

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with BMI held on 27 March 2013

#### Future strategy

1. BMI told us that demand for privately-provided healthcare was declining. That, in turn, was leading to low utilization and significant overcapacity in an industry with high fixed costs and a high capital requirement. As a provider, BMI had to grow its acuity or complexity and had a strategic programme directed at achieving that across three broad focus areas: reviewing its portfolio of hospitals, rendering its processes as effective and low cost as possible and continuing to build its relationship with insurers and other commissioners.
2. BMI owned a number of hospitals, with approximately [redacted] hospitals providing 50 per cent of the company's profit. [redacted]
3. BMI was also reviewing its current processes, aiming to become more efficient and as low cost as possible. There was a programme running to support those internal efficiencies and a pathway management process, which allowed BMI to reduce the friction costs and improve transaction-supporting processes.
4. BMI was currently considering its relationship with insurers and other commissioners, with the intention of increasing the volume of activity through its hospitals. Fundamentally, BMI's view was that it was not the portfolio of hospitals (ie footprint) that mattered, but the volumes that it was able to achieve through those hospitals. Its aim was to increase throughput across a [redacted] portfolio. [redacted]
5. Looking ahead five years or so, BMI expected (and BMI thought the NHS itself probably expected) to see real pressure on NHS healthcare and it believed that there would be an upturn in private contribution to healthcare. The current NHS approach, of undertaking everything for everyone everywhere, was not sustainable in a period of increasing demand and flat funding.
6. BMI said that people currently were unwilling to take on debt or fund healthcare themselves simply to exit a queue in the NHS. It had seen a decline in its self-pay market. This was in part due to the increase in NHS capacity and free competitive service available to individuals who might otherwise choose self-pay.
7. Since 2006, BMI had seen a [redacted] per cent reduction in inpatient activity with numbers dropping from [redacted] to [redacted] per cent of total activity. Its current strategy was to grow its inpatient and higher complexity caseload, even if it was at the expense of some of the more commoditized day cases.

#### Revenue and profitability

8. [redacted] per cent of BMI's caseload and approximately [redacted] per cent of its revenues came from NHS activity, with an increase in growth of about [redacted] per cent year on year. There were two broad sources of this work. First, there was 'choose and book', which was the standard system that ran through all GPs and NHS hospitals (and others providing NHS acute care) in England, and second, there were the cases which were contracted from NHS Trust hospitals as they ran up against the 18-week waiting time

target. BMI's cautious expectation was that NHS activity would, over time, also rise in Scotland but not at the same rate as it was increasing in England.

9. BMI was working towards growing volume through its hospitals. Growth in market share was not a target in itself. It aimed to be in a position where it was a sustainable part of health delivery, where the business was able to support itself and grow. To be successful, BMI believed it needed to be able to provide a full service, particularly to insurers. BMI's national enquiry centre (NEC) was a good example of end-to-end service for insurers: allowing patients in a single call to their insurer to authorize treatment and finish the call having been passed to BMI's NEC with an appointment to see a consultant (accepted by the insurer) at a BMI hospital.
10. Insurers were incredibly important customers to BMI. The self-pay market had declined as a consequence of the NHS waiting times being brought down and the economy was dampening self-pay demand. BMI had an NHS strategy for developing relationships and a sales force to implement that strategy opposite both NHS hospitals and new NHS commissioning groups.
11. In the last few years BMI had suffered a significant decline in profitability. From 2010 to 2011 it suffered a [X] per cent fall in its margin and its profitability fell from [X] to [X] million, pre-rent. This was due to the continued decline in the PMI market and to the increase in VAT (VAT on supplies is paid in full by BMI as the healthcare services it provided to its customers were VAT exempt). In the last year, profitability was broadly stable. However, to maintain stability, BMI had had to trim its cost base quite substantially. BMI was not in a position of excess profitability.

## **Competitors and competition**

12. Outside London, BMI saw Spire, Nuffield and Ramsay as its main competitors. Ramsay was focused on NHS activity, but BMI said that this in no way reduced Ramsay's ability to compete for private work. Spire was probably in a similar place to BMI in the value proposition to consumers. BMI believed that Nuffield was slightly behind the curve of service innovation but still provided very good care and was an important competitor. Overall BMI felt it probably had proportionately more intensive care beds than its competitors but this would vary by locality, and this was only an impression in response to a question—the data would be required to answer concretely.
13. BMI was a widespread organization geographically in England. BMI also had a widespread presence in the private healthcare market in Scotland. BMI accepted that it had solus hospitals but did not recognize the concept of clusters of hospitals within a region. The only hospitals that were viewed jointly by the business were those in very close proximity—a few hundred yards apart like Priory/Edgbaston or Kings Oak/Cavell. BMI did not use solus, clusters or its regional position as leverage in negotiations with insurers, and did not have a 'one-in, all-in' approach in negotiations with insurers. The main issues when negotiating were the national volumes and the level of patient direction that the insurers were prepared to apply, ie the confidence that BMI could have that volumes would be delivered. The main focus today was on direction of patients to units, which was reflected in BMI's approach to insurers. It believed there were efficiency gains when hospitals were very closely located through shared management etc. BMI's local market position did not come into play in national negotiations with insurers; there was also no evidence of this from the records of the negotiations themselves.
14. BMI introduced two schemes at its Bath Clinic, which were designed to give consultants financial participation in the efficiency generation of incremental activity at the

hospital in order to hold on to the workload in response to competition from Circle Bath which provided direct financial incentives to consultants. It sought to do this by reflecting some of the value of the contribution a consultant made to the Bath Clinic's overall profitability and make a contribution back to individual consultants.

15. BMI's competitive response to Circle's potential entry into the Manchester market included installing a seventh theatre at its Alexandra Hospital, to ensure that the kit was as good as it could be and to compete on quality and retention of consultants. Similar changes and refurbishment had been made to its hospital at Birmingham—again in response to Circle's potential entry. This investment was just a part of BMI's overall capex programme and BMI was focused on helping consultants develop their practices.
16. Although incentives were not offered to consultants at each BMI hospital, the executive directors at some hospitals without incentives had agreed to offer some consultants 'practice development support', which included, among other things, marketing support and employment of a medical secretary at no extra cost. It offered support to their practice rather than providing them with a financial interest. BMI told us that providing this sort of practice development support was effectively lowering the costs of providing the services of a complementary product which had the potential to be very good for consumers. None of BMI's arrangements with consultants were exclusive or exclusionary.
17. With regard to GPs, BMI told us that it might be acceptable for them to hold equity but it was not acceptable to stop GPs, consultants or anyone else from working at or not referring to any other unit. BMI considered that it was unacceptable to offer GPs direct financial incentives as the conflict of interest was too pronounced.
18. BMI viewed hospitals owning GP practices as a form of vertical integration which it was against. Such integration could lead to misaligned incentives in terms of referral patterns.

## **The London market**

19. BMI's main competitor in London was HCA. As part of its strategy, BMI was targeting increasing numbers of people who might be treated at central London hospitals to be treated at its peripheral London hospitals instead. By means of example, with investment in equipment, BMI had successfully attracted patients to its Clementine Churchill Hospital in Harrow away from HCA's Princess Grace Hospital.
20. BMI believed that insurers (Bupa especially) probably had contractual arrangements which prevented them from either recognizing or directing work out of central London. BMI also had concerns regarding the method used by insurers, [X].
21. Network recognition was not the same as getting activity. The way that activity was directed by insurers was complex but comprehensible. By scoring consultants and hospitals, insurers were trying to optimize where referrals were going. This was something that had changed over the last five/six years, which was why BMI had had to change its perspective on network recognition versus absolute volume.
22. BMI believed that most outer London GPs had relationships with consultants and not with the hospitals. BMI did what it could to put itself in front of the GPs to create a sense of what it was, and to create a brand identity, but most of the referring GPs would have a relationship with a consultant and refer to individuals primarily. Outer London consultants would typically have consulting sessions at HCA hospitals.

23. Networking between HCA, GPs and consultants was something that HCA invested a great deal of time and resources in. For instance, HCA ran a division called 'Galen' which interfaced provided outsourced services to GPs and consultants. These formal and informal networks were a constraint on BMI's ability to get patients into its hospitals in outer London.
24. BMI believed that although HCA had a strong position in central London, with excellent quality hospitals, BMI could still compete in that market. [X], BMI had a strong desire to increase its presence in the central London market. However, under its current financing structures, it was unlikely that BMI could deploy the capital to move significantly into central London in the next three or four years. One future objective was to open a unit in the Harley Street area. [X] However, in general, land and site availability was a barrier to entry in London.

## PPUs

25. BMI had bid for the management contracts of several NHS PPUs and was interested in using this as a way to increase its presence in the London market. BMI had great experience of running PPU units on NHS sites and believed it bid competitively.
26. Along with other private providers, PPUs provided competition to BMI in the outer London area as well as elsewhere.

## Prices

27. BMI told us that with regard to NHS work it was a price taker. Its basic approach to prices for self-pay and insured patients was covering variable costs and making contributions to fixed costs. BMI gave its hospitals guidance about the ranges within which it would anticipate self-pay prices covering costs and then let individual hospitals have some autonomy about where they actually set the prices to adjust to local conditions. Thus self-pay prices within and between individual hospitals could vary, depending on local competition, relationships with consultants of particular specialties, expected costs, co-morbidities, prosthesis choice etc.
28. In areas with fewer private hospitals, there were typically fewer people and demand for private healthcare was typically low and thinly spread. Hospitals in such areas tended to have relatively low levels of capacity utilization. The hospital in this position had an incentive to price to attract volume to cover fixed cost. Self-pay prices were also sensitive to NHS performance and if prices were increased, demand would be lost into the NHS. These factors constrained BMI's freedom to price self-pay episodes even where there were few local competitors.
29. BMI noted that the CC had not found any statistically significant relationship between self-pay prices and concentration for BMI. BMI itself had found that for some specific treatments in some 'solus' hospitals, there were higher prices. However, solus hospitals as a group also faced lower capacity utilization, much lower numbers of people living in the catchment and had lower margins. Solus status was a poor predictor of the presence of competition.
30. When asked what differentiated itself from its main competitors in the eye of the patient, BMI believed, first, that quality was better and secondly, value for money. With regard to self-pay patients, the issue for BMI was communication of the quality it was able to provide; the best advocates for that were patients who were left satisfied with the service they received. Obviously word of mouth was critically important and the way patients were treated was also important to BMI. Having undertaken

research and launched self-pay pilot products with varying discount strategies, BMI's experience was that patients saw self-pay as a premium choice over the NHS and preferred high quality together with clarity and predictability around price rather than necessarily seeking out the lowest cost option.

31. In general, self-pay patients paid higher prices than insured patients, with the NHS being charged the lowest fees for BMI services. However, that was not absolute and there was not a fixed mechanism that was predictive for every procedure. Insurer negotiations usually occurred on a global basis across a large portfolio of work. Over time and given the legacy nature of the tariff structures in place, the price points for specific procedures and services had fallen out of line with the general market and input costs. As such, the price schedules had needed to be 'rebalanced'. BMI had to be careful in the way that it negotiated these price changes with insurers. Together with the insurers, BMI was anxious to ensure that such 'rebalancing' did not result in any unanticipated revenue movement and recognized the importance of demonstrating revenue neutrality.
32. Clear marketing to GPs was important. Much of this was aimed at reassuring them that there was a safe space in which they could have conversations with their patients regarding the option of private healthcare, including self-pay.

### **Negotiations with insurers**

33. BMI had managed to negotiate increases in the real price of procedures over the last five years with some insurers. This was achieved by talking to insurers about the upward movement in input costs. BMI found that, as it moved from two-year contracts to three-year rolling contracts, most of the insurers were prepared to countenance an increase each year, tied to a measure of inflation—which inflation measure was subject to negotiation, but always extracted from publicly available data. Most of the contracts that BMI had negotiated over the last two/three years were pegged to such transparent economic measures. The inflation mechanisms were generally known upfront, which enabled insurers to plan more effectively around their underwriting for the future premium levels. [REDACTED]
34. Typically, BMI held robust clear and transparent price negotiations with insurers. It did not consider that it had 'must-have hospitals' that gave it a strong negotiating position. It pointed to its internal documents prepared prior to negotiations to demonstrate that it planned its strategy on the basis that insurers were able to direct away [REDACTED] of their demand if they wished. BMI was keen to reach agreements with insurers which provided incentives for insurers to actually use BMI's hospitals rather than simply recognize them. In a world where insurers had the ability to recognize a hospital but then failed to direct any patients to it, recognition alone was not enough to see volume actually delivered. There were still no volume commitments or guarantees in these agreements.
35. BMI believed that the significance of insurer network recognition was declining. Where it might still be of significance would be in some of the tighter or low-cost networks where participation was on an insurer network with a limited footprint. BMI had offered to participate in these, particularly if they were used to support a new service or product line that the insurer was taking to market, as these would be growth opportunities to access new demand. AXA PPP Pathways and Health Online were both examples of this.
36. Both exclusivity and guaranteeing recognition of a newly-built or -acquired facility was gradually dissipating and becoming less prevalent in the contracts that hospital operators had with insurers and, in any event, exclusivity was often only nominal in

character with insurers adding to initially tight or restricted networks over time. As a rough estimate, BMI thought that less than 20 per cent of the market was characterized by nominally exclusive contracts.

37. BMI said that a hospital might have no recognition from an insurer but still have volume. For example, Bupa had delisted Gisburne Park and Lancaster, but BMI had [REDACTED].
38. Hospital delisting was a very powerful tool in negotiations, and one that insurers could effectively deploy to exercise market power. Going into this negotiation, Bupa had shown no commitment or engagement around price for volume or direction. As a result, network recognition was very important. Bupa had always negotiated a national price and started the negotiation with BMI wanting a reduction to the national price. Bupa was not interested in local hospital pricing until around late September/October 2011. BMI did not reject local hospital pricing but was unable to obtain sufficient information from Bupa—especially around anticipated volume—that would have supported hospital-by-hospital pricing. BMI's negotiating position was not unusually weakened by any debt restructuring as there was no debt restructuring going on at the time. Delisting did not merely threaten Bupa activity at BMI's hospitals but caused consultants to start to shift their entire practices. BMI felt the impact of having its hospitals delisted immediately upon Bupa notifying its members, consultants and GPs of any delisting and advising them to use alternative facilities. Admission numbers dropped sharply immediately on Bupa's announcement to delist; the effect was not delayed until delisting actually occurred. Moreover, admissions did not recover after relisting either. Bupa volumes remained sharply down throughout 2012, dropping [REDACTED] per cent year on year across the whole business—not just the delisted hospitals. This was far larger than the rate of erosion in Bupa's customer base, which, according to BMI's reading of Bupa's most recent accounts, was around 6 per cent.
39. BMI considered Bupa and AXA PPP to be 'must-have insurers'; although recent negotiations with Bupa had been lengthy and difficult, the relationship with AXA PPP was quite different.
40. BMI tried to be collaborative, and supportive in its approach to all the insurers reflecting mutual interest in growing the market, regardless of their size. BMI considered that smaller insurers were very important to it. BMI tried to approach pricing and insurer negotiations on a constructive basis to help grow the market, which was a big part of its strategy opposite insurers. [REDACTED]

### **Open referral**

41. [REDACTED]

### ***Self-pay and corporate patients***

42. For hospital-generated self-pay episodes, where BMI had advertised directly to the patient or GP, BMI would have prearranged charges with individual consultants to support package offers to patients that were price competitive.
43. AXA PPP's pathway products with BMI involved patients being directed [REDACTED] This method provided price assurance to both AXA PPP and the patient. BMI felt that the open referral system it had designed jointly with AXA PPP was efficient and provided a better service for patients. It was developed and used as a corporate proposition for AXA PPP clients and was then later cross-sold to other insurers, eg [REDACTED]. Bupa

had its own open referral system, with consultants each having a fee-assured ranking. Bupa's customer service teams used that ranking to place a referral. This process had been sold as a default position to Bupa's corporates from January 2012. However, BMI understood that a number of these corporates had decided to go back to the more traditional referral path. In BMI's experience, other insurers were pushing to access and direct open referrals.

44. BMI was of the view that the insurer could influence the direction of referrals. Consultants had resisted this strongly, specifically as they considered that it involved insurers taking clinical judgements. As open referral processes developed, BMI believed that consultants were becoming more involved in the way open referral worked, particularly in the open referral products that BMI supported. BMI aimed to work with consultants to get the right patient to the right type of consultant with the correct set of information and data.
45. Open referral offered a contingent interest for BMI because where Bupa was allocating its work to fee-assured consultants, BMI needed to make sure it had access to the fee-assured consultants and potentially to help consultants at its hospitals understand why going Bupa 'fee-assured' and, potentially, taking a reduction on the individual per case income as a result, might still be a sensible course of action if more work came through. This was a difficult line to tread with individual consultants.
46. For corporates which had signed up to AXA PPP Pathways' open referral product, the employees were told that they could only access the Pathways hospital list. Using the open referral process therefore moved referrals from central London and put them into BMI hospitals in the Greater London area. The London Clinic, King Edward VII and St John and St Elizabeth were the only central London hospitals included in AXA PPP's pathways. Referral to these hospitals was AXA PPP's (rather than BMI's) responsibility.

### ***Low-cost networks***

47. Low-cost networks had been brought forward by three insurers. BMI had reached agreement with two of the three, ie AXA PPP through Health Online and Simplyhealth. Its current arrangement with Health Online included a [X] per cent discount against the standard AXA PPP arrangement on the basis that the Health Online product targeted new subscribers with a very different sales platform and brand from 'normal' AXA PPP. The Simplyhealth low-cost network (again with approximately a [X] per cent discount) was driven from a legacy product, which also had a different brand and had subsequently been expanded as a low-cost offering to consumers and to corporate customers. The third insurer offering low-cost networks was Bupa. However, although BMI had actively participated in the tender for this product, critical information on the new process, specific product features and target audience had not been forthcoming. BMI had found the negotiations difficult, with no indication of the potential volume that would result from the network and whether this would be new volume or existing customers trading down. Bupa was only interested in a national flat discount. BMI's final proposals, [X], were rejected by Bupa which launched the product without BMI.

### ***Service line tenders***

48. BMI told us that service line tenders were, in principle, fine, especially as the market had moved away from exclusivity and towards volume discounting. The challenge that BMI had with them was where there had been a negotiation with an insurer for a package of activity for a fixed term, and during the term the insurer removed some

element of the package. Doing that undermined the basis of the original deal and made it difficult for BMI to maintain pricing across the rest of the service bundle.

## Consultant power

49. BMI had a contract with a group of consultant oncologists who worked at its Beardwood Hospital in Blackburn. Together they had formed the 'North West Cancer Centre' and split the responsibilities, with BMI dealing with the administration and consultants ensuring provision of the treatment side of the business. In addition to BMI, there were [redacted] consultant shareholders who were involved in future development of the oncology unit at the hospital. [redacted] This arrangement provided the consultants with an incentive to conduct most of their private work at Beardwood Hospital, and indeed [redacted] per cent of their work was carried out at the hospital. However, the arrangement was not exclusive and work was occasionally carried out at other hospitals. BMI told us that it would expect the consultants involved to inform their patients that they had a financial interest in the business.
50. BMI had a second joint venture with a group of consultants at its Garden Hospital. BMI jointly owned an MRI scanner with the consultants and to ensure transparency and inform patients of the consultants' financial interest in the business, a sign had been put in the imaging waiting room, alerting patients to their shareholder status.
51. Anaesthetists had a stronger relative position to negotiate on price when they were part of a group, and BMI had found some negotiations difficult. BMI recognized the CC's views, as outlined in our annotated issues statement, regarding anaesthetist groups and the strength of position of such groups.
52. BMI had also found professional resistance from other specialists, eg radiologists and pathologists, when negotiating to adjust fees. When negotiating fees with BMI for NHS surgical work, the consultants were prone to comparing it with the Bupa or AXA PPP rate and seeing it as one on which a discount was being imposed rather than seeing it as a different rate with different types of activity lines.
53. Turning to the issue of recent changes to Bupa's fee maxima, BMI told us that typically the younger consultants were accepting the change as they saw it as a way of increasing the volume of their work. However, the older consultants were more sceptical about the amount of volume increase they would see as a result of the change. There had been reports of an adverse impact on working relationships, not only in the private sector but in the NHS as well, between those who signed up and those who had not, with consultants who had not signed up to the scheme reporting a drop in work being referred to them. BMI's concern was to ensure that a sufficient number of consultants using its hospitals were fee-assured, so as not to have work diverted from its facilities. BMI had heard a lot about consultants exiting the private healthcare market as a result of Bupa's changes but had not seen this happening in fact.

## Barriers to entry

54. BMI had considered entering the market in Edinburgh. There was volume but BMI had doubts about its ability to achieve new or additional volume reasonably quickly. This was due to two main reasons. First, there was not enough unserved volume, and secondly (at least on the second occasion when BMI looked to enter), the type of entry anticipated would not have been big enough in its scale to allow BMI to engage fully with the market. This was not always the case. BMI had been very successful with some small-scale new-build entry, such as Syon Clinic in West London. This



was a similar proposal to the one it had contemplated in Edinburgh. At Syon, based in Brentford, BMI successfully took work away from the Cromwell Hospital by referring inpatient work up to BMI CCH in Harrow, but movement of inpatient work from Edinburgh to Glasgow would have been a different undertaking.

55. There was always a risk when entering a new market, whether by acquisition or new build. However, building new hospitals was an expensive business and although BMI had considered a large number of new-build opportunities, a consistent theme was that the market opportunity was not big enough to support the additional fixed cost of building a new hospital. There were ways around this. One way to grow business was to scale up existing hospitals and increase speciality and complexity capability; this was usually easier than buying competing hospitals.
56. BMI's view was that Circle's entry into Bath had not stimulated demand. As expected, the pre-existing demand had been roughly split 50:50 between Bath Clinic and Circle Bath. [X] To incentivize consultants and meet competition from Circle's equity model, BMI had introduced two schemes at its Bath Clinic, both of which were designed to give consultants a financial participation in the efficiency generation of incremental activity at the hospital. BMI had also offered reduced rates to its self-pay prices customers. BMI estimated that some self-pay prices went down by between [X] and [X] per cent, depending on the procedure.
57. One of the barriers to entry in central London was the challenge of finding the right sort of premises in the right location. This was a significant problem. [X]