

HCA : CC'S PRIVATE HEALTHCARE MARKET INVESTIGATION

1. Introduction

- 1.1 HCA International Limited ("HCA") is submitting in this paper some brief initial comments to the Competition Commission ("CC") with regard to the scope of its market investigation of private healthcare ("PH"). HCA will make a more detailed submission, and will develop these points more fully, in response to the CC's Issues Statement in due course.
- 1.2 HCA is a London-based PH provider. HCA competes in a highly competitive and dynamic market, arguably the most competitive part of the UK. There have been several new private sector entrants in recent years, and there are also significant growth plans by many NHS private patient units ("PPUs") in London.
- 1.3 The CC's investigation comes at an important juncture for the sector. The UK private acute healthcare market has a total value of over £7 billion¹ and makes a major contribution to the UK economy. The sector is witnessing numerous significant changes in the way in which private healthcare is purchased and delivered:
- The major providers of private medical insurance ("PMI"), which enjoy substantial buyer power, are increasingly dictating the way in which clinical services are delivered. They have embarked upon a "managed care" strategy which has had a significant impact on PH providers (both hospitals and consultants) and is severely limiting patient choice. As discussed below (section 5), PMI providers have secured greater control over the patient referral pathway through their network strategy and other initiatives such as BUPA's Open Referral scheme.
 - The Government's "choice" agenda, which allows NHS patients to choose to have NHS treatments performed at private hospitals, has opened up the potential for more competition between the NHS and the private sector.
 - The NHS is also playing a much greater role, both in the delivery of PH through PPU's and in the procurement of PH through NHS contracts with private hospitals. The lifting of the income "cap" for PPU's is expected to lead to further expansion of NHS private facilities.
 - There are broad shifts in medical practices which are moving patients out of hospitals and into ambulatory and outpatient settings, and these developments are generating growth in new diagnostic and treatment centres.
 - Over the last few years there has been innovative new entry, including clinical-lead partnerships and venture capital-backed groups which have engaged in new build projects right across the UK.

¹ Laing's Healthcare Market Review 2011-2012

- 1.4 The CC's review will need to take account of all of these developments which are increasingly re-shaping the landscape of private healthcare for the future and HCA looks forward to engaging with the CC to provide evidence and analysis on these issues.

2. HCA

- 2.1 HCA is the largest non-government healthcare organisation in the world with 183,000 employees operating hospitals in the US and UK. HCA brings a high level of focus and expertise in private acute healthcare.
- 2.2 HCA owns and operates 6 private acute medical hospitals and a number of outpatient and diagnostic centres in London and has also entered into partnerships with NHS Trusts.
- 2.3 HCA's strategy is to invest heavily (£159 million over the last four years) in its facilities and services in order to provide cutting edge healthcare and to create advanced clinical infrastructure upon which London consultants can rely.
- 2.4 HCA, unlike many of its competitors, has a high proportion (approximately [REDACTED]) of international patients which account for [REDACTED] of its profits. It generates very little business from NHS contracts.

3. Market context

- 3.1 From HCA's perspective, the PH market is an extremely competitive one. In London alone, there are 25 independent hospitals and over 20 dedicated NHS PPUs alongside HCA. There has been significant new entry throughout the UK, and the removal of the PPU "cap" on revenue is paving the way for NHS Trusts to grow their PPU operations in competition with the private sector. Many of HCA's key competitors are PPUs and charitable hospitals which enjoy inbuilt economic advantages (and one key competitor – the Cromwell – remains vertically-integrated with BUPA). The PMI purchasers, the main purchasers of PH services, exercise substantial bargaining power. In addition, NHS public hospitals impose constraints on the size and scale of PH and the ability of PH providers to grow their business.
- 3.2 There is lively and vigorous competition between PH providers at a number of levels:
- PH providers compete fiercely to attract and retain consultants who will bring their private patient practices to the hospital;
 - they compete vigorously for self-pay patients;
 - they also compete for recognition on PMI networks in order to get insurance contracts, which typically generate the major part of a hospital's business.

There is competition in relation to quality, price and innovation, as providers strive to offer the highest quality product at the best possible value.

- 3.3 This highly competitive landscape provides significant benefits for patients. Fierce competition in London drives investment in facilities and innovation. HCA has made significant capital investment in new, innovative equipment and treatment technologies, which have delivered pioneering treatments for patients and widened healthcare choices. Recent examples include:

- the Cyberknife radio surgery system;
- the HD/3D Da Vinci SI robotic surgical system;
- high intensity focused ultrasound ("HIFU") pioneered at the Princess Grace hospital;
- the use of mobile iPad technology to provide consultants with 24/7 mobile access to clinical data on their patients.

4. OFT Report

4.1 The OFT's Private Healthcare Market Study of April 2012 concludes that there are features of the market in the "supply or acquisition" of PH which prevent, restrict or distort competition.

4.2 HCA contests a number of the OFT's findings relating to PH providers and believes that the OFT has mischaracterised the market and has failed to take account of market developments. In particular, while the OFT's Report is heavily focused on the supply side (PH providers), it has not given proper weight to issues affecting the demand side (PMI providers in particular) and has provided a highly one-sided view of the market. HCA's key concerns about the OFT's findings are summarised as follows:

- The OFT ignores the highly concentrated nature of the PMI market and the substantial purchasing power exercised by the two leading insurers.
- The Report pays scant regard to the PMI providers' network strategy and the importance of PMI recognition for any hospital provider – this confers substantial bargaining power on the major insurers and itself represents an important barrier to entry. This point has been starkly illustrated by recent reports of BUPA's threats to de-list BMI hospitals as part of its pricing negotiations².
- The OFT has also failed to pay proper attention to a number of PMI initiatives which in recent years have asserted greater control over the way in which clinical service is delivered by both hospitals and consultants, including pre-authorisation, the diversion of patients to favoured providers, BUPA's launch of its "Open Referral" policy, and a whole variety of other managed care initiatives which interfere with patient choice and restrict competition between PH providers.
- The OFT alleges that contractual provisions between PH providers and insurers create barriers to entry, but provides little evidence of any real foreclosure effects – indeed, the OFT wholly ignores evidence of new market entry into PH provision.
- While HCA supports initiatives to improve transparency of clinical information and pricing of healthcare providers, the OFT has not fully recognised the range of initiatives that PH providers have already undertaken in publishing quality information.
- The Report recognises that NHS public provision provides some competitive constraints on private providers but this is not given sufficient attention in the OFT's description of the competitive dynamics of the private healthcare market.

² See e.g. "GHG takes cut in BUPA fees", Daily Telegraph, 30.01.12

- The Report also largely ignores the competitive advantages enjoyed by NHS PPU's and the market distortions which this can create.
- The OFT's conclusions on consultant incentives are vague and generalised and offer little tangible evidence of market foreclosure.

4.3 The CC's detailed and in-depth investigation provides a welcome opportunity for these issues to be comprehensively considered and explored.

5. PMI

5.1 In relation to PMI issues, the OFT's Report mischaracterises the market in two respects:

- It fails to give sufficient weight to the bargaining position of PMI providers and the degree to which they exercise buyer power which constrains PH providers.
- The Report concentrates on PH supply issues and wholly ignores the extent to which PMI purchasing practices themselves have restrictive features which prevent, restrict or distort competition.

5.2 PMI remains the principal and most important source of funding for private hospitals, accounting for 78% of PH purchases³. PMI drives demand for PH services and acts as the gateway to private healthcare for most UK consumers since the vast majority of private patients are insured under PMI policies. The OFT's failure to take proper cognizance of PMI purchasing practices has created an unbalanced and misleading picture of the market on which the OFT has based unwarranted concerns about competitiveness.

5.3 Given the central role of PMI providers, it is impossible to conduct an assessment of competition in PH without a full and detailed assessment of the PMI market at all levels of its supply chain:

- It is not possible to evaluate the degree of any market power possessed by PH providers without a full assessment of the PMI providers' market power in selling PMI (the latter being a significant determinant of their bargaining power) and the choices available to PMI customers.
- The incentive and ability of PH providers to invest in better quality and innovative products is crucial for market outcomes. It would not be possible to assess the effects of competition on these outcomes without fully analysing issues such as PMI recognition, PMI networks and their ability and incentives to limit or expand the scope of PMI cover.

5.4 There are a number of areas which HCA urges the CC to consider in its investigation.

Concentration

5.5 The PMI market is highly concentrated. There are five PMI providers accounting for 90% of the market. The two largest providers, BUPA and AXA/PPP, together account for 66% of PMI policies⁴, thus enjoying substantial negotiating power over hospitals and consultants. There is little discussion in the OFT's Report about the oligopolistic nature of PMI, the strong

³ Para. 1.4, OFT Report (excludes NHS purchases of acute care)

⁴ Laing's Healthcare Market Review 2011-2012

bargaining position of the major insurers, and the fact that there is lack of effective competition in PMI.

PMI recognition

5.6 As the OFT Report acknowledges⁵, PMI recognition is a key barrier to entry, since a new PH facility needs to be included on insurance networks if it is to be financially viable. The major insurers have a significant negotiating advantage since no hospital can afford to be delisted from these networks. The OFT Report correctly refers to the recent instance in which "*BUPA was able to credibly threaten to delist a limited number of GHG's PH facilities*" as evidence of buyer power⁶. BUPA's Preliminary Results for 2011 specifically notes that BUPA has "*initiated a more robust approach to negotiation with private hospital groups to help drive better value care for its customers*"⁷. In recent years, there has been considerable evidence that the failure to obtain PMI recognition has impeded new entry and has even led to some high-profile market exits.

5.7 [REDACTED].

Network strategy

5.8 Moreover, the PMI providers have engaged in a network strategy over the last few years, creating specialist treatment networks e.g. ophthalmics, arthroscopy, MRI. This enables them to control which providers are authorised to provide which types of treatment to subscribers. There is vigorous competition between PH providers to secure a position on these specialist networks.

Pre-authorisation

5.9 Insurers are increasingly becoming involved in directing PMI subscribers to particular hospitals and consultants of their choice when pre-authorising treatment thus asserting greater control over the patient referral pathway and diverting patients to lower-cost providers.

Open Referral

5.10 BUPA has launched its Open Referral scheme which applies to all its corporate policies. This aims to further control patient referrals by substituting the insurer's, in place of the GP's, choice of consultant. It is a wholly new departure which enables the insurer to control patient referrals and direct how and where patients are treated. The Report acknowledges that this allows BUPA "*to gain some control over the choice of consultant and/or PH facility accessed*"⁸. BUPA decides on the most appropriate consultant and there is no transparency about how it takes these decisions. Open Referral has substantial implications by taking away the GP's right to recommend the most appropriate consultant based on the patient's clinical needs – hitherto the cornerstone of the UK healthcare system.

Control over consultants

⁵ Paras. 8.9 – 8.23, OFT Report

⁶ Para. 6.64, OFT Report

⁷ In addition, a recent BUPA communications document "Our BUPA World" explicitly refers to "*a revised and massively improved contract with a major hospital supplier*" and states that BUPA has "*radically shifted from passive insurer to healthcare leader*".

⁸ Para. 6.74, OFT Report

5.11 PMI providers are also imposing increasingly restrictive provisions which affect consultants and impact on patient choice:

- the arbitrary delisting of individual consultants without reference to transparent, non-discriminatory criteria;
- the introduction of fixed pricing schedules by both BUPA and AXA/PPP which set a fixed level of reimbursement and prohibit "top-up" fees, and only recognising consultants willing to accept the insurer's reimbursement levels, thus preventing a patient from seeing the consultant of his or her choice (which the OFT Report acknowledges are capable of distorting supply)⁹;
- the fee-capping of consultants, which can also be arbitrary and discriminatory;
- substantial reductions in PMI reimbursement rates to consultants for a number of common clinical procedures, such as ENT, gastroenterology and dermatology¹⁰.

Managed care

5.12 There are also a whole variety of other "managed care" strategies which include introducing increasingly proscriptive requirements regarding the treatment of patients within the hospital facility, such as designating the patient's length of stay, growing involvement in consultant recognition and audit, and introducing PMI policy restrictions.

Vertical integration

5.13 The OFT Report makes no mention of vertical integration between insurers and providers, and mistakenly considers that it is no longer an issue in the PH market¹¹. BUPA owns the Cromwell Hospital which gives it a significant foothold in London, and is one of HCA's key competitors. In addition, both BUPA and PPP have significant interests in the primary care sector, with BUPA owning the largest primary care practice (BUPA Wellness) as well as a home-help agency. PMI involvement in primary care better enables the insurers to influence patient referrals to hospitals and consultants.

5.14 HCA urges the CC to include these issues in its investigation and to invite and consider evidence about PMI purchasing from a wide range of stakeholders.

6. NHS

6.1 The OFT's Report¹² rightly notes that, as a result of a number of developments, NHS public healthcare provides competitive constraints on the private healthcare market and suggests that the CC may wish to examine this further as part of its more detailed investigation. HCA strongly agrees that there are now significant interactions between public and private healthcare and that it is no longer possible to compartmentalise public and private provision as wholly distinct markets.

6.2 There are several ways in which the NHS as a whole constrains the scope and extent of private healthcare:

⁹ Para. 5.96, OFT Report

¹⁰ See e.g. report "BUPA defends its fee cuts", Independent Practitioner, April 2012

¹¹ See para. 4.2, Private healthcare – a scoping paper, OFT

¹² Para. 4.41, OFT Report

- (i) The NHS determines the availability of consultants to the private sector.
- (ii) The Government's "choice" agenda, and the ability of patients to choose between NHS and independent sector providers willing to provide services at the NHS tariff, opens up much greater potential for competition between the NHS and the private sector.
- (iii) There are also substantial numbers of patients who, despite being covered by private insurance policies, elect for NHS rather than private treatment, e.g. because of the severest nature of the treatment or to receive cash benefits under their policies.
- (iv) There are clear correlations between NHS waiting times and PH demand. Over the last decade, the reduction in NHS waiting times has adversely impacted on PMI demand and hence on demand for PH services.
- (v) The NHS is also emerging as an increasingly important customer for private hospitals, with NHS-funded contracts representing nearly 25% of funding for private acute hospitals in the UK, reflecting the growth and central commissioning of ISTC provision and local procurement by NHS Trusts¹³.
- (vi) Furthermore, it must also be remembered that the NHS is active itself in the provision of private healthcare by operating PPUs and pay-beds in competition with the private sector (see below).

6.3 Given the significant changes in NHS procurement, and the "any willing provider" model, this is a particularly opportune time for the CC to take into account the role of NHS public provision in the private healthcare market.

7. PPUs

7.1 HCA supports the OFT's findings in its Report that PPUs, particularly in London, compete effectively with PH providers. In London, there are over 20 dedicated NHS PPUs accounting for around one-fifth of the total PH bed capacity. Many of these are attached to prestigious teaching hospitals which have national, and indeed global, reputations, e.g. Royal Marsden, Royal Brompton and Harefield, and King's College London.

7.2 The CC's investigation of the market will need to take account of the competitive advantages which NHS PPUs are able to exploit:

- The NHS can use its core NHS public facilities (infrastructure, equipment and staff) to support its PPUs, and there are concerns as to whether PPUs are operating on a genuinely stand-alone commercial basis.
- Co-located PPUs have access to infrastructure, such as intensive care units, which may well be unavailable to independent providers in many areas.
- NHS facilities can often be provided for private patient activity at marginal or zero cost.
- PPUs also enjoy significant tax advantages since the NHS pays no corporation tax.

¹³ Laing's Healthcare Market Review 2011-2012

- There is also evidence that NHS Trusts are restricting their consultants from carrying out private patient work other than in the Trust's own PPU.

7.3 The OFT's Report notes that PPUs benefit from a number of competitive advantages and even states that "*There is a risk that the market will not operate effectively due to resources being used inefficiently. This could potentially lead to higher prices and reduced value for tax payers.*"¹⁴ However, while the OFT make a cursory reference to this in the Report, it is wholly absent from the OFT's core findings relating to the competitiveness of the PH markets.

7.4 HCA calls on the CC to investigate these competitive benefits for PPUs and consider whether there are appropriate remedies (e.g. increasing the transparency of accounting of PPUs) which could help to ensure a level playing-field between PPUs and private sector providers.

7.5 This issue will become increasingly important in view of the Government's Health and Social Care Act 2012 which removes the current income cap on PPUs and which will pave the way for further PPU growth and expansion.

8. NHS/PPU partnering

8.1 The OFT has noted that in recent years a number of NHS Trusts have sought to partner with PH providers to establish or develop PPUs and the OFT has raised the question whether these partnering arrangements may give rise to local concentration¹⁵.

8.2 HCA points out that NHS/PPU partnering to build and develop PPUs is fundamentally pro-competitive in encouraging PPU start-ups or expansion which will compete with existing PH providers. The partnering arrangement allows NHS Trusts to tap into and utilise private sector experience and expertise in the operation of private patient services and this will be a further source of new entry and growth for the future.

8.3 Where there are issues of local market concentration (for example where a PH partner has existing PH facilities in the relevant catchment area of the PPU) the OFT already has powers to investigate PPU partnering arrangements as qualifying merger situations under the Enterprise Act 2002. In these cases, as the OFT's Report notes, the OFT already has the power to investigate transactions which give rise to a substantial lessening of competition. The Enterprise Act provides an adequate mechanism to address any local competition concerns, and therefore HCA rejects the OFT's suggestion that there is any basis for the introduction of a competition test based on local market share¹⁶.

9. Other issues

Consultants/GP incentives

9.1 The OFT considers that incentives provided by PH providers to consultants/GPs may raise barriers to entry. The OFT offers little clarity over specifically what types of incentive may impede competition and provides no evidence that foreclosure would be possible at all nor of

¹⁴ Para. 9.10, OFT Report

¹⁵ Paras. 9.5 – 9.7, OFT Report

¹⁶ Para. 10.43, OFT Report

any actual foreclosure effects. PH providers compete vigorously to attract and retain consultants and their ability to offer financial and non-financial incentives is part of the competitive process. HCA has not seen any evidence that the type of incentives referred to in the OFT Report are blocking new entry – on the contrary, there have been significant new entrants into London over the last few years.

9.2 However, HCA agrees with the OFT that, in considering the issue of consultant incentives, the analysis should include consideration of PMI incentives as well. As the Report notes¹⁷, BUPA has consultant partnership schemes which provide financial incentives which influence where and how patients are treated and the impact of these should also be considered.

9.3 Indeed, HCA would emphasise that it is largely PMI behaviour rather than hospital incentives which has a greater impact on where the consultant practices. Where an insurer delists a hospital, or excludes a hospital from a speciality network, a consultant may well be forced to relocate his practice to a different hospital in order to continue treating his insured patients. It is these impediments imposed by the insurers which can affect the consultant's choice where to practise.

PMI policies

9.4 The OFT's decision, early in its investigation, to exclude consideration of the retail sale of PMI policies was wholly misguided¹⁸. There are, in HCA's views, serious questions to be considered about the role of PMI policies on the market and their transparency and the information provided to subscribers about policy restrictions, including restrictions concerning the hospitals/consultants offered to the subscriber, and the extent to which shortfall payments may arise. It is artificial to exclude these issues from an investigation into the private healthcare sector since the way in which PMI policies are sold affects 78% of all private patients and has a direct bearing on PH consumers. The CC is urged to include all aspects of the PMI retail market and in particular PMI point-of-sale transparency in its market investigation.

Charitable status

9.5 HCA also invites the CC to consider the fact that a number of leading PH providers are registered charities under the Charities Act 2006 and their charitable status provides them with significant advantages which include:

- access to free capital through charitable donations
- no corporation tax
- no VAT
- no requirement to pay dividends
- no shareholder accountability

There are legitimate questions whether commercial hospital operators which are currently registered as charities can justifiably claim that they provide sufficient "public benefit" to

¹⁷ Para .8.76, OFT Report

¹⁸ Paras. 3.27 – 3.29, "Private healthcare – final statement", OFT

retain charitable status. Charitable status provides these hospitals with significant financial advantages over commercial competitors and may be a further source of unfair competition. This is a further matter which should be included in the CC's review.

10. Consumer detriment

- 10.1 The OFT's Report conspicuously fails to identify any consumer detriments which allegedly flow from its concerns about the PH market. The OFT tentatively suggests that there are "*possibly*" higher prices for PH and limited choice of patients, and that its concerns "*might be expected to result*" in lower quality of service, but cites no evidence for this whatsoever¹⁹.
- 10.2 As stated above, HCA operates in a highly competitive market in London where competition between PH providers has driven heavy investment in technological innovation and world class facilities which offer enormous clinical benefits to insured and self-pay patients. HCA, and indeed many of its competitors in London, have made considerable investments in state of the art treatment technologies. HCA, at least from a London perspective, vigorously rejects the OFT's unsubstantiated assertions that concentration in the PH market has led to lower quality of service. This is demonstrably not the case.
- 10.3 The OFT also provides no evidence that PH pricing to insurers is above competitive levels. The level of PMI premiums is likely to be due in no small measure to the highly concentrated nature of the PMI industry and the lack of effective competition between PMI providers – an issue which the OFT has consciously declined to consider in its market review.
- 10.4 HCA would also invite the CC to consider the consumer detriments arising from PMI initiatives which have been flagged up in the OFT's Report:
- Some BUPA and AXA/PPP policies prohibit "top-up" fees and thus patients are prevented from seeing a consultant who charges above the insurer's reimbursement rates – the OFT accepts that these are capable of distorting competition²⁰.
 - The Report refers to allegations of "inappropriate referrals" by PMI providers to insufficiently experienced consultants on grounds of cost²¹.
 - The OFT study has also made findings about the lack of transparency of PMI policies particularly in relation to the possibility of a shortfall²².

11. Conclusion

HCA hopes that these initial comments are helpful in identifying the issues which merit investigation and HCA welcomes the opportunity to develop these submissions and provide further evidence.

¹⁹ Para. 10.35, OFT Report

²⁰ Para. 5.96, OFT Report

²¹ Para. 5.86, OFT Report

²² Para. 9.4, OFT Report