

# Bupa Health Funding

## Response to Working Paper

### Barriers to entry and expansion

#### 1) Overview

- 1.1 Bupa Health Funding (“BHF”) welcomes the three in-depth case studies on hospital entry published by the Competition Commission (“CC”) on 31 May 2013. This response sets out our comments on some of the important findings the CC has reached about barriers to entry and expansion based on these case studies. The CC also published a Working Paper on “*Hospital competition for clinical referrals*” on 5 June 2013. This response addresses the findings of that Working Paper to the extent that the CC considered the effects that consultant incentive schemes have as entry barriers.
- 1.2 Please note that we also made substantive comments about barriers to entry and expansion in our Annotated Issues Statement (“AIS”) response<sup>1</sup>.
- 1.3 In relation to the case studies put forward by the CC, we note three points at the outset:
  - i. The contestability of local hospital markets, particularly with respect to inpatient services, is manifestly limited<sup>2</sup>. It is clearly not a market where ‘hit and run’ entry is possible.
  - ii. Only Circle’s entry into Bath (“the Bath Case Study”) is an example of the entry of a full service-line hospital providing inpatient services. The London Clinic’s (“TLC”) Cancer Centre example (“the London Case Study”) is an incumbent provider expanding its presence in a local market. The case study of The Edinburgh Clinic (“the Edinburgh Case Study”) is an example of entry on a limited scale only i.e. outpatient/day-case services without inpatient services.
  - iii. The CC’s three examples are instances of successful entry, where barriers were overcome. However, this is a very limited sample and should not be interpreted as suggesting barriers to entry are surmountable in all or even most local markets<sup>3</sup>. We expect that, while operators frequently contemplate entry into local markets, most plans do not make it off the drawing board because of the significant barriers to entry identified by the entrant. The CC should also look at cases of abandoned or failed entry to get a full picture on entry barriers and avoid selection bias. We note, for example, that in the Edinburgh Case Study there is evidence that Circle aborted entry even after acquiring a £9 million site.

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<sup>1</sup> BHF AIS Response, paragraphs 2.151 to 2.179.

<sup>2</sup> The AIS (Appendix E, paragraph 3) explained the CC had identified only seven instances of entry in the previous five years: Circle Bath and Reading, Nuffield Health in Cardiff and Guildford, BMI in London, The Edinburgh clinic and Kingsbridge hospital in Belfast. We are also aware of Spire entering in Brighton.

<sup>3</sup> For example, each case study considers entry into urban areas where dynamics of private healthcare demand are favourable (even here, in both the Bath and Edinburgh Case Studies there is evidence that BMI did not consider these areas could support a second hospital). Clearly, however, many local markets in the UK face weaker demand meaning that the incumbent is protected from new entry because a new hospital could not achieve efficient scale.

1.4 With these comments as context, BHF believes that the three case studies share some common themes:

- i. **Incumbents used tactics to raise entry barriers:** Incumbent providers have the incentive and ability to discourage entry<sup>4</sup>. In each case study there is evidence the incumbent sought to make entry more costly and uncertain for the rival. Examples of protectionist strategies include 'opt out' consultant incentive schemes, strategic capacity expansion, and applying pressure on private medical insurers (PMIs) not to recognise the new facility. Further there is evidence that these actions or threats from the incumbent do impact the entrant's decision-making<sup>5</sup>.
- ii. **Relatively muted pro-competitive response from the incumbent:** Other than Spire's strategic capacity expansion in Edinburgh, where the threat of entry did encourage the incumbent to invest in new services, the scale and scope (in terms of equipment and specialisms) of any investment by the incumbent appears relatively small. For example, BMI's response in the Bath Case Study was to replace equipment in its Endoscopy suite that was already 10 to 13 years old and of degraded quality (and so ripe for reinvestment in any event). Capital investment made by Spire Murrayfield in the Edinburgh Case Study appears to be around £3.3 million (spread over several years), which again appears relatively small in the context of the Edinburgh market of over £20 million per annum<sup>6</sup>. Further, there is little evidence that incumbents responded to the entry by lowering prices to PMIs or self-pay patients. Indeed, incumbents threatened higher prices to PMIs if their volumes fell.
- iii. **PMIs did not act unreasonably:** Most PMIs recognised the new entrants without issue or delay, often in the face of significant pressure not to from the incumbent. [§<]. Where AXA or Aviva exhibited reservations in recognising the Circle Bath these appear to have been driven to a large extent by concerns that there was no need for additional provision in the local market and by concerns about upsetting BMI [§<].

1.5 BHF is, however, concerned that some of the CC's emerging conclusions are not supported by the evidence. **We ask the CC to reconsider** the following:

- i. **Consultant incentives schemes:** The case studies and Working Paper on '*Hospital competition for clinical referrals*' appear to conclude that consultant incentive schemes do not necessarily cause barriers to entry, principally because they are available both to the incumbent and the entrant. We agree that consultant incentive schemes may not be an insurmountable barrier in every case; however, we would strongly disagree if the CC's emerging thinking is that consultant incentive schemes have no impact on entry barriers. Where used by a dominant incumbent we believe these schemes can be used strategically to discourage or exclude entrants. See Part 2 below.
- ii. **PMI recognition.** The CC concludes that PMI recognition was the most significant barrier in the Bath Case Study, with the impression that recognition is cast in a negative/anticompetitive light. We disagree with this interpretation. Insurers act in their customers' interests in making recognition decisions. Insurers have strong incentives to work with new entrants that offer high quality and affordable care. However, insurers also

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<sup>4</sup> The CC notes that the incumbent faces "a different calculation than a new entrant when deciding whether or not to expand, with the potential costs of losing its existing *solus* position being taken into account". For example, the Edinburgh Case Study explains that Spire's internal business case for investing in a new hospital stated that "its ambition would be to deter Circle or other competitors from entering the market" (paragraph 31). Further Spire believed this strategic investment was a successful deterrent: "Spire noted in internal documents that it believed that its construction of Shawfair Park caused Circle to withdraw from Edinburgh" (paragraph 48).

<sup>5</sup> The Bath Case Study explains that Circle was concerned about 'guerrilla' tactics by local incumbents in its risk assessment of entering the Bath market (paragraph 25). It had been a victim of guerrilla tactics when its application to build a new hospital in Southampton was taken to appeal by rival hospitals.

<sup>6</sup> The Edinburgh Case Study notes "In 2007 Circle saw Edinburgh as a market with PMI and cash pay revenues in excess of £20m" (paragraph 26).

have a responsibility to their customers to make sure that entry will improve competition/outcomes so in some cases the insurer will, not unreasonably, not recognise a new facility or at least continue to negotiate with that hospital until improved terms are reached. A larger hospital may affect an insurer's recognition of the entrant if it threatens to impose significant additional costs on the insurer; this is however an anticompetitive action by the hospital, not the insurer, and not a situation that the insurer would *willingly* participate in. See Part 3 below.

- iii. **Entry barriers in London:** The emerging conclusions in the London Case Study understate the extent of entry barriers in Central London. See Part 4 below.

- 1.6 We would ask the CC to recognise also that certain types of entry barriers have not been identified in the context of the three case studies, but could be material in other circumstances (see Part 5 below).

## 2) Consultant incentive schemes can raise entry barrier

- 2.1 We believe that consultant incentive schemes can have exclusionary effects when applied by a dominant incumbent to raise the costs of smaller rivals and entrants.
- 2.2 We, therefore, have concerns that the CC appears to be discounting the effects of consultant incentive schemes on entry barriers. The Working Paper on '*Hospital competition for clinical referrals*' sets out the CC view that:

*"87. For such schemes to constitute a barrier to entry, they would have to prevent or deter (a) a sufficient number of consultants in (b) a commercially important specialty from practising at all or for a significant proportion of their time at the entrant's facility. In addition, the ability of the entrant to make such schemes available would have to be constrained relative to the incumbent's ability to do so.*

*88. We have seen no examples of contractual arrangements between PHPs and consultants that would prevent absolutely an individual consultant from working for a rival. In all cases, any such general obligations have been qualified by, for example, the overriding need to take account of the patient's clinical interest. However, and even with these caveats, such arrangements may, in practice, lead a consultant to work exclusively or predominantly at the PHP's facilities even if he or she were not prevented from working elsewhere by contractual obligations since to do so might be more convenient than 'multi-homing'.*

*89. We have also seen that such arrangements may be entered into with groups of consultants who are increasingly establishing 'chambers', partnerships or other business entities which enable them to deal with hospital groups jointly. In these circumstances it would be possible for a hospital operator to enter into agreements with a large proportion of local consultants in a particular, commercially important, specialty more quickly and easily than it could do if dealing with consultants individually.*

*90. However, we note that such strategies are available to the entrant as well as to the incumbent."*

- 2.3 The London Case Study concludes:

*"79. There is more evidence to suggest that the ability of hospital groups to identify clinicians who are likely to be significant sources of patient referrals and admissions (and thus revenue) and to then encourage them to admit or refer patients to their hospitals rather than rivals' might restrict entry and expansion.....However, this case study has demonstrated that such measures may also be open to the entrant as well as the incumbent... We therefore do not consider that, on the basis of these two episodes of entry and expansion [Circle entry into Bath and TLC expansion], that such arrangements necessarily constitute a barrier to entry"<sup>7</sup>.*

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<sup>7</sup> The London Case Study, paragraph 80.

- 2.4 We agree that consultant incentive schemes will not be barriers to entry in every case i.e. not inevitably or “necessarily”<sup>8</sup>. But there are circumstances in which consultant incentive schemes increase entry barriers. The CC must recognise this risk and factor these concerns into the adverse effects on competition analysis of consultant incentive schemes. In particular, we believe the CC’s two-part test in paragraph 87 of the quotation above can often be met by a dominant incumbent. The CC’s two-part test is:
- (A) Do the incumbent’s incentive schemes foreclose a material amount of revenue from the entrant? AND
  - (B) Is the entrant’s ability to offer schemes constrained compared to that of the incumbent?
- 2.5 In respect of (A), we agree that an exclusionary effect is only likely to arise if a ‘material’ amount of revenue is foreclosed from the entrant. However, as the CC knows, the incumbent may have to lock in only a small number of ‘high revenue earning’ individual consultants or a key chamber/group of consultants to have a material effect on the entrant’s viability<sup>9</sup>.
- 2.6 The London Case Study provides an interesting thought experiment. TLC planned its Cancer Centre on the basis of an ongoing, deepening relationship with the key oncology consultants in the London Oncology Clinic (“LOC”).<sup>10</sup> However, unexpectedly for TLC, Hospital Corporation of America (“HCA”) bought a stake in LOC in 2010. Now, by this time the Cancer Centre had already opened and HCA has since argued that LOC consultants have continued to take patients to TLC post acquisition. However, we believe that, had HCA bought the stake in LOC earlier, TLC would not have gone ahead with its Cancer Centre expansion (or certainly not on its current scale). The expansion would have been undermined by the significant uncertainty over whether TLC could attract sustainable volumes from HCA-affiliated LOC consultants. Therefore, had HCA acted earlier, it could have foreclosed TLC entry (and the tying of LOC to HCA may have already dissuaded entry by other potential providers of Oncology services in Central London).
- 2.7 In respect of (B), there are a number of reasons why an incumbent has a significant advantage over the entrant in offering these schemes.
- 2.8 First, even when the incumbent’s scheme can be matched by the entrant it will raise costs (with no commensurate benefit to patients), and in raising costs will make profitable entry less certain. The risk that the entrant may have to enter into a costly, consultant incentives arms race with the incumbent may dissuade entry.
- 2.9 Second, the entrant will likely have to “**more than match**” the schemes offered by the incumbent given the incumbency advantages of:
- i. The incumbent having existing day-to-day contact and relationships with local consultants.
  - ii. The incumbent having the ability to offer consultants benefits prior to the entrant starting operations.

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<sup>8</sup> We recognise that both Circle and the Spire Brighton entered the market using consultant incentive arrangements – i.e. consultant equity models. However, we continue to have concerns about the impacts of this business model in encouraging unwarranted variation, consultant switching costs, and information asymmetry.

<sup>9</sup> The effect could be magnified if the incumbent tied in specialists in a critical specialism, where without this specialism the entrant could not offer effective competition in the local market (and could not therefore attract sufficient numbers of consultants and patients for other specialisms).

<sup>10</sup> “Certain oncologists had been identified as a significant source of patient referrals by TLC, in particular those associated with what was to become the London Oncology Clinic (LOC).” (Paragraph 40) “It is clear from the minutes of senior management meetings that TLC assumed that it would continue to work closely with LOC and its consultants and this assumption was factored into TLC’s plan projections.” (Paragraph 63)

- iii. The incumbent having the established hospital facility and reputation. This makes it less risky for the consultant to stay with the incumbent than relocate his or her practice to an entrant with an as yet unproved record<sup>11</sup>.
  - iv. The incumbent having the ability to punish the consultant who signs with the new hospital (e.g. through suspending practice privileges or not making available theatre slots). This threat becomes more significant in solus markets where the consultants have no choice but to return to the incumbent if the entrant later aborts.
  - v. The entrant needing to match existing financial incentives but also to overcome additional switching costs that the consultant may have e.g. the costs of relocating their practice.
  - vi. The entrant needs to achieve a critical mass of consultants at its hospital to be viable. So it may need to offer attractive incentives to a large number of consultants. By contrast, the incumbent benefits from (a) knowing which consultants are of most value, and (b) only needing to target that relatively small part of the entrant's consultant base that would prevent it reaching critical mass.
- 2.10 Each of the case studies illustrates that incumbents used or considered using incentive arrangement with consultants to protect against entry. The Bath Case Study, for example, shows that [X]. The nature of these schemes is particularly revealing: in addition to seeking to match Circle's financial incentives, the Mark 1 scheme apparently seeks to strike directly at the Circle business model (where the consultant is a contractual owner in the business) by preventing a consultant who signed the Mark 1 scheme from signing an agreement or having a financial interest in a rival facility<sup>12</sup>; the Mark 1 scheme appears to have a 6 year contract period with a balloon payment that would incentivise very strong loyalty at the expense of the Circle; and, the Mark 2 scheme was deployed to BMI's consultants on an "opt-out" basis which clearly could not be matched by the entrant<sup>13</sup>.
- 2.11 Given the significant structural entry barriers a hospital faces in any event (e.g. sunk costs and economies of scale), the perceived or real additional costs and uncertainty brought about by a dominant incumbent's incentive schemes could be decisive in the entrant's decision to proceed. Therefore, we do not believe that the CC can on the basis of the two case studies conclude that incentive schemes do not augment entry barriers.

### 3) PMI recognition as an entry barrier

- 3.1 The CC appears to characterise PMI recognition in a negative light as potentially restricting entry. This conclusion is drawn from AXA's decision not to recognise Circle in Bath. The CC argues that AXA's decision was due to it wanting to maintain good relations with BMI (given they were jointly launching the AXA Pathways product which relies heavily on the BMI network of hospitals) rather than BMI threatening AXA<sup>14</sup>. We note however that other insurers (including BHF) did recognise the Circle Bath hospital.
- 3.2 It is important that the CC recognises the important role an insurer plays on behalf of its customers when recognising a new facility. The insurer must be sure that the new facility will

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<sup>11</sup> The importance and fragility of the entrant's relationship with consultants is recognised in the Edinburgh Case Study. A Spire Board paper "reported that Circle had lost some credibility among the consultants due to its failure to keep to its original timetable." (paragraph 38).

<sup>12</sup> The Bath Case Study, paragraph 38: "Consultants were also required to agree that they would not enter into any form of agreement or contract with any Competitor relating to operation of a private medical practice including acquiring any financial interest in such Competitor, although they could retain practicing privileges elsewhere."

<sup>13</sup> The Bath Case Study, paragraph 43.

<sup>14</sup> The Bath Case Study, paragraph 97: "AXA PPP's decision not to recognise Circle when it opened appears to have been based on the importance of its broader, national commercial relationship with BMI rather than specific contractual terms which would have obliged it to incur higher charges at the Bath Clinic as a result of recognizing Circle Bath".

improve the outcomes it can achieve for its customers in that local market (e.g. improving price, quality and competition). If the insurer already has adequate provision in that market to fulfil its needs, or the entrant is less efficient, and so the entry may makes the insurer's customers worse off (e.g. raising cost in the market) then it should not recognise the facility automatically. BHF believes, therefore, that the CC must recognise the strong pro-competitive and efficiency-enhancing motives the insurer has when considering recognising a hospital. The insurer has strong incentives to work with a new hospital that enhances competition, quality and choice.

- 3.3 We note that AXA had reasons other than the BMI relationship for not recognising Circle Bath: *"However, according to AXA PPP internal documents, AXA PPP decided not to include Circle Bath on the grounds that: (a) it had to take into account the broader national relationship that it had with BMI; (b) AXA PPP did not need additional provision in the Bath area based on existing subscriber numbers there; and (c) Circle Bath did not offer any additional services to the BMI Bath Clinic"*<sup>15</sup> (emphasis added).
- 3.4 We do not however find it surprising that the BMI relationship was an issue for AXA in the particular circumstances of this case. AXA Pathways is AXA's main corporate product. It was launched in 2010 (and so would have been in planning for a significant period before the Circle recognition decision needed to be made) and is critically dependent on the BMI hospital network; it could not function effectively without BMI hospitals<sup>16</sup>. [X].

#### **4) Central London has particularly high entry barriers**

- 4.1 Central London has very significant entry barriers. The CC recognises this in the London Case Study: *"TLC did encounter quite significant problems in acquiring the necessary land and planning permissions for its Cancer Centre and that the project took over five years to complete"*<sup>17</sup>. The materiality of these barriers is particularly notable given that this was an expansion of a well respected player who already had an established presence, reputation, relationship with landlords and consultant relationships in the local market. A completely new entrant to London would face far greater risks. Further, this expansion focussed on a single specialism, where entry on a full-service line inpatient basis would require a larger site, a more complex network of consultants and wider regulatory/planning permission approvals.
- 4.2 Therefore, while we agree with the CC's conclusion that *"the ability of an entrant to find, acquire and build on a site in the immediate vicinity of Harley Street may represent a barrier to entry or expansion"*, we believe the CC can be more definitive in stating these factors "are" a barrier to entry. Further, these issues are not confined only to the immediate vicinity of Harley Street area **but apply to Central London more broadly.**
- 4.3 In their AIS responses, both Nuffield and BMI raise concerns about the atypically high barriers in London. For example, in relation to its small Fitzroy Square facility, BMI states: *"In its present state, it was and remains ill-suited in terms of capacity and layout to efficiently provide PH services, this might have been improved had BMI been able to develop a second theatre;*

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<sup>15</sup> The Bath Case Study, paragraph 70. Indeed, BMI has argued in its AIS response that *"entry is not always efficient. Bath now has two underutilised hospitals [redacted]. Circle's entry has merely divided the private healthcare market – there has been no growth and NHS opportunities are insufficient to fill the gap"*.

<sup>16</sup> The BMI AIS response explains: "Through Pathways, BMI sought to incentivise AXA PPP to place more volume with BMI via a deep discounting strategy and a directional (i.e. restricted) network....Pathways originally anticipated a narrow, BMI-only network (except where a patient was over 20 miles from a BMI hospital) with discounts off the usual network prices in return for directing patients to BMI... BMI is to remain the preferred provider in the 'Pathways' network .... The new Pathways network now consists of around 120 hospitals – with BMI facilities accounting for approximately 50% of the hospitals in this network".

<sup>17</sup> The London Case Study, paragraph 81. TLC's AIS response emphasised: *"Our experience in the construction of the Cancer Centre was actually that barriers to entry were significant. The key barriers were access to land and planning issues"* (TLC, AIS response, paragraph 4.2.).

*however, these plans were frustrated by both planning constraints and the costs of development*<sup>18</sup>.

4.4 [REDACTED]<sup>19</sup>. [REDACTED].

## 5) Other entry barriers exist not recognised in these case studies

5.1 BHF's Original Issues Statement Response (OISR) set out a series of barriers to entry faced by hospitals – see paragraphs 5.42 to 5.73. The three case studies have not enabled the CC to cover all possible types of barriers to entry. Some further types the CC should continue investigating are:

- i. **'One in, all in' negotiation tactics** by larger hospital groups can restrict the expansion of independent hospitals. First, the incumbent hospital group can use this tactic to require the insurer to recognise the group's hospital in a local market where an independent hospital in that local market offers better value for money. The independent hospital has to share patient volumes with the group's hospital. This affects its ability to move down its cost curve through economies of scale. Second, this tactic has frustrated the launch of insurer networks and service line tenders – [REDACTED]. Launching cost-saving network products is critical to growing the PMI market through providing customers with more affordable PMI options. Tactics that frustrate the launch of networks have a negative consequence for all participants in the hospital market, but in particular restrict the entry and expansion of independent operators (which need to achieve scale and are not in a position to protect their slice of market revenues as the larger groups do).
- ii. **'National pricing'** by larger hospital groups can restrict the expansion of independent hospitals. This removes the signals of price, quality and profitability at a local level that may attract efficient entry. For example, a hospital group could spread the market power (and profits) conferred from a 'must have' hospital into more competitive markets when it ties its hospitals together and charges a single national price. This means that entry may not be forthcoming in the 'must have' market because its supernormal profitability is spread across the other markets in the group's portfolio.
- iii. **'Revenue-neutral negotiating'** by an incumbent hospital group also discourages the insurer from launching initiatives that make cost savings, as some of these cost savings are clawed back immediately by the large hospital group. This means that initiatives that may favour more efficient, innovative independent hospitals never get off the drawing board.
- iv. **Vertical integration by hospitals into the GP level.** Through capturing the patient at the start of their journey, a hospital can raise entry/expansion costs for rivals<sup>20</sup>. We are most concerned about this in London [REDACTED] (see also Paragraph 2.197 of BHF's response to the AIS).

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<sup>18</sup> Response of BMI Healthcare to the CC's Annotated Issues Statement, paragraph 9.4.

<sup>19</sup> [REDACTED]. We note also in the London Case Study that "AXA PPP told us [the CC] that HCA had sought contractual arrangements which would have had the effect of 'locking out' new provision in London." In particular, HCA sought "network integrity" meaning that AXA should not add further radiotherapy facilities to its London network. The final contract contained an obligation on AXA not to recognise new providers until after June 2010 and AXA stated that "the provision, without the cut-off date, had been included by HCA at draft contract stage but that the time limitation had been inserted during negotiations" (paragraphs 46 and 56).

<sup>20</sup> The Bath Case Study shows that BMI also contemplated incentive arrangements with GPs – BMI launched "a pilot scheme to subcontract GPs to undertake pre-operative examinations of patients referred by them to the Bath Clinic and to receive payment for these examinations in the event that the patient was treated at the Bath Clinic" (paragraph 41).

- v. **Financing cost uncertainty.** Hospital entry (particularly on an inpatient basis) involves significant costs, most of which are sunk. Given the scale of costs, financing can be difficult to achieve. See, for example, Circle's failed entry in the Edinburgh case: "*Circle was able to secure [redacted] funding of approximately £9 million from AIB, which allowed it to complete the acquisition of the Edmonstone site in March 2008. Circle subsequently appointed architects to draw up more detailed plans for a new hospital on the site. However, the business was unsuccessful in raising the financing required to build the hospital*"<sup>21</sup>.
- vi. **The lack of readily accessible, comparable data on quality and price.** The lack of comparable information raises entry barriers because an entrant cannot easily demonstrate its superior services in order to compete patient volumes away from the incumbent. This reduces the likely profitability of entry even if the entrant is more efficient than the incumbent.
- vii. **Existing excess capacity.** Many incumbents already operate with significant excess capacity in local markets:

*"Across the portfolio, BMI's hospitals on average have significant spare capacity."*<sup>22</sup>

*"[T]here is significant excess capacity in the provision of private healthcare services in the UK."*<sup>23</sup>

This can discourage entry even if the entrant is significantly more efficient than the incumbent. This is because the entrant does not know whether the incumbent will respond aggressively to entry in the short term e.g. the incumbent could bid aggressively for NHS Choose and Book volume restricting the entrant's ability to achieve necessary scale.

- 5.2 Finally, as we have noted in the OISR and AIS response, we believe that PPU's face additional entry barriers e.g. their duty to serve NHS patients before private patients; the challenges in attracting consultants; and political uncertainty. These barriers for PPU's are particularly high in Scotland, as noted in the Edinburgh Case Study.

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<sup>21</sup> The Edinburgh Case Study, paragraph 28.

<sup>22</sup> BMI AIS response, para 8.8(a).

<sup>23</sup> Ramsay AIS response, para 7.9(b).