



Private healthcare market investigation

Response to Provisional Findings and Possible Remedies

Aviva Health UK

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Non-confidential version

Aviva Health Response to Provisional Findings and Possible Remedies

Aviva Health (Aviva) welcomes the Competition Commission's (CC's) provisional findings. We are largely supportive of the provisional findings but have concerns that the possible remedies that the CC has put forward will not adequately address the AECs that it has identified. In this response, we provide a brief summary of Aviva's position on the CC's provisional findings and possible remedies before discussing each of the possible remedies in more detail, having regard to some of the specific questions that the CC has outlined in its *Notice of Possible Remedies*. This response puts forward Aviva's initial position in relation to the provisional findings and possible remedies.

Summary

1. We agree with the CC's finding that there are weak competitive constraints in many local markets including central London and that there are high barriers to entry for full service hospitals. We also agree with the CC that together these features give hospital operators market power in negotiations with PMIs. However, we do not agree that market power is limited to just HCA, BMI and Spire. Aviva has direct experience of other hospital operators exercising market power in negotiations with us. We have previously submitted evidence to the CC to support this claim¹.
2. The structural remedies proposed by the CC do not effectively address the weak competitive constraints in local markets that lead to hospital operators' market power, particularly in single or duopoly areas where the CC does not propose to make divestitures. Indeed, the CC's proposed structural remedies will not meet its own definition of a successful divestiture: 'A successful divestiture will address at source the lack of rivalry resulting from structural features of the market.'² As we explain in more detail in the following sections, a combination of structural and behavioural remedies are required.
3. The behavioural remedies that the CC has proposed will need to be carefully designed and monitored if they are to be effective. There is a significant risk that these remedies will be circumvented by hospital operators and the CC needs to engage with PMIs and other stakeholders to mitigate this risk. In addition, below we set out reasons why we believe these behavioural remedies should apply to the market as a whole and not solely to the three hospital groups (BMI, HCA, and Spire) that the CC has identified.
4. Aviva agrees that incentive schemes run by hospital operators are a feature of the market which contributes to an AEC. The CC has proposed that the remedy to address this should apply to incentives offered to consultants. Aviva believes that any remedy addressing incentives must also address incentives offered to the providers of primary care services, such as GP or Occupational Health provision, as these are also a source of referrals.
5. Aviva believes that the significance of price and quality information in the private healthcare market has been underestimated. More robust information remedies, which require the provision of quality and cost information in a way that is uniform, comparable and accessible, will empower consumers to make informed decisions about their care, allow insurers to procure private healthcare effectively and efficiently on behalf of their members and further drive competition between providers and incentivise them to increase their efficiency.
6. We agree with the finding that there is a lack of sufficient publicly available performance information on consultants and on hospitals but we have concerns that the proposed remedies to address this will not be sufficiently effective. Aviva believes that cost and quality information must be available to consumers of private healthcare (and to insurers who purchase private healthcare on their behalf). This must include cost and quality information for both private hospitals and consultants. The types of data that the CC has proposed making available (e.g. PROMs), are insufficient on their own to address information asymmetries in this market. In addition, there are risks inherent in attempting to specify at this point, exactly what information is required and how it should be collected and made available. Information

¹ See paragraph 5.4.15 of Aviva's response to the statement of issues for an example demonstrating [>] exercise of market power in negotiations with Aviva.

² CC guidelines for market investigations, page 79, para 373

remedies need to be flexible so as not to limit the potential for continuous improvements for the benefit of patients. Information about the costs of proposed treatment will not drive competition between providers unless quality data is also available just as quality data is of limited use to consumers if they cannot see the relationship between quality and price.

7. Aviva believes that the CC should be mindful of the risk that changes to the market resulting from this investigation may disproportionately advantage Bupa and Axa. These larger insurers are already likely to benefit from higher volume discounts from hospital operators, they have an operational advantage resulting from their size and their higher market shares bring stronger bargaining power than smaller insurers enjoy.
8. Aviva is generally concerned that the problems that the CC has identified with the market will not be fully addressed by the remedies which are proposed. High barriers to entry, weak competitive constraints and market power of some hospital groups have all contributed to a market which is not serving patients effectively. Hospital operators have not faced sufficient competitive constraints that would create incentives for them to become more efficient. Their market power has allowed them to operate profitably even where developments in healthcare and changes in demand have resulted in over-capacity in the market. Until the over-capacity is addressed and until hospital operators are incentivised to make changes to their facilities to better suit the current demand, new entry - either by acquisition of a divested facility or otherwise - is unlikely to have much impact. The CC must ensure that the remedies it proposes do not just make small adjustments to this market, but instead foster the development of effective competition between private hospitals that has until now been absent³.

³ The Commission's guidance recognises that more comprehensive remedies may be required to address longer-term and structural problems in a market: 'The more an AEC reflects longer-term and structural problems within a market, the greater the significance the CC is likely to accord to the long-term development of competition in the market and to the less quantifiable consequences of an improvement in the competitive pressures in the market' (CC Guidelines for market investigations, page 74, para 351).

Possible remedies on which views are sought

Structural remedies

1. Divestiture of one or more hospitals and / or other assets in areas where competitive constraints are insufficient.

Aviva generally supports the CC's view that divestitures will be required to address the structural features of the market that contribute to the market power of hospital groups. However, divestitures are likely to be more effective in central London than elsewhere in the UK and a robust package of behavioural remedies and information remedies is required to effectively address the market power of hospital operators.

Central London

Aviva believes that a divestiture remedy is likely to have the greatest impact in central London given the area's importance to patients, the high prices that HCA charges to PMIs⁴, and the fact that HCA owns a cluster of 8 hospitals in this area with a share of supply of above 45% of inpatient admissions⁵. The specification of divestiture packages in central London will be particularly important to ensure that purchasers of the divested hospitals are able to compete effectively⁶. Relationships between GP practices (as well as private GPs engaged by businesses for the benefit of their employees) and HCA hospitals play some role in generating referrals⁷. Any divestiture package should include similarly integrated GP practices to ensure that any new entrant can compete effectively against HCA and is not undermined by any attempts by HCA to use vertical integration to foreclose the market.

Although the CC has concluded that vertical integration between HCA and GP practices is not leading to significant harm⁸, Aviva believes that entrenched referral patterns and the offer of incentives may be used by HCA in an attempt to reduce the effectiveness of structural remedies, at least in the short-term. For this reason divestitures in central London must be considered alongside the CC's proposed Remedy 4 (prohibition on consultant incentive schemes). Proposed remedy 4 will address the incentives provided by hospital operators to consultants but there is also a danger that entrenched patterns of behaviour will mean that consultants continue to favour HCA hospitals making it difficult for a facility owned by a new entrant to attract consultants.

There is also the risk that the divestiture of certain key hospitals in central London will merely transfer market power from one owner to another. Aviva has previously provided evidence that the acquisition of a hospital facility by a hospital operator has resulted in immediate price increases at that facility⁹. We have concerns that if a different operator acquires an HCA facility there is a likelihood it will be taken over as a "going concern", and so continue to be run in the same way with the same staff. It is difficult to see in this situation how, at least for an initial period, there will be much impact on price. The location of, for example, the London Bridge Hospital means it is likely to have a degree of market power regardless who owns it. For these reasons it is important that additional remedies, such as behavioural remedies around tying and bundling, also apply in central London.

UK, outside central London

Outside of London, divestiture remedies are less likely to be effective given the relatively small proportion of hospitals of concern that will be affected by these remedies. The CC has identified 101 hospitals of concern outside of central London but has proposed fewer than 20 divestments, for hospitals belonging to BMI and

⁴ The Commission found that HCA charges significantly higher prices to PMIs and this difference is not fully explained by differences in costs (PFs, page 230, para 6.247(a)).

⁵ PFs, page 186, para 6.125.

⁶ 'In defining the scope of a divestiture package that will satisfactorily address an AEC, the CC will normally seek to identify a divestiture package that comprises a viable, stand-alone business that can compete successfully on an on-going basis and is of sufficient scale and scope to enable its acquirer to become an effective competitor' (CC guidelines for market investigations, Annex B: remedial action, page 92, para 9).

⁷ Even if the scale of this vertical integration is limited as the Commission has concluded (PFs, page 192, para 6.141).

⁸ PFs, page 192, para 6.141.

⁹ Aviva Market Questionnaire response 30(a)

Spire alone¹⁰. Aviva agrees that the CC should require divestitures in those areas where they will be expected to lead to an increase in the competitive pressure exerted on other hospitals in the area. Aviva does not believe that there is likely to be an immediate effect on prices as a result of the changed competitive dynamic. In addition as many hospitals of concern will not be divested, rigorous behavioural remedies will also be required to address the market power of hospital groups. Aviva's position is that the existence of so many solus and must-have hospitals severely impacts competition between hospital operators and the proposed structural remedies will not address this issue.

Behavioural remedies

2. Preventing tying or bundling

Aviva believes that behavioural remedies preventing tying or bundling will be crucial in addressing the market power of hospital groups in national negotiations with PMIs. The CC is only proposing to address the market power of a small proportion of hospitals of concern outside of London using structural remedies. This means clearly specified and rigorously enforced behavioural remedies and information remedies will be required to prevent hospital operators from leveraging the majority of their hospitals of concern, (those unaffected by the proposed divestitures) in national negotiations with PMIs. Although the proposed behavioural remedies will address the ability of operators to leverage their solus hospitals across all their facilities nationally, the limited competitive constraints facing the solus facilities themselves is not addressed.

Aviva disagrees with the CC's proposal that behavioural remedies restricting tying or bundling should apply only to BMI, HCA and Spire. Aviva has direct experience of other hospital groups exercising market power in national negotiations with us and using bundling and one-in-all-in negotiations to leverage their solus facilities¹¹. The CC's analysis of profitability also suggests that Ramsay earned returns in excess of the cost of capital in the last three years of the period¹² which is consistent with a finding that they have market power¹³. If this remedy does not apply across the market, we would argue it is not "future-proof" as ownership of facilities across geographic locations will change over time.

We are concerned that, despite concluding that the large PMIs have a stronger negotiating position with hospital operators¹⁴, the CC has not adequately taken this conclusion into account in its proposed remedies.

Aviva believes that if remedies 2(a) and 2(b) are being considered as alternatives then 2(a) should be preferred from the perspective of effectiveness and proportionality. Remedy 2(a) is more likely to address hospital market power and will be considerably less costly on an on-going basis compared to negotiations by hospital operators and insurers on a hospital by hospital basis.

2a. Preventing BMI, HCA or Spire from raising its price nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall.

Aviva generally supports this proposed remedy to address the exercise of market power by hospital operators. However, Aviva is concerned that this remedy may be subject to three of the four key risks for behavioural remedies identified by the CC in its guidance: specification risks, circumvention risks, and monitoring and enforcement risks¹⁵.

The remedy proposes to prevent a hospital operator from raising its prices nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall. However, it's

¹⁰ Notice of possible remedies, para 26 and 36).

¹¹ See paragraph 5.4.15 of Aviva's response to the statement of issues for an example of how [B&C] raised its prices at key hospitals in response to Aviva's attempt to remove some of its facilities from our hospital list.

¹² PFs, pages 248-249, para 6.292.

¹³ In addition, finding that a firm did not earn excess profits does not necessarily mean that they do not have market power. As the Commission's guidance makes clear, incumbent firms may be able to use market power to mask their inefficiency: 'Low profitability may be concealing ineffective competition... Incumbent firms, despite being protected from new entry, are not earning high profits because they are inefficient and operate with higher costs than would be sustainable with stronger competition in the market...' (CC guidelines for market investigations, page 29, para 125).

¹⁴ 'We established that the two larger PMIs, Bupa and AXA PPP, achieve significantly lower prices than the smaller PMIs. We concluded that smaller PMIs had no countervailing buyer power, and that larger PMIs had some countervailing buyer power, Bupa more than AXA PPP' (PFs, pages 10-11, para 41).

¹⁵ See CC guidelines for market investigations, Annex B: remedial action, page 99, para 40.

not clear what conduct the CC proposes would fall under this prohibition and how the remedy would distinguish between legitimate price increase by hospital operators driven by increases in costs and prohibited price increases driven by changes in PMIs' network policies.

The difficulty of comprehensively specifying this remedy will also increase the risk that hospital operators will attempt to circumvent it. For example, the CC has found that volume is important in negotiations between PMIs and hospital operators and that hospital operators use a variety of mechanisms to incentivise PMIs to direct high volumes of patients to their hospitals¹⁶. We would expect that hospital groups will use mechanisms such as volume discounts to achieve the same outcome as before the remedy was imposed. In our experience, hospital groups price in a way that allows them to achieve (or attempt to achieve) a revenue neutral position whatever we as buyer of their services do in terms of moving volumes or rewarding efficiency. The CC's own guidance recognises that circumvention risk is a particular issue in markets, like this one, where firms have significant market power:

"The CC will have particular regard to avoiding circumvention risk in implementing measures limiting the behaviour of firms with significant market power that has been found to prevent, distort or restrict competition. This is because firms with significant market power may readily evolve new forms of behaviour to replace prohibited or restricted conduct"¹⁷. [our emphasis]

This remedy is also likely to require significant levels of monitoring and enforcement to be effective. We would expect that disputes between hospital operators and PMIs on whether a given price increase was in breach of this remedy would have to be resolved by the OFT or a third party. However, it will be difficult for a third party, even one with considerable knowledge of the private healthcare market, to determine whether a price increase in commercial negotiations between a hospital operator and a PMI should be permitted or prohibited.

We believe that the proposed additional information remedy (8) would go some way to address this. Hospital groups should be required to publish details of their charges in a uniform manner. Detailed costs information, (provided that it is issued by all hospital operators in the same way) will allow like for like comparison between operators. Aviva believes that increased transparency will encourage competition between operators and allow for more effective price negotiations between hospital operators and PMIs.

Aviva believes that ultimately the pricing that hospital groups offer to PMIs should be related to the cost of providing care to patients. We do not accept that pricing on a revenue neutral basis or on a national basis is appropriate or fair to consumers. At present hospital operators have little incentive to improve their efficiency or drive down their operating expenses as they have an almost guaranteed level of income. Changing the way hospital operators charge for their services will require a huge change in their strategy and approach and we have concerns about how they can be encouraged to do that. Any remedy that the CC proposes with respect to national pricing needs to allow changes in volume to act as an effective market signal that strengthen the incentives for hospital operators to offer competitive prices and high quality care.

The CC has specifically asked about whether this possible remedy should come into force once current contracts have expired. Aviva believes that were this remedy (or any variation) to come into force it should apply across the market immediately. Contracts could continue to apply until their expiration but clauses that would be prohibited under this remedy would be struck out and cease to apply.

2b. Require BMI, HCA and Spire to offer and price their hospitals separately

Aviva does not believe that the CC's proposed remedy 2(b) should be pursued as an alternative to 2(a) as it is unlikely to be any more effective than that remedy and it would be more onerous for both PMIs and hospital operators to implement.

In terms of effectiveness we do not believe "reputational risk" is likely to have a material impact on pricing behaviour of a hospital operator in a single hospital area. Nor are we confident that price rises in solus areas would lead to new entry given the high barriers to entry, such as high capital costs and economies of scale, which the CC has identified¹⁸. This makes it likely that certain local markets can only support one private

¹⁶ PFs, page 205, para 6.185.

¹⁷ See CC guidelines for market investigations, Annex B: remedial action, page 103, para 53.

¹⁸ PFs, page 6, para 24.

hospital as it could be impossible for two facilities to achieve minimum efficient scale given the number of patients in the local area. As a result, the limited competitive constraint that exists for the hospitals of concern that the CC has identified will not be addressed by this remedy. Pricing at the individual hospital level could lead to the same outcome as the current market. Hospital operators could exercise their market power at individual hospitals that are “must haves” for PMIs and extract sufficient revenues from these facilities to make up for lost revenue at hospitals that are subject to competitive constraints.

For many smaller insurers, negotiating and contracting at an individual hospital level would be operationally very challenging. Were the CC to pursue this proposed remedy further, pricing hospitals by region may be a more practicable, particularly if it is agreed between the parties. We can envisage a situation where “baseline” pricing is agreed with a hospital operator and then facilities are “tiered” depending on factors like location. However, Aviva would like to have the opportunity to agree terms with a hospital operator on a national basis where appropriate. On grounds of proportionality, remedy 2(b) should be discarded in favour of remedy 2(a)¹⁹.

3. Preventing the owner of a hospital in a Single or Duopoly area from partnering with an NHS Trust to operate a PPU

Aviva is supportive of this remedy but we do not believe that it is likely to have a significant, immediate impact on the competitive constraints face by hospitals in single or duopoly areas. Currently PPUs only account for a small portion of Aviva’s total spend²⁰ and we are not aware of any immediate plans for PPUs to expand into single or duopoly areas.

If this remedy were implemented it would need to be “future-proof” to ensure that if ownership of hospital facilities changes over time, restrictions on PPU ownership would also change.

4. Prohibiting private hospital operators from offering consultants any cash or non-cash incentives to encourage them to undertake work at their facilities

Aviva’s position is that no one should be offering incentives, in cash or in kind to encourage referral of patients to or for treatment at a hospital. This should include incentives offered to providers of primary care services as well as consultants. All incentives which are capable of influencing the patient pathway should be covered by this remedy. Aviva also believes that consultants should be obliged to inform patients of their options in relation to hospital facilities and, where appropriate, tell the patient why they are proposing a particular hospital

Aviva’s position is that the burden of proof to show the pro-competitive effects of any incentive scheme must rest with the provider of the scheme. Providers of such schemes should be required to demonstrate to the CC that these schemes qualify as Relevant Customer Benefits (RCBs), as defined by the CC, and lead to lower prices, higher quality, or greater choice or innovation.

Information remedies

5. A recommendation to the health departments of the nations.

Aviva’s general position is that making additional information on cost and outcomes available to patients is a good thing. However, the data that is made available under the NHS England scheme is limited to 10 specialities and covers measures that are not necessarily important to private patients. Therefore any recommendation made to the health departments of the nations should not be limited to only the data made available under the NHS England scheme. In addition, any information remedy needs to be flexible enough to allow for changes in technology and information availability in the future.

¹⁹ ‘A proportionate remedy is one that: (a) is effective in achieving its legitimate aim;...(c) is the least onerous if there is a choice between several effective measures; and...’ (CC Guidelines for market investigations, page 73, para 344).

²⁰ Aviva’s spend with NHS PPUs accounts for around [3<] % of total hospital spend.

It is also important for the CC to be aware of the risk that its recommendation may be ignored or may not be implemented in the way in which the CC envisaged²¹. This is especially important when considering how this remedy will interact with proposed remedy 6. Were the CC to require consultants to make price information available to customers but corresponding quality information is not also available it could lead to unintended adverse consequences. In the absence of information on consultant quality, patients may take high prices to be a proxy for high quality leading to an increase in private healthcare costs that are unrelated to the quality of care delivered.

6. An information remedy: a remedy that would require consultants to provide patients with price information prior to the commencement of treatment.

Aviva agrees with this proposed remedy and we believe that all consultants who are practising privately should disclose their outpatient consultation fees. It is not clear that there is any justification for some consultants to be excluded from this requirement on the basis that they only carry out a limited amount of private work. A uniform requirement would be easier to review than requirements that are linked to a level of work carried out. It should not be difficult for consultants to estimate fees even where unforeseen complications may arise provided that the customer is made aware that added complications may result in the fee being revised. In order to enable a customer to make a decision about which consultant to use, fee information must be made available before any treatment is carried out. Such visibility of the costs is equally important to customers of the PMIs, they expect to be appropriately advised of the impacts of choices they make through the treatment journey and how those choices affect the cover they have available throughout the claim.

We reiterate the point made above that for consumers to benefit from improved information it must be information about both cost and quality. In designing and implementing a remedy about price information, the CC must also consider the risk that such a remedy may unintentionally facilitate coordination by consultants on price. This is a particular risk in this market as insured patients are unlikely to be sensitive to any prices that are below the maximum reimbursement rate paid by their PMIs and may even interpret lower priced consultants to be of lower quality. This may give consultants the incentive to match the highest observed price of competing consultants in each speciality provided that it is below the maximum reimbursement rate for the PMI in question. This could have the effect of driving up private healthcare costs without increasing the quality of care provided to patients. The CC should consider “road-testing”²² informational remedies on consultants’ fees to determine the effect they would have on the behaviour of consultants and patients.

7. An information remedy: a remedy that would require that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients in the UK and that appropriate arrangements are made for its publication to consumers.

Aviva is supportive of making more information available to patients, however we have concerns about these proposals relating to information. These proposals, while positive, are limited. Our position is that both hospitals and consultants must provide cost and quality information that is comparable and accessible. We believe that cross-industry participation is required to determine exactly what information should be collected and how it should be presented. Any information remedy imposed by the CC will need to be flexible enough to allow for changes in the availability of healthcare information in the future driven by technological changes. Any attempt to limit exactly what is required at the current point in time will stifle future improvement.

Aviva believes that the manner in which information is made available to patients is as important as the data itself. Quality information needs to be made accessible to patients and presented to them in a manner that is easy to interpret and draw conclusions from. Any information remedies proposed by the CC need to be accompanied by remedies that provide this information to patients in a way that empowers them to facilitate

²¹ ‘The fact that recommendations are not binding on the party to which they are addressed represents an intrinsic risk to their effectiveness as a remedy. A recommendation may not be accepted, may not be implemented in a way that is consistent with the CC’s intentions, or may become redundant following a change of policy. There may be a risk to the effectiveness of a wider package of remedies, if the success of other measures in the package is dependent on a recommendation being followed’ (CC guidelines for market investigations, page 113, para. 97).

²² The Commission’s guidance states that it will ‘consider carrying out specific customer research into informational remedies (or ‘road-testing’) before they are put in place’ (CC Guidelines for market investigations, Appendix B: remedial action, page 107, para 70).

more effective competition between hospital groups and consultants. The CC took this approach in the Home Credit market investigation²³.

An additional information remedy

8. A remedy that would require hospital operators to provide cost information.

The remedies suggested are all capable of changing how the market functions, however the fundamental issue of price, one of the key outcomes of negotiation remains. Whilst a competitively functioning market will effectively set and maintain prices at the right level Aviva believes that this will take a long time without an additional remedy.

Currently hospital operators approach price negotiations with insurers on the basis that they wish to achieve a revenue neutral position. PMI providers have no visibility over how hospital operators price for the services they offer. The disconnect between a nationally agreed contract price and the service received by a customer means it is not possible for purchasers such as PMIs to ensure that they are achieving the best outcome for their customers. In many other markets open book accounting is normal practise and this provides the necessary clarity for all parties. Aviva would ask the CC to consider a remedy that requires hospital operators to present, for a basket of common procedures, an open book analysis of their proposed charges.

Conclusion

Aviva is largely supportive of the CC's provisional findings and proposed remedies. We believe that improved information and a combination of structural and behavioural remedies will be crucial to bringing effective competition to the private healthcare market and ensuring that this market is sustainable in the long-term. We believe that the availability of cost and quality information about both hospitals and consultants along with effective and proportionate behavioural remedies preventing tying or bundling will have the greatest impact on competition in the private healthcare market and the market power of hospital operators. We look forward to continuing to engage with the CC to assist in this process.

²³ As one of the remedies in this market investigation, the Commission required that lenders publish the price and other terms of their home credit loans. The Commission also appointed an independent website operator to publish this information in a way that made it possible for consumers to compare prices in different regions: <http://www.lenderscompared.org.uk>