

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with Spire Healthcare held on 14 March 2013

#### Introductory remarks

1. Spire raised three introductory issues it wished to address concerning the private healthcare industry: how the industry had evolved over the past five years; how Spire's business had developed over that same period; and the importance of ensuring that choices were available to patients.
2. Spire had observed five key trends in the development of the private healthcare industry over the last five years. First, it had seen an increasing range of treatments available to patients through the private healthcare sector that were historically only available through the National Health Service (NHS). Spire had also seen growth in the number of alternative private healthcare providers including 'high street' providers supplying services that had traditionally been available in the hospital sector. For example, Optical Express which offered ophthalmic services to customers.
3. Spire had also observed an expansion in the supply of home-based healthcare, beyond palliative care into services including chemotherapy, as well as the emergence of consultants establishing independent private healthcare services. Spire noted that there had been a growth in the provision of private healthcare services by private patient units (PPUs) and the NHS, with an estimated 50 per cent of insured patients being treated in the NHS system.
4. Since its acquisition by Cinven in 2007, Spire had invested heavily in distinguishing its business from the NHS and other providers. It had invested in new bedrooms, theatres and consulting rooms at its facilities, new imaging services and developing more efficient, less-evasive techniques, which aimed to reduce private medical insurers' (PMIs') costs and improve the clinical experience of patients.
5. Spire had expanded its range of services available to patients, including by offering cancer treatment, cardiothoracic surgery, neurosurgery and bariatric services, which had traditionally been available to patients through the NHS. It had also brought in a consultant base to provide a wider range of treatments to patients and decentralized its management structure allowing local hospital directors significant autonomy and ability to respond to local market conditions.
6. Spire noted that patients in the UK had the choice between private healthcare and healthcare that was free at the point of provision throughout the NHS. It therefore considered that it competed with the NHS at all points along the patient pathway, including to attract patients at the outset and to prevent them from switching to the NHS at a later stage of treatment.
7. Spire made two preliminary comments on the annotated issues statement (AIS) published by the Competition Commission (CC). It considered that as the CC's analysis focused on inpatients, it ignored the industry trend away from inpatient care to day-case and outpatients, which was reflected in Spire's business. Spire also had a different view on the relative bargaining strengths of PMIs and hospital operators.

## Competition between hospital operators

8. Spire considered that it competed with other private hospital operators on a local basis. It identified its competitors to include Nuffield, BMI, Spire, Aspen and Circle among others. Spire decided how it would compete with a given hospital operator based on its offering in an individual local market, rather than at a national level.
9. Spire also identified the NHS as a competitor. It competed with the NHS for free at the point of delivery for NHS patients as well as with PPU's. The NHS was the fourth largest provider of private patient work in the UK, but was more significant in England than elsewhere in the UK. Spire considered that the NHS had a competitive advantage over it in the provision of intensive care facilities.

## Competition in London

10. Spire operated five hospitals on the periphery of London. [REDACTED]
11. Spire said that the extent to which its outer London hospitals might compete with those in central London needed to be considered on a procedure-by-procedure basis. For example, its hospital in Bushey would be able to compete with central London hospitals on orthopaedic care, and its Southampton hospital would be able to compete on more complex services. However, Spire said that its five hospitals would not compete on a broadband basis for all of the services that central London hospitals offered.

## Pricing

12. Spire's pricing for self-pay patients was [REDACTED]. Spire indicated that it monitored its competitors' prices for self-pay patients on a local basis, often by conducting cold calls or reviewing information available on websites.
13. Spire said that the level of competition it faced from the NHS varied from location to location, depending on the NHS waiting list and the level of funding. If there was a strong NHS trust, with no issue regarding waiting times and funding, there tended to be a correlation between that and demand for PMI and self pay.

## Negotiations with PMIs

14. Spire said that in approaching its negotiations with PMIs, it was looking to enter into a long-term agreement, that was a period of two to three years, and to achieve annual price increases to cover its costs. It also aimed to explain to PMIs how Spire had improved its business. Spire's priority was also to ensure that all of its hospitals could compete for patients, by getting its hospitals on to every type of product that the PMI offered. If it was excluded from a network, it could not compete.
15. In Spire's view, the larger PMIs primarily focused on the bottom line in their negotiations with hospital groups, while smaller PMIs were looking to achieve coverage, the best possible quality outcome for their members and a hospital directory that they could sell their product from.
16. Spire said that the agreements which it reached with PMIs [REDACTED].
17. Spire did not agree that PMIs were at a weaker bargaining position to it and other hospital operators in negotiations. There was a risk that PMIs, in particular BUPA,

might delist its hospitals at any time. BUPA had shown that it would do so in its recent negotiations with BMI.

18. Spire said that although it had a contract with BUPA, [REDACTED]. It would have no choice but to compete at the tender price or otherwise it would lose activity Spire said that in its current negotiations with BUPA, [REDACTED].
19. Spire considered BUPA and AXA PPP to be 'must-have' insurers. Whether smaller insurers would be considered by Spire to be must-haves was dependent on individual markets.
20. [REDACTED]

### **Agreements with PMIs**

21. Some of Spire's contracts with PMIs provided for [REDACTED]. These types of agreements were a remnant of the restrictive networks which PMIs sought to introduce in the late 1990s. [REDACTED]
22. Spire said that it was not [REDACTED]. It wanted to compete equally with every hospital and would like every PMI product to have every hospital on it so it was competing equally with other providers.
23. Spire's contracts with BUPA [REDACTED], however, its contracts with AXA PPP [REDACTED].

### **Controlling of costs by PMIs**

24. Spire provided its views on three initiatives that PMIs had introduced to control their costs: service line tenders; low-cost restrictive networks; and open referral schemes.
25. PMIs had introduced service line tenders in relation to services where volumes had increased over time or there had been an improvement in technology, which had reduced the cost of providing the service. Spire did not object to service line tenders, so long as it was provided with reasonable notice by PMIs. Spire said that if it was provided with short notice about a service line tender, which might require it to offer up to a 40 to 50 per cent discount from the current price on a certain service, it might cause delay or lead it to cancel its other capital plans.
26. Spire would not typically be concerned if it was excluded from low-cost networks, depending on how the PMI offered the product. Spire had participated in tenders to join BUPA's and AXA PPP's low-cost networks [REDACTED], although it had been included in PruHealth's baseline product. Spire had been in discussions with AXA PPP to be included in its Health Online low-cost network, which had been gaining market penetration, [REDACTED]. Spire did not consider that there had been significant take-up of BUPA's low-cost network. Spire believed that the private hospital product was very good and that if PMIs had every hospital included, they would probably be able to sell their products more easily and work with corporate customers to understand the private healthcare market.
27. Spire had heard that as a result of open referral schemes, some consultants were looking to leave the market because the fees they were being asked to sign up to by PMIs did not justify them continuing in private practice. Anecdotally, Spire understood that new consultants were choosing not to enter private practice, as it was not an appealing opportunity by the time they had to manage set-up, indemnity and other costs.

28. Spire did not consider that open referral schemes were in the best interests of patients, because their choice of consultants was restricted by such schemes. Spire provided an example of where a patient had been directed by an open referral scheme to a consultant who had not properly performed a procedure, and required a new referral for it to be carried out again by a more suitable consultant.
29. Spire considered that if open referral schemes were more widely adopted, it would be likely to provide PMIs with increased bargaining power in their negotiations with hospital operators, as they might direct patients to other private hospitals or the NHS.

### **Consultant groups**

30. Spire suggested that it had seen benefits in working with some consultant groups. For example, in an area such as urology, there might be a group of four urologists that covered different sub-specialties. This could be beneficial as it provided a single point of referrals for general practitioners (GPs) into a trusted urology brand. Spire said that consultant groups could use these benefits to their advantage in negotiations with PMIs, but considered this to be within their remit. It could not say whether this allowed consultant groups to demand a better fee or not in negotiations with PMIs.
31. [✂]
32. Negotiating with groups of anaesthetists on price could be challenging. In most cases, Spire had had to conform to the anaesthetist group's demand in terms of price. Spire was not aware of any local markets where it had a problem in securing an effective price with a group of anaesthetists because they were the only group available in the particular region.
33. Spire had heard a range of 'noise' in the industry about consultants' response to actions taken by BUPA. This included in response to price decreases, open referral schemes, doctors who were losing referrals and doctors who thought they were fee-assured not getting Spire's patients. BUPA had written to doctors and given them only two to three weeks' notice of a price change. Spire had observed a lot of tension between doctors and BUPA.

### **Incentives and vertical integration**

34. Spire did not agree with hospital operators providing incentives to GPs for referrals. Spire was aware that BMI had provided incentives to GPs for a triage service and report writing in some locations in the past and Circle at some stage was issuing equity to GPs as well as cash payments. Spire considered it inappropriate for hospital operators to pay or incentivize GPs to refer patients to their hospitals, as it undermined the concept of choice.
35. Spire indicated that it employed GPs as part of its health screening service. Spire essentially acted as a franchisee to provide this service on behalf of BUPA. It would pay the GP a fee for undertaking the screening process, but there was no link between it and Spire's hospital activity. Many of the GPs that worked for Spire's screening service were locums and did not have a patient list, therefore they could not influence referrals. Spire also worked with GPs in an advisory capacity in relation to its hospital committees, to assist it in understanding the market and new product development. In some instances these GPs received a fee, but Spire did not have any evidence of this influencing referrals.

36. Spire did not provide incentives to consultants to refer patients to its hospitals. Spire had some local arrangements to attract and retain consultants—which affected less than 5 per cent of its national consultant base—such as discounts from rates, but it did not consider that these arrangements had any connection with bringing patients into hospitals. Spire said that the consultant’s fundamental duty was to act in the best interests of patients and for that reason it would not look to require a consultant to bring a patient to it or have any kind of exclusivity.
37. Spire had not encountered any issues with or seen any evidence of consultants over-treating patients, by carrying out, for example, unnecessary scans or tests, as a result of the payment of incentives. Spire said that it met with counterparts of the main PMIs on a regular basis and that this issue had never been raised with it. If Spire was aware of any patients being either under-treated or over-treated by any of its consultants, it would have and would take action.
38. Spire had a joint venture with a group of consultants, the ‘Spring Group’ in the Brighton market. At the time that Spire was looking to enter the Brighton market, the Spring Group was equally looking at setting up a service towards Hove and had identified a building it wished to use. Spire effectively funded the construction costs of the site. [REDACTED] Spire considered that the joint venture delivered a market opportunity for it and while the Spring Group was locked into an arrangement with Spire for a period of time, it was not an extensive period of time that reflected the investment that was made.

### **Barriers to entry and expansion**

39. Spire did not consider that it faced any barriers to entry in new markets, but there were a number of internal and external considerations which it took into account in determining whether to enter a market. These considerations included whether there was sufficient local demand for a new hospital in light of the economic conditions and level of PMI penetration in the relevant area. Spire also needed to ensure that it could have its facility recognized by the major PMIs.
40. Another issue Spire would consider was whether there were any restrictive networks in play and any local arrangements in place between existing hospital operators and consultants and/or GPs. Availability of management expertise, access to capital and the strength of local competition, including the NHS and PPU were also important considerations in evaluating entry. Spire did not rely on demand from NHS patients in determining whether it would enter a new market, as this demand could be turned on and off relatively quickly.
41. Spire would be typically looking at a lead time of two to three years into a new opportunity, where it had a well-established investment case. There had been evidence in the last five to six years of entry into the market both in terms of full-service hospitals and other types of entry.
42. Spire said that to enter the central London market, a hospital operator needed to find the right building, the right proximity to a trust and an ability to market itself in the area in order to be successful. Spire noted that the lead time for a new hospital to build credibility, given the complexity of the offer, would be longer in central London than in a different market, with a different aim or a less complex offer. More investment and more lead time would be required to generate returns.
43. Spire said that the new entry of Circle in Reading had impacted its Dunedin hospital. [REDACTED]

44. In Spire's view, new entry in the private healthcare industry was not only about establishing full service hospitals. The main game in its opinion was being played out underneath that, for example, through satellite clinics, which it had seen distort referral patterns. There were a lot of satellite clinics opening all the time and single-service providers—such as Optegra for ophthalmology services, the Vale for orthopaedics in Wales or Nucleus for endoscopy work—were emerging. It also noted the growing popularity of home healthcare, particularly in cancer treatment, which it considered was taking work away from full-service sites. Spire also believed that the NHS and PUs were hiring in management expertise and becoming a proper competitive threat.
45. Spire had also seen a number of overseas players entering the market including Nueterra, the University of Pittsburgh Medical Centre, Topishikai from Japan and Optegra from America. Spire said that there was an awful lot going on below the full-service space and considered this to be the changing face of private healthcare in the UK.

### **Profitability**

46. Spire agreed that its profitability had improved significantly in the period from 2007 to 2011. It described a number of drivers of its growth in profitability including a significant growth in its volumes or number of patient episodes as well as investments which it had made in expanding the range of services it offered. Spire had also reduced the business's fixed costs substantially and had been able to reduce costs further as activity had increased. This had played a considerable part in how overall profit margins and, to a certain extent, absolute profitability, had increased.
47. Spire's investments in quality had delivered benefits to the business in terms of improving clinical cost efficiencies. Spire's NHS mix had also changed and its ability to use NHS work to utilize marginal capacity had had a scale benefit. Spire noted that its prices had not increased outside of inflation parameters over the last five years.
48. Spire considered that over the next five years, its growth was likely to be derived from adding additional services to its offering. This included both on-site and off-site services [X]. Spire also referred to the ageing population as a source of growth, noting a source which predicted that over the next 20 years, there would be 50 per cent more patients over the age of 55 when compared with current figures.

### **Closing remarks**

49. Spire confirmed that in its view, the NHS generally as well as PUs competed with its hospitals. Spire wanted to be able to negotiate with PMIs in an open fashion, but it struggled to do so as the PMIs' goalposts changed all the time.
50. Spire shared the CC's interests in improving patient choice and considered that there needed to be openness and transparency. Spire considered that GPs played a significant role in this regard and referred based on a lot of information they received from the NHS and knew the consultants which they worked well with.
51. Spire expressed some concern in relation to the CC's LOCI analysis. It considered that LOCI analysis presented the same problems as catchment analysis as market shares were being calculated based on arbitrary geographic areas or sub-markets. As such, aggregating market shares might not lead to meaningful figures in economic terms.