

Bupa Health Funding

Response to Working Paper

Private healthcare in Central London: horizontal competitive constraints

Introduction

- 1.1 Bupa Health Funding (“BHF”) welcomes the Working Paper assessing ‘Horizontal competitive constraints in Central London’ (“the Working Paper”) published by the Competition Commission (“CC”) on 7 June 2013. This submission sets out BHF’s comments on the Working Paper; these comments are non-exhaustive given the short period allowed to respond to the Working Paper.

Structural concerns in Central London

- 1.2 BHF agrees that Central London should be considered separately and in detail. Central London is a critical region for PMI; in particular, due to its importance for many large corporate accounts. The CC’s findings that “*private hospital revenue in both Greater and central London has been growing at around 8 per cent a year since 2009*” (para 8) are remarkable when considered in the context of the extremely challenging market conditions faced by private medical insurance (“PMI”) and self-pay due to the affordability crunch and the consequent decline in PMI customer numbers during this period. This rate of cost inflation is unsustainable to Private Medical Insurers (“PMIs”). And, in simple terms, if the dynamics of the PMI market hit tipping point in London (e.g. large corporates reduce or stop purchasing PMI for employees) there will be negative fallout for markets across the UK.
- 1.3 There is a structural problem in Central London. Central London is highly concentrated, and is becoming increasingly so¹. [redacted]². [redacted] (see further 1.15 *et seq.* below).
- 1.4 The situation will not improve or be resolved on its own. As shown in the entry barriers case studies, entry and expansion of new or existing players in Central London would be very costly, difficult and, even if theoretically possible, would take years. All the while, [redacted]. This is an attractive market for hospital operators; the fact that so little entry and expansion has taken place underscores the barriers faced.

HCA’s Reputation

- 1.5 BHF disagrees with HCA’s representation of BHF’s views in paragraph 52 of Appendix A of the Working Paper. [redacted].
- 1.6 [redacted].
- 1.7 [redacted]:
- i. [redacted].

¹ BHF’s own claims spend estimates an HHI of around 3,000 in Central London; with this being significantly higher at a specialism level.

² The CC notes that HCA “has a very high share of supply when considering only central London”; “HCA has the highest share of both admission and revenue for these [complex] specialties in central London” (para 55); “HCA has high shares of supply by admissions for individual specialties in central London” (para 61); “HCA has almost half of the theatres in private hospitals in central London and more than half of the overnight beds” (para 62).

ii. [REDACTED].

1.8 [REDACTED]³.

Networks

1.9 HCA argues that “*all of the PMIs sold products that did not include HCA*”, suggesting that “*there was no shortage of consumer choice for a network product which was not HCA hospitals*”. BHF disagrees that these products, such as lower cost networks, demonstrate that insurers have sufficient bargaining power against HCA. Indeed, as the CC is aware HCA has actually been in a position to impose contractual terms [REDACTED]. We suggest that the CC examines whether these lower cost ‘non-HCA’ networks actually prevent HCA from accessing a significant amount of an insurer’s spend within Central London. We expect these products are very much at the margin; and that HCA still dominates the lion’s share of the relevant insurer’s spend.

1.10 [REDACTED].

Claimed innovation

1.11 [REDACTED].

Competitive pressure from NHS PPUs

1.12 HCA argues that PPUs in London are already a significant competitor to private hospitals, and represent a ‘sleeping giant’ of potential competition⁴. We disagree with both statements.

1.13 In BHF’s view, even the strongest PPUs in London do not currently provide an effective competitive constraint [REDACTED]. These PPUs tend to focus on a much narrower set of specialisms (e.g. the Royal Marsden focuses on Oncology) and are smaller than the main private facilities. Further, as explained in Annex A of BHF’s Original Issues Statement Response, PPUs continue to face significant barriers to expansion in private healthcare⁵.

1.14 Further, HCA’s strategy of partnering with PPUs neutralises their alleged competitive threat before it is ever allowed to emerge. It also further concentrates the market in HCA’s favour. HCA entered into ventures to run the PPUs at University College London Hospitals (in 2007) and Queens (2011). In 2012, HCA was awarded a contract to develop, operate, and manage a PPU at Guy’s and St. Thomas’ NHS hospital. HCA’s strong position and promise of high prices mean that it is able to outbid other providers to win these PPU partnership contracts.

Breadth of geographic market

1.15 We agree with the CC that although “*central London hospitals (at least HCA hospitals) draw patients from a relatively wide area including Greater London and outer London, this does not necessarily mean that hospitals located outside central London represent a strong constraint on central London hospitals*”⁶. First, there are a significant number of customers ‘captive’ in Central London and that show no willingness to travel out of London for treatment. Second, a significant proportion of customers based outside of Central London who receive treatment in Central London do so because of work-commuting patterns (i.e. they would come into Central London

³ See 5.105 of BHF’s Original Issues Statement Response for further information.

⁴ Working Paper, paragraph 30, Appendix A.

⁵ Some of these barriers are unique to PPUs including: (i) negative patient perceptions; (ii) preference of consultants not to treat at PPUs; (iii) small size and therefore limited capacity, meaning they have significant investment requirements; (iv) weaker capabilities in commercial strategy and contract handling and organisational pressures (such as the duty to serve NHS patients first, the political pressures of expanding private provision, and the pressures from private hospital complaints about competitive neutrality and state aid); and (v) the fact that they act as individual operators and do not therefore constitute a competitive constraint at a national level.

⁶ The Working Paper, paragraph 15.

for work in any event, and now seek treatment in a location convenient to work rather than because HCA attracted them away from hospitals closer to their homes).

1.16 This recognition that hospitals outside Central London offer limited constraint on hospitals within Central London further illustrates why we are concerned that the LOCI measure understates the strength of HCA's facilities⁷. LOCI will understate the strength of HCA facilities because of:

- i. **Specialism effect** – [§<].
- ii. **Corporate effect** – [§<].
- iii. **Commuter effect** – commuting patterns into Central London overstate the catchment areas over which Central London hospitals compete⁸.

[§<]

1.17 We would have welcomed further analysis in the Working Paper of the competitive constraints faced by, and the market position of, each of HCA's hospitals individually. [§<]⁹. [§<].

Satellite facilities

1.18 There is surprisingly little analysis in the Working Paper about HCA's increasing use of small satellite facilities in the outskirts of London that direct volume into its Central London hospitals. We are concerned about this practice because entry of one of these satellite facilities into a local market can actually increase the average healthcare costs of that local market.

Pricing

1.19 BHF will not be responding separately to the working paper on the CC's price comparison methodology¹⁰. We noted, however, that the CC would calculate a price index based on a basket of common procedures by hospitals. [§<]¹¹. [§<].

1.20 With respect to pricing we note two other interesting comments HCA has made in its submissions to the CC.

- i. HCA argues that a "*price index that compares value for money relative to quality across different providers has proved to be the elusive 'Holy Grail' for insurers and providers*".¹² We agree that comparing prices is difficult; but this should not be used as a defence by HCA, [§<]. We believe the onus must be on the hospital to justify its price through demonstrating higher quality, [§<]. Further, HCA's recognition of the challenges of comparing hospitals because of the lack of standardised price and quality data, provides

⁷ The Working Paper found only three HCA facilities (the Wellington, the Lister, and the Portland) had weighted average market shares of over 40%; although the other three main HCA facilities (Harley Street Clinic, London Bridge and Princess Grace) were close to this level.

⁸ A significant number of insured customers travel into Central London every day to work. For these customers it may appear that hospitals closer to their home postcodes are possible alternatives for inpatient treatment. However, for many their local hospital may continue to be a weak alternative because they will begin their treatment journey with a consultant located inside Central London who, being close to their place of work, is convenient to meet during the working day for the first consultation or diagnostic. Once the patient has met the consultant it becomes highly likely that they will receive inpatient care at a facility at which that consultant has practicing privileges. Therefore, while it appears that the patient has "chosen" to have inpatient care inside Central London (far away from their home postcode) this does not reflect the Central London hospital being superior but rather that the patient was seeking convenient outpatient/diagnostic care inside Central London.

⁹ The convenient location of the HCA facilities was the factor most often cited by respondents to the CC survey (para 39). The CC notes: "[t]he location of the London Bridge Hospital, in particular, made it possible for employees of City firms to minimise their absence from the office when attending medical appointments". Some respondents noted it was HCA's reputation for quality although "others told us [the CC] that since no appropriate quality measures were available it was impossible to draw value-for-money considerations". BHF shares concerns that HCA's price premium is unjustified by evidence of superior quality.

¹⁰ "Empirical analysis methodology of price outcomes in negotiations between hospital operators and insurers" published 6 June 2013.

¹¹ See for example Table 11 of BHF's Original Issues Statement Response.

¹² HCA's Observations on Aviva's Response to the AIS, para 6.5.

evidence why the CC must act to increase the amount of information published by hospitals.

- ii. We note that HCA repeatedly acknowledges that “*PMI fees are not negotiated on a ‘treatment-by-treatment’ basis but by reference to ‘the total pricing envelope’*”¹³. This absence of a direct link between price and the actual cost (or quality) of individual procedures should be a point of concern for the CC since it inhibits market forces (e.g. it distorts a hospital operator’s entry decisions and allows the incumbent hospital operator to use cross-subsidisation to protect or build its position in certain treatments) and [redacted].

Vertical integration

1.21 Although we recognise that the Working Paper is about horizontal constraints rather than vertical effects, we noted with interest the statement that “*a relatively small proportion of GPs are responsible for a disproportionately high number of HCA referrals*”¹⁴, with approximately 65 GP practices identified as delivering the majority of those referrals. This illustrates the potentially significant distortions that can arise where HCA locks in referrals through acquired financial interests in major private GP practices (e.g. Rood Lane, General Medical Clinics and Blossoms Healthcare).

Barriers to entry in London

1.22 We comment separately on the CC’s three barriers to entry case studies; one of which demonstrated the significant challenges the London Clinic faced in Central London. However, for completeness, we draw the CC’s attention to the numerous statements by other hospitals operators about especially high barriers to entry in London:

- i. Nuffield Health stated that “*[i]n London, barriers to entry and expansion [are] the most important factor causing the generation of supernormal profit*”, that they are “*atypically high*” and that vertical integration and consultant incentives contribute to these barriers¹⁵.
- ii. BMI noted that “*Central London poses unique difficulties for hospital providers in terms of barriers to entering the market*”¹⁶ and that they “*were frustrated by both planning constraints and the costs of development*” in developing a second theatre at its Fitzroy Square hospital in London.
- iii. The London Clinic said that “*the CC has understated the barriers to entry in Central London*”¹⁷ describing the ‘significant’ barriers to entry, in terms of access to land and planning issues, it faced in developing its London Cancer Centre despite being an already established player in the market.

1.23 We would also like to clarify several examples of supposed London entry and expansion made in HCA’s AIS response:

- i. [redacted]¹⁸ [redacted].
- ii. [redacted]¹⁹. [redacted].
- iii. HCA claimed as an example of insurer-funded expansion an investment made by Bupa in a cancer unit at the Charing Cross Hospital PPU in 2005. [redacted].

¹³ HCA’s Observations on Aviva’s Response to the AIS, para 6.7. Also see HCA’s submission to the CC on 22 February 2013, para 16.2.

¹⁴ Paragraph 16, CC Working Paper “Private healthcare in central London: horizontal competitive constraints”

¹⁵ Nuffield Health AIS response, para 1.10.

¹⁶ BMI AIS response para 9.3.

¹⁷ London Clinic AIS response, para 4.1.

¹⁸ HCA AIS response, para 7.13.

¹⁹ Ibid, para 7.6.