



SPIRE HEALTHCARE

COMPETITION COMMISSION PRIVATE HEALTHCARE MARKET INVESTIGATION

RESPONSE TO THE ANNOTATED ISSUES STATEMENT AND PROFITABILITY WORKING PAPER

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1. INTRODUCTION

1.1 Spire Healthcare (*Spire*) appreciates the opportunity to respond to the Competition Commission's (the *CC*) Annotated Issues Statement (*AIS*).

1.2 In a number of respects, the *AIS* correctly reflects aspects of how the UK private healthcare sector operates and the competitive dynamics within it. For example, the *AIS* has properly identified that:

- (a) **Market definition:** The NHS has a key role in driving competition in the provision of privately funded healthcare services.¹
- (b) **Local market power (Theory of Harm (ToH1)):** Healthcare providers can change the treatments they provide quickly.² Patients travel different distances depending on the type of treatment involved.³
- (c) **Negotiations between hospitals and PMIs (ToH3):** Bupa in particular, and Bupa and AXA PPP together, represent a very large proportion of the private market for consultants. As such, they have a significant effect on the operation of the market as a whole.⁴ Indeed, the influence of the PMIs is so pervasive that it impacts the selection and delivery of healthcare services in the private sector.⁵ A PMI's negotiating position is likely to be materially influenced by 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').⁶ Similarly, the *CC* has correctly recognised that the buyer power of Bupa, or of Bupa and AXA PPP together, restricts patient choice in the market for consultants through the prevention of 'top-up' fees.⁷
- (d) **Barriers to entry (ToH5):** The *CC* has recognised the high fixed costs of operating private hospitals⁸ and similarly the difficult balance between those costs of entry and the potentially limited overall demand for private healthcare in a given locality.⁹ The *CC* has also recognised that the conduct of PMIs in respect of new hospital recognition may impede entry.¹⁰

¹ *AIS*, paragraphs 25-26.

² *AIS*, paragraph 29.

³ *AIS*, paragraph 30.

⁴ *AIS*, paragraph 110.

⁵ *AIS*, paragraph 12.

⁶ *AIS*, paragraphs 87-89.

⁷ *AIS*, paragraphs 108-112.

⁸ *AIS*, paragraphs 122-123.

⁹ *AIS*, paragraph 138.

¹⁰ *AIS*, paragraph 139.

1.3 However, in a number of instances the AIS does not fully address the way in which private healthcare is delivered to and used by patients in the UK. This position leads the AIS to overlook some of the most significant market features and developments: the AIS does not for example reflect four of the main drivers of competition in healthcare in the UK. This is not for want of evidence on these points. On the contrary, as is clear from the published evidence on the CC's website, the information provided to the CC by Spire and other healthcare market participants demonstrates that the omitted points are clear features of the UK private healthcare marketplace. For example:

- (a) All respondents to the market inquiry – especially PHPs and PMIs – have evidenced the differences in competitive conditions among local areas across the UK. Spire, for example, has made substantial and differing investments in its facilities in response to specific local competitive conditions. There are different providers, different patients, different service offerings, and different types of facilities. The consistent body of evidence to this effect has been overlooked. Instead, the AIS seeks to apply an unsubstantiated template assessment of local competitive conditions, which significantly underestimates the complexity of private healthcare in the UK. So far as Spire is aware, no analysis has been conducted to suggest that local competitive conditions are sufficiently homogenous across the UK to sustain the approach taken in the AIS. Moreover, the analytical framework for local competition proposed in the AIS in any event flawed and untenable.
- (b) Although the AIS does recognise that the NHS plays a key role in assessing competition in the provision of privately-funded healthcare services, the AIS does not reflect the published evidence on the extent of NHS interaction with private healthcare. First, private provision within the NHS has been growing, both in PPU's and in private beds within the general NHS. The NHS is already the 4th largest provider of private healthcare in the UK with total revenues of £445 million in 2010/2011 and that growth will accelerate with the lifting of the private revenue cap. The AIS wrongly assumes all of this revenue has been generated in PPU's. In fact, numerous NHS trusts without PPU's (e.g., North Bristol NHS Trust, Southampton University Hospital NHS Trust, Royal United Hospital Bath NHS Trust, South Tees Hospitals NHS Foundation Trust, Derby Hospitals NHS Foundation Trust, Ipswich Hospital NHS Trust) have been developing strategies to increase their private revenues and many, in fact, already generate significant private revenues outside PPU's. Second, although the AIS discusses the clarity of the patient pathway to obtain private healthcare, the AIS does not accurately reflect the interactions of the general NHS with that private patient pathway. Indeed, the AIS omits the CC's own survey evidence that many patients choose between accessing treatment free at the point of service on the NHS and paying for private treatment. It is notable that non-PPU NHS trusts compete for private work on this basis.¹¹ Third, the AIS does not reflect the fact that Spire hospitals have made significant investments to respond to competition from the NHS.

¹¹ See Appendix G for examples of NHS marketing materials.

- (c) The analysis in the AIS addresses only a minority of the private healthcare business. The majority of Spire’s revenues, and the majority of patient episodes at its facilities, relate to outpatient and day-case treatment. By focusing exclusively on inpatient care, the AIS overlooks the majority of the market for private healthcare, and thereby fails to recognise and analyse the effect of interactions between outpatient/day-case competition and inpatient care.
- (d) In considering negotiations between PMIs and PHPs, the AIS has looked at ways in which PHPs may be able to exercise market power, but has overlooked or misunderstood evidence presented by the PHPs on ways in which PMIs may be able to exercise buyer power. There is clear and consistent voluminous evidence presented to the CC (and again published on the CC’s website) which discusses the various ways in which PMIs have been able to – and continue to – exercise bargaining power over PHPs. AXA PPP states that it can hold its own in negotiations. As a result, the AIS omits relevant evidence from consideration and presents an incomplete and inaccurate picture of negotiating dynamics. ✂ In addition, the AIS fails to appreciate the significant role that PMI steering of patients is coming to play in the market. A consideration of the position of both parties to a negotiation is central to any theory of bargaining power, but is omitted.

1.4 Rob Roger, Spire’s CEO, set out many of these points in his opening remarks at the issues hearing on 14 March 2013 (the *Issues Hearing*), as reflected in the draft transcript of the hearing.

1.5 Similar concerns arise in relation to the analysis of PHP profitability set out in the AIS, where again the analysis set out is not substantiated by the available evidence. For example:

- (a) The AIS sets out “current thinking” that PHPs are making excess profits over cost of capital, but does not seek to understand how any EBITDA improvement might have arisen. The AIS has not considered, for example, that improved financial performance might reflect a fully competitive and efficient response to the markets concerned in this MIR. ✂
- (b) Moreover, several sections of the profitability analysis are reflective neither of the private healthcare sector, nor of more general market conditions in the UK. A simple litmus test would have highlighted many of these issues. For example, the AIS’s treatment of intangibles is extreme – few, if any, patients would wish to be treated in a hospital that had no intangible assets, yet the AIS’s starting point would effectively assume this to be the case.

1.6 In summary, the AIS sets out a static view of the UK healthcare market, while in reality this market has undergone and is undergoing significant changes many of which have already fed into market practice. Spire appreciates that this is a complex analysis to undertake, but healthcare is a complex market and complexity is not a reason to short-cut the analysis or omit key market features.

2. PROFITABILITY

2.1 The AIS and the Profitability Working Paper (*PWP*) express the “current thinking” view that Spire and other private healthcare providers are earning excess profits. This view is incorrect (at least in the case of Spire) and cannot be rationally be maintained. In short:

- (a) The PWP’s approach to capital employed in the business is fundamentally flawed;
- (b) The PWP’s ROCE analysis is therefore similarly flawed and cannot be relied upon by the CC; and
- (c) The position in the PWP that any returns over the cost of capital are symptomatic of market power is purely presumptive, not founded on any analysis and is inconsistent with the CC’s own published guidance.

2.2 Spire’s core concern with the PWP’s approach to profitability assessment is that much of that assessment does not reflect how a private hospital business actually works. In a number of instances, the positions reached in the PWP appear to be the product of presumptions applied without consideration of the evidence to check their applicability to the market under investigation. Put simply, a private healthcare business could not be operated in the way hypothesised in the PWP.

2.3 There is a very simple litmus test that could have been used to cross-check the PWP capital employed calculation. Spire has recently built and opened a new hospital in Brighton at a cost of around £35 million. Taking that as a conservative figure of hospital capital asset value (since Brighton is a comparatively small unit), grossed up for Spire’s 34 freehold hospitals (not all 37) produces a total replacement cost of £1.19 billion. Compared to the PWP’s calculated valuation of $\pounds 1.19$ billion, it is obvious that the PWP figure is wrong. There is no conceivable way that a hospital estate comparable to Spire’s could rationally be thought to be based on the capital asset base allowed for in the PWP.

The PWP approach to capital employed is flawed

2.4 The PWP analysis of capital employed in running a private hospital business is theoretical and does not take into account today’s commercial reality for PHPs. The approach taken by the CC to valuation of the assets of the business cannot be sustained by reference to objective evidence. To provide the CC with the necessary objective evidence, Spire has obtained expert assistance from L.E.K. Consulting LLP (*L.E.K.*), Ashkirk Properties Ltd. (*Ashkirk*) and Knight Frank LLP (*Knight Frank*). Their reports are attached at Appendix A and Appendix B and Appendices C and D, respectively. The detail of their respective evidence can be read in those reports and is summarised here.

2.5 Spire commissioned L.E.K. to comment on the CC’s methodology for assessing Spire’s return on capital employed from a commercial perspective, and the composition of Spire’s profitability. Ashkirk has detailed knowledge of Spire’s property portfolio and Spire commissioned Ashkirk to comment on the CC’s approach

to the land valuation for Spire's hospitals. As a result of its analysis, Ashkirk recommended that, given the obvious deficiencies in DTZ's analysis, Spire have an independent valuation prepared and Spire commissioned Knight Frank to comment on the CC's approach to land valuation and to prepare a land valuation report for its hospitals. Spire also commissioned Knight Frank to prepare an assessment of the reinstatement costs for its hospitals.

2.6 **Land valuations.** The land valuations used in the PWP cannot be relied on for a number of reasons.

- (a) First, DTZ recognises that the methodology it uses ("alternative equivalent location"/modern equivalent asset value) is not a RICS-recognised valuation method. Indeed, DTZ itself notes in its report that the proposed methodology is suitable only where there are no market transactions to inform valuation. That is plainly not the case here. It is quite clear that there are such market transactions and they should have been provided to DTZ. DTZ specifically notes that, if there had been market transactions, that information should be provided to them as it could affect their valuations. There is no explanation as to why this important control step has not been carried out by the CC.
- (b) Second, further more detailed criticisms of DTZ's methodology are crisply articulated in Ashkirk and Knight Frank's reports. In summary, DTZ has not carried out a sensible valuation exercise that takes into account the marketplace in which Spire operates.
- (c) Third, in the face of these valuation difficulties, the analysis in the PWP has persevered in relying on the alternative use methodology and it appears that DTZ used a methodology that it believed was unsustainable. There are limited possible explanations for this: either the CC has not heeded advice that the valuation methodology is wrong or the CC has pursued only a pre-conceived position without taking into account the obvious flaws. As a matter of law, either explanation would render the PWP's methodological position untenable.
- (d) Fourth, setting aside the methodological problems in the PWP, the estimates that flow from DTZ's application of this methodology are not robust. The factual errors in the DTZ valuation, set out in the attached Ashkirk and Knight Frank reports, range from simple lack of understanding of a hospital's site requirements to more serious errors such as fundamental flaws in the identification of possible alternative sites:
 - (i) The report shows a lack of understanding of a hospital's site requirements. ✗.
 - (ii) The report assumes that any available space would be a suitable site for a hospital, irrespective of available services, proximity to patients, staff or consultants.¹² In fact, location is important to the success of a

¹² DTZ is not expert in the identification and valuation of land for hospital premises. DTZ has understandably focused on residential property valuations because that is the expertise of their

hospital and Spire's planning team spends a significant period of time assessing and identifying a location before constructing a new hospital. In addition to proximity to hospital users, proximity to the NHS is an important factor. For example, \pounds .¹³

- (iii) The report assumes that planning permission will be obtainable on any available site and that planning designations will not affect value. This assumption is incorrect. For example, as Knight Frank point out in their report, if agricultural land were available for alternative development, it would not be sold as agricultural land. To reference its value as agricultural land is irrelevant. Moreover, even if agricultural land were available, this still does not pass the CC's test: the valuation of that field is not its agricultural price, its valuation is the price a hospital operator would need to pay to acquire it. In other words, DTZ has simply valued the wrong thing. The valuation would need to take into account that if such land could be sold to build a hospital, it could also be sold for any number of alternative uses. This is a simple logical flaw that neither the DTZ report nor the PWP has spotted and addressed

2.7 Given these difficulties, the methodological position in the PWP must be reviewed. To assist the CC, Spire commissioned Knight Frank to conduct a properly specified valuation exercise.

- (a) Knight Frank has conducted a valuation exercise based on its own healthcare team's expertise in sourcing land for hospital sites. That methodology is explained in detail in the attached Report. \pounds . However, in aggregate, Knight Frank estimates the value of Spire's land portfolio in 2012 at \pounds , substantially in excess of the DTZ valuation.
- (b) For control purposes, Knight Frank also sought to conduct a valuation exercise based on the CC's methodology. Properly conducted, that valuation exercise produced a similar aggregate land valuation for 2011 of \pounds . Although the total valuation determined through this exercise is very similar to the total valuation determined based on Knight Frank's expertise in sourcing land for hospital sites, the valuation of individual hospital sites varies significantly between the two methods.

2.8 Based on these deficiencies, the PWP assessment cannot be maintained. The PWP needs to substitute the revised valuations prepared by Knight Frank for the flawed DTZ valuations.

2.9 **Buildings.** The PWP uses 2008 reinstatement costs as the basis for calculating the value of the buildings needed to operate a hospital business. The 2008 approach is insufficient for the CC's purposes: it reflects the reinsurance value of existing

team. There is no evidence that residential property expertise provides insights on where one can build a hospital.

¹³ \pounds .

hospitals, £, rather than the cost that would be required to construct these hospitals today. Knight Frank has estimated new reinstatement costs using the industry-wide accepted standard reinstatement cost assessment methodology. The Knight Frank assessment takes account of several important factors that are not reflected in the PWP:

- (a) First, the reinstatement values need to be adjusted to recognise the fact that a newly built hospital would be more complex to build now. The reinstatement costs in 2011 would therefore be considerably higher than the reinsurance costs for older buildings (reflected in the 2008 data).
- (b) Second, Spire has invested significantly in expanding its facilities to accommodate the growing and changing demand, for example, by £; these extensions were not captured by the CC. The reinstatement costs in 2011 (properly reflecting the current configuration of the Spire estate) would be considerably higher than they would have been in 2008;
- (c) Third, Knight Frank has separately valued internal layout reconfigurations and improvements to fit specialised, high construction cost areas such as £, which were required to keep pace with the changing nature of healthcare provision. These improvements are not reflected in the 2008 data.

2.10 Further, the PWP treated one leasehold Spire hospital as part of the capital base (Sussex), which Spire believes to be the right approach. For consistency, the remaining three leasehold hospitals (Hull, Fylde Coast, and Clare Park) also need to be added to the capital base.

2.11 More detailed analysis of these market dynamics can be found in the attached L.E.K. and Knight Frank reports. Based on this assessment, the PWP's buildings valuation for Spire of £ must be replaced with £.

2.12 **Equipment.** The application of NBV fails to take into account various significant factors affecting the reinstatement cost of equipment: technological evolution in equipment (which would be captured by an appropriate MEA methodology), difficulty in acquiring used equipment, and the use of assets with average economic lives that can be extended beyond their depreciation period. As explained in detail in the L.E.K. Report, compared with the unrealistic PWP NBV figure of £, L.E.K. estimates that: new acquisition cost of the necessary equipment would be approximately £; a realistic acquisition cost would be £; and a fully depreciated acquisition cost would be £. The most appropriate value to rely on is the realistic acquisition cost of £.

2.13 **Intangibles.** Ignoring intangibles in a sector like private healthcare, where the competitive dynamic is based on quality, reputation and knowledge, makes no commercial, economic or legal sense. Again, the PWP appears to have pursued a pre-conceived position, without reference to the facts of the surrounding marketplace, that intangibles need to be excluded either because they are difficult to value, or because they might, in theory, reflect capitalised market power. This position cannot be sustained based on the facts before the CC.

- (a) The PWP must as a matter of law consider whether the facts of the marketplace require an assessment of intangible assets. If that analysis has been carried out, it has not been provided to Spire for input or response.
- (b) To place the burden on PHPs to meet very strict requirements of proving their existence before the CC would include any intangibles in the asset base biases substantially upwards the CC's measure of profitability. That is an unreasonable and procedurally unfair position to adopt.
- (c) It also means that the approach taken to intangibles is again inconsistent with the CC's published guidance.¹⁴

2.14 In contrast, the L.E.K. Report explains clearly what categories of intangible assets are needed for a private hospital to operate. In valuing those assets, L.E.K. has taken a conservative approach and excluded from its calculations categories of intangible asset that are needed but where valuation cannot be properly be undertaken, L.E.K. has also excluded any assets that might result in double counting and focused only on the key components of the intangible assets. This conservative approach yields an intangible asset value of \pounds compared to the PWP figure of \pounds . The assets valued in the L.E.K. report include:

- (a) Recruiting a large base of highly qualified staff, and training these staff to harmonise their methodologies and use of specific care pathways;
- (b) Developing standard, efficient and safe clinical pathways to ensure that the hospital delivers high quality outcomes; a new operator cannot trust its staff members and consultants to work together efficiently and effectively due to their different backgrounds and methodologies;
- (c) Developing a good reputation with patients, GPs and consultants in order to attract them to the hospital.

2.15 A simple cross-check of the PWP approach is to ask the simple, commercial question whether a private hospital group comprising 37 hospitals could operate with an intangible asset base comprising a \pounds website. That is clearly not a sensible position when quality and reputation are key parameters of competition. A website alone does not drive patient flow: an operator must invest to develop relationships with key stakeholders (patients, GPs and consultants), and to build its reputation both through marketing and through the development of excellent clinical governance systems.

2.16 In light of these considerations, the PWP position on intangible asset values cannot be sustained as a matter of substance or process.

2.17 **Working capital.** As set out in more detail in the L.E.K. Report, the PWP approach to working capital allowance is too low, and does not sufficiently allow for unpredictability of cash flows. The business is highly exposed to bill settlement risk and there is a very significant variation in working capital in the business, retaining

¹⁴ *Guidelines for Market Investigations* at para 14.

sufficient working capital to balance this risk is a prudent step. Making even a moderate allowance for this variation (e.g., two weeks of operating profits as was used in the CC’s Buses Inquiry) would add \pounds to the PWP capital asset base.

2.18 **Summary.** In light of the above analysis and the more detailed consideration of the PWP profitability assessment in the L.E.K. and Knight Frank Reports, the PWP’s assessment of capital employed cannot stand. It requires serious reconsideration by the CC, together with a proper review of the available evidence. The following table summarises the differences between the PWP analysis and Spire’s analysis.

\pounds

Cost of capital

2.19 Spire does not currently have additional comments on the assessment of the cost of capital in the PWP, but reserves its right to make comments at a later stage.

Return on capital employed compared with cost of capital

2.20 Turning to the ROCE analysis contained in the PWP, the position that any returns over cost of capital are symptomatic of market power is purely presumptive, not founded on any analysis and is inconsistent with the CC’s own published guidance.

2.21 **The PWP significantly overstates Spire’s ROCE.** As set out in the attached L.E.K. report, Spire’s ROCE has grown from \pounds to \pounds and averaged \pounds over the relevant period, significantly below the \pounds average ROCE proposed by the CC. \pounds . The drivers of the growth in Spire’s profitability are summarised below and set out in detail in the attached paper.

2.22 **Drivers of profitability.** As the CC’s Guidance notes, the CC will seek to understand the reasons for any observed trends in profitability.¹⁵ This is not an analysis featured in the PWP. Had the PWP conducted this analysis, it would have been apparent that the growth in Spire’s EBITDA performance over the last five years has been driven by competitive responses, not by ineffective competition. Further information about the drivers of profitability are set out in the L.E.K. paper and summarised in the chart below.

Factor	% contrib’n to EBITDA uplift (2007-11)	L.E.K. commentary
\pounds	\pounds	\pounds
\pounds	\pounds	\pounds

¹⁵ Competition Commission, *Guidelines for Market Investigations: Their role, procedures, assessment and remedies* (April 2013), paragraph 124.

✂	✂	✂
✂	✂	✂
Total	100%	

2.23 In considering Spire’s profitability and pricing, there are two important facts that are not reflected in the CC’s analysis:

- (a) ✂¹⁶;
- (b) ✂¹⁷. ✂.

2.24 These evidential points mean that the PWP’s assessment of profitability is at best incomplete and requires significant additional work.

2.25 ***Implications of returns exceeding the cost of capital.*** The CC’s Guidance notes that the fact that returns exceed the WACC is not, in itself, evidence of excess profits or, indeed of any competition problem. The CC must therefore do more than point to the fact that returns (on its measure) exceed the WACC in order to show that there is any potential competition issue.

- (a) Persistent returns exceeding the WACC may simply reflect rewards to providers who offer the most competitive product through innovation and investment. Even in a competitive market, only the “marginal” (i.e. least efficient) firm may break even in the long run equilibrium. Infra-marginal (i.e. more efficient) firms can earn above their cost of capital without this being a sign of ineffective competition.
- (b) It follows that it is not possible to extrapolate an industry-wide story of market-power based on the aggregate profitability of 75% of the market. Furthermore, focusing on the aggregate profitability measure of the most successful 75% of the market provides a skewed and misleading assessment of profitability for the purpose of drawing inferences on market power, as it fails to consider the marginal firm.
- (c) Through offering a better service quality, Spire achieved substantially greater patient volumes allowing it to spread its fixed costs (where substantial savings were also made) over a larger patient base thereby improving its efficiency and its profitability at the same time. Such pro-competitive behaviour should not be penalised.
- (d) Moreover, measurement issues are particularly problematic in a market like healthcare where the investment cycle is longer than in some other industries, and certainly longer than the CC’s 5 year window, intangibles are critical for

¹⁶ ✂.

¹⁷ ✂.

patient care yet hard to measure precisely, and NHS revenues (⌘) hard to disentangle from overall profitability.

2.26 In short, Spire strongly disagrees with the CC's view that its approach to measuring profitability has been conservative. On the contrary, it is likely to overstate substantially true profitability in the provision of private healthcare.

2.27 When these factors are taken into account, they show that the profitability achieved by Spire is by no means excessive. It is not possible for the PWP to maintain a position that excessive profitability has been achieved when, over the period of alleged supra-normal profits, the benefits of Spire's investments and efficiency gains have been passed back to consumers in the form of a wider range of services and higher quality services, ⌘.

3. THEORY OF HARM 1: MARKET POWER OF HOSPITAL OPERATORS IN CERTAIN LOCAL AREAS

3.1 We understand that the CC has identified ⌘ of Spire's thirty-six hospitals¹⁸ as "hospitals of potential concern". The suggestion that ⌘ of Spire's hospitals may have local market power does not reflect the extensive evidence presented to the CC by Spire and many other inquiry participants. The basis of the CC's thinking does not withstand any serious scrutiny.

3.2 More specifically, the AIS finding of areas of concern suggestive of local market power is wrong for several reasons:

- (a) It is based on an incorrect identification of the relevant competitor set: by focusing exclusively on inpatient care, the CC has addressed less than half of Spire's and UK private healthcare business and has therefore overlooked the significant role played by competitors in these areas. A provisional view based on analysis of only half the market is plainly not tenable. In addition, the CC has created an artificial division between routine and complex care.
- (b) The significant role played by the NHS in private healthcare competition in the UK has been materially understated by focusing only on PPUs. The CC's view in this respect again has not taken into account the ways in which patients move between private and public healthcare provision, and the various non-PPU ways in which the NHS provides private healthcare.
- (c) Primary catchment area results have been determined based on a misconceived foundation and cannot be relied upon. More specifically, the fascia approach relied upon in the CC's assessment:
 - (i) is based on catchment areas centred on hospitals rather than on patients; and

¹⁸ Spire's Edinburgh facilities (Murrayfield and Shawfair Park) are treated as a single facility. Spire's new Brighton facility (Montefiore) opened in November 2012 and has not been included in the CC's analysis.

- (ii) understates local competition by applying inappropriate distances derived from PMI data, excluding all self-pay data.
- (d) The price concentration analysis does not control for a number of crucial market characteristics and, therefore, cannot be considered a reliable measure of potential pricing power of local hospitals in relation to the competition they face.
- (e) LOCI is not a sound conceptual basis for any local market analysis.
- (f) There is a particular focus on oncology services in the AIS, but again this section of the analysis overlooks key competitors, the role of PMIs and the NHS.

3.3 Any one of these problems taken individually is enough to invalidate the CC's current thinking on local market power. Taken together, they show that there are so many factual and legal errors that this workstream needs to be reassessed. Each of these issues is addressed in further detail below.

Incorrect identification of the competitor set

3.4 The CC has significantly under-estimated the level of local competition in its analysis by excluding many significant and growing providers from its competitor set. The incorrect identification of the competitor set results in an incomplete and inaccurate understanding of the market.

3.5 First, the CC's analysis addresses *less than half of Spire's private healthcare business*. The majority of patient episodes at Spire, and the majority of Spire's revenues, relate to outpatient and day-case care. The CC's exclusion of outpatient and day-case care significantly alters its perception of the market, and means that a key factual consideration has been omitted from the CC's analysis.

- (a) It is wrong to think that day-case and outpatient treatments are peripheral to private healthcare priorities in the UK: in fact, they represent the core of the business and there is trend toward moving more procedures to a day-case or outpatient environment. The share of Spire's total private revenue comprised by in-patient revenue has fallen from 80% in 2007 to 40% in 2012. Given the high fixed costs that PHPs face, inpatient and day-case revenue streams are critical to the success of a facility. A broad range of treatments across a broad range of specialities is now provided on a day-case or outpatient basis including cardiac catheterisation, hand surgery, ophthalmic surgery, diagnostic procedures, varicose vein surgery, tonsillectomy and haemorrhoidectomy. Many of these procedures can be provided on either an inpatient or a day-case basis depending on patient and consultant choice (e.g. hernia repair or knee arthroscopy). A policy brief published by the European Observatory on Health Systems and Policy in 2007 on the move to day surgery, which suggests that there are opportunities to switch to daycase treatment across a range of inpatient treatments, is attached at Appendix E.

- (b) The focus on inpatient care excludes from the CC's consideration many significant and growing competitors in private healthcare. These are a significant threat to the \propto of Spire's revenues that are generated from outpatient and day-case services.¹⁹ In addition (as set out in more detail in paragraph 3.7(a) below) these are competitors that Spire believes have the potential to expand into the inpatient sector if current inpatient facilities do not sustain a competitive offer. This is not a theoretical proposition – \propto . As set out in Spire's response to Question 72 of the Market Questionnaire, since 2007, 164 competing hospitals have opened within a 30 minute drive time of a Spire hospital.²⁰ Many new competitors focus on outpatient or day-patient care. For example:
- (i) \propto
 - (ii) The PMIs have also introduced outpatient services to redirect patients away from hospitals. The Bupa Musculoskeletal Centre at the Barbican provides assessment, diagnosis and treatment for a variety of musculoskeletal problems relying on a team of physicians, podiatrists, physiotherapists and osteopaths. Treating patients at this facility not only allows Bupa to redirect outpatient revenues to itself, but also provides Bupa with greater control over the onward referral process.
- (c) Spire has made significant investments in its facilities and services to ensure the competitiveness of its outpatient and day-case services. These include investments in upgraded, static, diagnostic imaging equipment, refurbishment of patient facilities and extension of outpatient facilities to ensure availability²¹. Investments to improve outpatient and day-case services also benefit people seeking inpatient treatment through an improved patient experience, better access to related outpatient appointments and more effective diagnostic imaging. Conversely, Spire's investments in developing high acuity care bolster its "less complex" offering by enhancing the reputation of the hospital, increasing the skill level of the staff and increasing the level of critical care available on site in case of emergency.
- (d) Spire has invested in developing a significant number of satellite facilities providing outpatient consultation and diagnostic services (as have many of its competitors). This has been a key parameter of competition over the last few years that the CC has not considered in its analysis. The failure to review and analyse properly a key aspect of competition invalidates the CC's local analysis. These facilities not only compete to provide outpatient services, but also serve to expand the geographic reach of the hospital they are attached to.

¹⁹ Based on 2012 numbers; \propto of Spire's private revenues were generated from outpatient and day-case services in 2011. The AIS approach obviously leads to an analytical inconsistency between the profitability analysis in the PWP (referenced in the AIS) and the analysis of competition in the AIS.

²⁰ "Hospitals" within the meaning given to that term by the CC.

²¹ See, for example, descriptions of investment at \propto in the hospital case studies attached at Appendix K.

They therefore play a role in competition between inpatient facilities, which is currently disregarded in the CC's analysis. As set out in response to Question 11 of the Market Questionnaire, Spire's satellite facilities include the Droitwich Clinic (to attract patients to Spire Southbank), the Newcastle Clinic in Jesmond (to attract patients to Spire Washington), and the Windsor Clinic (to attract patients to Spire Thames Valley).

(e) ✗.

3.6 In any event, the exclusive focus on inpatient care cannot be sustained by the CC because it results in a lack of analytical consistency. The CC has excluded outpatient/day-case competitors from its analysis, but has included Spire Shawfair, which is an outpatient/day-case facility. The inconsistency is also apparent in the CC's approach to profitability where Spire's profitability is assessed across all patients, recognising the inherent connections between the different services.

3.7 Second, *the analysis presented by the CC incorrectly suggests that there is some identifiable demarcation between routine and complex care, and between outpatient/day-case care and inpatient care.* This is not borne out in practice and, in fact, there can be significant supply-side substitution between the two.

(a) One recent model for entry into private healthcare services is to start with a smaller facility providing outpatient and/or day-case services and then expand into inpatient services. As set out in Appendix F, this model has worked successfully ✗²².

(b) The suggestion that there is a clear separation between hospitals providing higher or lower complexity care is similarly problematic. As explained in Spire's submission on critical care, hospitals may be able to easily move from providing level 2 to providing level 3 critical care in the same beds. The cost and time required to upgrade HDU facilities to ITU facilities is not prohibitive. Spire provided examples of the cost of setting up HDU and ITU beds in various of its facilities in response to the CC's critical care information request.

(c) In considering competitive dynamics with respect to acute care, the CC must also consider the role of the NHS. Patients have traditionally turned to the NHS for complex treatment, even where they have been willing to seek less complex treatment through private providers. The NHS has an advantage in providing complex care because of the availability of extensive on-site critical care and specialist support. The NHS relies on this strength in marketing materials for its private services, for example, material published regarding Southend University Hospital NHS Foundation Trust states "[t]here will always be a doctor who can see you immediately in an emergency, with adequate support from specialist trained nursing staff" (see Appendix G for additional examples of NHS private care marketing materials)²³. In order to

²² ✗.

²³ See also the ✗ case study at Appendix K. ✗

compete with the NHS for complex work, Spire must invest significantly in its facilities and processes, and market its services to patients, GPs and consultants.

3.8 Third, *the CC has understated the significant role played by the NHS in private healthcare in the UK by focusing only on PPUs* and not considering the significant roles played either by other private provision (both private provision in pay beds and private provision in general NHS facilities) within the NHS or by the general NHS service. The CC is correct in identifying PPUs as significant competitors to other private facilities: throughout the UK PPUs are significant and growing competitors to other PHPs and Spire has outlined its evidence on this point in its overview of competition from the NHS at Appendix H.

3.9 The AIS, however, incorrectly ignores a significant portion of the market by disregarding the significant private patient revenues the NHS generates outside PPUs. By failing to consider private patient treatment outside PPUs in its analysis, the CC has disregarded approximately £100 million in private healthcare revenues in England.²⁴ This is not a trivial omission. In addition, even where current private work is limited, the ease with which such services can be established in an NHS facility implies the development of a private NHS alternative is a credible threat if Spire did not provide a competing offer.

(a) The NHS actively markets its non-PPU private services against services provided by PHPs. The NHS may, in fact, have certain advantages over PHPs in the provision of private care. The NHS benefits from on-site staff and facilities that are in place for the provision of public healthcare that can also support the provision of private healthcare at a low cost. Examples of NHS marketing material are included at Appendix G. This marketing material points to benefits such as:

- (i) the availability of a full range of general and specialist medical services on site 24 hours a day providing immediate access to additional care, if needed;
- (ii) the availability of the consultant's specialist team and back-up support from on-site expert care;
- (iii) highly competitive prices; and
- (iv) supporting the NHS – income generated from private services within NHS facilities support the hospital's general finances.

3.10 The AIS also overlooks significant dynamics in the market by disregarding the role played by the general NHS. Patients switching between the NHS and private care, patients with PMI coverage opting to access treatment on the NHS and PMIs incentivising patients to use the NHS all play a significant role in the market.

²⁴ See, for example, the case studies attached at Appendix K.

- (a) The survey evidence gathered by the CC indicates that a large proportion of private patients considered accessing treatment through the NHS²⁵ “[70]²⁶ per cent of self-pay patients considered having their treatment on the NHS, 31 per cent did not. The respective proportions for PMI patients were 19 per cent and 80 per cent.” (paragraph 7). Given the large proportion of patients who considered having their treatment on the NHS, at a minimum, based on the CC’s own evidence, the CC should consider whether particular NHS facilities in a local area may exercise a competitive constraint on private providers. Simply excluding NHS facilities from the fascia count provides an inaccurate picture of the local market. ✗.
- (b) Many patients with PMI access care through the NHS, a fact that is not reflected in the CC’s analysis. The Boston Consulting Group survey evidence that HCA submitted to the CC at Annex 3 of its response to the issues statement indicates that 34% of patients with PMI had (or someone in their family had) NHS treatment in the past three years. The specialty for which the NHS was most frequently used in favour of a private hospital was orthopaedics, a specialty widely available in private hospitals across the UK. In addition, the L&B report submitted by HCA indicates that between a quarter and a third of people with private medical cover that were admitted to hospital for non-emergency medical/surgical treatments in England in 2011 were estimated to be treated on the NHS, funded by the NHS.²⁷ Patients with PMI have many reasons for choosing to access treatment through the NHS, including:
- (i) Avoiding excess costs associated with their PMI policies: ✗²⁸;
 - (ii) Avoiding premium increases: many PMIs offer their members a no claims bonus if the member does not claim for private treatment in the course of a policy year, or increase the premium charged to members who do claim during the year;
 - (iii) Obtaining incentive payments from their PMI: many PMIs offer their members payments, potentially worth several thousand pounds, to access treatment on the NHS rather than their private scheme; and
 - (iv) GPs failing to ask patients whether they have PMI coverage and refer patients into the NHS by default, which is one of the reasons it is

²⁵ Although the survey evidence gathered by the CC indicates that the NHS is viewed as an important alternative by private healthcare patients, the surveys conducted by the CC can be expected to understate the role of the NHS due to flaws in the survey structure, which were first identified by Spire in comments provided to the CC in Autumn 2012.

²⁶ Although the presentation published by the CC states that 68% of self-pay patients considered having their treatment through the NHS, the data provided by the CC indicates that the number should be 70%. It is not clear whether the presentation and data tables are shown on different bases, but Spire refers to the information in the data tables.

²⁷ HCA Laing & Buisson Survey published 30.01.13.

²⁸ ✗.

important for Spire to invest in informing GPs about its services and in encouraging patients to proactively consider private care.

3.11 In response to patient concerns regarding excess costs and premium increases, and patient interest in incentive payments, Spire must compete to demonstrate to patients that it provides greater value than accessing treatment through the NHS.

3.12 There is a consistent body of evidence supporting the significant role played by the NHS that has been ignored in the AIS. An overview of this evidence is set out in the table at Appendix H.

3.13 Having incorrectly identified the relevant set of competitors and the ways in which they compete for business, there is no prospect of the CC's local market analysis being able to capture in an accurate or sustainable way the dynamics of local competition. This is also evident from a review of the CC's catchment area analysis.

Demand centring is preferable to reliance on hospital-centred catchment areas

3.14 Attaching too great a weight to hospital-centred catchment areas risks presenting a false picture of competition in the market. As the CC rightly notes at paragraph 61, patients may be located between two facilities which are not within each other's catchment area, but which are both part of the isochrone centred on the patient. This in turn would suggest that the patient in question has the option to consider two separate facilities, a trade-off which would not be identified when only considering competitors within a specific road distance of the Spire facility.²⁹ This same problem has been identified by the CC in prior cases and has been corrected for by using demand-led catchment areas.

3.15 For the purpose of developing an initial filter or screening process to determine which hospitals should be analysed in more detail, Spire considers that a demand-centring approach has substantial theoretical and practical advantages over an approach which centres on the point of supply. A demand centring approach is also substantially better than the LOCI method employed by the CC. By analysing the number of fascia within a reasonable distance from a patient's house, Spire is able to consider the actual choice of private hospital available to any given patient that attended a Spire facility. Spire considers these aspects in greater detail at Appendix I to this paper.

The CC fascia screen understates local competition by applying inappropriate distances

3.16 Whether a supply-centred or a demand-centred assessment is taken, it is important to identify the correct drive times or distances for the catchment areas. The CC's (supply centred) fascia assessment incorporates inappropriate drive time

²⁹ The "fascia count based on hospital centred catchment areas" approach does not capture adequately the true nature of competition in private health care. As Spire has highlighted in the past, the distance over which a Spire facility competes for patients may vary significantly by location and according to the procedure concerned. The CC's screens cannot therefore be a substitute for a proper analysis of local conditions and patient choice.

distances which are likely to understate the degree of local competition in a number of cases.

- (a) The CC has relied only on the Health Code data to assess the distance travelled by PMI patients at each Spire facility. It therefore effectively ignores \mathcal{K} which in turn suggests that a significant fraction of patients does not feature in the analysis. This is problematic as self-funding patients on average travel further than PMI patients. Indeed, the CC's own survey results suggest that self-funding patients travel on average 44 minutes³⁰ in comparison with an average of 29 minutes for PMI patients. Not accounting for these patients may therefore grossly understate the distance over which hospitals compete for patients. In the case of Spire, the 80th percentile for inpatients travels approximately 37 minutes if they are insured, and 44 minutes, if they are self funding.
- (b) The CC has adopted a drive distance by road as opposed to a drive time isochrone (despite the CC surveys which tested willingness to travel based on drive *times*). Working back from road distance to drive time, it becomes clear that, in many cases, the CC has adopted a drive distance catchment that is likely to be too small. For example, the CC presumes a catchment with a drive-distance of just 13 miles, or less, for \mathcal{K} Spire hospitals. At a typical road speed outside London of 30mph, 13 miles can be achieved in 26 minutes³¹. The AIS approach is therefore too cautious given the evidence on willingness to travel in the CC's survey and from Spire's own hospitals as noted above. More specifically, the survey evidence has confirmed that 27% of patients travel further than 30 minutes to attend their private hospital, and 44% of GPs considered a travel time greater than 30 minutes when referring patients to a private hospital. In addition, in the CC's survey, PMI patients have indicated the willingness to travel up to an hour to access a better facility, and for self-funding patients up to 82 minutes.

3.17 In addition, the CC's approach gives rise to a methodological inaccuracy. The CC says that it is focusing on self-funding patients locally, which is why it uses self-pay prices in the Price Concentration Analysis – but this is inexplicably matched with PMI travel distances. Any robust analysis would include self-pay data to identify travel distances.

3.18 It is important to subject the catchment area analysis to sensitivities (and indeed the scope for straightforward sensitivity tests is a key advantage of a catchment area approach compared to a LOCI approach). The CC has not conducted a sensitivity test to assess whether its approach is likely to be overly cautious or more generally to assess robustness; Spire therefore presents a sensitivity analysis below.

³⁰ Note: in the presentation published by the CC, the number is 44 minutes, but in the data tables it appears to be 45 minutes.

³¹ Normal speed on urban A roads reported in 'The supply of groceries in the UK market investigation' by the Competition Commission (2008).

3.19 When Spire accounts for catchment areas which are more consistent with the actual local evidence collected during the CC's investigation, the number of Spire hospitals with at most one competitor fascia within the relevant distance is significantly decreased. Table X, shows the distribution of the number of competitor fascia for Spire hospitals according to the following criteria: the results obtained by the CC (in the first row), Spire's results using the hospital specific catchment area drive distances used in the CC methodology (second row) and drive times of 30, 40 and 60 minutes (in the third to fifth rows). Finally, the last row shows the number of competitors identified by Spire facilities in response to Question 14 of the CC's market questionnaire.

3.20 As can be seen in the table (by summing the first two columns), the number of hospitals of "potential concern" (according to the fascia count screen) is reduced from X when 30 minute drive time isochrones are used instead of the drive time distance adopted by the CC. Moreover, when the drive time is extended to 40 minutes, the number of hospitals of "potential concern" is further reduced to just X. As noted above, the 80th percentile for Spire inpatients travels up to approximately 37 minutes, if they are insured, and up to 44 minutes, if they are self-funding. Finally, all Spire facilities identified X in response to the CC's market questionnaire.

X

LOCI is not a sound basis for any local market analysis

3.21 As explained further in the attached Appendix J, Spire has serious concerns about the CC's reliance on a LOCI analysis to identify areas of potential concern. Specifically, there are a number of problems that make it difficult to draw meaningful inferences about market power from the weighted average market share (WAMS) and the LOCI screen (which is derived from the WAMS).

3.22 The WAMS is not a good measure of a hospital's market share in a sensibly defined geographic market. Neither is it a good measure of the probability that a hospital will win patients in any given collection of submarkets. This is for two related reasons.

- (a) First, if the geographic sub-markets employed in the construction of the WAMS (i.e. outward postcode sectors) are not meaningful economic markets, then the measure itself has little economic meaning. Put simply, aggregating non-meaningful market shares does not create a meaningful market share. However, the WAMS (and hence LOCI) measures are potentially very sensitive to the submarket adopted and there is no reason to believe that an outward postcode sector is a meaningful economic market. The CC has conducted no analysis on this question. So the conclusion that shares in a postcode area equate to market shares is nonsensical. Moreover, it can be shown that segmenting the relevant geographic market into arbitrary submarkets can cause the WAMS and LOCI to overstate concentration substantially.
- (b) Second, the preceding issue arises in part due to the way that submarket shares are weighted. The WAMS substantially overstates a hospital's market share

of any given collection of submarkets because rather than weight each submarket share by the *size of that submarket* it instead weights each submarket share by the *percentage of a hospital's patients that it draws from that submarket*. For example, consider two similar sized submarkets in which a given hospital is equally well placed to compete. Suppose that a hospital competes hard to win patients in both areas but is “unlucky” in one submarket (ending up with a low share) and “lucky” in the other (ending up with a high share). If each share was weighted by the size of submarket demand, the good and bad luck would cancel out. However, the WAMS fails to do this. On the contrary, it weights the lucky submarket by *more* than the unlucky submarket because the former generates more patients for the hospital. This weighting mechanism clearly gives rise to upwards bias. Local concentration is therefore substantially overstated by the CC's mathematical model.

- (c) Further, the CC's approach to measuring the LOCI is data intensive (and incomplete³²), very difficult for anyone to replicate, hard to sensitivity test and limited in its ability to capture local dynamics. Aside from the procedural consensus that the CC's approach raises, for the purpose of developing an initial filter or screening process to determine which hospitals should be analysed in more detail, Spire considers that a demand centring approach would have substantial theoretical and practical advantages over the LOCI screen employed by the CC. A suggested demand-centring approach is presented in Appendix I. Consistent with Spire's concerns that the LOCI screens are overly cautious, the demand-centred approach points to far fewer hospitals where further investigation would be merited.³³

3.23 In addition, Spire is not aware of any precedents for the use of LOCI in assessing healthcare markets, either in the UK or elsewhere. During the Issues Hearing, the CC indicated that the FTC uses LOCI to assess hospital mergers in the United States. Spire has reviewed twenty hospital mergers challenged recently by the FTC in the US and in no cases has the FTC referenced a LOCI analysis in its complaint. Furthermore, this is not a measure that has received any degree of wider academic support. We are not aware of any empirical research testing whether the LOCI's conceptual approach has proved insightful. And even if another authority had used LOCI, the CC has used catchment areas numerous times in the past, including demand centred catchment areas.

The price concentration analysis is not able to correctly identify pricing power

3.24 The CC's price concentration regressions suffer from a number of theoretical and practical issues which mean that the resulting analysis is unlikely to be meaningful. Consequently, it is inappropriate for the CC to use this analysis to inform

³² Health Code excludes certain private hospitals and does not include data on self-funding patients.

³³ Further, Spire notes that the characteristics of the provision of private healthcare for insured patients are far from those mentioned by the CC that would link a LOCI measure to a theoretical model of price setting. In particular, postcode sectors by no means bundle patients with homogeneous preferences. Further, prices paid by PMIs are based on national negotiations, rather than local price setting by PHPs and PHPs compete on quality as well as price.

the CC about the extent to which higher levels of concentration give rise to local market power. Spire summarises its main concerns in the paragraphs below (Spire welcomes the CC provision of a data room and will make most of its substantive comments on the CC’s econometric analysis following access to the data room).

- (a) First, the price concentration analysis developed by the CC does not account for a number of factors that are crucial determinants of the prices charged to self-funding patients. Amongst such factors are treatment-specific costs that can vary by patient (e.g. the prosthesis used), patient health (e.g. co-morbidities), hospital specific quality and costs and NHS competition (which the CC’s own survey indicates to be particularly important in the case of self funding patients). Ignoring these factors implies that the analysis is not likely to be reliable, and any measured effects of concentration on price may be merely driven by these omitted variables rather than a true causal relation between price and concentration.³⁴
- (b) Second, Spire notes that the CC has focused on the PCA results based on the LOCI measure on the basis that a supply-centred fascia count is a “less refined” measure of concentration than the LOCI (PCA for self pay patients, paragraph 35). However, Spire notes that the LOCI as measured by the CC is a misconceived measure of local concentration for the reasons set out in Appendix J; it cannot be presumed a better measure than a supply centred fascia count (a measure that the CC has considered in numerous past cases). Moreover, the CC simply presumes that, even if the LOCI were valid for insured patients, it would be closely correlated with whatever LOCI measure would arise if a LOCI were calculated for the eight self-pay procedures under investigation. This assumption is extreme and has not been tested. Spire is therefore surprised that the CC has favoured the self pay regression based on LOCI and substantially downplayed the regression based on fascia counts, where the CC was not able to identify a statistically significant relationship between higher concentration and higher prices³⁵. Spire notes further that that the LOCI based on self-pay patients would not necessarily be closely correlated to that for insured patients due to (i) the different treatment mix that self funded patients consume compared to insured patients and (ii) the fact that self pay patients travel further than insured patients. This is evident from Spire’s own self-pay data and from the CC’s survey data. In short, since the regressions assess self pay prices, the concentration variable based on PMI data is measured with error casting considerable doubt on the validity of the results.

³⁴ The CC’s approach to the data used in its analysis is non-transparent and may further bias the results of this analysis: (i) Multiple treatment visits – we understand this is a common feature in the Spire data, and ignoring this feature can skew the results; (ii) removal of “outliers” – the CC has removed what they believe to be “too low prices”. This is not appropriate, as removing these observations changes the distribution of prices, and therefore potentially undermines the validity of the entire analysis; (iii) the CC has only focused on analysing the prices of 8 major treatments, therefore excluding a large fraction of activity at private hospitals.

³⁵ Paragraph 34.

3.25 While the above concerns are sufficient to place no weight on the CC's econometric analysis, yet further evidence of bias or misspecification of the model can be found in the CC's sensitivity tests as reported at page 27 of the CC's PCA working paper. If the CC had estimated a reliable and robust relationship between concentration and price for *all* hospital providers, we would expect the same relationship to apply for *individual* hospital providers that have a large number of hospitals in their portfolio. However, it does not. For BMI and Spire, who both have a large number of hospitals in their portfolio, the estimated relationship between price and concentration is no longer statistically significant, and is also of a significantly smaller magnitude than the CC's base specification. This may be an indication that the relation between concentration and price suggested by the results of the CC's main regression are in fact not robust and therefore unreliable.

The results of the primary catchment area do not concur with business reality

3.26 The above discussion shows that primary catchment area results based on a flawed foundation do not provide a basis for assessing competition and cannot be relied upon by the CC as a matter of law, economics or fact. This conclusion can also be tested by reviewing Spire's internal business documents. These demonstrate that there is no evidence of local competition working in the way postulated by the CC.

3.27 Attached at Appendix K are case studies of ✂ Spire hospitals, ✂, that are included in the CC's list of hospitals of potential concern, and that the CC specifically asked about during the Issues Hearing. As is apparent from the attached case studies and the evidence provided to the CC in response to the First Day Letter, the Market Questionnaire, and the Financial Questionnaire, each of these facilities faces significant local competition, and this local competition affects the business of each of these facilities.

- (a) ✂.
- (b) ✂.
- (c) ✂.
- (d) ✂.
- (e) ✂.
- (f) ✂.

Analysis of oncology overlooks key competitors, and the role of PMIs and the NHS

3.28 The CC has focused specifically on oncology. There is significant competition in oncology services from other private providers and the NHS, and barriers to entry in the provision of chemotherapy are very low.

- (a) Oncology is a specialty that is frequently provided in day patient, outpatient and alternative settings (such as home care). Private competitors include other

private providers with physical facilities, home care providers such as \mathcal{K} and NHS facilities, including \mathcal{K} .

- (b) The NHS plays a significant role as a competitive constraint in oncology. There are relatively few self-funding patients for oncology services due to the costs associated with the chemotherapy drugs, and the inability of providers to set a fixed price (it is very difficult to anticipate treatment requirements as it is not possible to predict how the patient's body will react to treatment). There are four main reasons why a PMI policy holder may end up being treated in the NHS: (i) the patient's policy does not include cancer cover; (ii) the patient's GP initially refers the patient to the NHS and the patient continues their treatment on the NHS (there is a two-week wait target for cancer treatment on the NHS, so delivery of care is usually rapid); (iii) the patient may require services not offered in the private sector (e.g. radiotherapy in an area where private provision is unavailable); or (iv) the patient may be incentivised by their PMI to be treated in the NHS.
- (c) PMI steering plays a significant role in oncology:
- (i) PMIs frequently provide patients with incentives to access oncology care through the NHS rather than through private healthcare facilities. For example, Bupa's comprehensive policy offers a benefit for eligible treatment obtained on the NHS: £100 per session /night for in-patient and certain outpatient, day-patient and home treatment for cancer. Not all PMI plans provide cover for cancer treatment, further adding to the constraint imposed by the NHS.
 - (ii) In addition, Bupa is vertically integrated with an alternative healthcare provider, Bupa Home Healthcare, and encourages consultants to refer patients to this and other home care providers for chemotherapy in \mathcal{K} .
- (d) Setting up a chemotherapy service is relatively straightforward and inexpensive. Requirements include a designated area (although this is not essential), clinical equipment (these requirements are limited beyond the necessary drugs), and a qualified consultant and nurse. As such, barriers to entry in oncology are low and entry is a threat in any area where oncology services are currently provided.³⁶

Summary

3.29 In short, the CC's analysis of local market power is unsustainable. It suffers from a multitude of procedural and substantive flaws. Put simply, the CC's analysis fails to deal with such a large proportion of the UK private healthcare market that the analysis presented cannot on any basis be said to discharge the CC's statutory obligations to report on the UK healthcare market. The work contained in the CC's

³⁶ Cancer surgery is typically carried out by a specialist surgeon, not an oncologist (e.g. an orthopaedic surgeon would carry out surgery for bone cancer and a neurosurgeon would carry out surgery for brain cancer). Private radiotherapy is a very limited service outside London.

AIS and associated annexes therefore needs to be set aside and conducted correctly and in accordance with the evidence.

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

4.1 The CC recognises at the beginning of the AIS that “*a key issue for this investigation is the way in which the privately funded healthcare sector is affected by the conduct of, and interaction with, the private medical insurers*”³⁷. Despite this, the actual assessment in the AIS of negotiations between insurers and healthcare providers is unbalanced and incomplete because it does not include a proper assessment of the ways in which insurers might exercise buyer power. This one-sided consideration provides a misleading and incomplete picture of the market, and overlooks many key dynamics. In particular, the AIS:

- (a) understates the strength of the PMIs’ bargaining levers;
- (b) overstates the strength of the PHPs’ bargaining levers;
- (c) gives insufficient weight to the evidence of PMI bargaining power; and
- (d) incorrectly assumes that patients’ decisions should be guided only by the cost of treatment.

Background – basic bargaining theory

4.2 Before turning to the detail of the AIS’s consideration of insurer market power, it is worth reviewing the bargaining power analytical framework against which the evidence of PMI negotiating power needs to be considered.

4.3 Standard bargaining theory between two players (e.g. a PMI and a PHP) considers:

- (a) the ‘fall back’ option (what each player gets if the contract is not signed). For example, a PHP may become *unviable* if it fails to deal with Bupa or AXA PPP; and
- (b) how the bargaining pie is split. If the contract is signed, it generates “surplus” relative to the players’ fall back options – that surplus, the “bargaining pie”, is then somehow shared between the players based on the outcome of the negotiations.

4.4 In standard bargaining models, how the bargaining pie is split can depend on numerous factors. The AIS does not in fact consider these points. When properly analysed as part of the market inquiry, it becomes clear that these factors all fall in favour of PMIs exercising greater bargaining power.

³⁷ AIS, paragraph 3.

- (a) *Cost of delay.* In all commercial bargaining, failing to reach agreement has a financial cost associated with it. Logically, therefore, the party that is keener to see the bargain struck will be willing to give up some share of the bargaining pie. Where the profitability of a private hospital would suffer dramatically from a failure to be recognised by a PMI, the PHP will be keener to settle and, other things being equal, agree to a lower price.
- (b) *History.* The outcome of a particular ‘bargain’ is highly likely to have been influenced by previous dealings between the parties. The AIS has not considered this. For example, in the late 1990s AXA PPP determined its hospital network by competitive tender. This put in place a competitive structure for prices that remains to a considerable degree today. ✕
- (c) *Reputation.* PMIs may establish a reputation for aggression, for example, through having recently delisted a hospital so as to secure better terms. This can of course have market-wide effect in influencing how other firms deal with the aggressor (as Bupa did to the largest PHP group, BMI).
- (d) *Information on cost.* PMIs are sophisticated purchasers with a detailed knowledge of medical cost, inflation, trends in procedures (such as the shift from inpatient to day case and from day case to outpatients). PMIs are able to use this knowledge to impact on the sharing rule (for instance by agreeing to pay only day case rates for procedures that are capable of being conducted as day case treatments though they sometimes require inpatient treatments due to complications or other factors).

4.5 Standard models of bargaining and competition also show that parties may act strategically to improve their outside options or weaken their counter-party’s outside options and thereby improve their share of the bargaining pie. For example:

- (a) A PMI may weaken a PHP’s fallback option (and improve its own) by steering patients away from that PHP’s hospitals to other rival hospitals. Steering can also harm a PHP’s revenues during contract negotiations (i.e. during an out of contract event), making a PHP keener to settle on a lower price. PMIs may engage in a wide range of other strategic practices (discussed in detail below) to enhance their bargaining strength.
- (b) A PHP may invest in facilities and services that rival hospitals do not have. In so doing, it makes itself more attractive to PMIs because it will be harder for the PMI to steer patients away to rival hospitals by offering patients services that they value highly.

4.6 To offer a properly founded and reasoned treatment of Theory of Harm 3, the AIS should have considered all of these factors against the evidence base available to the CC. The following sections of this Response, therefore, review the available evidence of bargaining power against the full analytical framework.

The strength of the PMIs' bargaining levers has been understated

4.7 The AIS, to date, appears to have considered primarily the fall back options of PMIs, which present only part of the picture. Put another way, while the AIS has asked the question what happens to a PMI if it fails to deal with Spire, it has not adequately considered the fundamental adverse impact on Spire (or any other PHP) if it fails to deal with either Bupa or AXA PPP.

4.8 PMIs use a number of significant levers in negotiations with PHPs, including:

Delisting can undermine the viability of hospitals and is a powerful credible threat

4.9 ✂

4.10 ✂.

4.11 Delisting a hospital or a group of hospitals may have negative financial consequences for a PMI as well as for a PHP. However, while a PMI can re-direct patients to alternative facilities (see further below), a PHP does not have the same ability to mitigate the situation. Spire could not hold out as long as a major PMI in a delisting situation and Spire believes that the major PMIs are aware of this fact. For example:

- (a) The CC itself has acknowledged the relative strength of the larger PMIs in negotiations with PHPs. The CC noted that AXA PPP's response to the CC's issues statement "*certainly suggested that it regarded itself in a position to negotiate with most hospital operators*".³⁸
- (b) The CC also noted that "[w]e have identified evidence from recent negotiations that suggested that Bupa, in particular, is aware that its purchases represent a significant proportion, although declining, of some hospital operators' overall revenue, and considered this an important bargaining chip it could use in negotiations".³⁹

4.12 Indeed, the CC recognises (in the AIS) the importance to PHPs of securing high volumes for fixed cost recovery. However, the AIS appears not to have considered the fact that private hospital operators have many hospitals that would not be financially viable without recognition by one of the main insurers, enhancing the buyer power of insurers with respect to those local areas and the portfolio as a whole. The implication of this is that the prices for insured patients negotiated at a hospital operator level may be lower than if the PMIs did not have this local buyer power. ✂.

PMIs weaken PHPs' outside options by acting strategically to steer patients

4.13 *The AIS understates the significance of patient steering in the market.* PMIs have numerous ways in which they can steer patients and have become more active in using these steering mechanisms. PMI steering mechanisms include:

³⁸ AIS, Appendix D, paragraph 30.

³⁹ AIS, Appendix G, paragraph 48.

- (a) providing guidance to patients at the time of pre-authorisation;
- (b) open referral (guided patient referral);
- (c) recognising only fee-assured consultants;
- (d) ownership of primary care facilities;
- (e) co-payments (the CC calls this “co-insurance” in the bargaining paper);
- (f) cash bonuses and no-claims bonuses favouring the use of the NHS; and
- (g) restricted network of hospitals.

4.14 *The AIS incorrectly suggests that, unless a patient has purchased an insurance product that specifies a substantially restricted network of hospitals, insurers have little influence on the choice of consultant or hospital.*⁴⁰ The AIS does not recognise or consider the importance of the fact that agreements between healthcare providers and PMIs are enabling contracts only: they provide no guarantee of volumes and thereby leave considerable scope for PMIs to steer patients away from any recognised hospital. Even where a patient’s PMI product does not specify a substantially restricted network, PMIs exercise significant influence over patients’ choice of consultant or hospital through directing patients, the use of specialist networks, cash incentives and other steering mechanisms. Guidance that PMIs provide to patients can take many forms and Spire expects steering to grow further over the next few years.⁴¹

- (a) PMIs may guide patients toward alternative providers such as home-based healthcare services, or indeed the local NHS at the point of patients seeking pre-authorisation.
- (b) PMIs have also effectively guided patients to alternative providers by providing consultants with incentives and threatening consultants with penalties in order to influence their referral patterns. ✂⁴²
- (c) PMIs routinely suggest patients use consultants whose fees will not give rise to financial shortfalls. The PMI approach to fee-assured consultants creates uncertainty for patients who may lack information about the proportion of their costs that will be covered if they use a non-fee-assured consultant. This uncertainty is likely to induce patient switching.
- (d) As outlined in paragraph 3.5(b)(i), above, some insurers have established their own outpatient facilities (for example, the Bupa Musculoskeletal Centre). Once an insurer successfully guides a customer to one of these centres, the

⁴⁰ AIS, paragraph 15.

⁴¹ See the hospital case studies attached at Appendix K for examples of the effect of PMI steering.

⁴² Provided in response to first day letter.

centres provide the insurer with control over outpatient treatment pathways and over onward referral patterns.

- (e) Several insurers now seek to engage with the customers at the earliest possible stage in order to maximise their influence and stay involved in cases, which allows them to influence patient choice at multiple points along the pathway.

4.15 *The AIS understates the importance of open referral in the market.* Open referral is a growing trend in the market and is hugely significant in the development of the industry. Several insurers either have introduced open referral products or are planning to introduce such products. The effect of open referral is a factor that Spire considers in its negotiations with insurers.

- (a) Bupa's open referral plan requires that patients be referred for treatment by a GP without a designated consultant or hospital. The patient then contacts Bupa who will offer the patient a choice of two to three consultants – this approach allows Bupa to direct its customers to particular facilities or consultants, and thus away from any particular physician or hospital that the PMI wishes to disadvantage.⁴³ In 2012, Bupa promoted an open referral product to all corporate customers when they renewed their insurance plans.
- (b) AXA PPP has offered an open-referral-style product since May 2010 whereby it would direct patients to a specific hospital. In October 2012, AXA PPP introduced a new product, the Healthcare Pathway, in which AXA PPP also directs patients to specific consultants. AXA PPP offers its Healthcare Pathway product to corporate customers that are looking to reduce their costs.
- (c) Aviva has indicated that it plans to introduce an open referral product in 2013.⁴⁴

4.16 While open referral plays a significant and growing role in the industry, it is worth noting that it is not an approach that has been embraced by all PMIs. Some PMIs, such as Cigna, have expressed concern about open referral models: *“It is not appropriate for us to give an opinion on the quality of the clinicians our members choose to use”* and *“We strongly believe that patient choice is at the cornerstone of what differentiates the private medical experience from using the NHS. By restricting access to selected hospitals and/or consultants you erode the value of the private patient experience”*.⁴⁵

4.17 PMIs can effectively steer patients between consultants and facilities by recognising, and diverting patients to, only fee-assured consultants. Where PMIs will only reimburse a patient for the cost of being treated by a fee-assured consultant, and ban the use of top-up fees, the PMIs can effectively control which consultants a patient can see. The requirement for a patient to see a fee-assured consultant can also

⁴³ ✂

⁴⁴ See: <http://www.hi-mag.com/health-insurance/product-area/pmi/article411542.ece>

⁴⁵ Quote from Kirsty Jagielko, head of product management at Cigna UK HealthCare Benefits. Available online at: <http://www.hi-mag.com/health-insurance/product-area/pmi/article411542.ece>

result in the patient switching away from their first choice facility in order to access the PMI's choice of consultant.

4.18 *The AIS has not considered the manner in which co-payments may be used to direct patients.* The use of co-payments is another mechanism for directing patients, although it is a less distortive mechanism because it allows patients to choose whether to pay an additional fee to access their preferred consultant or facility. The CC has suggested that the link between price for private hospital services and consultant services and demand is weak⁴⁶. This suggestion does not accord with the available evidence, including the CC's own survey results and the use of cash benefits by PMIs to direct patients to the NHS (discussed further below). Spire recognises that insured patients may not always take the cost of treatment into account, but, as noted by the CC in paragraph 19, insured patients may take into account possible consequential changes to their insurance costs, for example due to the loss of no-claims bonuses and may also take into account co-payments.

- (a) The CC's patient survey indicates that cost does play a role in decision making by PMI patients. According to the survey report, 29% of respondents listed "whether your PMI would cover their fees" as one of the most important reasons for choosing a consultant⁴⁷ and 32% of respondents (40% of respondents with PMI) listed "whether PMI would cover their cost" as one of the most important reasons for choosing a private hospital,⁴⁸ suggesting that price does have relevance for PMI patients.
- (b) In addition, 37% of patients with PMI coverage who were surveyed by the CC indicated that they paid for their treatment in full or in part by themselves.⁴⁹ The average cost of treatment for these patients was £327.⁵⁰ As such, PMI patients do face some notable costs in association with accessing private healthcare, which appear to be relevant to patient choices.

4.19 *Many PMIs offer their members payments, potentially worth several thousand pounds, to access treatment on the NHS rather than their private scheme.* When patients accept these incentives they are diverted away from private hospitals, and the private hospitals lose revenues. Private hospitals must compete to ensure that their proposition is sufficiently strong that patients will choose private treatment even at the cost of losing the promised incentive payment.

4.20 The AIS hypothesises that PMIs might be constrained in their ability to steer as a result of limited choice of alternative hospitals. Spire rejects this view fundamentally. The CC has substantially understated the degree to which Spire

⁴⁶ AIS, Paragraph 15.

⁴⁷ Patient survey at p. 32.

⁴⁸ Patient survey at pp. 42 and 43.

⁴⁹ Patient survey at p. 54.

⁵⁰ Patient survey at p. 57.

hospitals face competition. ✂⁵¹. ✂⁵². ✂ The analysis must also recognise that, where Spire has invested to develop a very good hospital (which is attractive to patients) or where local demand might only support one hospital, the position of the hospital in question is evidence of an efficient market outcome, not ineffective competition.

PMIs can weaken PHPs' outside options by single-line tenders / partial delisting of certain services

4.21 *PMIs, including AXA PPP and Bupa, have used tenders to remove certain services or facilities from the scope of their contracts with PHPs. ✂.*

4.22 *Delisting or partial delisting can harm substantially a PHP's ability to retain patients as well as its reputation. The AIS recognises⁵³ that delisting or partial delisting could lead consultants to switch hospital in order to maintain recognition and the ability to see patients. ✂.*

4.23 Losing recognition (even if partially) is likely to lead to a natural reallocation of volume, as consultants are given the incentive to relocate their business to a rival hospital. Since patients are mostly referred to consultants rather than private facilities, the flow of volumes will move with the consultant without causing significant reputational or redirection costs for the PMI. In contrast, this comes with a significant reputational cost for Spire, as patients may associate the removal of recognition with low quality standards at the facility.

The AIS fails to consider the effect of PMIs' portfolio purchasing patterns

4.24 The CC recognises the role of portfolio purchasing in its *Merger Assessment Guidelines*: “[w]here customers have no choice but to take a supplier’s products, they may nonetheless be able to constrain prices by imposing costs on the supplier. For example, customers may be able to refuse to buy other products produced by the supplier...”.⁵⁴ This effect is important to competitive dynamics in private healthcare, but has not been considered in the AIS.

4.25 As set out with respect to Theory of Harm 1, the majority of Spire’s revenues are generated through outpatient and day-case procedures, and through less acute care. Even if the CC were to conclude that there was a separate market for inpatient or higher acuity care, and that there were fewer providers in that market, the PMIs would retain significant power in their negotiations with Spire due to their portfolio purchasing patterns ✂.

⁵¹ As discussed at paragraph 3.16(a), the CC’s patient survey results suggest that self-pay patients travel on average 44 minutes and PMI patients travel on average 29 minutes to a hospital. The survey also found that patients would be willing to travel considerably further to access a better hospital (Patient Survey, p. 49).

⁵² ✂.

⁵³ Bargaining Annex, para 50.

⁵⁴ Competition Commission and Office of Fair Trading, *Merger Assessment Guidelines* (September 2010), paragraph 5.9.3.

- (a) Even if a PMI had to recognise a Spire hospital for certain higher acuity treatments, which is not the case, that PMI could retaliate against any attempt by Spire to increase prices for those treatments by re-directing patients requiring lower acuity treatments (which would represent the majority of its purchases) to alternative facilities.
- (b) In addition, the PMI could retaliate by switching those inpatient treatments that can be provided at other local hospitals to those competitors.
- (c) As the AIS acknowledges, Spire faces high fixed costs and relies on the high volume of patients from individual PMIs. This reliance adds to the risk faced by Spire if a PMI switched its outpatient and/or day case patients to competing facilities.
- (d) In this context, it should also be noted that ~~✗~~ and a ~~✗~~. In Spire's experience, PMIs generally focus on the overall expected change in price as opposed to the change for a specific in-patient procedure.
- (e) Finally, PMIs always have the ability to retaliate against activities by a PHP at one hospital by redirecting their customers away from another of that PHP's hospitals.

PMIs engage in strategic treatment of new facilities and procedures

4.26 While the evidence set out above indicates the substantial buyer power of PMIs in relation to *existing* hospitals and procedures, Spire highlights that the AIS overlooks methods the PMIs can implement to weaken attempts by PHPs to improve and invest in their facilities, by:

- (a) refusing to recognise new facilities or services; and
- (b) including carve-outs from policies to limit claims made.

4.27 *PMIs have threatened not to recognise new facilities developed by Spire unless they receive significant discounts.* ~~✗~~.

4.28 ~~✗~~.

The strength of PHP bargaining levers has been over-stated

4.29 The AIS over-states the significance of the threat of price increases by PHPs in negotiations with PMIs. The AIS suggests that, if an insurer removes a hospital from its network, many patients may continue to use it, and if the hospital operator then increases prices at that hospital, this can prove very costly for an insurer. The CC further states that: *"The documents we reviewed suggested that this was often a pressing concern for insurers and the threat of a significant price rise (which can be in excess of 30 per cent) was a common approach utilized by hospital operators in negotiations when responding to a threat of delisting."* In Spire's experience these statements do not accurately reflect the negotiating dynamics between PMIs and PHPs.

- (a) ✕.
- (b) ✕.
- (c) ✕.
- (d) ✕.
- (e) ✕.

4.30 More generally, where a PHP and a PMI fail to reach an agreement, a PHP faces several risks. First, if the PMI continues to allow its patients to be treated at the PHP's facilities, the PMI may reimburse the PHP at the prior year's rate, which would not reflect inflation, resulting in an effective price decrease in real terms. Second, the PMI may guide its patients to alternative facilities or even delist some or all of the PHP's hospitals or services (as happened in the dispute between Bupa and BMI), depriving the PHP of a substantial proportion of its revenues and potentially undermining the financial viability of its hospitals. Third, if a PMI delays signing a contract, a PHP faces substantial uncertainty regarding its future revenues, which may lead the PHP to increase its working capital balance and delay investment decisions.

4.31 Not only has the threat of price increases been overstated, but the AIS does not consider the ways in which PMIs have been able to impose price decreases on PHPs.⁵⁵ PMIs may introduce restricted networks and effectively threaten to delist facilities unless they receive a substantial discount. ✕.

4.32 ✕.

The AIS gives insufficient weight to the evidence of PMI bargaining power

4.33 The AIS does not reflect the substantial body of evidence the CC has received regarding the exercise of market power by PMIs. In addition to the evidence set out above, Spire submitted further substantial evidence in its response to the Issues Statement and response to the Market Questionnaire, which has not been repeated here and which does not appear to have been considered in the AIS assessment of bargaining power. In this respect, Spire would draw the CC's attention to the following points.

4.34 First, the AIS has not properly reviewed the evidence on pricing in the private healthcare marketplace. We understand that the CC is undertaking more detailed work on the price differences that arise from different private hospital operator/PMI pairings and the factors that affect these. In undertaking this analysis, the CC will need to take into account the different focuses and baskets of purchases of different PMIs and how these may affect their negotiating strategies. In particular, Spire notes the following:

⁵⁵ For example, Bupa imposes effective price decreases by unilaterally moving treatments from an inpatient to day-case reimbursement level, as noted at paragraph 3.5(e) above.

(a) ✂.⁵⁶

(b) ✂.⁵⁷

4.35 Second, the AIS does not give due weight to the threat of delisting and the reputation gained by Bupa following the recent BMI delisting episode. Specifically, as noted above, the most prominent recent example of a PMI taking an aggressive stance in order to secure better terms in a negotiation with a PHP is the Bupa delisting of several dozen BMI hospitals in 2011. This event confirmed to other suppliers that Bupa is willing to carry out delistings, in turn confirming the credibility of the threat in negotiations with other PHPs. This was also not an isolated incident. ✂.

4.36 Third, as noted above, PMIs are sophisticated purchasers and can use their knowledge to impact on the sharing rule in their favour. For example, Bupa specifies the treatment environment in its episode coding (e.g. some procedures that could be performed in either an inpatient or a daycase environment are coded as day case procedures for reimbursement purposes – which in turn implies a lower reimbursement level).

4.37 Fourth, the CC has also received and published substantial evidence from consultants and third parties. The evidence consultants and third parties have provided to the CC on the effect of PMI steering in the market is set out in detail in Appendix M.

Failure to consider the interaction between price and quality

4.38 While the AIS bargaining annex includes extensive discussion of prices, it is striking that there is little, if any, discussion of quality. The CC's guidance on market investigations acknowledges that prices and costs are not the sole indicators of competition in a market and that other factors such as quality, innovation and product range can provide evidence about the functioning of the competitive process.⁵⁸ This is unsurprising since, in many previous cases, the CC has noted that value for money logically entails an understanding of the price-quality ratio.

4.39 The absence of any quality discussion is a material omission from the analysis, especially in an industry which is far from commoditised. Quality is a key differentiator in private healthcare⁵⁹ and Spire has invested significant resources over

⁵⁶ Spire's coding for outpatient procedures was changed in 2010, resulting in a lack of consistency in data across years. Only those outpatient prices that are comparable across the relevant period have been included in Spire's assessment of price increases against inflation.

⁵⁷ ✂.

⁵⁸ Competition Commission, *Guidelines for market investigations: Their role, procedures, assessment and remedies*. (April 2013), paragraph 127.

⁵⁹ The CC's patient survey indicates that quality is an important factor for patients in choosing a private hospital with patients identifying the following factors as affecting their decisions: comfort and quality of accommodation (33%), quality of care (e.g. care by nurses) (29%), clinical expertise of staff working there (22%), reputation (20%), clinical outcomes (17%), medical facilities (14%) and better aftercare in follow-up visits (13%).

the past six years in improving the quality of care in its facilities across all treatments and across a range of quality indicators⁶⁰.

4.40 Investments in better quality and new procedures are quintessentially pro-competitive yet hard to “measure” when comparing price changes over time. For example, if such investments increase the overall value of the PMI basket and/or make PMIs willing to pay more for certain services, this need not reflect a harmful outcome for patients. Over time, the number of procedures available at Spire hospitals has increased. Further, the quality of provision of existing treatments has increased. These are reflected in the following indicators: unplanned returns to theatre, infections, mortality, and feedback from patients and consultants.⁶¹

4.41 As noted above, this significant investment has not been reflected in significant real price increases to either insured or self-funding patients. As such, patients (or their PMIs) are paying effectively the same price for a better service. Put another way, real prices have fallen in quality-adjusted terms.

4.42 Patients have an interest in both the cost and quality of the treatment they receive. It is important the AIS analysis not overlook the fact that PMIs have an independent interest in the cost of treatment and may place less emphasis on quality than patients would.

Summary

4.43 In short, the one-sided consideration of bargaining between PMIs and PHPs provides an unbalanced and incorrect assessment of the market. The analysis is unsustainable because it overlooks many key dynamics in the market.

5. THEORY OF HARM 4: BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS

5.1 In the context of consultant fees, the CC has noted that *“it is not evident to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice.”*

5.2 Spire concurs with the CC’s view, particularly when the alternative and indeed the current position is that PMIs can (and do) deny patients access to certain consultants or facilities. In Spire’s view, the private healthcare market works best when patients are free to choose their own consultants and facilities, and where consultants and facilities are free to compete on price and quality. Top-up fees allow a patient to make decisions based on both the price and quality of the available care: if a patient’s PMI plan does not fully cover a particular set of fees, the patient can decide whether the quality of the service warrants an additional payment. This applies to both consultants and facilities: a patient may wish to pay a top-up fee, for instance, to access a more experienced consultant, to access a hospital with better clinical

⁶⁰ See, for example, the hospital case studies at Appendix K. ✂.

⁶¹ ✂.

outcomes, or to stay in a hospital with more luxurious hotel facilities. The prohibition of top-up fees unnecessarily fetters patient choice and access to individual and institutional services.

6. THEORY OF HARM 5: BARRIERS TO ENTRY

6.1 While the AIS may be correct in identifying certain factors that could potentially restrict entry, as explained during the Issues Hearing, there are no insurmountable barriers to entry in the UK. This view is supported by the significant evidence of recent entry and expansion. The AIS is incorrect in suggesting that small scale entry is unlikely to be efficient. There has been significant recent entry by small scale operators, supported by the ongoing shift toward more day-case and outpatient procedures.

Barriers to entry into privately-funded healthcare resulting from bargaining between insurers and hospital chains

6.2 The AIS incorrectly suggests that bargaining patterns between PHPs and PMIs may lead to hospital operators placing pressure on PMIs to recognise all of their facilities, and not to recognise the hospitals of new entrants.

- (a) First, the AIS does not recognise the fact that agreements between healthcare providers and PMIs are enabling contracts only: they provide no guarantee of volumes.
- (b) Second, the CC has misunderstood the bargaining dynamics that have resulted in restricted networks and related discounts. Discounts tied to restricted networks have been introduced by PMIs, not by Spire. PMIs threaten to delist facilities unless they receive a substantial discount and promise that, in exchange for the discount, a PHP will have preferred access to that PMI's patient flows at those specific facilities. The possibility that a discount may be removed, if a preferred access provision is removed, does not reflect an attempt by a hospital operator to prevent recognition of a new entrant, rather, it reflects a response to a change in the terms that were negotiated for that specific local area. As noted above, Spire believes that the private healthcare market works best if patients are free to choose between healthcare facilities and, as such, Spire does not believe that restricted networks are beneficial for the market.
 - (i) For example, AXA PPP solicited bids from hospital operators to lower their prices in particular areas in exchange for some form of preferred recognition (this promised benefit of course also reflects the converse threat: that hospitals that are unsuccessful in the bidding process will be de-recognised). In theory, the restrictions imposed by AXA PPP will lead a greater number of local AXA PPP patients to use the recognised hospitals, and the prices by hospitals to win a place in the restricted network offered reflect something akin to a volume discount. If AXA PPP recognises an excluded local hospital, the flow of AXA PPP patients to the previously recognised hospital would be expected to decrease, and the discount provided in that area could then be

removed: this is inherent in the way that AXA PPP has set up its restricted networks. ✂.⁶² ✂.

Barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants and GPs

6.3 As Spire has stated in its prior submissions and during the Issues Hearing, Spire does not believe that it is appropriate for hospital operators or insurers to offer GPs incentives in return for referring patients to a particular private hospital operator or alternative healthcare provider. Spire agrees with the view expressed in the AIS that such incentives are inappropriate.

6.4 Spire competes with other hospitals for consultants on the basis of its facilities and clinical governance and is confident in its ability to compete on this basis. If the CC were minded to restrict, or even prohibit, consultant arrangements, Spire would not have any commercial difficulty competing in such an environment. An outright prohibition of consultant incentives, however, may have unintended consequences in terms of the level of clinical services being offered to patients. For example:

- (a) it could result in the removal of support for new consultants entering private practice, such as free or discounted consulting rooms or medical secretarial support. The removal of such support may mean that the costs of entering private practice are prohibitive; and
- (b) it could result in a ban on co-investment by consultants in facilities and services, which may mean that certain new services are not introduced to the market.

6.5 That said in assessing the effect of arrangements between PHPs and consultants, the AIS does not include any competition analysis or evidence that would support an assessment of the potential effects of these arrangements on competition or entry. The material Spire has seen to date from the CC includes no context as to the proportion of consultants who may have entered into such arrangements. If only a minority of consultants in a particular specialty in an area have entered into an arrangement with a PHP, there is no evidence that this would prevent (or indeed has prevented) entry by another PHP.

Other barriers to entry into the provision of privately-funded healthcare services

6.6 The CC's finding that neither capital requirements, nor planning issues constitute a significant barrier corresponds with Spire's evidence that there are no insurmountable barriers to entry. The attached case studies of local areas set out many examples of recent entry, including:

- (a) ✂;
- (b) ✂;

⁶² ✂.

- (c) ✂; and
- (d) ✂.

6.7 The CC has suggested that the combination of economies of scale with limited market size may restrict entry by firms wishing to enter or expand in the inpatient segment of the healthcare market.⁶³ Evidence in the private healthcare market shows that this is not the case and these factors would not result in market power for PHPs.

- (a) Even in local areas with a limited population with PMI coverage, entry is a real possibility. There are several ways in which such entry could occur. For example, the local NHS could develop a private patient offering, at relatively low cost, given its existing infrastructure, ✂. Another possibility is that a new entrant could open a day-case or outpatient facility, and expand into inpatient as, again, has happened or is expected to ✂. In addition, an existing provider may decide to widen its catchment area by establishing a satellite facility in the area in an attempt to draw patients to a facility located at a somewhat greater distance.
- (b) If a local market is too small to support more than one hospital (which Spire does not believe would be the case), a single local site will not create significant market power because there must be insufficient demand in that local area to make it critically important to the PMIs.
- (c) If a local area is large enough to support multiple facilities, then that area is contestable and an exercise of market power by a local operator would be expected to create enhanced opportunities for entry. PMIs have the ability to sponsor entry in this way even if, in practice, they have sought to act strategically and opportunistically to exploit the importance of securing network recognition as explained in the discussion of Theory of Harm 3 above.

Barriers to entry into the provision of consultant services in private practice

6.8 The CC has said “*We think the conduct of PMIs, particularly the larger ones, in respect of new hospital recognition may impede entry. However, 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.*”⁶⁴ Spire shares the CC’s concern that the conduct of PMIs in respect of new consultant recognition may impede entry and thinks it is important that the CC consider this issue since it may, in the long term, limit patient choice.

7. THEORY OF HARM 6: LIMITED INFORMATION AVAILABILITY

7.1 Spire believes that the private healthcare market works best when patients have the freedom and information required to make their own choices. Spire expects

⁶³ AIS, Appendix C paragraph 18.

⁶⁴ AIS, paragraph 139(b).

that patients will use the information available to them, in combination with consultations with their GP or other advisors, to make decisions about their treatment. The information gathered in the CC's survey suggests that this is, in fact, how patients operate. The CC's patient survey found that 47% of patients had looked up information on line before deciding on a private consultant or hospital and 76% of patients spoke to someone before making their decision (most commonly their GP, friends/family, or the private consultant they were treated by)⁶⁵.

7.2 Spire already makes extensive information regarding the quality of its facilities available on its website. Spire is also participating in the PHIN project, which will make comparable data regarding the cost and quality of treatment at private facilities available to support patient decision making. Information about PHIN has been separately provided to the CC, so Spire does not repeat it here.

7.3 Spire is concerned however by statements in the AIS which imply certain consequences of recognised information asymmetries. For example, the CC has suggested that *"these asymmetries, combined with the industry's fee for service model, [create] an inherent incentive for the provider to take advantage of that asymmetry and refer patients for unnecessary or more elaborate diagnostic tests or forms of treatment for reasons other than the patient's best interest"*.⁶⁶ Spire takes patient care very seriously and has extensive clinical governance structures in place to prevent both overtreatment and undertreatment.

7.4 Although Spire understands, based on statements from the CC at the Issues hearing that *"these are not allegations against Spire"*⁶⁷, outlined below are several reasons to believe that overtreatment and unnecessary diagnostic tests are not an issue in the UK private healthcare industry. The CC's allegation is very serious and has been made without reference to any apparent evidence that over-treatment or over-diagnosis is occurring in UK private healthcare.

- (a) It is the consultant, not the provider, who refers a patient for diagnostic tests or treatment. With respect to diagnostic tests, in a large proportion of cases, a consultant could have no financial interest in the testing. For example, many patients are diagnosed through the use of imaging equipment. The imaging equipment is typically owned by a healthcare facility, and the imaging is typically carried out by a radiologist (who would not be the patient's primary consultant). The CC is making a blanket and unfounded assumption that consultants will have a financial interest in further testing or treatment for their patients. It is unfair and inappropriate to make such an allegation in the absence of evidence.
- (b) The CC is making these assumptions in the face of no apparent evidence that over-treatment is a significant issue in private healthcare in the UK. As Spire explained to the CC during the Issues Hearing, Spire has clinical governance systems in place to protect against both over- and under-treatment. In a case

⁶⁵ Patient survey at p. 63.

⁶⁶ AIS, paragraph 143.

⁶⁷ Draft transcript, p.104, lines 8-9.

where Spire found evidence of either over- or under-treatment by a consultant at one of its hospitals, it would not hesitate to refer that consultant to the GMC. It appears that the PMIs have raised over-treatment as a concern with the CC. Spire engages in regular discussions with all of the major PMIs in the UK on a wide variety of topics relating to its business and the PMIs have not raised over-treatment as a concern. If over-treatment were an issue in Spire hospitals, Spire would expect the PMIs to raise it during these discussions. No PMI has done so during the period in which Spire has owned the hospitals.

7.5 As the CC has noted, there is a risk that publicly-funded capitation models such as the NHS in the UK face incentives to ‘under-treat’. The role of the NHS is to maximise utility for the community using its limited resources. Individuals choose private care to maximise their personal utility and achieve the best outcomes. As such, the level of treatment available in the NHS may not be an appropriate point of comparison for the level of treatment available in private facilities. There is, in fact, significant objective evidence of under-treatment in the UK:

- (a) as set out in the L.E.K. report attached at Appendix A, the UK is significantly behind other developed countries in the availability of diagnostic imaging services and has significantly fewer MRI and CT units per capita than other European countries; and
- (b) UK radiotherapy capacity is 34% below the OECD average and there is a nationwide shortage of NHS radiotherapy units. As many as 13% of cancer patients in the UK who could benefit from radiotherapy are not receiving it.

7.6 The fact that certain diagnostic tests and treatments may be more widely available and more frequently provided in private facilities than in the NHS does not therefore reflect over-provision in the private sector. This is especially the case given the under-provision of several significant healthcare services in the NHS in the UK. The AIS provides no basis for concluding that any difference in provision levels reflects anything other than patients maximising their personal utility and accessing important services that may, in fact, not be available in sufficient quantities in the public sector.

8. CONCLUSION

8.1 The concerns set out by the CC in the AIS and PWP all ultimately relate to the availability of choice for patients and the ability to evaluate and exercise those choices effectively. These concerns could be readily addressed by focusing on three characteristics of the private healthcare market:

- (a) **The operation of the PMI patient referral pathway:** unnecessary “noise” and influence must be removed to ensure that choice is available to patients and that patients can exercise that choice.
- (b) **Equal treatment for PMI and self-pay patients:** PMI patients should, as far as possible, be put in the same position as self-pay patients in their ability to exercise choice concerning quality and price of treatment, and to benefit from the pricing and quality information that will be available to them under PHIN.

- (c) **The opportunity for patients to give fully informed financial consent:** patients (both PMI and self-pay) must have full freedom to choose their own hospital and consultant, and have full and timely access to the information they need to make fully informed financial decisions.

8.2 More specifically, Spire proposes that these concerns could be addressed in the following ways:

- (a) On the GP referral of patient to consultant and/or hospital:
- (i) The provision of more information regarding quality and price by consultants;
 - (ii) The provision of more information regarding quality and price by hospitals;
 - (iii) The provision of clearer information from PMIs to patients about policy entitlements; and
 - (iv) A bar on arrangements that could distort GP referral patterns, including incentives paid to GPs and outside ownership of GP practices.
- (b) On the consultant referral of patient to hospital:
- (i) The provision of more information regarding quality and price by hospitals; and
 - (ii) A bar on arrangements that could risk distorting consultant referral patterns, such as volume and revenue incentives; and full disclosure of all other consultant arrangements (see below).
- (c) On the restrictions on PMI patient choice of facility and consultant imposed by PMI networks (and also to allow both existing hospitals and new entrants to compete for all patients):
- (i) PMI patients to have the right (enshrined in their policies) to seek treatment for an insured procedure at the hospital of their choice and with the consultant of their choice;
 - (ii) To the extent there is a shortfall between the price negotiated by a PMI with a hospital and/or the fee paid to the consultant by the PMI, PMI patients to have the right in all cases to pay top-up fees for both hospital costs and consultant fees; and
 - (iii) Each PMI to be under a duty to ensure that, when communicating with their customers about their treatment options, those customers are fully and fairly informed of the options available to them, including their right to go to any hospital and/or consultant.
- (d) A standardised approach to ensuring fully informed financial consent for patients, including requiring the provision of:

- (i) Written disclosure of any consultant arrangements prior to treatment;
- (ii) Written disclosure of consultant and hospital outpatient fees before consultation takes place (including an indication of the costs of any tests, scans etc that may be required at or following the consultation);
and
- (iii) Written disclosure of consultant and hospital inpatient fees before inpatient treatment takes place.

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