

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with BMI held on 25 November 2013

Introduction

1. BMI indicated its support of the CC's provisional findings with respect to several areas, including the vital role that improved information provision would play in sharpening competition in the private healthcare industry, the proposed remedies with respect to consultant incentives (subject to some minor modifications), and although it did not agree with the finding of an adverse effect on competition (AEC) in this area, it accepted the CC's remedy with respect to restricting the expansion of PPUs.
2. However, BMI highlighted the following areas of the CC's analysis which it considered to be fundamentally flawed and either unsupported or flatly contradicted by the evidence. These were simply not points where reasonable people could rationally come to differing views.

Barriers to entry

3. BMI noted that the CC analysed three case studies of successful entry into the market and concluded that barriers to entry were high. BMI felt that this conclusion was incompatible with the evidence. It said that the CC's view (on whether capital costs associated with entry create a barrier to entry) had changed between the annotated issues statement and its provisional findings, yet the evidence it relied on had not. A new entrant, apparently, had to incur capital costs of just [redacted] of those carried by BMI. This was the opposite of a barrier to entry—BMI carried a cost which was far greater than that which would be incurred by a new entrant.
4. Secondly, other parties, and in particular those that would benefit from a finding adverse to BMI, had not agreed with the CC's view that there were high capital barriers to entry.
5. Thirdly, there was a significant gulf between the observed actual costs of entry of comparable hospitals and the CC's replacement cost valuation of BMI's hospitals. BMI submitted that both could not be right. Its hospitals were comparable with new entrants when the characteristics (eg number of theatres) of the hospitals were compared.
6. Fourthly, given the extreme level of consumer detriment claimed by the CC, the barriers would need to be high indeed. BMI questioned how high barriers to entry actually were in practice and the robustness of the CC's analysis. Capital costs were not high and it noted that potential entrants had not reported any difficulty in obtaining funding. It stressed that the CC's current view of high capital costs of entry and high profitability was incoherent: either there were high capital costs of entry and BMI had low profitability, as a result of capital employed reflecting a modern equivalent asset value of hospitals; or BMI had higher profitability, as a result of depressed value attributed to hospitals, and there were low capital costs of entry. BMI said that the CC had found economies of scale to be a barrier to entry, yet had not attempted to quantify it, and that this also contradicted observed evidence of the existence of small inpatient hospitals, including a number of single theatre hospitals. BMI believed that there was no evidence to support the CC's claim that site availability (at least outside

London) was a relevant barrier to entry. Finally, there was no evidence to support the CC's claim that BMI induced private medical insurers (PMIs) to resist recognition of new entrants. The evidence showed that BMI did not have the ability to induce PMIs to refuse or delay recognition of new entrants.

7. BMI did not support the CC's view that two hospitals in a given local market were insufficient in order for competition to operate effectively. However, it noted in respect of barriers to entry that the CC considered that an incumbent was expected to react aggressively to entry. BMI questioned why this view was not applied to the CC's analysis of a local market with two different providers. These positions were completely contradictory and the CC should choose one or the other.
8. BMI concluded that the CC's case for barriers to entry was entirely unsupported by the evidence. It believed that it was contradicted by other parts of the CC's case and was flatly inconsistent with the evidence in the CC's own assessment. As the CC's case was built on barriers to entry, if there were indeed low barriers, there was no basis for remedies.

Profitability

9. The CC's profitability assessment had consistently grossly overstated BMI's profitability. This was primarily driven by the CC's approach to land and building valuation. BMI had provided the CC with evidence of a number of cross-checks which concluded that excess profitability was not a conclusion which any rational fair-minded authority could plausibly reach:
 - (a) instructing independent surveyors to conduct DRC valuations using the CC's preferred methodology. This was prepared to full Royal Institution of Chartered Surveyors (RICS) standards, while the exercise relied on by the CC was not, by DTZ's own admission, either a valuation or in compliance with RICS professional standards;
 - (b) comparing BMI's hospitals with comparable new builds based on theatre numbers;
 - (c) instructing independent surveyors to prepare valuations of the current market based on RICS methodology that explicitly did not capture excess profits; and
 - (d) [REDACTED]

Local assessments

10. BMI noted that while the 'Local assessments outside London' working paper identified issues with 47 BMI hospitals, at that point the CC admitted that it had not read the internal documents that BMI provided about local competition. BMI said that the evidence it had collected and submitted had had no impact on the substantive outcome.
11. The CC had based its assessments on market share. BMI believed that LOCI was an inappropriate tool, entirely unknown to industrial economics, and one which predetermined the outcome by using a technique that would inflate the market position of BMI. In addition, there had been no assessment of quality outcomes in the local competition assessments. The CC had not assessed how an observed level of concentration would affect the quality of BMI's service or affect its patients. The local competition analysis was restricted to an exceptionally narrow exercise in self-pay

pricing, capturing less than [redacted] per cent of BMI's total activity. There was no evidence of any analysis of the adverse effect of low levels of competition on quality outcomes, despite this being front and centre of the CC's new approach to mergers between NHS Foundation Trusts.

12. BMI found it odd that the CC had suggested that a cluster creating market power existed where hospitals within that cluster were delisted by a PMI, therefore removing all of that insurer's demand. The CC had claimed to have identified a cluster of five hospitals, four of which had been delisted. If the cluster theory was coherent, the assumption must be that the remaining hospital would pick up the extra work. However, in reality this was not the case and patient volume [redacted]. It seemed odd that the CC considered the proportion of NHS episodes to be a determining factor in suggesting whether a nearby competitor was an inadequate constraint to BMI, but when a BMI hospital was the weaker competitor by that NHS caseload metric it faced a competitor that did significantly less NHS work, this factor was not mentioned in the provisional findings.
13. It seemed odd that the CC accepted that it was possible to switch into a new specialty using common equipment in the context of the product market definition, but consistently used a narrower specialty focus to dismiss the competitive constraint that a hospital may impose on BMI in any given local market. The CC analysis showed inconsistencies, especially when there was no analysis of why it was that the competitor would find it so difficult to expand their provision to include specialties that the BMI hospital currently undertook.
14. It seemed odd that the CC had bundled a number of BMI hospitals together as one, making them appear larger and acquiring each other's individual characteristics and strengths, yet the CC had not done this with competitor hospitals similar distances apart.
15. BMI believed that the proper and sensible way forward would be for the local assessments to be undertaken on the back of the full body of evidence and BMI's response to the provisional findings, and for the findings to be comprehensively revised. This would result in a significant drop in the number of hospitals that were found to be of concern by the CC.

Price concentration and insured prices analysis

16. BMI thought that the price concentration and insured prices analyses were areas where the CC's analytical failures were profound, material and leading to outcomes which were unsustainable and irrational.

Bargaining and insurer negotiations

17. BMI submitted that the conclusion that Bupa had fully-countervailing power was inescapable and any assertion by Bupa to the contrary was not credible. Any conclusion by the CC that Bupa did not have fully-countervailing buying power opposite BMI would be contrary to evidence and irrational.

Divestiture—outside central London

National bargaining

18. BMI believed that there was no evidence of the existence of clusters, certainly no evidence that the clusters identified by the CC gave BMI bargaining power against

PMIs, and therefore no evidence that divestment would be an effective remedy. In its view, each cluster of hospitals already included competitor hospitals. In theory, the introduction of new competitors into cluster areas where there was not already a competitor may impact pricing and could lead to downward pressure on prices, but each of BMI's hospitals in each of the clusters identified by the CC was already sufficiently constrained. The CC had examined exactly this in the PCA and found no relationship between BMI's ownership of hospitals and price.

19. BMI believed that the healthcare market was national. PMIs did not buy on the basis of clusters at a regional level, preferring instead to deal with comprehensive national networks, typically composed of two, three or four providers. Negotiations with PMIs did not centre on an attempt to withhold or otherwise leverage local market power.
20. A number of PMIs, including Bupa, typically wanted access to the widest possible range of hospitals to which they could refer patients and would use their negotiating strength as the lever. AXA PPP was focused on tighter networks so that it could concentrate the volume and obtain the right network for its clients. The network was important for every PMI and that tended to be a national focus for them.
21. The PMIs were in control of network construction, and by creating a network and excluding certain hospitals, they were able to concentrate volume. BMI believed it conceivable that a PMI could run a network without its hospitals in the long term. BMI's experience during 2011/12 when Bupa delisted its hospitals had highlighted the industry awareness of this.
22. Should hospital prices fall as a result of any divestiture remedy, BMI was sceptical about whether any price reductions would be passed on to the consumer. BMI was sceptical about whether Bupa would pass savings on and noted that the CC had done no analysis on pass-through.
23. BMI said that the CC would have to consider carefully how pricing strategies would change with and without the CC's remedies and it was not immediately obvious that smaller PMIs would benefit from price reductions in a post-remedy world. Substantive analysis was required to determine how the remedies would affect the distribution of prices and BMI thought that analysis would be important.
24. BMI did not consider that smaller PMIs would stand to benefit more from a divestiture remedy than larger PMIs like Bupa. [✂]

Divestments

25. Although any divestment of a BMI hospital would have a negative effect on BMI, it believed that their divestment would have no impact on the market as a whole. [✂]
26. Consultants faced with uncertainty about continuity of a hospital or business unit from change in ownership would take steps to secure practising privileges at another hospital. Consultants would be likely to look to partially or indeed wholly move their practice to an alternative hospital. [✂]
27. BMI suggested that there might be overseas buyers, including operators based in [✂], who might potentially be interested in acquiring hospitals in the UK. However, it felt that the private healthcare market was currently on hold as it was unclear what the impact of the CC's market investigation would be and what impact it might have on the valuation of hospitals. [✂]

28. New entrants to the market would make consultants feel quite anxious about continuity of service, because of the regulatory side of healthcare. It might be unclear whether the services that consultants offered to patients at those hospitals would be able to continue, at least for the initial period whilst that regulatory process was undertaken.
29. Forcing BMI to divest hospitals would lead overseas operators and other new entrants to perceive that regulatory risk in the UK market had been increased. [REDACTED]
30. [REDACTED]
31. BMI believed that any smaller market entrant would be most likely to open a walk-in outpatient day case with the NHS rather than target the private market. Such an entrant would struggle to negotiate with some of the PMIs. Any new entrant would find it difficult, and was unlikely, to enter with a high capital expenditure and high acuity strategy.
32. With regard to economies of scale, BMI had been able to centralize certain hospital support services which had meant that it carried the infrastructure cost. This approach gave it greater national service capability which PMIs liked. BMI benefited from the efficiencies of [REDACTED]. Any operator of a reasonable scale (running ten or more hospitals) could benefit from these economies, but only if they were to make a conscious decision to adopt a similar system.
33. BMI believed that the main driver of quality was consistency of delivery. There was a real correlation between BMI's systems that were used throughout its hospitals and the delivery of quality, which individual units were not able to achieve. [REDACTED]
34. BMI did not support the view that a new entrant to the market would automatically lead to competitors increasing their investment or availability of equipment. Rather a new entrant would focus their investment in areas where there was an opportunity.
35. BMI believed that there was no evidence to support the CC's suggestion that the current cluster areas identified by the CC resulted in an AEC. There was no excess profitability and no price concentration relationship.

Central London

36. BMI had been successful in attracting [REDACTED], patients from central London hospitals to its Harrow and London Independent hospitals in Greater London. [REDACTED], it had encouraged patients to come into central London consulting rooms on the basis that the consultants would undertake further work in the Greater London hospitals. [REDACTED]
37. Looking at the CC's local market assessments, BMI noted the ability of central London hospitals to pull patients in from Greater London. Such constraints were asymmetric. Patients were keen to attend the central London hospitals and it was harder to attract them to the Greater London hospitals, where BMI had its facilities.
38. [REDACTED] PMIs were keen to refer patients to the Greater London hospitals.
39. BMI would be interested in expanding in the central London market.

Remedy 2

40. BMI saw that a principal issue of Remedy 2 was that it effectively delegated price control to the counterparty on the insurer side. BMI believed that if price control was desirable, having an adjudicator or regulator provide a price control solution would be a fairer solution than the proposed Remedy 2.

Remedy 3—Restrictions on expansion re PPU

41. Although BMI disagreed with the features of the market that the CC had identified, it was prepared to accept this remedy, but felt certain modifications were required for the current proposal to be workable in practice.
42. This remedy would be quick to implement, and if the objective was to stop growth by either a solus provider or one of the duopoly providers, then the proposed remedy would have that impact.
43. Although BMI had concerns about the CC's definition of the remedy, how the remedy would be applied and the consistency of the approach adopted, it believed that the remedy would be more effective than Remedy 1 since it had a wider applicability. Remedy 1 only applied to cluster areas, yet Remedy 3 applied to solus and duopoly areas. This remedy would work most effectively if it was brought under the current merger regime.
44. The main advantage of Remedy 3 was that it would help reduce barriers to entry in some areas by allowing hospital providers the opportunity to enter the market via PPUs; it therefore directly addressed the underlying cause of the problems the CC claimed existed, unlike Remedy 1.
45. BMI also said that Remedy 3 would be far more proportionate than Remedy 1, particularly in the context of prospective disruption to patients. In particular, it noted the CC's consideration of the disruptive effect of divestments on consumers in rejecting divestments in its Groceries market investigation and argued that the disruption to patients as a result of divesting a hospital would be multitudes higher.
46. BMI acknowledged that PPUs were a competitive force. Since the introduction of the Health and Social Care Act 2012, NHS trusts were generally looking at private income as a way of bridging the efficiency gap challenge. Private income would become a means of balancing their books and PPUs would become an increasing feature of the market.
47. BMI had held discussions with a number of NHS Trusts regarding PPUs and had been involved in tender processes. [REDACTED]
48. Of the arrangements BMI had entered into with PPUs, [REDACTED].
49. BMI had been invited to [REDACTED].

Remedy 4—Incentives

Consultant incentives

50. BMI supported the CC's remedy on consultant incentives, but felt the proposed remedy was too wide to be effective and proportionate, but that the underlying direction of the remedy was correct and would help to ensure a level playing field.

51. It considered that there should not be any financial incentives paid to consultants by hospital operators for the referral of patients. Consulting rooms, nurses and other facilities should be charged at a fair market price.
52. BMI believed that operators should be responsible for suitable insurance/indemnity cover for consultants carrying out any NHS caseload as this was not a benefit to the consultant. Since consultants did not make decisions about the referral, BMI considered that it was a cost that belonged to the hospital which was undertaking the work and allowed BMI to compete on a level playing field with the NHS. Hospital operators met the contractual requirement for insurance either through membership of the NHS Litigation Authority's Clinical Negligence Scheme for Trust or through purchase of commercial insurance.
53. With regard to private indemnity insurance, BMI did not think hospital providers should be allowed to pay or subsidize the costs of consultant's indemnity insurance. The cost of medical indemnity was a significant part of the cost base of any consultant's practice. Some consultants received subsidies or even the whole of that cost from certain hospital groups and that currently created an unlevel playing field. It was a disadvantage to not only BMI but the small providers, where the amount involved was significant against their absolute profit and loss. BMI was against incentives that influenced consultants or tied them to one particular hospital operator.
54. BMI believed that there could usefully be a de minimis provision to allow hospitals to support new consultants entering private practice, with a financial limit. This could include an information pack which covered, for example, generic information on tax and indemnity cover. The other area was the inclusion of consultant's name in information sheets or registers that were issued to GPs' surgeries. There was a cost in producing such information, and BMI could not see why a hospital provider should not be allowed to pay for that.
55. Whatever the outcome of the CC's remedy, BMI asked the CC for guidance to help ensure greater clarity and consistency.

Equity participation

56. BMI was against the exception to the CC's proposed remedy—which carved out equity participation by consultants—having interpreted it as being in favour of Circle's practice. Circle currently offered free equity to consultants. By not investing any of their money into a facility or new equipment, consultants faced no financial risks. There was, however, a case to be made for equity participation where consultants were legitimately investing their money, the return was proportionate to the investment, it was a pro-competitive introduction of new services, new techniques or new equipment, and the investment was transparent. BMI thought that joint investments between hospitals and consultants, bringing together complementary services and products, could be beneficial if done in this manner. The reservation BMI had about Circle's arrangement was it was not pro-competitive and was not something which BMI thought passed the probity test. Referral incentives dressed up as equity needed to be prohibited.
57. BMI believed that the remedy should be clear and a possible 5 per cent threshold for investment was one option. Although arrangements with consultants were not entered into in order to secure funding, they gave the hospital group the assurance that the modality or the equipment was going to be supported by clinicians. It did not think there should be a limit on those who used any equipment they had invested in where that consultant did not control the referral pathway.

58. BMI thought the General Medical Council (GMC) would be well placed to hold formal records of any equity arrangements between consultants and hospital providers and disclosure could be part of a consultant's revalidation process and annual appraisal. NHS consultants had a responsible officer who was the medical director of the employing NHS trust. Those consultants just working in private practice usually reported to a responsible officer employed by a hospital operator. Such officers generally monitored a consultant's behaviour and investigated any areas of concern.
59. With regard to the introduction of any remedy preventing consultant incentive schemes, BMI felt that thought would need to be given to a reasonable timescale to unwind any current arrangements, and that [redacted] years would be required. It was important that the onus to exit such arrangements was placed on the consultants as much as the hospitals to prevent hold-up risks.

Remedies 5 to 7—Information

60. While BMI supported the CC's proposed informational remedies, it did not think that the lack of information on consultant performance, consultant fees and hospital performance was sufficient to establish an AEC on their own.

Remedy 5—Consultant performance

61. In BMI's view, this remedy was one of the most important of the proposals made by the CC and once implemented would have a near immediate impact on the market. BMI believed there was a vital role that improved information provision would play in sharpening competition, allowing consumers and patients to select hospitals and clinicians on the basis of the cost, quality and capability matrix which mattered most to the patients and their agents. PMIs, GPs and consultants had a vital role to play in stimulating rivalry between hospitals by making informed choices that rewarded those firms that best meet customer needs.

Remedy 6—Consultant fees

62. BMI believed that it would be possible for consultants to provide information about their outpatient fees and their five or ten most commonly-conducted procedures in advance of their first outpatient consultation. Complexities and difficulties due to the extension of the patient pathway could be overcome, although it would not be possible to give an absolute guarantee on price per procedure or episode in cases of supervening conditions. BMI would support a proposal that it be made a condition of practising privileges at a hospital that consultants produced fee information in a standardized format. It believed that this was something the CC should institute and monitor over time.

Remedy 7—Hospital performance

63. BMI believed that the Private Healthcare Information Network (PHIN) was best placed to publish any data relating to the quality of hospital operators and consultants. PHIN currently had the same data and metrics, other than clinical coding, as the NHS system Hospital Episode Statistics. While BMI fully supported publication of data at this higher level of granularity, one main setback was that [redacted]. Discussions were ongoing to try to agree which data should be made available. BMI encouraged action by the CC to help publish this information.

64. BMI would be willing to help with the inputting of information on the GMC number of each consultant, so that patients would have the information to help them make an informed choice about consultants. It pointed out that risk stratification and adjustment would be critical again so as to prevent data from being potentially misleading.
65. BMI was in favour of adopting the Healthcare Resource Groups coding, which was the Office of Population Censuses and Surveys coding used in the NHS. Most hospital operators had the capability to undertake that coding as it was used for NHS work. However, the settlement system with private medical insurers currently used the Clinical Coding & Schedule Development coding system, which was much less detailed in its coding content and led to fewer codes for each procedure.
66. Although PHIN had yet to confirm its governance structure, the Chairman and Chief Executive were in place. BMI believed that the confidence in PHIN would grow as it started to publish more data and that it was best placed to translate this into useful information for patients. At the moment PHIN [✂].