

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with HCA held on 20 November 2013

Introduction

1. HCA considered there to be a number of fundamental issues about the private healthcare industry that the Competition Commission's (CC) Provisional Findings (PFs) had overlooked or had not been properly understood. As a result, HCA believed that the CC's provisional findings were based on insufficient evidence and fundamental errors of assessment. This included the failure to properly consider the special nature and characteristics of the London market, the nature of competition between private healthcare providers on quality and innovation, and the implications that any forced divestiture might have on investment and future incentives to invest in the UK.
2. HCA did not think that the PFs took into account the very special nature and characteristics of London, its primary market. From HCA's perspective, it did not recognise the description of central London being a concentrated market with high barriers to entry. HCA believed it had a wide range of serious competitors and in recent years there had been significant growth in the London market which was still ongoing. HCA said it was seeing new providers coming into London, including a brand new hospital development in west London. The NHS private patient units (PPUs) had been the fastest growing segment of the London market, with very aggressive growth plans for the future.
3. HCA did not think that competition on quality had been addressed in the PFs. Quality was considered key to how HCA operated and to competition between hospital operators. For example, HCA had been working with a number of partners to introduce new technologies and procedures to the private healthcare industry, including working with Stanford University on clinical trials to use CyberKnife to treat patients with irregular heartbeats, UCL and Yale Universities to open a new state of the art genetics lab to change the way cancer is provided, and Memorial Sloan-Kettering and UCLH on new techniques for treatment of prostate cancer. It had also introduced new inter-operative radiation therapy for the first time in the private sector in the UK and had seen one of its competitors, the hospital of St John and St Elizabeth, develop a competing service following the success of HCA's offering. In the context of the CC's competition assessment, HCA said that there had been no consideration of whether there has in fact been a lowering of quality or a stifling of innovation in the market and nor had there been any assessment of how improvements in the quality of care and new innovations in the market were demonstrative of the market functioning competitively.
4. HCA told us that a divestment remedy would be unjustified and disproportionate and HCA believed that a decision to divest would undermine the many years of strategic investment HCA had made in its facilities. HCA said it would also lead to poorer standards of care in London, potentially at the expense of patients' lives, and be to the detriment of London's international standing. HCA said that such a decision would chill future investment in private healthcare.
5. HCA would like to work with the CC to improve transparency on meaningful quality outcomes and fees. It considered the CC had the opportunity to improve the standard of care in the UK by setting national standards on reportable outcomes and quality measures.

Remedy 1—divestment

Central London

6. HCA considered that any proposed divestment remedy concerning its hospitals would be an unjustified and disproportionate interference with its property rights. It felt aggrieved that it may be ordered to dispose of key business assets which it had legitimately acquired, developed and expanded, [REDACTED]. HCA said that the CC's views on competition in London were at odds with that in the OFT's clearance, and since the date of the OFT's decision, the competitive landscape in London had become more, not less, competitive through new entry and expansion and the CC had not suggested otherwise. HCA considered that there were no relevant structural adverse effects on competition in central London on which an order for divestment could be made. Divestiture would, instead, have significant adverse effects on the market.
7. HCA told us that the CC's analysis in the PFs contained fundamental omissions, flaws in approach, errors of assessment and a lack of evidence for key findings, in particular omitting considerations of competition on quality and important features of the central London market.
8. HCA submitted that the requirement of proportionality was not met in this case, particularly given that divestiture represents a serious intrusion by the CC which requires it to exercise particular care in its assessment. HCA said that the requirements of proportionality were not met because the remedy was not effective to achieve its aim, that it would, in any event, be considerably more onerous than is required to achieve the CC's aim (a 'sledgehammer to crack a nut'), and that such a remedy would produce significant adverse effects to the detriment of patients.

Competition on quality

9. HCA believed the CC had failed to give proper consideration to quality and innovation as parameters of competition, since the CC's analysis focused almost exclusively on price. Quality was an important factor in an industry where patient health and welfare was paramount and a key factor in choices made as to consultant and hospitals. HCA believed that there had been no consideration in the PFs as to whether there had been a lowering of quality or a stifling of innovation in particular markets, or conversely, no assessment of positive quality and innovation.
10. HCA said that it had submitted detailed evidence of its high levels of investment, innovation and quality of service, which had been driven by competition from national and international rivals. This evidence showed that the market was functioning well, yet the PFs contained no assessment of that evidence.

Features of central London

11. HCA submitted that the PFs had not taken into account the unique features of the provision of healthcare in central London. The CC's conclusions on barriers to entry and expansion had applied a general conclusion derived from the UK as a whole to central London, namely, that economies of scale together with high capital costs in a static market constituted the greatest barrier to entry. This conclusion failed to take into account that the London market had shown substantial growth and continued to grow. It also believed there was no supporting evidence for the CC's conclusion that site availability and planning permission constituted a barrier to entry, as it had failed to take into account evidence before it to the contrary.

12. The CC's conclusion in the PFs that there were weak competitive constraints facing HCA in central London was considered to be erroneous. HCA believed that this conclusion failed to take into account competition on quality and innovation, the competitive constraint posed by hospitals in the Greater London area on hospitals within central London, the significant competitive constraint posed by PPUs and the competitive constraint posed by the NHS in central London, given the number of prominent teaching hospitals in that market. HCA indicated that a significant proportion of its patients treated in central London travelled from locations in the Greater London area.
13. HCA said that there had been evidence of entry and expansion in London, including the London International Hospital, the Kent Institute of Medicine and Surgery and substantial expansion by PPUs, in spite of issues over PMI recognition as a barrier to entry (for example, in the case of the London Heart Hospital) and the general economic climate. HCA said that the key issue behind new entry into the market was PMI recognition and that a prospective entrant would need assurance of recognition before committing to investing in the market.
14. HCA also noted that the CC's conclusion that HCA's prices were higher than those of The London Clinic, failed to take into account, among other things, the complexity of cases and patient characteristics at HCA hospitals and was therefore not an effective comparison of "prices". HCA also felt the insured price analysis was methodologically flawed to the point of being unreliable.

National bargaining

15. HCA noted that the CC appeared to conclude in its PFs that HCA had market power in its negotiations with PMIs. To the extent that such a conclusion formed part of the analysis of adverse effects on competition to ground any divestment remedy, HCA submitted that this represented a further error in the CC's analysis. It believed that the evidence showed that PMIs had a range of strategies available to them to increase their bargaining position which they had increasingly used by PMIs to divert business from HCA in central London, including the ability to de-list, the open referral program, service line tenders and restricted network products. HCA describes its own experience of PMI bargaining power and investment hold-up [§]. HCA said that the harm of excessive PMI bargaining power had been felt by other providers in London too, for example, by the Singapore Parkway Group, when the London Heart Hospital was forced to exit the market following a failure to secure recognition from AXA PPP. In this case, HCA said that a PMI had directly influenced the level of supply in the market, but now that same PMI was complaining about a lack of strong alternative hospitals to HCA.

Effectiveness of divestiture

16. HCA did not consider divestiture in central London to be an effective remedy and could in fact be potentially damaging, given HCA's investment in the provision of high acuity services. There was no guarantee that a new purchaser would adopt HCA's strategy of investing in high acuity services or would execute their provision to the same standard. A hospital operator would need to have the income to continually invest in these services and the clinical volumes to maintain the competence of staff to continue to develop the level of care required. In HCA's view, other hospital operators in the UK had not matched its level of investment, skill and diligence. Even if a new purchaser of any divested hospital in central London continued to operate it at the same standard as HCA, there was no evidence to show that this would lead to a reduction in prices.

17. HCA said that it was not the case that simply by acquiring a hospital and thereby having access to the doctors and nursing staff that a new operator would be able to do what HCA did. The new owner would, for example, need to be willing to fund the current level of nursing care ratio. HCA's hospitals relied on centralised systems including IT, imaging, pathology, sterile services for surgical equipment, clinical governance and quality information services, which a new owner would need to replicate.
18. If divestiture went ahead, there was a serious risk that it would jeopardise the continued operation of certain aspects of its clinical care services, that would it have an adverse effect on the level of innovation, the quality of care patients receive and on future investment in the market. HCA submitted that divestment would therefore be detrimental to customers and to London's international standing in private healthcare. In response to the question of whether one more rival in the market would enhance innovation, HCA responded that there were already a number of competitors in the market and that there was evidence of significant innovation in the market. HCA also said that it was not aware of any economic theories or economic models which drew a direct link between the number of competitors operating in a market and the level of innovation that was produced in that market. HCA said that divestiture would undermine years of strategic investment which have helped to make [redacted]. If forced to sell off [redacted], HCA felt it would be extremely difficult to convince its management in the US to commit to future investment in the UK.
19. HCA submitted that there were advantages to hospital operators having scale. For example, it allowed collaboration between specialists to decide on the most effective course of treatment for individual patients and provided access to a sufficient volume of samples to test whether treatments were effective. If HCA hospitals in central London were to be broken up, they could not access the same systems, clinical trials and multi-disciplinary teams. Scale also enabled patients to be followed and tracked throughout their care. As soon as this was broken up, the supply of services became fragmented and there was a chance that patients might fall through the cracks.

Innovation and PMIs

20. HCA suggested that innovation and expansion by hospital operators might be limited by PMI's unwillingness to agree to prices and recognise facilities until they had been built, and HCA referred to [redacted]. New facilities may require a significant amount of capital investment and no hospital operator would be willing to make those investments without knowing whether it would be recognised and what prices it would be recognised at.
21. HCA said that it regularly saw PMIs attempting to suppress innovation. For example, it was not in PMI's interests to see intensive care facilities develop in private hospitals as previously a patient requiring intensive care would be treated by the NHS at no cost to the patient or PMI. HCA said that it saw any sort of complex areas of care that it developed pushed back and suppressed by PMIs. It had also seen some PMIs offer patients financial inducements to have their care provided by the NHS rather than claiming on their private health insurance. HCA said there was a tension in the market between PMIs and hospital operators. Hospital operators such as HCA invest in widening the scope of care available in their hospitals in order to attract international patients and to offer UK patients a private alternative for treatments that were previously only available in the NHS. From the PMI's perspective, this has the undesired effect of increasing the volume of claims for healthcare that could have otherwise been delivered through the NHS. HCA said that this tension was at the heart of some of the hospital-PMI relations existing today.

Suitable purchasers

22. HCA believed there would be willing purchasers available if any of its hospitals were to be divested in central London as this would be an opportunity to acquire [redacted]. Potential purchasers included existing UK-based hospital operators, foreign healthcare providers and financial buyers, including private equity purchasers and sovereign wealth funds, although HCA noted that some of these buyers would be interested principally in extracting the property value from the business. [redacted].
23. HCA noted that a potential buyer would not want to commit to purchasing any divested facilities unless it had a commitment from BUPA and AXA PPP in advance that they would continue to recognise the facility.

Outside central London

24. HCA did not comment on whether there may be potential purchasers interested in acquiring divested sites outside of central London. HCA said that its hospitals compete with facilities outside central London and so it was aware of their market offering, but HCA said its focus, for the purposes of the hearing, was to demonstrate how inappropriate and unfair divestment would be to HCA.

Remedy 2—tying and bundling

25. HCA suggested that the CC's proposed remedy 2 may lead to unhelpful developments in the market. HCA believed it could price its hospitals separately (as it was unlikely to be as onerous for it as some of the larger hospital chains) however, it was not certain that any consumer benefit would result from pricing hospitals individually.
26. HCA was sceptical that PMIs would pass through to consumers any price reductions that they were able to obtain from the hospital groups from any remedy. It may be straightforward to measure if savings had been passed through to corporate customers (by reviewing billing), however HCA considered it would be difficult to determine whether savings had been passed through to individual customers. Individual customers were where PMIs typically made their margins, and they did not have the degree of flexibility and pass through as large corporate customers. HCA was sceptical that cost savings would be passed through to individual customers by PMIs.
27. HCA considered that more transparency in the PMI market was needed, for example, more transparency on the minimum loss ratio of PMIs. It noted that the US had focused on understanding the minimum loss ratios of PMIs to ensure that any pass through was transparent, that PMIs were not holding on to unreasonable margins and were passing it on to customers.
28. HCA said that it would consider a remedy which had been proposed to the CC, that PMIs should be allowed to make their own procurement arrangements for prostheses, pathology, diagnostics and scans, with providers being given the opportunity to match those prices or PMIs could source the items themselves. However, HCA said that there were items which hospital operators thought were under-priced and PMIs considered overpriced, with fairness in both arguments. An alternative would be for the industry to review how its negotiation process worked, as it may not be workable to re-price individual pieces without recourse to the remaining part of the value chain. HCA said that there was a risk of disruption to the patient pathway and subsequent harm to the quality of care a patient receives, but conceded

that PMIs were already embarking on such a strategy, for example, through service line tendering.

Remedy 3—restriction on expansion of PPUs

29. NHS Trusts were all looking for ways to improve their revenue streams as it became increasingly difficult for them to survive in the healthcare market. This included growing their private-patient market, and that this strategic objective had been most notably pursued by Foundation Trusts in central London. The PPU procurement process was heavily regulated and the Trust had to fulfil a number of criteria to ensure that they selected the right provider.
30. HCA said that the scenario of an incumbent monopoly supplier enhancing its monopoly by taking over the management of a neighbouring PPU did not apply to London where there were several competing providers.
31. While HCA do not consider that it was proportionate to have an outright prohibition on the expansion of specific hospital operators into the operation of PPUs, an alternative would be for each transaction—whether it was the acquisition of an existing PPU or a joint-venture to create a new PPU—to be reviewed on a case-by-case basis by the relevant authorities, the OFT currently and the CMA in due course. HCA pointed out that there was existing legislation, whether the merger control provisions of the Enterprise Act or commercial contracts control provisions of the Competition Act, and EU procurement law, that applied to new PPU development opportunities.
32. When told that the CC might consider the possibility of applying Remedy 3 to London as an alternative to divestiture (ie Remedy 1), HCA responded that it would wish to submit comments on this issue, as such a scenario was not apparent in the Notice of Possible Remedies.

Remedy 4—incentive schemes

Cash incentives

33. HCA supported the CC's proposed remedy of prohibiting the payment of cash incentives to consultants. Services provided by hospital operators to consultants should be provided at fair market value. It would like consultants to choose which hospital they worked at based on the quality of the hospital, not in response to financial incentives. HCA stressed that any remedy formulated by the CC relating to the limitation of specific consultant incentives should apply equally, and on a non-discriminatory basis, to all healthcare providers.

Equity participation in facilities

34. While HCA did not think that equity participation by consultants in hospitals was absolutely necessary to open a new facility, it thought that the KIMS development was a good example of how it could promote investment and competition—without equity participation in this case the new facility would not have existed. HCA felt that leaving room for equity participation in the industry was a useful tool to create investment and create new competition.
35. For example, in New Malden in the Greater London area, HCA was approached by a group of GPs who had identified a need for imaging services to be made available to the local community. HCA needed some level of local consultant and doctor

commitment to buy-in to the proposed investment. HCA entered into a joint-venture with the local doctors and was able to bring a diagnostic centre to the local community which would not have otherwise had that kind of facility. The doctors who were part of the joint-venture were entitled to a profit share at the facility. [✂].

36. HCA said that it had not seen any evidence of over-treatment as a result of these arrangements and had multi-disciplinary teams, clinical governance programs and audits in place to manage this. It noted that consultants also had codes which they had to abide by. It also referred to its CyberKnife clinic, which was established as a joint-venture. Each patient referred for CyberKnife treatment was assessed on a case-by-case basis by a multi-disciplinary team of consultants to work out whether the treatment was right for them or not. Patients may be refused treatment if the consultants decided there was a better treatment available to the patient. HCA said that it managed these issues closely.
37. In terms of enforcement mechanisms for this remedy, HCA thought that if the CC made it clear that there was a prohibition on the payment of cash incentives to consultants applied to everybody, this only left the consultant equity participation challenge. HCA thought that the General Medical Council ('GMC') would be the appropriate body for administering what was permissible in the area of equity participation by consultants in hospitals.
38. In HCA's view, the advantage of equity participation was that it provided consultants with a sense of "mutuality", whereby they were working together with the hospital operator. It provided a sense of ownership over the services they provided, rather than being merely an employee. Ownership brought a different mindset and different level of involvement by the consultants.

Equity participation in equipment

39. HCA submitted that there could be benefits from consultants buying equity participation in new equipment. For example, HCA was able to introduce the first CyberKnife technology into the UK with the assistance of investment by a number of consultants. CyberKnife technology was a high risk and expensive investment by HCA and equity participation was beneficial in ensuring development of the new unit and bringing the technology to the market within a shorter period of time than would have otherwise occurred. It also ensured that HCA had commitments to the facility from doctors who had the knowledge and experience in using this new technology. HCA believed this had had the effect of improving patient care.
40. It was acknowledged that the CC wished to draw a line in terms of what was appropriate equity participation, whether for new equipment or facilities. HCA said it was for the CC to determine whether a line was required and what this should be. HCA felt that any remedy or prohibition should be applied in a non-discriminatory fashion to all providers in the industry.

Leaders of Oncology Care (LOC)

41. HCA said that working with LOC has enabled it to improve its services to this group of consultants and the service that they are able to provide to their patients. It was originally approached by the consultants who were seeking to streamline processes for arranging consultations, requesting and receiving scans and results. The consultants did not want to place five different calls to request different scans and wanted to be able to have a test and results received on the same day for priority

patients. HCA had been able to deliver this. There was no contractual requirement that LOC doctors refer patients to its facilities.

US Stark Law

42. HCA provided information about the Stark Law in the US. The core purpose of the Stark Law was to remove the payment of direct financial incentives to consultants e.g. the making of a cash payment to a consultant for ordering a particular test. However, the Stark Law could be a very difficult piece of legislation to monitor and manage, and may be quite cumbersome.
43. HCA did not think the UK required legislation as cumbersome as the Stark Law in order to achieve compliance with any prohibitions placed on the payment of consultant incentives, as long as there were clear rules about what was not acceptable. It considered the GMC would be able to monitor and enforce rules relating to incentives.

Remedies 5, 6 & 7—information remedies

Consultant quality information

44. HCA considered that the Private Healthcare Information Network (PHIN) would be an appropriate body for collecting information on consultant quality.
45. HCA considered that the adoption of ICD-10 coding was an important part of the process of collecting and measuring information on consultant quality, but further work could be done. PHIN had started collecting information called 'IHES', which made a comparison to the data which the NHS collected, however some of HCA's competitors had tried to slow down the implementation of this initiative.

Consultant fees

46. HCA was supportive of a remedy requiring the publication of out-patient fees, but thought it could be quite onerous and cumbersome for day-case and in-patient fees. HCA supported the idea that consultants should post their consultation fees openly and transparently, however would be concerned if this led to a burdensome process in complex clinical treatment. HCA noted that more complex care and difficult cases were carried out in central London, therefore it could be more difficult to predict how care and treatment would be provided.
47. One of the challenges HCA's doctors had raised with it related to PMI's fee schedules, eg BUPA's fixed fee schedule. PMI fee schedules were national schedules and did not take into account that the costs of providing healthcare in central London were much higher than outside London. There was no way for doctors to compensate for this since PMIs were de-listing consultants that charge shortfalls. PMIs were effectively cutting off the supply from a lot of doctors based in London because they treated more complex cases and had a higher cost base, leaving a shortfall.

Hospital performance

48. HCA was supportive of the remedy proposing that more information was made available about private hospital performance. HCA considered that an effective information remedy would be a step forward for the industry and if this information

was made available and transparent, it would force poor quality providers to lift their game or exit the industry. HCA observed that experience from international markets had shown that as more information is made available to patients on a clear and transparent basis, competition over quality of care is enhanced.