

Bupa Health Funding

Response to Working Paper

Assessment of hospitals of potential concern (excluding Central London)

1) Overview

1.1 Bupa Health Funding (“BHF”) welcomes the Working Paper assessing ‘hospitals of potential concern (excluding Central London)’ (“the Working Paper”) published by the Competition Commission (“CC”) on 21 May 2013. This submission sets out BHF’s comments on the Working Paper and supporting Excel Spreadsheets.

1.2 [§<]]

1.3 In summary:

- i. BHF welcomes the CC’s detailed analysis of competition along hospital characteristics, concentration metrics (e.g. LOCI), and hospital operator internal documents. The CC has clearly covered significant ground in coming to its list of hospitals of potential concern.
- ii. Based on this detailed analysis, the Working Paper finds that around 70% of the 140 hospitals outside Central London initially identified remain of potential concern.
- iii. BHF agrees with the CC that a substantial number of hospitals outside Central London, in fact even more than the Working Paper suggests, face “insufficient competitive constraints”¹ and that within these local areas an adverse effect on competition may exist. These hospitals have local market power over patients and, as the majority of these hospitals are owned by the main hospital groups, these hospitals confer market power to hospital groups in negotiations with insurers.
- iv. BHF has concerns that the CC’s approach understates the number and strength of the hospitals with local market power. A number of these concerns are set out in detail in Section 2 of BHF’s response to the Annotated Issues Statement (“AIS”). In particular: the CC’s assumption of supply-side substitution across the 16 common specialisms is too strong, and as such the aggregation of specialisms will hide pockets of market power; certain specialisms outside those considered in the CC’s analysis (the 16 common specialisms and Oncology) confer significant bargaining power; and, the geographic catchment areas assumed are in some cases too broad.
- v. On the basis of BHF’s concerns, the CC should undertake its analysis at a specialism level. For example, this would illustrate that some of the “symmetric duopolies” identified by the CC have a high degree of asymmetry across specialisms. In this regard, we are concerned that the Working Paper does not comment specifically on hospitals of potential concern in relation to Oncology alone, a specialism which the CC was considering separately at the AIS stage².

1.4 In Part 2, we comment on the CC’s approach set out in the Working Paper. In Part 3, we then comment on the results of the analysis and certain hospitals that we consider the CC should

¹ The Working Paper, paragraph 6.

² AIS, Appendix B, Annex 1 – Measuring local concentration.

investigate in further detail. We are of course happy to discuss any of these comments further with the CC if required.

2) The CC's approach set out in working paper

- 2.1 We set out below some general comments about the CC's approach. Please read these in conjunction with our comments in the AIS response about Product/Geographic Market Definition and Theory of Harm ³.

Unilateral effects and coordinated effects may arise at the local level

- 2.2 Paragraph 1 of the Working Paper explains that the CC's assessment is seeking to identify hospitals that give rise to local competition concerns due to "unilateral market power".
- 2.3 However, we note that given the very high degrees of concentration in many local markets, and the presence of entry barriers, the potential risk of coordinated conduct between hospitals within a local market should also be recognised. For example, two hospitals in a local market may each (tacitly) focus on separate specialisms (or sub-specialisms) so as to soften direct competition for patients and consultants.
- 2.4 Therefore, we would request that during its review of the internal documents of hospital operators, the CC considers whether there is any evidence of coordination at the local level.

Barriers to entry and expansion are a relevant consideration

- 2.5 Paragraph 1 explains that the analysis "*does not address barriers to entry and expansion*". However, we believe these are relevant to an assessment of unilateral effects in local markets. In many of the local markets considered outside of London, 'natural barriers' mean that the dominant incumbent's position of market power will be preserved, even increasing over time (as smaller hospitals place an increasingly less effective constraint due to falling volume and therefore rising unit costs).

Weak competition can exist even in a local market with several players

- 2.6 The CC's analysis recognises that even in a multi-provider market there can be hospitals of potential concern. However, the CC appears to use the filters of common ownership, size and occasionally Oncology to identify the hospitals of potential concern in these instances. We note that even in markets where several similar (e.g. equally sized) hospitals are present there may be weak competition⁴. This is because there can be very little incentive for each hospital unilaterally to compete against the others through cutting price or increasing quality. The lack of transparent information on cost or quality means that the hospital may not gain any additional volumes from its action. Further, both consultants and insured patients are unlikely to be price sensitive at the point of treatment.
- 2.7 Competition may also be muted inside a local market (and constraints from hospitals outside the local market may be weakened) because hospitals are able to price discriminate between the patients they serve (e.g. based on postcode⁵ or payor type⁶). To illustrate: Hospital A may face a competitive constraint from Hospital B for some self-pay patients in Hospital A's catchment

³ Bupa AIS response, paragraphs 2.16 to 2.19, 2.33 to 2.37, and 2.42 to 2.61.

⁴ For example, a market with 3 firms of equal size is still highly concentrated (with an HHI of over 3,000).

⁵ The CC will be best placed to verify based on its review of hospital transaction data; however, it is our understanding based on market intelligence that on occasion different self-pay patients receive different price quotes (or discounts from national tariff) for the same procedure at the same hospital i.e the hospital varies the price depending on the individual's circumstances.

⁶ This is seen clearly by hospitals adopting different price schedules for insured work, self-pay, international and NHS.

area, meaning that Hospital A needs to offer discounts to retain customers in this area of overlap between A and B. However, this does not necessarily mean that other patients in Hospital A's catchment (i.e. those outside the overlap region) will be given the same discounts. Through price discrimination Hospital A can minimise the effects of the competitive constraint from Hospital B.

Network effect is important given the extent of common ownership

- 2.8 At Paragraph 4(h) we welcome the CC's consideration of the network effect. As explained in our AIS response (paragraph 2.49), the scale of some of the main hospital groups confers significant additional power to the individual hospitals within the group. This effect of scale is felt strongly in certain regions where a single operator owns the major share of hospitals; for example, [redacted].
- 2.9 This network effect can also increase market power of the individual hospitals in the group over time (i.e. it can have both a static and dynamic effect on market power). The large hospital groups can use their scale to achieve pricing, contractual and/or recognition terms with insurers that advantage their own hospitals relative to 'as efficient' independent hospitals (and new entrants). Given the relatively high fixed costs of hospitals, and the contraction in the PMI market, this means that over time smaller independents within a particular local market (without the network effect advantage) are more likely to suffer (or even exit that local market or be sold to one of the major chains), leaving the group's hospitals in a strengthened position.

Considering the impact of specialisms will broaden the list of hospitals of concern

- 2.10 The CC assumes a high degree of supply-side substitution across the 16 common specialisms, allowing them to be assessed as a cluster. In BHF's view, this assumption on supply-side substitution is too strong. As noted from paragraphs 2.19 to 2.21 of our AIS response, BHF does not believe the conditions necessary for effective supply-side substitution are present in many local markets. From an insurer's perspective, during a negotiation dispute with an incumbent provider of a particular specialism, the insurer needs to secure access to alternative supply very quickly and maintain continuity of care at competitive prices. BHF considers that in many cases it would take too long for new supply to come to market at a sufficient scale for the 'threat' of supply-side substitution to be a credible constraint on the incumbent hospital at the point of renegotiating prices with the insurer.
- 2.11 When commissioning care, an insurer must make sure it is able to give customers access to the full range of services covered under their policies. Therefore, a hospital will be 'must have' for a particular specialism where there are no other providers in the local market offering that specialism. As stated in paragraph 2.23 of BHF's AIS response, BHF has observed several cases of a hospital in a local market focussing on particular specialisms with a rival focussing on non-competing specialisms. This will make both facilities 'must have' to the insurer.
- 2.12 This is for example illustrated by examining a few of the 'symmetric duopolies' that the CC has identified.
- 2.13 Figure 1 shows the proportion of Bupa claims expenditure in 2012 by specialism at two hospitals: [redacted]. In 2012, at an aggregated level, both facilities accounted for a similar proportion of BHF's claims expenditure. However, there is significant asymmetry at the specialism level. While the [redacted] focuses on particular specialisms – Orthopaedics, Obstetrics and Gynaecology, Gastroenterology, Neurosurgery, and Ophthalmology – the [redacted] focuses on non-competing specialisms such as Oncology, Haematology, and Clinical Radiology.

Figure 1: [X]

2.14 Figure 2 illustrates a similar story when the symmetric duopoly of [X] and [X] is analysed at a specialism level.

Figure 2: [X]

2.15 Both of the above examples illustrate the differentiating effect a specialism can have for a hospital within its local market. Oncology is a clear differentiator. However, the Working Paper provides very limited references to the results of examining Oncology separately (other than in Footnote 3 referring to a Fascia count for Oncology) and Oncology appears only in [X] cells of the Detailed Assessments in the supporting spreadsheets.

2.16 BHF also notes that the Working Paper does not appear to examine some of the specialisms outside the common 16 and Oncology that we consider important. [X]. As shown in Appendix A of our AIS response, BHF considers the CC should also investigate the hospital market power in the following specialisms: [X].

2.17 Specialisms do have an important impact on the commissioning decisions insurers make. [X]

i. [X]

ii. [X]

iii. [X]

Geographic catchment areas may be too broad

2.18 As noted in BHF's AIS response, BHF believes that the LOCI and catchment area concentration measures understate the importance of the local dimension for insurers (and patients). At the point of purchasing PMI, many customers have strong preferences for access to their local hospital and expect their insurer to be able to offer this access. Hence, for the insurer, at the point of negotiating with a hospital, both the insurer's choices as to local hospitals and the applicable geographic market are very narrow.

2.19 We ask the CC to exercise caution in its statement at Paragraph 5(f) that "*two hospitals located at a considerable distance from each other may still impose a constraint on each other*". This constraint is likely to be weak. The observed travel patterns may be the result of:

- i. One hospital being the only provider of a key specialism, sub-specialism, or piece of equipment so patients have no option but to travel to that facility.
- ii. Some patients (particularly self-pay) having to travel further afield because their local hospital has already exercised market power by raising prices significantly above the competitive level. For example, a self-pay patient may seek treatment at his local hospital but the local hospital may charge such a high price (i.e. exercising its market power) that a hospital further away became a possibility. Given the concentration of local markets there is a significant risk of the "cellophane fallacy"⁷ occurring that would result in inappropriately broad catchment areas.

2.20 Critically, hospitals can price discriminate between self-pay patients (where hospitals often apply bespoke pricing packages/discounts). Therefore, the fact that a hospital 'competes' on

⁷ See paragraphs 2.4 to 2.14 of "Merger references: Competition Commission Guidelines June 2003"

price for some customers at the margin of its catchment area does not necessarily mean that ‘infra-marginal’ customers inside that hospital’s catchment area benefit from lower prices.

- 2.21 At Paragraph 4(c) we agree with the CC that “*patients are considered to be more likely to travel inwards (from outside towards the inner city) than outwards*”. However, we do not believe that the relatively larger catchment areas for urban hospitals imply they compete over a broader area. Customers decide to attend a hospital not based on the price and quality but based on the convenience of location to that customer’s workplace. For example, if a patient has his or her first outpatient consultation with a consultant who practices only within a city, hospitals outside that city are unlikely to provide an effective constraint on that inner city hospital.
- 2.22 At Paragraph 4(d), BHF notes that the CC recognises that hospitals in Greater London may actually face limited constraint on price from hospitals in Central London because the latter are significantly more expensive. [redacted]⁸.
- 2.23 Some examples of hospitals where BHF believes the CC should reconsider the geographic catchment areas are:
- i. [redacted]
 - ii. [redacted]

3) List of hospitals for further consideration

- 2.24 As stated above, **BHF asks the CC to conduct a detailed assessment of each hospital at a specialism level** (disaggregating the common 16 specialisms and separately examining also [redacted]).
- 2.25 We believe this will reinforce the CC’s concerns about many of these hospitals of potential concern already identified and will identify further hospitals of concern. For example, [redacted] which we believe should be included in the list of hospitals of potential concern.
- 2.26 In addition to identifying further hospitals based on specialism, we ask that the CC consider the following hospitals not currently identified by the CC but which we consider on the basis of geography.

Table 1: List of hospitals for further consideration based on geography

Hospital	Rationale for further consideration
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

⁸ See paragraph 27.6 of BHF’s response to the Market Questionnaire.