



**Response to Competition Commission's  
Annotated Issues Statement**

12 April 2013

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## 1. INTRODUCTION

- 1.1 The Competition Commission ("CC") published its Annotated Issues Statement ("AIS") on 28 February 2013, reflecting its "current thinking" on the various issues in this investigation and identifying the areas on which it would be focusing its investigation. HCA responds as follows.
- 1.2 This response concentrates on a number of the theories of harm set out in the AIS.
- 1.3 There are, first, a number of general, overarching comments and observations which HCA makes concerning the CC's approach in this investigation and the issues set out in the AIS.
- 1.4 The CC has departed from its normal practice of publishing detailed working papers (other than in respect of profitability) on the various strands of its investigation, allowing the parties to review and comment on the evidence behind the CC's emerging thinking. The AIS, and the various appendices which set out a fuller description of the CC's analysis, provide (by comparison to working papers) more high level, generalised observations on the issues in this inquiry. The CC's practice of publishing working papers provides procedural fairness in allowing the parties to consider and assess the strength of the evidence on which the CC is proposing to rely. HCA does not consider that the CC has to date provided sufficient disclosure of the factual and economic evidence for its economic analysis, and HCA's ability to respond to the various theories of harm is correspondingly limited.
- 1.5 HCA has not as yet had access to the CC's data room which, the CC has indicated, will provide further data on which the CC is relying for its economic analysis. This means that HCA is only able to set out high level views on the CC's methodology, in particular in relation to the CC's analysis of concentration and pricing in London. It is unable to comment on the CC's views in particular on either market shares or pricing until it has had a chance to review the underlying data, and HCA reserves the right to supplement this submission once it has been granted access to the CC's data room.
- 1.6 The AIS in many cases makes very broad and superficial generalisations, without reference to the evidence relating to specific healthcare markets. The AIS advances general propositions, for example about the relative negotiating position of insurers and hospital operators, without reference to the position of individual operators in individual markets. This leads to a "one size fits all" approach, where high level conclusions based on the position of a hospital operator in one geographic market are applied to the sector as a whole. This is particularly the case for London, where the AIS appears to ignore much of the evidence which HCA and other hospital organisations have submitted concerning the competitiveness of the market and new entry and expansion.
- 1.7 There is also a high degree of inconsistency, and even contradiction, within the AIS in its approach to the various theories of harm. For example, PMI recognition is (rightly) recognised as a significant barrier to entry in Theory of Harm 5, but is ignored in the CC's assessment of PMI / hospital bargaining power in Theory of Harm 3. The CC acknowledges in relation to consultant incentives that competition for consultants in London is "intense", but in Theory of Harm 1 the CC cites concerns about competitiveness in London. Similarly, there is an apparent contradiction in the CC's views on barriers to entry, and its recognition in relation to "vertical effects" that hospital groups have been readily expanding into the provision of outpatient diagnostic centres in London. The AIS views the various theories of

harm in isolation, without regard to the "bigger picture" of the way in which the market functions.

- 1.8 Much of the analysis in the AIS is undermined by the CC's failure to carry out an assessment of the lack of competitiveness of the PMI sector. The CC's terms of reference for this market inquiry were expressed as follows: "*The OFT has reasonable grounds for suspecting that a feature or a combination of features of the market or markets for the supply or acquisition of PH prevents, restricts or distorts competition*"(emphasis added). The terms of reference cover both supply and demand-side issues. HCA and other hospital providers have submitted evidence about: the highly concentrated nature of PMI; the dominance of BUPA and its ability to dictate PMI strategy; the barriers to entry into PMI; the lack of new entrants and the absence of innovation in PMI products – and how these features can result in consumer detriment in the private healthcare market. There is, remarkably, no discussion in the AIS about the uncompetitiveness of the PMI market or about the market position of BUPA and AXA PPP and the barriers to entry in PMI which protect the main incumbents. To the extent that the AIS refers to PMI, this is narrowly confined to an assessment of the relative bargaining position of PMI and hospital operators. There is no analysis of competitive conditions in PMI as a whole or how the current structure of the market affects the availability and affordability of private healthcare to consumers. In HCA's view, any analysis of private healthcare would lack credibility if it failed to deal with demand-side issues which are integral to the way in which private healthcare is delivered to consumers.
- 1.9 HCA is also concerned that the CC has decided no longer to consider a theory of harm relating to PMI buying power. The AIS merely states "*We have not seen persuasive evidence that any buyer power insurers have over hospital operators is harmful*" but there is no explanation of the CC's decision, or the reasons why it has rejected the evidence put forward or any disclosure of its analysis (either in the AIS or in working papers) which third parties can comment on. This is a significant change in the CC's inquiry and if the CC has reached views on this issue, in the interests of transparency and fairness the CC should set out its analysis and invite affected parties to comment. In that regard, HCA notes that the CC has acknowledged that PMIs can credibly threaten to not recognise new facilities. HCA considers that, given this power of PMIs, there is a potential for harm to patients through under-provision (or lower quality provision) of private healthcare services. The CC should consider this in its analysis.

## 2. EXECUTIVE SUMMARY

### Section 3 – Market definition

#### *Demand side considerations*

- A demand side consideration of whether one treatment is an effective substitute for another should, at the very least, be assessed from the consultant's perspective, i.e. the extent to which consultants will consider the range of alternative treatment modalities that are appropriate in light of the patient's individual circumstances.
- The CC mistakenly dismisses the importance of outpatient and ambulatory facilities in constraining inpatient facilities. There is an important trend in the private healthcare market in which technological innovation and consumer preferences are driving hospital operators to expand the scope of care available on a day-case or outpatient basis.
- PMIs can and do influence the choice of consultant, the type of treatment and the facility in which the treatment is delivered.

#### *Supply-side considerations*

- HCA welcomes the CC's acknowledgment that private healthcare providers ("PH providers") are able to introduce new treatments within existing specialties. There is a constant stream of healthcare developments leading to new treatment modalities and improved patient outcomes.
- Given the importance of attracting consultants and the fixed cost nature of hospital operations, hospital operators have a strong incentive to expand their service line offerings.
- The CC overplays the difficulties and cost of introducing new specialties. The private healthcare market has witnessed hospital operators introducing new specialties and expanding the scope of care available in their facilities.
- HCA is encouraged by the CC's intention to take account of competitive constraints imposed by the NHS. This analysis will highlight: the considerable competitive constraint that applies for self-pay and insured patients, the ability of the NHS to leverage its relationship with its captive consultant base, the advantages yielded by its formidable clinical infrastructure and hospital capacity and the importance of major NHS teaching hospitals.
- The CC's methodology for generating the competitive set of 16 specialties offered by private hospitals is not robust and adequate reasoning for considering oncology separately is not provided.

#### *Geographic market*

- The CC's approach risks being inherently biased towards a narrower geographic market scope. For example, the CC relies solely on data for insured patients, but, as noted by the CC, insured patients generally travel shorter distances than self-pay patients. The exclusion of international patients (a major segment of HCA's business) also unduly narrows hospital catchment areas.

- The CC has not addressed the factors that apply in Greater London, for example, the evidence submitted by HCA indicates that Londoners are prepared to travel longer for healthcare services than individuals in other parts of the countries. HCA considers that travel time, rather than road distance, should be analysed.
- Based on HCA's analysis of its own patient database, the catchment areas for its hospitals extends to at least to the perimeter of the M25, with many patients travelling from beyond Greater London.

#### **Section 4 – Theory of harm 1: Market power of hospital operators in local markets**

- HCA outlines a number of concerns with the CC's local market power analysis and may expand on these concerns once it has obtained access to the CC's data room. In particular, with: the adoption of LOCI, in itself, as a tool for measuring local market power, the way in which the CC's LOCI analysis has been conducted (such as the material omission of data and flawed assumptions). In addition, HCA has significant doubts over the robustness of any inferences that can be drawn from the CC's local market power analysis, for example, the use of LOCI, as a proxy for local market power, to infer market power at an aggregate/national level.
- HCA takes issues with the adoption of an arbitrary LOCI threshold of 0.6 to determine which hospitals may have local market power. There is no legal or economic basis for a mechanistic threshold to assess market power. In that regard, the LOCI methodology used by the CC does not bypass the need to conduct a proper assessment of the breadth of constraints faced by PH providers.
- [X]
- HCA also identifies concerns with the CC's PCA analysis, in particular, with respect to the underlying data and the CC's methodology. This includes: concerns with the exclusion of competitors such as PPU's and NHS facilities; the existence of inconsistencies in the data set; the use of concentration measures based on insured patients for a self-pay PCA; and potential omitted variable bias. In addition, HCA casts doubt on the statistical significance and economic significance of the CC's econometric analysis in this section.

#### **Section 5 – Theory of harm 3: Market power of hospital operators in negotiations with insurers**

- The CC has failed to assess the outside options of both PH providers and PMIs in order to assess the relative bargaining strength that these outside options confer on each party. If the CC is basing its analysis on the premise that private healthcare market power affects a PMI's outside option, the same consideration must also apply when considering the PH provider's outside option.
- The CC rightly notes that PMIs may be in a stronger negotiating position where a PH provider asks a PMI to recognise a new facility that was not previously included on its hospital network, however, the same reasoning also applies with respect to existing facilities.
- The CC identified PMI recognition as a potential significant barrier. It therefore follows that PMIs are in a powerful position to dictate entry and expansion in the private healthcare market and can leverage this position to encourage growth and sponsor entry in the market.

- Given the weaknesses identified with other parts of the CC's analysis, for example the analysis undertaken in relation to Theory of Harm 1, HCA is concerned by the extent to which the CC has relied on results from other areas of its analysis as a premise for its findings on bargaining power.
- Overall, the CC's high level conclusions concerning bargaining power appear to disregard much of the detailed evidence which HCA has already submitted about the strategies adopted by the PMIs in contractual negotiations with HCA, and the specific evidence relating to the PMI's outside options in London. A proper consideration of these factors will reveal that the PMIs in fact hold the most bargaining power. Indeed, the outcomes of HCA's network negotiations with PMIs demonstrate that the PMI's ability to exclude HCA hospitals from their core networks or to only recognise specific services is not only credible, but has in fact been executed on a number of occasions.

#### **Section 6 – Theory of Harm 4: Buyer power of insurers in respect of individual consultants**

- There is significant evidence that the erosion in PMI reimbursement rates, combined with increases in the cost of practice (including significant rises in indemnity costs), is disincentivising consultants from entering private practice.
- The CC is wrong to suggest that PMI managed care strategies are not creating "competition problems" in healthcare markets. The letters submitted by consultants on the CC's website provide numerous specific instances of patient harm and are highly representative of the views of the consultant community.
- The delisting of consultants and re-direction of patients has a direct impact on competition and patient choice.
- Furthermore, as many of the consultant letters attest to, there are significant concerns about the impact of PMI initiatives on the quality of clinical care. Quality and innovation are important factors on which healthcare providers compete and therefore these are issues which are directly relevant to the CC's inquiry.

#### **Section 7 – Theory of Harm 5: Barriers to entry**

- There is in fact strong evidence of new entry and expansion, particularly in London, which the AIS does not properly take into account. New development activity in London has been robust.
- The record of new entry/expansion in London includes: BMI's recent entry involving the development of two Central London hospitals; current new build projects, including the London International Cancer, Heart and Brain Hospital; many examples of expansion of existing facilities, including the London Clinic's new £80 million cancer wing and BUPA Cromwell's £30 million investment programme; and a plethora of new, state-of-the-art outpatient facilities right across London.
- There are also significant further development opportunities which will come on stream in future which will be keenly competed for by healthcare providers.
- The special characteristics of London as a leading centre for tertiary care, and the growth opportunities in this sector, are encouraging significant new investment on the part of healthcare providers.

- The AIS also surprisingly fails to make any mention of PPU entry and expansion following the lifting of the PPU income "cap".
- PMI recognition is the principal barrier to entry in this market and HCA fully supports the CC's finding that the conduct of the larger PMIs impedes entry and expansion.
- The AIS provides no concrete evidence that consultant incentives are creating any foreclosure effects in the market. The consultant survey indicates that they affect an insignificant proportion of consultants in private practice. There is no evidence that they have any "tying" effects and are limiting consultant switching between facilities. Indeed, consultant incentives may have a pro-competitive effect by allowing for new business models enabling providers such as Circle to enter the market.
- The AIS also provides no evidence that volume-related discounts or rebates in PMI/hospital contracts are having foreclosure effects. As far as London is concerned, there is no evidence that new entry and expansion has been hampered by contractual arrangements.
- HCA agrees that there is ease of switching by consultants from one hospital to another and this has been demonstrated by the history of consultant moves between London hospitals.

#### **Section 8 – Theory of Harm 7: Vertical effects**

- HCA strongly rejects the proposition that the ownership of either primary care or outpatient facilities distorts referrals patterns.

##### *GPs*

- HCA owns three GP practices: Roodlane, Blossoms and GMC.
- The referral data indicates that in fact there has been no material change in referral pathways since HCA acquired these practices.
- The GPs concerned are not subject to any referral obligations or incentives.
- In any event, there is no potential for these acquisitions to give rise to foreclosure effects:
  - Only a small proportion of GP appointments results in a referral into secondary care
  - These three GP practices account for [3%] out of the 9,000 NHS and private GPs which make referrals to HCA hospitals
  - The private primary care market is extremely competitive and there are numerous other providers in London, including BUPA, AXA PPP, Nuffield, BMI and a range of other commercial providers.
- HCA's involvement in these three GP practices and the synergies arising with its hospitals business are delivering clinical benefits to patients.

##### *Outpatient facilities*



- Outpatient facilities form part of the core offering of any hospital and there is a long-term trend from inpatient to outpatient care which hospitals need to cater for through investment in new outpatient facilities.
- Only a small proportion of outpatient consultations results in a referral to an inpatient facility and therefore the investment in new outpatient clinics is a response to market growth in outpatient care.
- The allegation that HCA is establishing outer London "satellite" outpatient clinics which are capturing inpatient referrals for its Central London hospitals is groundless [§<].
- The provision of outpatient care in London is very broad-based and fragmented. There are low barriers to entry, as demonstrated by the strong record of new entry and expansion right across London.

### 3. MARKET DEFINITION

- 3.1 In the AIS the CC has set out the approach it has taken to: identify the relevant market or markets for the goods and service concerned; and to assess competition in the market and whether any features of the market create an adverse effect on competition.
- 3.2 The CC has noted a number of issues that it considers relevant when considering the relevant product market(s). These include: the varying complexity and differentiation of treatments; the limited ability of patients to switch between treatments; the possibility of supply-side substitution of private hospitals and consultants; the extent to which treatments (or specialities) can be aggregated in to clusters for the purposes of defining the market; and the competitive constraint the PPU's and the NHS place on PH providers.<sup>1</sup>
- 3.3 Based on its analysis of the product market, the CC suggests that asymmetric constraints appear to exist among the different providers and in particular whilst general hospitals providing inpatient care may constrain day- and outpatient clinics the reverse constraint may not apply.<sup>2</sup> On the basis that the CC considers that the supply of inpatient care appears to be the most concentrated and financially significant, it has focused analysis in this area and identified 215 general private hospitals and PPU's providing inpatient care across the UK.<sup>3</sup> With regard to medical specialty the CC has identified 16 specialties and considered these together. Oncology has also been singled out for further analysis given the significant share of patient admissions and revenues it accounts for.
- 3.4 On the relevant geographic market(s), the CC has suggested the following:
- Local (willingness and ability to travel for treatment) and non-local (negotiations between PMIs and PHs taking place at a group level) factors are likely to be relevant for the geographic market.
  - Patient's willingness to travel may differ across treatment types.
  - Competition may take place between hospital chains as well as between individual hospitals.<sup>4</sup>

#### Product markets

- 3.5 HCA has reviewed the CC's product market analysis and findings as summarised in the AIS and set out in more detail in Appendix A. In defining the boundaries of the relevant product market, the CC has assessed how the competitive constraints vary across different types of care (i.e. inpatient, day patient and outpatient care) and medical specialties. As part of the product market definition, the CC took into account both demand- and supply-side substitution across medical treatments and specialties.

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<sup>1</sup> CC, AIS, para. 29 (a)

<sup>2</sup> CC, AIS, para. 32

<sup>3</sup> HCA notes that these are all the private general hospitals with inpatient care owned by BMI, HCA, Nuffield, Ramsay and Spire; 19 of the largest other private general hospitals with inpatient care (including Aspen and Circle); all general PPU's with inpatient care managed by BMI, HCA, Ramsay and East Kent Medical Services; and the 40 largest general PPU's with inpatient care by revenue across the UK.

<sup>4</sup> CC, AIS, para. 30

- 3.6 On the demand-side, the CC has found very limited evidence of patients switching between treatments<sup>5</sup> as, in its view, patients cannot typically substitute one treatment for another.<sup>6</sup> Equally, it has found constraints on the supply-side based on consultants' specialties. The CC states that consultants are typically qualified to practice in a single specialty and, therefore, cannot easily obtain the required qualifications and skills to provide treatments across specialties.<sup>7</sup>
- 3.7 With respect to different types of care, the CC identified asymmetric constraints, meaning that general hospitals providing inpatient care may constrain day- and outpatient facilities, but the reverse constraint may not apply. The CC, therefore, concluded that inpatient, day-patient and outpatient care appear to constitute separate product markets.<sup>8</sup> However, in conducting its analysis of the competitive constraints the CC largely focused on the provision of inpatient care. The CC explains that the rationale for this is that the supply of inpatient care appears to be both the most concentrated and financially significant.<sup>9</sup> Day- and outpatient care were considered by the CC to a lesser extent.
- 3.8 Using the approach outlined above, the CC identified 215 general private hospitals and PPU's providing inpatient care in the UK.<sup>10</sup> On the basis of the supply-side substitutability, the CC aggregated 16 specialties offered by 80% or more of the aforementioned facilities.<sup>11,12</sup> The CC also singled out oncology for further analysis on the grounds that although it is a specialty offered by a lower number of general private hospitals and PPU's, it nevertheless represents a significant share of both patient admissions and revenue.<sup>13, 14</sup>

#### ***HCA's review and critique of the relevant product market defined by the CC***

- 3.9 In this section HCA sets out its review and critique of the relevant product market defined by the CC. HCA begins by looking at factors affecting the degree of substitution on the demand-side before considering a number of supply-side factors to assess the substitutability between: (i) in-, day- and outpatient treatments; and (ii) treatments, within and across specialties.

#### ***Demand-side substitution***

- 3.10 In relation to the assessment of demand-side substitution, the CC itself stressed that, in certain cases, patients may be able to switch between alternative approaches for a particular treatment. The CC provided the example of patients substituting surgery with physiotherapy.<sup>15</sup> The CC is at risk of over-simplifying its analysis of demand-side substitution. For example, there is no consideration of the role of consultants in determining the most appropriate treatments for patients. Treatments are determined based on clinical need in the patient's best interests and achieving the best clinical outcome. By way of example, the consultant multi-disciplinary team (MDT) that oversees patient admissions into

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<sup>5</sup> HCA notes that the CC has not defined what it means by 'treatments' and how narrowly those are defined.

<sup>6</sup> CC, AIS, para. 29 (b).

<sup>7</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 14.

<sup>8</sup> CC, AIS, para. 32 (a).

<sup>9</sup> CC, AIS, para. 32 (b).

<sup>10</sup> CC, AIS, para. 32 (c).

<sup>11</sup> CC, AIS, para. 33 (a).

<sup>12</sup> In the AIS, the CC stressed that it may want to look at other specialities. See CC, AIS, para. 33.

<sup>13</sup> CC, AIS, para. 33 (b).

<sup>14</sup> CC, AIS, para. 55.

<sup>15</sup> CC, AIS, para. 29 (b).

its Cyberknife unit at the Harley Street Clinic first assesses whether alternative treatment modalities may be more appropriate for a patient in light of various factors, such as disease type and progression.

- 3.11 Treatments can be differentiated on both horizontal and vertical lines. Treatments can be horizontally differentiated because different treatment options may be more or less suitable for a given patient. For example, in the case of knee replacement surgery, different types of prosthetic (e.g. cemented or uncemented) may be more appropriate depending on the patient's characteristics and specific lifestyle needs. Vertical differentiation arises when two or more treatments are relevant for the same condition or diagnosis but are of varying quality, for example, standard radiotherapy fractionation and Cyberknife may both represent potential treatment options for a form of cancer, but Cyberknife may be the clinically most effective treatment option.
- 3.12 Each broad specialty will include a large number of individual treatments and procedures. Some of these may be relatively standard core treatments and it is likely that most PH providers offering services within that specialty will provide at least these core treatments (or slight variants). However, there are also likely to be innovative or new ways to treat certain conditions which could be made available to a patient to improve clinical outcomes. Some of these individual specialised treatments may be substitutes for others as they offer an alternative approach to treat a particular condition. For example, the da Vinci robotic surgery system represents a substitute to conventional laparoscopy, but offers enhanced visualization, precision and ergonomics for the surgeon.
- 3.13 With regard to the degree of demand-side substitution between in-, day-, and outpatient treatment, the CC states that use is driven by the clinical and safety requirements of each treatment.<sup>16</sup> However, it is important to note that the healthcare market is constantly evolving. As HCA explained in its Response to the CC's Issues Statement<sup>17</sup>, certain procedures which previously required inpatient care can now be performed as day- or outpatient care, and without necessarily having inpatient care available at the same facility as a backup. An increasing number of patients are able to, and prefer to get treated and discharged within the same day, rather than needing to stay at the hospital for a longer period of time. HCA recognises that patients place a high value on having the option to be treated on an outpatient or day case basis rather than be admitted as an inpatient. For this reason, HCA has actively sought to expand the settings in which patient care can be delivered. This is key part of the explanation behind the growth in outpatient facilities and the treatment of more patients in ambulatory care settings. Within HCA, outpatient activity now accounts for [x%] of total revenue and over [x%] of surgical procedures. PMIs themselves are actively engaged in the delivery of care outside of hospital settings, for example BUPA's Home Healthcare service, which is intended to be a substitute for hospital-based care. The CC's focus on inpatient care to the exclusion of outpatient care is therefore misconceived.
- 3.14 Moreover, HCA considers that the treatment received by patients does not constitute a single service provided at a single point in time. Rather, the treatment is composed of a set of services, each of which is provided at a different stage of the patient's pathway. More specifically, the treatment provided to patients within the private healthcare system can be broken down into three stages: (1) consultations; (2) specific diagnostic tests (e.g. blood test, radiography); (3) surgical procedures, which can be sub-divided into inpatient and day-

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<sup>16</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 10.

<sup>17</sup> HCA, Response to CC's Issues Statement, para. 4.9.

patient care. For some inpatient and day-patient care treatments, outpatient care (e.g. diagnostic tests, follow-up) may also be required for patients. That outpatient care may be provided in a separate facility to where any subsequent inpatient treatment is conducted.

- 3.15 HCA comments on the lack of a clear demarcation between in-, day- and outpatient services in more detail in relation to supply-side substitution.
- 3.16 The CC contends that PMI providers may be able to influence the choice of PH provider or level of reimbursement, but cannot determine the choice of treatment to a large extent. According to the CC, insurers may only have an impact on the choice of treatment received by patients when there is some scope for substitution between treatments that address the same clinical need.<sup>18</sup>
- 3.17 HCA, however, considers that PMI providers do have the ability to influence the choice of treatment and are interfering with clinical practices to a much greater extent than previously. Moreover, the PMIs have positioned these directional influences as a form objective "patient advocacy", whereas in reality the motivation is cost avoidance – a prime example being the use of cash incentives to encourage patients to use the NHS instead of PH provider hospitals.
- 3.18 As already pointed out by HCA in its response to the CC's Issues Statement, PMI providers dictate the terms on which insured patients may access private healthcare. BUPA's Open Referral policy can be seen as an example of how the incumbent PMI provider (and potentially other PMI providers) is trying to control the patient pathway by choosing where he/she will be treated and by whom.<sup>19</sup> BUPA has also introduced a form of the Milliman Care Guidelines, which specify whether a patient should be hospitalised, predict their daily progress, and determine how long a patient with a particular condition should stay in hospital.<sup>20</sup> PMIs are also able to determine which treatments are covered by their policies and so available to insured patients. For example, in some instances PMIs have failed to recognise new treatments. These initiatives clearly show how PMI providers are increasing their ability to impact on the choice of treatment received by insured patients.

#### *Supply-side substitution*

- 3.19 In assessing the degree of supply-side substitutability between treatments, within and across specialties, the CC found that private hospitals may be able to change the treatments they supply if they provide a range of different treatments, and may be able to change how they operate.<sup>21</sup> The CC also stressed that private hospitals may have the ability and incentive to introduce new treatments as long as they have some spare capacity (measured as utilisation of operating theatres and overnight bed capacity). In this respect, the CC itself recognised that most private hospitals maintain some spare capacity in order to respond to unexpected demand shocks.<sup>22</sup>
- 3.20 HCA welcomes the fact that the CC has recognised the ability of PH providers to introduce new treatments within specialities. PH providers compete through investments to provide new treatment options and technologies in order to improve patient outcomes. The investment required to develop a new treatment can, in some instances, be substantial, for

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<sup>18</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 11.

<sup>19</sup> HCA, Response to the CC's Issues Statement, paras. 6.98-6.102.

<sup>20</sup> HCA, Response to the CC's Issues Statement, paras. 6.76.

<sup>21</sup> CC, AIS, para. 29 (c).

<sup>22</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 18.

example due to the costs of new equipment, facilities and investment in staff training. In addition, these investments will be risky since at the outset as it will not be clear whether the treatment will be widely adopted or recognised by the PMIs.

- 3.21 However, once a new innovative treatment has been introduced and developed by a given PH provider, the costs involved in another PH provider also including that treatment in its broader product offering will be substantially lower than the costs associated with the original investment. The costs involved in innovating and developing the treatment will not be required since they are incurred by the original investor. The financial risks are likely to be lower as the treatment is already in use and recognised by PMIs. In addition, knowledge relating to best clinical practice and governance tends to diffuse across the private healthcare sector as there is often collaboration between consultant groups when adopting new treatment technologies (for example, training sessions were held at HCA's Cyberknife unit for consultants who have based their practice with other hospital organisations), therefore later adopters would benefit from this.
- 3.22 Furthermore, an existing provider of a specialty is likely to have the necessary facilities in place and the staff with appropriate skills<sup>23</sup> to begin providing new treatment options within that specialty. Importantly, an existing PH provider of a specialty may already have agreements with PMIs relating to that specialty and may already have attracted consultants in that specialty to their practice. As a result, beginning to offer a new treatment within the same specialty as already offered by a PH provider is likely to involve relatively low costs, although there may still be some risk involved related to securing PMI recognition.
- 3.23 The development of CyberKnife facilities in the UK provides a good example of the speed and ease with which PH providers can offer a further specialist treatment options, once the investment has already been made by one PH provider. Following the launch of HCA's CyberKnife Centre in early 2009 (the UK's first CyberKnife treatment facility), the London Clinic opened its own CyberKnife treatment clinic later in 2009. Following this, three further CyberKnife facilities were built at the Royal Marsden, Mount Vernon and St Bartholomew's Hospital.
- 3.24 The ability of other providers to offer further specialist treatment options within a short timeframe and at a relatively low cost acts as an important competitive constraint on PH providers.
- 3.25 In terms of the ability of PH providers to introduce treatments in new specialities, the CC appears to conclude that supply-side substitution on this basis may be limited, depending on the availability of consultants and of in-patient and day-patient facilities and staff. Whilst the costs to a PH provider of expanding beyond its existing specialty are likely to be greater than the cost of expanding treatments within a specialty already provided, HCA considers that it would be relatively easy and financially affordable for a facility already offering in-patient care to offer treatments in a new specialty, as:
- (i) it could attract new consultants for that specialty to practice at its facility, given that consultant switching costs are low; and
  - (ii) for PH providers, such a switch would represent a one-off cost in specialised infrastructure.

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<sup>23</sup> Notwithstanding any additional training that may be required.

- 3.26 Several facilities, such as London Independent Hospital, have undertaken these kinds of investments and now are able to compete with HCA for specialties that they had not provided previously. Additionally, in response to the CC's Market Questionnaire (Question 9), HCA has provided a number of examples, including costs and time involved, of where it has switched capacity into the provision of new medical treatments both within and outside of specialties it already provided. The costs and timescales of these vary depending on the specifics of the new treatment being provided. For example, HCA has developed new clinical areas at a number of its facilities in order to deliver new services with the costs ranging from around [£<] for the CCU at London Bridge Hospital to [£<] for the new critical care facilities at the Harley Street Clinic. The costs of introducing new equipment, however, in a number of cases are considerable lower, for example [£<] for the 1.5T MRI scanner introduced at the London Bridge Hospital in 2009. There are many such examples of investment in new clinical services and equipment in London, which demonstrates the ease of supply-side substitution.
- 3.27 The relative proportion of indirect and direct costs in the provision of private healthcare services also provides some evidence in relation to the ease of expanding into new services. Indirect or common costs are incurred regardless of the specialties and treatments offered (i.e. fixed or semi-fixed costs that are non-specific to an individual treatment, such as building costs and central administrative staff). To the extent that there is any spare capacity at a private healthcare facility, PH providers will have an incentive to increase the services they offer up to the point at which further indirect costs would need to be incurred. A sizeable proportion of costs at a PH provider's facilities are likely to be common across specialties (for example, the costs of an operating theatre that can be used for many types of surgery). This provides an incentive for PH providers to increase the services they offer, for example by expanding into new specialties, in order to fill capacity and increase the ability to recoup its sizeable common costs.
- 3.28 The CC considers that in the provision of consultant services, each specialty can be considered a separate product market. Whilst HCA agrees with the CC that consultants cannot easily switch between specialties, PH providers are readily able to attract new consultants in different specialties in order to expand or switch the scope of their services. It does not consider that there are significant, if any, constraints on the availability of consultants (in London there is a large pool of over 7,500 consultants with NHS posts) and that PH providers, to the extent that they do not currently have facilities or staff in place to expand the scope of services, would be able to do so within a feasible timeframe and for an acceptable investment cost. HCA notes that the OFT in a recent hospital merger case examining the provision of neurology services in London noted that two years would constitute a "timely period".<sup>24</sup> HCA believes that most hospital operators would have the ability to introduce a given specialty within this timeframe.

*Assessment of the competitive set: supply-side factors*

- 3.29 In assessing the supply-side competitive set, the CC has considered the extent to which firms compete to supply different products and the conditions of competition between firms for each product. It has reviewed the set of specialties offered by private hospitals and PPU's and noted that more than 80% cover a set of 16 specialties<sup>25</sup> that represent a large

<sup>24</sup> *Acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services*, 21 February 2013, ME/5574-12.

<sup>25</sup> The 16 specialties identified by the CC are: Obstetrics and gynaecology, General surgery, Trauma and orthopaedics, Anaesthetics, Urology, Gastroenterology, Ophthalmology, Otolaryngology,

proportion of patient admissions/revenues. The CC then goes on to use these specialities and set of competitors in its analysis of local concentration.

- 3.30 HCA has concerns with the approach the CC has adopted, particularly as the rationale for adopting the 80% threshold employed to select the 16 specialities that lie in the same product relevant market is not clear. This threshold, in fact, seems to be arbitrary and it may become problematic when it comes to define catchment areas and compute LOCI. Indeed, the analysis the CC has used to show the relevance of these specialities in terms of revenues and patient admissions is inconsistent given that the patient admission proportions are for in- and day-patient care and the total revenue proportions are for in, day-, and outpatient care.<sup>26</sup> This is despite the CC stressing that it has decided to focus primarily on inpatient care.
- 3.31 Whilst the CC has highlighted a number of other non-negligible (in terms of admissions and revenues) specialities that are provided by fewer than 80% of general private hospitals and PPU's, HCA considers that the CC has not provided adequate explanation as to why oncology is being analysed separately from the other 16 specialities as part of the local market concentration analysis.

#### *The role of the NHS*

- 3.32 HCA is encouraged that the CC has indicated that it, "*will take into account the competitive constraints that the NHS may impose on providers of privately-funded healthcare, as appropriate, in the detailed competitive assessment*".<sup>27</sup>
- 3.33 As already stressed by HCA in its Response to the CC's Issues Statement, the NHS acts as a powerful constraint on PH providers. This constraint impacts on both the demand and supply-side.
- 3.34 On the demand-side, the NHS acts as a competitive constraint given that it provides an alternative, free at the point of use, service for patients. This constraint is particularly relevant when considering self-pay patients. A patient journey through the private healthcare system usually begins with a visit to a GP who, where necessary, refers the patient to a consultant practicing within a particular specialty. In most cases that consultant practises in both NHS and private facilities and broadly the same medical services are available in both types of facilities. At this point the patient will decide whether to be treated through the NHS or a private healthcare facility with the decision generally made on the grounds of factors such as waiting times, price, quality of service and innovation. It should also be noted that a patient may also be able to be treated through the NHS at a PH provider through the Any Qualified Provider scheme.
- 3.35 For self-pay patients the price constraint may be particularly important as the price of private healthcare services compared to the free services available on the NHS will be weighted against quality differences between treatments. The high quality of NHS services means that it competes strongly with the private hospitals. This is especially so in London. Its teaching hospitals (Guy's and St. Thomas', St. Bartholomew's, King's College, UCH, Royal Marsden etc.) boast a strong global reputation in developing the latest advanced technology. As shown in the CC's patient survey results 68% of self-pay respondents stated that the NHS

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Dermatology, Plastic surgery, Cardiology, General medicine, Neurology, Oral and maxillofacial surgery, Rheumatology, and Clinical radiology.

<sup>26</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 27-28.

<sup>27</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 37



was an alternative for them<sup>28</sup> In addition, HCA understands that there has been reported growth in self-pay patients by the top five providers over 2010-12 that may be linked to the NHS' access restriction to so-called 'procedures of limited clinical effectiveness'.

- 3.36 The NHS has managed to leverage its close ties with consultants to bolster its own private healthcare offering. For example, through its roll-out of a new consultant contract, it has managed to increasingly tie consultants to the NHS Trust, to the exclusion of private hospital operators. A recent report was explicit about this objective,<sup>29</sup> noting that the 2003 consultant contract "...was designed to provide... increased consultant commitment to the NHS, for example, by preventing an increase in private practice work;"<sup>30</sup> These measures appear to have been successful too. In the report, it highlighted that lower numbers of consultants are going into private practice.
- 3.37 The NHS also has a strong infrastructure in London, boasting 15 times the bed capacity of the private sector. Additionally, the NHS serves as a particularly strong competitor in relation to innovation and technological advancements. It can often roll out new investments with a lower demand risk (given their access to the wide pool of NHS patients) than that faced by PH providers. These innovation and quality constraints apply equally for both self-pay and insured patients.
- 3.38 As highlighted in HCA's response to the CC's Market Questionnaire (Question 13) for certain specialities the NHS provides a particularly strong constraint and HCA views it as a formidable competitor for tertiary care services including cancer and cardiac amongst others. Whilst many patients (both self-pay and insured) will consider a private healthcare facility appropriate for some types of 'commodity' treatments, the NHS would be the preferred choice for complicated tertiary care. The results of Boston Consulting Group's Opinion Health Online Survey<sup>31</sup> showed that of the patients with PMI in London and Greater London 31 per cent had used the NHS for treatments within the last 3 years. The results of the CC commissioned survey also show that 28% of respondents (private patients) considered having their treatment done the NHS and that self-pay patients were more likely to have considered NHS treatment<sup>32</sup>.
- 3.39 Additionally, actions taken by PMIs to encourage, or require, policyholders to opt for the NHS rather than a PH provider affect the competitive dynamics of the private healthcare market and increase the role the NHS plays as a competitor. HCA highlights two schemes offered by PMIs: (i) the "six-week rule" policy whereby a PMI customer is only be allowed to have insured private treatment if the treatment is not available on the NHS within six weeks; (ii) cash-back incentive: whereby a PMI customer receives a cash payment if they choose to be treated by the NHS. These payments may be geared up to a much higher level for cardiology and cancer patients, thereby pushing the burden of such cases back onto the NHS. Additionally, a patient may choose to go to the NHS for treatment rather than a PH provider either to get the insurers' no-claim bonuses or to avoid paying any top-up fees.

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<sup>28</sup> GfK Survey of Patients, Private Healthcare Market Investigation, November/December 2012, slide 16.

<sup>29</sup> The National Audit Office's report "*Managing NHS Hospital Consultants*", 6 February 2013,

<sup>30</sup> National Audit Office, *Managing NHS Consultants*, para 1.6.

<sup>31</sup> The Boston Consulting Group, *Opinion Health Online Survey*, July 2008.

<sup>32</sup> GfK Survey of Patients, Private Healthcare Market Investigation, November/December 2012, slide 21.

- 3.40 More broadly, the NHS provides a constraint on the healthcare provision to PMI patients via the decision of an individual to be covered by health insurance or not. The better the quality of healthcare provided by the NHS, the lower the incentive for an individual to seek health insurance coverage (whether personally or through the individual's employer).
- 3.41 HCA considers the role of the NHS must also be considered when assessing the competitive constraints in relation to the provision of critical care. The CC has indicated that it will consider the higher acuity care (based on intensive care availability) provided by hospitals in London, particularly in Central London.<sup>33</sup> Whilst it is correct that all six HCA general hospitals provide intensive care at critical care level 3, as HCA has explained to the CC both in response to the Market Questionnaire (sections 2 and 10) and the Critical Care Questionnaire (section 3), over the last 6 years HCA has invested heavily in reconfiguring and expanding its hospital space to install and upgrade critical care facilities across all of its hospital space. This investment has enabled HCA to compete more effectively with NHS hospitals. The CC also notes that BMI, Spire and Nuffield also have hospitals providing critical care level 3 at a number of their hospitals. Their strategies align with HCA's strategy to focus on higher acuity services (which, by nature, may be more likely to require critical care facilities) and demonstrate the active competition between providers, both for patients and leading consultants, resulting in patient benefits in terms of enhanced quality of care.
- 3.42 However, in its assessment of the competitive set for intensive care services, the CC at this stage has failed to take account of the role of the NHS in providing critical care facilities. The NHS provides critical care facilities that private patients from both PPU and private hospitals can be transferred to if needed. The latest available data from the Department of Health (January 2011)<sup>34</sup>, shows that in the NHS there are 843 critical care beds in hospitals within the London Strategic Health Authority, of which 485 are at level 3 and 358 at level 2 (L2). The majority of these beds are general critical care beds (i.e. not specialty specific) although there are some dedicated units for example cardiothoracic and neurological units.
- 3.43 Tertiary treatments that may require level 2 or level 3 critical care are also carried out in hospitals that do not have such critical care services, with procedures in place to transfer patients to the NHS. Although HCA has taken measures to minimise the incidence of transfers out of the hospital into the NHS by ensuring that HCA hospitals are in a position to offer the full range of critical care needs that may arise in the patient pathway, other private hospital operators rely on transferring patients to the NHS in the event that a higher level of critical care is required.
- 3.44 HCA notes that the CC has also indicated that it is considering whether clusters of the product market, for example a higher acuity cluster (possibly based on ICU facilities) may be appropriate.<sup>35</sup> As HCA has explained to the CC in response to the Critical Care questionnaire, there are a number of complexities in terms of both defining tertiary care and determining the treatments that may specifically require critical care facilities. The potential requirement for level 2 or level 3 critical care is not specialty- or procedure-specific but is based on clinical judgement in relation to the complexity of the treatment and impact on the patient, and individual patient factors. It is not possible to define a product market based on a

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<sup>33</sup> CC, AIS, para. 34

<sup>34</sup> Department of Health, 'NHS Organisations in England, January 2011', Open and staffed adult critical care beds at 17 January 2010, by location and level of care. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Beds/DH\\_077451](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Beds/DH_077451)

<sup>35</sup> CC, AIS, para. 34

definitive set of treatments that require critical care support at either level 2 or 3. While there may be a set of treatments that are more likely to require critical care services, there is not a definitive list and furthermore, hospital PH provider's ability to undertake treatments is not restricted by a requirement to have their own critical care facilities (due to the ability to transfer out to the NHS).

- 3.45 In London there are a number of alternative PH providers who have intensive care facilities at critical care levels 2 and 3 within their facilities. There are also NHS hospitals of the highest quality with critical care facilities that other PH providers can use. This shows that there are considerable alternatives to both PMIs and self-pay patients. Many of HCA's competitors have invested in these facilities in recent years and in view of the growth opportunities in tertiary care it is likely that more providers will invest in critical care facilities in future.

#### *Geographic markets*

- 3.46 In its AIS, the CC set out its current approach to geographic market definition. Appendix B (including Annexes 1 and 2) provides a description of the methodology followed by the CC to measure local market concentration. In order to define the boundaries of the geographic relevant market and to assess the provision of private healthcare services in local markets, the CC carried out a catchment area analysis (coupled with a fascia count). The CC also computed the Logit Competition Index ("LOCI").
- 3.47 In identifying the relevant geographic market, the CC has based its analysis on inpatients only and considered the cluster of 16 specialties identified through its analysis of the relevant product market, plus oncology (separately in the case of the catchment area analysis, jointly with the other 16 specialties in the case of LOCI).<sup>36</sup> The CC has indicated that it considers it appropriate to focus its competitive analysis at a local and, possibly, at a hospital-group level.
- 3.48 The catchment area analysis carried out by the CC identified the geographic area, expressed as a distance in miles, within which each private hospital attracts the majority (the 80<sup>th</sup> percentile) of insured inpatients. The CC found that most of the hospitals analysed have a catchment area between 10 and 25 miles.
- 3.49 The CC has indicated that the hospital catchment areas and weighted market shares for all geographic sub-markets both may be viewed as a proxy for local geographic markets.<sup>37</sup> HCA is unclear as to how the CC interprets LOCI as a proxy for the geographic market. Rather HCA understands that the CC uses it as a measure of local market power. We discuss the use of LOCI in detail in Section 4 below.

#### *HCA's review and critique of the CC's approach to geographic market definition*

- 3.50 HCA has reviewed the analysis and findings of the CC in relation to the geographic market, specifically the catchment areas and sets out its comments in relation to the CC's geographic market definition in this section. However, as HCA has not yet been granted access to the CC's data, its comments are necessarily high-level at this stage.

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<sup>36</sup> CC, AIS, para. 38.

<sup>37</sup> CC, AIS, para. 36.

### *Catchment area analysis*

- 3.51 As HCA highlighted to the CC in its response to the Market Questionnaire (Section 2, Questions 10 and 11), catchment areas can significantly underestimate the size of geographic market. This, HCA believes, is particularly likely in the case of PH providers where providers face significant fixed costs making marginal consumers particularly important.
- 3.52 Indeed, as the CC itself noted in the Grocery Inquiry: "*[c]atchment areas show how far consumers are likely to travel to reach a store, but should not be read as directly corresponding to the size of geographic markets. Catchment areas can be wider or narrower than the relevant geographic market, which is defined by the location of competitor stores, not the location of customers*".<sup>38</sup>
- 3.53 Furthermore, HCA notes that the CC has only considered insured patients. As the CC itself stressed, insured patients generally travel shorter distances than self-pay patients.<sup>39</sup> As a result, HCA considers that the analysis carried out by the CC may underestimate the actual size of the catchment areas. Furthermore, by excluding international patients, it is clear that the CC will underestimate the catchment areas around facilities. This is particularly relevant for HCA given that it derives a sizeable proportion of patient admissions and revenues from international patients. HCA directly competes with leading hospitals around the world (such as facilities in the US, Germany and Singapore) suggesting that the boundaries of the geographic relevant market are much broader than those defined by the CC. These hospitals impose significant competitive pressure to HCA in terms of its incentives to invest and provide high quality care.
- 3.54 HCA also has concerns with the metric the CC has used for defining catchment areas. The CC defines the catchment areas based on the road-distance of insured patient journeys. In describing the methodology followed to determine the catchment areas, the CC stressed that road-distance accounts for the differences in local road networks, and it is more conservative and less subjective than drive-time. HCA, on the contrary, believes that catchment areas should be defined on the basis of travel time (accounting for both drive-time and public transport time). This is because travel distances in high-density urban and residential areas, such as London, are often highly dependent on how a patient travels to a hospital. A measure based on road distance will not be suitable to capture the behaviour of those patients using the rail networks (underground, over-ground and mainline services) to access HCA's facilities and those of HCA's competitors in and around London. These patients bypass the road system and hence measures of road distance are irrelevant to them.
- 3.55 As HCA set out in detail in its response to the Market Questionnaire, there is a higher propensity to use public transport in and around London which is relevant when determining the scope of the geographic markets surrounding facilities in London. Also, evidence from the National Transport Survey shows that Londoners are prepared to travel longer for healthcare services than individuals in other parts of the countries. This indicates that the geographic markets around facilities in London may be wider than in the rest of the UK.
- 3.56 Whilst the CC acknowledges that catchment areas may be sensitive to the chosen measure of distance<sup>40</sup>, the CC appears to have disregarded the analysis provided by HCA based on

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<sup>38</sup> CC, "The Supply of groceries in the UK market investigation", 2008, footnote 1, page 73.

<sup>39</sup> CC, AIS, Appendix B, Annex 1 – Measuring local concentration, slide 6.

<sup>40</sup> CC, AIS, Appendix B, Annex 2, para, 8(e).

its own patient data. Furthermore, the CC appears to have disregarded the OFT's views from its market study which indicated that London has notable differences which mean that willingness to travel for healthcare may be different from the rest of the country due to the high use of public transport and a larger commuter population<sup>41</sup>.

- 3.57 Using its own patient data, HCA found that on average, the catchment area for 80% of patients to get to an HCA facility would be equivalent to a travel time of [redacted] by road or [redacted] by public transport.<sup>42</sup> By looking at the location of UK patients travelling to HCA's full hospitals, HCA concluded that the catchment areas of patients to each of its facilities extends to at least the perimeter of the M25, with many patients coming from beyond Greater London, such as from the Home Counties. Moreover, there are significant numbers of international patients who travel to HCA facilities from outside the UK who are not captured within the analysis.

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<sup>41</sup> OFT, Private Healthcare Market Study, April 2012, para. 4.64.

<sup>42</sup> These catchment areas are based on revenues. The catchment area for 80% of patients calculated on a per trip/visit basis would be a travel time of [redacted] by road or [redacted] by public transport.

#### **4. THEORY OF HARM 1: MARKET POWER OF HOSPITAL OPERATORS IN CERTAIN LOCAL MARKETS**

##### ***Assessment of local areas where private hospitals may potentially have market power***

- 4.1 Under Theory of Harm 1, the CC postulates that a PH provider may have market power with respect to patients in a particular local geographic area. This may be a result of patients having few alternatives because of the absence of similar hospitals, or because a particular treatment is not offered by enough competitors, or finally, because there may not be sufficient spare capacity.
- 4.2 In order to identify whether individual hospitals and hospital groups may have local market power, the CC has used two techniques to identify hospitals of potential concern: the LOCI and fascia count analysis (based on the catchment area analysis). Hospitals of potential concern were identified by the CC as:
- those hospitals with a weighted average market share, by patient numbers and revenue, of 40% or higher (which corresponds to a LOCI measure equal to or lower than 0.6); or
  - those hospitals that face one or no competing fascia in their catchment area.
- 4.3 The CC identified 144 hospitals of potential concern. Of these, 119 hospitals either have a patient or revenue LOCI lower than 0.6 and an additional 25 hospitals face no more than one competing fascia in the provision of the 16 specialties, and separately of oncology, in their catchment areas.
- 4.4 HCA has set out its significant concerns with the CC's geographic market analysis in section 3 above. As this analysis is then used by the CC to identify hospitals of potential concern, HCA considers that the same criticisms raised in relation to the CC's geographic market analysis are relevant here. HCA sets out additional concerns with the CC's assessment of local market concentration below. Indeed, HCA notes that the CC has stressed that both the catchment area analysis and LOCI as a proxy of local market concentration present some limitations.<sup>43</sup>

##### ***Critique of the CC's approach to assessing local market concentration and identifying hospitals of potential concerns***

###### *LOCI analysis*

- 4.5 The CC computed LOCI for general and specialised private hospitals and PPUs that have been identified as providing inpatient services for one or more of the 17 specialities of interest to the CC that are present in the Healthcode data, with the aim of understanding their local market power. HCA has conducted an initial review of the analysis undertaken by the CC and sets out its concerns below both in relation to the approach adopted and the validity of the inferences that the CC draws in relation to its assessment of Theory of Harm 1.
- 4.6 The CC has rightly pointed out that LOCI is not widely used as a concentration measure, and that it has never used this measure in an inquiry.<sup>44</sup> In particular, the CC has indicated that

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<sup>43</sup> CC, AIS, Appendix B, Theory of Harm 2: Local competition, paras. 6-12 and 41-45.

<sup>44</sup> CC, AIS, Appendix B, Theory of Harm 2: Local competition, para. 41.

only the Federal Trade Commission and the Dutch Healthcare Authority (NZa) have used this measure before. HCA understands that the NZa has used LOCI in its assessment of a few healthcare mergers, where it used the change in LOCI pre-/post-merger to estimate the change in prices pre-/post-merger. This use of LOCI is different from one where a competition authority proposes to argue that a specific level of LOCI is *ipso facto* an indication of local market power.<sup>45</sup>

- 4.7 HCA also notes that the academic paper that proposed LOCI, to which the CC referred, is an unpublished manuscript dated 2006<sup>46</sup>. This document states on the opening page "*ROUGH DRAFT: NOT FOR CITATION OR QUOTATION*". It is in the nature of economics, as an academic discipline, that new techniques require a process of testing and scrutiny in an academic context before they are used to take important and very consequential decisions on markets in a practical context. HCA would be concerned if the CC were to base its analysis of market power in this inquiry on a measure with little or no basis in the academic literature, let alone a satisfactory set of precedents where competition authorities have used this measure. Indeed, HCA notes that using LOCI as a measure of concentration is only mentioned for the first time in the CC's Market Investigation Guidelines published on 5 April 2013 and did not feature previously. Furthermore, LOCI does not appear in the CC's and OFT's joint commentary on retail mergers<sup>47</sup>, which has an extensive discussion of measuring concentration in local markets analysis.
- 4.8 In this section HCA first sets out its critique of the LOCI approach, and secondly discusses its concerns with the conclusions the CC draws from it.
- 4.9 One limitation of the LOCI as computed by the CC, and which the CC itself acknowledges, is that this index ignores the competitive constraint exercised by those hospitals on which the CC does not have any information.<sup>48</sup> The CC itself stated that Healthcode does not provide information on invoices for 50 hospitals, 8 of which are private general hospitals.<sup>49</sup> As a result, the weighted average market shares of the remaining hospitals are overestimated.
- 4.10 Moreover, the CC has neglected to account for the competitive constraint exerted by the NHS. As HCA has outlined above (paragraph 3.32 onwards) and in previous submissions,<sup>50</sup>

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<sup>45</sup> In the context of a recent review of selected healthcare specialties, the NZa stated that (inverse) LOCI cannot simply be interpreted as an indicator of market power. Rather, according to the NZa, (inverse) LOCI gives a first indication of the alternative hospitals that patients can access in a given geographic area. The NZa emphasises that a high market share is not problematic by itself and that a case-by-case analysis is needed to correctly assess the presence of significant market power. The NZa, in fact, stressed that a particularly high market share may be compensated by the existence of other countervailing factors (See NZa, Marktscan Ketenzorg weergave van de markt 2007-2010, page 28.). The NZa made a similar point in its review of the market for specialist medical care (see NZa, Marktscan Medisch specialistische zorg, page 22) and separately in its market study into mental healthcare (see NZa, Geestelijke gezondheidszorg, Marktscan en beleidsbrief, page 39). Further, when the NZa presented the results of its concentration analysis in the context of a review of selected healthcare specialties (see NZa, Marktscan Ketenzorg weergave van de markt 2007-2010, page 28), it employed an inverse LOCI threshold of 2.2 (which corresponds to a weighted average market share of 55%) to provide some summary statistics on the extent of local market concentration. Although the rationale for NZa's choice of this threshold is not clear, HCA notices that it is well above the 40% threshold employed by the CC to identify the hospitals of potential concern.

<sup>46</sup> Y O D Akosa Antwi, M Gaynor & W B Vogt, 'A competition index for differentiated products oligopoly with an application to hospital markets', unpublished manuscript, 2006.

<sup>47</sup> Commentary on retail mergers - a joint report by the OFT and the CC (2011).

<sup>48</sup> CC, AIS, Appendix B, Theory of Harm 2: Local competition, paras. 43-45.

<sup>49</sup> CC, AIS, Annex 1 – Measuring local competition – Appendix B, slide 21.

<sup>50</sup> See Section 7 of the Response to the Issues Statement.

the NHS exerts a considerable competitive constraint over the private healthcare market. Further, the extent of the competitive constraint exerted by the NHS may be different across sub-markets. The CC's computation of the LOCI does not account for this.

- 4.11 Further, HCA believes there may be an inconsistency in the CC's approach to the bundling of specialties for the computation of LOCI. HCA may explore this issue in further detail following access to the CC's data room.
- 4.12 HCA also considers that the way the CC has computed LOCI is at odds with some key features of the UK healthcare market. For example, the typical patient journey involves a patient going to a GP, who then refers him/her to a consultant, who may then suggest a procedure at a hospital to that patient. The CC's use of LOCI is instead based on a logit model which relies on a patient choosing a hospital. Moreover, as recognised in a presentation made in 2011 by RS Halbersma (from the NZa), the logit model (on which LOCI is based), when used in the context of private healthcare, typically assumes that PMIs are price-takers<sup>51</sup> (which, as the CC itself acknowledged is not the case in the UK private healthcare market where prices are negotiated).
- 4.13 Also, as recognised in an academic literature review prepared for the OFT in the context of the market study that led to the current CC's market inquiry, the logit model (on which LOCI is based) assumes that patients are sensitive to prices. However, on this latter point, HCA notes that the Healthcode data used by the CC captures insured patients, who (at the point of seeking healthcare) are generally unlikely to be price-sensitive.<sup>52</sup>
- 4.14 There are further considerations about the use of the market share analysis in general, and the logit model (underpinning LOCI) specifically which are at odds with key features of the UK healthcare market.
- 4.15 In terms of the relevance of market share analysis (including LOCI) in general, HCA believes that the CC should consider the following issues
- LOCI (especially if used as a proxy to assess local market power without suitable controls) assumes that hospitals (or hospital groups, depending on the version of the LOCI used by the CC) are only differentiated in terms of where they are located. In particular, LOCI assumes that there are no differences in the types of treatment offered by hospitals, in patient outcomes, in the expertise of consultants or clinical staff, in the equipment used, in the extent of care and support provided, in the level of accommodation offered, or in any other dimension. These factors are likely to particularly affect the validity of the Revenue LOCI, which takes prices into account.
  - LOCI assumes that – conditional on hospital choice – patients have no scope to determine the level of service they wish to receive (for example, they cannot choose whether they want a better quality prosthesis).
- 4.16 Furthermore, HCA considers that
- LOCI assumes that within a submarket (defined by the CC as the patient population living within the geographic area denoted by the postcode district, e.g. WC1X),

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<sup>51</sup> R.S. Halbersma, Dutch Healthcare Authority, Market Definition in Healthcare, February 2, 2011, slide 24.

<sup>52</sup> Oxera, *Techniques for defining markets for private healthcare in the UK*, December 2011, para. 4.4.4.



patients are homogenous. For example, patients living within the same submarket are assumed to have the exact same preferences over what features of a healthcare service (or hospital) they care about, and they value different levels of quality or service in the exact same way.

- The basic LOCI measure used by the CC ignores PH providers that own multiple hospitals. The CC's adjustment for network ownership is not theoretically valid unless two hospitals owned by the same operator are perfect substitutes (i.e. identical in the eyes of all patients). However, different hospitals are not identical, starting from the simple observations that they have different locations (moreover, they may offer different treatments, possibly of different quality, access to different consultants and so on).<sup>53</sup>

4.17 In the remainder of this section, HCA sets out its initial considerations with regard to what the CC may (or may not) infer from the LOCI measure.

4.18 It is clear to HCA that there are two ways in which the LOCI identified cannot be used.

4.19 First, one cannot use LOCI as a proxy for local market power to then infer something about market power at an aggregate (e.g. national) level. This is because the argument would be circular. The revenue LOCI merely captures the prices negotiated between the PMI and PH provider. These reflect the balance of the relative bargaining power between a PMI and a PH provider. Furthermore, the revenue of a hospital may reflect the extent to which PMIs choose to direct their policyholders toward it (through open referrals for example) and a low LOCI may be the result of good terms earned by the PMI rather than a sign of PH providers having high bargaining power in the negotiations.

4.20 The CC has also computed the LOCI measure based on patient volume data. However, the problem set out in the paragraph above also arises when looking at patient volumes due to the issue of hospital recognition. That is, a patient might have travelled to a certain hospital not because that hospital was closer to home/work, or provided better quality of healthcare than any other hospital but simply because it was the only one it could attend given his/her PMI policy (given network restrictions or open referrals). This would be an endogenous outcome of the negotiation between a PH provider and a PMI.

4.21 Secondly, because LOCI is itself an endogenous market outcome (determined by factors external to the competitive process), there may be issues with using it as the explanatory variable in a model that tries to explain the variation of prices (which are also market outcomes depending on similar factors). This issue is particularly relevant in relation to the price-concentration analysis performed by the CC on self-pay patients (which we comment on below, from paragraph 4.37).

4.22 Interestingly, this problem of the "endogeneity" of LOCI is addressed in the same paper on LOCI on which the CC relies:

*"LOCI is likely endogenous, for the usual reasons. Market shares are not likely to be independent of unobserved factors that determine price."*<sup>54</sup>

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<sup>53</sup> There is a theoretically more robust way to account for multiple hospitals owned by a single owner and this correction is described in the paper by Akosa Antwi et al. (2006) cited by the CC.

<sup>54</sup> YOD Akosa Antwi, M Gaynor and WB Vogt. *A competition index for differentiated products oligopoly with an application to hospital markets*. Unpublished manuscript, 2006.

- 4.23 Furthermore, HCA considers that the LOCI computed at network level is likely to understate the level of competition. Hospitals belonging to the same network may compete among each other (as recognised by the CC itself).<sup>55</sup> [3<]. By failing to take this into account in the network level LOCI, the CC does not consider part of the competitive set and, as such, concentration appears higher than may actually be the case.
- 4.24 HCA is also concerned by the CC's use of an arbitrary LOCI threshold of 0.6 to determine which hospitals may have local market power. There is no legal or economic basis for a mechanistic threshold to assess market power. The LOCI methodology used by the CC does not bypass the need to assess the appropriate area for which market shares need to be calculated nor the need to consider the breadth of constraints faced by PH providers that may not be measured in the LOCI calculations. More specifically, HCA considers that given the way in which LOCI is calculated, particularly given the weighing of submarkets being based on the relative importance of those submarkets for a given hospital, LOCI will necessarily overestimate the market power of PH providers. The choice of submarkets will affect the value of the LOCI for a given facility.<sup>56</sup> Furthermore this issue is not resolved by using narrower submarkets. At the limit, if each individual patient location was defined as a submarket, this would lead to the LOCI reaching the value associated with a monopoly.
- 4.25 In sum, LOCI is a measure of concentration that has received limited attention in the academic literature, has hardly been used by competition authorities and when it has been used it was in a very different context of merger analysis. It raises a number of methodological issues, especially applied to the data in the CC's possession and to the realities of the UK private healthcare market.

#### *Fascia count analysis*

- 4.26 Given HCA's concerns with the CC's catchment area analysis (set out in section 3 above), HCA also has some concerns with the fascia count analysis and the extent to which the CC can rely on the results to make inferences about a PH provider's local market power given these deficiencies.
- 4.27 The catchment area analysis conducted by the CC identified the geographic area, expressed as a distance in miles, within which each private hospital attracts the majority (80 per cent) of insured inpatients. For each catchment area, the CC then computed a hospital's fascia count by counting the number of competitors (one or more general hospitals or PPUs belonging to the same rival operator) located within the catchment area. HCA notes that the CC has not presented any sensitivity analysis around the catchment areas and fascias to test for robustness.
- 4.28 However, HCA considers that the results of the fascia count need to be interpreted with caution, particularly as this method may overestimate the degree of market concentration at the local level. HCA considers that the fascia count method understates the competitive constraint exercised by those hospitals not included in the competitor set. Indeed, HCA notes that the CC has also highlighted this as an issue<sup>57</sup>.

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<sup>55</sup> CC, AIS, para.30c.

<sup>56</sup> This can be easily illustrated, for example by using a simple Hotelling line and choosing different arbitrary segmentations to represent submarkets.

<sup>57</sup> CC, AIS, Appendix B, Annex 1, slide 16.

- 4.29 As noted above in relation to the network LOCI (see paragraph 4.23), HCA also considers that the fascia count analysis risks overestimating the level of local concentration as it does not account for the competitive constraint exercised by those hospitals operating within the same hospital network.
- 4.30 HCA also notes that the CC has highlighted a number of issues that can arise when using fascia counts based on catchment areas as measure of concentration. These include the fact that catchment areas may overlap, and as a result concentration measures may be misleading or counterintuitive.
- 4.31 Finally, HCA considers that the competitive constraint exercised by the NHS over PH providers should be taken into account in the fascia count analysis. HCA has outlined its views on the role of the NHS as a competitor in Section 3 above, and notes that the CC has also indicated that the competitive constraints that the NHS may impose on providers of privately-funded healthcare will be taken into account in its competitive assessment.<sup>58</sup>

#### *London*

- 4.32 The CC has indicated in its assessment of Theory of Harm 1 that, "*many PMIs expressed concerns that HCA hospitals in London have market power*"<sup>59</sup>. HCA strongly disputes this. As it has stated to the CC in a number of its submissions and responses, HCA operates in a highly competitive market and faces vigorous competition from a wide range of providers. In Inner London there are six private providers, and sixteen NHS PPUs in addition to other key independent competitors such as the Cromwell, London Clinic, London Independent and St. John and St. Elizabeth. In Outer London, major providers include BMI, Spire and St. Anthony's which compete across the full spectrum of acuity. Additionally, HCA draws patients from a wide catchment area extending beyond London where it competes with major providers across the Home Counties and South East.
- 4.33 HCA notes that the CC has indicated that whilst its local analysis has identified some hospitals of potential concern in London it considers that it may not fully capture the extent of any competition problems in London. HCA is unclear of the basis on which the CC has reached this judgement.
- 4.34 [redacted]
- 4.35 As set out above, HCA has fundamental concerns with the use of the LOCI measure as well as the arbitrary threshold applied by the CC. Notwithstanding these concerns, [redacted].
- 4.36 The revenue LOCI measure is affected by pricing differentials between competing hospitals. As HCA has consistently submitted to the CC, there are a host of competing providers in London that have significant cost advantages over HCA (such as PPUs and charities), which HCA has argued results in an unlevel playing field<sup>60</sup> in which competitor hospitals are able to price below HCA. A pricing differential can also legitimately reflect differences in the quality of care and overall level of service. Indeed, in a differentiated services market, such as private healthcare, a price differential is not probative of the absence of competition - rather, it is to be expected and is consistent with effective competition. This is particularly the case in the private healthcare market, where competing parties offer different quality propositions

<sup>58</sup> CC, AIS, Annex to Appendix A – Analysis of product markets, slide 37

<sup>59</sup> CC, AIS, para. 65.

<sup>60</sup> In the case of NHS PPUs see: *A fair playing field for the benefit of NHS patients: Monitor's independent review for the Secretary of State for Health*, 26 March 2013.

and where each patient's circumstances can affect the complexity of the medical procedure. On that basis, significant doubt must be placed upon the probative value of the revenue LOCI, which may be biased by such price differentials. [§<].

### ***Self-pay Price-Concentration Analysis***

4.37 As part of its assessment of Theory of Harm 1, the CC has undertaken some preliminary price-concentration analysis using self-pay patient data ("PCA"). The approach taken and initial results are included in the AIS and discussed further in Appendix B (Annex 3). The CC has subsequently published a Working Paper on *Price-concentration analysis for self-pay patients* ("Working Paper") setting out the PCA in more detail. In this response, HCA uniquely comments on the PCA as set out in the AIS. HCA will respond to the Working Paper in due course and reserves the right to expand the scope of its critique of the CC's approach to the PCA.

4.38 The CC states that its PCA has identified a positive and statistically significant relationship between levels of local market concentration and prices paid by self-pay patient for private healthcare treatments.<sup>61</sup> It adds that its current thinking is that some private hospital operators have local market power in particular areas, and that this may lead to higher prices of private healthcare treatments, and/or lower quality, than what a competitive market would lead to.<sup>62</sup>

4.39 HCA has reviewed the CC's methodology and the results of the PCA analysis included in the AIS and sets out its initial views in this section. As with the other areas of analysis, HCA stresses to the CC that these are preliminary views only and HCA reserves the right to provide a more detailed response after access to the data room.

### ***Review and critique of the CC's approach to the PCA analysis***

4.40 Having reviewed the approach adopted by the CC for undertaking the PCA, HCA has identified a number of issues with the analysis based on the data used by the CC and its approach to cleaning it, in addition to concerns regarding the actual methodology followed by the CC in carrying out its PCA. HCA addresses the following issues:

- Exclusion of competitors such as PPU's and NHS facilities;
- Data inconsistencies;
- The use of concentration measures based on insured patients for the self-pay PCA; and
- Potential omitted variable bias.

4.41 The CC focused on what it considered to be the eight most common treatments,<sup>63</sup> jointly accounting for 68% of patient visits and 43% of revenues.<sup>64,65</sup> HCA notes that the CC only

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<sup>61</sup> CC, AIS, para. 68.

<sup>62</sup> CC, AIS, paras. 69 and 72.

<sup>63</sup> These treatments are: hip replacement; knee replacement; inguinal hernia surgery; gastric banding; rhinoplasty following trauma; prostate resection; cataract surgery; and removal of gallbladder.

<sup>64</sup> CC, AIS, Appendix B, Annex 3, slide 9.

<sup>65</sup> HCA notes, however, that the CC computed these percentages *after* its data cleaning. To the extent that the CC's data cleaning process was inaccurate or arbitrary, these figures would have little meaning.

uses episode data from the five largest PH provider groups.<sup>66</sup> This excludes PPU, which exert a competitive constraint (especially in London). This also excludes a number of individual independent hospitals operating in London which compete directly with HCA, e.g. St. John's and St. Elizabeth's, King Edward VII, Parkside, St Anthony's, the London Clinic and BUPA Cromwell.

- 4.42 Furthermore, it is not clear whether different PH providers report prices for a given treatment or episode on a consistent basis. As a practical example, the type of prosthesis employed as part of a surgical procedure, or whether it is cemented or non-cemented, will impact on the cost of providing that treatment and will be reflected in the price faced by the self-pay patient. The CC recognises that there may be potential differences, but states that “*any inconsistencies are expected to be minor and limited*”.<sup>67</sup> More generally, it is not clear how the CC treated the cost of medications in its analysis, nor whether different PH providers offer comparable medications as part of the care offered to patients. Without access to the full database, and without a clear understanding of how other PH providers classify their treatments and compile their data in their day-to-day business, HCA is not in a position to judge whether these inconsistencies are “minor and limited”. To the extent that certain PH providers may provide more services than others for the same treatment (as identified by a CCSD), the CC’s PCA would not capture this difference in scope and any effect identified by the PCA may be spurious. The degree of price dispersion for a given treatment may give an indication of the potential differences in the scope of services provided in addition to quality differentials. Differences across PH providers in scope and/or quality of services offered as part of the treatment are likely to result in differences in costs, which should be expected to be reflected in differences in prices across PH providers.
- 4.43 HCA also has a number of concerns in relation to the methodology employed by the CC in conducting the PCA. HCA considers that a central aspect of any concentration analysis is how to construct the concentration variable(s). The PCA relies on two separate concentration measures and presents results for each case: LOCI (weighted market share analysis) and fascia count (catchment area analysis). HCA has set out its critique of these measures earlier in this section.
- 4.44 A key point to note is that the CC uses Healthcode data to compute the concentration measures. The CC itself notes that this data relates to insured patients, not to self-pay patients, however, justifies its approach by stating, “*Concentration measures calculated on the basis of insured patients are expected to be highly correlated with those calculated on the basis of self-pay patients*”.<sup>68</sup>
- 4.45 The CC provides no evidence for this statement and indeed it is not clear to HCA that the two concentration measures would be highly correlated. In fact, to the extent that the competitive dynamics between PH providers are different for self-pay patients than for insured patients, it is not clear why local market shares of PH providers should be expected to be similar for self-pay and for insured patients. For example, the levels of concentration for insured patients are likely to reflect PMIs’ networks or the use of open referral policies, also there may be different sensitivities to prices between insured and self-pay patients, which the CC itself recognises.<sup>69</sup> Further, the patient survey commissioned by the CC also suggests

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<sup>66</sup> CC, AIS, Appendix B, Annex 3, slide 13.

<sup>67</sup> CC, AIS, Appendix B, Annex 3, slide 5.

<sup>68</sup> CC, AIS, Appendix B, Annex 3, slide 13.

<sup>69</sup> See, example, AIS, para. 21, where the CC states that “[s]elf-pay patients [...] are likely to be characterized by greater price sensitivity than insured patients”.

that self-pay patients have a much higher willingness to travel to be treated at a better hospital than insured patients.<sup>70</sup> This has been borne out by HCA's own catchment area analysis.

- 4.46 HCA has significant concerns about potential sources of omitted variable bias in the CC's PCA. HCA considers that the CC has neglected to include in the PCA other factors that have a relationship with both the main explanatory variable (local concentration) and the variable the PCA seeks to explain (price). There is likely to be omitted variable bias from the PCA failing to control for the quality of healthcare services provided, for example. Self-pay patients will select facilities not only on the basis of price but also on quality. The prices charged will reflect quality differentials which the CC does not control for in its analysis. Depending on how this and other additional factors are associated with concentration and with prices, the effect identified by the CC of concentration on prices may be either underestimated or overestimated.
- 4.47 HCA considers that the "patient" controls the CC has included (patient age, patient gender and patient stay length) are unlikely to be sufficient and that there are other factors that affect prices which should be taken in to account, such as the severity of a patient's condition or his/her general health conditions. To the extent that some patients may present a higher risk to a PH provider because of poorer general health or more severe conditions, this may affect the expected cost (and liability) for a provider, and may thus affect the price charged for a given treatment. Therefore, the CC's patient controls do not necessarily control the significant price differences which can arise from treating patients with different clinical needs.
- 4.48 There are numerous factors which can affect the level and intensity of an individual patient's treatment, including:
- The existence of co-morbidities (i.e. existing unrelated conditions) such as diabetes and respiratory disease which increases the complexity of treatment.
  - The need for HDU or ICU support.
  - Type of prosthesis which will depend on lifestyle and how active a patient wants to be afterwards and which can have a significant impact on price.
  - Whether there has been previous surgery, e.g. surgery on patients with a previous history will be more complicated and require more clinical input.
  - Patients transferred in to HCA hospitals from other facilities (i.e. "transfers-in") will have higher clinical requirements and may have special nutritional needs or have infections.
  - Disease process e.g. the same surgery could be carried out for malignant or non-malignant disease but might require additional pathology, imaging, etc.
  - For patients with cancer, personalised chemotherapy regimens will also have an impact in conjunction with any of these self-pay treatments.

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<sup>70</sup> GfK Survey of Patients, Private Healthcare Market Investigation, November/December 2012, slide 49. This states that PMI patients would consider travelling, on average, 60.6 minutes to "attend a better hospital", while self-pay patients would consider travelling, on average, 82.8 minutes (i.e. over one-third more than PMI patients).

- 4.49 While the CC is controlling for length of stay, there may still be significant differences in clinical requirements even for patients with the same or similar lengths of stay. Thus, a patient with co-morbidities may have the same length of stay than other patients but may require greater or more intensive medical or nursing care to account for the increased complexity. There may also be different treatment modalities which will not be reflected in differences in length of stay e.g. prostate re-section can be treated by laser treatment and gall bladder removal is subject to alternative "open" or laparoscopic procedures. Also, length of stay is not in itself a measure of acuity since there are cases where low acute, less intensive treatment results in a longer hospital stay because of the social needs of the patient (e.g. in the case of elderly patients who cannot be discharged immediately because of their personal circumstances).
- 4.50 HCA is therefore concerned that the CC's PCA is an extremely simplistic analysis of self-pay pricing which does not take into account the significant variability in the nature of the treatment provided to individual patients. The CC has not controlled for these variations in price. HCA hospitals tend to see patients with higher levels of acuity and this will affect HCA's self-pay prices.
- 4.51 HCA also considers that the "demand-side" controls fail to control for the role played by consultants. The CC itself noted that the typical patient journey goes via the GP to the consultant and then to a hospital.<sup>71</sup> One may therefore expect that a self-pay patient's desire to be treated at a certain hospital may be related to his/her demand for a given level of "consultant quality". Consultants themselves decide which hospitals to practise at, based on a number of factors including quality, the level of innovation and reputation of the PH provider.
- 4.52 HCA also has a number of concerns with the "supply-side" controls employed by the CC. It is not clear that the only supply-side control used in the PCA (hospital average direct cost) is sufficient to capture potential biases in the data. The costs across PH providers differ significantly due to numerous factors including: the quality of their services; the degree of complexity of services provided in general; the infrastructure required to support those services; and the tax status of the provider. Any failure to adequately control for these differences in costs (which will be reflected in prices) will limit the meaningfulness of any results of the PCA. Additionally, any inconsistency across the PH providers in recording and reporting their average direct costs would affect the results. Case mix throughout the private healthcare sector is not homogenous and in general the complexity of HCA patients is greater than that of other PH providers.
- 4.53 In addition to excluding PPU's from its PCA, the CC did not seek to control for the presence of NHS hospitals in the proximity of a PH provider. In the patient survey commissioned by the CC, 68% of self-pay respondents stated the NHS was an alternative for them.<sup>72</sup>
- 4.54 HCA notes that the CC considers that its use of geographic dummy variables may allow it to capture different levels of quality and cover of NHS provision across different areas in the UK. This control, however, would assume that there is perfect homogeneity within a certain

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<sup>71</sup> CC, AIS, para. 126. ("Consultants' relationships are very important to hospital operators since patients are usually referred by their GP to a consultant rather than to a hospital. Consultants play a major role in bringing patients into a hospital").

<sup>72</sup> GfK Survey of Patients, Private Healthcare Market Investigation, November/December 2012, slide 16.

region (e.g. “Inner London”,<sup>73</sup> in the case of the NUTS-2 control used in the CC’s baseline specification, or “West London”,<sup>74</sup> in the case of the more granular NUTS-3 control used in one of the robustness checks performed as part of the CC’s PCA). HCA submits that even within these areas there are likely sources of significant heterogeneity, including differences in terms of household incomes, land/property costs, staff wages and the extent of competitive constraint exerted by (NHS and private) hospitals not covered by the PCA.

- 4.55 The competitive constraint exerted by the NHS may be particularly strong in the case of the eight treatments the CC focused its PCA on. This is because patients have the opportunity to access treatments offered by PH providers (e.g. under the "Choose and Book" system for NHS patients<sup>75</sup>) but procured through the NHS, i.e. at no cost to the patient.<sup>76</sup> This service would constrain the self-pay prices offered by PH providers. **Table 4.1** below reports, for the specialties in which the CC’s focal treatments belong, the proportion of NHS episodes carried out in 2011/12 at the private healthcare facilities of four major PH providers. This table shows that these four major PH providers carried out a significant number of NHS treatments. The proportion of the total NHS episodes in these specialties carried out by PH providers (reported in Table 4.1) is in fact an underestimate, given that more PH providers engage in such activity. The effect of NHS activity on the pricing of private procedures is not taken into account in the CC’s analysis (over and above including geographic dummy variables, as discussed in the previous paragraph).

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<sup>73</sup> This includes the boroughs of Camden, City of London, Hammersmith and Fulham, Kensington and Chelsea, Wandsworth

Westminster, Hackney, Haringey, Islington, Lambeth, Newham, Southwark, Lewisham and Tower Hamlets. NUTS stands for “Nomenclature of Territorial Units for Statistics” and is a standard for listing the administrative divisions of EU countries.

<sup>74</sup> This includes the boroughs of Camden, City of London, Hammersmith and Fulham, Kensington and Chelsea, Wandsworth and Westminster.

<sup>75</sup> This is a national electronic referral system which gives patients a choice of place, date and time for their first consultation.

<sup>76</sup> See also HCA’s response to the CC’s Issues Statement, paras. 4.14 and 7.36-7.39.



**TABLE 4.1: NHS episodes carried out by selected PH providers, selected specialties, 2011/12**

Provider	Specialty				
	General Surgery <sup>77</sup>	Urology <sup>78</sup>	Trauma & Orthopaedics <sup>79</sup>	Ophthalmology <sup>80</sup>	Plastic surgery <sup>81</sup>
BMI	8,128	3,771	16,251	3,285	351
Nuffield	2,045	506	5,615	1,420	39
Ramsay	20,221	5,264	30,463	6,433	1,425
Spire	10,492	2,276	17,737	1,981	758
Total (BMI, Nuffield, Ramsay, Spire)	40,886	11,817	70,066	13,119	2,573
Total (incl. NHS)	1,739,981	807,546	1,189,743	629,637	252,126
Proportion of NHS episodes accounted for by BMI, Nuffield, Ramsay, Spire	2.3%	1.5%	5.9%	2.1%	1.0%

Source: HCA analysis of NHS data (*Hospital Episode Statistics, 2011/12*)

*Significance and materiality of the CC's preliminary findings*

- 4.56 In this section, HCA provides some comments on the CC's "simple analysis" (graphs and correlation analysis), before commenting on statistical significance and economic significance of the CC's econometric analysis.<sup>82</sup>
- 4.57 The CC reports some results from its "simple analysis", which only looked at the correlation between average prices to self-pay patients and each of the two measures of concentration, without taking other variables into account.<sup>83</sup> For there to be a causal relationship between concentration and prices, it is typically the case that these variables should be correlated.<sup>84</sup> However, as the CC itself notes, there is "*no clear, overarching pattern across the graphs*" (which plot, for the eight treatments selected, the local market concentration of a hospital and the average price charged for that treatment).<sup>85</sup>

<sup>77</sup> The following CC focal treatments are included in this specialty: Removal of gallbladders; Gastric banding; Hernia

<sup>78</sup> The following CC focal treatment is included in this specialty: Prostate resection

<sup>79</sup> The following CC focal treatments are included in this specialty: Knee replacement; Hip replacement

<sup>80</sup> The following CC focal treatment is included in this specialty: Cataract surgery

<sup>81</sup> The following CC focal treatment is included in this specialty: Rhinoplasty after trauma

<sup>82</sup> Put simply, in the context of the type of econometric analysis performed by the PCA, statistical significance denotes the confidence with which the analysis can reject the hypothesis that there is no effect of an explanatory variable on the variable the model seeks to explain. Economic significance, by contrast, is concerned with the predicted magnitude of the impact of a certain change in the level of the explanatory variable on the variable the model seeks to explain. For example, a model may find that an extra year of tertiary education has a positive statistically significant effect on predicted earnings for an individual. However, to the extent that this identified (statistically significant) effect is 'small' (say, one extra year of tertiary education is associated, on average, with higher earnings by 0.03%), one may say that that the effect of the explanatory variable (years of tertiary education) on earnings is not economically significant. There are no clear rules over what magnitude of an effect should be considered 'economically significant'. This will instead depend on the context of the analysis at hand.

<sup>83</sup> CC, AIS, Appendix B, Annex 3, slides 21-25.

<sup>84</sup> The reverse does not hold true: correlation does not necessarily imply causation.

<sup>85</sup> CC, AIS, Appendix B, Annex 3, slide 21.

- 4.58 HCA notes that in the graphs presented by the CC there does not appear to be a consistent, downward relationship, which would indicate that more concentrated markets are associated with higher prices.<sup>86</sup> Indeed in some cases there is an upward trend suggesting that price and the level of concentration are positively correlated.<sup>87</sup> This is confirmed by looking at the correlation coefficients (which HCA notes are relatively low, regardless of whether using LOCI or fascias as concentration variables).<sup>88</sup> Six of the 16 correlation coefficients reported are positive (so that less concentrated markets are associated, perhaps counterintuitively, with higher prices). Only five out of the 16 coefficients reported are both negative (so that more concentrated markets are associated with higher prices) and larger than 0.1 in absolute terms (where 0.1 does not typically indicate strong correlation in any event, as the CC has previously acknowledged).<sup>89</sup> The CC's 'simple analysis' of the prices and concentration measures is inconsistent with the identification of higher treatment prices in local areas characterised by higher market concentration.
- 4.59 The CC also reported results in the AIS from its econometric PCA for ten different model specifications: five of these used fascia count as a proxy for concentration measure, and the remaining five used LOCI. In none of the five PCA models using fascia counts as the proxy for concentration was the CC able to identify a statistically significant relationship between prices to self-pay patients and local market concentration. HCA considers that the results do not support a conclusion that there is a clear economic relationship between concentration and prices.
- 4.60 Whilst the CC may have found statistically significant results from the PCA analysis in a limited number of cases, it is not clear to HCA that these results are economically significant, for a number of reasons.
- 4.61 LOCI is an index that, by construction, varies between 0 and 1. LOCI takes a value of 0 in the case of a monopoly supplier and 1 in the case of an infinite amount of suppliers. The CC itself admits that the difference between these two market structures is, "*hypothetical and very extreme*".<sup>90</sup> One should therefore look for a comparison between two more meaningful or realistic concentration (LOCI) levels.
- 4.62 Depending on the model specification adopted, the CC identified a four to six per cent price<sup>91</sup> reduction for a 0.20 change in LOCI. However, it is not clear from the data provided by the CC whether a differential as large as 0.20 in the LOCI represents a plausible change in market concentration from which price effects should be assessed. Depending on the distribution of LOCI across areas, a change of 0.20 in LOCI may be too large to assess whether the model identifies economically significant effects of local market concentration on prices. In addition, even if the CC's assumption that a 0.20 change in LOCI is appropriate in this context, such a change in market concentration would be associated with a relatively modest increase in prices of around four to six per cent on average.<sup>92</sup> Furthermore, HCA considers that it may not be appropriate to assume that the relationship between LOCI and

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<sup>86</sup> CC, AIS, Appendix B, Annex 3, slide 21.

<sup>87</sup> For example, "Knee Replacement" (fascia count) and Prostate resection (LOCI).

<sup>88</sup> CC, AIS, Appendix B, Annex 3, slide 21.

<sup>89</sup> See the CC's final decision on Stena-DFDS (2011), para. 12.12, where it states that correlation coefficients between 0.39 – 0.42 are "small to modest in size".

<sup>90</sup> CC, AIS, Appendix B, Annex 3, slide 29.

<sup>91</sup> HCA notes that in the new PCA set out in the CC's working paper, the result is a 3.6 per cent price reduction.

<sup>92</sup> CC, AIS, Appendix B, Annex 3, slides 27 and 29.

price the CC finds holds for changes in concentration and price outside the range of the CC's analysis.

## 5. THEORY OF HARM 3: MARKET POWER OF HOSPITAL OPERATORS IN NEGOTIATIONS WITH INSURERS

- 5.1 Under Theory of Harm 3 the CC has set out its opinion in relation to the market power of PH providers in negotiations with PMIs. The CC has also included in Appendix D to the AIS its analysis in relation to bargaining. The CC has indicated that it has assessed the *"evidence in the round and [its] view is that it is consistent with some large hospital groups having market power in some negotiations"*.<sup>93</sup>
- 5.2 Overall, HCA disagrees with the CC's bargaining power assessment, which in turn casts doubt upon its finding that *"certain private hospital operators have market power in negotiations with PMIs"*.<sup>94</sup> HCA's objections are based on a number of broad grounds.
- 5.3 First, HCA takes issue with the CC's failure to assess the outside options of both PH providers and PMIs in order to assess the relative bargaining strength these outside options confer on each party. The CC states that, *"if a hospital operator has market power in its negotiations with a PMI, this is likely to derive, at least in part, from the hospital operator's market power in certain local areas"*.<sup>95</sup> The CC is correct in stating that to the extent that one party to the negotiation has a degree of market power over its customers, this is relevant in the assessment of the other party's outside option. However, the same consideration must also apply when considering the PH provider's outside option. The CC is not in a position to take a view on the relative bargaining strength of PMIs and PH providers in negotiations without also considering the market power of PMIs in the selling of insurance policies. This omission seriously undermines the CC's conclusions in the main text of the AIS under Theory of Harm 3.
- 5.4 Secondly, HCA is concerned by the extent to which the CC appears to have relied on results from other areas of its analysis as a premise for its findings on bargaining power.
- 5.5 Thirdly, HCA believes the CC has not identified important factors in the PMI/PH provider bargaining process. A proper consideration of these factors would dramatically alter the CC's perspective on which of the two sets of parties in the bargaining process actually holds the most bargaining power.
- 5.6 Fourthly, the CC's high level factual conclusions concerning bargaining power appear to disregard much of the detailed evidence which HCA has already submitted about the strategies adopted by the PMIs in contractual negotiations with HCA, and the specific evidence relating to the PMI's outside options in London.

### **The CC's approach to assessing the bargaining by PH providers and PMIs**

- 5.7 In its Response to the CC's Issue Statement,<sup>96</sup> HCA presented its concerns in relation to the CC's initial consideration of Theory of Harm 3. It argued that, in order for the CC to assess whether any PH providers have any market power vis-à-vis PMIs, the CC

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<sup>93</sup> AIS, para. 90.

<sup>94</sup> AIS, para. 84(a).

<sup>95</sup> CC, AIS, para. 84(a).

<sup>96</sup> HCA, Response to the CC's Issues Statement, Section 10.

would have to consider the PMIs' outside option relative to the PH providers' and vice versa.

- 5.8 The CC's own bargaining power framework outlined in Appendix D is based on an assessment of the outside options of each party.<sup>97</sup> It recognises that the parties' respective bargaining power depends on the value of each party's outside option. Despite setting out its bargaining power framework, the CC has not proceeded to use this as the basis of its own analysis. Rather, the CC has conducted a one-sided assessment, considering only the outside options of the PMIs without any apparent consideration of the outside options available to the PH providers and the implications of this on the bargaining position. In the absence of such an assessment, the CC cannot adequately assess each party's relative bargaining position.
- 5.9 HCA noted in its Response to the CC's Issue Statement<sup>98</sup> that the CC could not be in a position to assess the relative bargaining strength of the PH providers unless it engaged in an assessment of the level of downstream competition in the PMI market. This is relevant as it is directly related to the difficulty faced by PH providers in finding an alternative sales channel to that represented by a given PMI.
- 5.10 If the downstream PMI market were competitive, one would expect corporate and individual PMI customers to switch easily in response to small but significant changes in the product offering. In this context a PMI provider would be concerned about not reaching an agreement with a high quality PH provider as it would worry about its PMI competitors' offering being seen as better value and losing customers. However, as HCA set out in its Response to the CC's Issues Statement,<sup>99</sup> the PMI market is not competitive and is characterised by a highly concentrated market with stable market shares over time and limited ability for customers to switch in response to small but significant changes in the value of competitor offerings.
- 5.11 The CC acknowledges in the AIS that the conduct of the PMIs will be "key" to the investigation.<sup>100</sup> HCA agrees with this, however, the CC has not engaged in any analysis of the PMI market, save for a short narrative on employer healthcare schemes. HCA considers that in the absence of such an analysis, the CC is not in a position to correctly assess the relative bargaining strength of any PH providers vis-à-vis the PMI providers and any conclusions drawn by the CC risk being fundamentally flawed.
- 5.12 As HCA has previously submitted, other key elements for this assessment include the potential value, cost and time associated with each potential strategy should a hypothetical negotiation fail. HCA has outlined why it is important to consider these factors in paragraphs 10.7 – 10.10 of its Response to the CC's Issues Statement. While some of these factors are considered for PMIs, there appears to be no corresponding analysis or evidence presented in relation to these for the PH providers. This is despite HCA submitting considerable evidence to the CC in response to the Market Questionnaire on its contracts, negotiation and pricing with PMIs and the impact of delisting from a network and failing to obtain recognition for new treatments and facilities.

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<sup>97</sup> AIS, Appendix D, paras. 9 and 10.

<sup>98</sup> HCA, Response to the CC's Issues Statement, para. 10.66.

<sup>99</sup> HCA, Response to the CC's Issues Statement, Section 6 and 10.

<sup>100</sup> AIS, para. 3.

- 5.13 Evidence submitted by HCA demonstrates that it has very limited feasible outside options should negotiations with a PMI fail. The failure to reach an agreement with a PMI would result in the loss of the vast majority of that PMI's business. Whilst PMI providers have a range of potential strategies that they could adopt should negotiations fail (for example, there are a number of other alternative PH providers that their customers could use, and there has been new entry and expansion of the private healthcare market over recent years) the alternative strategies for HCA to replace PMI business are extremely limited.
- 5.14 The two main PMIs, BUPA and AXA PPP, account for a considerable share of HCA's revenues and HCA is reliant on recognition in order to generate the patient volumes required to cover its fixed costs and achieve the economies of scale inherent in private healthcare provision, as well as to attract and retain consultants (who in turn need recognition from the main PMIs). In its Response to the CC's Issues Statement, HCA set out an assessment of four potential alternative strategies which may hypothetically be available to PH providers: (i) switch to an alternative PMI, (ii) new entry in the PMI market; (iii) switch demand to non-PMI customers, (iv) scaling down or market exit. HCA does not consider any of these to be credible outside options.<sup>101</sup>

#### **HCA's comments on the CC's analysis**

##### ***Managing network composition – the credibility of a PMI delisting***

- 5.15 The CC postulates that the "*PMI's negotiating position is likely to turn on the credibility of any threat it may make not to include a given hospital or private hospital operator in its network(s), or only to include certain treatments at a particular hospital (so called 'delisting')*".<sup>102</sup> Furthermore, the CC notes: "*If the PMI can credibly use the threat of delisting, the CC would expect the PMI to "obtain a better price"*" (paragraphs 87 and 89(a)).
- 5.16 A "delisting", as per the meaning adopted by the CC, occurs when a PMI decides:
- (i) not to include a given hospital or private hospital operator in its network(s), or
  - (ii) only to include certain treatments at a particular hospital.
- 5.17 This is an appropriate definition as a PMI's decision to list or delist a hospital operator is not black or white, i.e. a decision to include all of the operator's hospital facilities on all of its networks for all services or nothing at all. Rather, the PMI's decision involves a number of separate levers – relating to hospitals and/or specific medical procedures - which can each be pulled by the PMI as part of the bargaining process. In some cases, for example, with specialty networks, the PMI may act entirely unilaterally and outside of any periodic contract negotiations.
- 5.18 If we take the example of a PMI that has established two network lists (let us name them the Core List and Extended List) and one specialty network (MRI). If, as a result of bilateral negotiations, HCA is only listed on one product network (the Extended List), but not listed on the Core List or on the MRI specialty network, the PMI has effectively decided not to include HCA for all of its patients on the Core List and for patients requiring MRI procedures. In effect, HCA has been delisted for a proportion of the PMI's customers.

<sup>101</sup> HCA, Response to the CC's Issues Statement, paras. 10.54 – 10.62.

<sup>102</sup> AIS, para. 87.

- 5.19 In addition, HCA would suffer a further "quasi-delisting" for an additional set of patients due to the knock-on "consultant drag effect" that arises because HCA is not listed on the Core List or MRI specialty network. That is, consultants would be faced with (i) the prospect of splitting their list of patients across two private hospitals and given consultants' preferences to concentrate their private practice, consultants may decide to transfer their entire practice to a rival hospital (which is recognised on the Core and Extended List) and (ii) a disrupted patient pathway due to MRI procedures not being recognised by the PMI, which may also deter consultants from practising at HCA's hospitals. There is, therefore, a "multiplier effect" on being delisted on any one PMI network.
- 5.20 The CC notes that the bilateral negotiations over the PMI contract, when seen in isolation, appear to indicate that insurers are often in a "relatively weak position".<sup>103</sup> HCA submits that by taking account of the full range of "delisting" options available to PMIs, particularly for the four major PMI providers (accounting for 88 per cent of the PMI market), the CC will observe just how credible the PMI's delisting threat is. Furthermore, as explained above, the outside options available to PH providers when negotiating with PMIs are very limited. This means that, when considered alongside the PH providers', the PMI's outside option is strong enough and credible enough to swing the balance of bargaining power firmly in the PMI's favour. Below, HCA describes instances in which it has been "delisted" in terms of (i) facilities on given networks, and (ii) specific treatments or procedures.

*Delisting of HCA facilities*

- 5.21 HCA continues to be delisted by each of the four prominent PMIs on at least one of their key networks – and on each of these networks the PMI has listed HCA's London-based competitors. See Table 5.1 below for a sample of such networks.

**TABLE 5.1: Networks excluding HCA facilities (non-exhaustive)**

Insurer Network	HCA facilities listed	HCA facilities not included by the PMI on Network	Sample of HCA's competitors on Network
<b>Aviva</b>			
Key List	Harley Street at UCH; Harley Street at Queens; the Christie Clinic.	Harley Street Clinic; Lister; London Bridge; Portland Hospital; Princess Grace; Wellington.	BUPA Cromwell; London Clinic; King Edward VII, Parkside, St John's & Elizabeth's, London Independent, and a host of major London PPUs
<b>AXA PPP</b>			
Corporate Health Pathways	None	Harley Street at UCH; Harley Street at Queens; the Christie Clinic; Harley Street Clinic; Lister; London Bridge; Portland Hospital; Princess Grace;	London Clinic; King Edward VII, Parkside, St John's & Elizabeth's, London Independent, BMI Weymouth and Fitzroy Sq

<sup>103</sup> Paragraph 15, Appendix D.

		Wellington.	Hospitals, and a host of major London PPU's
Health-on-line	None	Harley Street at UCH; Harley Street at Queens; the Christie Clinic; Harley Street Clinic; Lister; London Bridge; Portland Hospital; Princess Grace; Wellington.	London Clinic; Parkside, St John's & Elizabeth's, London Independent, BMI Weymouth and Fitzroy Sq; and a host of major London PPU's
<b>BUPA</b>			
Extended Choice	Harley Street at Queen's; Sarah Cannon Research Institute; The Christie Clinic.  (Also includes selected outpatient facilities such as New Malden Diagnostic Centre; Brentwood Medical Centre and Sevenoaks Medical Centre)	Harley Street at UCH; Harley Street at Queens; the Christie Clinic; Harley Street Clinic; Lister; London Bridge; Portland Hospital; Princess Grace; Wellington.	Aspen Parkside; St Mary's Hospital; St George's Hospital; Spire Bushey; Royal National Orthopaedic Hospital; Mount Vernon Cancer Centre (CyberKnife); BMI Garden Hospital; New Victoria Hospital (Kingston); BMI Clementine Churchill; BMI Coombe Wing (Kingston)
<b>PruHealth</b>			
Countrywide	Harley Street at Queen's Hospital; The Christie Clinic.	Harley Street at UCH; Harley Street Clinic; Lister; London Bridge; Portland Hospital; Princess Grace; Wellington.	London Clinic; King Edward VII; Aspen Parkside; BMI Weymouth and Fitzroy Sq.

Source: Online insurer network lists

5.22 Table 5.1 demonstrates that, in the case of HCA, it cannot be said that PMIs have "little or no choice" to contract to list all HCA hospital facilities on their networks. Rather, it reveals that PMIs have been able to exclude HCA hospital facilities from their networks and, on those very same networks, include some of HCA's major rivals based in London and the South East, such as the BUPA Cromwell, the London Clinic, King Edward VII Hospital, St John's and Elizabeth's and the Aspen Parkside.

5.23 Furthermore, the PMI networks excluding HCA hospitals are important and significant PMI networks. This includes Aviva's long-established Key network, PruHealth's Countrywide network (both representing core network products) as well as networks operated by AXA PPP and BUPA. For example, Aviva describes its Key network list as its "core cover" product in its PMI marketing brochure.<sup>104</sup> When a customer visits the Aviva website and requests a PMI quote, it generates a quote by default for the Key list product (on entering a London residential postcode). On the online results page, it states under "Your Quote Summary" the words "Hospital List Core (Key)". There is no mistake in our minds as to which list Aviva considers to be its "core" network – it is the Key List. Indeed, the CC notes this too (paragraph 40 of Appendix E): "*The majority of [Aviva's] customers hold a product that*

<sup>104</sup> <http://www.aviva.co.uk/healthcarezone/document-library/files/ge/gen4685.pdf>



*provides access to the hospitals on its Key list*". HCA believes that this is also likely to be consistent with Aviva's overall London spend data.

- 5.24 If HCA had sufficient market power to leverage its local market power to secure recognition for all its facilities on all PMI networks (i.e. if PMIs had "little or no choice" to include HCA on their networks), one would not expect to see HCA excluded on significant PMI networks, in particular those which include HCA's major rivals in London. Yet this is the exact situation that prevails. The fact that PMIs can, and do, exclude PH providers' facilities from core networks indicates the strength of PMI's in negotiations with HCA. They are able to do more than simply threaten to delist individual treatments but are able to exclude entire facilities from their networks, switching substantial volumes away from HCA. This clearly shows that the threat of delisting is a current and very credible one.
- 5.25 In addition, Table 5.1 indicates that PMI providers have not found it "impractical" to list specific HCA facilities and exclude others owned by HCA. Rather, the outcome of HCA's bilateral negotiations with PMIs reveals that PMIs have been able to freely select specific HCA facilities for inclusion on their networks. For example, the Sarah Cannon Research Institute, Harley Street at UCH, Harley Street at Queens, the Christie Clinic, and HCA's outpatient and diagnostic facilities have all featured on networks that exclude HCA's other hospital facilities.

#### *Delisting of designated treatments at particular hospitals*

- 5.26 As noted by the CC, delisting can also arise when a PMI decides not to recognise a hospital operator for the provision of designated treatments or procedures at particular hospitals.<sup>105</sup> HCA has experienced this form of delisting too, for example:
- **MRI services:** As part of its MRI network, which came into effect on 20 April 2006, BUPA decided to exclude a number of HCA hospital facilities from its MRI network. [redacted]. When informing doctors of its decision to delist HCA for MRI services, BUPA informed consultants that it was confident the remaining capacity in London (excluding HCA) will provide sufficient MRI coverage for BUPA members. During this time BUPA encouraged consultants practising at HCA to move their practice to other hospitals in London (see paragraph 5.51).
  - **Ophthalmology services:** In 2006 BUPA set up its ophthalmology network, mandating all hospital operators and consultants to tender to provide a range of specified ophthalmic procedures. Only two of HCA's hospitals, the Lister and Wellington Hospitals were recognised on its network.
  - **TAVI:** In 2012, BUPA setup its TAVI network tender. Following HCA's tender submission, BUPA decided to delist all HCA hospitals for the provision of TAVI (Transcatheter Aortic Valve Implantation) procedures. The hospital facilities that were successful following BUPA's tender process were all NHS PPUs.
- 5.27 In short, the outcomes of HCA's network negotiations with PMIs demonstrate that the PMI's ability to exclude HCA hospitals is not only credible, but has in fact been executed on a number of occasions. In addition, PMIs have been completely free to charge different PMI premiums for network products that exclude HCA compared to those that exclude HCA – for

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<sup>105</sup> CC, AIS, Appendix D, paras. 15 and 25.

example, Aviva charges a very significant premium to its Key List policyholders to upgrade to the Extended List.

### ***Managing network composition – insurer difficulties***

5.28 The CC notes that the "*principal mechanism insurers use as a bargaining tool in negotiations is the shape and size of their network*".<sup>106</sup> As demonstrated above, in HCA's case, PMIs have actively used network configuration to great effect. HCA's facilities are regularly excluded from important networks. This also shows that HCA is in no position to leverage any alleged "must have" facilities to ensure all of its facilities are recognised on all networks or indeed to extract better terms from PMIs.

5.29 In assessing the credibility of the PMI's delisting decision, the CC indicates that it has considered evidence to verify the two main difficulties the PMIs have identified when facing a delisting decision:

- The cost to the PMI itself of removing a hospital from its network can be significant; and
- Removing a hospital from a network can harm the PMI's business and cause it to lose policyholders.<sup>107</sup>

5.30 HCA sets out its comments on each element of the CC's evidence in turn.

#### *The cost to an insurer of removing a hospital from its network*

##### *(a) Increase in rates at the delisted hospital*

5.31 A PMI is able to extract sizeable discounts from hospital operators in return for listing that operator's hospitals on its network(s). A delisting means a hospital operator will face a loss in patient volumes and therefore a re-negotiation of pricing may be necessary in order to make sure the hospital is able to cover its costs. Hospitals have a large fixed cost component to their business; a loss in volume results in an increase in unit costs.

5.32 In any event, HCA strongly disputes the PMIs' position that they face significant costs if they fail to reach an agreement with a PH provider on prices or other contract terms. The premise of the argument, based on patients' continued use of the hospital after it has been removed from a PMI's network, is flawed. PMIs can and do find ways of avoiding or mitigating such costs, as we set out next.

5.33 For treatments or indeed consultations, patients are normally required to obtain pre-authorisation from the PMI. Therefore, the PMI, if it wishes, is in a position to prevent patients being treated at any facility or for specific procedures. Such pre-authorisation protocols are a well-established and entrenched feature of the PMI market. In response to Question 33 of the CC's Market Questionnaire HCA provided examples of where a PMI has changed the process for the eligibility of funding for various medical procedures. The PMI can, and does, use its pre-authorisation procedures to limit the admission of patients to HCA's delisted hospitals. This can take the form of a hard exclusion or general guidance.

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<sup>106</sup> CC, AIS, Appendix D, para. 20.

<sup>107</sup> CC, AIS, Appendix D, paras. 22-23.

- 5.34 There may, nonetheless, be a limited number of patients where, due to exceptional clinical circumstances, the patient is permitted to be treated by the PMI in a HCA hospital on an "out of network" basis. For example, this has occurred with respect to patients on Aviva's Key List.
- 5.35 [X].
- 5.36 Alternatively, the PMI can and often does choose to pass on the excess cost of using the delisting hospital to its customers – in the form of a co-payment option. Therefore, for those customers treated on an out-of-network basis, the PMI may reluctantly agree to permit treatment subject to the customer's own financial contribution. This form of co-payment is a well-established cost-control mechanism and means of influencing policyholder choice that is available to all PMIs. In addition, this cost is borne by the consumer rather than the PMI.
- 5.37 Furthermore, given the lack of effective competition in the PMI market, HCA has not seen any evidence that PMIs are likely to face significant consequences when there is a material change in the value of their offer either in terms of the scope or quality of their network.
- 5.38 A PMI can implement an alternative credible strategy that avoids this cost altogether. This is a strategy that has in fact been successfully utilised by PMIs. Rather than delist a HCA hospital from a network, a PMI can choose to recognise HCA's competitors on a different or newly established network and encourage or re-direct policyholders to this network. Examples of this strategy being implemented include:
- PruHealth decision to include HCA's major London competitors on its Countrywide Network, but continue to exclude HCA.
  - Aviva's decision to include HCA's major London competitors on its Key List, but continue to exclude HCA.
  - AXA PPP's decision to establish a new corporate pathways PMI plan, which excluded HCA (this product has since been relaunched and incorporates a greater number of HCA's major London rivals, such as the London Clinic).
- 5.39 A PMI can subsequently inform its customers that access to world-class healthcare in London is now available on a cheaper network. As customers switch to the alternative network, the PMI achieves a delisting of HCA hospitals "by effect". The establishment of multiple PMI networks has therefore expanded the means by which insurers can exert bargaining power over hospital operators such as HCA.
- 5.40 By contrast, it is not in HCA's interest to face the uncertainty of being in an out of contract period for any length of time. HCA is reliant on securing recognition from PMIs, particularly the two largest players, as they account for a significant proportion of its (and of its consultants') business. During an out of contract period HCA has no clarity over the expected volume of patients or the prices it will be able to charge for treatments going forward. The CC does not acknowledge this factor and its ability to impede a PH provider's business planning.
- (b) Delay before amending network*
- 5.41 The second claim is that PMI providers would face a delay before being able to amend their network.
- 5.42 The matter of agreeing pricing and network recognition are both decided during contract renewal discussions (unless the insurer decides to launch a new network for strategic

reasons). Therefore a PMI is aware, well in advance, of the period during which bilateral negotiations will commence. That is, a PMI cannot be taken by surprise, but, rather, will have ample time to prepare for contract renewal discussions. PMIs are able to utilise this time carefully, for example, by raising the issue of a potential delisting with intermediaries, corporate clients and present opportunities for rival hospital operators. The CC notes in paragraph 28 of its AIS that it found examples of insurers planning how they engaged very carefully with their customers and used the media to put pressure on hospital operators. These are tactics that have been deployed most notably by BUPA around the time of its delisting of BMI hospitals.<sup>108</sup>

- 5.43 Therefore HCA walks into such negotiations with uncertainty as to the extent of any delisting preparations performed by the PMI. As far as HCA is aware, at the point at which a deal must be struck, the PMI may be in advanced planning to delist HCA hospitals. This uncertainty means HCA is more likely to capitulate to a PMI's demands during the negotiation process.

*(c) The cost of alternative hospital operators*

- 5.44 [X]. As HCA has explained above, given the degree of horizontal and vertical differentiation in the market, price dispersion amongst providers is entirely consistent with a competitive market. If it is the case that HCA tends to be relatively more expensive for specific procedures, then it would seem unlikely that diverting patients to alternative hospital operators would be more expensive. In London, the alternatives for PMIs are in fact likely to have several pricing advantages over HCA. In the case of PPU, there are cost advantages (related to the hospital infrastructure, staffing and tax benefits). In the case of hospital organisations set up as charities, there are benefits in being able to access capital, minimise tax liabilities and benefit from large donations (that can be applied toward large-scale capital projects). An example of the latter is King Edward VII's nursing accommodation development, which HCA understands was funded by a sizeable donation. In the case of large chain operators such as BMI, it is able to achieve significant economies of scale from its UK operations. Therefore, a PMI is not short of alternative operators in London able to achieve lower price points than HCA.

*(d) The potential loss of policyholders as a result of removing a hospital from a PMI's network*

- 5.45 For the reasons set out above, HCA fundamentally questions the CC's ability to assess whether the removal of a hospital from a PMI's network can cause it to lose policyholders given that it has not engaged in an assessment of the PMI market.
- 5.46 HCA would point the CC to the fact that PMIs have, and frequently do, decide to exclude hospitals from their networks (including HCA hospitals, see Table 5.1) and develop new networks with a limited number of PH providers. This clearly speaks to their ability to satisfy policyholders with networks that include only a subset of the hospitals available to them. Furthermore, the CC does not take any account of any discount in price the PMI may decide to pass on following the delisting in order to mitigate any loss of policyholders.
- 5.47 Additionally, the CC should consider the extent to which PMI policyholders are effectively 'locked in' due to medical conditions they have developed during the course of holding a PMI policy. HCA has presented its arguments in relation to this issue to the CC in paragraphs

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<sup>108</sup> <http://www.telegraph.co.uk/health/expathealth/9675584/Health-insurers-try-to-slam-the-brakes-on-spiralling-prices.html>

6.16-6.21 of its Response to the CC's Issues Statement. Even in the case of corporate PMI customers, there is likely to be switching inertia due to the transaction costs in initiating new HR logistics planning, conducting new negotiations with alternative PMIs and the potential loss of loyalty discounts accrued with the incumbent PMI. Furthermore, the CC has presented third party evidence from corporate contacts in the financial services sector and from a number of other large companies in other sectors which demonstrated that such parties do not consider it important to provide access for their staff to HCA hospitals.<sup>109</sup> Therefore HCA would query the extent to which PMIs would suffer a loss in policyholders as a result of delisting HCA on one of their networks. Indeed, BUPA, AXA PPP, Aviva and PruHealth have all decided not to list HCA on at least one of their networks, while listing HCA's main competitors.

*(e) Transferring pricing power to other hospitals*

- 5.48 The CC also suggests that the PMI must take into account that delisting a particular hospital or a PH provider may weaken its negotiating position with other PH providers.<sup>110</sup> HCA does not consider that this is necessarily the case as the PMI still has (in London) a very wide range of alternative hospitals and PH providers available. Rival hospital operators would happily engage in offering discounted rates to a PMI in order to secure more of HCA's business. Indeed, as noted above, a number of the PMIs operate networks that do not include HCA, but include HCA's close rivals. This demonstrates the ability of PMIs to meet customer demand without one (or more) of the main PH providers and that the impact of this course of action is not so significant (if at all present) to deter this course of action from ever occurring.

*(f) Reputational issues*

- 5.49 In fact, the PMI's decision can send a clear signal to the other PH providers as to the bargaining power enjoyed by the largest PMIs. The CC has failed to recognise the implicit signal sent to the market about the PMIs' bargaining strength and credibility of its threat to delist a hospital/ PH provider. This reputational effect allows the PMI to wield its buyer power in subsequent negotiations.
- 5.50 Nor does the CC refer to the significant reputational harm that arises for hospital operators from being delisted. A delisting may be interpreted by patients as a signal for inferior quality – particularly as PMIs tend to conflate network recognition with the notion of high quality standards. Furthermore, there is harm to the hospital's relationship among consultants. Consultants may be deterred from practising at a hospital where a proportion of their patients are no longer eligible to be treated there.
- 5.51 Insurers and competing hospital operators can exploit this period of weakness (in which the hospital operator is permanently or temporarily delisted), by pressuring or encouraging consultants to switch their practice to another hospital. This is what occurred when HCA was delisted for MRI services by BUPA in 2006. The exclusion of MRI services had the effect of severely disrupting the patient pathway, impacting both the consultant and patient. In a letter dated [redacted] (**Exhibit 5.1**) from BUPA to a consultant practising at the [redacted] and the [redacted], BUPA responded as follows to concerns expressed by the consultant regarding the disruption to services at the [redacted]:

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<sup>109</sup> CC, AIS, Appendix F, paras. 37-38.

<sup>110</sup> CC, AIS, Appendix D, para. 22.

"[redacted]."

- 5.52 Competitors can also exploit such moments to attract consultants and their patients. HCA has obtained a copy of a letter from the Chief Executive of the King Edward VII's Hospital dated [redacted] (**Exhibit 5.2**), addressed generally as "Consultants", which notes:

*"... The BUPA MRI network comes into effect from 20 April 2006.*

*You may also be aware that BUPA has excluded HCA hospitals and is unlikely to pre-authorise BUPA members for MRI scans in hospitals such as the Princess Grace, Harley Street Clinic, The Lister and The Wellington. For those of you who do not routinely use our scanning facilities you should be aware that we have both a four slice spiral CT scanner and a 1.5 Tesla MRI machine. We are also prepared to recruit additional staff to meet extra demand which may result from this change for BUPA members."*

- 5.53 All hospital operators, including HCA, are therefore extremely vulnerable to losing consultants and patients when confronted with a PMI delisting. This applies even in the case of being delisted for a single procedure – due to the wider disruption to the patient pathway. This vulnerability enhances the bargaining power of insurers during such negotiations.

- 5.54 The CC further notes that hospital operators may choose to "impact" the customer directly in order to put pressure on the insurer to agree a deal. The CC does not make clear what it means by "impact" the customer. If the CC is referring here to a decision to bill a customer directly (rather than through their PMI), there are two points to note. [redacted]. Therefore, such a course of action can only legitimately be taken by a hospital operator either when the existence of a valid and enforceable contract is uncertain or where the insurer has not reimbursed a hospital within the payment period [redacted]. The hospital, acting within the terms agreed with PMIs, may be left with the only option of seeking compensation directly from the patient for the services it has already provided. This is a course of action that HCA is always desperate to avoid, and, on occasion, [redacted]. Secondly, this can hardly be characterised as a viable negotiating strategy for a hospital operator to routinely adopt. HCA relies on its reputation for excellence and customer service to attract consultants and patients – "targeting patients" is never an attractive option as it severely damages the hospitals' reputation and goodwill with both.

- 5.55 In sum, the reputational impact of a delisting on PMIs is marginal, whereas there is a severe disruption to a hospital operator's business. Importantly, the CC has not considered the impact of a delisting on PH providers and their motivations to avoid being delisted as delisting weakens a hospital operator's own negotiating position going forward. For example, in future negotiations with other PMIs, after failing to reach an agreement with one PMI, HCA would become heavily reliant on the remaining insurers. However, by only looking at one side of the bargaining equation, the CC has failed to recognise these effects. This again highlights the importance of considering the relative positions of both the PMI and the PH providers.

- 5.56 Furthermore, on every occasion that a PMI decides to exclude a PH provider from a PMI network, they will not only directly impact on that PH provider's revenues but also on its ability to attract and retain consultants, further weakening the PH provider's bargaining position.

#### ***PMIs' use of network recognition in negotiations***

- 5.57 Before addressing the different ways in which PMIs use networks in negotiations with hospital operators, HCA would like to address the CC's reference to AXA PPP's submission

in relation to HCA, that, "*it regarded itself in a position to negotiate with most hospital operators, although HCA's status in London results in commercial constraints*"<sup>111</sup>.

- 5.58 If by "commercial constraint" AXA PPP is implicitly arguing it cannot create a network that excludes HCA, it is evident from Table 5.1 that it has not in fact been constrained in marketing PMI networks which incorporate London healthcare providers but exclude HCA. The London market is highly competitive and HCA faces vigorous competition from a wide range of providers and across the full spectrum of acuity. AXA PPP has been able to leverage this competition in the market when developing these networks. For example, AXA PPP relaunched its corporate pathways product in October 2012 (the product continues to exclude HCA but now includes hospitals such as the London Clinic and Aspen Parkside in addition to BMI's London hospitals). Around the time of this re-launch, Paul Moulton, sales and client relationships director at AXA PPP healthcare, said the insurer wanted to "*broaden the capability and appeal of the Pathway*" and that "*open referral is not the default option for large employers, but that AXA PPP would hope that in two to three years' time, the majority of its clients would opt for this model.*"<sup>112</sup> If anything, AXA PPP appears to be confident of convincing corporates to join the scheme. This is consistent with the CC's third party evidence (Appendix F), which indicated that many large corporates in London do not consider HCA hospitals to be "must-have" facilities.
- 5.59 However, if by "commercial constraint" AXA PPP means it faces difficulties steering patients away from HCA's facilities because consultants and patients are drawn to the high standards of care and clinical excellence achieved at HCA's hospitals and therefore reluctant to switch to a different quality offering, then AXA PPP must surely realise that HCA's standing in the market is, in itself, both a product and evidence of competition in the market – with quality and investment being the drivers of competition.
- 5.60 AXA PPP's statement also implies it is able to balance the market power of hospital operators with monopoly positions - (i.e. solus hospitals with 100 per cent market share). Despite this ability, it maintains it is nonetheless subject to "commercial constraints" with respect to HCA's position in London. Evidently this "constraint" cannot be put down to HCA's market share.
- 5.61 HCA discusses in its section on barriers to entry the implications of AXA PPP's statement that it counterbalances the market power of other hospital operators by leveraging the PH provider's "*objective to achieve recognition for as many of their non-solus hospitals as possible*".<sup>113</sup>
- 5.62 At the outset, it should be noted that PMI networks were created in order to foster competitive tendering scenarios in which PMIs could offer hospital operators access to a greater volume of patients in return for more attractive terms. As BUPA states in its submission to the CC's Issues Statement, networks have the effect of "*encouraging hospitals to offer discounts to get into the network in order to access more volume*".<sup>114</sup> This greater volume is achieved by limiting the number of hospital operators on any given network. Therefore, the delisting of hospitals is not "rare", but a commonplace and inevitable consequence of PMI networks.

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<sup>111</sup> AIS, para. 30.

<sup>112</sup> This reference is cited by the CC at para. 47 of Appendix F.

<sup>113</sup> CC, AIS, Appendix D, para. 30.

<sup>114</sup> BUPA response to the CC's Issues Statement, para 1.77(i).

AXA PPP also states in its response to HCA's submission that "*our networks are central to our competitive ability to negotiate advantageous price terms*".<sup>115</sup>

- 5.63 The existence of networks enables PMIs to use "network recognition" in a number of different ways when negotiating with hospital operators.
- 5.64 First, a PMI may develop a new network and seek fresh negotiations with some or all hospital operators for inclusion on this new network. For example, AXA PPP adopted this strategy with regard to its Corporate Health Pathways Plan and Health-on-line product. BUPA sought tenders from hospital operators in respect of its new low cost network, later manifested by BUPA "By You". Each of BUPA's new "carved out" specialty networks triggers fresh network negotiations. As part of these network negotiations, a PMI may decide that if the terms offered by a hospital operator are not attractive it will not recognise some or all of that that hospital operator's facilities.
- 5.65 Secondly, existing networks also play an important part in the contract negotiations. A PMI may, for example, solicit more attractive terms from hospital operators by offering to expand the number of networks that the operator's facilities are listed on. For example, Aviva sought an average discount of [X] (in addition to its already discounted contractual rates) from HCA in order for HCA hospitals to be included on the Key List.
- 5.66 Thirdly, a PMI may decide to actively exclude a hospital operator from its existing networks. As the CC correctly notes with the example of the BUPA/BMI delisting (paragraph 29 of the AIS), a "delisting" is not necessarily limited to a removal of every single hospital operated by the PH provider, but can also include a decision by a PMI not to include designated hospitals or services, which can have a significant impact on the PH provider. One example is BUPA's delisting of HCA's hospitals for MRI services in 2006 and its later delisting of HCA hospitals for TAVI procedures, both of which formed part of the general agreement between the parties before being "carved out" by BUPA.
- 5.67 Fourthly, a delisting can be achieved "by effect" through PMI network reconfiguration. PruHealth's last network reconfiguration highlights how network reconfiguration can be used to weaken the bargaining power of specific hospital operators, such as HCA. This is discussed in further detail below.

*Delisting "by effect" – network reconfiguration*

- 5.68 Prior to its network reconfiguration, that is, at the time PruHealth contracted with HCA in December 2009, it operated four networks:
- The Local List
  - The National List
  - The London List
  - The Premier List (intended to incorporate all private hospitals and PPU's)
- 5.69 During its negotiations with HCA, PruHealth decided the following recognition status for HCA's hospital facilities:

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<sup>115</sup> AXA PPP response to HCA submission, para. 128.



- HCA's six hospitals, Harley Street at the UCH and Harley Street at Queens (and HCA's outpatient facilities) would be on Premier List and London List.
  - Harley Street at Queen's would be listed on all four lists.
- 5.70 HCA secured its inclusion on the London List in return for highly favourable discounts. PruHealth also decided to incorporate HCA's hospital unit at Queen's on the Local List and National List, i.e. there was no one-in all-in position with respect to network inclusion here.
- 5.71 Without consulting HCA, PruHealth restructured its networks. This reconfiguration amounted to dropping the London List and expanding the scope of facilities included in the National List (which was rebranded as the "Countrywide List"). Specifically, PruHealth added HCA's major London competitors to its Countrywide network but continued to exclude HCA's hospitals. As a result of this network reconfiguration, policyholders on the Countrywide List are able to access the following non-exhaustive list of hospitals:
- London Clinic
  - King Edward VII's Hospital Sister Agnes Hospital
  - Aspen Parkside (including the Parkside Oncology Clinic)
  - BMI Weymouth Hospital
  - BMI Fitzroy Square Hospital
  - Great Ormond Street Hospital
  - National Hospital for Neurology and Neurosurgery - Nuffield Ward
  - The BMI London Independent
  - The Chelsea and Westminster Hospital – Chelsea Wing
  - King's College – Guthrie Clinic
  - Royal Free Hospital PPU
  - St Anthony's Hospital
  - Moorfields Eye Hospital - Cumberlege Wing
- 5.72 The list of providers above are capable of offering the range of complex tertiary services, such as neurosurgery, cardiac surgery and cancer care in London that have become an important element of HCA's market offering. PruHealth's Countrywide List cannot be considered a "non-London" regional PMI network.
- 5.73 In short, HCA went from a position of having its six hospitals listed on two of four networks to being listed on one in three networks - reducing the proportion of PruHealth customers able to access HCA hospitals. Furthermore, on the most important of these three networks, the Countrywide List, HCA's London competitors were included on the network. Naturally, those consumers that would have ordinarily opted for the London list (because they did not wish to pay for the Premium List) would now be more likely to opt for the Countrywide List given its London healthcare coverage. As the proportion of policyholders on the Countrywide List increases, HCA is increasingly delisted "by effect".

- 5.74 A further example of network reconfiguration that affected HCA's position in London is Aviva's network reconfiguration.
- 5.75 At the time of contracting with HCA in November 2009, Aviva had in place the following networks:
- Trust Care List
  - Key List
  - Fair + Square List
  - Extended List
- 5.76 Following its contract negotiations with HCA, Aviva decided the following recognition status for HCA hospital facilities:
- HCA's six hospitals and Harley Street at UCH would be listed on the Extended List and Fair + Square List.
  - Aviva also agreed to recognise the Harley Street at Queen's unit (when it opened) on the Key and Extended List.
- 5.77 HCA offered significantly discounted rates to Aviva to be incorporated onto the Fair + Square List. However, without notifying HCA, Aviva went on to "close" the Fair + Square List.<sup>116</sup> In addition, Aviva added in the summer 2011 a number of HCA's major London-based competitors to the Key List (a list which still excludes HCA's six hospitals), including the London Clinic, BUPA Cromwell and King Edward VII's Sister Agnes. This means that the range of London healthcare options for a consumer opting for the Key List now includes every single one of HCA's London-based competitors (the following is a non-exhaustive list):
- BUPA Cromwell
  - London Clinic
  - King Edward VII's Sister Agnes Hospital
  - BMI London Independent
  - Aspen Parkside
  - The Royal Marsden – Granard House
  - BMI Weymouth Street
  - Chelsea & Westminster Hospital – Chelsea Wing
  - St Mary's Hospital – Lindo Wing
  - National Hospital for Neurology and Neurosurgery - Nuffield Ward
  - King's College – Guthrie Clinic
  - BMI Blackheath Hospital

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<sup>116</sup> The closure of the list meant it ceased to be marketed to PMI customers.

- Great Ormond Street Hospital PPU
- Moorfields Eye Hospital - Cumberlege Wing

- 5.78 The Key List cannot therefore be characterised as a non-London or "regional" hospital list. It offers a very comprehensive list of London hospital facilities – in fact the only London private hospitals in London not included in the Key List are HCA's six hospitals.
- 5.79 The effect of closing the Fair + Square List and adding HCA's major London competitors to the Key List is that HCA is "delisted" for a proportion of Aviva's customers that travel to London for private healthcare.
- 5.80 The "delisting" effect of such network reconfigurations is multiplied by the consultant drag effect. Once HCA's London competitors had secured a listing on Aviva's Key List, no opportunity would have been wasted to inform consultants that they can bring their entire patient lists (comprising patients on the Key List and other PMI networks) to their hospitals without needing to go through a burdensome clinical justification process for "out-of-network" patients. As a result of the consultant drag effect, the risk would be that any defecting consultants would take their entire patient list with them.

#### **Impact of changing contracting arrangements on the bargaining position of PMIs**

- 5.81 The CC has referred to evidence in relation to PMIs' use of regional tendering, commenting that it has been provided with two examples of where the insurers have constructed part of their core network by way of a tendering exercise (AXA PPP's regional network and PruHealth's reconfiguration of its hospital networks).<sup>117</sup>
- 5.82 The CC must exercise caution in adopting the term "core network". From a hospital operator's perspective, the objective is to be listed on as many of the PMI's constituent networks. If HCA hospitals are not included on any given PMI network (which is in fact the case for each of the four major PMIs), then it is effectively delisted with respect to the policyholders that have elected to join that network. In the case of Aviva, HCA is not listed on its most important "core" network, the Key List.
- 5.83 The CC has also considered evidence presented by one PMI in relation to local pricing. This PMI had indicated to the CC that it had not tried to negotiate differentiated pricing based on the location of different facilities. HCA notes that the CC has concluded that it is, "*not convinced that insisting on differential pricing across different hospitals will necessarily improve an insurer's bargaining position*".<sup>118</sup>
- 5.84 On this note HCA submits that insurers are able to achieve differential pricing with HCA hospitals. BUPA secured recognition of HCA's [X]. This was in part a successful investment hold-up by BUPA, and in part a reflection of BUPA's desire to have rates broadly matched with comparable facilities in the surrounding area (HCA was not presented with data by BUPA evidencing this, but had to submit to BUPA's assertion that this was the case). In addition, PMIs have recognised inpatient procedures at [X]. Therefore, PMIs can and do achieve regional differential pricing with respect to HCA facilities.

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<sup>117</sup> CC, AIS, Appendix D, para. 32

<sup>118</sup> AIS, Appendix D, para. 34.

## Other factors that may impact the bargaining position of PH providers or PMIs

5.85 There are a range of other issues that the CC acknowledges may influence the negotiating position of PMIs or PH providers.

### *Recognition of new facilities*

5.86 The CC rightly notes that PMIs may be in a stronger negotiating position where a PH provider asks a PMI to recognise a new facility that was not previously included on its hospital network. HCA agrees that PMIs are in a strong bargaining position in this context and has provided evidence supporting this.<sup>119</sup> However, the PMI's strong bargaining position also applies where the newly acquired hospital was previously included on its hospital network (under different ownership) – [X] – where HCA faced difficulties securing BUPA recognition.

5.87 In its response to the CC's Market Questionnaire, HCA included a number of examples where behaviour by PMIs (leveraging their buyer power) has stifled investment in facilities outside of central London.<sup>120</sup> Additionally, even where facilities or treatments eventually have been recognised by a PMI, this has often been at a significant discount, for example in the case of BUPA's recognition of [X]. Even in the case of new facilities in central London, such as the [X], HCA only secured recognition from BUPA subject to [X]. This is a negotiating tactic applied by BUPA as part of the cost of securing terms of recognition.

5.88 HCA submits that any PMI with significant market power in the PMI market will be in a position to limit access to healthcare for patients to a much larger extent than if the PMI market was characterised by healthy competition. This limitation in access can take the form of either a restriction in (and hence the volumes of) treatments (or facilities) made available and/or in terms of private healthcare quality offered.

5.89 It is difficult to see how a PMI with downstream market power may have an incentive to offer (from the patient population perspective) the efficient level of private healthcare provision, both in terms of volumes and in terms of quality. Any benefit to a PMI from recognising a new facility or a new treatment would have to arise through either a volume effect and/or a price effect.

5.90 The volume effect would be due to a market expansion effect (i.e. new consumers buying a personal PMI policy or new corporate clients signing up) or through a business-stealing effect (i.e. that PMI attracts policyholders and/or corporate clients from competing PMIs). HCA notes that the latter channel may be constrained by the inability of policyholders to switch PMI (e.g. because of existing conditions or other switching costs, see paragraph 5.47).

5.91 A price effect could arise through the potential ability for the PMI to raise its premiums (on a number of network products) thanks to the inclusion of a new innovative facility or treatment. However, a PMI may see limited direct benefits arising from the recognition of a new facility or treatment.

5.92 In deciding whether to recognise a new facility or treatment, a PMI would weigh any benefit against the costs of recognition. These costs would include the expected payments it would have to make to the innovating PH provider, which in turn would depend on the price that would be agreed for each new treatment and the expected volume of such treatments to be carried out. A successful new treatment may be seen by PMIs as leading to more patients

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<sup>119</sup> See Section 7 of the Response to the Market Questionnaire.

<sup>120</sup> HCA Response to IS, paras. 10.71 – 10.93.

being treated, where they previously would have either relied on the NHS (albeit perhaps with a longer waiting time) or simply not been treated at all (like in the case of certain cancer treatments with innovative techniques, such as CyberKnife).

- 5.93 It is unsurprising, therefore, to see PMIs resisting the introduction of higher quality and innovative treatments or failing to communicate the benefits to their patients. This is consistent with a non-competitive PMI market, where PMIs see little scope for (or benefit in) improving the quality of their network, and instead see an immediate potential effect on their costs which is higher the more the treatment actually benefits consumers. Indeed, AXA PPP's recent submission responding to HCA highlights the PMI's reluctance to authorise new technology such as CyberKnife or NanoKnife and the PMI's preoccupation with cost over quality.<sup>121</sup>
- 5.94 PMIs may point to HCA's investment record and growth of outpatient / day case care as a means of rebutting this argument. However, the reluctance of PMIs to recognise new treatments may well have a greater "chilling" effect on other hospital operators which are even more dependent than HCA on PMI revenue and have less overseas business, and, furthermore, the reluctance of PMIs to support new treatments has had the effect of dampening the pace at which new treatment technologies are implemented in the private sector, rather than preventing it altogether.
- 5.95 Furthermore, the ability of PMIs to withhold recognition of new facilities should be considered as a theory of harm in its own right. It limits choice for consumers and holds up new investment which can translate into poorer health outcomes which potentially cost lives.
- 5.96 PMI recognition (particularly from BUPA and AXA PPP) for a new facility is essential to ensure financial viability. Without PMI recognition, the investment risks in terms of the ability to generate sufficient patient demand would be prohibitive.
- 5.97 [X].
- 5.98 [X].

*Attempts by a PMI to partially delist a hospital*

- 5.99 HCA considers that attempts by a PMI to partially delist a hospital demonstrates the strength of their bargaining power and the availability of outside options to PMIs that can be exercised in negotiations. Whilst HCA agrees that it is not as extreme as a full delisting, it can nonetheless significantly affect the performance of a hospital and represents a highly credible PMI negotiating threat.
- 5.100 The delisting of particular specialties, particularly by larger insurers, can lead to the end of the provision of such services as there are insufficient patient volumes to continue to offer a given specialty. Even in the case of a delisting by smaller insurers, the consultant drag effect may result in consultants choosing to rebase their practice at another hospital should a proportion of their patients no longer be eligible for treatment in a HCA facility.
- 5.101 HCA understands the importance of excelling in the provision of healthcare services at every potential stage of the patient pathway. By offering a full-pathway service, the highest potential quality standards can be upheld, chiefly because the process of diagnosis, treatment and post-treatment support and rehabilitation become integrated functions and mutually

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<sup>121</sup> AXA response to HCA submission, para. 31-38.

reinforcing. The removal of designated specialties or medical procedure is capable of disrupting a hospital's ability to offer services across the full patient pathway. By way of example, HCA provides copies of letters written by consultants to BUPA (**Exhibit 5.3**) explaining how BUPA's delisting of MRI services at HCA hospitals would harm the quality of care to patients and disrupt an otherwise efficient pathway.

- 5.102 In addition, HCA prides itself on its growing range of specialties and sub-specialties on offer at its hospital facilities. This not only broadens its appeal to patients, but is a key factor in attracting consultants. HCA, in particular, is actively trying to attract the consultants at the very top of their fields. The delisting of HCA hospitals for designated specialties or procedures has the effect of significantly diminishing the appeal of HCA hospitals to consultants and their patients.
- 5.103 BUPA's specialty networks, discussed below, are a demonstrably effective means of delisting hospital operators for specific groups of treatment or procedures. HCA experienced the potency of this strategy when delisting for MRI services and, more recently, for TAVI procedures. BUPA's new CT (Computerised Tomography) network represents BUPA's next specialty network, and HCA anticipates this network will culminate in partial delistings for operators.
- 5.104 HCA does not agree with the CC that, *"it could be difficult to communicate to customers that they could be treated for some specialisms at their local hospitals not others"*. The fact that the PMIs have delisted some specialties at HCA's facilities demonstrates that if there is a difficulty it is certainly not insurmountable and is something that the PMIs appear to have been able to do quite easily. At the point of a patient referral from a GP practice to a consultant, in order to obtain pre-authorisation for a consultation and any treatment, the patient will contact their PMI provider to obtain the authorisation under their PMI policy for the particular consultant. At this stage, the PMI will only need to provide information on the facilities covered at which that consultant practices for the particular specialty required. It may not be apparent to the patient that they would be unable to go to the same facility to see a consultant practising a different (not required) specialty.

#### *Co-payment*

- 5.105 The CC correctly notes (at paragraph 41 of Appendix D) that another option open to an insurer that is concerned about the cost of a particular provider is to adopt a co-payment mechanism with its customers, whereby if the customer wants to be treated at a more expensive hospital in a network, it can give customers the choice of paying a surplus to do so. The CC had identified examples but noted that it did not appear to be widely used in practice.
- 5.106 This mechanism is indeed utilised by PMIs, and we would urge the CC to obtain more definitive data from PMIs as to the proportion of claims that do involve a co-payment. A smaller insurer, WPA, has successfully launched a "Shared Responsibility" product in which policyholders are able to derive a lower premium for equivalent healthcare coverage on the basis that the policyholder pays a proportion of any claim (up to a maximum).
- 5.107 In addition to an "in-network" co-payment, the CC has not acknowledged another (possibly more powerful) co-payment mechanism utilised by PMIs in respect of "out of network" hospitals. This mechanism can be used by hospital operators to substantially mitigate the impact on its own business of delisting a hospital operator. Specifically, the PMI can exclude a hospital operator from a given network (for example, Aviva's exclusion of HCA hospitals on

the Key List network), but then provide an option to be treated at the delisted hospital on an "out of network" basis with the proviso that part of the cost may need to be paid by the customer.

- 5.108 On page 1 of Aviva's hospital list marketing brochure (highlighted prominently in a large yellow box), it notes:

*"Please note*

*If you receive treatment as an in-patient or day-patient in a hospital that is not either: included on your hospital list and recognised by us for the treatment that you need, or an NHS pay bed (unless you have the Fair+Square hospital list, where pay-beds aren't available)*

*we will calculate the average cost of equivalent treatment across all hospitals, and that average cost is the maximum we will pay. This could leave you with a shortfall that the policy does not cover. If the actual cost of the treatment is less than the average cost, we will pay the hospital costs in full. We will cover specialists' fees up to the limits in our fee schedule."*<sup>122</sup>

- 5.109 On BUPA's FAQ section, in response to the frequently asked question: "How do hospital networks work?",<sup>123</sup> the website notes the following:

*"...If you go to a Bupa recognised hospital that is outside of your chosen network you will have to pay a proportion of your treatment costs."*

- 5.110 In a prominent part of the PruHealth website, it tells insurance sales advisers that:<sup>124</sup>

*"If your clients use a hospital that isn't on their chosen list, for in-patient treatment or MRI, CT or PET scans, then they'll need to pay 40% of their treatment costs (excluding the specialists' fees). If they want to avoid paying this, they'll need to travel to a hospital on their list. If they need treatment that the hospitals on their list can't give them, then they can contact us. We will find a hospital and a consultant to give them the treatment they need."*

- 5.111 Therefore the co-payment mechanism adopted by PMIs to enable customers to visit excluded network hospitals is in fact very prominent. It is a mechanism that enables the PMI to delist HCA hospitals operator, but still provide a limited number of customers the opportunity to visit HCA on a co-payment basis, thereby limiting the loss of policyholders by the PMI and capping its financial exposure to the level of reimbursement it considers fit for that specialty and geographic area.

#### *Encouraging growth of alternative hospitals*

- 5.112 Given the high level of market concentration in the PMI market and the relative stability of these market shares over time, the major PMI providers have significant leverage as purchasers of private healthcare. This puts them in a very strong position to encourage the growth of alternative hospitals. The CC has correctly considered the option of offering more

<sup>122</sup> Available at: <http://www.aviva.co.uk/healthcarezone/document-library/files/ge/gen2318.pdf>

<sup>123</sup> <https://www.bupa.co.uk/individuals/health-insurance/quote-faq>

<sup>124</sup> <http://pruhealth.pruhealth.co.uk/advisers/literature-and-tools/choose-a-hospital-list>

generous terms and conditions for those consultants practising at alternative hospitals in order to encourage them to move more or all of their practice to a designated hospital.

- 5.113 Another "encouragement" strategy is for a PMI to provide "guaranteed" or faster PMI recognition for new facilities, expansions or medical technologies introduced by an alternative hospital. Contrast this with the "growth limitation" strategy deployed by BUPA to inhibit HCA's growth outside of London.
- 5.114 A genuine assurance by BUPA to recognise and support the growth of HCA's competitors enables those competing hospital operators to invest in new services and facilities with a sufficient degree of certainty that a large pool of PMI customers will be eligible for treatment at agreed rates. Contrast this with the uncertainty faced by HCA when planning a new investment – particularly given the risk of investment hold-up.
- 5.115 An informal "guarantee" of recognition is a powerful form of encouragement. The CC has correctly noted instances in which PMIs refusing to offer recognition can cause significant difficulties for hospital operators looking to expand. At paragraph 40 of Appendix E, the CC notes:
- "We saw in our Bath case study that AXA PPP's refusal to recognize the new Circle hospital in Bath for day-case and inpatient treatment caused Circle significant difficulties."*
- 5.116 It must therefore follow that if AXA PPP had, instead, offered Circle guaranteed recognition (e.g. because it wanted to encourage expansion in Bath), this would have not only eliminated these "significant difficulties" but positively supported Circle's proposed investment. Indeed, the CC notes at paragraph 45 of Appendix E:
- "We did not, however, find PMI recognition to be a problem in the case of The London Clinic's expansion."*
- 5.117 These two cases clearly indicate that PMIs can use recognition as both a (i) barrier to entry/expansion and (ii) a means to encourage expansion or inhibit expansion. Its choice depends on the PMI's strategic goals. In the case of the London Clinic's expansion, the PMIs were supportive of London Clinic's investment because it suited their goal of encouraging growth in London.

#### *Sponsoring new entry and expansion*

- 5.118 The CC notes that PMIs can aid the expansion and development of credible alternatives to hospital operators, but that it has not found examples of an insurer sponsoring entry anywhere.
- 5.119 HCA draws the CC's attention to a news article describing a proposed investment made by BUPA in a new cancer unit at the Charing Cross Hospital PPU in 2005.<sup>125</sup> In the article it notes that:
- "A debt-laden NHS hospital trust is pouring hundreds of thousands of pounds into a deal with health insurer Bupa, which will provide state-of-the-art cancer care, but only for private patients."*

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<sup>125</sup> <http://www.guardian.co.uk/society/2005/may/29/nhsreform.medicinandhealth?INTCMP=SRCH>.



*The scheme, the first of its kind in the UK, will see public money being used to expand private care, with the justification that the NHS will recoup its costs by winning more private work.*

*A letter leaked to The Observer revealed that the £1.5 million scheme at the Charing Cross Hospital in west London will benefit only private patients.*

*A hi-tech day care centre, where cancer patients can receive their chemotherapy in the best surroundings, will be built at the hospital and is due to open next year."*

5.120 It goes on to note that the "new Bupa/NHS deal involves improving the private patient unit at the Charing Cross" and that a spokesman for the Hammersmith Hospitals NHS Trust said:

*"Basically, Bupa is putting some money in, we are putting some money in. Any revenue is ploughed back into the NHS."*

5.121 The CC may wish to discuss with BUPA how this project was later realised and the extent of BUPA's involvement.

5.122 A more discreet means by which PMIs can effectively "sponsor" entry and expansion is to utilise directional policies to assure an alternative hospital operator that directional policies will treat that operator's new facilities more favourably than existing providers in the relevant geographic area.

5.123 HCA considers that sponsoring entry (or expansion) of a new PH provider is a potential strategy available to PMIs. This does not necessarily have to be financial assistance but it could, for example, involve assurances of recognition or at least an agreement not to hold up recognition. The CC has indicated that, "*lack of recognition by one of the larger PMIs appears to be capable of restricting the profitability of new companies entering the market*",<sup>126</sup> but considers that capital costs associated with market entry do not create barriers to entry or expansion. As PMI recognition is an identified potential barrier, a PMI can address this itself and encourage new entry. This outside option confers bargaining power to the PMIs.

#### *Vertical integration by a PMI*

5.124 Vertical integration is another outside option that HCA considers viable for PMIs. HCA does not agree with the CC's opinion that BUPA's ownership of the Cromwell Hospital has not materially affected the extent of its negotiating power with London-based PH providers. BUPA's ownership of this facility put it among the top ten PH providers in the UK in terms of revenue.<sup>127</sup> By nature, after the purchase BUPA would have increased bargaining power as it would know that it had guaranteed capacity available at its own facility to meet a proportion of the demand from its PMI customer base. Thereby it would be less reliant on HCA and other London-based PH providers and could use this in its negotiations. It is an open-secret in the sector that BUPA's acquisition of the Cromwell hospital was to target HCA in London.

5.125 The CC should also be aware that PMI vertical integration into primary care, when seen in tandem with directional strategies, provides a means for insurers to either:

- shift elements of the existing secondary care offering into a primary care setting (thereby reducing the level of demand for private acute healthcare services); and

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<sup>126</sup> AIS Appendix E para. 46.

<sup>127</sup> Laing's Healthcare Market Review 2011-12.

- potentially re-direct patients to alternative hospital operators (on criteria that is not wholly clinically grounded, but cost-motivated) or to different types of clinicians (for example, directing patients to sports and exercise physicians instead of hospital based consultants).

### **Impact of the size and relative financial strength of a PMI or PH provider on the negotiating outcomes**

- 5.126 HCA welcomes the fact that the CC has recognised the significant bargaining strength of BUPA and that the consequences of having hospitals delisted and potentially losing a significant proportion of revenue, even for a short period of time, could be severe.<sup>128</sup> HCA considers that this applies to both BUPA and AXA PPP (both of which account for a significant proportion of HCA's total revenues) and that these PMIs are able to exercise that power in negotiations for all of HCA facilities.
- 5.127 HCA agrees with the CC's findings that:
- The impact on a PH provider of a threat by an insurer to withdraw its business is more severe when that PMI makes up a significant proportion of the PH provider's business;
  - Large PMIs such as BUPA and AXA PPP may not need to delist all of a PH provider's hospitals to affect its revenues materially; and
  - The effect of a PMI excluding a PH provider can be more pronounced if consultants decide to move the remainder of their patients to a different hospital.
- 5.128 The CC also rightly indicates that the large PMIs have the power to influence the competitive dynamics of the PMI market due to the bargaining power they exert in the private healthcare market. By using their bargaining power over PH providers to secure larger discounts compared to smaller PMIs they are able to entrench their competitive position in the PMI market and restrict the ability of the smaller PMIs to compete for corporate contracts in particular. HCA considers this is one of the many areas of interplay between the PMI market and the degree of bargaining power in PH provider/PMI negotiations, and another reason why the CC should also assess and take account of the structure of the PMI market and PMI practices and policies given the role they play in shaping private healthcare provision, including the scope, price and quality of provision as well as the rate of entry and expansion in the private healthcare market. BUPA should be all too aware of the way in which significant buyer power can impede investment and beneficial outcomes for consumers following its report into the impact on the care home sector of local councils reducing (in real terms) the level of fees paid for care home provision.<sup>129</sup> In the report, BUPA advocates: "*To reverse this trend, local councils must increase the fees they pay to promote and reward investment in quality care, better staff training and modern care homes*".<sup>130</sup> BUPA is of course in the business of operating care homes.
- 5.129 Furthermore, given the relatively stable and entrenched positions of the major PMI providers (in particular BUPA and AXA PPP), these insurers are able to withstand a short-term dispute with hospital operators. This was evidenced by BUPA maintaining its market leading share of the PMI market despite delisting hospitals operated by the largest hospital operator in the

<sup>128</sup> AIS Appendix D paras. 32-38.

<sup>129</sup> [http://www.bupa.com/media/479673/bridging\\_the\\_gap\\_final.pdf](http://www.bupa.com/media/479673/bridging_the_gap_final.pdf)

<sup>130</sup> *Ibid*, at page 5.

UK. Furthermore, BUPA has publicly stated its strategy to continue excluding hospital operators it deems too expensive for their network of approved providers,<sup>131</sup> which suggests BUPA believes it has the financial muscle to continue its aggressive approach and, if necessary, exclude PH providers.

- 5.130 The consequences for a PH provider of a delisting by a major PMI are also more "enduring". That is, even if the PMI subsequently decides to the list the hospital operator, a harmful reputational stigma can develop with respect to GPs and consultants. To assess this effect, the CC could, for example, examine whether, following BMI's delisting and re-listing, a significant proportion of GPs stopped referring patients to consultants based at BMI hospitals (despite being re-listed by BUPA) and/or measure the proportion of consultants that moved all or part of their practise from BMI's hospitals as a result of the delisting.
- 5.131 Lastly, the CC is correct to point out that smaller insurers can secure a more favourable discount (despite the smaller downstream PMI market share) in order to foster more competition in the PMI market.<sup>132</sup> However, this strategy has evidently not proved effective as the same major PMI providers continue to dominate in the PMI market with relatively stable market shares. In addition, being delisted by smaller insurers can deter consultants from basing their practice at a hospital (as it creates the need for a split list and therefore presents the risk of losing the consultant's practice altogether).

## **Part 2: Steps insurers have taken to improve their bargaining position**

- 5.132 Below, HCA addresses the other steps PMIs have taken to improve their bargaining position, including directional policies and service-line tenders.

### **Insurer's directional policies**

- 5.133 The ability of the PMIs to pursue strategies to direct patients away from PH providers is a sign of their buyer power and it adds to their bargaining strength in negotiations with PH providers.
- 5.134 HCA further considers that the ability of PMIs to offer cash-back to policy-holders where they use the NHS for treatment not only indicates that PMIs see the NHS hospitals as viable (albeit vertically differentiated) alternatives to PH providers, but also improves the PMI's bargaining position. It does this by providing PMIs with the option of targeting PMI patients that might ordinarily chose to be treated privately by a specific operator with NHS incentives. Furthermore, these incentives can be targeted at specific treatment areas (such as cancer) or geographic areas. Given the strength of London NHS hospitals, this strategy has added potency in London.
- 5.135 In Appendix F to the AIS, the CC presents evidence summarising the responses received from the CC to a survey of large corporate PMI customers. The findings support the view that such PMI strategies can improve their bargaining position vis-à-vis PH providers. For example:
- A number of large corporate PMI customers have sought to contain the costs by selecting restricted PMI networks or adopting open referral processes,<sup>133</sup> by

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<sup>131</sup> <http://www.telegraph.co.uk/health/expathealth/9675584/Health-insurers-try-to-slam-the-brakes-on-spiralling-prices.html>

<sup>132</sup> CC, AIS, Appendix D, para. 53.

<sup>133</sup> AIS Appendix F para. 3.

"adopting a more guided approach [to the patient journey]"<sup>134</sup> or by introducing or raising policy excesses (which respondents thought was effective in reducing the number of claims);<sup>135</sup>

- BUPA itself provided strong evidence to the CC to the effect that the take-up of open referral schemes has been very successful among large corporate PMI customers: *"BUPA launched open referrals as a pilot in 2011 at the request of one of its corporate customers. BUPA made it an option available to corporates as from January 2012. [...] all clients coming up for renewal from January 2012 were offered terms on an open referral basis, though also given the option to request continuation of their current service without open referral. BUPA told us that as of July 2012, just under half of the lives it covers or provides administrative services for in the corporate segment (including Health Trusts) were on open referral policies"*; <sup>136</sup>
- A 2013 report available on BUPA's website<sup>137</sup> indicates that BUPA has been very successful in its drive toward expanding the corporate uptake of its Open Referral. On page 14 of the report it notes: *"Eight of 10 of our renewing corporate clients and eight out of 10 of our new clients are now using Open Referral."*
- A respondent indicated that it believed that its employees generally preferred cash to benefits in kind and therefore provides a lower level of medical insurance benefits than its peers<sup>138</sup> (as HCA does not have the full survey results, it is not in a position to determine whether more respondents made similar comments). This may indicate that it would be wrong for the CC to assume that the overall demand for corporate PMI coverage was inelastic, as employers can and do substitute between benefits and cash as part of their remuneration packages; and
- With specific reference to corporate PMI customers with an interest in coverage at London hospitals, *"[the CC] asked companies with large numbers of staff based in London how important it was for their employees to have access to named HCA hospitals. Their responses varied."*<sup>139</sup> Some respondents, for example, opted for an open referral regime (some even explicitly excluding HCA hospitals). Other respondents stated they require employees to co-pay if they want to be treated by certain consultants or at certain facilities. Others simply responded that, for them, it was not important to provide their employees with access to HCA facilities.<sup>140</sup>

### Service-line tenders

- 5.136 The use of separate speciality networks created through service-line tenders was a relatively new concept in 2006, but is now a long-established feature of PMI negotiations. In addition to BUPA, other insurers have launched their own speciality networks too.

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<sup>134</sup> AIS Appendix F para. 4.

<sup>135</sup> AIS Appendix F para. 45.

<sup>136</sup> AIS Appendix F para. 46.

<sup>137</sup> <http://www.bupa.co.uk/jahia/webdav/site/bupacouk/shared/Images/General/Business/quality-hc-access/External%20Brochrue%20FNL.pdf>

<sup>138</sup> AIS Appendix F para. 21.

<sup>139</sup> AIS Appendix F para. 30.

<sup>140</sup> AIS Appendix F para. 30.

- 5.137 BUPA has a number of networks which require separate recognition in order for those services to be marketed to its PMI customer base. This includes, for example, bone marrow transplants, stem cell transplants and breast cancer services networks. Some of these networks are also subject to a separate tender process, such as MRI, Ophthalmology, PET scanning, TAVI and, in the very near future, CT scanning. In each case, hospital operators must meet BUPA's designated criteria in order to secure recognition. In addition to cost criteria, BUPA may also reject a hospital on other grounds too, such as deeming the provider to have performed insufficient volumes in the past.
- 5.138 HCA believes these service-line tenders are largely intended to drive down PMI costs, and that this strategy has been successfully deployed by BUPA. HCA also believes that this is another means of encouraging the growth of alternative providers at the expense of operators such as HCA.
- 5.139 [redacted]. However, in early March BUPA unilaterally decided to remove MRI units at the Princess Grace, Devonshire Clinic, Docklands Medical Centre and Old Broad Street. This was despite these units meeting BUPA's quality criteria and there being a reported shortage of MRI capacity at the time.
- 5.140 As a result, BUPA would not reimburse members who used HCA's hospitals for MRI scanning and could direct members to rival MRI network providers. It was feared that, over the medium term, this would result in radiologists moving their non-BUPA patients to other PH providers who are recognised by BUPA.
- 5.141 HCA described to BUPA the odd outcomes that had arisen from its delisting decision. For example, a patient on a corporate PMI scheme near Canary Wharf was denied pre-authorization by BUPA for an MRI scan at the Docklands Medical Centre, but allowed to use the London Bridge Hospital. The fact that this service is managed by the same HCA radiology service and charges the same price highlighted the logical inconsistency of BUPA's delisting decision and suggested that there were other motives behind the delisting.
- 5.142 BUPA informed HCA that its selection criteria were chiefly based on quality considerations. However, HCA later noted that BUPA's MRI network had included PH providers that had either not previously operated onsite MRI facilities or could only offer restricted access (such as NHS units that could only offer access times on an ad-hoc basis or mobile service providers only open 2 days a week and therefore unable to meet the "2 day guarantee" BUPA sought to implement). HCA had reason to believe BUPA's MRI network strategy was in fact being driven by cost considerations and that it had not objectively applied its quality criteria for all providers.
- 5.143 HCA also had concerns that BUPA had negotiated lower MRI rates with competing hospital operators by agreeing to increase the price it paid those operators for other services (thereby compensating them for any discount provided). BUPA would then be in a position to use its "lower" MRI rates to apply pressure on HCA to substantially lower its own rates.
- 5.144 Similarly, when BUPA launched its ophthalmology network, it led the Royal College of Ophthalmologists and the British Medical Association to express a number of concerns regarding the qualitative aspects of BUPA's proposed arrangements. Apparently the BMA had concerns about an insurer attempting to regulate quality in the medical profession and the consequent restriction of consumer choice.

5.145 BUPA decided not to include some of HCA facilities on its ophthalmology network and excluded all of HCA's hospitals on its TAVI network. HCA described in section 7 of its response to the CC's Market Questionnaire the details of its rejected TAVI tender, including the fact that BUPA chose to only include NHS PPUs in its network.

#### **Prices charged by PH providers to PMIs**

5.146 The CC indicates that as part of its assessment of Theory of Harm 3, it has compared the prices charged by various hospital operators, including HCA, to different PMIs. To the extent that the CC has outlined its methodology, HCA sets out its comments on this below. However, without having access to the CC's data or the results, HCA is not able at this stage to comment in detail and will comment further when access to the data is granted.

5.147 HCA has concerns about the weight the CC appears to place on the price analysis. The CC notes that, "*the prices charged by different hospital operators may provide a useful insight into the degree of any market power.*"<sup>141</sup> HCA considers that there are a number of important factors that explain price differentials, aside from market power, and the CC must fully understand these before attempting to draw any inferences from the results of its analysis.

5.148 Healthcare is characterised by considerable product differentiation, both in terms of treatments/services and the quality of those; where there is product differentiation, for example on the basis of quality, prices will reflect this, as higher quality provision is typically associated with a higher cost of providing it. HCA welcomes the fact that the CC appreciates that cost differences are a key driver of price differences: "*We have also analysed prices charged by private hospital operators to PMIs. These price differences are likely to be affected by various factors, especially costs.*"<sup>142</sup>

5.149 As HCA has explained to the CC, part of its strategy is to focus on high acuity tertiary care for which, in general, costs are higher than for treatments of a different nature.

5.150 Furthermore, HCA has invested heavily in new and innovative treatments and technologies to enhance quality and improve patient outcomes. Indeed, the level of investment and innovation of HCA is a signal of the competitive pressures in the market. HCA is frequently the market leader in terms of innovation, offering new treatments and technologies ahead of its competitors in order to maintain its competitive position by raising quality and improving patient outcomes. The investment required can be substantial and the nature of emerging technologies is that there is substantial risk associated with the investment and higher costs when new technologies and treatments are introduced. This is the natural competitive outcome in a number of industries where product innovation is important. Innovative products tend to earn high prices and margins when introduced and reduce over time, as do technology prices as they become more 'mainstream'. The presence of high prices *per se* is not an indication of market power in a context where the margins earned as a result of the higher prices are reinvested in the business. HCA's prices, margins and practice of reinvesting its profits back into its hospitals reflect the competitive nature of the market and its product differentiation.

5.151 There are, of course, also a range of other factors affecting HCA's prices as a result, for example, of its cost base in London. In addition, HCA does not enjoy the same cost advantages some of the other providers do, for example as a result of their charitable status.

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<sup>141</sup> AIS, Appendix D, para. 64.

<sup>142</sup> AIS, para. 91. See also AIS, Appendix D, para. 77.

These cost differentials are one of the reasons why HCA's prices may be higher on average than those of other PH providers.

- 5.152 HCA does agree, however, that the buyer power of the PMIs exerts a strong influence on the prices it is able to charge. [3<].

*The CC's methodology*

- 5.153 The CC has outlined the two approaches it has taken to compare prices charged by PH providers to PMIs, namely:

- Comparison of the average revenue per admission, without controlling for the mix of treatments; and
- Comparison of a basket of treatments, analysing the average prices of individual treatments in the basket, the revenue per patient admission across the basket and a weighted price index across the basket.<sup>143</sup>

- 5.154 HCA sets out its comments in relation to each of these approaches below.

*Comparison of the average revenue per admission*

- 5.155 The CC postulates that, "*the average revenue per patient admission offers a simple and potentially informative price measure that can be compared across pairs of hospital operator and insurer*".<sup>144</sup> HCA disagrees that the analysis is informative, particularly when comparing the prices charged by different PH providers. This is because there are a number of factors affecting the average revenue per admission, most notably the significant degree of product differentiation and the different cost bases of the PH providers. As the CC acknowledges, the analysis fails to take account of the different mix of treatments provided by different PH providers. HCA focuses on high acuity, tertiary care which by nature is more complex and more costly to provide. HCA's average revenue per patient will therefore, in general, be higher than that of other providers. As noted in section 4 above in relation to the CC's PCA, a number of factors affect the cost of treatment including co-morbidities, disease process (e.g. malignant or non-malignant), the patient's surgery history and whether they have directly transferred in from another facility. In general HCA's case mix is more complicated, requiring greater and more complex clinical input, leading to higher costs and so revenues.

- 5.156 HCA notes that the CC has attempted to control for the different patient mixes by comparing the average revenues across PH providers within and outside of London – recognising that there tends to be a greater propensity for hospitals in central London to perform high acuity treatments.<sup>145</sup> HCA consider this to be too simplistic, however, as even within London there will be differences in the exact mix of treatments offered by different providers in addition to a number of other factors influencing average prices. As outlined above, price differentials also reflect factors such as the degree of product differentiation, particularly based on quality, the investments levels of the PH providers and also variations in the cost advantages enjoyed by different PH providers. The CC's analysis fails to account for any of these issues and HCA thus considers that any conclusions drawn from the results of this analysis are equally flawed.

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<sup>143</sup> CC, AIS, Appendix D, para. 67.

<sup>144</sup> CC, AIS, Appendix D, para. 69.

<sup>145</sup> CC, AIS, Appendix D, para. 71.

5.157 Furthermore, without having access to the data used to perform the analysis, nor the actual results, HCA is unable to comment on the robustness of the data and analysis performed. The CC has indicated that it has used aggregate data for 2011 provided by PH providers covering the volume of patients they treated and the revenue they earned from different insurers to calculate the average revenue per admission. The completeness of this data set for other PH providers is not clear to HCA and to the extent that there are inconsistencies in the way in which each PH provider collected and reported this data, any comparison of the results across PH providers will also be affected.

*Comparison of a common basket of procedures – price index*

5.158 Given the limitations of the analysis based on the average revenue per admission, the CC has adopted a second approach to analyse the average prices charged by each PH providers for each different procedure. Again the CC does not report these results nor set out its findings. However, HCA is concerned that the CC considers that this analysis allows it to "make a like for like comparison across hospital providers".<sup>146</sup> Even where a PH provider is undertaking the same treatment in general terms the nature, complexity and quality of that treatment can be different across PH providers, for example, in terms of the experience of clinical staff, the technical equipment used, patient related factors (such as age, co-morbidities, disease process and surgical history, patient care (e.g. follow-ups and broader support to the patients and their family), the standards of accommodation, administrative support. As the CC concedes, "we have no information on the condition of the patient (severity, co-morbidities, illness) which may affect the level of the charges".<sup>147</sup>

5.159 The analysis the CC has performed comparing prices across a basket of treatments has a number of potential flaws as the results will be particularly sensitive to the basket of treatments selected. The CC appears to have performed no sensitivity analysis in relation to this, however. The CC's price index suffers from many of the same limitations as the other price analyses conducted by the CC (e.g. self-pay patient PCA). For example, vertical (i.e. quality) product differentiation is not controlled for, nor is the level of investment and innovation of a provider.

5.160 Additionally, whilst the CC has accepted that prices in London may be higher as a result of a higher cost base (and so have developed a separate index for London) the CC's analysis does not account for cost differentials across providers within London. As HCA has submitted to the CC, a number of the other PH providers in London have in some cases sizeable cost advantages over HCA, for example as result of tax status or the in-built cost advantages enjoyed by PPU's.

*Data limitations to the CC's analysis*

5.161 Whilst the CC has accepted that, due to the way prices are negotiated over the portfolio of treatments, "comparing the price of too small a number of procedures may lead to distorted results as the hospital operator may have higher or lower charges elsewhere",<sup>148</sup> it is not clear the extent to which the CC has been able to address this problem due to the data limitations. The CC has acknowledged that negotiations between PMIs and PH providers tend to focus on changes in the price of the overall portfolio of services/treatments (i.e. the "total price envelope") rather than on prices of individual treatments (there is a good illustration of this in relation to AXA PPP – see HCA's response to AXA PPP's submission,

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<sup>146</sup> CC, AIS, Appendix D, para. 74

<sup>147</sup> CC, AIS, Appendix D, para. 78(b)



section W, in relation to AXA PPP's claims about high pathology charges). As a result, the margins earned on some treatments may be higher on some and lower on others.

- 5.162 The CC's price index has been constructed by first identifying a basket that comprised all procedures where each of the major PH providers had treated at least five of the PMI's patients in 2011. As noted above the results are likely to be sensitive to the selection of treatments. It is unclear how many and which procedures are included in the basket, therefore, and how likely it is to be representative of the entire portfolio of treatments offered by each PH provider. Furthermore, the CC has highlighted a number of other ways in which the sample size has been restricted. For example 21% of the episodes captured in the invoice data has been excluded as the episodes related to more than one CCSD code.
- 5.163 The other data limitations highlighted by the CC raise considerable concerns with HCA about the representativeness of the data and the robustness of the results. For example, the extent to which there are inconsistencies in the way different PH providers invoice (bundling pre- or post-operative treatments/tests in some cases) or any invoicing errors would affect the prices and, hence, the results of the CC's analysis. Additionally, as stated above, the charges to insurers are highly dependent on the condition of the patient (severity, co-morbidity etc) and as the CC recognises, this is not reflected in the data. To the extent that a PH provider, on average, deals with more complex cases, the prices charged to PMIs (on average) will be higher.
- 5.164 HCA is reassured that the CC is considering the extent to which the baskets of treatments selected are representative and would urge it to consider more widely the robustness of its analysis and the weight it can place on any of the results due to the flaws in the approach and the data limitations HCA has highlighted above.

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<sup>148</sup> AIS, Appendix D, para. 66.

## **6. THEORY OF HARM 4: BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS**

6.1 As HCA has previously submitted, insurers enjoy substantial buyer power in relation to consultants. BUPA and AXA PPP have both engaged in practices towards consultants which are having a detrimental effect on patients.

6.2 HCA welcomes the CC's views that the introduction by BUPA and AXA PPP of "fixed fee" schedules, which prevent the charging of top-up fees, creates restrictions on choice. However, HCA also believes that many of the other strategies which BUPA (and, to a lesser extent, AXA PPP) has engaged in, which are referred to in the AIS, also give rise to significant distortions in the market place.

### **Consultant fees**

6.3 The CC states that it has not "seen evidence" that the substantial reductions in BUPA's fee schedules are creating any detriments in terms of lower quality, lower incentives to innovate, or a reduction in the number of consultants entering private practice.

6.4 It is not clear what, if any, analysis the CC has carried out with regard to the effects of the reduction in BUPA reimbursement rates on the economics of the consultant's practice. In commenting on the CC's draft surveys, HCA specifically raised a concern that the CC's consultant survey did not put any questions to consultants which would enable it to gather data about the erosion of PMI reimbursement rates combined with the rise in the costs of private practice, including indemnity costs. HCA noted that this was a significant omission in the CC's survey and it is now disappointing that the CC has missed the opportunity to collect data which would have enabled it to examine these issues in this market inquiry.

6.5 HCA also notes that, according to the CC's website, it has received in excess of 200 submissions from individual consultants, many of which raise specific concerns about the reduction in BUPA rates:

- Many consultants make the point that, not only have there been no increases since 1992, there have been substantial reductions in the fee schedule in excess of 50% (one letter, for example, states that the fee for arthroscopy has been cut from £548 to £289, not including the effects of inflation).
- Many letters cite the substantial increase in indemnity costs in recent years which have substantially increased the costs of practice – one letter refers to the fact that one spinal surgeon pays an indemnity premium of £72,000 annually and that it is "barely worth his while" to continue in practice.
- There are many letters which make it clear that these factors have substantially reduced the incentives for consultants to enter private practice. One consultant makes the point that the BUPA rate is now below the NHS rate which makes private practice pointless.

These letters themselves provide compelling evidence that the drastic cuts in reimbursement rates are having significant effects on many consultants.

- 6.6 HCA refers to the recent National Audit Office report "Managing NHS Hospital Consultants", 6 February 2013, which has highlighted the fact that there are lower numbers of consultants going into private practice. The reduction in PMI reimbursement rates can only exacerbate this trend by substantially reducing, and even eliminating, the incentive for consultants to use their "non-contracted" time in private practice.
- 6.7 Furthermore, the reduction in PMI reimbursement rates should also be seen in the wider context of the other measures which the AIS refers to, including the introduction of fixed fee schedules and the prohibition on charging top-up fees. The wider context also includes the arbitrary "delisting" of consultants and the re-direction of patients to lower cost providers. It is the combined effect of all of these BUPA and AXA PPP initiatives which are impacting on incentives to take up private practice and reduce the quality of consultant services.
- 6.8 The AIS states that "*Where a supplier reduces its price on the face of a strong buyer, this is usually likely to lead to lower prices for consumers.*" Once again, this depends entirely on the competitiveness of the market on which the buyer is operating – and HCA reiterates that the CC has failed to take account of the lack of competitiveness of PMI. With PMI premiums increasing, there is no evidence whatsoever that PMIs have been either reducing or containing premiums by passing on lower consultant costs to their subscribers.
- 6.9 The AIS also notes "*that it would probably be against an insurer's interests to reduce prices to such an extent that it had an inadequate supply of consultants.*" The major PMIs have, thus far, been blind to the financial impact of their policies on consultants. Given the limited competition which they face, they have no incentive to maintain high standards of quality and innovation amongst their service providers. They may well take the view that there will be an "adequate" supply of consultants, but the real question is whether experienced, high-quality specialists with several years' experience in complex clinical fields will be sufficiently motivated to continue in private practice. Interestingly, WPA as a smaller insurer is alive to this risk and in its response to the CC's Issues Statement warns that fees must be "sustainable in the long term" otherwise the pool of consultants will shrink.
- 6.10 It is instructive to note that BUPA, as a provider of care homes, has itself complained of the erosion of fee rates and the consequences of this for quality of care and investment. In its "Bridging the Gap" report<sup>149</sup> concerning the care home sector BUPA complains that local councils have reduced in real terms the level of fees paid for care home provision and notes that the consequences, going forward, could be shrinking capacity (as operators decided to close homes or sections of homes) and a reduction in choice. In the report, BUPA advocates: "*To reverse this trend, local councils must increase the fees they pay to promote and reward investment in quality care, better staff training and modern care homes*". This is precisely the concern which consultants are raising in the context of private healthcare. It is difficult to see how BUPA can credibly articulate this argument in the care home market, where it is acting as a major supplier, while at the same time denying these same concerns about quality and investment in the private healthcare market, where it is the dominant PMI purchaser. The contradiction in BUPA's position could not be clearer.

### **Other issues**

- 6.11 The CC rightly notes that BUPA and AXA PPP are engaging in a variety of other practices which are having a serious impact on consultants, as set out in paragraph 113 of the AIS.

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<sup>149</sup> [http://www.bupa.com/media/479673/bridging\\_the\\_gap\\_final.pdf](http://www.bupa.com/media/479673/bridging_the_gap_final.pdf)

- 6.12 It is not clear why the CC states (at paragraph 114) that the complaints in relation to these matters "*may not be generally representative*" of consultant views. As the CC notes in paragraph 99, it has received "*a large number of submissions*" raising a "*breadth of concerns*". The CC has published on its website over 200 letters from consultants and consultant associations, including FIPO, the BMA and the London Consultants' Association. These cannot be dismissed as unrepresentative. On the contrary, HCA regularly receives complaints and concerns from consultants practising in its own hospitals about these matters and can confirm that the views and concerns which are expressed in the letters to the CC are very widely and indeed passionately held by the consultant community in London. Indeed, as far as HCA is aware, there are no consultant submissions which support or endorse PMI managed care strategies or see any clinical benefits or benefits to private healthcare generally.
- 6.13 The CC appears to acknowledge the importance of these issues but wrongly argues that these do not point to a "competition problem" in the market.
- 6.14 The consultants' submissions to the CC consistently refer to PMI conduct which has a direct bearing on competition and patient choice:
- A number of respondents have been de-listed by BUPA or AXA PPP without cause or due process and are therefore no longer accessible to the insurer's subscribers. The removal of a consultant clearly reduces competition and limits patient choice. WPA's submission to the CC also makes the point that to "*potentially remove huge numbers of highly qualified specialists from the list of approved consultants is a huge restriction*".
  - There are also many specific complaints that, even though a consultant has been specifically recommended on clinical grounds to treat a particular patient, the PMI has re-directed patients to lower cost providers – numerous letters are in this vein, bearing out HCA's experience that this is a widespread problem. One consultant has a CD recording of an insurer persuading his patient to go to another provider.
  - A number of letters provide specific evidence that PMI re-direction has been *inappropriate* – e.g. in one case, a patient being referred for knee surgery to a hip specialist and, in another case, a patient requiring kidney surgery being referred to a consultant who performs surgery on a different part of the body (resulting in the patient having to return to his GP). Yet another case involved a patient, unhappy with the PMI's decision to re-direct to another consultant, going back into the NHS to see the consultant of his original choice. Cases such as these provide very real grounds for concern about the quality of clinical care to PMI subscribers.
  - A number of other cases show that referrals are not necessarily inappropriate, but are *inconvenient* e.g. patients in Northern Ireland being referred to the UK mainland for treatment (the same respondent states that this also often happens in London). Again, this has a direct impact on the level and quality of the service which is available to PMI subscribers.
  - There are also extraordinary instances of PMI interference with clinical treatment, e.g. a patient with breast cancer in both breasts being told by the insurer that it would only pay for the treatment of one.

- A number of respondents make the point that their PMI patients complain about the lack of information being provided in the PMI policies about the restrictions which are being imposed with regard to consultants, again giving rise to patient detriments.
  - There are also complaints about discriminatory treatment of consultants, with some subject to fee caps, and other consultants (within the same hospital) subject to no caps, without reason.
- 6.15 HCA fully appreciates that, as the CC states in paragraph 115, the focus of the investigation is on competition, but firmly believes that all of these PMI practices have a direct impact on the competitiveness of healthcare, the choices open to patients and level of transparency for consumers, consultants and PH providers, and are therefore quite clearly competition issues which need to be taken into account in this inquiry.
- 6.16 The delisting of consultants, the re-direction of patients to PMI-favoured providers, and PMI interference in the normal referral pathway limits patient choice by reducing the number of consultants which are accessible to PMI subscribers and preventing them from exercising a choice based on clinical grounds. This is pre-eminently a competition issue.
- 6.17 Furthermore, it is in the interests of consumer transparency that BUPA's Open Referral algorithm is subject to independent external scrutiny. It purports to be based on quality, in which case BUPA should willingly share this information. Similarly, consultants whose practices are directly affected by Open Referral have not been adequately informed by BUPA about how data being held by BUPA is being used to make consultant selection and referral decisions.
- 6.18 The referral of patients to less appropriate, or even inappropriate, providers affects the quality of the service which is accessible to PMI subscribers. As the CC notes in its draft guidelines on market investigations (paragraph 127) price is not the sole indicator of competition and *"poor quality, lack of innovation or unsatisfactory product ranges are prominent among other indicators of the competition in a market."* These are all issues which are directly relevant to the CC's inquiry.
- 6.19 These actions by PMIs also have a knock-on effect on hospitals. The re-direction of patients also has the effect of steering patients away from one hospital (where the relevant consultant is based) to another. It therefore also limits competition and choice in the hospital market, and hence is directly relevant to the issue in this inquiry.

## 7. THEORY OF HARM 5: BARRIERS TO ENTRY

### Introduction

- 7.1 The AIS makes various findings in relation to Theory of Harm 5 concerning the barriers to entry for hospital operators. There is more detailed analysis in Appendix E to the AIS.
- 7.2 HCA has a number of comments on the CC's views on barriers to entry and expansion:
- (i) The AIS does not properly represent the degree of new entry and expansion which has in fact taken place, particularly in London, and the prospect of further entry and growth by PPUs.
  - (ii) HCA supports the view that capital requirements and planning regulations have not acted as significant barriers to entry.
  - (iii) PMI recognition has been the most significant barrier to entry and expansion and has constrained hospital growth. This needs to be seen in the broader context of PMI bargaining power.
  - (iv) There does not appear to be any clear evidence that consultant incentives have the effect of creating barriers to new entrants.
  - (v) Similarly, certainly so far as London is concerned, there is no evidence that volume related discounts or rebates in hospitals/PMI contracts have blocked new entry.
  - (vi) HCA sees no evidence that there are any barriers which prevent consultants from switching some or all of their practice to another hospital.
  - (vii) HCA deals with each of these issues in turn.

### Evidence of new entry and expansion

- 7.3 The AIS, HCA submits, does not provide a fair representation of the level of new entry and expansion which has taken place and is taking place within the private healthcare sector. It wrongly asserts that "*the number of examples of entry or expansion in this market was limited*" and that "*entry is restricted*". The CC appears to ignore, or at least to downplay, much of the evidence of new entry and expansion, particularly in London, which in fact points to a more competitive, dynamic and evolving market than is suggested in the AIS. This is an important issue, because the CC to a large extent relies on its views about barriers to entry to support its various theories of harm. The evidence of new entry and expansion simply does not support the CC's view that entry is limited or restricted.
- 7.4 The CC states in Appendix E that it has found "only" seven examples of entry in the last five years. However, all of these involve new, multi-million pound developments of full service hospitals. They demonstrate that there is still an appetite for large scale investment, by hospital groups, clinician-led ventures and private equity investors, to commit to major new developments, notwithstanding the difficulties in raising capital over the last few years. The CC states that there are "only" seven such examples in recent years, but this record of new entry for large, new build hospitals cannot be dismissed as immaterial or insignificant and indicates that, notwithstanding the barriers to entry which the CC has identified, there

continues to be growing competition from new entrants across the UK as a whole. In addition, these events have occurred in the context of challenging economic conditions.

- 7.5 Furthermore, while these are all examples of full service hospitals, there are also many further examples of new, smaller-scale specialist clinics entering the market in areas such as eye surgery, ENT, cosmetic surgery, fertility and cancer. Laing's Healthcare Market Review 2011/2012 notes as follows: "*The underlying theme for new hospital and clinic development has been its specialist nature. Much of new small scale day capacity has focused on cosmetic surgery, bariatrics, eye surgery, fertility, and pain management, where private demand is being energised by technological advances and scant provision by the NHS. Other specialities which have seen new small scale capacity include cardiology, podiatric surgery (foot correction), dermatology and gastroenterology. In fact, Nucleus Healthcare's new facility in Newport, South Wales, claims to be the first specialist private gastroenterology hospital.*" Appendix E makes only a brief passing reference to new specialist entrants and does not pay due regard to the record of successful new entry in specialist clinical service lines. One example is cancer care, which has seen specialist providers such as Cancerpartners UK opening new radiotherapy centres in Portsmouth, Southampton, North London and Birmingham.
- 7.6 Appendix E makes no mention of the existing new build (full service or speciality clinics) projects which are currently under development. In London, this includes the new London International Cancer, Heart And Brain Hospital, a new 150-bed acute private hospital in West London, backed by a total investment of around £100 million, which is due to open in 2014. HCA would also cite the new Kent Institute of Medicine and Surgery, a new private hospital with a total project cost of £80 million being planned in Maidstone, Kent as a 100-bed full service hospital which is targeting patients who would otherwise come to London hospitals for complex procedures. Both are major pipeline development projects which demonstrate that there is ongoing capital investment in new hospitals.
- 7.7 There are also, as discussed at HCA's recent hearing, new significant hospital development opportunities which have been made available to the market:
- [REDACTED].
  - [REDACTED].
  - [REDACTED].
- 7.8 The CC concentrates on new entry in inpatient services but makes little mention of new entry through the development of outpatient facilities. Outpatient work accounts for [REDACTED] of its surgical procedures, and so it would be wrong for the CC to ignore outpatient provision in any discussion of the healthcare market. There are even lower barriers to entry in the case of outpatient facilities, which typically involve consulting rooms together with diagnostic equipment which can be set up at significantly lower costs than an inpatient hospital. The total project cost of establishing the new Wellington Outpatient and Diagnostic Centre, [REDACTED]. There are general trends in healthcare away from inpatient treatment to outpatient and ambulatory care and there are numerous examples of new outpatient and diagnostic centres in London and in other parts of the country which are responding to this shift in demand. Recent examples of new entry in London include:
- The St. John and St. Elizabeth which has recently opened a new outpatient facility, day care centre and primary care centre.

- BMI's diagnostics and outpatient centres in Bishopsgate, Bushey and Harley Street.
- Aspen's new "Parkside at Putney", an outpatient facility and diagnostic centre.
- The Cromwell, it is believed, has recently received planning permission for a specialist cancer diagnostic centre involving a £30 million investment.

7.9 There is a more detailed discussion about the provision of outpatient facilities (either within hospitals or in stand-alone facilities) in Section 8 below. This is an area which is witnessing significant growth in London, driven by the trends away from inpatient care and the development of advanced diagnostic techniques, and both hospitals and consultant groups are investing in new facilities right across London.

7.10 The AIS makes sweeping generalisations concerning the extent to which market size and economies of scale may restrict new entry, without having regard to the specifics of individual geographic markets. The CC concedes (paragraph 18, Appendix E) that "*these factors may apply more in certain geographic areas than in others e.g. sparsely populated or less prosperous geographic areas will have much less potential demand for private inpatient care than, say, London.*" However, there has been no attempt in Appendix E to consider growth opportunities within specific markets such as London and to carry out an analysis of the extent to which market opportunities encourage or restrict market entry. Laing's Healthcare Market Review 2011-2012 notes (page 79): "*Much development activity has been concentrated in London where the private healthcare market is particularly robust.*"

7.11 In London, the special characteristics of private healthcare provision create the conditions to encourage new entry in both inpatient and outpatient facilities and have attracted new investment and development:

- (i) London is recognised as a leading centre of tertiary care, both in the UK and worldwide. In view of demographic factors, specifically the growing population of over 65s, there is significant growth in higher acuity, tertiary services in London in specialisms such as cancer, cardiac, neurosciences, paediatrics, and orthopaedics. HCA refers to the Finnamore strategy paper "Private Tertiary Service Forecast Model" (March 2010) which projected a growth in demand for HCA's tertiary services at [3<]. This growing market is encouraging new investment by HCA and its competitors, including the Cromwell, London Clinic and BMI. There are significant growth opportunities which create a benign environment for investment in new facilities in these higher acuity clinical specialisms, and this has been borne out by the record of new entry and expansion in London in recent years.
- (ii) London and the South East benefits from a higher PMI penetration rate than other parts of the country. Laing & Buisson estimates PMI penetration in the South East at 18.5% compared to 12% for the UK as a whole. Furthermore, the presence of a large number of major corporates in London/South East has meant that London has been more resilient to the decline in PMI subscribers during the recession, since the decline has been lower for corporate subscribers than for individual subscribers. The Finnamore report projects a drop of 2% by the year 2030, but the reduction in London is only 0.6%. Thus, there will continue to be relatively robust demand for PMI, encouraging further investment into London.
- (iii) The Finnamore report also notes that London benefits from a higher growth of the 0-15 population which will drive demand for paediatric services in the coming years.



- (iv) There is a wide pool of around 7,500 NHS consultants, allowing new entrants to attract the consultant base necessary to launch new hospitals and facilities.
- (v) Furthermore, London attracts a higher proportion of overseas patients. [X]. Other competitors such as the Cromwell, the London Clinic, and numerous PPUs, also compete for significant numbers of overseas patients. This provides a further source of revenue to new entrants which may not be available to the same extent in other geographic markets.
- (vi) Furthermore, as referred to below, many London NHS Trusts are keen to develop new or expanded PPUs in conjunction with the private sector and this wave of PPU expansion affords further opportunities for new entrants. As HCA has previously submitted, it is aware of at least nine PPU opportunities in and around London which have been put out to competitive tender.

7.12 There is a danger in making over-generalised and simplistic conclusions for the UK as a whole, which do not take account of the specifics of individual markets. This is certainly the case in London, where the size of the potential market together with the demographic factors which are driving demand create significant opportunities for new entrants. The CC's sweeping statement (paragraph 119 of the AIS) that "*In many local markets, overall demand is not sufficient to support an additional, efficiently-sized private hospital.*" is simply wrong in the case of London.

7.13 HCA also notes that, while Appendix E concentrates on the record of new *entry*, it appears to overlook the record of significant *expansion* by existing providers which also attests to a lively and dynamic market:

- Appendix E rightly refers to the example of the London Clinic and its £80 million investment in a new cancer wing which is a formidable competitor to HCA in London.
- BMI opened a new gynaecological wing of the Fitzroy Hospital in 2011, offering a comprehensive range of services for women's health.
- The BUPA Cromwell has engaged in a £30 million investment programme on refurbishing the hospital's infrastructure and on new equipment to develop its cancer care, neurosciences, diagnostics, paediatrics, family medicine, endoscopy and orthopaedic services.
- The St. John and St. Elizabeth has recently invested £11 million in a new outpatient wing which includes outpatient diagnostics and GP services.
- There are numerous hospitals who have invested in new services and facilities. For example, the King Edward VII reported an investment of £3 million in a new critical care unit, scanning equipment, and hydrotherapy pool, and has made further investments in high tech new treatments for enlarged prostate.
- Examples of expansion in outpatient services are legion and far too numerous to list here – many cases involving the provision by existing hospitals of new consulting rooms or equipment.

7.14 There is a significant and surprising omission in Appendix E in that it fails to make any reference to PPU establishment and expansion as a source of new entry. The CC should be

taking into consideration not just past but also prospective entry and expansion. This has been fully discussed in HCA's previous submissions. The lifting of the PPU income "cap" is leading to a new wave of PPU expansion and development, certainly in London, but also in other parts of the UK.

7.15 As recently as last week, the Guardian reported that:

*"Hospitals are seeking a radical increase in revenue from the treatment of private patients as their budgets come under pressure from the needs of an ageing population, according to new figures obtained under the Freedom of Information Act."<sup>150</sup>*

7.16 Information obtained through the Freedom of Information request indicated that PPUs in London were, in particular, gearing up to expand their private patient activity. It was reported that:

*"Great Ormond Street children's hospital has budgeted for an extra £11m from treating private patients in the financial year ending in 2013 compared with 2010 – a 34% increase. The Imperial College Healthcare NHS Trust is also expecting to boost revenues by £9m over the same period – a 42% rise. The Royal Marsden is expecting an extra 28% increase on 2010 revenues, equating to about £12.7m. Across all trusts an 8% increase in revenues from private patients is expected to be posted for 2012-13 compared with 2010-11."<sup>151</sup>*

7.17 Even the insurers concede (see paragraph 77, AXA PPP response to HCA's submission) that *"recent changes following the House of Lord's approval to relax the cap that limits the amount that Foundation hospitals can earn from non-NHS income, however, give rise to the opportunity for potential expansion of individual PPUs."* NHS Trusts are either developing PPUs entirely by themselves or in partnership with private operators, and HCA's own PPU JVs have shown that this can provide a further entry opportunity to hospital providers. The CC cannot credibly exclude reference to PPU expansion in a fair and balanced assessment of the prospects for new entry into private healthcare over the next few years.

### **Capital costs and planning**

7.18 HCA agrees with the CC's findings that, in themselves, capital costs and planning requirements do not create barriers to entry or expansion.

7.19 HCA reiterates that there continues to be significant investment in new hospitals (see section 14 of HCA's response to the CC's initial Issues Statement). Laing's Healthcare Market Review 2011/2012 states: *"Market expansion has been facilitated by high investment interest in healthcare markets from private equity investors and commercial banks, but also from clinicians themselves looking to become partners in new private healthcare ventures that focus on clinical excellence. On a larger scale, major hospital "incumbent" groups have received solid financial backing to modernise and develop their hospital networks."* Investors include private equity funds (e.g. C&C Arthur Group which is behind the new London International Hospital), commercial banks (e.g. Clydesdale Bank which is funding the new Kent Institute of Medicine and Surgery), institutional investors, consultant ventures, hospital groups and also overseas healthcare operators. The level of investment interest in new development activity does not suggest that higher capital costs are deterring new entry and expansion.

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<sup>150</sup> <http://www.guardian.co.uk/society/2013/apr/06/nhs-hospitals-increase-private-patients>

<sup>151</sup> *Ibid.*

7.20 HCA agrees with the CC's assessment of the impact of planning regulations, and refers the CC to section 14 of its response to the CC's initial Issues Statement. The planning regime does not create any special barriers to entry for private healthcare. Once again, new entry and expansion demonstrates that the planning regime is not a particularly difficult hurdle for either inpatient or outpatient facilities.

### **PMI recognition**

7.21 The CC's findings about the importance of PMI recognition are surprisingly tentative and do not do justice to the compelling evidence which has been provided about the role of the PMIs in controlling and limiting new entry. It is clear that PMI recognition represents the single most important barrier to entry and expansion for hospital operators. The case studies referred to in Appendix E provide yet further evidence of the ability of PMIs to deter or sponsor, as the case may be, new entrants. HCA believes that the role of PMI recognition requires much greater emphasis in any assessment of the barriers to entry and expansion and that the AIS does not accord due weight to this issue.

7.22 The importance of PMIs to hospital operators, and the strong negotiating position which they enjoy as "unavoidable trading partners", is considered above in relation to bargaining power and is based on: the high proportion of business which they bring to the hospitals; and the range of alternative strategies – "outside options" – which they have at their disposal. As the CC notes, the importance of PMI recognition is compounded by the "consultant drag effect" i.e. the fact that failure to be recognised by one insurer would lead to a loss of business from other insurers because of the consultant's preference to avoid splitting patient lists between different hospitals.

7.23 The CC refers generally to PMI "recognition", and certainly the hospital would need to be "recognised" by (i.e. have contractual arrangements with) a PMI to be able to treat the PMI's subscribers. However, PMI recognition alone may not be sufficient, since the hospital may also need to compete to secure a position on a PMI network since the major insurers have pursued a network strategy involving the creation of restricted provider networks. The term "recognition" may be used as a catch-all to cover not only general recognition but also (where appropriate) network recognition to ensure that the hospital obtains a sufficient level of business to remain viable.

7.24 All the main insurers, including in particular BUPA, AXA PPP, PruHealth and Aviva, have embarked on a network strategy. Laing's Healthcare Market Review 2011/2012 notes as follows: "*The impact of network exclusion on a hospital's business can be significant. Historically, the degree of impact has been largely determined by consultant choice, as consultants may prefer to treat all their patients (network and non-network) at a network hospital (referred to as "consultant drag"), or may choose to support a non-network hospital by treating (network and non-network) patients there whenever possible (referred to as "counter-drag").*"

7.25 HCA has experienced significant delays in BUPA recognising its new outpatient and diagnostic facilities, which have detrimentally impacted their performance. HCA has also pointed out that it is not listed on a number of PMI networks i.e. there are some PMI networks which exclude HCA but include other Central London competitors:

- BUPA's "essential access" and "extended choice" policies

- PruHealth country-wide list which includes London Clinic, King Edward VII and NHS PPU's
- Aviva's key hospitals network which includes the BUPA Cromwell and the London Clinic
- Aviva has a Trust Care network which is restricted to NHS PPU's but excludes the HCA JVs
- AXA PPP's Corporate Plan Pathway is exclusive to BMI (and now also the London Clinic)
- HCA is also excluded from speciality networks e.g. BUPA's MRI (in 2008) and AXA PPP's oral/dental network.

7.26 HCA notes the further examples and case studies provided in Appendix E of PMI non-recognition and its effect on new facilities. This provides further, cogent evidence that PMI recognition is an important structural barrier for hospital operators, both new entrants and existing providers seeking to expand their services.

7.27 The AIS notes that the conduct of "*particularly the larger*" PMIs may impede entry. However, while undoubtedly recognition by BUPA and AXA PPP is essential for any new entrant, other insurers such as Aviva and PruHealth also provide significant volumes of business. Furthermore, the "consultant drag effect", as noted above, acts as a strong incentive on a hospital operator to secure recognition at least from the "top 4" PMI providers in order to retain consultants and ensure that consultants do not leave because they do not wish to split their patient lists. There is also a reputational factor, in that the failure to secure PMI recognition from a smaller insurer may also adversely impact the hospital's reputation amongst patients, GPs and consultants. Consequently, it is not just the recognition of the "larger" PMIs which may act as a barrier to entry and expansion.

7.28 In paragraph 139(b), the AIS states: "*We note that strategies are available to private hospital operators which may mitigate the effects of non-recognition, albeit at a possibly high or arguably unsustainable cost.*" This comment is not explained, and it is not clear what "strategies" the CC is referring to. There is also no further explanation of this point in Appendix E.

7.29 HCA refers to its discussion on the importance of PMI recognition in its response to the CC's initial Issues Statement and the relative strength of the "outside option" available to PMI providers and hospital operators. There are no, credible alternative strategies which would be available to a new hospital entrant without securing PMI recognition, at least of BUPA and AXA PPP:

- BUPA and AXA PPP combined account for [x<] of HCA's total revenue and it is fanciful to suggest that there is any other available source of revenue which could replace this level of business.
- The highly concentrated and oligopolistic nature of the PMI market means that a new entrant would not be able to replace lost demand through increased referrals from another PMI provider – there is no other PMI provider which could ensure the same level of business as BUPA and AXA PPP and there are substantial barriers to entry in the PMI market which make new entry very unlikely.

- The hospital operator would not be able to replace the demand with non-PMI customers. HCA derives [3<] of its business from overseas patients but it is extremely unlikely that it would be able to materially increase the number of overseas patients to replace the loss of business from BUPA and AXA PPP. If HCA was readily able to increase its proportion of overseas patients, it would have already done so; however, it is constrained by London-based competitors and by major international competitors when seeking to attract more international patients. Many other hospital operators, particularly outside London, are unlikely to be earning significant revenues from overseas patients.
- Some hospital operators such as Ramsay earn significant revenues from NHS-funded patients and may have the potential to increase NHS turnover to a limited extent but even this would not make up for the loss of business from the two major insurers. The NHS tariff is substantially lower than self-pay and PMI tariffs and NHS work which is put out to the private sector is typically high-volume, lower acuity procedures. Therefore, this is unlikely to be a feasible strategy for a new entrant, or hospital operator such as HCA, specialising in higher acuity, high cost procedures.

7.30 In HCA's experience it would be possible for PH provider, in the short-term, to run a new facility at a loss as it has done [3<] took a year to secure BUPA recognition. However, unless BUPA and AXA PPP recognition is eventually obtained, the facility would not be financially viable and there would be no commercial rationale in operating such a facility. Further, this recognition was only obtained on [3<].

7.31 HCA therefore strongly rejects the observation that there are alternative "strategies" which would be available to hospital operators seeking to enter the market or expand which could compensate for the effects of PMI non-recognition. Alternatively, to the extent that there are such strategies, they are certainly not sustainable.

### **Consultant incentives**

7.32 The AIS tentatively concludes that incentive schemes which preclude or deter clinicians from working for a rival "*may point to a barrier to entry/expansion*". HCA submits that the AIS has not presented any evidence that hospital/consultant agreements are creating foreclosure effects in local healthcare markets, or specifically any evidence of foreclosure in London. The evidence discussed in Appendix E does not bear out the concerns that these constitute barriers to entry or expansion.

7.33 HCA notes with interest the results of the CC's own consultants survey on the subject of incentives. Only 11% of private consultants were aware of incentives/benefits offered by private hospitals and just 3% said they had personally been offered any type of incentive or benefit in the last five years. The CC's theory of harm rests on measures affecting just 3% of consultants. The survey appears to reflect the earlier findings of the OFT's own survey in which the OFT noted that only "*a small number of PH providers*" offer direct incentives and that these affect just 15% of consultants. Consequently, the survey evidence indicates that any incentives are very limited in scope and are not pervasive. It is difficult to see how incentive arrangements can create material barriers to entry where they involve such a relatively small group of consultants.

7.34 Appendix E refers to HCA's agreements and HCA notes as follows:

- (i) Appendix E, paragraph 54 is incorrect. The "CyberKnife Partnership Agreements" (i.e. the Robotic Radiosurgery LLP) does not contain any restrictions on investing partners from "undertaking similar work for rivals in London". Please see paragraph 49.9 of HCA's response to CC's market questionnaire. [§<].
- (ii) [§<].
- (iii) [§<].
- (iv) It is worth noting that member consultants are in fact carrying out significant *inpatient* work at rival hospitals. HCA has checked the patient records for [§<] in 2012 (HCA stresses that it does not monitor these figures and has checked these records purely for the purposes of making this submission to the CC) which shows [§<] also treat patients at the London Clinic. Two of them take virtually all of their inpatients to the London Clinic:

[§<]:	[§<]
	[§<]
[§<]:	[§<]
	[§<].

It is the very fact that consultants are not "tied" to HCA hospitals that incentivises HCA to compete to ensure a high-quality offering to its consultants.

- (v) It is very difficult to see how these very limited non-compete covenants could give rise to any material foreclosure effects in the context of the London market. They only affect outpatient facilities, and as discussed above there is relative ease of entry into the provision of outpatient services right across London. There is a plethora of outpatient facilities in London with very vigorous competition between hospital operators. Appendix E does not put forward any evidence whatsoever that this limited, non-compete covenant has had the effect of excluding or limiting rival operators. On the contrary, the record of new entry and expansion in London, in both outpatient and inpatient services, provides sufficient evidence that there are no such barriers to entry.

7.35 Appendix E does not provide any concrete evidence that any hospital/consultant arrangements have actually had the effect of limiting or foreclosing new entrants. Appendix E offers no- support for the proposition that incentive schemes "*may point to a barrier to entry/expansion*".

7.36 The AIS suggests (paragraph 128) that there are two ways in which hospital/consultant agreements could deter entry and HCA comments as follows:

- (i) First, the CC suggests that this may arise where "*the new entrant is not recognised by one or more of the larger insurers*" and volume-related financial incentive schemes prohibit consultants from switching a proportion of their work to the entrants. There is an obvious and fundamental inconsistency with this proposition. If the new entrant is not recognised by the larger PMIs, consultants would not in any event seek to bring their practice to the new hospital because of the importance of PMI recognition to the consultant's own practice. Furthermore, in view of the "consultant drag effects", consultants would also be discouraged from bringing their other PMI patients to the hospital. This disincentive to switch to the new entrant is entirely related to the fact that

it has failed to secure PMI recognition and not the effect of any financial incentive schemes.

- (ii) The CC also indicates that there may be barriers where there are long term, exclusivity agreements with consultants. Appendix E however gives no such examples of long term, exclusivity arrangements. HCA has no such agreements and all of its standard agreements ([&lt;]) are terminable at relatively short notice. In the case of JV Agreements, member consultants have the ability to sell their equity share subject to the pre-emption rights set out in the Agreement. Appendix E cites no examples of long term agreements which lock-in consultants for a considerable duration of time. HCA would therefore challenge the CC to present any evidence that there are long term exclusivity agreements which are having a material foreclosure effect.

7.37 The CC also appears to ignore the evidence that there is a natural tendency for consultants to practice *principally* (but not exclusively) at a single hospital for convenience. HCA's 2010 consultant survey (see exhibit 55.2 of HCA's response to the CC's market questionnaire) found that 65% of HCA consultants carry out more than half of their private practice at the HCA hospital where they are based. Likewise the CC's own consultant survey found that over 75% of consultants see "most" of their patients at their main hospital. While "multi-homing" is relatively common, the fact of the matter is that for reasons of consultant convenience most consultants tend to focus the bulk of their practice at a single facility. This has nothing whatsoever to do with consultant incentive arrangements, i.e. it is not incentives which are "tying" consultants to particular hospitals.

7.38 Furthermore, incentive schemes are only likely to have foreclosure effects where an efficient operator is not able to offer similar terms and conditions. It is open to any new entrant to compete for consultants by offering the same types of incentives as incumbent operators, and indeed it should be noted that this is precisely what new entrants such as Circle are doing. From this point of view, incumbency brings no particular advantages. Incumbents and new entrants can compete on exactly the same terms to attract and retain consultants.

7.39 The CC also does not recognise the potentially pro-competitive effect of any consultant incentive arrangements. Again, there is an inconsistency in the evidence presented in Appendix E. Paragraph 55 specifically notes the example of Circle which has entered the market in the last few years with a consultant incentive model whereby consultants take an equity stake in the facility in return for commitment to undertake a designated proportion of their clinical practice at the hospital. This has allowed Circle to attract consultants in a relatively short space of time, and thereby attract significant volumes of business, which has served as Circle's route to market. This is a text book example of the way in which new entrants can compete by being innovative in the terms and conditions which they are able to offer consultants. This flatly contradicts the notion that consultant incentive schemes can foreclose new entrants.

7.40 HCA reiterates that in London there is a relatively large pool of NHS consultants (over 7,500) which ensures that new entrants have ready access to consultants which need to undertake a private practice. In these circumstances, it is inconceivable that any the types of schemes described in Appendix E are likely to have material foreclose effects in the London market.

7.41 Finally, HCA draws the CC's attention to the recent guidance ("Financial and commercial arrangements and conflicts of interest") issued by the GMC (which comes into effect on 22 April 2013). This acknowledges that consultants may have financial or commercial interests

in healthcare facilities provided they do not allow conflicts of interest to arise and disclose these interests to their patients. See, in particular, paragraph 17 of the guidance.

### **PMI / hospital contracts**

- 7.42 Theory of Harm 5(a) hypothesises that there are "*contractual terms that disincentivise PMIs from recognising new entrants*". The AIS however presents no evidence to support the proposition that PMI / hospital contractual terms, including volume-related discounts and rebates, have in fact impeded new entry and expansion in London.
- 7.43 HCA can only speak for its own contracts but as previously noted:
- HCA's PMI contracts do not contain any provisions which are aimed at shutting out competitors.
  - HCA has never sought "one in, all in" arrangements with insurers or offered preferential pricing based on the number of its hospitals in a network.
  - HCA does not seek to prevent or discourage PMIs from listing competitor hospitals on their networks.
  - HCA does not require "network integrity", i.e. PMIs are entirely free to add new hospitals to their networks. [§<].
- 7.44 The AIS refers to "volume for discounts" deals with PMIs. [§<]. As Appendix E notes in relation to volume-related pricing, the PMIs involved were not "*unwilling parties to these arrangements, given the discounts that meeting volume thresholds could bring*". [§<].
- 7.45 There is no evidence that either BUPA, or any other PMIs, have refrained from recognising new entrants in London because of any existing pricing arrangements with HCA. The record of new entry and expansion in London in both outpatient and inpatient facilities speaks for itself. HCA is unaware of, and has not seen any evidence for, any instance in which a PMI has failed to recognise a new entrant in London because of its existing contracts with HCA.
- 7.46 On the contrary, HCA can cite numerous examples where PMIs have not only recognised competing hospitals but have also created new network products which have excluded HCA hospitals whilst including HCA's competitors, e.g. BUPA "Essential Access" and "Extended Choice" policies, PruHealth Countrywide List, and Aviva's Key Hospitals network. It is clear that PMIs are creating new networks which exclude HCA hospitals and are not deterred from doing so by any contractual provisions.
- 7.47 Furthermore, the CC presents no evidence that volume-related discounts or rebates have a loyalty enhancing effect which may foreclose equally efficient competitors in accordance with the standard competition law tests (see e.g. the European Commission's Communication on abuse of exclusionary conduct). The CC would need to conduct a case-by-case assessment to establish whether the features of any discount or rebate scheme could foreclose competitors from access to the markets. There has been no attempt to do so in Appendix E.

### **Consultant entry barriers**

- 7.48 Theory of Harm 5(d) notes that there is very little evidence of barriers to entry in the provision of consultant services in private hospitals. HCA agrees.



- 7.49 Consultants can easily switch from one facility to another at very low cost. Indeed, paragraph 131 of the AIS notes that "*competition for consultants is intense*" in London and this is borne out by the level of switching between London hospitals. [38].
- 7.50 Furthermore, although the tendency is for consultants to focus the majority of their practice at a single hospital, "multi-homing" is widespread and there are numerous examples of consultants splitting their patient list between different hospitals, and the ease with which they can do so demonstrates that there are no significant barriers.
- 7.51 HCA would also point out that some of the consultant incentive arrangements which are referred to in Appendix E, notably the provision of subsidised consulting rooms (which, HCA understands, are widely available in London), can further mitigate any switching costs for the consultants and encourage switching between facilities. [39], which means that junior doctors who have a smaller patient base have lower costs at a time when they are building up their practice. HCA does not, as a condition of granting practising privileges, require consultants to investigate and treat their patients exclusively at its hospitals, unlike the BUPA Cromwell's 2010 Practice Privileges Document, which does contain such a condition.

## **8. THEORY OF HARM 7: VERTICAL EFFECTS**

### **Introduction**

- 8.1 In the context of Theory of Harm 7 dealing with vertical effects, the CC raises concerns (paragraphs 157 – 159 of the AIS) regarding the ownership by private hospital groups of primary care and outpatient diagnostic centres principally in London. HCA strongly rejects the proposition that its ownership of either primary care facilities or outpatient facilities distorts referral patterns or raises any competition concerns.
- 8.2 The CC refers to "vertical" issues in relation to primary care and/or outpatient facilities. This is not entirely correct since primary care, outpatient treatment and inpatient treatment may be seen as complementary forms of healthcare, based on the clinical condition and treatment needs of the patient, rather than as successive stages of a supply chain. However, irrespective of whether these are properly "vertical" relationships, HCA notes the CC's concern over whether ownership of these facilities distorts referral pathways and forecloses rivals, and this issue is addressed as follows.
- 8.3 HCA deals separately with: (i) its primary care (GP) practices and (ii) outpatient facilities.

### **Primary care**

- 8.4 GPs are the focal point for the delivery of primary care and are usually the first point of contact for patients. The vast majority of primary care is provided through the NHS. There is a relatively small, but growing, private sector which provides primary care services, encompassing in particular occupational health, health screening, company-paid healthcare (i.e. where primary healthcare is provided to employees as part of an employee benefits package), GP "walk-in" services and physiotherapy.
- 8.5 HCA has ownership links in three GP practices:
- HCA owns 90% of Roodlane Medical Limited ("Roodlane")
  - HCA owns 70% of Blossoms Healthcare LLP ("Blossoms")
  - HCA owns 100% of General Medical Clinics Plc ("GMC").
- Please refer to HCA's response to Question 65 of the CC's market questionnaire for further information about its ownership interests and about these three facilities.
- 8.6 HCA also rents out consultancy rooms to a number of GPs who practise within certain of its inpatient and/or outpatient facilities, and details are provided in the response to Question 63 of the CC's market questionnaire. HCA however does not have any ownership interest or rights in these GP practices and the GPs concerned practise entirely independently of HCA and on their own account.
- 8.7 The three GP practices which HCA owns provide a range of primary care services:
- Occupational health services, i.e. the management of healthcare in the workplace including medical services at the workplace, employee-related examinations and tests and sickness absence management.

- Health screening services i.e. executive health tests and check-ups to detect the possible presence of health problems with a preventative health focus.
  - GP services i.e. company-paid and self-pay GP consultations either on-site at the client's offices or at the practice's own locations.
  - Physiotherapy.
- 8.8 Roodlane, Blossoms and GMC derive the bulk of their revenue from the provision of these services to corporate City-based clients such as investment banks, City institutions, law and accountancy practices and other major corporate organisations. Their core business is corporate healthcare focused on City employers. They compete vigorously with a range of other providers, including BUPA, AXA PPP, Nuffield and many other GP practices to provide their corporate clients with access to high-quality primary care. A relatively small proportion of their revenue is derived from self-pay patients. Generally speaking, PMI policies do not cover primary care treatment.
- 8.9 It should be noted that, while GPs undoubtedly play a central role in making referrals to consultants and secondary care outpatient and inpatient facilities, it is only a small proportion of consultations which result in a referral. A referral may arise from a GP consultation or health screening. Occupational health and physiotherapy provision do not generally create referrals into secondary care. [redacted]. Therefore, to put the issue into context, the great majority of GP consultations involve primary treatment by the GP and do not involve any referrals into secondary care facilities.
- 8.10 It should also be noted that even when a GP refers a patient to a consultant for an outpatient consultation, that consultation will not necessarily result in the generation of new business for HCA. The consultant will charge his or her own fee to see and advise the patient. However, the initial consultation may not necessarily require the use of any diagnostic tests or equipment, in which case there will be no hospital fee. Furthermore, only a small proportion of outpatient consultations ([redacted] on average) result in a hospital surgical procedure (either inpatient or day case). Thus, many GP referrals to consultants will not give rise to any activity for the hospital. Also, as discussed further below, consultants practising at HCA outpatient facilities are not obliged to refer patients to HCA hospitals for inpatient treatment.
- 8.11 HCA's three GP facilities have a total of around [redacted]. However, not all of these GPs are based in London, since Roodlane has one practice in Glasgow and Blossoms has one practice in Birmingham and one in Edinburgh.
- 8.13 There are around a further [redacted] GPs who have licence arrangements for the use of rooms within HCA's facilities, but as stated above, HCA has no ownership interest in these GP practices and these GPs operate entirely independently of HCA. HCA does not impose any requirements or obligations on, or offer any incentives or inducements to, these GPs to refer patients to HCA facilities:
- [redacted]. There are no obligations to refer patients to HCA and the doctor shareholders are obliged to act in the patients' best interests when recommending treatment and referrals (see paragraph 65.3 of HCA's response to the CC's market questionnaire).
  - [redacted]. The Agreement similarly states that the member doctors must act in the patients' best interests when recommending treatments and referrals (paragraph 65.4 of HCA's response to the CC's market questionnaire).

- All other GPs practising at Roodlane, Blossoms and GMC are either locum GPs or employed by the relevant practice and their contracts of employment have no referral obligations or incentives whatsoever.
- As detailed in the responses to questions 61 and 62 of the CC's market questionnaire, none of the agreements which HCA has with other GPs practising within HCA facilities, including the Consulting Room Licences, contain any referral obligations or incentives.

- 8.15 In addition, HCA does not impose any targets which are based on or reference the number of referrals to HCA facilities.
- 8.16 The three GP practices are run autonomously within the HCA International group and report directly to the main Board. They retain their branding as Roodlane (which incorporates Roodlane and GMC) and Blossoms respectively, and are not branded as HCA. This reflects the fact that they are seen by HCA as separate primary care practices rather than being an integral part of HCA's secondary care services.
- 8.17 HCA does not systematically collect data on the proportion of referrals to its facilities from these three primary care practices. [redacted]. For the purposes of the CC's inquiry, HCA has conducted analysis of the estimated proportion of total appointments that culminated in a referral to a HCA facility before and after its ownership interest (on a six month, nine-month and twelve month before and after basis)<sup>152</sup> for each of the three primary care practices. Please note that this estimation also adopts a number of assumptions.<sup>153</sup> The results are summarised in **Table 8.1** below.

**TABLE 8.1 – Estimated referrals to HCA facilities as a proportion of total appointments at the primary care facilities, all patients (i.e. inpatients, outpatients and day cases)**

	Six months before	Six months after	Nine months before	Nine months after	Twelve months before	Twelve months after
<b>Roodlane</b>	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
<b>GMC</b>	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
<b>Blossoms</b>	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

- 8.18 The findings clearly indicate that, for each primary care practice, there has been no material change in the proportion of referrals to HCA out of total appointments when comparing the period before and after HCA acquired its ownership interest.
- 8.19 In addition, HCA has sought to estimate, based on the number of appointments and the average ratio of appointments to referrals, the likely number of referrals being made by each primary care practice for secondary care. Using this data, HCA has estimated the proportion of total referrals that are made to HCA facilities by each primary care practice.<sup>154</sup> The results are summarised in **Table 8.2** below.

<sup>152</sup> For the purposes of the analysis, the acquisition date used for: Roodlane is 01/08/2011, Blossoms is 01/04/2012, and GenMed is 01/07/2012 (i.e. the start of the month of acquisition).

<sup>153</sup> [redacted].

<sup>154</sup> [redacted].

**TABLE 8.2 – Estimated referrals to HCA facilities as a proportion of estimated total referrals made by primary care facilities, all patients (i.e. inpatients, outpatients and day cases)**

	Six months before	Six months after	Nine months before	Nine months after	Twelve months before	Twelve months after
<b>Roodlane</b>	[<]	[<]	[<]	[<]	[<]	[<]
<b>GMC</b>	[<]	[<]	[<]	[<]	[<]	[<]
<b>Blossoms</b>	[<]	[<]	[<]	[<]	[<]	[<]

8.20 Again, the data in Table 8.2 demonstrates that there has not been any material change in the proportion of referrals to HCA (out of total referrals) when comparing the period before and after HCA acquired its ownership interest.

8.21 HCA would also point out that the [<] GPs practising in its three owned primary care facilities represent a negligible proportion of the number of GP referrals to its secondary care facilities:

(i) In 2010, BCG estimated that there is a total pool of approximately [<] GPs which make referrals to HCA hospitals. HCA's three primary care facilities represent only 0.6% of this total. BCG estimated that approximately [<] GPs account for 80% of HCA's referrals, and [<] GPs would still represent only 3% of this pool of GP practices.

(ii) Research commissioned by the OFT in 2011<sup>155</sup> estimated that there are 5,390 GPs in London. The [<] Roodlane, Blossoms and GMC GPs would account for just over [<] of London GPs.

8.22 HCA estimates that patients referred from these three primary care facilities represent around [<] of the total number of outpatient visits to HCA facilities, and about [<] of HCA's total outpatient revenue.<sup>156</sup>

8.23 Therefore, even if for the sake of argument HCA's ownership of these facilities gave rise to any increase in referrals, it would not be capable of having any significant distortive effects or result in any material foreclosure of competitors. The number of GPs and potential number of referrals involved, relative to the total number of GPs referring patients to London private hospitals, is so small that even if (*quod non*) there were to be any change in the pattern of referrals, it would have no discernible impact on the market.

8.24 HCA considers that its ownership of primary care facilities offers significant benefits, including clinical benefits to patients:

(i) There are synergies which allow for the sharing of clinical experience and expertise in the treatment of patients, which may be particularly beneficial in view of the general trend away from inpatient care to treatment in local, ambulatory settings which includes minor surgeries in GP clinics.

<sup>155</sup> GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants Population Overview Report for the Office of Fair Trading*, August 2011.

<sup>156</sup> This is based on data on the total number of outpatient visits and outpatient revenue for 2012. The percentage attributable to the three primary care practices was based on the two-week rule described in footnote 153.

- (ii) There are also synergies through the provision of HCA head office support to the GP practices in terms of HR management, IT systems expertise, or assistance on project planning and execution.
- (iii) In addition, consolidation of the three practices creates savings in administrative costs.
- (iv) The acquisitions have brought capital investment in the three businesses. [X].
- (v) GPs referring patients to HCA hospitals can monitor their patients' progress over the entire referral pathway using software applications such as Patient Keeper, which provides a live online update on their patient's progress and wellbeing.

8.25 HCA's acquisitions of Roodlane, Blossoms and GMC were opportunistic investments as these businesses were brought onto the market by their owners. The rationale for HCA to invest in primary care is driven by a variety of factors:

- (i) HCA sees good growth opportunities in the delivery of private primary medical care to corporate clients. Roodlane for instance [X] underpinned by opening new sites and technological innovation. Private primary care is much less developed than private acute secondary healthcare. However, with growing constraints on NHS funding, HCA believes that this sector will grow particularly in the provision of services to corporate clients, where there is likely to be increased demand for company-paid healthcare options for employees. There is growing dissatisfaction with NHS GPs, and there is an opportunity for private providers to develop integrated and accessible primary care services.
- (ii) The three GP practices are focused on servicing major, City-based corporate clients. Laing & Buisson observe: "*There is clearly a private market for keenly priced, high quality company-paid primary care in the City of London, where wealthy corporate clients abound and where NHS primary care services are wholly inadequate to meet the needs of the day time working population, and perhaps in and around London where wealthy companies are established and population density is high.*" It is likely that, as the corporate market develops, larger GP practices which offer greater scale and an increased number of sites will be in a stronger position to compete for corporate healthcare contracts with City-based organisations.
- (iii) There are also opportunities to expand occupational health and screening services in London, in competition with providers such as BUPA and Nuffield, as corporates look to operators with wider coverage for their healthcare needs. The three GP practices provide a scalable platform to support their clients' needs.
- (iv) Since the GP practices focus on large corporate clients, there are wider commercial benefits for HCA to establish and cultivate good relationships with major corporates which can create a "halo" effect in enabling HCA to also market and promote its inpatient and outpatient facilities.
- (v) Although the current focus is on corporates, there is also an opportunity to grow self-pay business, by developing private GP services which offer convenience, quick accessibility, preventative health and a strong patient-GP relationship.

- (vi) In addition, HCA's acquisition of these practices enables HCA to obtain an insight into and a better understanding of GP practices and referral pathways which will assist in developing better interaction and liaison with GPs generally.
- 8.26 Thus, although the CC has focussed on HCA's aim to grow GP referrals, in fact its acquisition of the three GP practices is primarily motivated by the growth opportunities within primary care itself rather than any spin-off benefits in terms of increased referrals for its hospitals.
- 8.27 The provision of private primary care services is highly competitive and is attracting a very wide range of new providers in London, including insurers, GP-owned companies, hospital groups and other commercial providers:
- (i) BUPA is a major provider of primary care services, including occupational health, health screening and GP services. It is therefore fully vertically-integrated at the insurer, hospital and primary care level, and its primary care business is substantial. It has several primary care medical centres offering private GP services across the Capital, including at Canary Wharf, Austin Friars, the Barbican, Fleet Street and the West End. It is also (through BUPA Home Healthcare) a leading provider of home healthcare services to patients being treated at home as an alternative to hospital care. As the dominant PMI, it is in a much stronger position to "steer" secondary referrals to favoured providers such as the BUPA Cromwell or to lower cost network providers and distort referral pathways. As the CC notes: *"BUPA's move to open referrals gives it more control over the flow of patients and is likely to enhance its ability to direct patients to its hospitals."*
  - (ii) AXA PPP is also active in the provision of occupational health plans for large corporates through its employee programmes.
  - (iii) Nuffield is a significant competitor in occupational health for corporates. It has recently opened the Canary Wharf Medical Centre, providing a range of private GP services to City-based corporates and individuals. It also offers health assessments and check-ups through its various gyms in London, including at Battersea, the City and Covent Garden.
  - (iv) BMI operates private GP services in London, not only through a number of its London hospitals (including the London Independent and the Clementine Churchill) but also through its outpatient centres such as BMI City Medical.
  - (v) Many other competing London hospitals offer private GP services including: BUPA Cromwell; Aspen (at Highgate and Parkside); the London Clinic; and the Hospital of St. John and St. Elizabeth. Indeed, most of HCA's independent Central London competitors have GPs attached to their hospitals.
  - (vi) There are also numerous other commercial providers operating GP centres including Westover Medical, which has four clinics in west London, Doctorcall, and Endeavour Health.
  - (vii) Spire, which (HCA understands) benefits from the referrals from BUPA's health screening programme across the UK.

8.28 There are thus numerous competitors operating in all aspects of primary medical care. There is vigorous competition in London to provide primary care services to both corporates and individuals. BUPA's and Nuffield's wider geographic spread across the UK give them strong appeal for corporates with sites outside London. In this context, it is inconceivable that HCA's ownership of three GP practices could create any potential competition issues.

### **Outpatient facilities**

8.29 Outpatient treatment encompasses the initial consultation with the consultant, any requisite diagnostic tests and where appropriate minor surgical procedures. All hospitals offering inpatient treatments have outpatient facilities, including consulting rooms and diagnostic equipment, where a patient will receive initial advice and diagnosis, before being admitted where appropriate for inpatient or day case treatment. These facilities may be either co-located at the hospital's main site or in separate locations.

8.30 HCA is therefore puzzled by the CC's suggestion that the hospital ownership of outpatient centres may raise competition concerns. Outpatient services form part of the core offering of any hospital to take patients through the normal pathway of care involving initial consultation, diagnosis, ambulatory and inpatient treatments.

8.31 As the CC is aware, technical advances and innovation in drugs and clinical equipment are accelerating the trend in healthcare away from inpatient treatment towards care delivered in outpatient, ambulatory settings. Outpatient activity has grown and now accounts for [X] of HCA's revenue and over [X] of its surgeries. Patients typically prefer local outpatient facilities for convenience. This trend is driving new investment in outpatient facilities reflecting a shift in demand towards outpatient and day case procedures. Furthermore, the development of increasingly sophisticated diagnostic technologies is encouraging hospital operators to invest in new diagnostic equipment, such as state of the art CT scanners, ultrasound and density scans, to identify the most appropriate treatment options. Consequently, the investment and growth in outpatient facilities reflects long term market trends in the way in which secondary acute healthcare is now being delivered.

8.32 All of HCA's hospitals have outpatient facilities (consulting rooms and diagnostic services):

- (i) In some cases, these are located on the hospital's main site, e.g. the Lister has an outpatient department (Chelsea Medical Centre) with 17 consulting rooms, 3 treatment rooms, 1 colposcopy room and a plaster room.
- (ii) In other cases, HCA hospitals have established outpatient and diagnostic centres at separate, stand-alone sites located adjacent or close to the main hospital. For example, the Lister has developed the Chelsea Outpatient Centre at 280 Kings Road; the Harley Street Clinic has developed the Harley Street Clinic Diagnostic Centre at 13-18 Devonshire Street; and the Wellington has established the Platinum Medical Centre, a purpose-built dedicated outpatient complex which is just a short distance from the main hospital.
- (iii) There are also cases where HCA hospitals have developed "satellite" or "outreach" outpatient centres some distance away from the main hospital. The London Bridge Hospital has 5 such outpatient centres: Sevenoaks Medical Centre; City of London Medical Centre; Brentwood Medical Centre; 31 Old Broad Street; and Docklands Healthcare. The Wellington has developed the Wellington Diagnostic and Outpatient Centre at Golders Green, NW11, a purpose-built diagnostic and treatment facility



about 4½ miles from the Wellington hospital which provides an alternative to patients in north west London wishing to access medical care from the Wellington. In partnership with the Harley Street Clinic, the New Malden Diagnostic Centre provides outpatient and diagnostic facilities for the local community in south west London and beyond.

A full list of HCA's outpatient centres is provided in HCA's response to Question 1 of the CC's Market Questionnaire.

- 8.33 The transfer of outpatient services from the hospital into separate centres has the benefit of freeing up capacity within the hospital for inpatient beds and new clinical services. For example, the creation of purpose-built outpatient facilities at the Platinum Medical Centre and the Wellington Diagnostic and Outpatient Centre has allowed the Wellington Hospital to utilise more space within the hospital to create new services such as the acute admissions unit. Similarly, the Lister created space within the hospital for a new ICU by re-developing 6 outpatient consulting rooms, which was made possible by transferring this activity to the Chelsea Outpatient Centre.
- 8.34 The development of outreach centres is in response to market opportunities to provide new, high quality outpatient and diagnostics in local communities, where there is under-provision of such services. For example, there has been strong local support for the Wellington Outpatient and Diagnostic facility in Golders Green, allowing residents in north west London to access high quality outpatient treatments without the need to come into Central London. [X].
- 8.35 As fully explained previously (see HCA's response to Section 8 of the CC's Market Questionnaire), there are no requirements on consultants to refer patients to HCA hospitals:
- [X].
  - [X].
  - [X].
- 8.36 Also, to put this issue into perspective, it should be pointed out that outpatient consultations will not result in any revenue for the hospital (as opposed to the consultant) unless: (i) there are diagnostic tests using the hospital's equipment; or (ii) there are surgical procedures performed within the outpatient centre or the patient is referred for inpatient or day case treatment within the main hospital. It is only in these cases that there will be a hospital rather than only a consultant service, for which the hospital can make a charge.
- 8.37 The growth in outpatient services is encouraging new development and investment by HCA's competitors in outpatient and diagnostic centres. Exhibit 12.1 to HCA's response to the CC's market questionnaire lists a number of competing outpatient and diagnostic centres in London, demonstrating the very broad based and fragmented nature of competition. There is relative ease of entry and the costs of establishing a new outpatient centre are significantly lower than the costs associated with a new, full service inpatient facility. Examples of new entry include the following:
- The Phoenix Hospital Group (subsequently acquired by BMI) opened 9 Harley Street, a new outpatient, imaging and diagnostics facility.

- BMI has opened BMI City Medical at 17 St. Helens Place, London offering a wide range of outpatient and private GP services for city based employees.
- BMI has also opened the BMI Syon Clinic, a state of the art private outpatient clinic at 941 Great West Road, Brentford, Middlesex which has advanced diagnostic imaging facilities and a minor injuries unit.
- The Hospital of St. John and St. Elizabeth has recently invested £11 million in a new outpatient facility, day case centre and primary care centre.
- Aspen Healthcare has opened "Parkside at Putney" providing outpatient consultations, diagnostics and minor procedures.
- The Royal Marsden and the ICR's new Centre for Molecular Pathology in Sutton reached a major milestone when it was 'topped out' in late 2011. The new £18.2 million centre helps advance cancer research and treatment. The new centre and state-of-the art facilities will drive a move towards personalised medicine, bringing scientists and clinicians together to continue revolutionising the diagnosis and treatment of cancer.
- There are also numerous recent examples of consultants establishing outpatient and diagnostic centres: for instance, Fortius Clinic is a consultant-led outpatient and diagnostic centre specialising in orthopaedic and sports injuries at 17 Fitzhardinge Street, London W1, with MRI ultrasound and X-ray scanning equipment; another example is the Medical Chambers, Kensington which offers a wide range of outpatient services including cardiac diagnostic tests and ultrasound.

8.38 HCA does not systematically monitor or track the extent to which outpatient visits result in subsequent referrals to HCA hospitals or any other hospitals for inpatient or day case treatment. However, patient records for 2012 for a selected number of HCA outpatient facilities which were analysed for the purposes of this submission indicate as follows:

- (i) The average rate of referral to HCA is roughly [redacted].
- (ii) The rate of referral is higher in the case of outpatient centres in close proximity to the hospital: [redacted] in the case of Chelsea Medical Centre (close to the Lister); and [redacted] in the case of the Wellington Diagnostic and Outpatient Centre (close to the Wellington Hospital).
- (iii) The rate of referral is lower in outpatient facilities which are further afield. [redacted] had a referral rate of just [redacted]. Brentwood and Sevenoaks [redacted]. This indicates that patients in these local communities are largely using these outreach centres purely for outpatient services. HCA's own catchment area analysis (see response to Question 10 of the CC's market questionnaire and Table 10.2) shows that there is a significantly narrower catchment for HCA's outpatient services than for its full-service hospitals. These locations are therefore largely catering for local demand for outpatient and diagnostic services.
- (iv) It is impossible to ascertain whether HCA ownership of these facilities results in incremental referrals which would not otherwise go to HCA hospitals since there is nothing to benchmark these figures against. It is likely that in the case of outpatient centres next to or in close proximity to the hospital, patients would in any event have

been referred by their GPs to the relevant HCA hospital for inpatient care, and, following the outpatient appointment, the consultant concerned would be more likely to treat the patient within the relevant HCA hospital to which the outpatient unit is attached. However, for centres further afield, the comparatively low rates of referral would suggest HCA is not attracting a significant number of inpatients from other providers. The figures certainly do not suggest that the creation of outpatient outreach centres is distorting referral pathways.

8.39 The referral rates for the various outpatient centres for which HCA has analysed the data is as follows:

<b>Outpatient centre</b>	<b>Total visits</b>	<b>IP/DC referral</b>	<b>% visits resulting in referral</b>
Chelsea	[X]	[X]	[X]
Wellington (Golders Green)	[X]	[X]	[X]
Wellington (Platinum)	[X]	[X]	[X]
City of London (Tower Hill)	[X]	[X]	[X]
New Malden	[X]	[X]	[X]

8.40 HCA reiterates that the rationale for developing new outpatient centres in and around London is based on several factors and is not in fact driven by referrals:

- (i) Outpatient care is intrinsic to the core offering of any hospital rather than being a distinct "bolt-on" service.
- (ii) There is long term growth in outpatient services as more and more patients can be treated in outpatient settings without the need for a hospital stay.
- (iii) There is an increasingly competitive market for outpatient services, where barriers to entry are lower, and HCA needs to invest in outpatient facilities to remain competitive.
- (iv) The creation of separate outpatient centres allows HCA to utilise space within the main hospital in a more efficient way and create new clinical units and services.
- (v) The creation of new outreach outpatient centres in outer London and suburban locations is bringing high quality, state of the art facilities with advanced diagnostic equipment and services into communities which currently have only limited choice in these local areas and, as the Golders Green example has demonstrated, is responding to market demand for new outpatient services. There are opportunities to provide "state of the art" diagnostic techniques and equipment e.g. CT and MRI scanning in areas where locally-based hospitals do not provide these services.

8.41 There is no evidence that HCA's establishment of new outpatient and diagnostic facilities gives rise to any distortion of competition or foreclosure effects on third parties.

## Summary

8.42 It follows from the above that HCA's ownership, either of GP practices or of outpatient diagnostic centres, does not raise any competition issues.

8.43 As far as GPs are concerned:

- There are no referral obligations or incentives at Roodlane, Blossoms and GMC.
- There are only around [x] GPs in these practices which accounts for an insignificant proportion of the total number of GPs making referrals to London hospitals.
- The data indicates that ownership has not resulted in any material changes to referral patterns.
- The principal rationale for investing in primary care relates to the growth opportunities in this sector and other potential synergies which provide clinical benefits to patients.
- There is an extremely competitive, and growing, market for private primary care provision in London.
- There are demonstrable clinical benefits arising from HCA's investment in these GP practices, including the provision of clinical expertise and new capital investment in IT and premises.

8.44 In relation to HCA's ownership of outpatient facilities:

- Again, there is no requirement to make referrals and in fact only a small proportion of outpatient visits ([x] on average) tend to result in referrals for inpatient or day case treatment.
- The data does not suggest that "satellite" outpatient centres are making significant referrals to HCA hospitals – there is a very low rate of referral in HCA's outer London and suburban outpatient centres, and the [x] shows that consultants carry out a significant volume of inpatient work in rival hospitals.
- It is important and legitimate for hospital operators to develop their outpatient provision because the trend in healthcare is moving away from inpatient care to outpatient treatment.
- There has been significant new entry and expansion in outpatient facilities in London and barriers to entry are lower than for inpatient facilities.
- The creation of new outpatient centres is delivering clinical benefits by bringing new, state of the art diagnostic services and equipment to areas where these are not currently being provided.