

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with HCA held on 12 March 2013

#### Background

1. HCA, founded in 1968, was part of the HCA Group, one of the world's largest private healthcare organizations.
2. HCA had about 160 hospitals across the USA and six hospitals in London. HCA purchased four of those six in 2000: the Harley Street Clinic, the Portland Hospital, the Princess Grace Hospital and the Wellington Hospital. Approximately a year later, HCA merged with the St Martin's Healthcare Group, adding the London Bridge hospital and the Lister Hospital. HCA's vision was to transform these hospitals through investment and development, focusing on high-acuity services such as cardiac surgery, cancer care and neurosurgery.
3. HCA advised that it had made substantial capital investments in these facilities, installing new equipment and new clinical services, adding intensive care and critical care facilities and introducing cutting-edge technologies such as the Cyberknife. In recent years, HCA had added four NHS partnerships, allowing the NHS to draw on its expertise to create new cancer centres.
4. HCA saw the Competition Commission's (CC's) recent annotated issues statement (AIS) as largely focusing on price competition, and believed that this did not pay sufficient attention to the role of technology and innovation in creating and implementing new clinical services and new treatments, which improved clinical outcomes for its patients.
5. As a London provider, HCA noted that operating costs for the NHS, as well as for the private sector, were significantly higher than in other parts of the country. HCA also attracted patients from a wider catchment area. [REDACTED] (in terms of revenue) came from overseas patients.
6. HCA strongly disagreed that there were competition problems in London. It believed that the organization operated in one of the most competitive parts of the UK market, and faced stiff competition from other London providers which enjoyed world-class reputations. HCA saw new entry and expansion by other healthcare providers into London in both inpatient and outpatient facilities, which it said pointed to a lively, dynamic and competitive market.
7. HCA had argued consistently in the CC's inquiry that the private medical insurers (PMIs), and in particular Bupa and AXA PPP, were hugely influential purchasers of healthcare and exerted a strong constraint over HCA's business. HCA did not feel that the AIS properly reflected the power that PMIs wielded in contract negotiations with hospitals.
8. HCA had also highlighted its concerns regarding Bupa and AXA PPP's managed care strategies, which were, in its opinion, interfering with the competitive process, limiting patient choice and having the effect of discouraging investment and innovation.
9. HCA recognized that there were areas where the healthcare market could improve, for example in providing more standardized detailed information about clinical quality,

so that insurers and patients could make informed choices about hospitals and consultants. HCA saw the industry as being responsive to criticisms about information asymmetries. It emphasized that it was keen to play a role in discussing how the industry could move forward to improve things. HCA would also welcome guidance from the CC on the level of disclosure to be provided to patients during consultations.

## **Competition in London**

### ***General***

10. HCA saw its London competitors falling into four main categories. In the first category were the central London private hospitals: these included the London Clinic, Bupa Cromwell, King Edward VII, the Hospital of St John & St Elizabeth and BMI's hospitals in central London such as the London Independent.
11. In the second category were approximately 16 NHS private patient units (PPUs), including the Royal Marsden, Great Ormond Street and Moorfields Eye Hospital.
12. In the third category, HCA identified hospitals around the edge of London, such as Clementine Churchill, St Anthony's, BMI's the Blackheath Hospital, Spire Bushey Hospital and Aspen's Parkside Hospital in Wimbledon.
13. In the fourth category were hospitals that competed for HCA's international business. These included hospitals abroad, particularly in Germany and also in the USA, Singapore and Thailand, and also hospitals from the other three categories.
14. About [X] per cent of HCA's revenue came from patients who flew into London to access healthcare. HCA advised that UK self-pay revenue was about [X] per cent of its total revenue. The remainder came from PMI.
15. HCA had a core group of competitors in central London which matched it fairly closely in terms of technological and intensive care capabilities. HCA had invested approximately £[X] over the last four years in new technologies.
16. The competitive position among UK healthcare providers with regard to overseas patients, self-pay patients and insured patients had different characteristics but was similar in that the people that HCA was competing for were very often the same people other providers were competing for and those other providers were capable of attracting overseas patients to their facilities.
17. HCA saw the redirection by PMIs of patients from the centre to the periphery as a competitive aspect of the market. To offset that, HCA had to sell the quality of its hospitals and its consultants, and invested heavily in providing information that would give it credible benchmarking, to encourage patients to come into central London.

### ***PPUs***

18. HCA saw some of the NHS PPUs as niche players with excellent reputations in speciality areas, a strength that played to their global reputation. Others it saw as being broad-based competitors. Despite the PPUs accounting for less than 10 per cent of inpatient and day-patient admissions in central London, a figure that HCA expected to see double in the next five years, HCA saw new competitive developments arising from their presence in the marketplace. It noted that with the removal of the cap of revenue that trusts could earn from private patient activity, a number of trusts were exploring opportunities to expand their private care offering. For instance,

where HCA had gone into partnership with PPUs (in order to access a segment of the market that required NHS partnership) to develop new facilities, the latter saw their market shares increase as a result. In addition, the PPUs had expertise in high-acuity tertiary specialties, which was an area where they could be very competitive. HCA saw the potential for other providers such as BMI and Spire to partner with PPUs in the same way as it did as a major competitive risk. As a result, HCA would have to compete vigorously to make sure that it maintained a share of the consultants and patients.

19. HCA believed that the constraints faced by PPUs would be related to the market that they served, for instance, if they served an area where there was low PMI concentration. Conversely, there were significant built-in advantages for hospital trusts competing in the private sector, which HCA could not match, such as tax advantages, pension offerings, fewer fixed costs and pricing benefits. The fact that they were no longer limited by the income cap meant that they could create relationships with organizations like HCA and grow.
20. HCA also made reference to the Nicholson challenge, with NHS trusts set the target of generating £20 billion efficiency savings by 2015. HCA pointed out that, out of the 231 trusts, it was aware of at least 100 that were looking either to expand their private patient offering themselves or seeking partners to collaborate on developing new private patient capacity. HCA predicted that over the next two years, in particular, we were going to see signs of a greater private patient offering within the NHS.

### ***London NHS hospitals***

21. Despite this being difficult to measure, HCA thought that there was a significant competitive constraint from London NHS hospitals. According to the CC's own market research, a number of self-pay and insured patients went to NHS hospitals for higher acuity life-saving procedures because they believed they would be better off being treated there than at a private hospital.
22. In response to competition, HCA had changed its behaviour in recent times. For instance, it helped to move the boundaries in terms of cancer treatment by investing in technology and raising the protocols and standards for treatment. This was particularly apparent in areas such as cancer care. Ten years ago very few rare cancers were treated in a private setting, whereas now HCA had created a private alternative to the NHS.
23. Given that [REDACTED] and that its business model was mainly profitable due to its [REDACTED], HCA's focus in that area was on the highly-specialized and high-acuity treatments that these patients sought.
24. In relation to self-pay patients outside of London, [REDACTED].
25. When HCA looked at how its hospitals might become more competitive overall, it looked at the competition for consultants within specialities and more broadly. When it surveyed consultants and asked them what made the difference between a good hospital and a poor hospital, consultants usually talked about the quality of the facilities, the quality of nursing and other clinical staff, outcomes, clinical governance and the quality of their consultant colleagues.

## Negotiations with insurers

26. HCA recognized that insurers were concerned about the cost of medical insurance, however, HCA felt that the market needed to balance those pressures but not at the cost of harming innovation and resulting benefits to consumers from improving the way healthcare was delivered in the UK. HCA believed its focus on innovating, investing and being at the cutting edge of clinical practice by making new treatments available to consumers gave rise to a tension in the market, as evidenced by the relationship between Bupa and HCA. This was because the effect of HCA's investments was to make it possible for people with private medical insurance to get treatment in a private environment for illnesses (such as for some of the rarer cancers) that ten years ago just were not available under their private medical insurance policy. This expansion was creating a tension with PMIs. However, HCA felt that this tension also appeared to be due, in part, to basic misunderstandings between itself and the PMIs.
27. During negotiations with PMIs, [REDACTED]. HCA said that because of the nature of PMI negotiations, where the total relationship was considered, for one PMI it had negotiated a provision whereby [REDACTED].
28. When shown an internal document indicating that HCA had a [REDACTED], HCA noted that the internal document showed an estimate of HCA's share of market 'growth' and that the estimate was based on a subset of HCA's independent competitors instead of the whole market. HCA had never seen evidence that it had [REDACTED] per cent of the market share in London. It thought that it had [REDACTED] per cent of the beds in London and that Bupa had indicated to HCA that Bupa's spend at HCA hospitals accounted for around [REDACTED] per cent of Bupa's London PMI expenditure. HCA asked PMIs why was it that their customers travelled past the alternative hospitals that they could choose in order to be treated at HCA's hospitals. The answer was that HCA ran very good hospitals. HCA also pointed out that where it had been at the forefront of bringing in new technology and treatments, HCA would have obtained a high market share because it was the first to offer new services, but that this would change as other competitors followed with similar investments. HCA pointed out that the PMIs were promoting their non-HCA products to their customers, which showed that there was no shortage of consumer choice for products that did not include HCA hospitals. When provided with a choice, HCA believed that patients preferred its hospitals because they were great hospitals offering a high-quality service, for example, they were clean, provided good food etc.
29. HCA viewed the Boston Consulting Group data indicating that HCA had captured [REDACTED] per cent of growth of the total London market for the past ten years with a combination of pleasure at the thought that it was competing so successfully and scepticism at the figures, including, if they were accurate, whether they were sustainable.
30. HCA said that it probably seemed more expensive than the comparators used by PMIs, but that such straight comparisons were too simplistic. First, London was a more expensive place to operate than the rest of the country, but leaving that aside, there were several other factors that needed to be taken into account in these comparisons, including the fact that case mixes were not directly comparable and factors relating to the ownership status of its competitors, for example, some enjoyed sizeable tax advantages (relating to VAT and corporation tax) and free equity, such as hospitals owned by charities.
31. HCA believed that PMIs did have market power when negotiating with it. It also told us that the negotiations might have a different flavour if the industry were more

guided by the messages being sent it by consumers. Some of these messages included, for instance, that some consumers would be happy with products which did not include HCA options.

32. HCA confirmed that it did not offer individual prices for individual hospitals as part of its negotiations, but that it also did not see 'one in, all in' agreements with the PMIs, because this had never arisen. [REDACTED]. There were also clauses which referred to [REDACTED]. There were no clauses that created an automatic increase in price if the PMI recognized a competitor's hospital that it had not previously recognized.
33. [REDACTED]. HCA felt that this was a reflection of the fact that HCA was compelled to contract with Bupa as it was an unavoidable trading partner.
34. HCA thought that a PMI could realistically provide a sufficient scale of adequate coverage, including for high-acuity and specialized treatment, for its customers without HCA hospitals being included in a product, although it was not something which HCA had had to put to the test. HCA was aware that certain PMIs had been planning for such an eventuality. On the other hand, HCA did not think that it could live without insurer recognition.

### **Open referrals**

35. HCA saw Bupa's open referral scheme as introducing a significant shift in the way that the market operated.
36. HCA was opposed to open referrals, primarily on clinical grounds. First, it thought that the way in which Bupa introduced such a fundamental change to the market-place, ie without consultation, notice or discussion, was not constructive. Second, it did not believe that it was good healthcare for patients to be steered by their insurers, which had a financial interest in the process, rather than by their GPs. HCA thought that if Bupa had developed a mechanism for determining which consultants were good and which were not, that would represent a revolution in healthcare and that this mechanism should be subjected to some independent external scrutiny and shared with the industry, however, HCA was deeply sceptical about Bupa's algorithm. HCA felt its scepticism was, in part, justified by Bupa's reluctance to reveal how its algorithm worked, despite requests for its release to independent third parties. Third, HCA did not agree with Bupa restricting its list of consultants to those who did not shortfall, because that might not be in the best interests of the patient.
37. HCA had less frustration with AXA PPP's open referral system for two reasons. First, and in contrast to Bupa, it was offered on a non-mandatory basis. Second, when a GP made a referral to a specialist and did not object to which orthopaedic surgeon (for example) saw the patient, it was difficult for HCA in turn to object.
38. HCA had tried and failed to persuade Bupa that the Open Referral model developed by Bupa represented bad healthcare as it was devaluing the notion of private healthcare, where the service was highly personalized and the consultant was focused purely on the best clinical outcome. Relationships and trust were built up with patients over years and that relationship was being severed by an insurer, possibly to the detriment of the patient. HCA noted that it had seen a number of inappropriate referrals and people being referred to the wrong specialist. HCA had suggested to Bupa that it challenge HCA to cover some of the shortfalls encountered by consultants at its hospitals. It had also had conversations with customers and the intermediary community to ensure that they understood the downside of open referrals.

39. HCA found that London corporate customers were reacting differently to non-London corporate customers about open referrals—London corporate customers especially did not like the inflexibility and lack of choice of some open referral products.
40. HCA said that it was trying to sell the value proposition; that is, achieving better healthcare and innovation through spending more money and improving quality. [REDACTED]
41. HCA agreed that use of price comparisons by customers trying to compare HCA and its competitors was not a norm as it was often difficult to compare prices on a true like-for-like basis.

### **Consultants and consultant groups**

42. HCA did not find that the formation of consultant groups was affecting the way it was negotiating with them. Typically, HCA had conversations with individual consultants rather than with groups.
43. HCA told us that its discussions with consultants did cover fees, but that its primary relationship with consultants was about professional practice. No consultant was able to practise at HCA hospitals unless they satisfied the Medical Advisory Committee, an unpaid professional body, of their competence to do the type of work that they wanted to do with HCA.
44. In determining which consultants to grant practising privileges to, HCA looked at whether they were recognized in their field, whether there were lots of them coming to their hospitals (to create an attractive environment for other good consultants), and whether they had good reputations and standards. They were required to undergo a rigorous process. This included being interviewed by the Hospital CEO, providing documents required by the CQC and providing appropriate references. Their practice might also be monitored over a period of time.
45. HCA did not deal directly with anaesthetist groups (or any other groups), but if and when it got into offering packages directly to UK customers, HCA anticipated that such conversations might arise.
46. HCA was worried about the effects that the dramatic and unprecedented reduction in consultant reimbursement that Bupa had recently brought in would have on its business, but it had not to date witnessed consultants exiting private practice altogether due to the real terms cuts to reimbursement rates. HCA pointed to the National Audit Office report which described the doubling in the number of consultants over a ten-year period without any increase in the number of those doing private practice. HCA said that this highlighted the effects of NHS policy explicitly intended to discourage consultants from undertaking private practice outside of the NHS.
47. HCA did not have [REDACTED] with consultants [REDACTED].

### **Barriers to entry**

48. HCA would consider building new hospitals in central London if the opportunity arose.
49. HCA agreed that it was not easy to find locations that could be developed as a private hospital, however, it felt that a diligent hospital operator should be able to spot opportunities in the market by talking to developers. HCA believed that, provided

some creativity was applied, for example, on how to adapt a period building so that large and sophisticated diagnostic technology could be installed, solutions could be found by any hospital operator. HCA gave a number of examples of full-scale hospital development opportunities it had recently identified in central London. HCA said that there were currently quite a few opportunities under development. HCA also agreed that it was easier for PPUs, which had access to existing clinical infrastructure and activity, to enter and expand their business.

50. With regard to risk sharing with PPUs, HCA told us that each partnership was different but that that generally [redacted]. Then there would either be a revenue share or profit share split between the parties.
51. HCA would like to expand outside of London beyond the Christie in partnership with PPUs and through acquisition of specialist outpatient and day-patient facilities of its own. The main constraint for HCA was getting PMI recognition from Bupa, in particular. HCA recalled a previous discussion with Bupa in which it was made clear [redacted]. HCA felt that Bupa should be able to make recognition subject to the satisfaction of quality criteria, however, it was concerned by Bupa's potential to hold up investments by hospital operators. For example, Bupa could decide and had decided, shortly prior to when a facility was due to open, to withdraw its assurance of recognition unless the rates for that facility were further discounted. HCA believed this process was not conducive to investment.
52. HCA would also be willing to establish new outpatient and diagnostic facilities, for example, within the catchment area of a PPU, but only if there was an untapped need and requirement for it.

### **Vertical integration**

53. HCA had invested in primary healthcare as it saw it as part of the activity that it was already involved in. With trends in healthcare moving towards more of a focus on day-patient and outpatient care HCA saw a move into primary healthcare as a natural step. In addition, it saw other big companies such as Bupa, AXA PPP and Nuffield operating in that market. The opportunities in primary healthcare that HCA was involved with were ones that it was made aware of rather than HCA identifying them.
54. HCA confirmed that some of the GPs did hold minority equity stakes in the primary healthcare businesses, but that there were no obligations on or incentives to any GPs, whether they had an equity interest or were employees, to refer patients to HCA hospitals. This was also the case where any consultants had an interest in diagnostic centres with which HCA entered into a joint venture. Where there were dividends paid, [redacted]. Patients were made aware of any consultants' interests in these primary care facilities.
55. HCA explained that while the strategy behind investment in primary healthcare facilities was not to generate patient referrals to HCA hospitals, it was to create another point at which patients could access its services, and so to that end it did expand HCA's footprint and activity in private healthcare generally.
56. A very large proportion of people who had private medical insurance did not make use of it, opting to use the NHS instead. HCA did target GPs with marketing material and did ask for feedback as to how it could improve its standard of service in certain areas so that it could compete to get referrals.
57. HCA did not systematically monitor referrals from GPs, but it had in the past been able to estimate where a significant number of its referrals were coming from. For

HCA, this was a key determinant of how successful its hospitals were and therefore informed HCA strategy. [REDACTED].

58. [REDACTED].

### **Consultants and incentives**

59. HCA advised that within the healthcare sector, consulting rooms were generally licensed out to consultants based on licensing fees which tended to be less than [REDACTED] because there was no tenure, the leases were not long term, and there was no security. However, HCA said that this did not imply or create an obligation to refer patients to an HCA hospital. There was a convenience factor for patients in terms of accessing an HCA hospital, but there were no obligations or incentives for consultants to refer.

60. The business rationale for HCA's acquisition of Leaders in Oncology Care (LOC) was to access the gold standard in day-case chemotherapy treatment to be able to roll it out to its other chemotherapy units. [REDACTED]. LOC consultants were not obliged to refer their patients to HCA hospitals, and in preparation of the hearing, HCA said that a substantial proportion of the doctors' referrals from LOC had continued to be made to competing hospital operators. HCA had also reviewed their contracts in the past couple of years to ensure that they reflected good clinical practice.

61. In terms of what drove referrals and whether it was incentives or other factors which were unrelated to incentives, HCA drew evidence from the CC's survey. The survey stated that 75 per cent of consultants tended to practise largely at one facility. HCA suggested that this was driven by factors like convenience, quality and a desire to work alongside other doctors at the top of their respective fields.

62. HCA had professional service agreements with consultants, under which consultants provided services such as medical directorships, assistance on clinical governance meetings etc. Those agreements were determined based on a fair market value assessment.

### **Profitability**

63. [REDACTED] This was historically the case and their track record of growth as well as profitability had been high. HCA believed that this was mainly due to all the reasons discussed previously and significant capital reinvestment back into the facilities to make them relevant and world class.

64. There were cost synergies of being part of a group. HCA had a shared services model for back office functions such as payroll, billing and collecting, purchasing and payables. It also held negotiating powers with respect to purchasing medical equipment, and clinical practice benefits with respect to sharing best practice across the hospitals.

65. [REDACTED] HCA noted that it would be submitting its detailed response to the CC's paper on profitability very shortly, which would provide a more considered analysis.

66. If international business were to stagnate, [REDACTED]. HCA would then be less inclined to invest as boldly as it had done in the recent years.

67. HCA was actively improving the way it marketed its self-pay patient services as it felt [REDACTED] in terms of how its treatment packages were marketed and how information was



presented to potential patients. For those services, such as IVF treatment, HCA had developed a good self-pay model, where attractive package pricing offerings had been developed and outcomes were published in a clear way for very educated consumers to make decisions on quality and outcomes. In respect of other services, further work was required on how best to present self-pay services to patients in order to match some of HCA's competitors. When it was more difficult to make pricing decisions, HCA attempted to triangulate on a price using different data points, including looking at what others were doing in the market, covering its own costs and looking at its agreements with PMIs. Most common items had published pricing but as more esoteric procedures arose, HCA had to create different pricing.

68. HCA had an idea of what its competitors were charging for insured pricing based on what PMIs told it during negotiations, but it had not necessarily had clear (first-hand) visibility of what competitors were charging them. It did consider consultants a good source of pricing information because consultants were sending their bills to the insurers, and did not pay attention to price. HCA did not know what its prices were like in comparison with its competitors.
69. HCA acknowledged that it would not be surprised if it was the highest priced provider because it was in central London, where operating expenses were the highest and it did not have tax breaks, among other things. HCA was competing with charities and PPU's with a very different cost base. The difference in its price per bed compared with its competitors was in large part due to the high acuity of its treatments. HCA felt that [REDACTED], it seemed that its return on capital was about where it should be and the capital asset model was what the industry suggested it should be.
70. HCA commented that in the intermediate markets where there were bilateral negotiations, prices were not generally made public. In markets where prices were not disclosed, it was quite possible to have more intense competition than in markets where prices were disclosed, ie there was no link between the knowledge of pricing and the effectiveness of a competitive constraint exercised in the context of bilateral negotiation. Also, in the healthcare market there were large degrees of product differentiation, in terms of different services provided and in the quality of the services provided. So any price differences would have to be seen in the context of the quality and the type of service provided.
71. HCA also said that it had reinvested and continued to reinvest a large amount into its business and that that carried a very expensive price tag.
72. HCA believed that it was a feature of the market that [REDACTED], in the sense that its international business was based largely on high-acuity treatment for patients who might fall into a segment of the market that was [REDACTED], although equally one had to recognize the level of capital investment required to create the kind of products needed to attract these patients.
73. In terms of growth, HCA saw merit, quality and price for customers choosing HCA hospitals, both domestically and overseas.

### **Final points and summary**

74. As competitors upped their game in terms of the quality of service provided in their hospitals, HCA invested to match that, indicating that there existed a continuum of competitive response.
75. HCA identified key competitive events in the market place, including the London Clinic's investment in its cancer centre of £80 million, and the 2008 Cromwell

acquisition for £90 million by Bupa and Bupa's subsequent £30 million investment in the hospital, and the Lindo Wing upgrade.

76. In addition, HCA saw Bupa's cuts in reimbursement rates to consultants as an unusual event that had triggered a change in the way that the market operated and providers competed.
77. HCA believed that the removal of the income cap on PPUs was a game changer. It changed the nature of competition in the marketplace, as evidenced by the number of PPUs that were looking to increase their income through partnerships with private hospitals.
78. HCA also saw the development of consultant groups, which related to doctors coming together to exert market influence in a way that had not been commonly seen in the marketplace before as a significant competitive development in the market.
79. HCA reiterated that London was a very competitive market. There were a number of competitors in different categories and HCA had to focus hard on making sure that its hospitals were of the highest standards and that they could provide the best possible service to the consultants, who brought their patients to HCA hospitals and made HCA hospitals more successful in turn.
80. HCA believed that innovation was a key source of competition in the market, and that it had built its position on years of careful investment. Price was also important, as was the focus on quality of care.
81. HCA believed that PMIs had significant market power, and that there were barriers to entry in terms of PMI recognition. HCA also acknowledged that there were barriers to entry in terms of access to capital and planning, but said that these were not insurmountable.
82. HCA recognized that there was more work for it in respect of vertical integration, and information sharing in order to increase transparency for consumers and PMIs.