare (BMI's ultimate controlling shareholder): [§<] The only reason that the de-listing period was in fact relatively short was because BMI agreed terms.

⁵⁵ Natalie-Jane McDonald interview with Health Insurance, available at <http://www.hi-mag.com/health-insurance/product-area/pmi/article385126.ece?page=2>.

⁵⁶ [§<].

⁵⁷ BMI notes its delisting by Bupa has apparently been referred to by other PHPs at in the AIS, Appendix D, paragraph 29.

⁵⁸ [§<].

- (c) [redacted].
 - (d) BMI's contemporaneous planning documents show that in a worse case-scenario, Bupa could **divert away up to [redacted]% of its volume**. [redacted], it also illustrates the true scale of the 'leveraging' opportunity open to BMI. It is not credible to suggest that BMI would have the ability or incentive to use [redacted]% of Bupa's demand to leverage price rises for [redacted]%.
 - (e) BMI did not consider Bupa's starting position of a [redacted]% price reduction on declining volume to be credible. No evidence was offered to support this contention and indeed following a presentation from Bupa earlier in the year we believed the gap to be nearer [redacted]%. This approach anyway assumes that the price Bupa is able to extract from BMI's competitors is a directly comparable or competitive starting point for negotiation, given, for example, differences in quality.
 - (f) Bupa obtained a very significant price reduction – at least [redacted]% in real terms. Moreover, this should be seen against a background of BMI facing significant cost inflation across its business. In a competitive market, BMI would be expected to pass on input cost inflation to customers through price rises. [redacted].
 - (g) BMI would urge the CC to ask how, and indeed whether, this very significant price reduction was passed through to consumers.
 - (h) There was no debt refinancing ongoing at the time of Bupa negotiation. [redacted].
- 8.13 Outside of Bupa, other insurers have also demonstrated that they are prepared to use a network strategy to generate scarcity of "slots" and hence competition for their business. BMI notes in this context that if Bupa is able to direct away [redacted] of BMI's volume, this is also open to other insurers. The alternatives open to an insurer are not affected by that insurer's size.⁵⁹
- 8.14 The CC has referred to a letter from Julian Stainton of WPA to BMI which threatened precisely this – see paragraph 60 *Entry and Expansion Case Study: Circle Bath*.
- 8.15 As discussed below, Pruhealth operated a tender for network recognition and selected BMI and Spire, but excluded BMI's London hospitals. Pruhealth also sought to add [redacted] – despite the fact that [redacted] competes directly with [redacted].⁶⁰ [redacted] is one of the smallest PH providers in the UK and Pruhealth is one of the smaller insurers. It is very striking that BMI, as the largest PH provider was

⁵⁹ It is interesting to note that Aviva claims it does not have the same ability to delist as the larger insurers, but the example it uses to illustrate this at paragraph 5.2.4 of its response to the IS referred to the position of an NHS trust during negotiations relating to Aviva's Trustcare product. Given that the Trustcare product was specifically designed around NHS PPU's, it is unsurprising that Aviva's threat to de-list was regarded as unconvincing by the NHS PPU concerned

⁶⁰ [redacted].

not able to procure [X] exclusion from Pruhealth's local network – despite the fact that BMI had tendered and offered a price to Pruhealth on the basis that their product would be a restricted network (i.e. a network with an element of exclusivity). This outcome is not consistent with BMI being able to credibly threaten leveraging of local market power.

- 8.16 Aviva pushed back on any suggestion that BMI could influence its network definition. BMI not only acknowledged this point but affirmed explicitly in correspondence that this is a decision for Aviva alone. During the negotiation of AXA PPP low cost, AXA PPP initially excluded [X] in favour of the local [X] units. AXA PPP would not agree to include the BMI units, (let alone exclude the [X] units) on the basis that [X] had offered a better price in these areas. This is not consistent with an ability to leverage its market power in certain local markets.
- 8.17 Insurers of whatever size can use network recognition to drive competition between PHPs if they wish – indeed this is the principal reason why insurers use hospital networks.
- 8.18 Negotiations show again and again that **BMI is simply not able to determine the shape of PMI networks**. Given that network definition is the most obvious leveraging technique available to BMI, BMI's persistent failure to successfully determine insurers' network recognition is striking evidence of its inability to leverage.

Part 1 C: Changing contracting arrangements may improve the bargaining position of insurers

Regional and local tendering

- 8.19 Regional tendering is not a characteristic of PMI negotiations. It could be, if that's what PMIs wanted, but in practice it is not.
- 8.20 BMI showed itself willing to consider regional pricing as its participation in the AXA PPP acute network tender in the 1990s demonstrates. The reality is that national pricing is far more efficient and in the interests of both parties to the negotiation. It is notable for instance that only one insurer in the response to the CC's market questionnaire appears to have complained about the tendency to price on a full network rather than on a local or regional basis. This is unsurprising and reflects the fact that insurers very rarely seek to negotiate on a local or regional basis. The reasons for this include:
- (a) National pricing between chains (such as PMIs and PHPs) is a normal competitive outcome commonly seen in other sectors with portfolios of local facilities.
 - (b) PMI / PH provider negotiations and pricing is complex with a very large number of price points and commercial terms. This complexity is one

reason why AXA PPP has not repeated its regional tendering exercise undertaken in the late 1990s.⁶¹

- (c) National negotiation minimises transaction and contract administration costs for both parties. The complexity of the pricing structures means that a single national price proposition for each line item or procedure increases the ability to negotiate and administer the contract efficiently, significantly reducing scope for negotiation error and subsequent dispute for both sides.
- (d) National pricing permits package pricing that is more cost reflective. A large number of procedures are not carried out regularly at many hospitals making the base for pricing on a hospital basis artificially narrow. Not all central costs are allocated to hospitals and doing this on historic measures risks creating distortions over the lifetime of the contract. Bed numbers change and case-loads shift with medical advances and payor mix.
- (e) National pricing avoids creating perverse incentives for PMIs to direct work from one BMI hospital to another, distorting BMI's ability to plan investment, marketing effort etc and manage the business effectively.

8.21 The CC has identified two examples of instances where insurers have constructed part of their network via a local or regional tendering exercise. The first, the development of AXA PPP's network in the late 1990s, is very old and has never been repeated. The second, which is PruHealth's reconfiguration of its hospital networks (both core and restricted), is described below. In BMI's view, it is not correct to describe this as a 'regional' network. This is because PruHealth tendered the networks nationally, but for local provision, for which it looked at alternatives in local markets. The only area in which it could potentially be described as 'regional' is in respect of London.

8.22 In 2009, Pruhealth designed four networks allowing progressively more hospitals to be admitted. The "Local" network was intended to be restrictive based on a single provider within a 45 minute drive time – but operated nationally not regionally. The "Premier" list was intended to capture all UK hospitals. This structure is still in place.

8.23 Pruhealth ran a tender to identify the hospital providers that would be in the local network. BMI and Spire won this tender [redacted]:

[redacted]

8.24 The approach that Pruhealth took was to run a national tender for progressively more restricted networks, select BMI and Spire and exclude Nuffield and Ramsay except for some geographical 'gap filling'. Thus while the name of the product was 'Local Network', this was not an exercise in developing separate regional networks (except for London).

⁶¹ "The process was complex and took almost three years to complete" AXA PPP Response to the IS, paragraph 8.2.

Local pricing

- 8.25 BMI does not consider that local (differential) pricing across different hospitals is efficient or desirable either for it or insurers for the reasons described above. Moreover, local pricing is rarely requested in negotiations. The main exception to this was when Bupa, for a brief period between September and December 2011, decided for the first time that it wanted to re-structure its relationship with BMI and negotiate hospital by hospital. This was apparently so as to avoid "leveraging" of solus hospitals by BMI. Given that this approach to local pricing involved a complete change to their pricing structure that BMI had built its business around over the past 30 years, it was very surprising that Bupa did not signal this much earlier in the negotiation and, when it did raise it, offered BMI no time or information from which it could start to work out local pricing. Rather than being a genuine strategic shift therefore, Bupa's sudden (and short) interest in hospital by hospital pricing is far more consistent with their use of the market study/investigation process which they had invested a lot of effort in initiating to attain their commercial goals. It is worth noting that the OFT had raised "leveraging" of solus hospitals in its market study progress statement 4 weeks earlier.
- 8.26 Notwithstanding that national pricing is BMI's preference, BMI is prepared to offer local pricing if that is what insurers want. [redacted].⁶² [redacted] Bupa decided it would proceed with its low cost network without BMI.

Part 1 D: Other factors that may impact the bargaining position of hospital operators

- 8.27 This section of the AIS is narrow in focus and thin on analysis. There are a large number of tactics and options open to insurers in negotiations with hospitals.

(a) Recognition of new facilities

As the CC notes, this is indeed an area where PMIs have additional leverage, although the CC will want to ensure consistency with its assessment of barriers to entry. It is not obviously a good thing that insurers can generate artificial "hold up" risks by refusing to recognise a facility once a hospital provider has sunk investment to create or purchase it. Given this risk, it is to be expected that providers seek terms to mitigate this. [redacted].

(b) Partially de-list a hospital

Insurers can and do do this. Bupa did it in relation to cardiothoracic work at the [redacted]. This work at the [redacted] was left in Bupa's network during the delisting in 2011/12. The CC raises two points about this approach that supposedly make it difficult for an insurer to use – neither of which are compelling. The first is that it signals to the hospitals what the insurer apparently considers to be "must have" services and that a

⁶² [redacted].

"significant price increase" might result. There is no evidence for this claim as far as BMI is aware. No threats have been made or implied that would suggest such a strategy by BMI. Such a threat would anyway be implausible in a world where price negotiations occur on a national basis. It is not credible to argue that a hospital provider could significantly raise the price of a "must have" single specialty at a single hospital when to do so would threaten the rest of that insurer's business with the hospital provider.

The second point around difficulty of patient communications is also overstated. The number of patients this communication challenge applies to is likely to be very small. The vast majority of patients would not be seen at the delisted hospital at all. For the small numbers who need the specialist service left in the network, an even smaller sub-set of these may subsequently require a more mainstream service that has been delisted. Only for these patients would the insurer have to explain that a hospital the patient has been used to attending for [x] illness cannot be used for [y] illness.

(c) Co-payment

The CC apparently dismisses this as it is "not widespread". This does not consider the evidence of the CC's survey. Although 83% of patients interviewed had PMI, only 52% had their bill paid in full by their insurer and 2% had even paid themselves in full despite having PMI. This suggests that co-payment is in fact commonplace.

Moreover, if co-payment is "not widespread", why does the CC not consider the reasons for this and what might prevent its expansion? There is no reason why – in a world where PMI providers are seeking to use low cost networks and open referrals – that a co-payment mechanism might not become more a common and sophisticated tool for directing patients to lower cost hospitals. There is certainly no evidence as far as BMI is aware that PHPs have prevented this.

Any failure to use co-payment products to increase bargaining strength therefore is far more likely to be consistent with insurers not perceiving the need to use it to further increase bargaining power.

(d) Encourage growth of alternative hospitals

This is clearly open to insurers [x]:

[x]⁶³

Again, to the extent that this is rarely seen, the CC should consider the barriers to the insurers doing this if they genuinely wanted to use this tool. There is no evidence cited at present that suggest these are particularly significant.

⁶³ [x].

8.28 There are a number of approaches that insurers have to increase their bargaining strength and which were identified by BMI in the response to the market questionnaire that have either been ignored or dismissed:

- (a) PMIs can opt to increase PH providers' costs

This occurs through various forms of "hold up" – refusing to recognise a new facility is one example but there are many others: de-prioritising BMI hospitals in insurer's internal scoring systems for patient direction as Bupa does with BMI facilities in London, failing to deliver volume against pre-agreed discounts, failing to maintain exclusivity of restricted networks. This is also evident in insurers' push for BMI to offer package pricing that includes the consultant fee. Bupa's MRI network and AXA PPP's cataract and oral surgery networks required BMI to take responsibility for consultant fees but provided little ability to control which consultant took the referral, giving BMI no ability to control this cost.

- (b) PMIs can launch collateral litigation to increase pressure on PH providers

PMIs can start collateral litigation (contractual or defamation) in order to increase bargaining leverage over BMI during negotiations. This strategy is particularly aggressive and has only been used by Bupa to date [§].

Theoretically this strategy is also open to PH providers although has not been used in practice.

- (c) PMIs can launch media campaigns to increase pressure on hospitals

As with litigation, theoretically either side can use the media to increase pressure on the other during the negotiation. In practice this is rare and has only in recent times been adopted by Bupa. [§].

Part 1 E: Size and financial strength of an insurer of hospital is likely to impact negotiating outcomes

8.29 The CC has identified three relevant issues. These issues are very important and the treatment given over to them in the short paragraphs of this section in no way reflects their significance to the inquiry. Far deeper examination, particularly of the impact of delisting on hospitals and of Bupa's position, is required to fully appreciate the importance of these issues.

- (a) Position of large insurers

It is correct to say that discounts follow volume. It is also correct to say that the impact on a hospital operator to switch volume is particularly severe if it comes from Bupa or AXA PPP given the amount of volume that they represent. Although Bupa is obviously in a unique position of strength, there are many strategies open to insurers of all sizes.

Bupa's position of great strength in these negotiations is conclusively illustrated by the BMI/Bupa negotiation of 2011.

Unlike Bupa, BMI and AXA PPP have a collaborative relationship which is characterised by greater mutual trust and innovation in attempting to grow the PMI market together. The constructive and non (or at least less) confrontational nature of the discussions between AXA PPP and BMI are a good thing. This type of relationship reflects the essentially complementary nature of the services offered by BMI and the insurers and reflects the reality that BMI is dependent on PMIs to grow the market. BMI sees the AXA PPP Pathways product as a key innovation that has arisen from this – improving patient pathway, reducing incidence of shortfalls, lowering prices to end customers.

Indeed, this is what BMI strives to achieve with all PMIs.

(b) Financial strength of the parties

The analysis here is very thin. It is the case that financial strength matters to the outcome of disputes. This is again readily seen in the context of the Bupa/BMI negotiation in 2011 [§]. It is important to emphasise that this was not a one off effect and had **nothing to do with refinancing** as there was no refinancing going on. It is the simple arithmetic of losing significant numbers of customers with very limited ability to "turn off" on-going fixed costs that weakens BMI's ability to withstand protracted disputes – leaving aside the serious long term damage it does to the business – see below.

PMIs are mostly a component part of insurance businesses that are factors of magnitude bigger than BMI with balance sheet and cash flow strength to outlast BMI in any conceivable dispute. This inequality of arms is made even more acute by the different impacts a dispute has on cash flow and profitability of a PMI and PHP.

A hospital provider has a high proportion of committed and operational costs that it needs to fund through cash. A dispute with an insurer disrupts that cash flow and creates immediate difficulty in financing the business's working capital requirements. [§]. An insurer in a dispute with a hospital faces a stable cash flow from policyholders with, at worst, an increase in variable costs in the very short term as it diverts demand elsewhere. Importantly, the insurer can expect these costs to come down quickly as other PHPs offer deeper discounts for the greater volume being diverted to them. Moreover, costs will revert immediately on the settlement of the dispute to a 'normal' level. The PMI can therefore expect short term depressed operating profit; the hospital [§].

(c) Position of a small insurer

The CC correctly notes here that smaller insurers have continued to operate in the PMI market, notwithstanding the significant cost advantages that Bupa in particular benefits from.

There is good evidence of small insurers, such as [x], obtaining good deals from BMI – [x]:

[x]⁶⁴

[x], it is anyway the case that in a world of under-utilised hospitals and high fixed costs, BMI has a strong incentive to agree terms with all insurers to get the maximum volume through its units.

Lastly, by falling out with a smaller insurer BMI risks creating consultant drag effects and gifting an advantage to a competitor, if indeed they are able to argue to consultants that their hospital is recognised by the full range of insurers – whereas BMI is delisted by insurer [x].

As noted above, smaller insurers have strategies that they are able to use (or even threaten to use) that will cause PH providers to compete hard for their work. WPA's threat to introduce a network noted at 8.14 and Pruhealth's local network tender are both examples of this.

Part 2: Steps Insurers have taken to improve their bargaining position – restricted networks, open referral and service line tenders

- 8.30 The CC says that "*it is clear from documents and submissions that most insurers feel they are rarely able to secure favourable terms through traditional bilateral contract negotiations with hospital operators*". The surprise, given the incentives in the market investigation, is that **any** insurer told the CC it felt it was able to get favourable terms.
- 8.31 It is correct to say that service line tenders and directional policies met with resistance when they were first introduced. BMI took the view that it had competed once for the work, entered prices on the basis of a service 'bundle' and that it was therefore illegitimate for an insurer to seek to 'salami slice' a service line off mid-contract and seek to re-tender this while leaving all other prices the same. Moreover not all services in the bundle make an equal contribution to margin and a service line tender means BMI faces the prospect of losing the service's entire contribution to margin and fixed cost – without an opportunity to rebalance this elsewhere.
- 8.32 While certain insurers were doubtless "frustrated" by this, BMI's position in this context was neither surprising nor anti-competitive in anyway. Commitments to fixed costs cannot be made if the main service lines contributing to covering those fixed costs can subsequently be cherry-picked away. It cannot be a surprise that it would take some time for such practices to become embedded in PH providers' business models.

⁶⁴ [x].

- 8.33 The particular "flashpoints" the CC is referring to are discussed in great detail in BMI's response to the market questionnaire and are not repeated here.⁶⁵ All this is anyway of historical interest only as restricted networks, open referral and service line tenders are now well established features of the market – with BMI openly encouraging restricted networks and open referral as routes to growth as discussed above. Many PMI agreements now contain express provisions permitting insurers to undertake these activities, hence the insurers' initial "frustration" that their freedom of movement when they first had this idea was a little constrained by their subsisting contracts is irrelevant. Those agreements ended and they have now achieved what they set out to achieve.
- 8.34 The CC notes that hospital providers' approach to open referral has varied. This is a good thing and to be expected in a competitive market. BMI has been very clear about its approach. **BMI has invested significant resources in differentiating its offering so as to benefit to the maximum extent possible from insurers' ability to direct patient volume particularly through restricted networks and open referrals:**
- AXA PPP Pathways (an innovative restricted network product with a deep discount driving volumes for AXA PPP corporate clients – the AXA PPP default product for corporates);
 - Simplyhealth MSK trial (an innovative restricted network product for musculoskeletal patients that joins the PH provider, insurer and PH provider for the first time to design a new far more convenient patient pathway);
 - Aviva Trustcare (a low cost restricted network product that was built on NHS PPU's with BMI hospitals acting as "gap fillers);
 - Aviva Tailored Network (an attempt at designing bespoke thin networks for individual high value corporates);
 - Pruhealth local (aggressive pricing to win places on a restricted national network – ultimately built around BMI and Spire).
- 8.35 As explained at the hearing, BMI has made particular use of [redacted] as a service differentiator and to facilitate PMIs attempts to grow demand via discounted open referral insurance products. [redacted].
- 8.36 The CC notes that these products are "*new and to date we have seen relatively little impact on the wider contract negotiation*". This is incorrect. AXA PPP Pathways product is now the **default product offered to corporates**. Bupa has an existing sophisticated system for directing patients who call for pre-authorisation – this is in place now regardless of the network product that the policyholder bought. The CC will recall that Bupa and AXA

⁶⁵ Section 5, page 41; Section 7, page 25.

PPP together account for 65% of the market. In any event, in a world of low capacity utilisation an insurer gains significant bargaining power by being able to switch out even a portion of its demand. It is not necessary to switch out all of it in order to significantly enhance an insurer's bargaining position opposite a hospital – [X]:

[X]

Part 3: Prices charged by hospital operators

8.37 BMI is not in a position to comment on this until after this information has been provided.

Impact on hospitals of PMI negotiation strategies

8.38 As noted above, the **CC has not analysed the effect on hospital providers of PMI negotiating strategies**. This is important as without doing this it is impossible to properly understand the credibility of threats made by PMIs to hospital providers and the "outside option" that a hospital faces in a negotiation with an insurer.

What is the impact of de-listing?

8.39 The effect on a hospital group of being de-listed is grave and felt: (i) at the hospital; (ii) at a group level; and (iii) long after the actual period of delisting is over:

[X]

8.40 Lancaster is a solus hospital on the OFT definition. Bupa was able – despite the fact that it apparently has no local alternatives available – to push its demand down from [X] inpatient and day cases a month to [X] in January. Note how demand continued to decline to reach a low of just [X] IP/DC cases in May 2012 as this hospital continued to be delisted by Bupa, even after the agreement between Bupa and BMI.

8.41 Notwithstanding the fact that Lancaster remained de-listed, BMI offered Bupa pricing at Lancaster that was [X]. **BMI wanted to incentivise Bupa to use its hospitals**. [X]. The decline simply reflects Bupa's power to direct work away. This is entirely consistent with Bupa's expectations from its customer Q&A following delisting of 37 BMI hospitals:

Q: The alternative hospitals being suggested by Bupa are not appropriate in all instances and in some cases are considerable distances from the BMI delisted hospital. It seems you are underestimating inconvenience?

A: Distance between hospitals is not the issue, but rather the journey from the member's home to the alternative hospital that is relevant. We looked at the post codes serviced by the delisted hospitals and identified alternative hospitals that already served Bupa members in the same postcodes, demonstrating clearly that people were already choosing to access these hospitals from these post code areas. We then checked

*drive time, capacity at alternative hospitals and other factors before reaching these decisions.*⁶⁶

8.42 For a hospital in a more competitive location the proportion of demand that can be directed away is even higher. Gisburne Park provides an example of this. Gisburne Park is a rural hospital (located near Clitheroe, Lancashire) but not a solus unit on the OFT's definition. In this context the hospital has seen an [X] year-on-year decline in Bupa funded work on average since January 2012. July and August saw no Bupa funded episodes at all.

[X]

8.43 BMI as a whole has suffered severely from the Bupa de-listing, but particularly at the hospitals that were delisted. [X].

[X]

8.44 [X]

[X]

8.45 [X]

8.46 [X]

[X]

9. Theory of harm 5: barriers to entry

9.1 The CC's work so far has found low barriers to entry into the PH market and BMI agrees with this.

Natural/intrinsic barriers to entry and regulatory barriers (Appendix E)

9.2 With the exception of Central London, BMI concurs with the CC's findings that capital costs and regulatory/planning requirements do not constitute relevant barriers to entry.

9.3 Central London poses unique difficulties for hospital providers in terms of barriers to entering the market. A number of features specific to the Central London market mean barriers are higher than elsewhere. The most prominent issue is a lack of suitable land and buildings in the core W1 Marylebone area associated with top end private medical practice, combined with the very high capital costs. They are not directly comparable but it is still worth noting that London Clinic's Cancer Centre cost in the region of £90 million, while the new Circle hospital in Bath (which has four theatres and 28

⁶⁶ Website Q&A 16 December 2011 following decision to de-list 37 BMI hospitals. The full list of alternatives that Bupa arrived at in this way is available in MQ response, Section 7, Annex 1.

IP beds) cost around £30 million.⁶⁷ BMI believes that [redacted], the availability of land and the costs of entry, the opportunity for it [redacted].

- 9.4 BMI has tried to overcome these hurdles, most notably in respect of BMI Fitzroy Square. BMI bought Fitzroy Square as a cheaper smaller scale entry into the Central London market. The building had one non-laminar theatre, with 19 beds spread out over three floors. In its present state, it was and remains ill-suited in terms of capacity and layout to efficiently provide PH services, this might have been improved had BMI been able to develop a second theatre; however, these plans were frustrated by both planning constraints and the costs of development. [redacted].
- 9.5 The strength of both HCA and the NHS in Central London also hinders the ability to establish a sustainable presence in the market. The abundance of well-funded teaching hospitals across Central London serves to increase the competitive constraint from the NHS; while HCA's very strong presence in London has [redacted]
- 9.6 As a result of a combination of these unique conditions [redacted].⁶⁸
- 9.7 This said, PPU outsourcings remain possible opportunities for successful entry, although BMI notes that it would need to compete with and outbid HCA in order to win these.
- 9.8 Outside London, BMI notes that the CC's current thinking that economies of scale and limited market size are more likely to restrict entry (and even then only in relation to private inpatient care) in certain geographic areas, e.g. sparsely populated or less prosperous geographic areas. However, this is simply a reflection of the finding that capital costs do not as a general matter constitute a barrier to entry. If a market is not large enough to support entry on an efficient scale (e.g. it is too sparsely populated or insufficiently prosperous) then entry ought not to occur. What matters is that entry can occur when the opportunity reaches the appropriate scale. The CC's case studies in Edinburgh and Bath are powerful demonstrations of these points.
- 9.9 In respect of natural and regulatory barriers BMI makes two further points.
- (a) the CC must reconcile its findings on the capital costs of entry with the values of modern equivalent assets (i.e. the costs incurred by a new entrant) referred to in the profitability working paper⁶⁹; and
 - (b) the CC highlights the importance of consultant engagement and PMI recognition and ideally volume commitments as a means of mitigating the risk of investing in new facilities (and therefore facilitating new

⁶⁷ AIS, Appendix E, paragraph 11.

⁶⁸ [redacted].

⁶⁹ I.e. £30 million to build a hospital in Bath and the London Clinic's new cancer centre from approximately £90m), AIS, Appendix E, paragraph 11 vs. an implied value for BMI's hospitals of circa [redacted] million.

entry). This is true, although must not mean of course that the playing field is "tilted" in favour of new entrants.

Strategic barriers to entry (Appendix E)

Theory of harm 5(a) entry barriers resulting from bargaining between insurers and hospital chains

- 9.10 The CC says that it has not formed a clear view as to whether bargaining between insurers and hospital chains, in particular PMI recognition and consultant commitments, creates barriers to entry.

PMI recognition

- 9.11 In competition terms this essentially boils down to an analysis of exclusive or restrictive vertical agreements. As the CC recognises, there is a basic trade-off between volume discounts that exclusive networks might deliver versus potential foreclosure effects.
- 9.12 BMI acknowledged this in its response to the IS and has encouraged the CC to think about these agreements in terms of the analytical framework under Article 101 TFEU and developed by the European Commission's Guidance on Vertical Restraints. This framework is both well understood and well suited to considering this issue. While important progress has been made, there is still much to recommend a more forensic approach to the effect on competition of restrictive terms in PMI agreements.
- 9.13 In terms of progress that has been made since the OFT Report, the CC has found no evidence that PHPs have the ability to deter entry by forcing a PMI to deny recognition to an entrant (even had they the incentive to do so), nor to suggest that the PMIs are unwilling parties to such exclusive agreements.⁷⁰ This is clearly right as regards BMI and a welcome advance on the OFT's analysis that restrictive terms were a result of "pressure" from PHPs. The CC now recognises that hospital recognition is in the hands of the insurers.
- 9.14 PMIs are able to design their networks and direct their demand such that they withhold access to their policyholders to new facilities. PMIs also can and do decide the extent of exclusivity they desire for their networks and how they wish to steer their policyholders.
- 9.15 Lack of recognition by one of the larger PMIs is indeed capable of **restricting the profitability** of new entrants by denying them access to that PMI's customers (and potentially customers of other PMIs as a result of because of 'consultant drag'). In this way it is possible that restrictive networks create foreclosure effects (i.e. act as a barrier to entry).
- 9.16 However, as the CC has also recognised, the high fixed costs of hospital businesses make profitability very sensitive to variations in patient volumes. PMIs can therefore orientate their negotiating stance opposite hospitals in

⁷⁰ AIS, Appendix E, paragraph 47.

order to exploit this characteristic. One of the most common ways of doing this is via restricted networks – generating scarcity of network 'slots' in order to drive competition between hospital providers for the available market. In this way restrictive networks result in lower prices.

9.17 BMI notes that the Circle Bath case study which purportedly illustrates that AXA PPP's refusal to recognise the new Circle hospital for day-case and inpatient treatment caused Circle "significant difficulties" does not effectively evidence restrictive networks as a barrier to entry. Firstly it is not clear that AXA PPP had ever made a commitment to Circle that it would be recognised in its acute network. [redacted], yet Circle went ahead anyway – presumably in full knowledge of AXA PPP's position. Secondly, Circle were in fact admitted – [redacted]. Even before they did so BMI Bath Clinic saw a dramatic fall off in AXA PPP funded work as soon as Circle Bath opened⁷¹. BMI now understands that this was in part due to Circle Bath by treating patients at its own expense. As this is apparently possible, the short term cost of this should merely be considered as part of the capital cost of entry – which a prudent entrant can discover and plan for by approaching the PMI's before making their investment.

9.18 BMI strongly believes that **Circle's entry in Bath has been inefficient**. It is striking that there has been no growth in the privately funded (self pay and PMI) market in Bath as a result of Circle's entry – the market is now divided [redacted]:

[redacted]

9.19 A similar pattern is emerging in Maidstone. [redacted]. This is compelling evidence of the effect of entry in many of these markets. With the exception of Central London, lack of entry is categorically not evidence of barriers – it is merely the efficient outcome given the size of the available market opportunity.

Theory of harm 5(b) entry barriers into PH resulting from incentives arising from arrangements between clinicians and PHPs

9.20 It is uncontroversial that consultants are a critical input for PH and a key asset for PHPs, since they are the specifiers of a patient's type, volume and venue of care and often tend to focus their choices at one hospital. Hospitals therefore compete intensively to attract consultants. It is this process of rivalry – as much or even more so than competition for PMI funders – that drives hospitals to meet the existing and future needs of patients as effectively and efficiently as possible.⁷²

9.21 BMI makes no further comment in respect of consultant incentive schemes at this stage. BMI welcomes the role of the CC with respect to defining the boundaries of useful and pro-competitive interaction between consultants and PHPs.

⁷¹ [redacted].

⁷² Issues Statement, paragraph 45; AIS, paragraph 126.

Other factors

- 9.22 Conceptually BMI agrees with the CC's discussion that high profitability is consistent with but not a necessary or sufficient condition for high barriers to entry and *vice versa*.
- 9.23 BMI is the largest firm in the PH market, yet it does not generate excess profit. This is consistent with low barriers to entry.

ENDS