

PRIVATE HEALTHCARE IN CENTRAL LONDON: HORIZONTAL COMPETITIVE CONSTRAINTS

HCA's response, 28 June 2013

1. Introduction

- 1.1 HCA sets out its comments below on the CC's Working Paper of 7 June 2013 "Private Healthcare in Central London: Horizontal Competitive Constraints".
- 1.2 In this introductory section, HCA outlines the key elements of its response, including:
- Its concerns about the timing, scope and depth of the CC's analysis of horizontal competitive constraints in Central London.
 - The range of competitive constraints that in fact prevail in Central London, which are largely absent from the CC's Working Paper.
 - How these competitive constraints manifest in different ways, including competition to improve quality of care.
 - The arguments supporting the existence of low barriers to entry and expansion.
 - The relevance of PMI bargaining power to any assessment of horizontal competitive constraints in London.
 - The issues that affect the CC's measurements of private healthcare "capacity" in London.
- 1.3 The CC recently signalled its intention (in its Annotated Issues Statement) to carry out a separate assessment of competition in London. As a result, the Working Paper has been published at a very late stage in the inquiry, a little over a month prior to the release of the CC's provisional findings. Whilst this leaves little scope for engagement with the main parties in advance of the CC's provisional findings, HCA hopes its comments below will assist the CC to further develop its understanding of private healthcare competition in London, help to correct a number of inaccuracies in the Working Paper, and address certain points raised by PMIs in the Appendix to the Working Paper.
- 1.4 The Working Paper commences promisingly by seeking (paragraph 1) to set out "*the CC's] analysis of the competitive conditions in the provision of private healthcare in London, and in particular Central London, relevant to the assessment of horizontal competitive constraints*".
- 1.5 However, such an analysis is notably absent from the Working Paper. Part 1 contains a general summary of the characteristics of private healthcare in London. Part 2 is largely comprised of a discussion of HCA's share of supply in Central London, concluding that "*[t]here is a significant degree of concentration*". The Appendix provides an uncritical precis of the various submissions received by the CC from insurers and hospital operators. However, the Working Paper does not include an analysis of the "horizontal competitive

constraints" faced by HCA or any other London operator. Nor does the Working Paper describe how the competitive process manifests in London, which would have helped the CC to recognise the broad range of competitive pressures faced by hospital operators active in London.

1.6 As a result, the sole propositions in the Working Paper are that:

- (i) "London is different" in comparison to other private healthcare markets; and
- (ii) HCA is the largest provider in London, particularly for high acuity and complex treatments.

These propositions, in themselves, can only form one part of an analysis of the competitiveness of the London market. They explain nothing about the diversity and strength of competition which HCA faces. Furthermore, the CC's conclusion that "[t]here is a significant degree of concentration, particularly within Central London" (paragraph 1(b)) is at variance with its recognition that "there are 28 private hospitals and PPU's in Central London" and a further 46 within Greater London (paragraph 4).

1.7 It is not in contention that HCA is a successful operator of six hospitals in London. The history of HCA's acquisition of these hospitals, dating back to the 1990s, and its programme of strategic investment to create world-class, tertiary facilities to rival the NHS, has been fully set out in previous submissions.¹ That HCA is the largest single private healthcare provider in London has come about as a result of its vision to build and invest in high-quality facilities which offer state of the art clinical services and cutting-edge, innovative treatments. HCA has virtually created and grown a private market for high-quality, complex treatments, which previously had been the preserve of the NHS. Even HCA's critics acknowledge in their submissions to the CC² that HCA has "excellent quality hospitals which operate at a high level of complexity" which patients choose to come to.

1.8 However, the fact that HCA has six high-quality facilities, which account for 40%–50% of admissions in Central London (assuming that those estimates are correct) does not detract from the fact that HCA is subject to significant and evolving competitive constraints. The CC's Guidelines for market investigation (paragraph 190) state that the level of market share in itself does not necessarily indicate that competition within a market is weak, and that the CC needs to consider the constraints on the business including the prospect of entry and expansion and countervailing buyer power. Disappointingly, the Working Paper falls short in each of these areas.

1.9 The Working Paper does not analyse the horizontal competitive constraints faced by HCA, including:

- The strength and capabilities of independent competitors.
- The growth of NHS PPU's and their expansion plans in the light of the lifting of the PPU cap on private income.
- The role of NHS public hospitals in competing with private hospitals, particularly for high acuity treatments (NHS hospitals are widely seen by both PMI and self-pay patients as a natural option for complex treatments).

¹ See for instance HCA's response to the CC's Issues Statement.

² Paragraph 53, Appendix 1 of Working Paper.

- Competition from overseas providers, which helps to drive competition in innovation and quality in Central London.

1.10 Across the spectrum of competitive constraints listed above, there is a surprising absence of commentary on the different ways in which competition manifests itself. For example, competition takes place between hospital operators on the breadth of care, clinical and service quality as well as on price. This competitive dynamic has driven hospital operators, such as HCA, to invest, innovate and improve the quality of care to patients. Evidence of this competitive process in London can be seen over recent years by taking stock of HCA's record of investment in:

- The expansion and upgrade of its healthcare facilities.
- The recruitment and training of high-calibre clinical staff to support consultants.
- The innovative treatment technologies rolled-out to improve quality of care.
- The development of patient pathways that optimise the consultant's ability to successfully diagnose and treat patients.
- The implementation of collaborative working models with consultants that provide a platform for expert clinical input in the design and management of "centres of excellence" across a number of specialisms.

It is difficult to see how a marketplace devoid of competitive pressure could have led to such compelling improvements in the quality and scope of care available to patients. To capture the scale of development that has taken place, the CC need only compare the range of services and expected clinical outcomes for patients requiring cancer care in 1996 at a HCA hospital (when HCA first entered London) versus the position in 2013. Such a comparison would highlight the remarkable extent to which HCA's patients have benefitted from its investments.

1.11 At the outset of its decision to invest in London, HCA recognised the importance of high-quality care, cutting-edge treatments and excellent clinical outcomes in order to attract consultants and both domestic and international patients to its hospitals. Not accounting for this competitive process represents a significant omission in the CC's analysis.

1.12 The Working Paper also omits reference to the relatively low barriers to entry and expansion in London, as evidenced by the CC's London Clinic case study, the record of entry and expansion in London and the prospect of further entry and expansion in and around London. On a related note, the Working Paper does not adequately address the issue of supply-side substitution in respect of London providers (i.e. the ease with which hospital operators can change the range of treatments they provide).

1.13 HCA also considers that the CC should analyse horizontal competitive constraints using different analytical frameworks for self-pay and insured patients. While competitive constraints relating to self-pay patients can be assessed in a traditional "market" framework, a "bargaining" framework is the appropriate one for assessing constraints relevant to insured patients. The CC appears to be conflating the two approaches in this paper, making its approach to assessing competition unclear.

1.14 In respect of the PMI bargaining framework, the Working Paper does not contain analysis of the impact of a strong bargaining position of PMIs on hospital operators in London. This may

be intentional, since the Working Paper refers to "horizontal" competitive constraints only, however, PMI bargaining power is relevant to the CC's analysis.

1.15 PMIs have demonstrated their ability to leverage the competitive constraints on HCA's hospitals, for example, through network reconfiguration and directional policies, to divert demand away from HCA hospitals. PMI bargaining power therefore represents further evidence of such competitive constraints. In addition, PMI bargaining power serves to reinforce the horizontal constraints on HCA. For example, PMIs can sponsor or encourage new entry and expansion by HCA's rivals - whether by "assuring" recognition for new investments, designing directional policies and networks that increase demand for their services, or by providing favourable pricing terms that encourages growth – thereby strengthening the competitive position of HCA's rivals in London.

1.16 In that regard, issues related to the buyer power of PMIs are inextricably linked and indeed fully overlap with any assessment of horizontal competitive constraints between private hospital operators. The alternative that PMIs have to recognising a given hospital operator, and the consequences that a delisting can have for hospital operators, are all elements of the competitive constraints faced by private healthcare providers and directly affect the market outcomes. HCA notes that the Appendix to the Working Paper summarises PMI submissions which largely deal with issues of PMI "vertical" buyer power. This affirms the view that issues relating to PMI bargaining power are germane to the analysis of horizontal competitive constraints, but, as part of that analysis, the CC should also consider the role of PMI bargaining power from the perspective of hospital operators.

1.17 It may be that some of these themes are examined in more detail in the CC's other workstreams. However, many of these issues are specific to London and an analysis which purports to assess horizontal competitive constraints in London cannot credibly ignore these matters.

1.18 Lastly, HCA has concerns about the CC's assessment of available capacity in London. It presently contains a series of methodological flaws, such as the omission of PPU data and an overly narrow consideration of consulting room capacity, as well as data discrepancies which, together, undermine any conclusions that could be usefully drawn. HCA presents its own data analysis which supports the view that sufficient capacity exists for PMIs to switch, even in the short-term, from HCA hospitals to rival hospital facilities in Central London.

1.19 The structure and content of HCA's response is as follows:

Section 2: The range of other independent (non-PPU) competitors in Central London and their capabilities and strengths.

Section 3: Competition faced from hospitals located in Greater London and Outer London, given the breadth of HCA's catchment area.

Section 4: The strength of NHS PPUs and the wave of PPU expansion following the removal of the PPU income cap.

Section 5: Competition from NHS public healthcare, such as from the major NHS teaching hospitals in London, and the resulting quality and depth of NHS care available in London.

Section 6: Competition from overseas hospitals (which is important as [X] comes from overseas patients), for example in the US, Germany and Singapore.

Section 7: The record of new entry and expansion by HCA's competitors, which attests to the relatively low barriers to entry and expansion in London. The section also addresses the related issue of supply-side substitutability.

Section 8: The impact of PMI bargaining power on competition in London and the corresponding effects on HCA.

Section 9: A critique of the CC's flawed assessment of capacity constraints in London.

2. Independent competitors in Central London

2.1 As the Working Paper notes, apart from HCA there are six other independent providers operating nine hospitals in Central London (excluding PPU's which are discussed further below). Accordingly, even if the CC is justified in considering Central London on its own (which HCA rejects for the reasons discussed below), the CC recognises that there are at least six other direct competitors.

2.2 There is no discussion in the Working Paper about the strength of independent competitors. Each competing facility poses significant competitive threats to HCA having regard to their size, resources and capabilities.

2.3 These independent competitors are generally sizable, well-established and well-resourced facilities. They are recognised nationally and even internationally:

- The London Clinic, with 170 overnight beds³ and 13 theatres, has significantly more bed capacity than each of HCA's hospitals individually other than the Wellington. (It is misleading for the CC to claim that "*it is much smaller than HCA*" – it is in fact larger than most of HCA's hospitals individually.)
- The BUPA Cromwell, with 118 beds, including seven level 3 critical care beds, is comparable in size⁴ to each of HCA's facilities and, as the CC has recently noted⁵, is a key competitor in oncology given its adoption of a similar cancer strategy to that of HCA. (Again, it is misleading for the CC to state that it is "*much smaller*" than HCA.)
- The BMI, Aspen, St. John and St. Elizabeth, and King Edward VII hospitals are all sizable facilities with significant bed and theatre capacity and individually larger than many hospitals outside Central London.

HCA has already provided further details about the capabilities of each of these hospitals in Exhibit 12.2 of its response to the CC's Market Questionnaire, and this is attached to this response (as **Exhibit 1**) for ease of reference. Importantly, all of these competitors are constantly investing to expand or improve their existing offerings.

³ In Table 10 of the Working Paper, the CC reports only overnight (not total) beds. This appears to underestimate the capacity of other Central London hospitals. For example, the London Clinic is stated in the Table to have 170 overnight beds, but it is reported to have a total of 251 beds, suggesting significant further day case capacity. Similarly, the St. John and St. Elizabeth is reported on the Private Healthcare UK website to have 155 inpatient beds, but Table 10 reports just 49 overnight beds.

⁴ We note that Laing & Buisson Healthcare Market Review (2011-12), Table 2.9 (page 64), refers to the BUPA Cromwell as having 128 overnight beds rather than the 118 beds noted by CC.

⁵ See paragraphs 1 - 6, Appendix 1, London Clinic case study 2.

- 2.4 AXA PPP describes all of these hospitals as "elite" London hospitals which provide "*the closest competition*" and provide "*the strongest professional reputation for a broad range of treatments and which it believes were more important for its clients ...*" (paragraph 7, Appendix to the Working Paper).
- 2.5 Three competitors – the London Clinic, the St. John and St. Elizabeth, and King Edward VII – have charitable status. They therefore receive significant benefits in terms of tax exemptions, including exemption from corporation tax, business rate reliefs and VAT reliefs. HCA refers to the CASS research report of May 2013 into the tax advantages of charitable status for private hospitals.⁶ This report estimated that the total annual value of tax subsidies to these charitable hospitals was as follows:
- London Clinic - £9.9 million
- St. John and St. Elizabeth - £2.6 million
- King Edward VII - £0.9 million.
- 2.6 This compares with HCA's liability to corporation tax and business rates in 2011 of £[><]. These tax subsidies to the three charitable hospitals provide them with a significant competitive advantage which enables them to compete vigorously with HCA for patients, PMI contracts and consultants, both by freeing up capital for investment and reducing their cost base, which is likely to be reflected in their pricing. As noted on the London Clinic Website its charitable status allows it to reinvest its financial surplus to improve healthcare for patients. As a charity, The London Clinic states that it "*is able to continually invest in the latest medical technology, facilities, clinical and nursing support*".⁷ In 2011, for example, according to its Statutory Accounts,⁸ The London Clinic's capital expenditure was £27.4 million.
- 2.7 The BUPA Cromwell Hospital is a particularly strong competitor because of its vertical integration with BUPA. BUPA's vertical links with the Cromwell, and the directional strategy which it has developed within its PMI business, especially in Central London, makes the Cromwell a formidable competitor. The CC's own evidence⁹ confirms the strong links between the PMI and hospital businesses and the opportunities which this affords BUPA to use Open Referral to steer "*more patients to consultants [at the BUPA Cromwell] which will allow it to attract new consultant users ...*". The CC has also noted that the BUPA Cromwell benefits from BUPA's investment in both satellite outpatient clinics within BUPA's Wellness Centres and GP facilities which support the hospital.
- 2.8 HCA's independent competitors in London can all offer a large body of consultants with practising privileges and admitting rights. As HCA has previously explained, hospitals provide the "platform" for consultants to provide treatment services, and hospitals compete vigorously to attract and retain the leading consultants. Even a smaller hospital such as St. John and St. Elizabeth has 600 registered consultants across a very wide range of specialisms.

⁶ See HCA's submission dated 7 June 2013, enclosing a copy of the CASS research report.

⁷ See: <http://www.thelondonclinic.co.uk/about-us/our-charity-status>

⁸ Trustees of The London Clinic Limited statutory accounts, 2011.

⁹ London Clinic case study 2, Appendix 1

2.9 Most of HCA's Central London competitors have intensive care units and operate at critical care levels 1, 2 and 3 and therefore have the capability to offer a wide range of high acuity, tertiary treatments in competition with HCA:

- BUPA Cromwell
- The London Clinic
- St. John and St. Elizabeth¹⁰
- BMI London Independent
- King Edward VII
- Aspen Parkside.¹¹

2.10 HCA takes issue with the methodology used by the CC to construct Figure 14¹² of the Working Paper and does not believe credible conclusions can be drawn from it. Based on the methodology set out in paragraph 57 of the Working Paper, the CC reported total inpatient admissions and inpatient revenues (and possibly computed shares of supply too) for a selected set of private hospitals in Central London that offer intensive care at critical level 3. This has the potential to be highly misleading because a large proportion of the admissions and revenues included here will have been unrelated to critical level 3 care. Therefore, in following this methodology, HCA's market position would be artificially inflated as it neglects competitors that do not have critical level 3 facilities but who nonetheless earn revenues by competing with HCA for a large number of the services that were included in HCA's own figures.

2.11 It is also misleading for the CC to indicate (paragraph 62) that HCA has "70%" of critical care level 3 beds. As a measure of potential capacity, it is incorrect.

2.12 Whilst a current snapshot may show that HCA has a given proportion of critical care level 3 beds, all of HCA's rivals have the capacity and capability to expand the number of beds with critical care support within a relatively short timeframe. In that regard, the CC's Guidelines for market investigation (paragraph 197) state that the CC's analysis should focus on "*the ease with which these firms could expand existing capacity*".

2.13 As stated above, most of HCA's Central London competitors offer critical care level 3 facilities. This represents a platform from which to further expand critical care capacity. Taking an example, the BMI London Independent hospital has 58 inpatient beds and six level 3 critical care beds, a strong base to build on.

2.14 The ease with which critical care capacity can be expanded is evidenced by HCA's past investments in upgrading its own critical care units:

¹⁰ Table 10 of the Working Paper appears to be incorrect. It states that the St. John and St. Elizabeth operates only at level 2 critical care. The Hospital's website, and its entry in third party websites, such as Private Healthcare UK, indicate that it has three critical care beds currently with intensive care facilities.

¹¹ The Aspen Parkside website notes that the hospital has a 5-bedded High Dependency Unit (a term associated with level 2 critical care).

¹² Figure 14 is entitled "Hospital operators' inpatient admissions and revenue for hospitals/PPUs with intensive care at critical level 3 – central London, 2011".

- Five Paediatric Intensive Care Unit (PICU) beds and two Special Care Baby Unit (SCBU) beds at the Portland Hospital in 2011.
- Six level 3 critical care beds at the Lister Hospital in 2011.
- Five level 3 critical care beds and four level 3 critical care beds at the Princess Grace Hospital in 2010.

2.15 Indeed, other London hospital operators and national operators such as BMI and Spire have expanded their critical care level 3 capabilities in recent years and signalled their intent to continue to do so.¹³ Spire notes in its 2012 Annual Report that: "*Every one of our hospitals offers at least level 2 (HDU) care with five hospitals now operating level 3 (ITU) units*".¹⁴

2.16 In addition, the CC should note that:

- Hospitals can readily upgrade their critical care level 2 facilities in order to provide critical care level 3 to patients, a step HCA has itself taken (for example, in late 2008, the Princess Grace Hospital upgraded part of its level 2 critical care unit to level 3).
- The critical care level classification relating to each bed within a unit is not necessarily rigid.¹⁵ A change to the level of monitoring or support provided to the patient can result in an adjustment to the associated critical care level, for example, by increasing the level of nursing supervision, providing more advanced respiratory support and/or additional organ support.
- Alternatively, hospital operators without their own dedicated critical care beds can transfer patients to the NHS, as and when required (thereby transferring the cost and burden to the NHS). Such transfers are common in the sector.

2.17 The Working Paper does not make any acknowledgement of prospective new entry by independent operators in Central London in the short term (an issue discussed further in section 7 below). The threat of expansion and actual planned expansion raises competitive constraints both at the present time and in the near future:

- The London International Cancer, Heart and Brain Hospital, a new 150-bed acute private hospital under development in West London, is reportedly due to open in 2014.¹⁶
- Spire has indicated its intention to expand its operations in London within the next "*two to three years*".¹⁷
- The CC has already acknowledged the relative ease of entry and expansion within London.

¹³ <http://www.talkinghealthmagazine.co.uk/506/bmi/critical-care-one-standard-excellence/>. Also, see BMI Annual Report 2011-12, page 22 ("Investment"), Netcare Annual Integrated Report 2012, page 84.

¹⁴ Spire Annual Report 2012, page 34 ("Service Quality").

¹⁵ As HCA highlighted to the CC in its response to the CC's critical care questionnaire.

¹⁶ See paragraph 5.17 of HCA's response to the CC's Issues Statement of 31 July 2012.

¹⁷ Daily Telegraph, "Why the NHS must learn to tackle the risk of rationing", Andrew Cave, 15 April 2013.

2.18 The CC's analysis of competitors, brief that it is, appears to relate to inpatient services only and makes no mention of competitors in the provision of outpatient facilities. As HCA has previously submitted,¹⁸ there is an even broader range of competitors providing outpatient and diagnostic services in Central London. The barriers to entry in relation to these facilities are even lower than for inpatient facilities. In 2012, HCA derived [3<] from outpatient activity and performed [3<] in outpatient settings. This activity reflects a general trend (as observed across a range of academic literature)¹⁹ in healthcare away from inpatient to outpatient treatments as medical advances have removed the need for an overnight stay in hospital.²⁰ There are a wide range of competitors which have set up outpatient/diagnostic centres in Central London, including many consultant groups such as the Fortius Clinic and provision is highly fragmented and competitive. These groups represent a platform for further growth, for example, by potentially expanding into ambulatory and inpatient care.

3. Greater / Outer London providers

3.1 The Working Paper seeks to draw a distinction between "Central London" (the area inside the North and South Circular roads) and Greater London / Outer London. "Greater London" is the Government Office Region as defined by the ONS, and "Outer London" refers to *"the periphery – for example, commuter towns in counties that border London"*.

3.2 The Working Paper draws three conclusions concerning the competitive interaction between "Central London" and "Greater / Outer London":

- (i) The CC makes an initial premise (paragraphs 18 and 19) that "a significant proportion of patients are Central London residents".
- (ii) The CC then states that while there is evidence of patients travelling from Greater London / Outer London into Central London, there is no evidence of the reverse and that (paragraph 19) "there may be a significant cohort of patients resident in Central London who are largely captive to Central London providers".
- (iii) On the basis of the above, the CC concludes (paragraph 43) that "there are asymmetric constraints between hospitals in Central London and hospitals in Greater London (and possibly Outer London) in that hospitals in Central London exert a constraint on hospitals located in Greater London (and possibly Outer London), but the reverse may not be true, or may be true to a much lesser extent."

¹⁸ See paragraph 12.7 of HCA's response to the CC's Market Questionnaire, together with Exhibit 12.1

¹⁹ <http://www.aagbi.org/sites/default/files/Day%20Case%20for%20web.pdf>;
<http://www.rcseng.ac.uk/policy/policy-seminars/day-surgery-and-enhanced-recovery/day-surgery-and-enhanced-recovery>;
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/day_surgery_treat_day_surgery_as_the_norm.html

²⁰ The CC has not properly understood this point. Appendix A (slide 16) to the CC's AIS makes the point that out and day patient only clinics *"lack the appropriate facilities and staff capacity"* to offer inpatient treatments. However, medical advances are removing the need for surgery, and the trend is towards treatments (e.g. drugs) which are administered in outpatient settings. It is not that outpatient treatment is a competitor to inpatient, but that there is a shift in the pattern of treatment towards lower levels of medical intervention. Furthermore, even where some levels of day treatment may be required, these can and are provided in outpatient settings because they do not require "operating theatres, beds, staff". HCA's outpatient facilities such as the Platinum Medical Centre, have day-beds.

- (iv) Whilst HCA's administrative systems record the postcode given by the patient, it is not possible to deduce from this whether the patient, in fact, has his/her main residence in Central London, since patients may use a Central London postcode because: (i) their secondary residence during the week is in Central London; (ii) their temporary residence whilst receiving treatment is in Central London; or (iii) it relates to their place of work.²¹ This is noted in paragraph 18 of the Working Paper, which states BUPA's view that it is "*unclear whether these were all home rather than work addresses*".

3.3 Even if it were to be the case that a hospital is significantly drawing its patients from Central London, it is not clear what evidence the CC is relying on to indicate that residents in Central London are in some sense "captive" and would not travel out of Central London for treatment. It is not clear what analysis the CC has done to support this proposition. To suggest that these residents are "captive" to Central London providers is unfounded. In HCA's view, the willingness of patients to travel from Central London will be dictated by a number of factors:

- (i) Patients have a choice to make between different alternatives. Clearly many patients in Central London choose HCA's hospitals. This is consistent with HCA being successful in a highly competitive market. HCA is well aware that these patients would easily switch away to alternative providers (including the NHS, which boasts national centres in excellence) both in Central and Outer London if its quality were to drop. Self-pay patients and PMIs would also switch away/delist facilities if prices were to rise significantly.
- (ii) It will depend on where family or friends are based. A patient who has to go into hospital will often seek to be close to relatives. It should not be assumed that the patient's choice would always be to stay in Central London.
- (iii) A resident may simply reside in Central London during the week and have his/her main residence outside Central London – e.g. a City worker with a flat in the Barbican but the main family residence outside London. Such a resident may well prefer to go to a hospital which is closer to his/her main residence and closer to family and friends. It is likely that many residents with Central London postcodes will fall into this category.
- (iv) Consultant work patterns will also play a role, with some consultants having practising privileges in and outside Central London, offering a choice of facilities to their patients.
- (v) The convenience of location for aftercare (e.g. post-operative physiotherapy) can also influence a patient's choice of hospital.
- (vi) The price-sensitivity of self-pay patients, who "shop around" when seeking a healthcare facility for treatment, will also play a part.

3.4 In any event, it is abundantly clear from HCA's catchment area analysis, submitted in Exhibit 10.1 to HCA's response to the CC's Market Questionnaire, that HCA hospitals derive a substantial proportion of their patients from catchment areas which extend well outside London into neighbouring counties. An analysis of HCA's patient database shows that HCA hospitals typically draw [X] of patients from postcodes outside Central London. This means

²¹ According to census figures, nearly a quarter of a million people in London have a second home in which they live only part-time (see Evening Standard, 22 October 2012: "Homeowners with a part-time second property").

that at least this proportion of its patients is from outside Central London. For the reasons indicated above, this proportion is likely to be significantly higher, because a Central London postcode may mask the actual main residence of the patient.

3.5 Consequently, HCA's UK patients are heavily drawn from suburban and Outer London communities,²² areas which are served by local private hospitals that compete directly with HCA and other Central London providers.

3.6 This clearly demonstrates that patients are prepared to travel to receive the quality of care that is right for them and that represents the best value. There is no evidence to suggest that patients based in Central London would not also do the same if they felt the most competitive offer (e.g. based on price and quality) was located elsewhere. The CC has not presented any evidence to support the alternative view, nor has it provided any analysis to assess how Central London patients would behave following a change in the relative value of competing offers across the Central and Outer London areas. Instead it has simply observed that HCA draws a significant number of patients from Central London, a finding that is entirely consistent with a competitive outcome.

3.7 There are many providers outside Central London which are large, substantial and well resourced private facilities offering both low acuity and high acuity clinical specialisms. HCA refers to Exhibit 12.2 to its response to the CC's Market Questionnaire which sets out a detailed commentary on the capabilities and strengths of Greater London / Outer London providers. Examples include:

- BMI Clementine Churchill Hospital (Harrow), a substantial 141-bed facility with a level 3 ICU, which is a "head-on" competitor to the Wellington, Harley Street Clinic and Princess Grace.
- Spire, Bushey (Watford) which offers a comprehensive range of treatments and strong specialisms in cardiology, gynaecology and neurology, with a BUPA-approved cancer centre, as well as critical care level 2 facility.
- St. Anthony's Hospital (Cheam), one of the leading hospitals for complex cardiac procedures, which is supported by its level 3 critical care facility.
- New Victoria Hospital (Kingston) which has extensive imaging and diagnostic services in a wide range of medical and surgical specialities

3.8 HCA draws the example of a patient resident in Harrow, north-west London seeking private inpatient healthcare. The potential choice would at a minimum include:

- BMI Clementine Churchill (Harrow)
- Spire, Bushey (Watford)
- BMI Bishops Wood (Northwood)
- BMI Garden (Hendon)
- NHS Northwick Park Hospital PPU

²² The catchment area maps provided in Exhibit 10.1 of HCA's responses to the CC's Market Questionnaire indicate the Greater London and Home Counties regions from which each HCA hospital attracts patients.

- Central London providers.

The actual choice may be wider, depending on the patient's willingness to travel. HCA needs to compete at least with all of the above to attract this patient. The five providers in Greater London referred to above all offer a range of advanced clinical treatments. Therefore the patient's local alternatives would cater not only for low acuity conditions but also for highly complex, high acuity treatments including cardiac surgery and oncology services.

- 3.9 An analysis of the "top 10" areas of residence outside Central London of HCA's patients shows that there are substantial and credible alternative providers which compete in all these areas (e.g. [3<], etc.).
- 3.10 Even leaving aside the issue of whether and to what extent Central London patients would be prepared to travel, the fact that HCA draws a large number of patients from a wide geographic area, extending in to Greater London and the Home Counties, means that a large part of HCA's customer base is in competition with providers located outside Central London. There is no assumption that this patient would necessarily travel into Central London. The patient's choice would be based upon which hospital provides the better overall offering.
- 3.11 There are also major hospitals outside London which compete with HCA for patients and offer a locally-based alternative for patients. Examples include the Orwell Private Cardiothoracic Unit at Basildon, the Spire Harpenden Hospital and the Royal Buckinghamshire, a hospital that is strong in neuro-rehabilitation services. As HCA submitted in its response to the CC's Issues Statement, a new private hospital development, the Kent Institute for Medicine, is underway. The Institute will represent a new, highly-advanced tertiary facility, offering an additional local alternative for patients travelling to London, and looks set to become a strong competitor for HCA's hospitals.
- 3.12 One third party puts the position well in its comment to the CC (paragraph 24, Appendix 1, Working Paper): "*In the kind of Greater London space there are about 5 million people. They have a choice to make. They can move out of London or into London and we would like to equip our hospitals on the periphery to be able to attract some of those. Then we have the 1.6 million commuters that come into London every day to work and then go back out. Many of them pass our ... sites.*"
- 3.13 HCA cannot and does not distinguish, in its pricing or other aspects of its strategy, between patients in Central London and patients in Greater / Outer London postcodes (either self-pay or through its PMI contracts). Nor is HCA in a position to discriminate between any patients that would be able to travel large distances and those that would not. Therefore the choices available to such a large portion of HCA's customer base, located outside Central London, necessarily influence HCA's competitive behaviour in a way that affects all HCA's customers regardless of where they are located. For these reasons, it should be clear that the set of competitors that are relevant to assessing HCA's competitive constraints has to include providers located outside Central London. The CC has provided no evidence or analysis to indicate that this is not the case. HCA's pricing and its strategy towards PMI and self-pay patients is constrained by these hospitals and it necessarily takes account of competitors outside Central London when setting its strategy. The competitive constraints from these hospitals are therefore fundamental to HCA's business.
- 3.14 The CC also appears to be putting forward an alternative proposition that (paragraph 18) even if patients are not Central London residents, they are "*tied to Central London through*

work". However, there is no evidence to suggest that commuters into Central London feel "tied" to a Central London-based hospital for treatment. The CC does not refer to any considered analysis or survey evidence which indicates this to be the case. In HCA's view, it is unlikely that commuters who live in Greater / Outer London but commute into Central London for work would necessarily be treated in Central London or would not regard local providers in Greater / Outer London as competitive alternatives:

- (i) There may be a convenience factor in taking an outpatient appointment close to the commuter's workplace. By and large, however, patients may prefer to be admitted into a hospital which is close to family and friends, particularly for extended inpatient stays, unless there is a more compelling competitive offering based, for example, on quality and/or price that would lead them to consider a hospital further afield. This may ordinarily suggest a preference for a more locally-based provider. Accordingly, BUPA's allegation (paragraph 10, Appendix 1) that if a patient has a consultation in Central London it is "*highly likely*" that he/she will receive inpatient treatment at the same facility can be roundly dismissed. The CC's third party evidence seems to confirm this, with one party noting (paragraph 25, Appendix 1 of the Working Paper) that it "*had tried to put outpatient consulting rooms in Central London ... as a way to attract patients ... However, this was not a success.*"
- (ii) BUPA's Open Referral product and other directional initiatives (see paragraph 8.14 below) appear to be having some success in re-directing patients to lower cost hospitals outside Central London – this is a key plank of BUPA's strategy. This contradicts the assertion that commuters are somehow "captive" to Central London providers.
- (iii) BUPA itself has acknowledged that patients prefer to go locally for inpatient treatment. BUPA's Open Referral Q&A leaflet states: "*Generally, our members prefer to see a consultant close to their home address as 70% of all BUPA outpatient appointments lead to surgery and 70% of these are in the same location as the outpatient appointment.*"
- (iv) Indeed, the BUPA Minutes referred to in paragraph 10, which indicate that "*there would be potential benefits if its policyholders could be encouraged to have treatment outside Central London*" do not suggest that these patients are somehow "captive" or "tied".
- (v) HCA's experience with its outpatient facilities outside Central London confirms this. HCA has already provided the CC with the rate of inpatient referrals from its outpatient facilities to its own hospitals (see paragraph 8.38 of HCA's response to the CC's Annotated Issues Statement). [3<]. These locations are largely being used for local demand for outpatient and diagnostic services. Patient preferences can involve the desire to go to local hospitals for inpatient treatment, and therefore HCA has to compete vigorously to make the case to attract these patients into Central London, driving investment and innovation in its hospitals.

3.15 One third party refers to the "Harley Street aura". As a term, it is meaningless. Obviously, there are numerous successful high-quality providers in and outside Central London which are not on Harley Street. Indeed the two largest and best-performing HCA hospitals are not located on or anywhere near Harley Street. HCA believes the focus of any successful

provider must be on creating a high-quality clinical environment which leading consultants are willing to join. It is as possible to do this in Greater London as it is in Central London.

- 3.16 As the CC will have seen from HCA's strategy documents, it is increasingly conscious of competitors in Greater London and is looking to grow patient business in Greater London and Outer London catchment areas (see for example **Exhibit 2**, an extract from the HCA's 2012 [redacted]).
- 3.17 Insurers typically market both Central London and Greater London providers to their subscribers, which confirms that they view facilities outside Central London as viable, competitive alternatives to HCA's Central London hospitals:
- (i) PMI restricted networks include both Central London and Outer London providers. For example, AXA PPP's uses a single Greater London list. Aviva's former London list (no longer marketed) comprised hospitals across London, including beyond the North and South Circular. Similarly, BUPA's Extended Choice product includes both major Outer and Central London providers for London subscribers.
 - (ii) BUPA's facilities finder on its website gives a broad range of destinations for its London customers. For example, a search on this tool for a hospital in "NW8" (St. John's Wood) returns results as far and wide as Epsom, Sutton, Watford, Orpington and Beckenham amongst its top ten results.
- 3.18 The wholly contradictory position of the PMIs on this issue is illustrated by AXA PPP's submission to the CC of 20 July 2012 which presents a case study (page 46). The case study related to a "Dr. X" who practises both at Spire (Bushey) and at HCA's Wellington Hospital. [redacted]. It is apparent that AXA PPP regards Spire (Bushey) as a competitive alternative to the Wellington, and believes that "Dr. X" should carry out more of his cardiac tests in Bushey, at (allegedly) a lower price. Therefore, from AXA PPP's point of view, these two hospitals at which [redacted] practices are direct competitors which are suitable for AXA PPP subscribers.

4. NHS PPUs

- 4.1 The Working Paper does not sufficiently acknowledge the competitive constraints afforded by NHS PPUs and the significant expansion of PPUs which is taking place over the next few years, which will increase capacity in Central London even further.
- 4.2 Paragraph 33 of the Working Paper selectively lists some but not all of the PPUs in Central London (it omits for example King's and Imperial, both significant PPUs):
- Chelsea and Westminster
 - Great Ormond Street
 - Guy's & St. Thomas²³
 - Imperial (incorporating Hammersmith Hospital, Charing Cross Hospital, St. Mary's Hospital and Queen Charlotte's and Chelsea Hospital)

²³ HCA does not operate Guy's and St. Thomas' PPU – this appears to be a commonly expressed misconception. HCA has a partnership with Guy's to develop a new cancer PPU, which does not affect Guy's existing private services.

- King's College
- Moorfields
- Royal Brompton
- Royal Free
- Royal Marsden²⁴
- UCLH
- Barts Health
- Royal National Orthopaedic.

Please refer to the analysis of competitors in Exhibit 12.2 of HCA's response to the CC's Market Questionnaire, which set out full details of the size and capabilities of these PPU's.

4.3 There are also PPU's in Greater London:

- Kingston Hospital (BMI Coombe Wing)
- Northwick Park Hospital "Trustplus" PPU
- Harefield Hospital PPU
- The Knutsford Suite, Watford
- Northey Suit, Epsom Hospital.

4.4 These PPU's are strong competitors for numerous reasons previously set out in HCA's submissions²⁵ and briefly summarised as follows:

- Many of these are sizeable facilities with significant bed capacity.
- They are separate, dedicated facilities which offer the same patient experience, clinical outcomes on a par with independent hospitals.
- They provide the same breadth of clinical services as independent providers, some having highly specialised facilities in tertiary services including cardiac and cancer care.
- They enjoy the NHS "brand", being linked to major NHS teaching and research institutions, which gives them a national and international renown.
- In London, PPU's are typically recognised by the major PMI providers and attract significant numbers of self-pay and overseas patients, for whom the reputation of the

²⁴ The Royal Marsden, which operates a particularly large PPU and is enjoying double-digit growth with turnovers in excess of £50 million, has been highlighted as a highly formidable competitor in HCA's submissions to the CC, and was recognised by AXA PPP in its response to the Annotated Issues Statement as an "elite hospital".

²⁵ See e.g. section 7 of HCA's response to the Issues Statement; paragraphs 19.3-19.6, HCA response to the CC's Market Questionnaire.

major NHS hospitals has a strong appeal. HCA finds that [§<] it is competing to attract are regularly sent by their medical attaché team to NHS PPUs instead.

- Most consultants have an NHS post, and many typically use the Trust's PPU which is co-located on the same site for their private practices and thus PPUs have ready access to leading consultants in a broad range of specialisms.²⁶

4.5 In addition to PPUs, many NHS Trusts have pay beds within the main NHS hospital. Also, not all private treatment in the NHS requires an overnight bed. Accordingly, the income which NHS Trusts derive from private patients is likely to be greater than the income from the PPU alone. This needs to be taken into account in considering the competitive threat of NHS private provision.²⁷

4.6 There is no mention in the Working Paper of the in-built competitive advantages which PPUs enjoy over private sector providers such as HCA. These have been fully discussed in HCA's previous submissions²⁸ and are highlighted in previous reports by the Department of Health and by Monitor. These advantages include:

- Access to infrastructure – the ability to access the NHS's land and infrastructure such as intensive care units. Indeed, Aviva recognised that *“in the case of some complex surgery a consultant may recommend the use of a PPU due to the availability of NHS intensive care facilities”*.²⁹
- Consultant convenience – the co-location of the NHS hospital with a PPU provides a strong advantage in terms of attracting consultants for their private patient lists. In addition to the convenience that comes with the PPU's close proximity to the NHS hospital, the availability of junior medical staff allows for monitoring of the patient's condition, e.g. for high-acuity cases, which frees up time for the consultant. Consultants also prefer NHS PPUs over independent hospitals if they perceive there is an advantage to practising with a team of medical staff that they are very familiar with and have a high level of trust in. This also takes on added importance for complex, high-acuity cases. HCA has previously observed that consultants will bring NHS registrars with them into the private sector for this very reason.
- Pensions - PPUs have a competitive advantage in that they do not need to contribute to staff pension costs and can offer highly attractive NHS pensions without any additional cost to the commercial business.
- Cost of capital – NHS Trusts are able to raise capital at a considerably lower cost than private hospital operators which is particularly important given the growth and expansion plans of many PPUs.
- Tax – there are significant tax advantages e.g. no liability to corporation tax.

PPUs are able to reflect these cost advantages in their pricing to PMIs and to self-pay patients.

²⁶ HCA notes that according to the CC (paragraph 10, Appendix 1, Working Paper) AXA PPP suggested that *“specialists [have] a bias towards avoiding treating their private patients in the NHS facility they work in.”* This is totally contrary to HCA's experience in the market.

²⁷ See BMI's response to the AIS of 15 April 2013 (paragraphs 4.30-4.32)

²⁸ See e.g. section 7 of HCA's response to the Issues Statement

²⁹ See paragraph 14, Appendix 1, Working Paper

4.7 The CC's estimates of installed capacity in Central London are wrong because they exclude NHS PPUs. The CC states that it has focused on "*private hospitals only*" because "*We do not have data on the capacity of PPUs which is dedicated to private patients...*". However, the CC should note the following:

- Estimates based on Laing & Buisson data³⁰ suggest that PPU beds account for approximately 25% of total bed capacity in Central London. Failing to account for these competitors would therefore significantly misrepresent the supply market share of HCA's facilities.
- While PPUs may not have dedicated theatres, the theatre capacity within the main NHS hospital is available to the PPU and can be flexed according to demand. The CC would be able to obtain from NHS Trusts an indication of the extent of theatre use by private patients in any given year as a guide.
- PPUs also have dedicated outpatient facilities – e.g. the Royal Brompton Outpatients Clinic which is described as London's "*leading private diagnostic and treatment clinic for patients with heart and lung related conditions*".

The omission of PPU capacity, in a table which purports to indicate "installed capacity in Central London hospitals", is highly misleading and inflates the capacity shares of other hospital operators active in London.

4.8 Some third parties have sought to argue that, in terms of access to NHS theatres, NHS Trusts prioritise NHS over private patients. However, in the context of the lifting of the private income cap and the commercial pressures on NHS Trusts to maximise private revenue to compensate for cuts in Government funding, NHS Trusts are increasingly keen to develop their private offering, and are therefore unlikely to create "bottlenecks" which could damage their reputation with private patients. On the contrary, PPU, specifically market the fact that they offer easy transfer into NHS critical care beds to give patients peace of mind – for example Chelsea and Westminster's website³¹ states: "*The option of transfer to NHS care is available and fees will be calculated up to the date of transfer.*"

4.9 It must also be emphasised that the insurers themselves regard PPUs as direct and credible alternatives to independent hospitals for their subscribers:

- As stated above, PPUs in London are typically recognised by the PMIs.
- PPUs are invariably included across all network products that offer coverage in London.
- It has been shown that PPUs alone can comprise the constituent providers of a network product, e.g. Aviva's trust care network, a policy specifically tailored to PPUs.
- PPUs have been credible and successful bidders in service-line tenders. In the case of BUPA's TAVI network tender,³² the winning bidders in London solely comprised PPUs.

³⁰ Laing & Buisson, Laing's Healthcare Market Review 2011-2012, Table 2.13, pp. 85-86

³¹ www.chelwest.nhs.uk/private-care/private-maternity-unit/price-list

³² Transcatheter aortic valve implantation (TAVI), a cardiac surgery procedure that HCA has invested in as part of a well-established offering to international patients.

- 4.10 It is no surprise that PMIs are drawn to PPUs as there is a capability of cross-utilising NHS resources (e.g. critical care facilities) available to the PPU, at nil cost to the PMI, for example, once the patient is transferred into an NHS critical care bed, the NHS bears the costs.
- 4.11 The Working Paper makes no mention of the expansion of PPUs in London which is already well underway. The removal of the private patient income cap, under section 165 of the Health and Social Care Act 2012, is already paving the way for Foundation Trusts to significantly expand PPU provision. Longer term, the anticipated reductions in Government funding of the NHS provides a strong incentive for NHS Trusts to develop other revenue streams. By way of example, the CC has noted (paragraph 18, London Clinic case study 2) that the Royal Marsden "*hope to double the amount of revenue that [is] generated from private patients*" following additional investment in capacity at both its Chelsea and Sutton sites. A number of NHS Trusts are currently taking steps to expand their PPUs – either alone or in partnership with the private sector – which will significantly increase capacity over the next two to three years.
- 4.12 There are a number of examples of expansion plans which have been publicised:
- (i) St. George's Healthcare NHS Trust has launched a tender exercise for a new private patient hospital development. The Trust is seeking an independent provider to finance, build and operate a private patient facility at its Tooting site. The development will include out patient services, diagnostics, specialist surgical theatres, and robotic surgery plus state of the art laparoscopic theatres together with high dependency units. Services are expected to cover paediatrics, oncology, cardiothoracic surgery, neurosciences and neurosurgery.
 - (ii) The Chelsea and Westminster Foundation Trust has in its recent annual report³³ listed as a strategic priority "*exploring opportunities for growth*" and that it intends to "*grow private patient income through short term and long term opportunities, following changes to the cap on private patient activity*". The Trust is already investing in the refurbishment of its dedicated adult private patient ward. It has increased maternity revenues by 20% this year, recruited a new general manager for private patients, and is being promoted by BUPA for maternity patients.
 - (iii) King's NHS Trust has launched a tender for a strategic partner for new private hospital facilities. The contract notice states that "*the removal of private patients cap provides an opportunity to significantly increase the volume of private work currently undertaken*". The project is intended to build, finance and operate a dedicated PPU on the King's College Hospital site, including new operating theatres and approximately 60 beds (tripling its existing private patient bed capacity). It is expected that the Trust's existing private patient operations would then be migrated to the new PPU. The Trust anticipates that the project would be for a 20 year term with development costs in the region of £100-£200 million, with expected revenues of around £50 million per year. It will include a range of tertiary services, including liver surgery, bone marrow transplants and neurosciences.
 - (iv) Imperial College Healthcare NHS Trust has recently invested £9 million in upgrading the Lindo Wing PPU and plans to significantly expand private maternity services.

³³ Available at www.monitor-nhsft.gov.uk

- (v) Barts Health NHS Trust has advertised for a partner to develop and operate a new dedicated PPU at the site of St. Bartholomew's Hospital, and it is understood that the Aspen Hospital Group has been selected to take the project forward, significantly expanding the Trust's range of cancer and cardiac private healthcare services.
- (vi) The Royal Marsden's recent publication "Private Care"³⁴ highlights a whole series of investments to bolster its private care offering. This includes the opening of a "ground-breaking" cancer diagnosis and research facility, the refurbishment of its Chelsea PPU (with state-of-the-art facilities), the appointment of senior management dedicated to service quality in its Private Care Division, and enhanced diagnostic equipment which it claims: "*will enable us to provide a full suite of diagnostic services at each site, and we will be working closely with referrers and insurers to offer an excellent one-stop service for our patients*".³⁵

The OJEU contract notices advertising these and other London PPU partnering opportunities are attached in **Exhibit 3**.

4.13 While these are all examples of projects in the public domain, there are undoubtedly other expansion projects which have not been officially publicised.

4.14 The expansion plans of NHS Trusts, not only in London but across the UK as a whole, have received significant media attention. The Guardian carried a recent article which was based on information obtained under the Freedom of Information Act. It noted:

"Great Ormond Street Children's Hospital has budgeted for an extra £11 million from treating private patients in the financial year ending in 2013 compared with 2010 – a 34% increase. The Imperial College Healthcare NHS Trust is also expecting to boost revenues by £9 million over the same period – a 42% rise. The Royal Marsden is expecting an extra 28% increase on 2010 revenues, equating to about £12.7 million. Across all Trusts an 8% increase in revenues from private patients is expected to be posted for 2012-2013 compared with 2010-2100.

*Of the country's 146 Foundation Trusts – each of which has a significant degree of financial autonomy – 40 plan to open private patient units. Trusts are also involved in a range of spin-off businesses, from the Moorfields Eye Hospital's multi-million pound Dubai Eye Hospital to Rotherham Hospital's private hair removal service ..."*³⁶

4.15 Based on these figures, the private patient revenue of the three PPUs cited in the article (Great Ormond Street, Imperial, and Royal Marsden) is growing by over 30% (from £98 million to £130 million) in the period 2010/11 to 2013/14. Total private patient revenues across all London PPUs will account for a substantial and growing share of private healthcare.

4.16 It is noted that AXA PPP in its submissions to the CC recognises the potential for expansion of London PPUs and that many of these will "*become significant competitors in the Inner London "elite" market in the future...*".

³⁴ Issue 5, 2013, <http://www.royalmarsden.nhs.uk/private-care/magazine/private-care-magazine-5.pdf>.

³⁵ *Ibid*, page 4.

³⁶ "NHS hospitals in bid to treat far more private patients", the Guardian, Saturday, 6 April 2013.

5. NHS constraints

- 5.1 The Working Paper makes no reference to the role of the NHS and the constraints which NHS public healthcare exercise on the private healthcare sector, particularly in London, where major, internationally renowned NHS teaching hospitals exist alongside private hospitals.
- 5.2 The CC's Annotated Issues Statement rightly acknowledges the competitive interactions between the NHS and the private sector (paragraph 25, AIS). The CC stated: "*Our analysis to date has confirmed that these characteristics play a key role in assessing competition in the provision of privately-funded healthcare services.*" (paragraph 26, AIS). It is therefore all the more surprising that the Working Paper in relation to London omits any reference to NHS hospitals and the competitive impact they have on private healthcare operators.
- 5.3 The major NHS teaching and research hospitals (e.g. Royal Marsden, UCH, King's College, Royal Free, Barts, Guy's and St. Thomas' and St. Mary's) are a hallmark of healthcare in London and have made London a leading centre for tertiary services internationally. London is renowned as a major medical centre with clinical specialists at the top of their field. The London hospitals are leading centres of research and innovation. HCA has previously described (see response to question 13 of the CC's Market Questionnaire) the range of services and facilities which NHS hospitals in London provide in areas such as cancer care, cardiac, neurosciences, maternity and paediatrics.
- 5.4 Traditionally, the provision of complex, tertiary services such as oncology has been the preserve of the NHS. At the time that HCA first invested in its hospitals, private provision of high acuity procedures was very limited, save in the NHS PPUs. HCA's vision was to upgrade the hospitals it acquired and transform them through large-scale investment into leading providers of tertiary care which would offer an alternative to the NHS. HCA has led the way in creating and developing a private market (outside the PPUs) in areas such as cancer, cardiac and neurosurgery. Others, such as the London Clinic and the BUPA Cromwell, have followed in HCA's path. However, the NHS remains the dominant provider of these services and is free at the point of delivery.
- 5.5 In earlier submissions, HCA has described the competitive pressures which NHS hospitals provide:
- There is a strong and pervasive perception that major NHS hospitals, which have the full infrastructure of emergency support and intensive care, are a better option for high acuity complex cases.
 - There is a correlation between NHS waiting times and private healthcare demand, and in recent years improvements in waiting times for cardiac treatment has led to a reduction in HCA's patient volumes (Annex 4 of HCA's response to the Issues Statement illustrated this correlation for the CC). The CC's patient survey identified "reduced waiting times" and "availability of appointment times" as amongst the predominant reasons for choosing private healthcare, but these are factors which are entirely dependent on the performance of the NHS at any particular point in time.³⁷

³⁷ GfK patient survey, Nov/Dec 2012, slide 25.

- The Government's promotion of an open, competitive market within the NHS (for example, through its Choose and Book system) allows greater patient choice between different NHS hospitals, focuses investment by NHS Trusts in quality of care and has eroded the traditional delineations of public and private healthcare.
- The NHS also competes, to an extent, for consultant time over and above the NHS contracted hours.

5.6 The CC has seen compelling evidence that a large proportion of patients see NHS treatment as a competitive alternative to private healthcare:

- As the CC will note in one of HCA's strategy documents ([§<]), HCA estimated that [§<] Londoners with PMI were opting for NHS treatment instead of using private hospitals available under their PMI policy.
- A survey commissioned by HCA and carried out by Boston Consulting Group shows that a substantial number of patients using NHS treatments are covered by PMI policies. In the survey, [§<] of NHS patients in Greater London were insured but nevertheless elected for NHS rather than private treatment (see paragraph 7.17 of HCA's response to the CC's issues Statement).
- The CC's own survey³⁸ indicated that 29% of all private hospital patients considered having their tests/treatment done on the NHS, and 68% of self-pay patients considered NHS treatment. This demonstrates that the NHS is a very strong competitor for self-pay patients, and this will particularly be the case for more complex treatments. This proportion can be reasonably expected to be higher in London because of the presence of major NHS teaching and research institutions.
- Similarly, the CC's survey of GPs³⁹ showed that 55% of GPs do not usually discuss the options for private treatment with patients, indicating that at the point of GP referral, most patients are being "steered" towards NHS treatment as the most appropriate option, which bears out the comment above that the NHS is typically seen as the "natural choice" for more acute conditions.
- HCA recently submitted to the CC an independent survey from Laing & Buisson which concludes that 1 in 3 PMI subscribers elect for non-emergency NHS treatment rather than claiming on their PMI policy (see email to Christiane Kent dated 8 November 2012, with a copy of the L&B report).

5.7 There is therefore strong evidence that, given the presence of major, internationally renowned NHS teaching hospitals in London, patients view the NHS as the "natural" or "better" option for high acuity, tertiary treatment. This means that private healthcare provider such as HCA have to work hard to make the case for private healthcare to these patients. In other words, faced with NHS provision, private providers have to incentivise patients to opt for private healthcare as an alternative to NHS healthcare. This is one of the factors driving investment in innovation and new clinical services and technologies. The existence of major NHS hospitals creates a powerful incentive on private hospitals to "up their game" and maintain high quality standards and clinical outcomes. In the section entitled "Competing to innovate" in HCA's response to the Issues Statement, HCA provided examples of how NHS

³⁸ GfK patient survey, Nov/Dec 2012, slide 16

³⁹ GfK survey of GPs and consultants, Nov/Dec 2012, slide 28

hospitals can be key competitors in London when it comes to investing in innovative treatment technologies.

5.8 HCA also reiterates the point that the insurers clearly regard NHS hospitals as competitive alternatives for their subscribers:

- Insurers such as BUPA offer incentives to use the NHS rather than private healthcare by providing "no claims" bonuses or discounts.
- Some insurers offer "cash back" schemes to patients who opt for NHS rather than private healthcare. BUPA, for example, is offering significant cash payments of £500-£2,500 to patients for cardiac treatment and, for cancer patients, up to £10,000 for bone marrow transplants in the NHS.
- Some PMIs, such as AXA PPP, operate a "six week" rule whereby private healthcare is only available if treatment is not provided on the NHS within six weeks.

Thus, insurers create the conditions to encourage subscribers to be treated in the NHS rather than in private hospitals, and this in turn creates further competitive pressures on private hospitals to make the case for private healthcare by investing to improve and maintain quality and clinical services. This issue is discussed further in section 8 below.

5.9 All of these factors must be seen in the context of a growing commercialisation within the NHS. NHS hospitals are gearing up to establish commercial facilities overseas for international patients and the Royal Marsden, Great Ormond Street and Guy's and St. Thomas' Hospitals are establishing links with foreign governments with this objective in mind.

5.10 In London, the NHS has substantial holdings of land which can readily be used to create new NHS facilities and services, which would add further competition for private providers. By way of example, it is believed that the [§<] owns a large, empty building which can readily be converted for additional clinical use within a short space of time.

5.11 Competition from the NHS is further demonstrated by the fact that the existence and quality of an NHS hospital is one of the factors which new entrants take into account. This is illustrated in the Circle/Bath case study on entry and expansion, in which the problems and issues facing the main NHS hospital in Bath was one of the factors which Circle took into account when contemplating its new development, on the basis "*that the superior facilities of its new hospital will attract NHS patients ...*" (paragraph 17, Entry and Expansion case study 1).

5.12 Furthermore, in considering the total capacity of critical care beds in London, the CC needs to take account of NHS critical care facilities, given that the NHS is an important competitor for higher acuity treatments. It is estimated that in the NHS there are 843 critical care beds in hospitals within the London Strategic Health Authority, of which 485 are at level 3 and 358 at level 2.⁴⁰ This dwarfs the critical care capacity offered by private operators such as HCA. There is substantial ICU capacity within the NHS which competes alongside critical care offered within private hospitals and is available for private hospitals without their own ICU

⁴⁰ Department of Health, 'NHS Organisations in England, January 2011', Open and staffed adult critical care beds at 17 January 2011, by location and level of care at 17 January 2010. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Beds/DH_077451.

facilities, if required. BMI's response to the CC's Annotated Issues Statement (paragraph 4.24) gives the example of BMI's investment in an ICU at its Blackheath hospital, in an area where critical care provision was only available within the NHS. The same applies to other areas of tertiary care, such as radiotherapy, where private operators are increasingly creating facilities which offer an alternative to the NHS.

6. Overseas competitors

- 6.1 It is disappointing that the CC has not acknowledged the international dimension to HCA's business and the fact that HCA derives approximately [3%] of its revenues from overseas patients. This creates an additional competitive dynamic in that HCA competes for a significant proportion of its patient base against leading healthcare providers in other countries.
- 6.2 HCA hospitals draw patients in a number of countries, in particular Kuwait, Saudi Arabia, United Arab Emirates, Qatar, Cyprus, Pakistan, and Russia. These are countries where, as a result of growing economies, demographic factors and domestic medical infrastructure, patients wish to access private healthcare overseas.
- 6.3 HCA is in direct competition for these overseas patients with leading hospitals in the US (e.g. the Mayo Clinic and Cleveland Clinic), Germany, France, and Singapore as well as with other London based hospital operators such as The London Clinic. HCA refers to its "[3%]", submitted in response to the CC's first day letter.⁴¹ This document sets out HCA's view of the competitive landscape for international business, the range of providers competing for these patients, and the growth opportunities.
- 6.4 As indicated above, major NHS teaching hospitals, including the Royal Marsden, Great Ormond Street, Kings College and Guy's and St. Thomas', are also increasingly marketing their brands overseas with a view to attracting international patients.
- 6.5 Leading, world-class clinics contribute to the competitive constraints (in terms of pricing, breadth and quality of service) on HCA in respect of a significant proportion of its business. They provide further pressures and incentives for HCA to invest in its facilities, implement innovative treatment technologies and constantly improve clinical outcomes – all to the benefit of insured, self-pay and international patients.

7. Barriers to entry and expansion

- 7.1 The CC's assessment of horizontal competitive constraints cannot be carried out in isolation from its analysis of barriers to entry and expansion in London. The competitive constraints on a business include the potential for competitors to enter the market and/or develop and expand their services and respond to market opportunities. This potential imposes a competitive constraint on existing players, whether or not expansion actually takes place. This happens because incumbents want to avoid relaxing their competitive efforts in order to prevent new entrants from gaining market share in the future. Additionally, entry provides a direct constraint whenever it actually occurs, in response to an increase in demand or a

⁴¹ First day letter dated 4 April 2012, Annex C (off-the-shelf material), documents submitted in response to paragraph 4.

reduction in incumbents' competitive efforts. These imply that competitive constraints are much more significant than would be implied by market share and fascia measures.

7.2 HCA has evidenced in its previous submissions that there has been a strong record of entry and expansion in London (including Central London) in recent years:

- In 2009, and following its exclusive tie-up with AXA PPP on the Corporate Pathways network, BMI announced to its consultants a series of investments that had "*recently expanded its footprint into London*" (see **Exhibit 4**). This included the acquisition of the Fitzroy Square Hospital, which in 2011 opened a new gynaecological unit offering a comprehensive range of services for women's health.
- In 2010, BMI opened the Weymouth Hospital, a joint venture between BMI and the Phoenix Hospital Group, which provides a range of in-patient and day-case procedures close to Harley Street.
- The London Clinic has opened a new £90 million cancer centre, a purpose built state of the art facility dedicated to cancer care, diagnosis and treatments.
- BUPA has embarked on a £30 million programme of investments in the Cromwell facility to refurbish the hospital's infrastructure and on new equipment to develop its cancer care, neurosciences, diagnostics, paediatrics, family medicine, endoscopy and orthopaedic services.
- The London International Cancer, Heart and Brain Hospital is a current 150 bed acute private hospital development in Ravenscourt Park, backed by investors C&C Alpha Group. It is reported to be opening in 2014, with a total investment of around £100 million.

7.3 HCA is alive to the fact its competitors are constantly expanding their scope and quality of services. For example, BMI Healthcare noted in an Annual Report that its "*focus is now on...high acuity services, high end technology, and clinical innovation to respond to market dynamics*". It notes that this would involve an "[e]xpansion of the range of specialisms that can be delivered privately."⁴²

7.4 A number of PPUs have also invested in refurbishing and expanding their facilities in Central London:

- (i) The Royal Marsden opened a new private care wing in 2011 following a £6 million expansion and refurbishment programme.
- (ii) The Chelsea and Westminster NHS Foundation Trust recently refurbished and expanded its birthing centre PPU which completed in 2011.
- (iii) St. Mary's Hospital, part of Imperial Healthcare NHS Foundation Trust, recently refurbished and expanded its PPU, the Lindo Wing.

7.5 As stated above, given the lifting of the private patient cap, several London NHS Trusts are also looking to set up or expand PPUs, either on their own or in partnership with the private sector, which will significantly increase capacity in Central London over the next few years.

⁴² http://www.bmihealthcare.co.uk/graphics/images/about_BMI/BMI-AR-10-11.pdf. See page 7.

7.6 There has also been strong growth in outpatient and diagnostic centres in London, as an increasing number of new entrants have invested in outpatient and day case facilities, exploiting the trends in private healthcare from inpatient to outpatient/day case treatments:

- The St. John and St. Elizabeth Hospital has recently invested £11 million in new services including an outpatient facility, a day case centre and a primary care centre.
- BMI has opened a number of diagnostics and outpatient centres across London including BMI City Medical in Bishopsgate and 9 Harley Street.
- Aspen Healthcare established "Parkside at Putney" providing outpatient consultations, diagnostics and minor procedures in 2012.
- In addition, there have been a number of consultant groups which have established outpatient and diagnostic facilities in Central London, including Fortius Clinic and Medical Chambers UK. A simple "Google" search elicits an array of private outpatient, diagnostic and day case clinics in Central London such as Portabello Clinic and Cadogan Clinic, offering a wide range of consultations, treatments, diagnostic tests and related services.

7.7 London has special characteristics which create an attractive environment for investment and development by private healthcare providers:

- It has higher PMI penetration rates than other parts of the country: Laing & Buisson estimated that in 2006 PMI penetration was 18.5% in the south east as against 12% in the UK as a whole. On this basis, there are an estimated 1.5 million insured individuals in London.⁴³
- It is recognised as a leading centre of tertiary care in the UK and worldwide. In view of demographic factors, specifically the growth of the over-65 population, there is significant growth in higher acuity, tertiary services and specialisms such as cancer, cardiac, neurosciences, paediatrics and orthopaedics. The Finnamore strategy paper "[<]" previously submitted to the CC [<].
- The Finnamore report also notes that London benefits from a higher growth of the 0-15 population which will drive demand for paediatric services in the coming years.
- There is a large pool of around 7,500 NHS consultants available to new entrants.
- There is a significant proportion of overseas patients, particularly for higher acuity treatments, which would be a further source of revenue for new entrants.

7.8 Accordingly, there are strong long-term growth opportunities in London which make new entry and expansion both attractive and profitable. The CC's finding that in some parts of the country limited demand can potentially create entry barriers simply does not apply in the case of London.

7.9 There has been substantial growth in Central London in the last few years. An analysis of the published accounts of Central London providers in the period 2006-2011 shows the following:

⁴³ Estimated based on population figures available from the ONS based on the 2011 census. Data available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-270247>.

- The Central London market grew by at least £323 million (49% growth). This figure does not include Aspen and BMI Central London hospitals, since their accounts do not break down individual hospital figures, therefore the total growth is even higher.
- This growth shows significant expansion by PUs, including the Royal Marsden (which grew from £31.8 million to £51.1 million), Royal Free (£12.7 million to £19.9 million) and Great Ormond Street (£21.4 million to £25.5 million) in this period.
- While HCA has accounted for [§<] of the growth in revenue (including through its successful offering to international patients),⁴⁴ this still demonstrates that several other providers have achieved significant growth in this period, seizing the opportunities of the trends in demand, particularly in tertiary services.
- The growth in revenue is consistent with the increase in capacity and investments by providers, e.g. the London Clinic which grew from £75 million to £124.3 million in this period.
- Growth has been experienced by many different providers, including relatively smaller facilities such as St. John and St. Elizabeth (£35 million to £45.9 million) and King Edward VII (£15.2 million to £19.2 million).

7.10 The evidence which has so far been presented in this inquiry indicates that there are no significant barriers to entry and expansion in the London market which are deterring or impeding new entrants:

- (i) The CC has already indicated in the Annotated Issues Statement that capital costs are not in themselves a barrier to entry, and this is evidenced by the fact that, in London as elsewhere, there continues to be substantial investment in new inpatient and outpatient facilities.
- (ii) Similarly, the CC has stated in the Annotated Issue Statement that the planning regime does not impede or deter new entry and expansion. HCA has explained the approach of planning authorities to new healthcare facilities. Its own experience in securing planning consents has been positive.
- (iii) HCA highlighted in a recent submission to the CC⁴⁵ the wide availability of property sites for full-scale hospital development in prime locations in London that have recently been brought to its attention.
- (iv) The CC's Working Paper relating to consultant incentives rightly concludes that incentive schemes have not had the effect of excluding new entrants and, on the contrary, may in fact facilitate new entry by enabling new entrants to secure the commitment of consultants to the new venture. In London, where there is a large pool of NHS consultants, hospital providers have not experienced any difficulty in gaining access to consultants in order to launch new facilities or services.
- (v) There is no evidence that PMI/provider contracts in London have had the effect of impeding new entrants. There is no evidence that PMI contracts are having foreclosure affects. None of HCA's contracts with PMIs are exclusive or restrict the

⁴⁴ HCA has grown its international patient revenues in respect of a number of services lines, most notably in [§<].

⁴⁵ See HCA's comments on the CC's London Clinic case study, page 5 ("Availability of sites").

recognition of competitors. On the contrary, the PMIs have fostered and assisted HCA's competitors by creating networks which include HCA's competitors but exclude HCA's hospitals. Examples include AXA PPU's Corporate Pathway product, which is exclusive to BMI and the London Clinic; and Aviva's Key Hospitals network which includes the Cromwell and the London Clinic.

7.11 There are even lower barriers to entry and expansion for outpatient and diagnostic facilities, and as stated above there has been impressive new entry and growth by a range of providers which have established new outpatient and diagnostic clinics across London.

7.12 The CC's case study concerning the London Clinic illustrates the ease with which one of HCA's competitors has expanded its services with a substantial £90 million investment in a new cancer facility which is "operating profitably" within a space of just 2-3 years. HCA refers to its recent submission commenting on this case study. It is a textbook example of the way in which competitors are responding to the growth in tertiary services in London, increasing capacity, and widening choice.

7.13 The CC indicated in its case study that the availability of property "*in the immediate vicinity of Harley Street*" may represent a barrier to entry, but HCA has already submitted evidence that there are [§<]: please see HCA's response to the CC's London Clinic case study.

7.14 The CC's Guidelines for market investigations (see paragraph 205 et seq) stress the importance of the CC's assessment of barriers to entry:

"Entry or expansion by firms will often stimulate competition and, as noted in paragraph 175, the prospect of entry and expansion within a short timeframe can sometimes countervail against a prospective AEC decision. The possibilities of entry by outside firms, or the expansion of incumbent firms have featured in most findings on whether or not there is an AEC in the market."

7.15 The Working Paper wrongly takes a "static" view of the market and fails to recognise the dynamic and evolving nature of competition in London which has manifested itself in:

- greater choice for PMI and self-pay patients;
- increased investment in new clinical services and technologies;
- the delivery of care across a range of settings, including hospitals, day-case facilities (such as HCA's Platinum Medical Centre) and outpatient centres; and
- better clinical outcomes for patients.

7.16 In the Working Paper, the CC undertook analysis to assess hospital operators' shares of admissions by specialism (Table 9) and found that HCA has high shares of supply by admissions and even possibly higher shares by revenue for individual specialisms. HCA thinks this approach is misleading. As the CC noted in the Annotated Issues Statement, the product market for provision of hospital services is characterised by significant supply-side substitution.⁴⁶ HCA considers that there are generally low barriers to switching between specialisms, just like there are low barriers to expansion, as set out in this section. It is possible to attract new consultants for specialisms not currently provided and to invest in any additional equipment required. The CC has not explained in what way supply-side

⁴⁶ See Annotated Issues Statement, paragraph 29.

substitution might not operate in London to the extent that it does elsewhere. Therefore shares by individual specialisms do not provide a reliable description of market shares, and even less so of competitive constraints.

- 7.17 Similarly, the CC's analysis presented in Table 7 and Table 8 of the Working Paper is also misleading. The CC has analysed "complex specialties" as a potentially separate product segment. It has provided no justification for selecting the five specialisms, or suggested that there are specific barriers to hospital operators supplying treatments in these specialisms such that supply-side substitution is not possible. Table 7 presented the shares of supply for the five specialisms together, while Table 8 set out the number of hospitals by number of complex specialisms offered.
- 7.18 This does not represent an informative or robust approach to evaluating competition, for a number of reasons. First, it is not the case that a hospital operator has to be able to provide all five specialisms together in order to effectively compete. In each of the individual specialisms HCA faces a number of competitors, which the analysis in Table 8 understates. Second, PMIs are able to select a number of other hospital operators aside from HCA to provide treatments to its customers for each of the specialisms. They are not reliant on needing one provider to supply all five together. Third, for self-pay patients, hospital operators compete with each other on the basis of the specific specialism for which the individual patient requires treatment.

8. PMI bargaining power

- 8.1 As noted in section 1 above, the issue of PMI bargaining power is relevant to the discussion of horizontal competitive constraints in London for a number of reasons.
- 8.2 The CC initially indicated that it would publish a Working Paper on bargaining power, in which these issues would be considered, but it appears that the CC has decided not to publish such a paper. HCA will not repeat the detailed submissions it has already made concerning PMI bargaining power, but since there is virtually no discussion of this issue in the Working Paper, HCA briefly summarises the main points below.
- 8.3 HCA stated in its response to the Annotated Issues Statement⁴⁷ that it believes that the relative bargaining power of PMIs and hospital operators can only be properly assessed considering the outside options of each party at the same time. The market power of PMIs in their downstream market is an important determinant of a hospital operator outside option, and without explicit consideration of these factors, HCA's view is that any assessment of hospital operators' supposed bargaining power in their negotiations with PMIs is fundamentally flawed.
- 8.4 HCA has previously submitted to the CC that it faces significant PMI bargaining power. This has been supported by a number of factors, including the following:
- (i) PMIs have, in the past, leveraged their size and the horizontal competitive constraints in London to delist HCA's facilities or services and obtain sizeable price discounts from HCA based on the threat of a delisting.

⁴⁷ HCA Response to CC's Annotated Issues Statement, paragraph 5.7.

- (ii) PMIs can hinder or encourage the growth of designated hospital operators in and around London.
- (iii) PMIs have exerted greater control over the patient's care pathway (e.g. through pre-authorisation protocols that influence patient choices⁴⁸ and managed care strategies that "redirect" patients to alternative hospital operators across London).
- (iv) PMIs have used the availability of free high-end tertiary care in the NHS to financially incentivise patients to receive care at London NHS hospitals instead of at private facilities.

8.5 The above factors, which all mutually reinforce PMI bargaining power, are briefly summarised below.⁴⁹

PMIs can credibly threaten to delist HCA

8.6 The CC recognised that a "delisting" can occur when a PMI decides: (i) not to include a given hospital or private hospital operator on its network(s); or (ii) only to recognise certain treatments at a particular private hospital.⁵⁰

8.7 HCA has previously submitted to the CC that a PMI can credibly threaten to delist HCA facilities or services because of:

- *The existence of credible alternative healthcare facilities to serve patients in London*

HCA has submitted to the CC, as summarised in sections 2 – 4 above, that there is a wide choice of alternative private medical facilities in London.⁵¹ In section 9 below, HCA also highlights that there is sufficient hospital capacity for even the largest PMI to credibly switch their patients from HCA hospitals to competing hospitals. HCA has pointed out that PMI networks launched by AXA PPP, Aviva and PruHealth demonstrate the ability of PMIs to launch networks offering coverage in London that excludes HCA. By way of example, Aviva's Trust Care Network only provides policyholders with access to NHS PPUs in London.⁵²

- *The variety of "mechanisms" through which PMIs can achieve a "delisting"*

HCA has submitted that PMIs have a wide range of mechanisms in order to achieve a "delisting" of HCA hospitals.⁵³ First, a PMI may decide not to recognise HCA hospitals or services on an existing network. Second, a PMI may decide not to recognise HCA hospitals or services on newly-launched networks. Third, a PMI may carve out a specific service line (e.g. MRI services) and subject it to a separate tender process which excludes HCA. Taking the example of MRI services, [redacted].⁵⁴ Fourth, a PMI can reconfigure its networks in such a way so as to achieve a delisting of HCA facilities "by

⁴⁸ This includes authorisation for: consultations, diagnostic scans, treatment, admission into critical care, continued inpatient stays and "tertiary" referrals to specialist consultants.

⁴⁹ Please note that a fuller description of these points is contained in section 5 of HCA's response to the Annotated Issues Statement.

⁵⁰ Annotated Issues Statement, para 87

⁵¹ See section of 5 of HCA's response to the Issues Statement.

⁵² HCA discusses Aviva's Trust Care Network product in para 3.2 and 3.9 of HCA's observations on Aviva's response to the Annotated Issues Statement.

⁵³ See section 5 of HCA's response to the Annotated Issues Statement.

⁵⁴ [redacted]

effect".⁵⁵ Fifth, a PMI can market directional products to policyholders which empower the PMI to redirect demand for services to alternative hospital operators (for example, BUPA's Open Referral policies or AXA PPP's Corporate Pathways product).

- *Evidence of previous conduct by PMIs to delist HCA hospitals*

HCA has provided the CC with numerous examples of where PMIs have, in fact, implemented the mechanisms described above to delist HCA facilities/services or obtained significant discounts (on top of existing discounted prices) based on the threat of a delisting decision.⁵⁶ This demonstrates that the threat of delisting is more than a "theoretical possibility" - but something HCA continues to experience in its dealings with PMIs. In that regard, HCA continues to be delisted by all of the four major PMIs on at least one network that includes HCA's rivals in London.

- *PMIs possessing the resources and knowhow to minimise any resulting costs*

HCA submitted to the CC that PMIs can and do find ways of avoiding or mitigating any costs associated with delisting of hospital facilities and that the greater harm is inflicted upon the hospital operator rather than the PMI.⁵⁷ In the case of the larger insurers, who are unavoidable trading partners for HCA, the impact would be so severe so as to threaten the viability of a hospital.

PMIs can hinder or encourage the growth of hospital operators

- 8.8 HCA has highlighted the power of PMI providers to "dictate" which hospital operators can expand, where they grow and on what terms.
- 8.9 HCA has noted examples of how BUPA has been able to hinder its investments in new facilities as part of a growth limitation strategy against HCA. [X]. In the case of HCA's medical facilities in Brentwood, Sevenoaks and New Malden, [X].
- 8.10 HCA has also cited examples of where PMIs have been able to encourage or sponsor⁵⁸ the growth and expansion of rival hospital operators.⁵⁹ In particular, the major PMIs can provide a future "guarantee" or assurance of recognition - a powerful form of encouragement as it mitigates against the risk of investment hold-up by the PMIs. The risk of hold-up is always on the forefront of HCA's mind when making long-term investment decisions, particularly given its experience in [X].
- 8.11 As noted in HCA's Response to the Annotated Issues Statement⁶⁰ the interest of PMIs is not necessarily aligned with that of insured patients and it may not have the incentives to offer (from a patient's perspective) the efficient level of healthcare provision, both in terms of volumes and quality. In deciding whether to recognise a new treatment or facility a PMI would weigh any benefit of recognition (arising from a market expansion and price effect) against the potential costs faced by it.

⁵⁵ See paragraphs 5.38 – 5.39 and paragraphs 5.68 – 5.80 of HCA's response to the Annotated Issues Statement.

⁵⁶ See paragraphs 5.21 – 5.28 and paragraphs 5.68 – 5.84 of HCA's responses to the Annotated Issues Statement.

⁵⁷ See paragraphs 5.31 - 5.56 of HCA's response to the Annotated Issues Statement.

⁵⁸ For example, HCA informed the CC that BUPA and the (then) Charing Cross NHS Trust jointly funded a new private patient facility in 2005 (**Exhibit 5**).

⁵⁹ See paragraphs 5.112 – 5.123 of HCA's response to the Annotated Issues Statement.

⁶⁰ See paragraphs 5.88 – 5.93 of HCA's response to the Annotated Issues Statement.

PMI managed care strategies

- 8.12 HCA has made a number of submissions concerning the PMIs ability to influence the patient pathway.⁶¹ PMI influence stems from its pervasive role and numerous "control points" across the patient pathway (**see Exhibit 6** for an illustration). Some PMIs, such as BUPA and AXA PPP, have successfully expanded their influence through the adoption of directional or "Open Referral" or "Pathways" policies. These policies enable the PMI to comprehensively redirect policyholders away from designated hospital operators and HCA has recently felt its effects.
- 8.13 BUPA's Open Referral literature explicitly refers to the objective of targeting patients travelling into Central London for care.⁶² BUPA claimed in a 2013 report that uptake of its Open Referral product had been very successful, with 8 out of every 10 renewing clients and new clients now purchasing Open Referral policies.⁶³ The financial impact of BUPA's successful implementation of Open Referral, which is intended to reduce the number of patients travelling into Central London, is expected to be highly material [X].
- 8.14 BUPA's newly launched "Back Care Support Team" is another example of a PMI mechanism for controlling the patient pathway that [X]. Separately, HCA notes that the British Orthopaedic Association's submission to the Annotated Issues Statement raised a series of clinical concerns regarding BUPA's managed care strategy in this area. All relevant policy claims must be filtered through this "patient navigation" team as they also pre-authorise treatment. Once the member is captive, BUPA offers "*practical advice on back-pain management*", potentially as an alternative to funding care.⁶⁴ If a referral is required, BUPA is in a position to ensure that this is to a provider on its physiotherapy network (believed to largely comprise Nuffield facilities). If a consultant referral is required, BUPA is also able to control the choice of hospital and consultant. In 2013, HCA [X] and believes this is evidence of a successful "re-directional" strategy that utilises HCA's horizontal competitive constraints. [X].
- 8.15 Yet another mechanism available to PMIs is to amend its funding policies. For example, BUPA's policy announcement on funding for medically-necessary caesarean sections (BUPA informed hospital operators in 2012 that it will not cover obstetric procedures unless the insured mother's life is in danger, even where there is a risk to the foetus).⁶⁵ At the same time, HCA believes BUPA is encouraging women to use PPU's for maternity services as they offer neo-natal intensive care facilities (within the NHS hospital). [X].
- 8.16 As an aside, BUPA's patient navigation and "concierge-style service"⁶⁶ has expanded into the realm of self-pay patients too through its "Bupa On-Demand" service. Under "Maternity care", BUPA's On-Demand web page notes: "*We now offer services for elective caesarean sections at the Lindo Wing, St Marys hospital and the Kensington Wing, Chelsea and Westminster hospital*". Both of these PPU's compete closely with the Portland Hospital for private obstetrics cases.

⁶¹ See section 6 of HCA's response to the Issues Statement and paragraphs 5.133 – 135 of HCA's response to the Annotated Issues Statement.

⁶² See Exhibit 11.1 of HCA's response to the Market Questionnaire.

⁶³ See paragraph 5.135 of HCA's response to the Annotated Issues Statement.

⁶⁴ <http://www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bupa-updates-archive/back-pain-int>

⁶⁵ See paragraph 6.66 of HCA's response to the Issues Statement.

⁶⁶ <http://www.bupa.co.uk/individuals/self-pay-treatments/bupa-on-demand/on-demand-why-choose-bupa>

NHS incentives

- 8.17 In previous submissions, HCA has highlighted the strength of competition from NHS hospitals in London (as summarised in section 5 above). The cluster of major NHS hospitals in London are particularly keen competitors in the range of tertiary specialisms that HCA has strategically invested heavily in.
- 8.18 PMIs have instituted policies leveraging this competitive constraint by offering policyholders (at the time of policy purchase and at the time care is required) financial incentives to use the NHS instead of private medical facilities.⁶⁷ HCA has learned from consultants that a number of their cancer patients have been informed by their PMIs that they can receive the same quality of care in the NHS and benefit from a financial windfall.
- 8.19 This is another mechanism (albeit one deployed by PMIs) by which NHS hospitals impose a competitive constraint on HCA's hospitals. HCA encourages the CC to fully investigate the scope and scale of incentives to redirect demand away from private hospital operators such as HCA into the NHS.
- 8.20 On a broader note, the use of such incentives is revealing of the PMIs' commercial interest in shifting care provision from private operators to the NHS. It is no surprise then that PMIs who pursue this objective, such as BUPA, come into direct conflict with HCA – a hospital operator who has implemented an investment strategy with the aim of growing the scope of care in private hospitals to attract patients who would have otherwise elected to have their care in the NHS.

9. Capacity

- 9.1 HCA strongly rejects the CC's views concerning the extent to which there is available capacity within Central London, as set out in paragraph 62 and Table 10 of the Working Paper.
- 9.2 The CC's apparent view, concerning the extent of HCA's ownership of existing capacity, and the limitations of the capacity which would be available at different facilities, is flawed.
- 9.3 Table 10 has a number of serious errors and omissions. While some of these have already been outlined and discussed above (see paragraph 2.11 to 2.16 above), they are briefly summarised as follows:
- (i) The Table omits the available capacity (in terms of beds, theatres, consulting rooms and ICUs) within Central London PPUs. This significantly underestimates potential available capacity in Central London, and ignores the significant growth in PPU capacity which is already underway.
 - (ii) As stated above, the CC appears to have underestimated bed capacity even for independent operators since there are discrepancies between published figures and the estimates in Table 10. This may be due to the discrepancy between overnight and day case beds. That said, given the decline in inpatient care towards day case and outpatient treatments, excluding day case beds (if that has happened), provides a very misleading view of available capacity.

⁶⁷ See paragraph 6.96 of HCA's response to the Issues Statement and paragraphs 3.39 of HCA's response to the Annotated Issues Statement for a description of these incentives.

- (iii) The CC has grossly underestimated the total number of consulting rooms in Central London. It is only counting consulting rooms within the main hospitals of the listed independent providers. However, there are numerous outpatient facilities throughout Central London, many set up by groups of consultants, with diagnostic services and outpatient consulting rooms, e.g. Fortius Clinic and Medical Chambers UK. Even in terms of the listed independent providers, the CC has ignored the considerably greater number of consulting rooms available in those providers' outpatient facilities e.g. at BMI clinics. The suggestion that HCA has 55.8% of all consulting rooms in Central London is simply wrong.
- (iv) As stated above, there appear to be some inaccuracies as to whether some operators have level 2 or level 3 intensive care – HCA believes that St. John and St. Elizabeth has level 3, and HCA notes that BMI's recent submission in response to the Annotated Issues Statement (paragraph 4.24) specifically states that BMI has invested in an ICU at its Blackheath hospital.
- (v) Even if it is correct that some of the listed operators have level 2 rather than level 3 critical care, it is relatively easy for an operator to upgrade to critical care level 3. HCA notes BMI's submission (paragraph 5.20, BMI's response to the AIS) that hospitals can quickly upgrade within 12-18 months or less, as BMI has demonstrated at the Clementine Churchill and Blackheath hospitals. HCA has itself provided evidence to the CC (see in particular its response to question 67 of the CC's Market Questionnaire) of the relative ease with which HCA has in recent years expanded and upgraded its critical care facilities and adding beds to its ICUs, such that all its six hospitals now operate at critical care level 3. This was done relatively quickly and at a low cost. It is therefore misleading for a table on installed capacity to ignore the intensive care facilities provided by existing level 2 providers.
- (vi) The Table also ignores the important role of the NHS, particularly in providing higher acuity services and critical care beds which compete with those of private hospitals. This competition is particularly strong for self-pay patients but as explained above, PMIs are also incentivising subscribers to use the NHS as an alternative for tertiary treatments such as cancer and cardiac care.

9.4 Since the Table is based on data which is both incomplete and wrong, it cannot be used to support the CC's view concerning capacity availability.

9.5 The PMIs contend that "*it would face difficulty in directing patients to alternative hospitals were they to have a dispute with HCA*" because of "*limited capacity at comparable hospitals*" (Paragraph 2, Appendix 1 to the Working Paper). However, this is not borne out by the number of PMI patients in HCA hospitals, which could in fact easily be absorbed into other Central London hospitals:

- (i) At the peak time of an average day, HCA has [x] BUPA patients and [x] AXA PPP patients admitted to its facilities.⁶⁸
- (ii) If either BUPA or AXA PPP delisted HCA, it is clear from the alternative available beds and theatre capacity in Central London that these patients could be readily

⁶⁸ In the case of BUPA patients, the highest number of patients admitted at HCA facilities in 2012 on any one day was [x] ([x]).

accommodated in other Central London hospitals. Even excluding PPUs, there are 21 private hospitals in Central London alone, with 593 beds.

- (iii) BUPA itself owns the Cromwell with 118 beds and could divert a significant proportion, or even all, of its patients from HCA if it wishes to do so.
- (iv) AXA PPP would only need to find an additional [redacted] overnight beds in Central London, which could readily be accommodated given occupancy levels in other hospitals. Since the CC would have asked other hospital providers occupancy data, the CC is in a position to test these assumptions.
- (v) Further, as the BUPA-BMI delisting case shows, the more likely scenario is that an insurer delists a selection of a provider's hospitals, not all of them, thus further reducing the impact on its subscribers.

9.6 The capacity for PMIs to readily switch to alternative hospitals in Central London also applies in respect of their policyholders using HCA's critical care facilities:

- (iv) The average daily census⁶⁹ for BUPA UK patients is [redacted] in level 2 critical care and [redacted] in level 3 critical care.⁷⁰
- (v) The average daily census for AXA PPP patients is [redacted] in level 2 critical care and [redacted] in level 3 critical care.
- (vi) The CC estimates that, in Central London (excluding NHS critical care infrastructure available for use at Central London PPUs) there are 24 level 3 beds alone available at other independent hospitals.
- (vii) It can therefore be estimated that, at any one time, there is more than sufficient capacity in Central London alone (let alone taking into account critical care capacity available in Greater London), for PMIs to utilise critical care capacity at hospitals competing with HCA.
- (viii) HCA's critical care infrastructure is in fact largely utilised by international patients, often patients with very complex conditions who have travelled to London to receive world-class care and cutting-edge treatment modalities.

9.7 It should also be noted that HCA has been at the forefront of investing and upgrading its critical care capacity. However, as noted above, the competitive landscape for critical care provision is expected to shift as HCA's competitors in London and across the UK deploy similar strategies for enhancing the quality and scope of their care pathways.⁷¹ The range of hospital and PPU developments in the offing⁷² promises to further enhance competition in this area.

⁶⁹ The average daily census is calculated by determining the total number of "patient days" in critical care level 2 and 3 beds over a calendar year and dividing by the number of days in a calendar year. The "patient day" metric is a highly utilised key performance indicator.

⁷⁰ The average daily census for BUPA International patients is [redacted] and [redacted] for level 2 and level 3 critical care beds, respectively.

⁷¹ See section 7 above (e.g. paragraph 7.3).

⁷² For example, see section 4 and paragraph 2.17 above.

10. Concluding remarks

- 10.1 While HCA is grateful to the CC for this opportunity to comment on its formative analysis of horizontal competitive constraints in Central London, it is concerned that the Working Paper does not reflect the realities of private healthcare competition in Central London.
- 10.2 These concerns predominantly relate to: (i) the scope of the CC's analysis, which does not capture the full extent of the competitive pressures faced by hospital operators active in Central London; and (ii) the methodologies adopted by the CC when assessing competition between hospital operators. HCA believes that both sets of issues undermine the accuracy and robustness of the Working Paper and require addressing.
- 10.3 In terms of omissions, the Working Paper does not properly account for the full scale of current and potential competition from: independent providers across the breadth of London and beyond, NHS PPUs, major NHS hospitals and from competitors based overseas. HCA has submitted compelling reasons why each of these competitor cohorts is relevant to any assessment of horizontal competitive constraints in London. Furthermore, the CC has yet to fully recognise that several of HCA's competitors have in-built advantages that HCA must attempt to overcome by enhancing the quality and value for money of its own offering.
- 10.4 The Working Paper has not reflected the buoyancy and competitive dynamism that exists in Central London. In spite of the economic climate, private healthcare activity in Central London has witnessed significant growth and investment. When seen together with the low entry barriers that prevail in London, it is not surprising that there is an immediate prospect of entry and expansion by NHS PPUs and rival hospital operators.
- 10.5 Disappointingly, the different ways competition manifests in London is also absent from the Working Paper. Hospital operators compete on breadth of care, quality of care and on price. HCA has responded to competitive threats by seeking out better, faster and more cost-effective ways of delivering care to patients.
- 10.6 While HCA has been at the forefront of growing the market by expanding the scope of healthcare services available privately (thereby bringing it into closer competition with the NHS), HCA notes that its rivals are responding by similarly channelling their investments into "higher-acuity" healthcare services. This signals a further intensification of competition in London.
- 10.7 The Appendix to the Working Paper considers the views of PMIs, but it does not assess the interaction between horizontal competitive constraints and PMI bargaining power from the perspective of hospital operators. Evidence of the exercise of PMI bargaining power (including against HCA) both substantiates and reinforces the horizontal competitive constraints that exist in Central London. HCA has felt the effects of PMI bargaining power – for example, through a decline in demand for affected services, the inability to attract a critical mass of consultants to facilities blighted by a lack of upfront recognition, and [§<] due to their financial performance.
- 10.8 In terms of methodological flaws, HCA has expressed a number of concerns, such as about how the competitive threat of Greater London hospital operators has been assessed, the issues underlying the CC's assessment of share of supply and capacity in Central London and the lack of analysis on supply-side substitutability.

10.9 Finally, the CC will have noted a number of common concepts that cut across all of HCA's submissions. HCA recognises that the CC may wish to explore these concepts further as part of its analysis of competition in Central London. These include:

- What HCA means by competition in healthcare "innovation", a concept HCA has consistently referred to in its submissions when explaining how HCA has implemented new clinical practices and patient pathways or invested in new diagnostic procedures and treatment modalities to improve the quality of care.
- How case complexity and patient acuity shape strategic investment decisions and the provision of healthcare services - and how these decisions bring hospital operators in Central London into direct competition with the NHS.
- How collaborations between consultants and hospitals generate quality-enhancing improvements in healthcare provision.
- How advances in healthcare mean treatment can be provided across a range of different settings, including on a non-inpatient basis, thereby changing the landscape of private healthcare competition.

10.10 In addition to the above, there may be additional concepts that the CC is keen to explore and if it would be helpful to its further analysis, HCA invites the CC's staff and panel members to conduct a further site visit to its facilities in Central London. HCA believes that such a visit might be a conducive forum for illustrating how the above concepts play a key role in the competitive process.