

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Bupa held on 2 October 2013

Introductory comments on proposed remedies

1. Bupa considered that the private healthcare industry needed to become more accessible to consumers through greater affordability and transparency. Bupa welcomed the Competition Commission's (CC's) provisional findings and saw this as a golden opportunity to put the sector on a more sustainable footing. However, Bupa believed that there were three key issues facing the private healthcare industry which the CC should give further consideration to: (a) the need to take action on behalf of self-pay and insured customers in relation to those 'hospitals of concern' in Single (solus) or duopoly markets, which were unaffected by the proposed cluster divestments; (b) the need for transformational action in central London; and (c) the need to reopen its investigation into consultant groups.
2. Bupa supported the CC's proposed remedies including divestments in cluster markets, restricting further private patient unit (PPU) acquisitions by hospital operators in solus and duopoly areas (provided this included central London) and the banning of consultant incentives. It broadly supported the CC's proposed information remedies, although considered that far more work needed to be done to address the information problems in the market. Bupa supported the proposed 'no-tying' remedies, but considered that in their proposed form, they were likely to be easily circumvented.
3. The majority of the hospitals of concern identified by the CC were in solus and duopoly markets where there was currently no proposed divestment. This meant that hospital operators would retain their national bargaining power from their overall size and scale and ownership of hospitals of concern. Bupa suggested that the CC consider implementing price controls or further divestments in these markets, to ensure that self-pay customers received fairer prices and private medical insurers (PMLs) were in a better bargaining position with hospital groups.
4. Bupa considered that there was evidence that consultant groups had a negative impact on competition and choice in the market. It suggested that many of these groups were very large and dominant in their local hospitals, which led to reduced consumer choice and higher prices. Bupa expressed concern in particular about the conduct of anaesthetist and ophthalmic services groups.

Divestment remedies

Central London

5. Central London had the potential to be a competitive market. Bupa considered that divestments in central London would be an effective remedy, however, there should be further divestments than currently proposed by the CC.
6. The market share by specialism should be taken into account in selecting the appropriate facilities for divestment, rather than considering solely the overall market share of the hospital in central London. This was because if a hospital operator had a high market share or a high level of market power in a particular specialism, it could

give it market power in negotiations with PMIs, even if the hospital facility had a relatively low share of the central London market overall.

7. Any divestments pursued in central London should be made to separate buyers to promote greater competition. Bupa also considered it important that hospitals selected for divestment be sustainable on their own. There would be plenty of interest from buyers for hospitals in central London, including buyers within the UK and overseas. It generally would not like to see central London hospitals acquired by the major hospital operators, as they already had a high level of bargaining power over PMIs.
8. Divestments would need to be supported by behavioural remedies, such as a hold-separate manager and a ban on consultant incentives.

Outside central London

9. Outside central London, divestments of hospitals in cluster markets alone would not be sufficient to resolve competition concerns. Bupa was concerned that the majority of hospitals of concern outside central London were in solus or duopoly markets where no divestments were currently proposed. In its experience, the major hospital groups were able to use their ownership of solus/duopoly hospital sites to leverage better PMI prices nationwide. If major hospital operators had a large part of their estate in solus or duopoly markets, it would give them the power to raise prices in competitive areas.
10. Bupa proposed that independent hospital operators or smaller hospital operators would be suitable purchasers if divestments were pursued in solus and duopoly markets. It considered that international operators and private equity groups could also be potential buyers.
11. Bupa believed that divestments in cluster markets would improve competition which would drive down prices overall, including self-pay prices. However, it considered that the configuration or package of hospitals to be sold to potential buyers would be important, so that very large hospital groups would not be created.

Tying and bundling remedies

12. Bupa considered that the CC's proposed remedy of preventing BMI, HCA and Spire raising their prices if a PMI changed its network policy, might be too easily circumvented and might lead to unintended effects in the market. Bupa noted that this remedy would require a great deal of monitoring because there would be changes to the PMI networks that were negotiated during the ordinary course of business.
13. In terms of the CC's proposed remedy that hospital groups including BMI, HCA and Spire be required to offer and price their hospitals separately, Bupa did not consider that this remedy would appropriately address the situation in solus and duopoly markets. A consequence of parties pricing separately in these markets could be that prices rose to self-pay or monopoly prices.

Restricting expansion of hospital operators into private patient units

14. Bupa was supportive of the proposed remedy of restricting expansion by HCA into PPUs in central London, due to HCA's existing size and scale in that market. Bupa also considered that this remedy should apply to hospital operators in solus and duopoly markets outside central London.

Price controls

15. Bupa suggested that a price control remedy might be implemented to address competition concerns in solus markets. Bupa proposed to do this by benchmarking the prices paid by all PMIs for particular procedures across the UK in competitive markets compared with those markets proposed for price controls. The different PMIs' prices could be obtained from Healthcode data.
16. Bupa suggested that the price control might not necessarily be set at a specific price, but could be no more than a certain percentage or range from the average UK price on a procedure-by-procedure basis. It thought that a regulatory body of a similar scale to the CC could have responsibility for monitoring price controls and that this cost would be well beneath the potential benefit to patients from the price control.

Consultant incentives

17. Bupa was in favour of a ban on the payment of incentives by hospital operators to consultants. However, it thought that fair market value exchanges with consultants (eg consultants renting rooms from hospitals) should be exempted from any ban, but should be disclosed. Bupa considered that the General Medical Council (GMC) would be in a position to regulate these issues. It believed that there was a need for clear sanctions to enforce any ban on consultant incentives.
18. Bupa noted that in the USA it was illegal for hospital operators to provide incentives to consultants and indicated that major hospital operators had been fined for engaging in such practices. Other enforcement remedies such as suspending or restricting practice might also be pursued in the USA. Bupa considered these to be effective deterrents to hospital operators offering incentives to consultants.
19. Bupa acknowledged that the UK Bribery Act might apply to hospital operators providing financial or other incentives that induced consultants to act improperly. Bupa noted that the 'Essential Standards' administered by the Care Quality Commission (CQC) contained outcomes which assessed transparency between the patient and the hospital on admission, however, these had not been assessed by the CQC in any of its inspections of private hospital facilities to date. It believed that the mechanisms to regulate consultant incentives already existed within regulations, but the challenge was enforcing them. Bupa would like to see increased transparency and disclosure of incentives to regulatory bodies like the GMC, although its preference was for a ban on incentives.
20. If there was a ban on consultant incentives, then equity stakes held by consultants in hospital groups should be unwound. It would otherwise be inconsistent to say that incentives were acceptable so long as they were put in place before a certain period or under a specific structure. Unless equity stakes were unwound, they would act as a further barrier to entry to new entrants. Equity stakes should not be allowed for inpatient hospitals, but not necessarily banned for small outpatient clinics.
21. Bupa noted that the GMC rules required that doctors should not receive payments that could, or could have the appearance of influencing the way that they treated or referred patients. It considered that the GMC had not been enforcing these issues. Bupa wanted to see hospitals compete and new entry on the quality of care and value for money, not by how much they could pay doctors.
22. Bupa considered that although new entry which had taken place in the private healthcare industry recently had been with consultant incentives, this had been in response to an environment where in a lot of areas incumbent hospital operators

were using incentives to try to retain consultants or to seek them to switch back from a new entrant. In an environment where all of those incentives were disclosed and/or banned, there could be greater focus on the type of entry that delivered better quality.

Information on hospital quality and performance

23. Bupa suggested that it desired access to raw data on hospital quality and performance. It would also want to see quality data being made available to other organizations (such as Dr Foster), so that it could compare data from the private healthcare sector with the NHS. There was a need for standardization of coding in relation to raw data, and Bupa would like the CC to improve standardization of coding. Currently, hospitals would tend to have their own coding systems for a significant proportion of spend.
24. There was an opportunity for an industry body to not only bring the level of data collection in the private healthcare industry to that of the NHS, but to take it beyond that to a leadership position in terms of the measurement of quality and transparency. Bupa did not consider that the Private Healthcare Information Network (PHIN) was in a position to achieve this and that it might suffer from a conflict of interest, given that it was led by hospitals which did not want to go down this path. PHIN needed to have wider representation from the industry and powers to compel the production of data from hospital operators. Bupa also suggested that PHIN should have an independent board.
25. Any remedy in relation to data collection needed to be future-proofed, taking into account that the NHS would move in the next five to ten years, and the private healthcare sector needed to be able to keep up with that. Having access to patients' NHS numbers was critical. If NHS numbers could become a standardized data source across the industry, it would allow comparison between the private healthcare industry and the NHS and allow tracking of patients in and out of the NHS and private health systems.
26. Bupa would like to see the removal of restrictions in its contracts with hospital operators concerning the provision of information on quality to customers. At the moment, it had contractual obligations which prevented it from publishing what it knew about hospital quality. It would also like to see clinical registries mandated (where data was collected about individual patients as a way of managing performance), as this was occurring in other markets around the world.
27. Bupa believed that case after case had shown that when data was collected from doctors on performance and made visible the performance of doctors was improved. Getting all hospital operators and consultants to cooperate in providing data would be fundamental, ie data provision should be mandatory.

Information on consultant fees

28. Bupa was in favour of remedies requiring consultants to inform patients in advance of what fees for treatment would be. It was in favour of this data being published in relation to self-pay patients, but considered it would be complicated to do so in relation to insured patients, as consultants would have agreed different levels of fees with different PMIs.
29. Bupa expressed concerns about the general publication of outpatient consultation fees, as this might lead to a 'race to the top' from consultants as they competed with each other based on who charged the highest fees. This was because at the

moment, price was typically used as an indicator of consultant quality, given there was no objective data on performance readily available.

Consultant groups

30. There was evidence that market power exerted by consultant groups (in particular, anaesthetist groups) was having a detrimental impact on consumers. In Bupa's view, in the overwhelming majority of cases in the CC's own evidence, anaesthetist groups had led to higher prices, for example when considering prices pre and post the formation of the group in particular areas. Bupa believed that such groups were restricting choice, as patients were in a vulnerable position, with limited ability to 'shop around'.
31. Bupa said that consultants who were not part of groups offered a very weak constraint and there was an incentive for them to join the group to receive more money or to follow the pricing of the group.
32. In Bupa's view, some of anaesthetist groups were becoming extremely large, covering whole counties in terms of hospital coverage and the alleged benefits to consumers resulting from scale had not been passed on to consumers, because the prices were in fact much higher in those areas.