



# **Private healthcare market investigation**

## **Response to Annotated Issues Statement**

### **Bupa Health Funding**

**April 2013**

**Non-confidential version**

# TABLE OF CONTENTS

Main sections		Page
1	Introduction and Executive Summary	2
2	Bupa Health Funding’s comments on the AIS	6
	Characteristics of privately-funded healthcare	6
	Product Market	9
	Geographic Market	13
	Profitability	14
	Theory of Harm 1: Market power of hospitals at a local level	15
	Theory of Harm 2: Market power of individual consultants and consultant groups	20
	Theory of Harm 3: Market power of hospital operators in negotiations with insurers	26
	Theory of Harm 4: Buyer power of insurers in respect of individual consultants	34
	Theory of Harm 5: Barriers to Entry	39
	Theory of Harm 6: Limited information availability	44
	Theory of Harm 7: Vertical effects	46
Appendix		
A	Product Market and Competitor Set	49

## 1. EXECUTIVE SUMMARY

- 1.1 Bupa Health Funding (“BHF”) welcomes the Annotated Issues Statement (“AIS”) published by the Competition Commission (“CC”) on 28 February 2013. This paper sets out BHF’s comments on the CC’s current thinking on each Theory of Harm (“TOH”) and provides additional evidence where helpful to the CC. At points it cross-refers to evidence already submitted by BHF in its Original Issues Statement Response (“OISR”) and in its responses to the CC’s questionnaires.
- 1.2 The AIS shines a light on significant and interconnected failures in the provision of private healthcare (“PH”). Indeed, in some areas we believe the CC’s current thinking understates the adverse effects on competition caused by the strength of large hospital groups (for example, in Central London) and by the market power of individual consultants. These market failures need to be redressed urgently if customers are to continue to be able to afford PH. BHF looks forward to assisting the CC further with its investigation as it approaches provisional findings and remedies.

Issue in AIS	Executive Summary of BHF’s comments in the AIS
<i>Product Market</i>	<ul style="list-style-type: none"> <li>BHF agrees that there is no supply-side substitution between specialisms for consultants, so the product market for a consultant is at its broadest his or her individual specialism.</li> <li>BHF agrees that the CC should focus on hospitals that offer inpatient care, as facilities that offer only day-case and/or outpatient care place little constraint on inpatient providers.</li> <li>BHF has concerns, however, that the CC assumes a high degree of supply-side substitution between the 16 “common” specialisms that the CC uses in its analysis of hospital market definition. This assumption will hide pockets of market power. BHF also believes that specialisms outside of the main 17 (the common 16 plus Oncology) must be considered because these “less common” specialisms (e.g. Cardiothoracic Surgery) confer market power to the limited number of private hospitals that provide them.</li> <li>BHF continues to have concerns about NHS Private Patient Units being included in the competitor set. Many of the PPU’s are small and focussed on a narrow subset of specialisms, which combined with the barriers to entry and expansion in the market, mean that they are unlikely to achieve suitable scale, sufficiently quickly, to provide a real constraint on private providers.</li> </ul>
<i>Geographic Market</i>	<ul style="list-style-type: none"> <li>The CC does not appear to define the geographic market for consultants. BHF believes this should be done because it impacts the assessment of individual consultant market power. In BHF’s view these markets will be local. The geographic market for anaesthetists is likely to be very narrow (e.g. confined to the hospital at which the procedure is being delivered) as the point at which most patients meet their anaesthetist gives them little opportunity to switch.</li> <li>As for the hospitals, the CC has applied two filters to identify “hospitals of potential concern”. The filters rely on geographic catchment areas being defined for each hospital through observed patient travel patterns. BHF has significant concerns that the catchment areas defined by these approaches will be too broad. This will understate the market shares and bargaining strength of hospitals. For example, the approaches underestimate the importance customers place at the point of buying private medical insurance (“PMI”) on having the option to access their local hospital (even if once ill specific circumstances arise that lead to them travelling to a hospital further away). This strong preference for local access at the point of purchasing PMI forces the insurer to make available hospitals that are in close proximity to current or prospective customers. So from the insurer’s perspective the geographic market is narrower (and choices more limited) than may be observed from subsequent patient travel</li> </ul>

## Issue in AIS

## Executive Summary of BHF's comments in the AIS

patterns which may themselves be driven by factors other than choice and competition.

- BHF believes that defining a national market for hospitals is not appropriate as competition is not effective (and seldom takes place) at this level. And this will understate hospital group market power.

**TOH 1****Market power of hospitals at local level**

- BHF agrees with the CC that there are a substantial number of hospitals of potential concern. In BHF's experience, a significant number of hospitals have local market power. These hospitals tend to be concentrated in the hands of the main hospital groups.
- The filters applied by the CC to identify hospitals of potential concern suggest that over 75 hospitals have significant market shares in their catchment areas and that many individual hospitals gain incremental power through being part of a network of hospitals. However, BHF believes the filters will understate the number and strength of the hospitals with local market power. This is because: (i) aggregating the 16 common specialisms hides pockets of market power; (ii) some key specialisms outside the common 16 and Oncology (e.g. Cardiothoracic Surgery) confer significant bargaining power to the providers of these specialisms; (iii) the LOCI measure understates the importance of the local dimension for the insurer given that customers demand access to local hospitals when buying PMI; (iv) the measures do not account for the significant impact that losing a hospital may have on insurers' national corporate accounts; and, (v) a number of the small PPUs included in the analysis do not in reality provide sufficient competitive constraint on private hospitals.
- BHF agrees also that further work needs to be undertaken on the London market given the significant competition concerns BHF and other insurers experience in this market.

**TOH 2****Market power of individual consultants and/or consultant groups**

- BHF agrees with the concerns that anaesthetist groups weaken choice and can lead to higher prices. BHF encourages the CC to broaden its analysis to the growing, and equally concerning, trend of consultant groups forming in other specialisms.
- Contrary to the CC's current thinking, BHF further believes there is good evidence that individual consultants are in a position of market power (and that this evidence has been provided to the CC). Indeed, there is very little evidence of private consultants competing against each other on either price or quality. A consultant has the ability to specify the volume, venue and type of treatment in a fee-for-service system that can reward quantity ahead of quality. Patients have little ability to negotiate: they face information asymmetries and switching costs; they cannot assess quality in advance of (and often even after) treatment; and, they are typically in a vulnerable state that makes them unable or afraid to negotiate. The lack of information on cost or quality available to GPs also weakens competition between consultants. Individual consultants can raise price with little consequence on their referral volumes from GPs. Insurers provide some counterbalance on procedure fees, but little constraint on outpatient consultation fees or the volume/type of treatment specified by the consultant. Each individual consultant benefits from this position of market power – a position of not facing competitive pressure on price, quality or volume.
- BHF believes the CC should consider conducting an analysis of individual consultant earnings. Independent market research shows private consultant profits have remained strong even in the face of a declining number of customers.

**TOH 3****Market power of hospital operators in negotiations with insurers**

- BHF strongly agrees that the larger hospital groups have market power. This power comes from the groups' ownership of hospitals with local market power, their overall scale, their regional density, and the tactics they employ during negotiations to protect themselves from competition. As the CC has found, large hospital groups have aggressively fought against insurer initiatives to increase competition (e.g. service line tenders) even when those initiatives affected only small elements of hospital revenues.
- BHF shares the CC's concerns that excessive profitability in the main hospital groups signals that prices are too high and that entry barriers exist. Further, BHF believes the profitability analysis may underestimate the power of the main hospital groups given that facilities in many local markets are sheltered from competition.
- In contrast, insurers are in a weak position. It is very seldom that an insurer is in a position to

Issue in AIS	Executive Summary of BHF’s comments in the AIS
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delist a hospital within a group’s portfolio as this action causes serious harm to the insurer. The longer and more public the “out of contract” situation the greater the harm to the insurer, making this strategy highly unattractive where a hospital group is large (so affecting many customers) and financially strong (able to withstand a lengthy dispute).

- The uncertainty and inconvenience for the insurer’s customers caused by delisting their local hospital leads to the insurer losing existing customers and potential new customers. Customers want peace of mind and convenience from the PMI for which they have paid. They blame the insurer when uncertainty and inconvenience occurs. Delisting could only be used as a strategy on rare occasions – it is not a sustainable strategy. Being frequently out of contract with hospitals is not an attractive and sustainable customer proposition for an insurer (customers will move to another insurer or the NHS).
- BHF recognises that it is an important customer for hospitals. However, this does not mean BHF has countervailing buyer power. BHF accounts for under a quarter of an average private hospital’s revenues, and we would be unable to shift a significant proportion of this revenue away from the hospital in a dispute situation. BHF’s decision to delist BMI hospitals in early 2012 should be seen as exceptional. [x]

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**TOH 4**  
*Buyer power of insurers in respect of individual consultants*

- BHF agrees that there is no evidence that the supply or service quality of consultants is being distorted by insurer initiatives to manage cost on behalf of customers (e.g. benefit maxima). It is not in insurers’ interest to limit the quality and supply of consultants in the market. There is a highly competitive PMI market (to which the NHS is always an alternative). This means that insurers must consistently deliver value for money and that the benefits from buyer power, therefore, flow through to insured patients.
- BHF believes actions to address consultant “top ups” are essential to the survival of the PMI market and customers’ continued ability to afford to access this market. BHF disagrees that top ups are in general a reasonable customer experience and that our initiatives restrict patient choice.
- A confluence of factors mean it is essential that insurers assist customers in taking on these top ups/shortfalls. First, BHF’s initiatives are in response to customers’ desire for peace of mind and financial surety in a market where affordability is a critical concern. Second, these additional fees are often levied only when the patient has little or no ability to switch. Therefore, even if known “in advance”, the patient has little option but to pay the additional fee. Third, there is a lack of evidence provided by consultants to either patients or insurers to assess or justify the top ups. BHF emphasises that there is no evidence that the consultants who charge top ups are necessarily of higher quality. Fourth, BHF points to the CC’s own findings that *“there is a clear asymmetry between the patient and the provider as regards the appropriateness, quality or price of various treatment options”*. This makes it extremely difficult for the vast majority of patients to assess whether a top up is fair or appropriate. Fifth, there is no meaningful competitive pressure on consultant fees to constrain the levels of top ups, in particular mid treatment when the patient is captive to the consultant. Sixth, there is no evidence benefit maxima are below reasonable market prices for consultant services (as evidenced by the continued strong supply of consultants in private practice in spite of growing NHS commitments), which calls into question any need for additional fees.
- BHF receives thousands of complaints from members each year about shortfalls/top ups, which illustrates customers’ dissatisfaction with these additional fees. BHF is strongly of the view that any action to limit insurers’ abilities to address top ups/shortfalls would give consultants free rein to load additional costs onto patients. More dangerous still would be a perceived ‘endorsement’ of top ups as being in patients’ interests when there is little support for them being justified by evidence or market dynamics. A proliferation of top ups will accelerate the exit of customers from the PMI market for affordability reasons, removing from these customers’ the choice of accessing PH.

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**TOH 5**  
*Barriers to entry*

- BHF considers that the approach of large hospital groups to negotiations with insurers can create barriers to entry and expansion for smaller hospitals. Specifically: (i) the use of ‘one-in-all-in’ negotiating tactics by hospital operators forces insurers to take the majority of a hospital operator’s facilities even if they are not the best value operator in a local market; (ii) the use of national pricing and cross-subsidisation by incumbent hospitals obscures market signals on local price/profitability and discourages entry; (iii) hospital operators often penalise insurers with

Issue in AIS	Executive Summary of BHF's comments in the AIS
	<p>significantly higher prices if volumes fall below the hospital group's 'revenue envelope' of pre-determined income; and (iv) certain hospital groups use contractual clauses to protect themselves from competition.</p> <ul style="list-style-type: none"> <li>BHF has significant concerns about incentive arrangements between hospitals and clinicians (consultants or GPs) and considers that they should be banned.</li> <li>BHF believes that the CC has understated the barriers to entry and expansion new hospitals face in Central London. Despite [§&lt;] high prices in the market, we have not seen hospitals emerge to challenge their dominance.</li> <li>BHF does not believe that insurer initiatives have created any material barriers to entry for consultants into private practice. However, BHF notes that incumbent private consultants are protected from effective entry by rivals in other ways e.g. through entrenched referral patterns, a lack of transparency on quality or cost (which dis-incentivises any entrant from undercutting) and the presence of consultant groups. BHF notes also that the 2003 NHS consultant contract specifically sought to prioritise NHS commitments over private practice, which created an additional barrier.</li> </ul>
<p><b>TOH 6</b></p> <p><i>Limited information availability</i></p>	<ul style="list-style-type: none"> <li>BHF agrees with the CC's current view that a lack of information availability and transparency restricts patient choice and distorts competition. There is an absence of easily comparable information on consultant and hospital charges, quality and performance.</li> <li>BHF also agrees with the CC's view that there is a clear asymmetry between patient and provider as regards information about appropriateness, quality and price of various treatment options that may be available to that patient. BHF shares the concern that this asymmetry, combined with the fee-for-service model, creates an opportunity and incentive for providers to prescribe unnecessary care. There is evidence of unexplained variation (including over-treatment and over-diagnosis) in private healthcare – a symptom that the market is not working well. BHF notes also that, as described above, this significant asymmetry between patient and provider is a reason why insurer initiatives to take on consultant "top ups" to patients are critical.</li> <li>BHF sees significant potential consumer benefits from improved standardisation of coding and recording of activity and outcomes by hospitals and consultants.</li> <li>BHF shares the CC's concern that private hospitals and consultants lag the NHS in terms of information transparency and availability. BHF believes that the private sector should seek to be ahead of the NHS in terms of quality information published and that it is not so is a further indication of providers not competing to demonstrate value. It does not necessarily mean, however, that the NHS approach to collecting and publishing data should be imported into the private sector without some adjustments and careful consideration.</li> <li>BHF disagrees that insurers' steps to modify the referral mechanism give rise to consumer detriment through under-treatment/under-diagnosis; indeed, we believe the evidence suggests that these steps have improved patient outcomes. Insurers have a strong incentive to deliver quality to patients: (i) returning the patient to health limits cost exposure and also demonstrates the value of PMI (which, in turn, increases customer retention), and (ii) severe reputational damage falls on an insurer if customers perceive the insurer to have under-delivered (with the likelihood that customers are then lost to rivals or the NHS).</li> </ul>
<p><b>TOH 7</b></p> <p><i>Vertical effects</i></p>	<ul style="list-style-type: none"> <li>BHF agrees that Bupa's ownership of the Cromwell Hospital is unlikely to give rise to competition concerns. BHF emphasises that it sees vertical integration between funder and provision (as in the Kaiser Permanente or Sanitas models) as highly beneficial to customers.</li> <li>BHF shares the CC's concerns about hospital groups owning primary care and outpatient diagnostic units. These linkages create conflicts of interest for the GP and the consultant that can harm patient choice, can lead to overtreatment, and can create barriers to entry/expansion for rival hospitals.</li> </ul>

## 2. BHF'S COMMENTS ON THE AIS

- 2.1 We set out our comments in order of the main headings in the AIS. Where necessary we also provide comments on the Appendices to the AIS.

### CHARACTERISTICS OF PRIVATELY-FUNDED HEALTHCARE

- 2.2 BHF is in broad agreement with the CC's description of the main characteristics of PH. We consider, however, that some further characteristics of the PH market should be mentioned, as these frame the assessment of competition and consumer harm. There are also a few points of clarification in respect of the CC's analysis.

#### *Market trends of significant concern*

- 2.3 Structural trends have contributed to the challenging situation the PH market finds itself in today<sup>1</sup>. These trends, and their persistent nature, should be recognised as they illustrate the extent of harm already caused to consumers (a significant number of whom have been priced out of the market) and the urgent need for remedies to slow these trends going forward.
- 2.4 There have been sustained high rates of healthcare cost inflation over the past 15 years. Research by Laing and Buisson indicates that private hospital/clinic revenues rose from £1.1bn in 1995 to £4.1bn in 2011 – a rise of over 130% in real terms<sup>2</sup>. Private specialist revenues rose from £0.6bn in 1995 to £1.6bn in 2011 – a 65% rise in real terms. Therefore, PH spend by customers has risen at around 8% per annum.
- 2.5 This significant input cost inflation has caused an affordability crunch in the PMI market<sup>3</sup>. Premiums have risen rapidly and policy cover down-trading has taken place. In terms of people covered by PMI, the market is now the same size as it was in 1995 and PMI penetration in the UK is at its lowest level in over 15 years. There has been persistent structural decline in the Personal segment of the market across the 15 years. These trends have been accelerated by the continued economic uncertainty following the recession, with over 700,000 people having exited the PMI market since 2007.
- 2.6 A shrinking number of people in the PMI market means those left in the risk pool, and those who wish to enter the market, shoulder significantly higher costs. Evidence suggests that those PMI customers who remain are near the upper bound of what they are willing and able to pay. As such, continued healthcare cost inflation could accelerate the decline in the PMI market with

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<sup>1</sup> These trends are explained in more detail in Chapter 3 of the OISR.

<sup>2</sup> Laing and Buisson, *Private Acute Medical Care – UK Market Report 2012 (First Edition)*.

<sup>3</sup> As explained in paragraph 3.6 of the OISR, around 80 pence of each pound of premium flows through to PH providers (consultants and hospitals), meaning cost inflation from PH providers feeds directly into PMI premiums. A combination of unit price rises from PH providers and an increased volume of care delivered per patient causes claims cost per patient to increase well ahead of general inflation. Over the past five years, insurers have also faced a significant contraction in lives covered (which impacts premium income), which means the average claims cost per life covered is increasing rapidly. Between 2006 and 2011, for example, BHF saw average claims costs per life covered (excluding Health Trusts) increase by a compound average growth rate of around [x] per annum. This resulted in BHF having to raise premiums per life covered by [x] per annum over this period. These price increases understate the full financial impact of healthcare cost inflation on our customers because it focuses only on claims paid by BHF which means it does not capture additional costs ultimately paid by the customer due to policy down-trading and shortfalls.

a significant risk that this market is irreparably damaged<sup>4</sup>. This places the whole PH system at risk, as the majority of customers can only access PH through the risk-pooling and collective purchasing offered by PMI.

- 2.7 It is in the interests of the whole system that market forces are allowed to flourish, quickly, in PH provision to drive out inefficiency, encourage innovation, and better align provider interests with delivering value for money to customers.

### ***The fee-for-service model***

- 2.8 The fee-for-service reimbursement system provides financial benefit to providers that deliver more treatment. Its effect is important to recognise because many providers exercise market power through the volume and type of care they deliver, not just the prices they set. Fee-for-service also increases the risks, both financial and clinical, that patients face when clinicians have incentive schemes with hospitals.

### ***The regulatory gap in private healthcare***

- 2.9 There is insufficient oversight and sanction of the performance of consultants and hospitals in the PH market. Certain checks and balances in the NHS are not present in PH. For example, in the NHS there is routine collection and publication of activity data which allows improved benchmarking and scrutiny of providers. Similarly, responsible officers within the NHS conduct regular appraisals of the practice of individual consultants affiliated with their facility, raising concerns to the GMC where necessary.
- 2.10 BHF has raised the issue of this regulatory gap with the GMC and CQC, and both support greater protections for consumers of PH.

### ***The constraint of the NHS at point of purchasing PMI***

- 2.11 The CC explains the places at which the NHS impacts PH in paragraph 25 of the AIS. BHF emphasises the significant constraint that the NHS places on insurers by being a free alternative available to all customers at the point of purchasing or renewing PMI<sup>5</sup>. This forces insurers to demonstrate differentiation and value for money continually. It increases the price sensitivity of PMI customers at point of buying/renewing PMI – not only can customers switch to one of a number of rival insurers, but they can also switch to self-pay (or in the case of corporates self-insurance) or the NHS.

### **Points of clarification**

- 2.12 The CC states at paragraph 18 of the AIS that the consultant normally determines the amount they will charge for their services “*but this charge is subject to a schedule of maximum payments operated by the insurer for different procedures*”.

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<sup>4</sup> The CC’s survey of large corporates notes the comments from employee benefits advisor Towers Watson that a tipping point may be approaching: “*increasingly, its clients found the existing model of healthcare provision unsustainable as a result of rising costs*” (AIS Appendix F, para 51). Many corporates offer PMI benefits to compete for employees with other corporates in their sector. It only takes one large corporate in a sector to discontinue or significantly scale back its PMI benefit offering for there to be a risk of a tipping point for PMI in that sector.

<sup>5</sup> The NHS is an alternative for the insured customer at point of purchasing PMI, not at the point of treatment. See para 2.45 below.



- 2.13 For clarity, BHF's reimbursement limits – benefit maxima as set out in our Schedule of Procedures – apply to surgical procedures undertaken by the consultant. They do not apply to the fee for outpatient consultations offered by the consultant i.e. there is no “*schedule of maximum payments*” generally applied by BHF for outpatient consultation fees<sup>6</sup>. BHF has agreed reimbursement levels for outpatient consultation fees with [redacted]<sup>7</sup>. The vast majority of consultants recognised by BHF have full discretion on the level of outpatient consultation fee they set. Only around half of BHF's spend with consultants each year is on treatments to which “a schedule of maximum payments” applies, the remainder being on outpatient consultation fees and diagnostics. As shown in Figure 30 of the OISR, the rate of claims inflation on these ‘unconstrained’ outpatient consultation fees has been significantly higher than inflation on services to which reimbursement limits apply.
- 2.14 A “shortfall” or “top up” arises on procedures to which reimbursement limits apply<sup>8</sup>. The patient may also have to pay outpatient consultation fees and diagnostics if the patient has selected an outpatient policy limit when buying cover (as most customers do to help keep their premiums affordable)<sup>9</sup>. The insurer will then pay for outpatient consultations and tests up until the customer's limit is used up, from which point the customer will have to pay out of their own pocket (or change to be treated on the NHS). BHF has serious concerns about the rapid rise in outpatient consultation fees set by consultants because (i) the fees set by a consultant can quickly use up the patient's outpatient limit, leaving the patient needing to pay for any further outpatient care during that policy year out of their own pocket, (ii) the rapid inflation is driving up all policyholders' premiums, and (iii) BHF can provide only limited counterbalance to this inflation.
- 2.15 Finally, [redacted]<sup>10</sup>. This does not mean that all ‘fee assured’ consultants have agreed to charge a uniform level of outpatient consultation fee<sup>11</sup>. The patient may still have to pay out of their own pocket when seeing a fee-assured consultant where the outpatient limit they have selected is used up.

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<sup>6</sup> For further information see para 6.74 to 6.81 of OISR, the follow-up letter to the CC site visit (dated 26 July 2012), and the response to Question 42 of the Market Request. BHF notes that some other insurers may apply maximum reimbursement limits to outpatient consultation fees.

<sup>7</sup> BHF has contracts on the level of these outpatient consultation fees with approximately [redacted] consultants it recognises.

<sup>8</sup> For BHF customers, a ‘shortfall’ or ‘top up’ would arise on an outpatient consultation only if the consultant has entered into a contractual agreement on fees with BHF and then charged more than the pre-agreed level.

<sup>9</sup> The customer chooses their own outpatient limit from a wide selection of options (e.g. £500, £1000, £1500, unlimited/full refund etc). In effect, the higher the limit selected, the higher the premium.

<sup>10</sup> Fee assured consultants are able to seek uplifts on the benefit maxima (before or after a procedure) if a particular patient they are treating has additional complexity (e.g. because the patient has co-morbidities).

<sup>11</sup> Our legacy Consultant Partnership Scheme, for example, only gives fee assurance on the surgical procedures in the Schedule of Procedures, not the outpatient consultation fees these partners set.

## PRODUCT MARKET

2.16 BHF agrees that, from the demand-side, product markets are narrow. BHF believes, however, that there are limits on the degree to which markets can then be broadened through supply-side substitution.

### Consultants

2.17 BHF agrees with the CC's thinking that the limited supply-side substitution for consultants between different specialisms means that each consultant specialism should be assessed separately.

### Hospitals

2.18 BHF agrees with focusing on facilities that offer inpatient care for the purposes of this investigation. Care in an outpatient and/or day-case setting offers little constraint on care that must be delivered in an inpatient setting. However, the CC should be clear in its provisional findings that in focussing on inpatient care it is not giving a clean bill of health in relation to the function of competition in outpatient/day-case settings. Competition problems and distortions can still arise in these segments.

2.19 However, BHF has concerns that the approach being applied by the CC with respect to specialisms offered by inpatient hospitals will overestimate the degree of competition in the sector. This approach will fail to identify key pockets of market power used by hospital operators in negotiations. Three issues must be considered:

- i. The CC assumes a high degree of supply-side substitution between treatments within a specific specialism. This may be appropriate for many treatments, but for some higher-complexity treatments significant additional investment in specialist facilities, staff training and equipment is required. The CC has noted it will consider a segmentation of specialisms by intensive care level. BHF agrees that will assist in identifying pockets of market power.
- ii. The CC assumes a high degree of supply-side substitution across the 16 "common" specialisms, allowing them to be assessed as a cluster. The CC also points to the fact that a high proportion of inpatient hospitals already offer the specialisms. In BHF's view, this assumption on supply-side substitution is too strong. We discuss below that it is unlikely the conditions necessary to support this degree of supply-side substitution will be present in a majority of local markets. Similarly, we have concerns that while many hospitals may say they offer most or all of the 16 specialism, many will have such a limited scale in that specialism that they are not an effective competitor (or alternative for the insurer). Embedding these assumptions into the CC's analysis will hide many local markets where only one hospital provides a key specialism (e.g. cardiology) and faces little constraint from any other hospital, leaving insurers beholden to that hospital.
- iii. The CC focuses on the 16 common specialisms and Oncology. However, outside of these 17 specialisms are critical specialisms that an insurer must also be able to offer to its customers. An insurer has to purchase the "option" of delivering care to its members across a full range of specialisms, even if a particular specialism is lower in incidence.

Hospitals that offer “less common” specialisms often have a powerful bargaining chip<sup>12</sup>. As shown in Appendix A, BHF considers the CC should also investigate hospital market power in the following specialisms: [§<]. Therefore, BHF may have little choice but to maintain a material amount of spend at a hospital providing [§<] even if there are other hospitals nearby offering some of the more common procedures. [§<] is an example of a specialism that although somewhat smaller in spend terms is a bargaining chip for the few private hospitals offering this specialism. [§<].

### Supply-side substitution

- 2.20 BHF has previously set out its concerns about supply-side substitution being used to broaden markets beyond the specialism level (see paragraph 5.16 of the OISR). These concerns are based on BHF’s experience in commissioning care from hospitals. These concerns have also been reflected in previous regulatory decisions<sup>13,14</sup>.
- 2.21 In BHF’s view the following conditions must hold, simultaneously, for supply-side substitution to be effective: (i) it must take place in response to a small increase in price; (ii) the price increase must be from the competitive level (rather than a price where market power has already been exercised); (iii) it must take place sufficiently quickly to give customers a credible alternative; (iv) it must take place on sufficient scale to place a real constraint on the provider considering increasing its price; and, (v) there must be limited sunk costs in making the switch.
- 2.22 It is unlikely these conditions will hold in all local hospital markets:

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<sup>12</sup> By their nature, these ‘less common’ specialisms tend to be offered by only a small set of private providers within the UK, giving these providers a strong bargaining chip in negotiations with insurers.

<sup>13</sup> For example, the Cooperation and Competition Panel (“CCP”) has assessed supply-side substitution in its report on the merger of North Cumbria University Hospitals NHS Trust with Northumbria Healthcare NHS Foundation Trust (December 2012). The CCP concluded that: “Based on evidence from clinicians, it is our view that supply-side substitution possibilities are likely to exist within each specialty since, for example, consultants are trained and registered within a particular specialty. However, these possibilities tend to be asymmetric ones. For example, specialist/tertiary providers of a given specialty have the highly trained staff and necessary technology/equipment to also provide standard services, even if doing so would be comfortably within their capability. In contrast, the opposite does not necessarily hold. Providers only supplying standard services are unlikely to have the necessary staff and technology/equipment to be capable of quickly providing more specialist/tertiary services.... However, **supply side substitution possibilities are less likely to occur across specialties** since a provider of one specialty is unlikely to be in a position to provide another specialty. For example, a provider whose only service is standard elective orthopaedics would not be in a position to provide standard elective gastroenterology using its existing staff, facilities and equipment [footnote omitted]. It might be able to acquire the new staff, facilities and equipment that it requires to provide the service relatively quickly at additional cost. However, if these costs or liabilities are sunk then while the provider may still enter the relevant market relatively easily, this would not constitute supply side substitution (and would instead be an entry event). Similarly in order to establish that supply side substitution was likely to occur in a particular case we would need to consider whether the provider in question had the available spare capacity (e.g. beds, operating theatre slots) and the incentive (e.g. the ability to earn a higher margin than was possible from its existing services) to substitute into providing the product. There may also be some minimum sufficient volume required to gain accreditation as a clinically safe provider of certain services” (emphasis added).

<sup>14</sup> In 2001, HCA attempted to acquire certain assets of the London Heart Hospital. The transaction was aborted after the OFT referred to the merger to the Competition Commission on concerns that HCA’s market share in private cardiac treatment in Central London would be over 50%. On product market definition, the OFT concluded: “The facilities required for cardiac surgery are in some ways similar to those for other types of surgery but additional equipment is required. It is also necessary to have a fully equipped intensive care unit (ICU) and to employ nurses with specialist qualifications in cardiac nursing. On the demand side, cardiac consultants have specific technical requirements. The higher standards in terms of equipment and staff and the requirement for an ICU mean that a general surgical facility is not an adequate substitute for a cardiac surgery unit though the reverse could be true for certain procedures. On the supply side, it would be possible for a general surgical facility to be upgraded into a cardiac surgery facility but this seems unlikely to occur as a reaction to a small increase in the price of cardiac hospital services because of the difficulty for new facilities in attracting key medical staff. It is also difficult to enter the market for cardiac care on a small scale as there appears to be a minimum efficient scale of operation. **It thus appears unlikely there would be significant supply-side switching as a result of an increase in the price of cardiac facilities. In sum, it seems likely that the provision of cardiac facilities is in a separate market from general surgical/medical facilities**” (emphasis added). “Proposed acquisition by HCA International Limited of certain assets of the London Heart Hospital”, No. ME/1272/01.

- i. The standard framework for market definition is the “SSNIP” test: products are defined as substitutes if customers or suppliers find it profitable to switch in response to relatively small (5%) changes in price<sup>15</sup>. In hospital markets, it is often very difficult to observe pricing trends of certain specialisms at a local level. This is because of national pricing by the main hospital groups, the cross-subsidisation of services within a hospital, and the confidentiality of pricing between insurers and hospitals. Further, a hospital redeploying equipment into a new specialism may have concerns over whether it will actually be able to capture volumes (and so be profitable) given consultants are insensitive to hospital price.
- ii. The SSNIP test should be applied from a competitive price benchmark, not the existing price in the market if the firm could already be exercising its market power. In many local markets, entry into a specialism by rivals may occur precisely because the incumbent has already pushed its price too high (an example of the “cellophane fallacy”<sup>16</sup>). The high economic profitability observed in the main hospital groups supports the view that prices in general are already too high.
- iii. Insurers have to ensure that there is sufficient coverage of all specialisms for their customers and that there is continuity of care. During a negotiation dispute with an incumbent provider of a particular specialism, the insurer needs to secure access to alternative supply very quickly. BHF considers that in many cases it would take too long for new supply to come on line (at sufficient scale) for the ‘threat’ of supply-side substitution to be a credible constraint on the incumbent hospital at the point of renegotiating prices with the insurer.
- iv. The effectiveness of supply-side substitution depends on it being on sufficient scale to make the incumbent’s proposed price rise unprofitable. The presence of barriers to entry and expansion in the market (TOH 5) casts doubt on this being the case. Insurers need the hospital to reach, quickly (i.e. in weeks, not months), a scale sufficient to provide a credible alternative for the insurer’s volume if the hospital is going to act as a credible constraint during a negotiation with an incumbent provider of the specialism.
- v. Some operating theatres and equipment may be substitutable across specialisms. But investment in staff skills (e.g. specialist nurses) and specialist equipment takes time and is likely to be sunk if the hospital later chooses to exit the specialism.

2.23 Given these constraints, BHF is concerned that assuming a high degree of supply-side substitution may lead to the number of ‘hospitals of potential concern’ being understated. When commissioning care, an insurer must make sure it is able to give customers access to the full range of services covered under their policies. Therefore, a hospital will be ‘must have’ for a particular specialism where there are no other providers in the local market offering that specialism<sup>17</sup>.

2.24 BHF has observed several cases of a hospital in a local market focussing on particular specialisms with a rival focussing on non-competing specialisms. This will make both facilities must have to the insurer. As examples:

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<sup>15</sup> See paras 2.4 to 2.14 of “Merger references: Competition Commission Guidelines June 2003”.

<sup>16</sup> Ibid.

<sup>17</sup> Control of these ‘must have’ specialisms can be leveraged to the other specialisms the hospital offers as insurers are seldom able to recognise only some of the specialisms in a hospital and not others.

- i. [REDACTED]<sup>18</sup>. [REDACTED].
- ii. [REDACTED].
- iii. [REDACTED].

2.25 The fact that hospitals have pockets of strength in specific specialisms is shown by BHF's 'must have' analysis – see paragraphs 5.30 to 5.41 of the OISR. Within 30-minute drive-time isochrones of hospitals, over 135 hospitals controlled in excess of 80% of BHF's activity in specific key specialisms. Further, Table 7 of the OISR shows that, even when catchment areas are widened substantially to a regional level, the levels of concentration within specialisms is extremely high indicating little choice for insurers.

### **Competitor set**

- 2.26 BHF would like the CC to publish the names of the 215 general and specialized private hospitals/PPUs the CC has included in its competitor set. This would allow BHF to provide to the CC further analysis and insight on these hospitals.
- 2.27 BHF has concerns about NHS PPUs being included in the competitor set given the limited constraint many place on private hospitals<sup>19</sup>. BHF agrees with the exclusion of some of the smallest PPUs by revenue (the CC notes it includes 63 of 74 PPUs, including the largest 47 by revenue). However, many of those PPUs that are included are likely to be small and to offer most specialisms on a very limited scale<sup>20</sup>. Table 3 in Appendix A demonstrates that, based on BHF spend in 2011, [REDACTED].
- 2.28 Small hospitals would face barriers to expanding provision quickly to provide an alternative for insurers. In BHF's experience PPUs face significant barriers to expansion in PH – see Annex A of the OISR. Some of these barriers are similar to those faced by other small hospitals, but several are specific to PPUs including:
- i. PPUs consistently perform below other private hospitals in patient satisfaction surveys conducted by BHF and addressing these shortcomings would require significant investment;
  - ii. PPUs face organisational pressures that limit PH work, such as the duty to serve NHS patients first<sup>21</sup> and the fact that they are only able to increase the scale of their private work by 5% or more in any year following approval of the Foundation Trust's governors;
  - iii. PPUs struggle to attract private consultants; and

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<sup>18</sup> [REDACTED]

<sup>19</sup> In its submission of 22 February 2013, HCA argues that the fact PPUs were selected to be included in BHF's recent TAVI network indicates that BHF perceives PPUs as the "preferred" providers. HCA's statement does not recognise that (i) this service line tender covers a single sub-specialism treatment. That certain PPUs succeeded on this tender does not mean that these same providers can necessarily offer or compete across a broad range of specialisms to constrain HCA, and (ii) providers included in the TAVI network were selected through competitive tender and BHF did not approach PPUs only; and there was no 'preference' given to PPUs over other hospital operators. [REDACTED].

<sup>20</sup> According to Laing & Buisson only the top 10 PPUs had private revenues of over £10.5 million per annum in 2011/12. The top 10 PPUs accounted for 48% of revenues earned by NHS PPUs.

<sup>21</sup> This could mean that private patient operations are cancelled at short notice to allow the hospital to serve NHS patients of higher clinical need.

- iv. PPU's face political pressures (in particular, of expanding private provision at a time when NHS beds are being reduced).
- 2.29 Including PPU's in the competitor set will affect the Fascia Count analysis. Therefore, we propose stress-testing the Fascia Count analysis by excluding PPU's from the competitor set.

## GEOGRAPHIC MARKET

- 2.30 BHF believes that the strong local dimension to PH markets must be reflected in the CC's analysis.

### Consultants

- 2.31 BHF would like the CC to set out a geographic market definition for consultants given this is an input into understanding individual consultant market power. BHF believes consultant markets are local.
- 2.32 For anaesthetists the geographic market is narrower still; for example, being confined to the hospital in which the anaesthetist may be meeting the patient. This is because most patients meet their anaesthetist only just before surgery, meaning that the patient has little or no opportunity to switch without significant costs (e.g. rescheduling the surgery or moving to another hospital).

### Hospitals

- 2.33 BHF has concerns that the approaches used by the CC to define local markets for hospitals, which focus on observed patient travel patterns, will define catchment areas that are too broad geographically and will understate the strength of hospitals.
- 2.34 First, the CC's approaches understate the strong desire from customers at the point of purchasing PMI for access to hospitals local to where they live (or work)<sup>22</sup>. When ill, specific circumstances may arise that result in some patients travelling to hospitals further away. However, customers' preference for access to their local hospital when buying PMI means that the insurer may have limited choice other than to do business with the hospitals located in close proximity to the customers it wants to serve. So, for the insurer, at the point of negotiating with the hospital its choices and the geographic market are very narrow (giving power on the hospital)<sup>23</sup>.
- 2.35 Second, evidence that some patients travel a greater distance does not necessarily indicate that hospitals compete across broad geographic catchments. Travel patterns may not reflect customer choices or sensitivity over differences in the prices or quality of hospitals in different locations, but other factors such as the preferences of the consultant, the location of the

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<sup>22</sup> The BHF response to the Market Request Q 34 explains the significance customers place on access to local hospitals when buying PMI. For example, customer research conducted to inform the launch of the *Bupa By You* proposition noted that customers looking at the lists of hospitals available through PMI products "are able to make very simple decisions on the presence or listing of hospitals close to their home ... Customers do check this upon initial consideration – they look at the list of hospitals and make sure that the ones they know of near to their homes are on the list" (slide 17, Project Crossroads I, submitted to CC as part of Off-the-shelf request). The CC's corporate survey (AIS Appendix F) also demonstrates the importance employers place on having access to facilities in 'convenient' locations for staff.

<sup>23</sup> For a description of why hospital geographic markets are narrower for the insurer than may be observed in patient travel patterns see <http://www.ftc.gov/ogc/healthcarehearings/docs/vistnes.pdf>.

patient's place of work, or a lack of specific necessary equipment at the local hospital. Further, the fact that some patients travel greater distances away from their local hospital (which would reduce the estimated LOCI of the local hospital) does not necessarily mean that the local hospital does not have market power over those patients living close by who are unwilling or unable to travel to a hospital further away<sup>24</sup>.

- 2.36 BHF believes that narrower geographic markets should be defined than the CC appears to be applying currently. BHF, for example, considered it appropriate to conduct its own 'must have' analysis on the basis of a 30-minute drive-time isochrone around each hospital.
- 2.37 BHF does not believe it is necessary to define a national market for hospital provision. The scale of certain hospital groups does confer bargaining power. However, market shares at a national level are misleading as they hide the significant market power the groups derive from their control of 'must have' hospitals at a local level. Competition is not effective between the main hospital groups at the national level.

## PROFITABILITY

- 2.38 The CC's findings of excess profitability in the main seven hospital groups indicate that prices are already too high and entry barriers are substantial. The scale of the differential between Return on Capital Employed (ROCE) and cost of capital is high. The differential has also increased significantly over the five years analysed.
- 2.39 BHF believes the analysis in fact underestimates the strength of the main hospital groups:
- i. The working paper acknowledges at a number of points that the CC has been conservative in its estimate of ROCE and that returns could actually be higher. For example, capital employed is inflated by using 'reinstatement values' as a proxy for the modern equivalent asset value of buildings.
  - ii. A "quiet life" sheltered from market forces allows some large hospital groups to operate inefficient business models and excess capacity<sup>25</sup>. This weighs down returns and inflates capital employed, although occurs precisely because of significant market power.
- 2.40 BHF would welcome the CC publishing each group's profitability – in a ranking if precise figures are confidential – rather than an average across the seven. BHF would also welcome clarification on the weighting basis use to calculate the average profitability across the seven hospital operators. BHF expects that certain of the larger groups have substantially higher (and growing) differentials between returns and cost of capital.

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<sup>24</sup> See Department of Justice and Federal Trade Commission, "Improving Health Care: A dose of competition" (2004), which describes why observed patient travel patterns may overstate the catchment area over which hospitals compete. For example, it explains that the presence of patients in a postcode who travel greater distances out of that postcode does not necessarily protect the non-travelling patients in that postcode from the market power of the local hospital. This is described as the "silent majority fallacy", and the report notes: "The silent majority fallacy is a particular problem with hospital merger analysis, because the goods and services are not fungible commodities, but are 'highly differentiated by location and other dimensions'. Empirical evidence confirms that 'the majority of patients are truly reluctant to travel and do not view distant hospitals as close substitutes for most services, even though a sizable percentage of their neighbors may travel for care. Those who do travel have distinct reasons for doing so and the fact that they travel would not inhibit merging local hospitals from increasing prices substantially' (p9).

<sup>25</sup> As noted by economist Sir John Hicks: "The best of all monopoly profits is a quiet life" (Econometrica, 'The Theory of Monopoly').

## **THEORIES OF HARM**

2.41 BHF sets out below comments on the CC's current thinking on each TOH. BHF emphasises that in analysing the adverse effects on competition it is critical to consider the linkages between the TOHs (i.e. to take a holistic view rather than examine each separately). Many concerns are interconnected and reinforce each other. This should also ensure consistency between the findings under each TOH. For example, BHF has concerns that the CC's current thinking about the lack and asymmetry of information available to patients (TOH 6) appears at odds with the CC's current thinking that individual consultants do not have market power (TOH 2) and that "top up" fees are a reasonable customer experience (TOH 4).

### **TOH 1: MARKET POWER OF HOSPITALS AT A LOCAL LEVEL**

2.42 BHF agrees with the CC's current thinking that there are a very significant number of "hospitals of potential concern" that require further investigation<sup>26</sup>. Many of these hospitals are insulated from market forces by the barriers to entry and expansion – natural and strategic – identified in TOH 5. Patients and insurers have very little choice when facing these hospitals. And as a significant proportion of these hospitals are in the hands of the main hospital groups, they confer significant power to these operators in their overall contract negotiations with insurers.

2.43 BHF would welcome the CC naming the list of hospitals of potential concern so that BHF is able to provide additional information to the CC on these facilities to assist in its further investigations.

2.44 BHF has concerns that the CC's approach for identifying 'hospitals of potential concern' will underestimate the number of hospitals with market power in their local area and the strength of this market power. BHF also shares the CC's concern that the current approach "*may not fully capture the extent of any competition problems in London*" (para 66).

#### ***NHS provision***

2.45 The CC notes that survey evidence shows NHS hospitals do not act as a competitive constraint on private hospitals. BHF's own experience aligns with this conclusion. A key reason customers buy PMI is that it gives the customer access to care more quickly and with greater control than through the NHS<sup>27</sup>. Insured patients expect this speed at the point of treatment. They are also price insensitive at the point of treatment (as the insurer pays the hospital directly). This means for the vast majority of services the NHS is not a realistic substitute to private provision for insured patients at the point of treatment.

#### ***Identifying 'hospitals of potential concern'***

2.46 BHF believes that the two filters – weighted average market shares and fascia count – that the CC has applied to identify the 'hospitals of potential concern' will underestimate the number of hospitals with significant market power and the power of these hospitals. BHF understands the

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<sup>26</sup> See Chapter 5 of OISR where BHF sets out the high number of hospitals in the UK which it considers 'must have' because of the hospital's control of over 80% of activity in aggregate or in key specialisms within the local market.

<sup>27</sup> Speed of treatment tends to be particularly important for B2B customers for whom one of the key reasons to have purchased PMI was to minimise sickness-related absences (see, for example, the CC's Corporate Survey). Survey evidence for Personal customers in Table 1 in the OISR shows that many of the key motives for buying PMI, and so being able to access PH, relate to speed of treatment, convenience and control. These are factors that the NHS would be unlikely to be able to offer.



reasons these filters have been selected but proposes additional stress-tests to the CC's approach.

- 2.47 As noted above, a key concern is the aggregation of "common" specialisms and the omission of certain "less common" specialisms. These assumptions will hide market power leading to an underestimation of the number of hospitals of concern.

### *LOCI analysis*

- 2.48 BHF agrees that there are some benefits to the LOCI measure: it uses 100% of patient traffic, rather than say 80%; it fits the observed catchment area for the hospital endogenously, rather than having the catchment set out in advance; and, through the Network LOCI, it captures the benefits an individual hospital gains through being owned by a hospital group.
- 2.49 The CC's LOCI analysis demonstrates two important results:
- i. The effect on an individual hospital's market power of being part of a hospital group is substantial. It increases the list of hospitals of potential concern from 95 on the Individual LOCI (in volume terms) to 116 on the Network LOCI. The effect is particularly pronounced in London and Scotland. This highlights the power the main hospital groups achieve simply through the scale of their groups and the density of their hospital ownership within certain regions. Addressing these scale and density effects could significantly improve the bargaining position of buyers (patients/insurers) relative to these individual hospitals.
  - ii. Over half of the 173 hospitals analysed by the CC have a weighted average market share (in volume terms) of over 55%. This indicates presumptive dominance even on the hospital's broadest catchment area. The shares would be even higher when individual specialisms are considered.
- 2.50 However, BHF notes that the Network LOCI will underestimate the power of certain hospitals:
- i. As noted above at 2.33, customers expect insurers to make private hospitals available close to their homes. When ill, some customers in that locality may travel to hospitals further afield (which will reduce the hospital's estimated LOCI); but at the point of buying PMI customers expect their local hospital to be available. Therefore, when an insurer commissions care, there is a strong local dimension which confers significant strength to hospitals that are the only provider within a particular locality. The insurer 'must have' the local hospital if it wants its policies to be attractive to customers in that area. The Network LOCI understates this local dimension that increases the hospital's bargaining power when insurers are seeking to commission provision for that local area. This is illustrated by the fact that the LOCI identifies only 13 hospitals with a weighted average market share of over 80% while there are at least 48 "solus" hospitals that are the only provider within their local catchment (according to the CC's Fascia Count analysis). The strong local dimension is the reason that BHF undertook its own 'must have' analysis on a 30-minute drive time isochrone basis. The BHF 'must have' analysis concludes that hospital market shares (particularly at the specialism level) are significantly higher than are estimated by the LOCI analysis.
  - ii. Certain hospitals have power that extends beyond their own patient volumes. [§<]. Therefore, this hospital has power over insurers that would not be captured by its Network LOCI (based only on its own patient catchment).

2.51 A final consideration is that it is important the CC provides a clear indication to the market about how geographic market definition should be undertaken in future cases (e.g. abuse of dominance) regarding the PH market. The LOCI uses a rich source of data to model the shares and catchments of each hospital. But this level of data will not be available to the OFT in future cases. It is important there is clear, practical precedent, so that, for example, insurers can bring cases against hospitals abusing their power.

### **Fascia count analysis**

2.52 BHF understands the second filter the CC applies to augment the list of hospitals of potential concern to be: (i) count the separate fascia a hospital faces within the catchment area from which it draws 80% of its patients, and (ii) select those hospitals which face only one other fascia.

2.53 Based on patient travel patterns, the CC finds that most hospitals have a catchment area (for 80% of patients) between 10 and 25 miles by road with a median of 17 miles. On fascia count, 100 hospitals are found to be either the only hospital within its catchment (48 hospitals) or in a duopoly (52 hospitals). In BHF's view, this analysis should also be conducted at a specialism level, which would expand this list. It is notable that when the CC examines Oncology separately, 70% of hospitals offering the specialism are either 'monopoly' or 'duopoly' providers within their catchment area.

2.54 BHF is also concerned that including very small hospitals (such as many PPU) in the competitor set may cause the Fascia Count to underestimate the number of hospitals of potential concern.

### **Central London**

2.55 BHF strongly recommends that the CC looks at Central London<sup>28</sup> separately and in detail. BHF has significant concerns about the lack of effective competition in Central London<sup>29</sup>. Hospital Corporation of America (HCA) occupies a position of significant market power in this region. It has used this to rapidly expand its earnings from insurers through inflation in price and volume, while cementing its position through incentive schemes, PPU partnerships, vertical integration<sup>30</sup>, and anticompetitive contractual clauses.

2.56 BHF must offer coverage in Central London. [3<].

2.57 However, insurers' choices in Central London are very narrow. HCA has strong and growing control of key specialisms<sup>31</sup>. Its share within specialisms is typically [3<] – a point the CC

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<sup>28</sup> For clarity, when BHF refers to Central London it is the region within the North and South Circular Roads. Outer London refers to the area outside Central London but inside the M25.

<sup>29</sup> It is notable that similar concerns about the lack of effective competition in London is expressed by a number of insurers and smaller hospital operators.

<sup>30</sup> As explained in paragraphs 5.8 and 5.54 of the OISR, HCA has established satellite outpatient/diagnostic facilities outside of Central London which channel volume into its Central London hospitals. HCA has also acquired financial interests in private GP practices (e.g. Rood Lane, General Medical Clinics and Blossoms Healthcare) to secure referrals at the earliest point in the patient journey. We also understand it has a large number of staff employed as liaisons officers to target GPs, which is unmatched by other smaller providers.

<sup>31</sup> See Table 5 of the OISR.

recognises at a general level when it notes “HCA is by far the largest private hospital operator operating in the London area”<sup>32</sup>.

2.58 The CC’s analysis identifies eight hospitals in the London region that have a weighted average market share (based on Network LOCI) of over 40%, of which four have shares between 60% and 80%. [redacted].

2.59 We have concerns that the CC’s analysis will understate the strength of [redacted] facilities because:

- i. Many of the rival private hospitals in Central London are small or focussed on only a small subset of specialisms – see for example Table 3 in Appendix A which includes PPU’s in London<sup>33</sup>. These facilities generally do not offer an effective alternative for insurers. It is inappropriate to assume that these hospitals could quickly and on a suitable scale substitute between specialisms, or scale up an existing specialism, in response to price increases [redacted]. This is accentuated in London by (a) the presence of greater physical barriers to entry and expansion in a highly populated area, and (b) an increased presence of consultant incentive schemes which may limit an entrant’s ability to attract suitable staff<sup>34</sup>. The presence of these niche hospitals together with the CC’s strong assumption of effective supply-side substitution between the common specialisms undermines the effectiveness of the Fascia Count filter<sup>35</sup>.
- ii. [redacted] several of the less common specialisms that are currently outside of the CC’s focus of the 16 common specialisms and Oncology (see Appendix A). Without other options to turn to in or near Central London, the insurer knows it risks facing significantly higher prices on these specialisms in an out of contract situation.
- iii. As noted above, the LOCI measure underestimates the market power of a hospital that is important to corporate customers. If access to that hospital was lost, the insurer could lose the corporate’s business in other geographies. Our own experience dealing with corporates is echoed by the CC’s survey of large corporates which found that several respondents in London see [redacted] hospitals as “very important” or “essential”<sup>36</sup>. A key issue is the convenience of location for corporate customers in London<sup>37</sup>. [redacted].
- iv. Commuting patterns into Central London overstate the catchment areas over which Central London hospitals “compete”<sup>38</sup>. A significant number of insured customers travel into Central London every day to work. For these customers it may appear that hospitals

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<sup>32</sup> AIS, para 67. The CC notes also: “HCA appears to be particularly strong in a number of specialties, including, for example, cardiology, gastroenterology, oncology and radiology”.

<sup>33</sup> BHF notes also The London Clinic’s view that “In The Clinic’s opinion, PPU’s are not close competitors to HCA, The Clinic or the other private hospitals because they do not offer comparable service”. [http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-marketinvestigation/120516\\_london\\_clinic\\_initial\\_submission.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-marketinvestigation/120516_london_clinic_initial_submission.pdf)

<sup>34</sup> The CC notes “the use of such [consultant incentive] schemes is more common where competition for consultants is intense in terms of geography, for example in London” (AIS, para 131).

<sup>35</sup> Only 5 of the 41 hospitals the CC tests in the London region are identified as having one or no competing fascia. This clearly underestimates concerns in London.

<sup>36</sup> AIS Appendix F, para 30.

<sup>37</sup> The convenient location of the [redacted] facilities was the factor most often cited by respondents to the CC survey (para 39). The CC notes: “[t]he location of the London Bridge Hospital, in particular, made it possible for employees of City firms to minimise their absence from the office when attending medical appointments”. Some respondents noted it was [redacted] reputation for quality although “others told us [the CC] that since no appropriate quality measures were available it was impossible to draw value-for-money considerations”. [redacted]

<sup>38</sup> BHF disagrees that hospitals outside of Central London (e.g. in the Home Counties) provide an effective alternative for an insurer when negotiating with [redacted]. Indeed, to the extent they present any alternative at all is because [redacted]. Therefore, any broadening of the market would be a case of the *cellophane fallacy* in action.

closer to their home postcodes are possible alternatives for inpatient treatment. However, for many their local hospital may continue to be a weak alternative because they will begin their treatment journey with a consultant located inside Central London who, being close to their place of work, is convenient to meet during the working day for the first consultation or diagnostic. Once the patient has met the consultant it becomes highly likely that they will receive inpatient care at a facility at which that consultant has practicing privileges<sup>39</sup>. Therefore, while it appears that the patient has “chosen” to have inpatient care inside Central London (far away from their home postcode) this does not reflect the Central London hospital being superior but rather that the patient was seeking convenient outpatient/diagnostic care inside Central London.

2.60 The CC notes that the competitive constraint of the NHS could be different in London due to the presence of highly specialised/high acuity private and NHS hospitals. As noted above, in our experience, the NHS is not a credible alternative for the majority of insured patients at point of treatment. For many insured patients, much of their treatment journey (e.g. consultant and diagnostics) will have been conducted within private setting and it highly unlikely that at point of surgery they will switch to the NHS.

### **Stress-testing results**

2.61 BHF believes the current approaches to specialism aggregation and the filters applied may lead to the CC understating the number and strength of hospitals with local market power. BHF would ask that the CC recognises in its provisional findings that its filters potentially understate the local market power of hospitals. In addition, BHF would propose the following stress-tests:

- i. Run the filters – LOCI analysis and Fascia Count – at the individual specialism level (as has been done for Oncology).
- ii. Conduct the Fascia Counts excluding small providers e.g. PPU.
- iii. Analyse hospital market shares within a 30-minute drive time using the rich dataset underpinning the LOCI analysis – preferably at a specialism level.

### **Price-concentration analysis**

2.62 BHF notes with interest the findings that self-pay prices are significantly higher in more concentrated local markets. This illustrates the pricing power of hospitals. BHF notes also that the analysis is based only on the eight most common self-pay procedures. This is important because hospitals can and do cross-subsidise service lines. They may accept comparatively lower margins on these high volume interventions (where they face a greater number of rivals) while retaining even greater pricing power on less common services for self-pay patients.

2.63 BHF believes a further piece of pricing analysis the CC should undertake is a comparison of the charges paid by private patients with the NHS tariff for these procedures. A number of private hospitals perform a significant amount of NHS work. We understand that this work is undertaken at NHS tariff prices and yet is profitable.

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<sup>39</sup> The CC Consultant Survey found that, on average, consultants in London had practicing rights at 2.6 hospitals, showing that once the patient meets a consultant in London the field of hospitals in which that patient may have treatment narrows very considerably.

## TOH 2: MARKET POWER OF INDIVIDUAL CONSULTANTS AND CONSULTANT GROUPS

- 2.64 BHF agrees with the CC's current thinking that "*some anaesthetist groups appear likely to have market power*"<sup>40</sup>. We would like to see the CC's analysis go further and to investigate the prevalence and conduct of consultant groups in other specialisms.
- 2.65 BHF disagrees with the CC's current thinking to not pursue further the market power of individual consultants. BHF has provided evidence that individual consultants do not face effective competition on either quality or price and so are in a position of market power<sup>41</sup>. Failing to recognise the market power that individual consultants have over patients (self-paid and insured) leaves consumers in a very vulnerable position.

### *Patients do not have effective buyer power*

- 2.66 When engaging with consultants, patients are in a vulnerable position with little ability or willingness to negotiate:
- i. When seeking treatment, the patient faces a state of uncertainty, distress and may be debilitated.
  - ii. The patient is at a significant information disadvantage and cannot question the treatment recommended by the consultant. The patient cannot assess the relative quality of the consultant's service in advance and may even struggle to do so after the treatment is delivered<sup>42</sup>.
  - iii. The patient is unlikely to haggle with someone they need to trust to undertake surgery – the patient has much more at stake than the consultant. In our experience, some patients (in particular elderly patients) are afraid to negotiate or query the consultant because of concerns that this may adversely affect the care and attention they receive.
  - iv. The patient faces search costs if he or she wants to shop around – costs which are exacerbated in PH because of the absence of comparable information on consultant cost and quality.
- 2.67 An example of the weakness of the patient's position is that 92% of consultants say that self-pay patients (who should be price-sensitive) 'rarely' or 'never' attempted to negotiate the level of fees<sup>43</sup>. It is evidenced also by the CC Consultant Survey finding that 86% of patients presented with a 'top up' fee pay the fee, with only a tiny fraction negotiating or switching to another consultant<sup>44</sup>.
- 2.68 It is also important to note that the bargaining power of those few patients who do have more information or a greater ability to negotiate does not protect other, more vulnerable patients. The price and course of treatment is agreed bilaterally between the consultant and the

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<sup>40</sup> AIS, para 79.

<sup>41</sup> See Chapters 4 and 6 of the OISR.

<sup>42</sup> Many medical treatments have the properties of credence goods, where the utility from the good may be difficult for the patient to evaluate even after the treatment is experienced. In the absence of other information, patients may assume incorrectly that higher price signals higher quality.

<sup>43</sup> OFT Consultant Survey, p68.

<sup>44</sup> CC Consultant Survey, Q E13 and Q E14

individual patient and the consultant is able to discriminate (on price, level of service, course of treatment) between different patients. Therefore, the fact that some patients are able or willing to shop around does not alleviate the concerns about individual consultant market power at a general level.

### **Switching costs reduce patient buyer power further**

- 2.69 Once a course of treatment has begun, there are (often significant) switching costs for the patient. This limits further the patient's negotiating position if the consultant presents the patient with additional charges or tests mid-treatment<sup>45</sup>. Switching costs can be: (i) financial – restarting treatment with a new consultant means paying again for consultations and tests, which may not be possible for patients facing limited resources (or outpatient benefit limits); (ii) temporal – restarting a treatment pathway may not be possible if delay will compromise the patient's health; and (iii) practical – the patient may not have an outside option if no other consultants are willing to take on his case<sup>46</sup> or if other consultants in the local area belong to the same consultant group.
- 2.70 Anaesthetists, for example, benefit from the high switching costs patients face at the point in the journey when they meet the anaesthetist. Here a "top up" fee, even if disclosed in advance, is very difficult for the patient to avoid, as switching anaesthetist just before surgery could result in the surgery being postponed or relocated.
- 2.71 The situation is aggravated by many consultants not providing patients with information on the costs of their treatment at a point in the journey when switching costs are lower<sup>47</sup>.

### **GPs do not have sufficient information**

- 2.72 GPs are the most important influence on a patient's choice of consultant with many patients seeking to "delegate" choice of consultant to the GP because they do not have the knowledge or confidence to search themselves<sup>48</sup>. Yet at this critical stage there is insufficient information for GPs to provide fully informed advice or choice.
- 2.73 The CC's GP Survey found that 86% of GPs felt that they did not have sufficient information on at least one factor to help them identify the most appropriate consultant. This finding is reinforced by other surveys of GPs<sup>49</sup>.
- 2.74 A key area of weakness is that cost is seldom factored into referral decisions – a result found consistently across GP surveys. The OFT GP Survey found 75% of GPs 'rarely' or 'never' knew the cost of the consultant's first consultation fee. The GP would also not know the end-to-end

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<sup>45</sup> Switching costs emerge at the patient's first consultation visit to a consultant as switching at that point will mean paying a second consultant's first consultation fee. BHF claims data suggests that in 2011 the average outpatient consultation fee was around [£<], with [£<] of consultants charging more than [£<]. So switching costs can be high for the patient even after a single session with the consultant.

<sup>46</sup> Concerns about medical liability discourage a consultant taking on another consultant's patient mid-treatment.

<sup>47</sup> The OFT Consultant Survey (p128) found that only 43% of consultants provided a fee estimate at the first consultation. A survey by FIPO in 2010 found that over 30% of consultants said they do not give a fee estimate at all (<http://www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm>).

<sup>48</sup> OFT Patient Survey, para 5.9. The CC's Patient Survey showed that patients rely heavily on their GPs to provide consultant recommendation – less than 30% of surveyed PMI patients already knew the consultant they wanted to be referred to when seeking a referral from their GP (CC Patient Survey Question C2a).

<sup>49</sup> For example, a 2012 GP survey undertaken on Bupa's behalf by KantarHealth indicated that under a quarter of GPs considered that they had access to objective information about consultants. Of the information on consultants that was available, 58% of GPs found it difficult to use to make comparisons between consultants. (KantarHealth Survey, December 2011/January 2012, Base: 397 GPs).

cost of a consultant's treatment<sup>50</sup>. According to the CC's GP Survey, fees were the top ranking factor on which there was insufficient information<sup>51</sup>.

2.75 The CC GP Survey also found that the average GP refers only around five patients per month into private treatment, with 30% referring fewer than two per month. These are very small numbers when considering the breadth of specialisms, treatments and consultants in private practice. The GP has little incentive (financial or otherwise) to close the information gap. Further, very low referral volumes into private practice mean that patient feedback, when available, is unlikely to offer a comprehensive picture of consultant performance in the local market.

### *Individual consultants do not face effective competition on fees*

2.76 Given that cost is so seldom an important factor at the GP referral stage or at the point of onward referral from one consultant to another<sup>52</sup>, an individual consultant can increase his or her fees with little adverse effect on patient referral volumes. This also means that consultants have little incentive to reduce their fees unilaterally (i.e. to undercut) because this will not necessarily increase patient volumes.

2.77 This lack of incentive to compete is enhanced by:

- i. A significant proportion of consultants offering private practice in a local area are likely to work together in the local NHS Trust. Undercutting a colleague, particularly a superior in the case of new consultants, will be unattractive. Further, there is ample opportunity to discuss fees due to this contact; and,
- ii. Private consultant trade bodies, some of which actively encourage consultants to cooperate rather than compete<sup>53</sup>.

2.78 Competition authorities have previously concluded that consultant fees are not under sufficient competitive pressure; and there is little evidence this situation has changed. The MMC investigation in 1994 into the level of consultant fees found: "*We have noted that consultants enjoy a strong position in the private medical services market which, apart from a few dense urban areas, may be considered as a series of local markets where choice of either consultant or hospital may be limited. **The patient seeking PMS is vulnerable. He depends on the medical profession for both advice and treatment, but he is usually insured and for that reason not greatly interested in prices. It is therefore not surprising that we have seen no evidence of significant pressure on consultants' charges exerted by the patient and virtually no evidence of price competition between consultants***" (emphasis added)<sup>54</sup>.

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<sup>50</sup> In their response to the CC's original issues statement, Aviva submitted data (page 40) showing large variation in GP's perceptions of the cost of several procedures commonly performed by private healthcare providers. For example, GP estimates of the total cost of a cataract procedure ranged from £50 to £7,500. This suggests that the lack of available consultant fee information constrains GPs' understanding of the true costs of private healthcare provision.

<sup>51</sup> The CC GP Survey found 47% of GPs felt that they lacked sufficient information on consultant fees (Q H3).

<sup>52</sup> Although the primary channel, GP referrals are not the only way consultants receive patients. The OFT Consultant Survey found that over 55% of consultants made between 1 and 5 re-referrals of patients to another consultant during an average month.

<sup>53</sup> See Annex F of the OISR.

<sup>54</sup> Monopolies and Merger Commission (MMC) (1994), "Private medical services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants" paragraph 11.165, Chapter 11.



### *Insurers and hospitals cannot fully counterbalance the power of consultants*

- 2.79 It is unsurprising that customers expect insurers to manage the relationship with consultants on their behalf given the information asymmetries and weak negotiating position customers face. Survey evidence shows, for example, that: **84%** of customers expect their insurer to ensure that consultants do not charge members more than the standard cost for a treatment in order to keep PMI premiums affordable (only 5% disagree); **83%** expect their insurer to work with consultants to keep costs down (only 4% disagree); and, **87%** expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices (only 5% disagree)<sup>55</sup>.
- 2.80 Yet insurers cannot counterbalance the power of consultants. For the majority of consultants, insurer reimbursement limits constrain only a portion of fees. Even on this portion, shortfalling occurs. Direct agreements between insurers and consultants on fee scales cover a comparatively small part of the market, as shown by the CC Consultant Survey in which 59% of consultants said they did not have a fee agreement with any insurer<sup>56</sup>. In addition, the insurer has very little influence on either the volume or type of care the consultant specifies.
- 2.81 Open Referral by BHF improves the ability to get value for money on customers' behalf (and increases the interest of consultants in offering value for money). But it is only a partial solution. As noted by the CC's GP Survey currently under 10% of referrals across the sector are open referrals, the majority still being named referrals. Therefore, consultants continue to face little competitive pressure.
- 2.82 Even hospitals provide little counterweight to consultants. BHF has repeatedly approached hospitals seeking to address anaesthetist shortfalling at their facilities. Historically, there has been little success as hospitals have been reluctant to challenge anaesthetists/consultants<sup>57</sup>. [X].

### *Market power can be exercised not only through price, but also volume and restriction of choice*

- 2.83 Consultant market power can be exercised through several dimensions. BHF is concerned that the CC currently appears to be considering only one – price.
- 2.84 The dimensions include:
- i. **Price** – consultant fees are not under sufficient competitive pressure. There is some constraint on the surgical procedure fees set by consultants through reimbursement limits applied by insurers (e.g. benefit maxima). However, BHF is concerned that the CC has not understood the limited coverage of benefit maxima. For BHF, these limits apply only to surgical procedures and some diagnostics as set out in paragraph 2.13. Benefit maxima do not apply to outpatient consultation fees where the vast majority of consultants in the UK are unfettered in the levels of consultation fee set<sup>58</sup>. Outpatient consultation fees account for approximately 50% of BHF's consultant spend. They have

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<sup>55</sup> The Value Engineers, December 2010. Survey of 629 individuals, comprising 300 Bupa customers, 134 competitor customers and 195 serious considerers of PMI (submitted as part of Off-the-shelf request).

<sup>56</sup> CC Consultant Survey, Question E12. 36% of consultants said they had a fee agreement with Bupa. Fewer than one in eight consultants had an agreement with any other insurer.

<sup>57</sup> [X]

<sup>58</sup> See para 2.12.



risen well ahead of general inflation. Consultants can exercise market power through the high outpatient consultation fees they set. Consumers are harmed directly in that outpatient limits in PMI policies are used up quickly, leaving the consumer to pay for further treatment out of his or her own pocket. And it harms consumers indirectly by making it very costly for the consumer to switch to another consultant if this means paying consultation fees again.

Market power is also exercised through charging above insurer reimbursement limits (which creates shortfalls). This occurs in a material number of cases. The CC Consultant Survey found 19% of consultants set fees above insurer reimbursement limits in more than a quarter of their cases (only 39% never set fees above reimbursement limits)<sup>59</sup>. In BHF's experience, [redacted] in 10 surgical procedures faces a shortfall and [redacted] in 10 anaesthetic treatments face a shortfall. These shortfalls occur even though there is no evidence BHF's benefit maxima are too low. Indeed, benchmarking against consultant reimbursement in the NHS and in private practice in Australia, Canada and the USA suggests BHF benefit maxima levels are relatively high<sup>60</sup>.

- ii. **Volume** – the consultant is able to set the type and volume of care with little, if any, external scrutiny. Patients are unlikely to question or challenge the course of treatment recommended and, other than through a handful of medical reviews for specific procedures, insurers have little influence over the care pathway. Therefore, market power can be exercised through over-treatment and over-diagnosis, with the consultants being able to create his or her own demand (“supplier-induced demand”). BHF believes unwarranted variation is endemic in PH; in part because of the strong financial interest of the consultant to deliver more care. For example, simply asking consultants to fill out a short form explaining why a knee arthroscopy was necessary saw a [redacted] reduction in the number of arthroscopies requested by consultants – avoiding several thousand procedures a year for BHF customers, which one must conclude were unnecessary.
- iii. **Restriction of choice** – consultants are able to exercise power through not presenting patients with full, unbiased choice. For example, consultants have significant power in choosing the venue of care for the patient. The OFT Consultant Survey (p58) showed that only a small minority of consultants offered their patients a choice between of PH facility for treatment – almost half (48%) said they “never” offered a choice, a further 23% said they offered a choice in under a quarter of cases, and only 9% offered a choice in more than half of the cases. If the consultant's decision is biased by a financial or personal incentive, rather than the patient's best interests, then he or she is exercising market power.

### **Local markets are not contestable**

2.85 There are some barriers to entry for consultants into local markets (see paragraph 2.177 below). In particular, there are entrenched referral pathways which mean existing GP-consultant relationships persist even if better value consultants enter the local area. More challenging is the fact that new consultants cannot differentiate their practice, given the absence of comparable information on quality or fees. This lack of information also means the new consultant has little incentive to undercut incumbents' fees on entry.

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<sup>59</sup> CC Consultant Survey, Question E13.

<sup>60</sup> See OISR paragraph 6.101.

2.86 BHF notes that despite the strong pool of consultants serving private patients over the past 15 years<sup>61</sup>, there has been little downward pressure on consultant fees or revenues. Laing and Buisson data shows, for example, that private specialist revenues rose from £0.6bn in 1995 to £1.6bn in 2011 – a 65% rise in real terms – in spite the stagnation in lives covered by PMI over this period. Practice expenses as a percentage of revenues have remained around 30% over this period<sup>62</sup>. So average pre-tax profits have risen in real terms.

### **Consultant groups exacerbate the competition problem**

2.87 Individual consultant fees are already above competitive levels. The situation is exacerbated (i.e. taken closer to the monopoly price) by consultant groups which can restrict rivalry further in local markets.

#### **Anaesthetist groups**

2.88 BHF's own experience is consistent with the CC's analysis that some anaesthetist groups have market power, leading to higher prices. As set out in paragraphs 6.45 to 6.61 of the OISR, some groups are so large in their local markets that patients have little choice other than to pay significant shortfalls. [§<] <sup>63</sup>.

2.89 BHF would welcome the CC publishing the names, membership and locations of the 100 anaesthetist groups it has identified. BHF can then analyse in more detail the effects of these groups within its claims spend. This could result in additional evidence in support of the CC's investigation.

2.90 BHF notes the CC Consultant Survey findings that 39% of anaesthetists are in groups and that 60% of anaesthetists in a group said that they use the guidelines prepared by the group to set fees. However, BHF cautions that this may understate the competition harm and restriction of choice from groups. For example, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that 64% of Anaesthetist Groups "*share profits equally between members of the group*" meaning there is little reason to differentiate service for group members<sup>64</sup>. These types of arrangement may lead to common prices across the group even if there is no explicit guidance to set uniform prices. The presence of groups also blunts the effectiveness of any new entry to stimulate competition<sup>65</sup>.

2.91 Finally, non-group members may simply follow a group's pricing, as the lack of price competition means the non-group member gain little additional patient traffic from undercutting the group.

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<sup>61</sup> The MMC estimated there were around 17,100 specialists active in private healthcare in 1992. BHF now recognises over 25,000 consultants in private healthcare – an increase of over 40%.

<sup>62</sup> For current levels of practice expenses to practice income see Independent Practitioner Today, Stanbridge Associates Limited. The MMC report in 1994 estimated that the average rate of practice expenses to private practice income was 28% at that time.

<sup>63</sup> OISR, Figure 29 (p 119).

<sup>64</sup> See <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf> (accessed June 2012).

<sup>65</sup> The AAGBI notes, for example, that "*The way that a newly appointed consultant will enter private practice will depend upon local circumstances. If there is a local AG, they will most likely seek to become a member of the AG, and indeed may be invited to join the AG as an automatic consequence of their taking up a consultant post*"; *ibid*.

### *Groups in other specialisms*

- 2.92 BHF would like to see the CC's analysis go further in investigating the prevalence and conduct of consultant groups in other specialisms. The CC survey found that 22% of consultants are in groups. BHF identified [§<] potential consultant groups in specialisms outside of anaesthetics from its claims data<sup>66</sup>. The Nuffield Issues Statement response says it was aware of 170 groups in 2009, only 40 of which were in anaesthetics. Therefore, there is a high and growing prevalence of these groups across a wide range of specialisms.
- 2.93 Insurers cannot provide sufficient counterbalance to these groups; particularly given, as the CC will have itself experienced, there being little transparency on groups in the market. Our engagement with the groups usually follows specific complaints from our members about not having any choice but to accept a shortfall because of the size of the group locally. The willingness to enter a dialogue with BHF varies significantly between groups. Some groups have been willing to amend their billing practices in certain cases. Other groups, however, have been highly resistant.

## **TOH 3: MARKET POWER OF HOSPITAL OPERATORS IN NEGOTIATIONS WITH INSURERS**

- 2.94 The CC explains that the evidence from the extensive body of internal documents it has reviewed "*is consistent with some large hospital groups having market power in some negotiations*"<sup>67</sup>, that "*insurers are often in a relatively weak position*"<sup>68</sup> and that many initiatives by insurers to introduce greater competition have been met with considerable resistance. The CC also notes "*the evidence we reviewed shows that some large hospital operators are often the most assertive, willing to challenge insurers, and the most likely to emerge with the outcome they wanted from a negotiation*"<sup>69</sup>.
- 2.95 BHF strongly agrees that the larger hospital groups have market power in negotiations with insurers. This power is often abused to the detriment of hospital rivals and customers. Larger groups consistently expand, and protect through anticompetitive actions, the "financial envelope" that they require insurers to fund. Larger hospital groups' prices are significantly higher than smaller rivals, despite their scale and with little evidence of superior quality. There is also little evidence of the prices of treatments being linked to costs<sup>70</sup>. Insurers do not have countervailing buyer power against the larger hospital groups. Further, BHF believes this imbalance has continued to grow; in London, in particular. It is an unsustainable situation requiring urgent redress.

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<sup>66</sup> See Market Request response Q49.

<sup>67</sup> AIS, para 90.

<sup>68</sup> AIS, Appendix D, para 15.

<sup>69</sup> AIS, Appendix D, para 16.

<sup>70</sup> HCA's submission to the CC on 22 February 2013 explains its pricing is done at a "pricing envelope" level rather than with reference to the underlying service costs: "*HCA's pricing with any PMI provider involves numerous different elements and it is impossible to look at the pricing of any one particular service line in isolation from the total pricing which is agreed between the parties .... The issue of pathology charges has been specifically discussed with AXA PPP in the context of the total 'pricing envelope' and HCA offered to rebalance its charges having regard to the pricing of other service lines*" (para 16.2).

### *Drivers of hospital group market power*

- 2.96 The CC says it sees two distinct aspects to TOH 3: (i) the power derived from the hospital operator's strength in certain local markets (linking to TOH1); and, (ii) additional aspects of the negotiations which add to the power of hospital groups<sup>71</sup>.
- 2.97 BHF agrees that a hospital group's ownership of hospitals with local market power confers bargaining power. The group's bargaining power increases with its size and both the number and importance of the 'must have' hospitals it has within its portfolio<sup>72</sup>.
- 2.98 Each 'must have' facility has significant pricing power in its own right (particularly because insured patients, and consultants, are insensitive to the price the hospital charges). The insurer is reliant on continuing to use the facility, even if the hospital charges excessive prices, if the insurer is to continue to fulfil its obligations to policyholders. When these 'must have' hospitals are owned by a group they confer additional power. In a dispute situation the hospital operator can recover a significant portion of any lost funds at delisted facilities through significant price rises at the hospitals the insurer must continue to use<sup>73</sup>.
- 2.99 BHF also believes strongly that there are additional aspects of negotiations with larger hospital groups that confer power to them over and above the power derived from their facilities with local market power. These include:
- i. The group's **scale** – in terms of the number of hospitals it owns and the number of patients it serves – confers additional power:
    - The larger the group, the greater the operational and reputational cost faced by the insurer in an 'out of contract' situation. Operationally, the insurer is obliged to battle to maintain continuity of service for a larger body of customers across a larger number of fronts<sup>74</sup>. There are greater logistical challenges to being out of contract with a group than with a single standalone hospital. Reputationally, a large number of customers (and consultants) are negatively affected in the dispute and the dispute is likely to be covered widely in the national media.
    - The larger the group, the greater the pricing power individual hospitals within the group gain from being part of the larger group. There is a higher probability that any patient a hospital loses as a result of exercising its pricing power is recaptured (internalised) by a sister hospital within the group. This effect is illustrated by the CC's LOCI analysis which shows 95 hospitals of potential

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<sup>71</sup> AIS, para 84.

<sup>72</sup> The CC notes from its review of documents from parties that *"The evidence seems to indicate that the more hospitals with local market power a hospital operator has and the more important these are to the insurer, the stronger is the hospital operator's negotiating position vis a vis the insurer"* (AIS, Appendix D, para 15). The CC is correct that it is not only the number of 'must have' hospitals the group owns but also the importance of its hospitals. For example, some individual hospitals have market power that extends beyond their own local area through their impact on corporate accounts. If an insurer lost access to [§<].

<sup>73</sup> The money earned through higher prices at 'must have' facilities will be almost all profit as no additional costs will be incurred in serving patients at these hospitals. This cash injection to replace revenues lost at the delisted facilities can be complemented with strategies at the delisted hospitals to further moderate the impact (e.g. replacing the insurer's revenues with additional NHS activity).

<sup>74</sup> For example, with a standalone hospital, the insurer has only one local market on which to focus its resources to mitigate the negative effects of an out of contract situation. The countermeasures available, if any, are likely to be bespoke to the specific local market (e.g. agreeing arrangements with local rival hospitals or local consultants). However, when dealing with a large number of local markets simultaneously, an insurer will struggle to design and implement countermeasures in each affected market due to the resource constraints the insurer will face.

concern on an Individual LOCI which increases to 116 when the Network LOCI is considered.

- ii. The regional **density** of the group's ownership of hospitals. Where a single group owns a large proportion of hospitals within a region – as is the case in London and in Scotland – the insurer faces further constraint<sup>75</sup>. The insurer may not be able to effectively serve a whole region of the UK in a dispute situation. This will materially affect the attractiveness of its policies to customers (particularly for the corporate customers that expect nationwide access for their employees).
- iii. The **tactics** larger hospital groups deploy that weaken the insurers' bargaining position. These include tactics deployed during the negotiation: revenue-neutral negotiating (see paragraph 2.102) and 'one in, all in' negotiation (see paragraph 2.105). In a dispute situation, the hospital group also has other tactics it can deploy to increase pressure on the insurer.

2.100 The CC should also note that the negotiations take place in an environment where:

- i. There is limited rivalry between the main hospital groups at a group level. Local markets and regions are highly concentrated (particularly at a specialism level) leaving insurers with few options<sup>76</sup>. Each main hospital group owns 'must have' hospitals and so knows insurers have to continue to do business with it and also with rival groups. This limited rivalry weakens the incentives of groups to lower price. It also places constraints on insurers who know that if they enter dispute with one group they transfer significant bargaining power to the other groups they become increasingly reliant on.
- ii. Hospitals have diversified their revenue sources through increasing NHS activity. This has diluted the importance of any one insurer's business. According to Laing & Buisson, in 2011 an average private hospital earned 56% of revenues from PMI, 26% from the NHS, 15% from self-pay, and 3% from international<sup>77</sup>. The picture has changed significantly since 2004, when 69% was PMI-funded. NHS business may be lower margin than insured business, but it still appears to be profitable for hospitals.

### ***Negotiating tactics of the large hospital groups***

2.101 We set out below some of the tactics we have seen deployed by larger hospital groups to protect their position and maximise bargaining power.

#### ***Ever-expanding financial envelopes and revenue-neutral negotiating***

2.102 In BHF's experience, large hospital groups focus on a 'financial envelope' that must grow at each negotiation<sup>78</sup>. This envelope is a minimum level – a floor – that the hospital demands from the insurer. If during the negotiation the insurer seeks to reduce prices in one area of the

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<sup>75</sup> We agree with the CC's assessment that density negatively affects the ability for customers to control PH costs (e.g. through Open Referral and Networks): "a more guided approach may enable companies to reduce the cost of private health-care where alternative, cheaper facilities are available to which employees may be directed but where one hospital operator owns most of the private healthcare facilities in an area neither adopting a more guided approach nor attempting to negotiate preferential terms appear likely to reduce the private healthcare costs of even a large corporation" (AIS, Appendix F, para 55).

<sup>76</sup> See Table 6 of the OISR (p73) for evidence of the very high levels of concentration at the specialism level within broad regions of the UK.

<sup>77</sup> See Footnote 2.

<sup>78</sup> [ $><$ ].

hospital's services, the hospital simply raises prices in another. Further, some groups impose revenue protection provisions into contracts to protect against this revenue envelope shrinking during the term of the contract.

2.103 These tactics place considerable restrictions on insurers and are ultimately damaging to customers and smaller hospitals. First, as indicated above, the PMI market faces significant decline. [X]. Second, when hospitals allow negotiations to focus only on how much the financial envelope increases each year, there is no link between the price of individual services and actual costs (or quality). This disconnect between the price the insurer has to pay and the cost the hospital actually incurs in delivering the service impacts the insurer's ability to price risk (and so premiums) accurately from an actuarial perspective and also the incentives of rival hospitals to enter specific treatment and specialisms. Third, any better value the insurer gains for its customers (e.g. through a service line tender) is in part clawed back by the larger hospital groups (through contractual clauses and price increases in other service areas) rather than passed through to consumers.

2.104 Examples of this tactic from hospital groups include:

- i. [X]<sup>79</sup>; [X].
- ii. [X]<sup>80</sup>, [X].
- iii. When the Low Cost Network launched, [X]<sup>81</sup>.
- iv. When BHF launched the ophthalmic network in 2007, [X].

#### "One in, all in" tactics

2.105 BHF has set out its concerns on 'one in, all in' negotiations in detail in the OISR (paragraphs 5.57 to 5.66, and paragraph 5.123). In summary, a hospital group leverages power from its 'must have' hospitals to those parts of its portfolio in more competitive markets by tying the portfolio together as a bloc in negotiations with insurers. If the insurer wants access to the 'must have' hospitals, it must accept recognising the other parts of the hospital group's portfolio.

2.106 The large hospital groups can use the tactic to build entry barriers for smaller rivals, to weaken PMI innovation, and to protect less efficient hospitals within their portfolios. For example, the threat of 'one in, all in' significantly weakens an insurer's ability to launch cost-saving networks. The insurer knows that if it is to include the group's 'must have' hospitals into the network (which may be critical to give the network full geographic coverage), it may be forced to accept the group's hospitals in other, more competitive, markets even when these hospitals do not offer good value for money. This softens the cost-savings of the network, both through including the group's poorer value hospitals and also by blunting the incentives of rival hospitals to offer discounts<sup>82</sup>. The tactic, therefore, weakens a key tool for the insurer to increase competition and to welcome new customers into the PMI market with cheaper PMI products.

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<sup>79</sup> See para 5.122 of the OISR for details of the contractual restrictions imposed by [X].

<sup>80</sup> [X].

<sup>81</sup> See para 5.123 of OISR.

<sup>82</sup> Rivals will know that they will have to share the local market with the group's hospital even if they offer a better price because the insurer is obliged to include the group hospital on the network.

2.107 A feature of their market power is that large hospital groups set uniform prices across all, or the majority, of their hospitals – national prices that insurers have to accept given ‘one in, all in’. This means that prices in a local market bear little reflection to local costs, levels of efficiency, levels or rivalry, quality or demand. The tactic also means that the hospital group can leverage strength from ‘must have’ hospitals across into more competitive markets. By spreading the market power of its must have facilities across other markets in this way, it is more challenging (i) for any entrants to get clear signals on which local markets to enter; (ii) for insurers or others to challenge excessive pricing in the ‘must have’ facilities (including legal challenges); and (iii) for insurance risk to be priced appropriately<sup>83</sup>.

2.108 BHF has previously sought hospital-by-hospital negotiation and local pricing. However, this has been strongly resisted by the larger hospital groups<sup>84</sup>.

2.109 We note that the CC says that it has “*not yet formed any views as to whether hospital chain negotiations and uniform pricing across hospitals provide private hospital groups with any greater advantage than if charges were negotiated on a hospital-by-hospital basis*”<sup>85</sup>. BHF believes strongly that hospital group scale/density together with negotiating tactics confer *additional* market power. Allowing hospital recognition and pricing to reflect local dynamics would improve competition in the short term by incentivising all players in local markets to compete as well as over the longer term (it would encourage entry into ‘must have’ markets and would also improve the discipline offered by competition law). To achieve this, the balance of power between insurers and larger hospitals needs to be changed.

#### Tactics to increase pressure on the insurer during a dispute

2.110 Certain hospital operators also deploy tactics during negotiations which seek to further weaken the insurer’s position. Examples include:

- i. The group threatening significant price rises on the activity the insurer is unable to move away from the hospital in an out of contract situation. As the CC found “*the threat of a significant price rise (which can be in excess of 30 per cent) was a common approach utilized by hospital operators in negotiations when responding to a threat of delisting*”<sup>86</sup>.
- ii. The group engaging directly with the insurer’s customer base to create uncertainty and unrest. [§<] <sup>87</sup>. By involving customers, the hospital increases the pressure on the insurer to do a deal to minimise customer uncertainty. This uncertainty can lead to the insurer losing customers who want peace of mind and convenience from their policies; the knowledge that their local hospital will be available to them if needed, not delisted during a dispute. An advantage hospitals enjoy, and can seek to capitalise on, is the misperception by customers that cost is correlated with quality (which is not necessarily the case). The hospital therefore rallies concern amongst the insurer’s customers through the assertion that the insurer’s attempts to control cost will lead to lower quality care.

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<sup>83</sup> For simple illustration, assume a group owns 10 hospitals, one of which is a local monopoly. It could achieve the same effect of raising its price by 100 units in the ‘must have’ market through raising its national price 10 units in each of its 10 market. The insurer has to pay 100 units more in each case, but in the latter it is (a) less likely an entrant will enter the ‘must have’ market which will appear less profitable, so the group will retain its strength in that market for longer, (b) the insurer would have less chance of proving excessive pricing than if the group had attempted to extract 100 from one market, and (c) the insurer could see prices rise from rival hospitals in the 9 more competitive markets.

<sup>84</sup> See for example the BMI/Bupa negotiation case study submitted in response to Q19 of the Market Request.

<sup>85</sup> AIS, para 95.

<sup>86</sup> AIS, Appendix D, para 22.

<sup>87</sup> Relevant letters have been submitted as part of our response to Question 19 of the Market Request. [§<].



iii. [redacted]<sup>88</sup>.

iv. [redacted]<sup>89</sup> [redacted]<sup>90</sup>.

2.111 The tactics above have a greater negative impact on the insurer when used by a larger hospital group, as a larger number of customers are affected.

### ***Insurers do not have sufficient bargaining power***

2.112 It is in the interests of consumers that insurers' buyer power is improved<sup>91</sup>. Strong buyers are needed to place downward pressure on the excessive profitability of hospital groups, to restrain hospitals with local market dominance, and to encourage competition and efficiency. As the CC has observed in its evidence review, however, insurers are not in this position.

2.113 BHF agrees with the CC's current thinking that: *"the main negotiating lever [for an insurer] in these bilateral contract negotiations, delisting a hospital or hospital group, is often of limited credibility given that taking such a step can cause the insurer serious harm"*<sup>92</sup>. The harm to the insurer increases with:

- i. The price increases the insurer faces on the activity that remains at the group when out of contract;
- ii. The number of local markets affected, which increases the operational costs for the insurer during the out of contract period (e.g. arranging redirection logistics);
- iii. The number of customers affected by the dispute. Delisting causes uncertainty and inconvenience for customers. Peace of mind is a driving factor in buying PMI; uncertainty erodes this. Many will have bought PMI having in mind access to a convenient local hospital. Now being told their choice has narrowed inevitably causes concern and frustration (even if in reality there are satisfactory alternative hospitals within the local market). The insurer, as the funder of care to whom the customer has already paid a premium, is normally blamed for the inconvenience. The insurer needs to consider the impact on both existing customers, who can and do switch, and potential customers who may choose not to go to the insurer if there is uncertainty<sup>93</sup>. The effects are also magnified where the hospital group targets patients directly and rival insurers seek to poach affected customers;
- iv. The length of time the dispute will last; and
- v. The response of the rival hospitals on whom the insurer is now more reliant (the bargaining power of these hospitals rises).

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<sup>88</sup> [redacted].

<sup>89</sup> For example, a patient may want to know how much outpatient limit they have remaining. However, if the hospital has not submitted invoices for previous treatments, the insurer will be unable to tell the customer this information.

<sup>90</sup> This affects Corporate policies and Health Trusts in particular. Corporate policies are priced each year on the basis of the corporate's claims experience in the previous year. If the claims invoices are withheld, [redacted], the insurer's ability to price the renewal contract is significantly weakened. The insurer is also significantly limited in its ability to administer claims on behalf its Health Trust customers.

<sup>91</sup> The CC notes in para 50 of the AIS that it has not seen persuasive evidence that insurers have harmful buyer power over hospital operators.

<sup>92</sup> AIS, Appendix D, para 15.

<sup>93</sup> As a consequence of the BMI dispute, BHF lost existing corporate customers. [redacted].



- 2.114 The insurer must also consider that it is not sustainable for consumer perception of its offer to use delisting repeatedly i.e. to have a reputation for being frequently out of contract with hospitals. Each time it delists hospitals, it further erodes customer and intermediary confidence that when care is needed the insurer will make conveniently located hospitals available.
- 2.115 In considering whether to delist a hospital or hospital group, the insurer will need to consider all of the above factors. The reputational impact is particularly important for the insurer because the relationship with the customer is the key asset of the business<sup>94</sup>. Customers have a wide choice of other insurers competing for their business (and there is also the risk customers will be lost to the NHS if they no longer see value in PMI). By contrast customers are much less likely to switch hospitals as a result of a dispute both because there is unlikely to be the same level of choice locally, and because a patient's choice of hospital is typically guided by their GP or consultant.
- 2.116 BHF emphasises that its decision to delist BMI hospitals in early 2012 was a costly action for it to take and that the surrounding circumstances were exceptional. [§<]. It should not be taken as evidence that BHF or any other insurer is generally able to make a credible threat to delist hospitals.
- 2.117 The CC notes that "*it would seem that the bargaining position of Bupa (and to a lesser extent AXA PPP) is significantly stronger than that of smaller insurers*". It is not unexpected that BHF may achieve better discounts than smaller insurers. It is efficient that larger volumes are rewarded with larger discounts. BHF has worked hard to maintain its attractiveness to customers (through providing value for money, building a strong reputation and offering a high level of customer service) and so the size of its membership. BHF has also demonstrated unrivalled innovation in improving its ability to guide patients to better value for money providers. However, this does not mean it has sufficient countervailing power against large hospital groups.
- 2.118 BHF is an important customer for many hospitals, but it is not essential. Its share of "an average" private hospital's revenues is now under a quarter (smaller than the NHS at 26%)<sup>95</sup>, and given the high levels of local market power amongst hospitals, "an average" hospital will also be in a position where BHF cannot shift all of this revenue away in a dispute situation.
- 2.119 The CC is considering whether the effects of consultant drag increase the bargaining power of larger insurers i.e. if an insurer accounts for a large proportion of a consultant's business, then if the hospital is delisted the consultant may move all of their practice to another hospital to avoid splitting their practice. While BHF accepts that in theory this may happen, in practice the effect (both in timing and magnitude) is moderated significantly because:
- i. In many cases there will be no other hospitals to which consultants can move their practice.
  - ii. As explained in paragraph 2.128 below, consultants can operate highly profitable businesses even without the volumes of one of the largest insurers. They may choose to do this (by staying at their current facility) if the dispute between the insurer and the

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<sup>94</sup> There are significant costs to acquiring and retaining PMI customers. This is accentuated in a declining PMI market.

<sup>95</sup> Laing & Buisson estimated that 56% of hospital revenues in 2011 were earned from PMI. BHF market share by revenue in PMI is around 40%. BHF's share could in fact be lower given the CC Patient Survey found only 3 in 10 private patients seen by hospitals (i.e. excluding NHS patients in private hospitals) were insured by BHF.

hospital is likely to be short-lived and if the switching costs faced by the consultant are high. The consultants also always retain the option to split their practice during the period of the dispute.

- iii. The hospital retains the direct relationship with consultants on a day-to-day basis, meaning that during the dispute the hospital is able to mitigate any consultant drag effects through direct engagement with the key high volume consultants to increase loyalty (e.g. through incentive payments).
- iv. Many consultants already have links to their current facility, both financial and non-financial, that reduce the likelihood that they can or would switch away from that hospital during a dispute (unless the rival hospital could match these incentives).

2.120 BHF agrees with the CC that for an insurer to have any buyer power it “*must be able to exert some meaningful control over where (and by whom) its patients are treated*”<sup>96</sup>. However, larger hospital groups have been able to use their strength and tactics to frustrate and resist insurers’ initiatives (service-line tenders, networks and open referral) to develop a degree of influence over where patients are treated. There are also limits on the impact these initiatives by insurers can have. Service-line tenders, for example, will only ever apply to a sub-segment of treatments that are highly standardised across providers. Similarly, Open Referral is of limited use if a single hospital operator dominates a local area<sup>97</sup>.

2.121 Therefore, a more fundamental rebalancing of power between hospitals and insurers is needed. This should include reducing the scale and density of the main hospital groups (in particular in Central London and Scotland), limiting the proportion of hospitals with local market power within any one group, and where necessary regulating the conduct of hospitals that have natural monopoly positions.

### Further analysis

2.122 The CC notes that it is considering further analysis on hospital operators’ costs for insured business (paragraph 91). BHF welcomes this further analysis. BHF has a number of concerns about the connection between hospitals’ pricing and the costs of services:

- i. Excess profits are evidence that the link between prices and costs generally is distorted;
- ii. The tactics employed by hospital groups of ‘financial envelopes’, national pricing and revenue-neutral cross-subsidisation of services distort any link between an individual service’s costs (at a local level) and the price charged;
- iii. Hospitals price discriminate between customers (different insurers, the NHS, and self-pay patients) and there is little evidence these price differentials are objectively justified; and

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<sup>96</sup> AIS, Appendix D, para 11.

<sup>97</sup> BHF agrees with the CC that “*a more guided approach may enable companies to reduce the cost of private health-care where alternative, cheaper facilities are available to which employees may be directed but where one hospital operator owns most of the private healthcare facilities in an area neither adopting a more guided approach nor attempting to negotiate preferential terms appear likely to reduce the private healthcare costs of even a large corporation*” (AIS, Appendix F, para 55).

- iv. There is little evidence that any cost savings from economies of scale flow through to consumers<sup>98</sup>.

2.123 BHF believes there would be significant benefits from greater transparency, and so focus, on hospital costs.

## TOH 4: BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS

2.124 BHF welcomes the CC's current thinking that insurers play an important role in achieving value for patients from consultants and that there is no evidence that this is leading to a distortion of the supply of consultants to the market. The CC, however, raises a concern that some actions by insurers to negotiate lower fees on their customers' behalf and prevent shortfalling by consultants could limit patient choice. BHF maintains that there is no evidence for this.

### *Level of consultant fees*

2.125 BHF agrees with the CC's statement that "*In the absence of insurer action, either to influence the choice of consultants or to limit the fees charged, it is not clear that there would be effective constraints on the fees charged for insured patients*"<sup>99</sup>. As explained in TOH 2 above, consultant fees are not under competitive pressure. Therefore, reimbursement limits provide important clarity and protection for customers with respect of fees. However, for BHF these reimbursement limits do not cover all fees set by consultants (e.g. outpatient consultation fees) and some consultants exercise market power by other means such as the volume of care prescribed. Therefore, BHF cautions that insurer buyer power does not fully counterbalance the market power of consultants. Furthermore, in the absence of additional action to encourage consultants to charge within benefit maxima, these limits would be ignored by more and more consultants who would charge top ups.

2.126 BHF agrees also that "*it would probably be against an insurer's interest to reduce prices to such an extent that it had an inadequate supply of consultants*"<sup>100</sup>. BHF is committed to UK private healthcare for the long-term. It has no incentive to undermine the market's continued attractiveness to customers through distorting the supply of high quality consultants or by putting customers in the hands of inferior consultants. Further, there is no evidence that this supply is being constrained. The supply of new consultants remains strong, with over 1,200 new consultants being recognised by BHF each year since 2010. Indeed, the CC Consultant Survey shows that private practice remains very attractive: 47% of consultants said they had time available and wanted to do more private practice; 20% said they wanted to do more, but time was the constraint; and, 30% were happy with the amount of private work they were currently doing. Only 3% of respondents said they were intending to reduce or stop the amount of private work they do (with only 1.5% citing financial reasons)<sup>101</sup>.

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<sup>98</sup> See, for example, paras 5.96 to 5.102 of the OISR. This shows that the largest groups – [§<] – are significantly more expensive than smaller peers despite undertaking substantially higher procedure volumes (and not exhibiting superior quality). Similarly, [§<] have some of the highest mark ups on drugs and prostheses despite the savings we expect they achieve in procurement.

<sup>99</sup> AIS, para 100.

<sup>100</sup> AIS, para 106.

<sup>101</sup> CC Consultant Survey, Q B4 and Q B5

2.127 There is no justification for systematically increasing reimbursement rates. As noted in TOH 2, this is particularly the case given that (i) reimbursement rates in the UK already appear high relative to the NHS and international peers, (ii) consultant earnings and profits remain robust in spite of PMI market stagnation, and (iii) technological improvement reducing the time and complexity of treatments suggests that reimbursement rates for many procedures should in fact be reduced<sup>102</sup>.

### ***BHF recognition is important but not critical***

2.128 BHF understands that Bupa recognition is important to a consultant's successful private practice, but believes that the CC's overstates it as being "*critical*"<sup>103</sup>. BHF accounts for around 41% of the PMI market. The CC's Consultant Survey found that PMI patients account for around 72% of the private patients an average consultant sees. Therefore, BHF accounts for approximately 30% of a consultant's patient traffic in the private sector. Evidence suggests that, on average, private practice expenses account for around 30% of consultant revenues, leaving around 70% as pre-tax profit<sup>104</sup>. Therefore, even without Bupa revenues (and assuming all else equal), the consultant would have significant positive returns from private practice.

### ***Top up fees from consultants***

2.129 BHF disagrees strongly with the CC's current thinking that "*the buyer power of Bupa, or of Bupa and Axa-PPP together, restricts patient choice in the market for consultants through the prevention of 'top up' fees*"<sup>105</sup>. BHF maintains that mitigating top ups enhances patient choice in aggregate by allowing more patients to access private healthcare and to do so with peace of mind<sup>106</sup>. We can see no evidence that patient choice is restricted by these actions to any significant degree.

2.130 BHF believes its actions are appropriate because: (i) consultants have significant pricing power over patients; (ii) top ups are typically unfair because the patient has little option but to pay the additional fee; (iii) customers desire for peace of mind on treatment costs is undermined by these unwelcome fees; and, (iv) there is little evidence that reimbursement rates are too low, which calls into question the justification for these top ups in the first place.

### ***Consultants have pricing power***

2.131 As discussed in TOH 2, individual consultants do have pricing power over the patient, particularly when patients are mid-treatment, and consultant fees are not under sufficient competitive pressure. Further, the CC itself recognises the patient's weak position in TOH 6 in concluding: "*there is a clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient*"<sup>107</sup>. The consequence of these factors is that consultants are in a position to charge

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<sup>102</sup> The CC notes that "*due to technological and other improvements, Bupa argued that consultants were now able to conduct many of the procedures much more rapidly than when the fees schedules were set*" (AIS, paragraph 104). BHF would emphasise that improved speed of treatment is only one of a number of reasons why there is little evidence that reimbursement limits should be increased – see OISR Chapter 6 paragraph 6.106.

<sup>103</sup> AIS, para 110.

<sup>104</sup> Independent Practitioner Today, Stanbridge Associates Limited

<sup>105</sup> AIS, para 116.

<sup>106</sup> These additional costs add further expense to a customer who has already had to pay a significant premium. In an environment where affordability of PMI is such a pressing issue for so many customers, additional costs and uncertainty increases the rate of decline in the market.

<sup>107</sup> AIS, para 143.

unfair top ups, and there is insufficient discipline from patient buyer power or market forces to prevent this.

*Top up fees are unfair when, as is normally the case, the patient is unable to make a fully-informed, actionable choice*

2.132 BHF notes that the CC draws a distinction between “a shortfall”, which is “unwelcome”<sup>108</sup>, and “a top up” by saying the patient knows about the latter in advance (i.e. it is expected). However, BHF does not believe this distinction – based only on when the patient is told – between “shortfalls” and “top ups” is workable in practice. The patient may be informed about the additional fee before the treatment (so categorising it as a ‘top up’), but if this is at a point where the patient has no ability to switch or negotiate then the additional cost is still unfair and unwelcome (it is a shortfall). Consider, for example, an anaesthetist asking for a ‘top up’ just before an operation. Even with this advanced notice, the patient has no real choice other than to pay (given the costs of postponing the surgery).

2.133 The CC’s Consultant Survey illustrates the difficult position patients find themselves in. 86% of patients presented with a ‘top up’ fee ultimately pay the fee, with only a tiny fraction negotiating or switching to another consultant<sup>109</sup>.

2.134 BHF believes that ‘top ups’ would be fair to patients only if the following three conditions are fulfilled:

- i. The consultant provides full financial information to the patient in advance and fully-informed financial consent is achieved;
- ii. There is information on quality available to the patient with which a value-for-money decision can be made about whether the top up is justified and its scale is fair; and
- iii. All necessary information is provided to the patient at a point in the journey when the patient can still switch cost effectively.

2.135 However, based on its experience from operating in the market for many years, BHF does not believe these conditions are met in PH.

2.136 First, there is evidence that consultants fail to get fully-informed financial consent sufficiently in advance that a patient has choices<sup>110</sup>. This is in spite of guidance from regulators and associations being in place for many years saying this fully informed financial consent should happen.

2.137 Second, the absence of any publicly available, comparable information on consultant quality makes it extremely challenging (effectively impossible) for the patient to assess whether the scale of the top up levied represents objective value for money. Indeed, in the absence of information on quality and the ability to assess quality, the patient may incorrectly infer price to be a signal of quality<sup>111</sup>.

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<sup>108</sup> AIS, para 111.

<sup>109</sup> See footnote 44.

<sup>110</sup> See footnote 47.

<sup>111</sup> BHF emphasises that there is no robust evidence that more expensive consultants are necessarily of higher quality.

2.138 Third, as noted above, patients face switching costs, even after their first appointment with the consultant. Courses of treatment are often lengthy, requiring several tests and phases (e.g. in the treatment of cancer). Once the treatment journey is begun with a consultant, the patient faces real constraints on negotiating or switching midstream. Yet the consultant has the ability to change his or her pricing whenever they wish. This transfers significant financial risk and uncertainty onto the patient.

Customers want peace of mind on treatments costs

2.139 BHF's initiatives to mitigate shortfalls/top ups have been in response to a customer desire to have greater price certainty and peace of mind. For example, 84% of customers expect their insurer to ensure that consultants do not charge members more than the standard cost for a treatment in order to keep PMI premiums affordable (only 5% disagree)<sup>112</sup>. The risk of additional fees, unexpected at the point of purchasing PMI, threatens that proposition. And, as we have explained previously, this desire to control costs is part of an urgent pressure from customers that PMI remains affordable, as many customers are being priced out of PH.

2.140 BHF receives thousands of complaints about surgical and anaesthetic shortfalls each year. In 2011, for example, we received over [§<] complaints per week specifically about shortfalls. These shortfall complaints are one strand of wider dissatisfaction about the affordability of PH and PMI that we hear about from customers every day and which the market has seen through the tens of thousands of customers who have exited the market for affordability reasons over the past decade.

2.141 Therefore, unwinding insurers' initiatives to mitigate unjustified additional costs would run counter to the wishes and expectations of the majority of customers. A blanket allowance of top ups may make a very small number of customers happier (and even this is uncertain as top ups often simply add unjustified additional cost), but would simultaneously put at risk the significant majority of patients who want price certainty and peace of mind on costs. The net impact would be very substantial consumer harm.

2.142 Indeed, BHF believes it would send a very dangerous message to consumers if 'top up' fees are endorsed by the CC as in patients' interest; this would give consultants free rein to charge additional fees (indeed we believe this is why some consultants and consultant bodies are arguing in favour of top up fees). A misperception that the consultants who charge the most are the best will lead to a 'race to the top' at the expense of all patients. This could price more patients out of PH entirely (i.e. no longer having any access to private consultants) and would accelerate the decline of the market as a whole.

There is little evidence top ups presented to the patient are justified in the first place

2.143 There is little evidence that the benefit maxima are too low (i.e. below a market price); as the CC notes: "*We have not seen evidence that indicates that Bupa's fee schedules are leading to lower quality of service, to lower incentives to innovate, or dissuading consultants from entering private practice, or remaining active in it, in such a way as to result in a long-term detriment*"<sup>113</sup>.

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<sup>112</sup> See footnote 55.

<sup>113</sup> AIS, para 107.

2.144 Further, where consultants consider that there is evidence that the quality or complexity of their work should amount a higher fee they have the option to approach the insurer directly and agree a higher fee rather than presenting it to the patient<sup>114</sup>.

2.145 Given the lack of information widely available, it is difficult to understand how the consultant themselves determines the service they provide is objectively worthy of a higher fee than the fee paid by BHF to the vast majority of consultants who do not charge these additional top ups.

### **BHF's initiatives to mitigate top ups**

2.146 The CC raises some specific concerns about BHF's new consultant contract, under which the fees that the consultant will charge are agreed in advance.

2.147 The CC is correct that this enables BHF "to offer customers the assurance that fees will be fully covered, with 'no surprises'"<sup>115</sup>. The CC also notes that (i) buyer power is a good thing where it delivers better value for consumers; (ii) it has not seen any evidence that BHF's fee schedules are causing a deterioration in the supply of consultants or the quality of service offered, and (iii) the insurer is unlikely to have an incentive to distort supply.

2.148 We believe our benefit maxima are fair to consultants, and most importantly fair to our customers who expect us to get value for money from suppliers.

2.149 It is, therefore, unclear why the CC is concerned that BHF's initiatives "can be expected to lead to a reduced choice of consultants available to patients insured by these insurers"<sup>116</sup>. There is no evidence of a slowing of new consultants coming to the market due to BHF's initiatives – we have recognised over 1,200 new consultants a year since the contract has come into effect<sup>117</sup>. These consultants join a pool of over [3<] consultants recognised by BHF. Our customers therefore have a wide choice.

2.150 As the CC has itself stated, for an insurer to have any buyer power "it must be able to exert some meaningful control over where (and by whom) its patients are treated"<sup>118</sup>. Our use of the new consultant contract is a rare example where we are able to apply some control on behalf of our customers and to limit this in any way would be greatly to consumers' detriment.

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<sup>114</sup> BHF would note it has a facility available through which consultants can claim (in advance or after the treatment) an additional payment over the benefit maxima if a particular patient's treatment faces complexities that mean that the standard reimbursement level is inappropriate.

<sup>115</sup> AIS, para 109.

<sup>116</sup> AIS, para 112.

<sup>117</sup> The CC's Consultant Survey shows the strong continued willingness from consultants to enter private practice and that only 3% of respondents were considering (for any reason) reducing their private practice work. Indeed, a National Audit Office (NAO) report in February 2013 shows the continued strong supply of consultants for private practice in England in spite of specific Department of Health (DH) measures to slow this supply. "Managing NHS hospital consultants" studies the effectiveness of the 2003 NHS consultant contract in achieving its objectives, one of which was "increased consultant commitment to the NHS, for example, by preventing an increase in private practice work" (pg 17). The 2003 NHS contract was, therefore, a policy-measure specifically aimed at slowing the rise in private practice. The NAO finds that the 2003 contract has had its desired effect in that "most consultants, in line with the terms of the contract, prioritise NHS work over private practice work". However, the effect on the number of consultants participating in private practice is more moderate, indicating how attractive private practice remains. The NAO's survey estimated that 15,754 consultants in England engaged in private practice in 2012. This it compares with an earlier Health Select Committee report that 16,349 NHS consultants in England undertook private practice work in 2000. Therefore, there is only a moderate decline (around 3.5%) in the absolute number of consultants in England doing private practice. This moderate decline is not unexpected in the context of a contraction in customer numbers in PH between 2000 and 2012 (e.g. the number of people covered by private medical insurance fell by around 10% in the period) and the significant growth in NHS consultant earnings over the period (a DH study in 2012 showed that consultant earnings in England increased by 19.7% in real terms over the period 2002-03 to 2010-11).

<sup>118</sup> AIS, Appendix D, para 11.

## TOH 5: BARRIERS TO ENTRY

2.151 BHF agrees that entry into the inpatient private hospital market is “restricted”. This is evidenced both by the high levels of profitability in the industry and the very low levels of entry in the past decade.

2.152 As the CC notes, some entry barriers are ‘natural’ features of the market that derive from the economics of the industry. The combination of high fixed costs and limited demand in many local markets create structural barriers. BHF believes that the presence of these natural barriers means that entry can play only a limited role in disciplining the market power of incumbent hospitals. Therefore, more direct action is needed from the CC to redress the imbalance between these hospitals and patients/insurers.

2.153 It is the strategic barriers to entry and expansion erected by incumbent hospital groups that are a particular concern. These restrict the entry and expansion of smaller rivals even if these rivals deliver better value for money and innovative care practices. BHF believes action can be taken by the CC to remove these strategic barriers.

2.154 BHF notes that many barriers affect the ability to expand production, rather than only restricting entry. These barriers limit the ability of a small hospital in a local market to grow at sufficient speed and scale into a credible alternative to an incumbent larger hospital. The insurer may still not have a full alternative to the larger hospital if the smaller player does not have sufficient capacity to serve the insurer’s customers.

### ***5(a) Barriers to entry into privately-funded healthcare resulting from bargaining between insurers and hospital chains***

2.155 BHF believes that the negotiating tactics applied by larger hospitals create strategic barriers to entry and expansion. Please see paragraphs 5.56 to 5.67 and paragraphs 5.122 to 5.124 in the OISR for further detail. In summary:

- i. **‘One in, all in’** negotiation tactics can restrict the expansion of smaller hospitals. First, the incumbent hospital group can use this tactic to force the insurer to recognise the group’s hospital in a local market where an independent hospital in that local market offers better value for money. The independent hospital has to share patient volumes with the group’s hospital. This affects its ability to move down its cost curve through economies of scale. Second, this tactic has frustrated the launch of insurer networks and service line tenders – as was seen in BHF’s experience launching the Ophthalmology Network and the Low Cost Network. Launching cost-saving network products is critical to growing the PMI market through providing customers with more affordable PMI options. Tactics that frustrate the launch of networks have a negative consequence for all participants in the hospital market, but in particular restrict the entry and expansion of small operators (which need to achieve scale and are not in a position to protect their slice of market revenues as the larger groups do).
- ii. **‘National pricing’** can restrict the expansion of smaller hospitals. This removes the signals of price, quality and profitability at a local level that may attract efficient entry. For example, a hospital group could spread the market power (and profits) conferred from a ‘must have’ hospital into more competitive markets when it ties its hospitals together and charges a single national price. This means that entry may not be forthcoming in the ‘must have’ market because its supernormal profitability is spread across the other markets in the group’s portfolio.



- iii. **‘Revenue-neutral negotiating’** by an incumbent hospital group also discourages the insurer from launching initiatives that make cost savings, as some of these cost savings are clawed back immediately by the large hospital group. This means that initiatives that may favour more efficient, innovative independent hospitals never get off the drawing board.
- iv. **‘Restrictive contractual clauses’** imposed by the incumbent can limit the insurer’s ability to direct volume to better value for money operators or to launch products that may allow the growth of smaller, more efficient operators.

2.156 BHF wants to respond specifically to the CC’s statement that: *“We have seen no evidence that hospital groups have the ability to deter entry by forcing a PMI to deny recognition to an entrant even if that have an incentive to do so. We found commercial arrangements which would make it extremely unattractive to a PMI to risk failing to achieve agreed volume targets, by recognizing a rival for example, but **there was no evidence to suggest that the PMIs involved were unwilling parties to these arrangement**, given the discounts that meeting volume thresholds could bring”* (emphasis added)<sup>119</sup>.

2.157 The economics of the hospital industry – high fixed costs and economies of scale – mean that higher volume leads to lower cost, and so it is efficient that the purchaser that delivers higher volume is rewarded with a lower price. As an insurer seeking best value on behalf of our members, it is correct that BHF enters into volume discount arrangements, willingly, if this leads to lower prices for our customers. However, it is incorrect to characterise BHF as a ‘willing participant’ to all volume discount schedules from hospitals. BHF has significant concerns about hospitals seeking to impose schedules that penalise the insurer through very significant price rises (across all volumes the insurer must continue to purchase from the group) where volume falls. These price rises often do not appear to be cost-reflective. These have the effect of forcing the insurer to maintain volumes even if better value provision is available.

2.158 [§<]<sup>120</sup>. [§<].

2.159 [§<].

2.160 [§<]<sup>121</sup>.

**Figure 1:** [§<]

2.161 [§<].

### **Insurer recognition of new hospitals**

2.162 The CC has indicated that it thinks *“the conduct of PMIs, particularly the larger ones, in respect of new hospital recognition may impede entry.”*<sup>122</sup> BHF does not believe this is the case.

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<sup>119</sup> AIS Appendix E, para 47.

<sup>120</sup> [§<]

<sup>121</sup> For a shift in volume away from an incumbent to a new entrant to be total cost-neutral to the insurer, the discount offered by the rival needs to be prohibitively large (see paras 5.61 to 5.64 of the OISR for details).

2.163 Insurers have every incentive and interest in working with new hospital entrants that provide a value for money service to customers. However, insurers must take into account several commercial factors before recognising a new facility (in addition to the quality and regulatory requirements the entrant must meet):

- i. Whether the new entrant will enter at a price point above the prevailing level in that local market (e.g. because it is part of a national group that has a standardised national price) or may actually drive up the market prices in that local market<sup>123</sup>. If the new entrant's offering is not improving competition at the local level, then there are weaker incentives to recognise it.
- ii. Whether the entry will place at risk the insurer's broader commercial arrangements to the detriment of customers overall. Volume-related discounts are offered by some hospital groups and it is efficient (and in customers' interest) that insurers agree to these where they are cost-reflective. If new entry in a local market places these broader discounts at risk, then there could be a negative outcome for the insurer's customers overall if volume is fragmented between providers.
- iii. Whether the insurer is achieving the best deal it can on behalf of its patients. Once the hospital has entered the market and patient referral patterns have been established, there are significantly greater operational and reputational costs to the insurer in delisting the facility. So it is important that the insurer uses this opportunity to attempt to achieve the best deal possible on behalf of its customers.

2.164 Each of the above factors influence an insurer's recognition decision. Recognition cannot be automatic. The entrant must have the incentive to adopt a more innovative and efficient business model than those that currently prevail in the market<sup>124</sup>.

2.165 In addition, it should be noted that BHF cannot "guarantee" recognition of a new hospital that is still under development<sup>125</sup>. The hospital needs to demonstrate it meets minimum quality standards operationally before it can be recognised, otherwise our members are put at risk. However, BHF will work with new entrants to understand the local market, providing insight and data where appropriate. This is evidenced, for example, by our support for, and recognition of, the Circle hospital in Bath in the face of opposition from the incumbent provider BMI.

### ***Barriers to entry into privately-funded healthcare resulting from the relationships between hospital operators, consultants or GPs***

2.166 BHF is of the view that both GP and consultant incentive schemes should be prohibited. This is due to: (i) the conflicts of interest they create (which impact the financial, clinical and choice aspects of care); (ii) the potential they create to lock in clinicians (so locking out rival hospitals); and (iii) the unnecessary cost they may add to the system. As indicated in paragraphs 6.37 to 6.44 of the OISR, BHF has concerns that both financial and non-financial incentives create barriers to entry and expansion by raising consultant switching costs.

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<sup>122</sup> AIS, para 139(b).

<sup>123</sup> For example, BHF has raised our concerns about HCA opening satellite facilities outside of London which it may use to channel patients from that local market into HCA's more expensive Central London facilities.

<sup>124</sup> Some PH providers may argue that insurers are restricting entry when what has in reality taken place is a commercial negotiation where recognition has been delayed until the hospital delivers more reasonable commercial terms.

<sup>125</sup> See para 5.44 of OISR.

2.167 [§<] <sup>126</sup>.

2.168 However, the lack of transparency on these arrangements in the market (because they are confidential between the consultant and the hospital) makes them difficult to monitor.

2.169 BHF notes the CC's comment that some hospitals have recently withdrawn or softened incentive arrangements, in part due to the OFT and CC investigations. However, the risk is that these arrangements will proliferate again once the spotlight of the competition authorities is removed and no structural solution has been put forward.

2.170 BHF does not believe it is sufficient for a hospital to include caveats<sup>127</sup> in agreements with clinicians to remove risks of biasing referral patterns. There is no mechanism to monitor whether these arrangements are being adhered to. As the CC notes: "*A consultant or GP may, strictly, be bound by an obligation to refer a patient only on the basis of the patient's best and clinical interests but, if that clinician has a financial stake in a facility that is a possible referral route or could benefit in some other way by referring a patient to a particular facility, some conflict of interest may arise*"<sup>128</sup>.

#### Relationship between hospitals and consultants

2.171 BHF agrees that schemes in which consultants are offered incentives for referring or admitting patients to a specific private hospital are "*capable of influencing clinicians in ways that...restrict the prospects of new entrants in the healthcare market.*"<sup>129</sup> We are also concerned by arrangements where doctors have financial interests in pieces of equipment within a hospital as this may drive inappropriate usage of that equipment<sup>130</sup>.

#### GP incentives

2.172 BHF agrees that offering GPs incentives for referrals could be used by a private hospital operator with local market power to "*restrict the ability of a new entrant to attract patients based on clinical need or the quality of facilities*"<sup>131</sup>. BHF believes these incentive arrangements should be prohibited.

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<sup>126</sup> [§<].

<sup>127</sup> The CC gives examples of HCA including the following caveats "*[referrals should be in the] best and clinical interests of the patient*" and "*[the clinician] shall be under no obligation to refer patients to any [HCA] hospital*". AIS Appendix E, paras 54 and 58.

<sup>128</sup> AIS Appendix E, para 62.

<sup>129</sup> AIS Appendix E, para 63. See, for example, Annex C of the OISR where we provide an example of a BMI consultant contract that links payments to patient referrals.

<sup>130</sup> There is international evidence of clinicians increasing referral rates for tests/scans when they have an ownership interest in that equipment. See for example: Hillman BJ and Goldsmith J, "*Imaging: the self-referral boom and the ongoing search for effective policies to contain it*", Health Affairs (Millwood);29 (12), 2010; Kilani RK et al, "*Self-referral in medical imaging: a meta-analysis of the literature*", Journal of the American College of Radiology;8(7), July 2011; Levin DC et al, "*Recent payment and utilization trends in radionuclide myocardial perfusion imaging: comparison between self-referral and referral to radiologists*", Journal of the American College of Radiology; 6(6): 2009; and, Shah BR et al, "*Association Between Physician Billing and Cardiac Stress Testing Patterns Following Coronary Revascularization*", The Journal of the American Medical Association, Vol 306, No 18, November 2011.

<sup>131</sup> AIS, para 132. The Cooperation and Competition Panel notes its concerns about links between GPs and hospitals in its Merger Guideline: "*GPs are under an obligation to protect their function as gatekeeper and act as independent and unbiased providers of information to patients to allow them to effectively exercise their right to choice. In doing so, GPs must ensure they maintain neutrality in their referral of patients. In carrying out this function, GPs are required to declare any conflict of interest that may result from referrals to particular providers. This could include any financial interest or employment by a particular provider.*" Merger Guidelines, 25 October 2010, available at [www.ccp-panel.org.uk/content/Merger\\_Guidelines.pdf](http://www.ccp-panel.org.uk/content/Merger_Guidelines.pdf) (accessed 26 March 2013).

### 5(c) Other barriers to entry into the provision of privately-funded healthcare services

2.173 BHF believes that the significant sunk costs of opening a new inpatient facility are an entry barrier. BHF agrees this limits 'hit and run' entry. BHF appreciates that in the case-studies the CC analysed the parties mitigated capital cost and planning regime issues. However, there may be an element of selection bias in the CC's analysis: the examples considered appear to be cases of successful entry. It is unclear whether the CC has analysed instances where hospital operators have aborted entry plans earlier in the process.

2.174 BHF has particular concerns about entry barriers in Central London where acquiring a site suitable for an inpatient facility (that is both convenient, sufficiently large, and has planning permission) is very challenging.

2.175 BHF also notes that there are hurdles faced by PPU's expanding private work which the CC should recognise – see paragraph 2.28 above and Annex A of the OISR.

2.176 Information asymmetries present an additional structural barrier to entry that should be recognised. The lack of accessible, comparable data on quality offered by PH hospitals is a further reason that new entrants may not necessarily win market share away from an incumbent, even if it is offering better value for money care.

### 5(d) Barriers to entry into the provision of consultant services in private practice

2.177 The CC's current thinking is that "*there are no insurmountable barriers to entry into the provision of consultant services in private practice*"<sup>132</sup>. There has been a strong supply of new consultants entering private practice (see para 2.149). However, BHF has concerns there are some barriers to expansion for new consultants that limit their ability and incentive to compete effectively with longer-standing consultants and reduce prices to consumers.

2.178 In particular, barriers may arise from:

- i. Entrenched GP referral patterns together with the lack of comparable information on the price and quality of consultants, which means that new consultants can struggle to become established in local markets.
- ii. Limited incentives to compete against incumbent consultants who are often the consultant's colleagues, even superiors, at the local NHS Trust.
- iii. The growing phenomenon of consultant groups, which, while not strictly preventing entry *per se*, act to blunt the competitive impact that new entry has on the market. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) notes, for example, that "*the way that a newly appointed consultant will enter private practice will depend upon local circumstances. If there is a local AG, they will most likely seek to become a member of the AG, and indeed may be invited to join the AG as an automatic consequence of their taking up a consultant post.*"<sup>133</sup>

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<sup>132</sup> AIS, para 140.

<sup>133</sup> See <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf> (accessed June 2012).

2.179 Given that the significant majority of private consultants also hold posts in the NHS, the NHS itself can create limits on the number of consultants available for private practice. Examples include:

- i. Consultants have time commitments to the NHS under their contracts. This means that there is a limit on the amount of spare time which is available each week for private practice. For example, the CC Consultant Survey found that 20% would do more private work if they had more time<sup>134</sup>.
- ii. Consultants seek to locate their private practice close to their NHS facility (e.g. for time efficiency reasons). This, however, means that if a NHS hospital in a local area does not have vacancies for a particular specialist there may be little ability for a new consultant in that specialism to move into a local area to do private work.

## TOH 6: LIMITED INFORMATION AVAILABILITY

2.180 BHF agrees with the CC's current thinking that "*the market is characterised by: (a) information asymmetries; (b) the absence of information on the quality and performance of clinicians and facilities in private medicine; and (c) the absence of easily comparable information on both consultant and private hospital charges, particularly for self-pay patients*"<sup>135</sup>. We share the concern that a lack of information availability and transparency restricts patient choice and distorts competition (e.g. by creating barriers to entry and protecting inefficient providers).

2.181 BHF would like the CC to consider the implications of information asymmetries and information availability on barriers to entry. Private hospitals produce very little data that allows direct comparison between hospitals in terms of quality. This makes it difficult for a new efficient entrant to differentiate itself objectively in the eyes of patients, GPs, consultants or insurers. It is not rewarded for offering better service by capturing increased patient volumes. Similarly, new consultants entering a new local market struggle to break entrenched referral pathways.

2.182 If improved information on activity and outcomes was published by hospitals and consultants there would be significant benefits to consumers. For example, commissioners of care (e.g. insurers) could better analyse whether certain providers are exhibiting treatment patterns that are outside of evidence-based care. BHF conducts this type of analysis on its own claims data which has, for example, revealed outdated treatment practices by certain consultants.

### *Information asymmetry between patient and provider*

2.183 BHF agrees with the CC's view that "*there is a clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient*"<sup>136</sup>. This puts the patient in a vulnerable position. This asymmetry between patient and provider further weakens the patient's ability to make value-for-money decisions. This asymmetry is a key reason why addressing consultant 'top ups' is critical (see also above).

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<sup>134</sup> CC Consultant Survey, Q B4 and Q B5.

<sup>135</sup> AIS, para 142.

<sup>136</sup> AIS, para 143.

2.184 We share the concern that this asymmetry, combined with the fee-for-service model, creates an opportunity and incentive for providers “to take advantage of that asymmetry and refer patients for unnecessary or more elaborate diagnostic tests or forms of treatment for reasons other than the patient’s best interest”<sup>137</sup>. BHF would also like the CC to recognise that where a provider takes advantage of this asymmetry it is abusing its position of power over the patient. The patient is not in a position to negotiate or question the provider’s choice of clinical care, and the patient’s advisors – GPs and insurers – cannot provide counterbalance. As set out in Annex E of the OISR, BHF has significant concerns that unwarranted variation is prevalent in PH and that certain features of the market (e.g. consultant incentive schemes) facilitate it. The CC could markedly improve the quality and affordability of the PH system by setting out remedies that would provide a basis on which unwarranted variation could be identified and addressed.

### **Insurers’ response to the lack of published information**

2.185 Insurers have taken steps to inject information into the system to give customers real and valuable choice.

2.186 BHF disagrees, however, that insurers’ steps to modify the referral mechanism may give rise to consumer detriment through under-treatment/under-diagnosis. Insurers have a strong incentive to deliver the right care to patients because:

- i. returning the patient to health aligns with minimising insurance liability and also demonstrates the value of PMI (thereby improving customer retention); and
- ii. there is severe reputational damage for insurers if customers perceive that they have received inferior quality care.

2.187 Indeed, BHF believes there is evidence that modified referral mechanisms can deliver improved outcomes for patients compared to prevailing channels. For example, the NHS has conducted studies of the effectiveness of allowing patients to bypass the standard referral mechanism and use a telephone-based assessment mechanism to consult direct with a physiotherapist. A controlled, randomised trial concluded: “*Providing physiotherapy via PhysioDirect is equally clinically effective compared with usual waiting list-based care, provides faster access to treatment, appears to be safe, and is broadly acceptable to patients. PhysioDirect is probably cost-effective compared with usual care*”<sup>138</sup>.

### **Survey results**

2.188 BHF welcomes the CC’s surveys of patients, GPs and consultants. These surveys illustrate that information transparency is unsatisfactory in PH. They reinforce the conclusions from the OFT surveys<sup>139</sup>. It is clear, for example, that there is little pressure on consultant fees as so few GPs take these into account in their referral decisions.

2.189 BHF notes that the CC’s Patient and GP Surveys demonstrated the importance of ‘clinical expertise’ in the choice of consultant. BHF cautions that the surveys did not define ‘clinical

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<sup>137</sup> AIS, para 143.

<sup>138</sup> National Institute for Health Research, “A pragmatic randomised controlled trial of the effectiveness and cost-effectiveness of ‘PhysioDirect’ telephone assessment and advice services for physiotherapy”, Health Technology Assessment, Vol 17 Issue 2, January 2013 (available at: <http://www.hta.ac.uk/fullmono/mon1702.pdf>). See also evidence at <http://www.csp.org.uk/topics/self-referral>.

<sup>139</sup> We also note that information availability has not improved significantly since the MMC looked at this issue in 1994 when conducting a survey of 100 GP practices.

expertise'. Some respondents may have misinterpreted 'clinical expertise' to be either the consultant's relevant specialism (e.g. a heart patient would want a cardiologist because he or she has relevant clinical expertise) or the consultant's clinical performance/quality. BHF believes there is an absence of comparable data on clinical performance/quality and would caution the CC against concluding based on its survey that patients and GPs feel there is sufficient information on clinical performance/quality<sup>140</sup>.

### **Improving information availability and relevance**

2.190 BHF looks forward to engaging with the CC on how information transparency could be improved in the sector. There would be significant consumer benefits in greater comparability on clinical outcomes and value for money. BHF agrees that there is no reason private hospitals should lag the NHS in relation to transparency and availability of data. BHF would, however, caution that the NHS approach should not be imported into the private sector without proper consideration of impact and phasing. For example, the NHS procedural classification structure (OPCS) does not cover all independent private sector work and is not continuously updated to accommodate new procedures and tests.

2.191 One aspect BHF would want the CC to consider is the significant consumer benefits from improved standardisation of coding and recording of activity by hospitals and consultants. For example, there is currently a lack of industry standardisation in coding outside of CCSD codes on inpatient surgical treatments. [§<] of BHF's claims expenditure is on non standardised codes covering diagnostics, drugs, prosthesis, and therapies. This lack of standardisation adds costs to the system and undermines effective competition. For example, it is very difficult for insurers to compare the costs of certain treatments across hospitals or to identify unwarranted variation in certain areas of activity. Steps to move the industry towards greater standardisation of coding and invoicing have been resisted strongly by PH providers.

## **TOH 7: VERTICAL EFFECTS**

### **Vertical integration by PMIs**

2.192 BHF agrees with the CC that "*Bupa's ownership of the Cromwell Hospital is unlikely to give rise to competitive concerns*"<sup>141</sup>. The real threat to competition in London is the growing market power of HCA. BHF's relationship with the Cromwell is unlikely to change as a result of Open Referral, in part because of [§<].

2.193 BHF strongly believes that linkages between the funding and provision of healthcare can deliver substantial benefits to patients. Linking funding and provision better aligns the incentives of the provider to deliver high quality and affordable care (as the provider shares in the benefits of the insurer's success in attracting and retaining customers), rather than simply seeking to maximise revenues (through price and volume) as is the case when independent. For example, we have seen substantial efficiency gains in Spain through the integration of our Sanitas subsidiary's insurance business with three hospitals and 17 smaller medical/diagnostic

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<sup>140</sup> A survey of GPs in 2011/12 found that 79% 'Strongly' or 'Slightly agreed' that they would find it useful if they had more information about consultants' clinical performance and clinical outcomes data. KantarHealth Survey commissioned by Bupa, December 2011/January 2012. Base: 397 GPs

<sup>141</sup> AIS, para156.



centres. As a result of this model, Sanitas has observed enhanced patient satisfaction scores, improved quality performance [3<], and cost-effective treatment practices (e.g. higher rates of outpatient surgery rather than more costly inpatient care and lower rates of surgery readmissions). The insurance business has also seen significantly lower policy lapse rates in the customer group using the Sanitas provision than in the wider PMI population.

2.194 We note that the CC has “*not yet formed any view as to whether full or part ownership of primary care or outpatient diagnostic centres by PMIs is likely to give rise to competitive concerns*”<sup>142</sup>. For the same reasons as given above, BHF considers there to be significant potential benefits from this type of integration. The Kaiser Permanente model in the US, for example, shows the significant improvements in clinical and financial outcomes for patients that can be achieved from the funder integrating with different levels of care including primary care and outpatient diagnostics.

### **Vertical integration by private hospitals**

2.195 BHF shares the CC’s “*concerns regarding the ownership by private hospital groups of primary care and outpatient diagnostic facilities principally, but not exhaustively, in London.*”<sup>143</sup> These vertical linkages can entrench referral pathways, build entry barriers, reduce patient choice and gives an incentive to maximise the number of referrals to the integrated provider’s secondary care facilities<sup>144</sup>. Where the integration does not involve an alignment between the funder and the provider, the benefits as set out in 2.193 do not arise.

2.196 We note that the Cooperation and Competition Panel (CCP) shares these concerns. It notes in its merger guidelines: “*The [GP] gatekeeper function is particularly relevant in vertical mergers involving GPs.... The CCP is concerned about the effects that such a [vertical] mergers may have on the incentives for GPs to refer patients to integrated service providers instead of allowing patients to exercise choice when they are entitled to do so... this has an adverse impact on choice per se, with associated risk of a reduction in competition. The ability to affect the GP gatekeeper function arises due to the integrated nature of the organisation and the fact that, usually, the management of an organisation will be able to direct its staff, or influence its behaviour*”<sup>145</sup>.

2.197 The CC has indicated that it is doing further work to assess how incentives and referral patterns are affected when hospitals own GP practices and outpatient centres. BHF will seek to assist the CC with this analysis where possible<sup>146</sup>. Some examples that the CC may wish to investigate include:

- i. HCA acquired the Rood Lane private GP practices in London in 2011, a stake in Blossoms Healthcare in 2012 and acquired General Medical Clinics in 2012. It is noteworthy that commenting at the time of HCA’s acquisition of Rood Lane, but before

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<sup>142</sup> Ibid.

<sup>143</sup> AIS, para 157.

<sup>144</sup> This could manifest itself both in an increase in the proportion of patients the GP sends its integrated secondary care facility or in an overall increase in referrals generally. For example, if pre integration the GP sent 50 out of a 100 patients to a hospital, post integration the GP can increase referrals to 75 patients to the hospital either by sending 75 of 100 or by increasing total patient referrals to 150.

<sup>145</sup> Paras 6.98 of Cooperation and Competition Panel, “Merger Guidelines, 25 October 2010, available at [www.ccp-panel.org.uk/content/Merger\\_Guidelines.pdf](http://www.ccp-panel.org.uk/content/Merger_Guidelines.pdf) (accessed 26 March 2013). Therefore when reviewing a potential NHS merger, the CCP takes into consideration “*whether or not the merger creates or enhances the ability of the merged entity to undermine the GP gatekeeper function*” (para 6.101).

<sup>146</sup> There are some data limitations, however, as BHF does not collect data on its customers’ referring GP.



HCA took a stake in Blossoms, Magnus Kauders, the commercial director of Blossoms Healthcare, said: *"Vertical integration between primary and secondary care has always been viewed as a potential conflict of interest so it has been massively avoided in the UK, though it is common in the US... It's good advice to separate advice about service from provision of service. Independence really is the key and knowing you are getting the best care and support. I'm not sure that the question over why a referral is being made hanging over the consultation is in the best interests of the insurer or the patient"*<sup>147</sup>. HCA is pursuing a concerted strategy to integrate into primary and outpatient care. This is a strategy consistent with the approach of its US parent<sup>148</sup>: *"... fundamental to our growth strategy is, within our local markets, we feel we have to have scale. And our scale gives us the ability to internalize the patient flow across the continuum, where we are able to offer a complete array of services, and in most instances, keep patients within our system of care. And so if we are able to create enough access for care in these metropolitan areas, where people can access the HCA system, and then we can keep them in the system throughout the continuum, we've been able to generate, what I call, internal growth through that approach. And so one of the key aspects of what we've been doing is establishing greater numbers of access points across all of our markets, so that we have a broader array of entry points into our system. And that's come in the form of outpatient services, physician practice acquisitions or placement, freestanding emergency room, other initiatives to really create an opportunity for a patient to access our system."*

- ii. In 2011, Spire Healthcare acquired Lifescan Ltd, a private provider of computerised axial tomography (CAT) scans. At the time of the acquisition, the Spire Healthcare CEO noted that this was *"a great acquisition that will result in an increase in the number of patients being referred to Spire hospitals for follow-up care"*.<sup>149</sup>

2.198 BHF would also like the CC to consider instances where a hospital and clinician take joint interest in a piece of medical equipment. This form of integration can also drive additional costs into the system through incentivising the consultant to increase usage of the equipment, even where additional tests may not be in the patient's best interests.

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<sup>147</sup> Health Insurance & Protection, "Analysis: HCA buys Roodlane – reaction", 4 October 2011, retrieved from <http://www.hi-mag.com/health-insurance/product-area/pmi/article381259.ece?paging=off&fullPage=true&service=print> (accessed 26 March 2013).

<sup>148</sup> W. Mark Kimbrough, HCA's Vice President of Investor Relations in the US, described the US strategy in March 2013. Sourced from transcript of HCA Holdings' Management presentation at Barclays Global Healthcare Conference (available at <http://seekingalpha.com/article/1268121-hca-holdings-management-presents-at-barclays-global-healthcare-conference-transcript>, accessed 26 March 2013).

<sup>149</sup> Health Insurance & Protection, "Spire Healthcare announces acquisition of Lifescan Ltd", 30 August 2011, available at <http://www.hi-mag.com/health-insurance/product-area/pmi/article378662.ece> (accessed 26 March 2013).

## A. Product Market and Competitor Set

A.1 BHF considers that there are specialisms outside the CC's 16 common specialisms and Oncology that are important, particularly when considering Central London. Table 1 shows that, in 2011, the CC's 16 common specialisms accounted for [X] of BHF's hospital spend nationally and [X] of spend in Central London. Some specialisms outside of the CC current focus are very material – for example, BHF spent approximately [X] on [X], an amount significantly greater than spend for [X] of the CC's 16 common procedures.

**Table 1: Proportion of BHF hospital expenditure by specialisms, 2011**

	Specialisms	BHF national expenditure	BHF Central London expenditure	BHF expenditure at HCA in Central London
CC 16 specialisms	Trauma and orthopaedics	[X]	[X]	[X]
	General surgery	[X]	[X]	[X]
	Cardiology	[X]	[X]	[X]
	Obstetrics and gynaecology	[X]	[X]	[X]
	Urology	[X]	[X]	[X]
	Gastroenterology	[X]	[X]	[X]
	Clinical radiology	[X]	[X]	[X]
	Otolaryngology	[X]	[X]	[X]
	Ophthalmology	[X]	[X]	[X]
	General medicine	[X]	[X]	[X]
	Dermatology	[X]	[X]	[X]
	Plastic surgery	[X]	[X]	[X]
	Neurology	[X]	[X]	[X]
	Anaesthetics	[X]	[X]	[X]
	Rheumatology	[X]	[X]	[X]
	Oral and maxillofacial surgery	[X]	[X]	[X]
<b>CC 16 specialisms as a proportion of BHF's total expenditure</b>		[X]	[X]	[X]
	Oncology	[X]	[X]	[X]
<b>Oncology expenditure as a proportion of BHF's total expenditure</b>		[X]	[X]	[X]
Other specialisms	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
<b>CC 16 specialisms and other specialisms (excluding oncology) as a proportion of BHF's total expenditure</b>		[X]	[X]	[X]
	Total BHF hospital expenditure	[X]	[X]	[X]

Source: BHF claims data 2011, no decimal places shown.

Note: It is possible that BHF definition of a specialism varies slightly from the definitions applied in the CC analysis.

A.2 There is a similar picture when only inpatient hospital claims are assessed. As shown in Table 2, in 2011, the CC's 16 common specialisms accounted for [X] of BHF's inpatient hospital

spend nationally and [X] of Central London inpatient expenditure. For example, BHF spent approximately [X] on inpatient [X], an amount significantly greater than the amount spent for [X] of the CC's 16 common procedures.

**Table 2: Proportion of BHF inpatient expenditure under CC's 16 specialisms, 2011**

	Specialisms	BHF national expenditure	BHF Central London expenditure	BHF expenditure at HCA in Central London
CC 16 specialisms	Trauma and orthopaedics	[X]	[X]	[X]
	General surgery	[X]	[X]	[X]
	Cardiology	[X]	[X]	[X]
	Obstetrics and gynaecology	[X]	[X]	[X]
	Urology	[X]	[X]	[X]
	Gastroenterology	[X]	[X]	[X]
	Clinical radiology	[X]	[X]	[X]
	Otolaryngology	[X]	[X]	[X]
	Ophthalmology	[X]	[X]	[X]
	General medicine	[X]	[X]	[X]
	Dermatology	[X]	[X]	[X]
	Plastic surgery	[X]	[X]	[X]
	Neurology	[X]	[X]	[X]
	Anaesthetics	[X]	[X]	[X]
	Rheumatology	[X]	[X]	[X]
	Oral and maxillofacial surgery	[X]	[X]	[X]
	<b>CC 16 specialisms as a proportion of BHF's total inpatient expenditure</b>	[X]	[X]	[X]
	Oncology	[X]	[X]	[X]
	<b>Oncology expenditure as a proportion of BHF's total expenditure</b>	[X]	[X]	[X]
Other specialisms	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]
	<b>CC 16 specialisms and BHF specialisms (excluding oncology) as a proportion of BHF's total inpatient expenditure</b>	[X]	[X]	[X]
	Total BHF expenditure	[X]	[X]	[X]

Source: Bupa claims 2011, no decimal places shown.

Note: It is possible that BHF definition of a specialism varies slightly from the definitions applied in the CC analysis.

A.3 Table 3 below shows that across the [§<] NHS facilities to which BHF paid claims in 2011, the majority have extremely limited (or no) levels of activity in the specialisms covered by the CC. A white space in the table means that the hospital undertook more than £25,000 of activity on BHF members in 2011. A filled space means that the hospital undertook less than £25,000 for BHF in that specialism, a very low level of activity (although we accept this captures only the BHF portion of the private activity the facility may undertake). The large proportion of filled squares indicates that NHS facilities tend to be smaller players focussing on a subset of specialisms rather than a full suite.

**Table 3:** [§<]