

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Spire held on 19 November 2013

Introduction

1. Spire was of the view that there were fundamental flaws in the Competition Commission's (CC's) provisional findings, in particular in relation to the CC's analysis of profitability, analyses of pricing, local competition assessments and bargaining.
2. Spire submitted that there was evidence of inconsistency, wrong methodology and mathematical errors in relation to the CC's profitability analysis. It also considered that the local competition assessments did not take into account what was actually happening in the market and had not taken into account the evidence which Spire had submitted. It did not consider there to be a market-wide effect as claimed in the provisional findings. Spire submitted that the PCA did not support the CC's findings and that the IPA, in fact, showed that Spire's prices were often below and rarely materially above prices set by one or more firms without market power. Spire also did not agree with the CC's position with respect to bargaining between hospital operators and insurers, the evidence submitted by Spire showed that the balance of power in negotiations was not weighted in favour of Spire. Spire was of the view that there was no adverse effect on competition and no need for the remedies which were proposed to apply to Spire.
3. Spire believed that the proposed remedies would have negative and unwarranted consequences for its business. It could lead to the widening of the relationship between insurers and providers

Profitability analysis

4. Spire considered that the CC's profitability analysis contained mathematical flaws and felt that the comprehensive mathematical and descriptive evidence that it had submitted prior to the publication of the provisional findings had been ignored. Spire's capital base had been understated and its return on capital employed had been overstated.
5. Spire noted that the CC had assumed that profitability had arisen as a result of excess market power and not from other factors. However, its increased profitability had been significantly driven by improved efficiencies since its acquisition of the business from BUPA, which had not been taken into account in the CC's analysis. Only a small proportion of its increase in profitability had been driven by price increases.

Local competition assessments and price-concentration analysis

6. The CC's local area assessments did not accurately reflect Spire's business. It believed that the hypothetical construct had been favoured over the evidence of real competition. Spire referred to some local areas where it was aware that new competitors had recently entered the market, but this had been omitted from the CC's report.
7. The CC's price-concentration analysis did not support the findings and the dataset was very general and was not robust. Breaking down the price in the concentration

analysis of Spire, the price-concentration analysis did not find that Spire charged higher self-pay prices in areas where Spire hospitals had a higher weighted average market share.

National bargaining

8. Spire believed that the balance of power between private medical insurers (PMIs) and hospital operators in PMI negotiations was not weighted towards Spire and/or other hospital operators. It had submitted evidence of PMI power at both a local and national level, which it considered had not been taken into account by the CC. It was concerned that as there was currently no behavioural remedy proposed for PMIs, there would be no motivation for PMIs to pass on any price reductions by hospital operators to patients. Spire was concerned about a profitability shift from hospital operators to PMIs as a result of the proposed remedies, with no patient benefit at all.

Remedy 1: Divestiture—outside of London

9. Spire indicated that it did not recognize the need for divestments outside of central London. Spire told the CC that it believed the LOCI analysis was flawed and that, [REDACTED]. Spire considered that there were issues regarding the use of the LOCI for this particular divestment screen; it believed that the measure was misconceived, as an increase in competition could give rise to an increase in the weighted average market share. It could actually give rise to a situation where more competition could trigger the divestment screen. Spire was amazed that the CC had used this particular tool for guiding its divestment policy. The measure itself was highly problematic.
10. Spire noted that the CC's price-concentration analysis did not find that Spire charged higher self-pay prices in areas where Spire hospitals had higher weighted average market shares. The basis for motivating any divestment was in the case of Spire, therefore absent.
11. There was also no evidence to suggest that there might be a broader market-wide effect. However, even if there were, Spire believed it would not be a sufficient legal basis to reach a finding as to what would happen if a particular Spire facility was divested in a particular area, since the only point that was relevant to the consideration of that question was what Spire did when it was faced with higher or lower concentration in a particular area. Based on the CC's evidence, Spire did not believe the CC could conclude that a divestment of a Spire hospital would be an effective remedy.
12. Spire believed there were a large number of UK and overseas hospital groups that might be interested in making acquisitions in the UK. If the divestment option involved one or two single sites, there would be a couple of players in the UK market that would be interested. The private equity environment was keen to buy up assets cheaply and basically as a network, although forcing packages onto the market would risk limiting the number of potential purchasers. A larger divestment package would attract a lot of investors who were keen to create one network. Investment might come from pension funds in Canada, Singapore and the Middle East.
13. Spire suggested that a purchaser might have some interest in a non-solicitation undertaking from any firm which might ultimately divest any hospitals, to mitigate the risk of consultants being solicited away from the hospital. Another important factor of any divestment was PMI recognition. As part of this remedy Spire felt that the CC should carefully consider having a rollover of PMI recognition to the new owners of any divested hospitals.

14. Spire argued that a new purchaser would be unlikely to be as efficient as Spire: Spire would be sceptical about a new entrant coming into the market with all of the overheads that would be necessary to establish a presence in the market and being able to absorb that cost and deliver improved efficiency on a limited network of hospitals in the UK.
15. Spire thought there should not be an absolute restriction placed on existing UK hospital operators purchasing any hospitals which might be divested.

Remedy 1: Divestiture—central London

16. There were systematic barriers to entry in the central London market, such as expensive real estate, lack of available space and difficulties locating a suitable site.
17. The key aspects of getting PMI support within the London area would involve a reduction in the prices that were currently charged in London, thus making it more affordable for the PMIs. Uncertainty about what PMI recognition would look like adds significant risk to purchasing in London, [X].
18. Although the majority of GPs were independent, the Roodlane and Blossoms practices were both tied to HCA and therefore a natural referral source for HCA hospitals. If, prior to any disposal, HCA were to decamp its highly-skilled clinical teams into other hospitals in its network, that would be a significant barrier to the new purchaser of successfully delivering on the hospital case.

Consultants

19. A major concern for any new entrant into the London market would be whether they could retain the consultants currently working at that facility. Consultant bodies attracted the top surgeons and a hospital provider would want to ensure it maintained good relationships with such groups. Spire believed its ability to safeguard the clinical service delivery in any hospital it acquired would be key to any investment case as a whole.

Competition

20. Spire noted that there was no concrete analysis or had been no investigation of how the diversion ratios had worked in the private healthcare market, whether between two Spire hospitals or between a Spire hospital and a BMI or Ramsay hospital. There was no reason why two Spire hospitals could not compete with each other. Although this was not a general policy, Spire saw no reason why hospital directors could not compete for new services and it would not actively prohibit hospitals competing against each other. Consultants could also compete with each other and operate from different facilities within Spire's network on an exclusive or inclusive basis.

Remedy 2—Preventing tying and bundling

21. Spire did not support the CC's proposed remedies 2(a) and 2(b). Spire believed that Remedy 2(a) was unclear and was not relevant to its business. It had concerns that this remedy would give the PMIs more bargaining power. In terms of implementing the remedy, Spire felt it would be complex, not only in terms of the resources that would have to be invested but monitoring would almost be impossible. This remedy could actually force the insurers and providers further apart, whereas Spire believed that they needed to come closer together, to help grow the market relative to other

countries. In the short term the marketplace would likely react by simply contracting locally in order to deal with the contracting situation.

22. Another concern around remedy 2(a) was that it implied a site could be delisted by a PMI and Spire would have no ability to address that decision or the resulting loss of volume. Presuming the hospital had no quality issues and had been delisted due to prices, after time the hospital would have no option but to negotiate its price down to the local market value and this would end up achieving the same objectives as those laid out in remedy 2(b). A behavioural remedy should be added for the PMIs requiring them to price to customers on a regional basis. Under a national contract delisting a single hospital was not possible.
23. With regards to remedies 2(a) and 2(b) Spire again felt there was no clear case for any remedies. Spire's approach had always been to approach negotiations with insurers with a view to agree to a position forward that could help to grow the market, and working toward attracting more patients into the business on a combined basis. Some PMIs liked to negotiate on a national basis and others down the track might want to have local pricing.
24. If remedy 2(b) was adopted it would lead to more direct commercial dialogue between the PMI and the hospital provider if a delisting scenario occurred. The reasons for the delisting would be made clear and the hospital provider could respond directly. In the 2(a) scenario, the situation was more opaque. PMIs could delist a hospital provider or steer patients to alternative hospitals, making it difficult for a hospital provider to respond competitively. For remedy 2(b) to be effective, Spire felt that the insurers should price their customers on a regional basis.
25. Spire supported the idea of moving to a more localized form of pricing, however, if the PMIs were not also required to offer local pricing to their customers, then customers would not see any benefit.
26. Clearer rules and understanding could be put in place to help hospital providers get services recognized by the PMIs.

Remedy 3—Restrictions on expansion

27. In relation to the acquisition of private patient units (PPUs), Spire thought that each should be dealt with as ordinary mergers and dealt with under merger control. An example of such a case was HCA's acquisition of Guy's and St Thomas' PPU, which the Office of Fair Trading reviewed in November 2012. Going forward the Competition and Markets Authority and/or Monitor could review commercial arrangements. Although Monitor had an obligation to ensure the financial stability of hospitals, it also had a competitive objective.

Remedy 4—Consultant incentives

28. Spire supported a ban on direct cash payments to consultants and cash benefits to GPs referrals. It was keen that any remedy was proportionate and focused on the issues identified. Clear definition should be given to what was considered an incentive and what was not, eg providing consultants with free car parking. However, Spire believed that other incentives could be pro-competitive and perform a useful tool to increase competition in the market. The first was encouraging consultants to come into private practice for the first time. Indemnity premiums were a big problem for consultants and were rising at quite significant rates. Spire felt there was a good case for saying that, for a limited period (of 12 to 24 months) in order to encourage

new market entry from consultants, hospital groups or anyone hosting consultants were able to offer discounted consulting rooms, administrative and secretarial support. By removing the ability of hospital groups to provide such incentives, Spire thought that the number of consultants entering private practice would shrink.

29. Spire was aware of established consultant neurosurgeons and spinal surgeons leaving private practice, due to the administrative burden and costs. Spire said that it had also seen junior consultants who had spent two years in private practice leave the industry because the costs, as a result of indemnity, regulation and capping by PMIs, were too great.
30. It was important to provide consultants with a holistic approach to healthcare. Encouraging people to be part of a team, which Spire believed led to better outcomes. It developed its practice alongside the consultant, getting out to the kind of GP network around what new services, effectively, they offered, issues around their quality. These aspects were key.
31. An example of where equity participation by consultants had been successful was at Spire's Montefiore Hospital. [X] Spire's potential [X] and its diagnostic centre in Windsor were two other examples where consultants/doctors having an idea for a business and having located a suitable site approached the private hospital operators. This method of entering the healthcare market helped to provide services into areas where they did not previously exist.
32. Spire was aware of new services that had been set up in partnership with consultants with equity interests. Consultants were not only thinking commercially but also about ways to introduce new technology or new services and were actively looking for business partners to help them achieve this. The best way to encourage innovation was to set consultants free from bureaucracy. Spire was keen to invest in services that were new to the market, which were unproven, not clinically, but in terms of their ability to attract a private patient market.
33. Spire was concerned the CC's proposed remedy would suppress future innovation. However, under the scope of the proposed remedies, consultants would still be able to propose ideas and approach hospitals about financing the venture.
34. With regard to monitoring restrictions on clinician incentives, the General Medical Council had rules regarding disclosure and imposing a duty on consultants not to do anything which might impinge their medical judgement. They were best placed to deal with any medical ethics and disclosure.
35. Putting the medical ethics point to one side, Spire proposed a quasi-disclosure regime with Monitor, which involved a register detailing any arrangement a consultant had made with a hospital. It had also suggested that Monitor enforce a disclosure remedy, which entailed an obligation on consultants to make disclosure to patients of arrangements that they had.

Remedies 5 to 7—Information

36. Spire was in agreement with the proposed information remedies, but was concerned that there was a lot of emphasis behind the Private Healthcare Information Network (PHIN). [X].
37. The PMIs should benefit from the data and had themselves basic life cycle data that could help the PHIN project. However, the data should be robust and should be

transparent across the hospitals and the consultants. Eventually PHIN would provide a definitive dataset across all patients that entered a hospital.

38. Spire did not believe that the publication of consultant fees would lead to a rise in their fees. It currently published the cost of the top 75 procedures in all of its hospitals. Another 50 would follow shortly. Self-pay patients wanted certainty of what they were going to get and Spire had moved towards full and comprehensive pricing, covering any unexpected extra costs.