

HCAHospitals

World-Class Healthcare

HCA INTERNATIONAL LIMITED

**Response to Competition Commission's
Provisional Findings**

11 November 2013

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1. INTRODUCTION

- 1.1 On 2 September 2013 the Competition Commission (CC) published its Provisional Findings (PFs) and a Notice of possible remedies (Remedies Notice) in its private healthcare market investigation.
- 1.2 This submission is made by HCA in response to the CC's PFs. As a result of the confidentiality restrictions put in place by the CC, this submission is comprised of two parts, which together form a single response. The first part, contained here, is this document (with the exception of section 7 "Bargaining") and Appendices 1, 3, 5 – 7. The second part comprises section 7 of this document and Appendices 2 and 4. The second part has been submitted by HCA's legal and economic advisers from within the CC's data room. A separate submission was prepared by HCA in response to the CC's Remedies Notice. These responses should all be read in conjunction.
- 1.3 In its PFs the CC set out its provisional findings in its investigation, based on the analysis it has conducted and evidence reviewed to date. The CC identified two structural features in the provision of private healthcare by hospitals which it provisionally found to give rise to an adverse effect on competition (AEC):
- High barriers to entry for full service hospitals; and
 - Weak competitive constraints in many local markets including central London.
- 1.4 Additionally, the CC identified conduct features in the market which it also provisionally found to give rise to an AEC. These features related to:
- The operation of incentive schemes by private hospital operators to encourage patient referrals for treatment at their facilities;
 - The lack of sufficient publicly available performance information on private hospital performance; and
 - The lack of sufficient publicly available performance and fee information on consultants.
- 1.5 The CC suggested that these features may, in some cases, result in: distortions of referral decisions and patient choice of diagnosis and treatment options; reduced competition between private hospital operators on the basis of quality and price; and reduced competition between consultants on the basis of quality and price.
- 1.6 HCA bases its response to these PFs on the perspective it brings as a London-based private healthcare provider and the competitive dynamics it faces in the London market.¹ It also draws on its experience of the wider competitive dynamics which are not necessarily only specific to London, such as the power of the private medical insurers (PMIs) and the competitive constraints on its hospitals which extend beyond London as well as internationally.

¹ In this section of its response, HCA does not distinguish between London, central London and Greater London. Its views on the CC's market definition and, accordingly, the market in which it competes are discussed in section 4 below. HCA's use of "London" through this response should not be misconstrued as acceptance of the CC's geographic market definition.

- 1.7 HCA emphasises that the two structural AECs identified in the CC's provisional findings simply do not apply in the geographic area in which HCA is active. Specifically, the CC's findings on competition in London are unfounded, based on a misunderstanding of some key aspects of the market and not supported by robust evidence or analysis. In particular, the overly simplistic and largely static approach adopted by the CC in assessing competition in the market has biased the CC's analysis and, as a corollary, its findings.
- 1.8 HCA has been extremely disappointed by the CC handling of the market investigation. The CC's decisions relating to the level of disclosure, the terms of which disclosure is provided to the parties, and the timing in which information has been made available for review and comment, has significantly prejudiced HCA's ability to respond during the CC's consultation period. Such was the restrictiveness of the CC's disclosure regime that the main parties to the market investigation were forced to take the extreme step of applying to the CAT to judicially review the fairness of the CC's disclosure process. The CAT's judgment found that the CC's disclosure regime has been both unfair and irrational.
- 1.9 HCA has also expressed ongoing concerns about the CC's failure to take into account evidence and responses it has submitted. HCA had already voiced concerns that, due to the very late timing of the London working paper publication, the CC would be unable to fully engage with the parties' evidence submitted in response to that working paper prior to publication of its PFs.² Based on the CC's PFs and Appendices, it is striking that the CC has failed to undertake a considered assessment of HCA's previous submissions, and appears to have disregarded salient evidence that is highly relevant to its market investigation.
- 1.10 The remainder of this response is structured as follows:
- **Section 2: Executive summary**
 - **Section 3: Supply of private healthcare in London**
 - **Section 4: Private healthcare in London**
 - **Section 5: Competitive assessment in London**
 - **Section 6: Entry and expansion**
 - **Section 7: Bargaining**
 - **Section 8: Consultant incentives**
 - **Section 9: Information availability**
- 1.11 HCA has also prepared a number of appendices setting out its detailed response in relation to a number of key areas:
- **Appendix 1: Future growth of PPUs**
 - **Appendix 2: Self-pay price concentration analysis ("PCA")**
 - **Appendix 3: A technical critique of the CC's analysis of the bargaining framework**
 - **Appendix 4: Analysis of insured prices**

² HCA, Response to the CC's London market working paper, para. 1.3.

- **Appendix 5: Profitability**
- **Appendix 6: HCA's investment in innovative practice, techniques and treatments.**
- **Appendix 7: HCA business cases and their rationale**

1.12 The CC should note that, in the time provided and with the level of disclosure provided to HCA, this submission does not respond to every finding and view expressed by the CC in its PFs. This submission focuses on issues affecting HCA. The fact that HCA does not expressly respond to a point in the PFs does not imply that HCA agrees with it. HCA reserves the right to supplement this response with further papers and submissions, including at its forthcoming hearing before the CC.

2. EXECUTIVE SUMMARY

Introduction

2.1 HCA vigorously rejects the CC's Provisional Findings (PFs) that there are adverse effects on competition (AEC) in the supply of private healthcare, as far as London is concerned. The CC's core provisional findings that there are features of the market which give rise to AECs, particularly in the form of (i) weak competitive constraints and (ii) high barriers to entry are misconceived in the case of London.

2.2 There are numerous errors, omissions and contradictions in the PFs, in particular:

- The PFs fail to take account of the role of quality and innovation in driving competition for both patients and consultants, particularly in London. HCA's record of investment in high quality and innovation, and the record outcomes it produces in terms of patient care, provides clear evidence that the market is functioning well for the benefit of consumers.
- The CC does not provide any robust evidence that HCA is in a position of market power and that its prices do not represent good value for money. The CC's insured pricing analysis does not measure prices appropriately and has serious omissions and methodological flaws which render its results highly unreliable. Furthermore, tests of the statistical significance of the findings cast serious doubts on the CC's assertion that *"prices charged by HCA were significantly higher than those of other operators"*. The CC's analysis does not support the CC's provisional findings that HCA has bargaining power in negotiations with insurers.
- The CC's self-pay price concentration analysis does not support the case of a robust, causal and economically significant relationship between local market concentration and self-pay prices in London.
- The CC errs in its approach to assessing bargaining power, by overestimating the bargaining position of hospital operators and underestimating the bargaining position of PMIs as well as failing to take account of the alternative strategies which PMIs have used, and are increasingly using, to divert business away from HCA hospitals.
- The CC errs in its approach to market definition in London and ignores the wide range of competitors to HCA – including other private providers, PUs and NHS hospitals. The CC relies on shares of supply that are uninformative and based on a flawed market definition assessment. The CC therefore underestimates the wide range of competitive constraints on HCA's business. The central London admissions and revenue figures include a large number of patients, including these in outer London and international patients, who have a range of alternative competitive options, and it is therefore misleading to calculate shares of supply which exclude these other sources of competition.
- The CC's concerns that static demand for private healthcare is a barrier to entry manifestly does not apply in the case of London, which has witnessed year on year growth and continues to expand. That is why London – unlike other parts of the country – has seen significant new entry and expansion, and this trend will continue. Indeed, leading NHS PUs are embarking on a strategic programme of expansion – the Royal

Marsden for example is targeting revenues of £100 million over the next few years. Contrary to the PFs, the evidence before the CC further reveals that site availability and planning are *not* barriers to expansion or entry in London.

- There are also serious flaws in the CC's profitability analysis which overestimates HCA's return on capital employed (ROCE), underestimates the Weighted Average Cost of Capital (WACC) and to the extent to which the CC finds that HCA has earned profits in excess of the WACC fails to take account of the extent to which these derive from its successful track record on investment, innovation and efficiency making the profits entirely consistent with a successful company operating in a competitive, dynamic market.

2.3 HCA briefly highlights key points in this submission as follows.

HCA's record of investment in high quality and innovation

2.4 The PFs focus on *price* competition in this market; they essentially sideline competition on *quality* and *innovation* for the purpose of the competitive assessment in London (in over 1,000 pages of text in a market investigation on private healthcare there are surprisingly few references to quality).

2.5 The supply of private healthcare involves the provision of highly differentiated products and services. Hospital operators compete on quality, innovation, clinical expertise, and types of clinical treatments and facilities. These form a key part of the competitive process, particularly in London.

2.6 Although quality can sometimes be difficult to measure, it is both real and of critical importance. Both consumers of healthcare and market participants recognise this. Some measures of patient outcomes are available as are a range of proxies for quality including nurse to patient ratios. Furthermore, many consultant groups have found ways to measure quality using complex statistical techniques, and the CC's proposed remedies on information availability will help to further unlock this valuable information for patients and other bodies. It is true that consumers often rely on consultant collective judgment as a strong indicator of good quality hospitals. Submissions from consultants to the CC clearly illustrate how highly regarded HCA-managed hospitals are to healthcare professionals.

2.7 There may be varying degrees to which the right services and level of quality determine the success of a private healthcare provider. However, in a market where providers compete to offer acute complex care, offering the right treatments and providing top quality care are key determinants for the success or failure of a business.

2.8 HCA's strategy, in focusing on high quality, high acuity tertiary care has differentiated its clinical offering in London. It has made heavy investments over the last 10 to 12 years [X] to realise its vision of creating centres of excellence in tertiary care to provide a private alternative to the NHS. This has required considerable foresight and indeed investment risk.

2.9 To compete effectively in high-end tertiary services requires continuous capital investment and the pace of medical advances and technological improvements necessitates the ongoing introduction of new innovative, state of the art treatments and clinical facilities. HCA continues to make substantial investments, driving up quality, improving clinical outcomes and bringing to the market new and highly innovative treatments which shorten recovery times and improve (and indeed save) patient lives, providing incalculable but demonstrable

customer benefits which contribute in no small way to London's pre-eminence as a centre of clinical expertise worldwide.

- 2.10 This commitment to quality and excellence is driven by strong competitive pressures from other private providers, from the NHS, and also from other hospitals internationally. The CC need only review the business cases for HCA's investments which evidence how HCA is incentivised to maintain and improve levels of quality and innovation to keep abreast of its competitors. This in itself attests to the lively and dynamic nature of competition in London.
- 2.11 HCA can justly claim a strong quality record, relative both to the NHS and to its private sector peers: it is the only private hospital operator to have achieved a 100% compliance with all Care Quality Commission (CQC) clinical outcomes; it has the first and only private integrated rehabilitation unit in the UK to win quality accreditations; its unplanned returns to the operating theatre are over 10 times lower than the national average; and it boasts a string of quality awards, including the 2013 Health Investor Public/Private Partnership Award. These are just a few of the metrics against which it scores higher than its peers.
- 2.12 HCA has pioneered in the UK a wide range of new clinical services and diagnostic techniques, such as CyberKnife, da Vinci robotic surgery and 3T MRI for prostate cancer – in many cases, HCA's lead is followed by the NHS and by other private hospital operators. These are just a few examples of new treatments that have made a real difference not just to HCA patients, but to the provision of healthcare across the UK.
- 2.13 Such levels of continuous product improvements and innovation and such high levels of quality are simply inconsistent with the conclusion that HCA has a position of market power and faces "weak" competitive constraints. Indeed, it is precisely *because* of strong competition that HCA continuously invests to improve the services it delivers to patients. To miss this important fact would lead to mistaking commercial success for weak competition, i.e. an "efficiency offense".

HCA's prices are competitive

- 2.14 HCA is not just a high quality and innovative provider – its services represent good value for patients and PMIs. The CC's pricing analysis, far from showing that HCA is charging prices above competitive levels, in fact demonstrates that HCA is highly competitive.
- 2.15 In terms of prices paid by PMIs, the CC's insured pricing analysis is deeply flawed and unreliable as:
- It is not informative of insured prices since, instead of prices, it analysed episode charges which themselves are subject to considerable variations due to, for example, complexity of cases and patient characteristics. The CC failed to control for these factors in its analysis or recognise them in interpreting its results. The CC also failed to account for retroactive rebates paid to PMIs, which can represent material payments (and effectively are additional price discounts to the PMI).
 - It cannot be informative of the level of bargaining power held by hospital operators, since it failed to account for other important features of the private healthcare market which affect hospital operators' prices, namely quality and cost differences between operators.
 - There were also a number of important methodological issues with the CC's analysis, including data flaws, incorrect and incomplete data for key PMIs including Bupa and Cigna, sample size issues and a failure of the basket of treatments to adequately

represent HCA's range and complexity of treatments and the revenues it derives from insurers.

2.16 Given these considerable flaws the CC's analysis cannot be used to support a finding relating to HCA's "price" compared to the prices of other hospital operators, and certainly cannot be used to determine HCA's bargaining position in negotiations with insurers. Moreover, in relation to the comparison of HCA to the London Clinic, the analysis conducted in the CC's data room demonstrates that the CC's findings, even ignoring the analytical flaws mentioned above, are not supported by the underlying data. HCA's average episode charges are not significantly higher than key London competitors. In fact, in many cases HCA's average charges are *lower*. The variation in the value of the indices across operators and over time cannot be explained by differences in market concentration – therefore, even if the CC chose (incorrectly) to consider indices as a meaningful proxy for bargaining power, that bargaining power could not arise from HCA's ownership of its hospital (i.e. market share). In summary, the results obtained by the CC do not support its provisional findings.

2.17 In terms of self-pay patients, the CC's price concentration analysis (PCA) fails to demonstrate any robust or reliable relationship between prices and local market concentration:

- the PCA excluded many of HCA's key competitors because the relevant data was unavailable (55% of invoices were missing in London);
- the relationship between local market concentration and self-pay prices that the CC claimed to have established through the PCA is almost solely driven by the episodes occurred at a single operator (Nuffield Health);
- the PCA only focused on four treatments (from only three specialties), which are completely unrepresentative of HCA's business; this, among other factors, implies that the PCA has no relevance for HCA;
- there are numerous methodological errors which undermine the CC's attempts to infer a causal relationship between local market concentration and self-pay prices; and
- in any event, even with all these flaws, the most the PCA concluded is that a 20% increase in the weighted average market share of a given hospital is associated with about a 3% price increase for a self-pay treatment – a very low order of magnitude, which cannot support the kind of draconian remedies that the CC is proposing.

PMI bargaining power

2.18 The PFs are also undermined by the CC's failure to conduct a proper assessment of PMI bargaining power:

- The CC has overestimated the strategic alternatives available to hospital operators in their negotiations with PMIs.
- It has, conversely, underestimated the range of strategic alternatives available to PMIs which, in practice, enable them to exercise leverage in their negotiations with hospital operators.

- The CC's bargaining framework is incorrect from an economic perspective, as it has failed to consider that the relative position of the negotiating parties following temporary disagreements is important in determining negotiating outcomes.

2.19 The available evidence in fact shows that PMIs have a strong negotiating position in relation to HCA:

- PMI directional products have been very successful – Bupa states that 80% of its new and current corporate clients have opted for its Open Referral product.
- On HCA's modelling, a delisting of HCA's facilities by Bupa would lead to a [§] in HCA's revenues, and a delisting by AXA PPP, a [§] in HCA's revenues. [§].
- PMI patients in HCA hospitals can readily be absorbed by competing hospitals in central London in the event of a breakdown in negotiations.
- PMIs can and do delist hospitals, and previous hospital delistings in London (for example, AXA PPP's decision not to recognise the new Heart Hospital in London, which led to this state-of-the-art hospital ceasing to be a private operator) have created an indelible impression of the power PMIs wield over hospital operators. The fate of the Heart Hospital, when compared to the fact that Bupa recorded a 124% increase in profits the financial year after its delisting of BMI hospitals, is illustrative of who exercises the greater threat points in the bargaining relationship between hospitals and PMIs.
- PMIs can and have vertically integrated into the provision of primary care and acute private healthcare. Notably, in London, Bupa owns the Cromwell Hospital, which enhances its bargaining power when negotiating with London-based hospital operators.
- The PMIs are rolling out lower cost, restricted network products which are gaining in popularity with major London corporates. Each of the six main PMIs considered by the CC has been able to exclude HCA hospital facilities in at least one of their important network products whilst, on those same networks, including a number of HCA's major London rivals. Indeed, AXA PPP has specifically conceded that *"these products, such as lower cost networks, demonstrated that PMIs have sufficient bargaining power against HCA"*.
- HCA has informed the CC of a pattern of unreasonable and disruptive conduct by PMIs that HCA believes is intended to harm its reputation as a high-quality provider. Such conduct, [§], is simply inconsistent with the finding that HCA exercises market power over PMIs.
- Patient "lock-in" (for example, due to the PMI underwriting constraints in relation to existing medical conditions) significantly hinders the ability of policyholders to switch PMI. The profit incentives of the PMIs, coupled with a highly concentrated PMI market, have led to individual PMI customers being charged close to their reservation price for healthcare benefits. Bupa itself noted that there was little room for further price increases to PMI policyholders.

Competitors

- 2.20 The CC notes that there "are 28 private hospitals and PPUs in central London and 46 outside central London but within Greater London".³ Despite this, the CC provisionally finds that "central London" is highly concentrated.
- 2.21 In arriving at this finding, the CC has adopted an unreasonable and unjustified approach to market definition which ignores important competitive constraints on HCA. The CC's rationale for disregarding the competitive constraint on HCA from private providers in outer London, the NHS and leading overseas providers, all of which influence and inform HCA's competitive strategy, is based on a flawed methodology and an incorrect evaluation of the available evidence.
- 2.22 There are serious flaws in the CC's methodology:
- The CC has focused on pricing but has failed to consider the competitive pressures that drive incentives to invest and innovate which come from a much broader category of providers, including the NHS and international hospitals.
 - The CC has failed to analyse in full patient preferences over different geographic locations. It unfortunately missed the opportunity in its own surveys to obtain the relevant data on patient choices in London which would have properly informed its conclusions on market definition.
 - Without any justification based on a full analysis of patient preferences, the CC has adopted one methodology for analysing the geographic market applying to those providers based in central London and quite another for providers based in other parts of the UK. If the CC had adopted a consistent approach to geographic market definition across all providers in all locations, it would have found that HCA's hospitals compete with facilities over a broader geographic area, including Greater London, the Home Counties and even internationally.
- 2.23 The CC accepts that the NHS provides a competitive constraint to private healthcare, but crucially, in the very market in which major NHS teaching hospitals are most prominent (London), the CC conducts no analysis whatsoever of NHS constraints. This is surprising given that the CC's own survey showed that:
- 68% of self-pay patients considered having their treatment on the NHS rather than at a private hospital.⁴
 - 19% of PMI patients considered having their treatment on the NHS rather than at a private hospital.
- 2.24 In response to which facility a self-pay patient would use if their private hospital was unavailable, 12% would opt for an NHS facility as their next best alternative. This number is likely to be a significant underestimate, given the set-up of the CC's survey. However, this is still perfectly consistent with patients currently choosing private providers because of the competitiveness of their offering and the NHS exerting a strong competitive constraint. The NHS in London is a leader in innovative technology and acute care and as such provides a

³ CC, Private healthcare in central London: horizontal competitive constraints, para. 4.

⁴ CC, Patient Questionnaire, Question B2 (Did you consider having your treatment done on the NHS?).

strong competitive constraint on HCA's facilities. HCA has provided strong evidence (wholly ignored in the PFs), and provides further evidence in this submission, about the competitive interaction between the NHS and HCA.

Barriers to entry

- 2.25 There is a fundamental contradiction at the heart of the CC's conclusions on barriers to entry. The CC points to the static demand for private health services and the lack of significant growth prospects which are likely to deter new entrants from making the high capital investment in new facilities – the CC finds that economies of scale and high capital costs in a *static* market constitute "the greatest barrier to entry".⁵ However, as the CC itself has noted, the London market is growing and creating new opportunities for market entry and expansion. Hence the CC's key finding on barriers to entry simply does not apply to London.
- 2.26 There is a strong record of market entry and expansion in London (even in the midst of a recession), including: BMI's entry; the London Clinic's recent expansion in cancer services; and the expansion of numerous other private providers including the Bupa Cromwell, the St. John and St. Elizabeth, and the King Edward VII.
- 2.27 There is also concrete evidence of planned new market entry by full-service hospitals in London and the South-East: the London International Hospital is a new 150-bed specialist hospital which is due to open next year; the Kent Institute of Medicine and Surgery will also open in 2014, targeting tertiary referrals into central London; and Spire have recently announced their intention to launch a new flagship hospital in London.⁶
- 2.28 The CC also, quite correctly, noted that NHS PPUs in London are gearing up for growth. The PFs however underestimate the extent to which, with the lifting of the PPU cap on income, PPU expansion is likely to change the competitive landscape in London in the coming years. The revenues of the 12 major PPUs in central London have grown by more than 36% over the last three years and the annual reports of leading NHS Trusts demonstrates that they are embarking on a strategic programme of expansion. Whilst PPUs already exert a strong competitive constraint over HCA there is clear evidence that this will increase. There is also the prospect of significant NHS hospital developments in London, including a large PFI redevelopment project involving the Royal London Hospital and St. Bartholomew's Hospital to create state-of-the-art facilities, including one of Europe's largest renal units.
- 2.29 The CC has made unfounded assertions that limited site availability raises the costs and risks of new market entry into London. HCA has provided the CC with details of numerous sites currently available on the open market in central London, including surplus NHS sites which have the convenience of existing planning permission for medical use and are expected to increase in number. At any one time, there are several properties available which are suitable for use as inpatient and outpatient facilities, and as the NHS restructures and sells off more land, such opportunities can only increase. The CC has not put forward any convincing evidence to the contrary.
- 2.30 The CC's assertions about difficulties in obtaining planning permissions restricting new entry and expansion in London are also unfounded. The CC has presented no evidence as to the impact of obtaining planning permission on the costs and risks of entry and expansion.

⁵ CC, PFs, 6.79.

⁶ <http://www.propertyweek.com/spire-nurses-london-ambition/5062589.article>

Rather, the evidence suggests that there are numerous examples of planning permission for healthcare facilities being granted in the past and that entry and expansion has been achievable.

Profitability

2.31 The CC's analysis of HCA's profitability contained significant flaws which undermine its conclusions that returns in the market are substantially and persistently above the cost of capital:

- The scope of the CC's analysis is too narrow and fails to sufficiently analyse the supply of private healthcare, as it excludes profits from a number of smaller firms, PPUs and overseas competitors.
- The duration of the analysis is inadequate as it ignores significant differences in the period preceding its analysis.
- The CC did not consider failed firms or future changes in the market brought about by anticipated increases in capacity.

2.32 HCA strongly disagrees with the CC's calculation of HCA's returns and cost of capital. [REDACTED].

2.33 Furthermore, HCA disagrees with the CC's interpretation of its profitability results. It submits that the CC failed to follow its Guidelines⁷ and carry out analysis into the causes of profitability. Even to the extent that the CC finds that [REDACTED], it failed to take into account that these derive from HCA's track record on investment, innovation and efficiency and are entirely consistent with a successful company operating in a competitive, dynamic market.

⁷ CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013.

3. SUPPLY OF PRIVATE HEALTHCARE IN LONDON

Key points

- The CC has failed to recognise that competing to improve quality and to innovate is a key feature of competition in the supply of private healthcare.
- HCA has provided overwhelming evidence of the magnitude of its investments and the high quality of its services, which are driven by the need to stay ahead of its competitors. This attests to a lively, competitive market.

Introduction

3.1 HCA has serious concerns with the CC's understanding of the supply of private healthcare, particularly in London.

3.2 The CC's understanding and assessment of competitive behaviour has failed to take proper account of the most important outcome in the sector, quality of care. This omission has distorted the CC's perception of the market and, in turn, prejudiced the way in which competition is assessed. In particular, it means the CC has failed to recognise:

- That hospitals compete by investing and innovating in order to drive improvements in quality and patient outcomes;
- That this competitive process is dynamic and best observed over a period of time; and
- The full range of competitive constraints in London when taking account of this competitive process.

3.3 In section 4, HCA submits why this competitive process is particularly important in London.

(1) The CC has not accounted for the crucial role of driving improved quality through competing to invest and to innovate

3.4 The provision of healthcare is fundamentally different to other product or service markets. The quality of care a patient receives, in terms of their overall safety, comfort and clinical outcome, is the most important driver of activity in the private healthcare market, and is increasingly receiving more attention in NHS and private hospitals.

3.5 In a market where clinical outcomes and quality are crucial, investment and innovation are key inputs to driving improvements in these areas. The need for investment is even more important when providing treatments in complex specialities where the rate of innovation is high. These specialities comprise the complex, high acuity areas of care for which HCA is renowned.

3.6 In short, it is when hospital operators compete across these parameters that quality of care is improved for patients. However, despite repeated calls to do so, the CC has still not considered this important competitive interaction among hospital operators. Doing so would dramatically reshape the CC's understanding of the competitive constraints faced by HCA.

The importance of competing to improve quality of care

- 3.7 It is simply not the case that price is the key distinguishing feature between the competing hospital operators. Quality is paramount to the success of a hospital operator, particularly when competing in London.
- 3.8 In light of the events at Mid-Staffordshire, the NHS has re-examined its practices in relation to ensuring quality outcomes and how it can improve further. The subsequent Berwick Review into patient safety⁸ highlights the need to place quality of patient care above all other aims and the importance of investment in supporting this.
- 3.9 It is a fundamental omission by the CC in this market investigation that it has failed to assess how hospitals compete to invest in the quality of care as part of its local competitive assessment. This competitive dynamic is supported by overwhelming evidence and is widely acknowledged, including by the OFT and CC, as demonstrated by its recent merger assessments.⁹
- 3.10 In *Poole Hospital NHS Foundation Trust / Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*, the CC noted that: "*if patients and/ or GPs tend to choose between [healthcare providers] on the basis of quality when deciding where to go for a treatment, then we [the CC] would expect [healthcare providers] to take account of the impact on referrals of changes in the quality relative to one another. In this context there may be a range of different quality metrics that hospitals compete on*".¹⁰
- 3.11 In *UCLH / Royal Free*, which specifically concerned the provision of tertiary neurosurgery services in London, the OFT considered:¹¹
- "... whether the Transaction might reduce the parties' incentives to undertake investment or actions (for example to continue to enhance the quality of those services over the minimum required standards), to compete for patient income by not undertaking the same level of investment, or actions which attract patients to a particular hospital (such as shorter waiting times and better auxiliary services)".*
- 3.12 The importance of research and development (R&D) and innovation in healthcare has previously been acknowledged by the CC¹² and the Department of Health.¹³

⁸ National Advisory Group on the Safety of Patients in England, 'A promise to learn – a commitment to act: Improving the Safety of Patients in England', August 2013. Available at:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

⁹ See the OFT decision on the acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services, ME/5574-12 and the CC Final Report into The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/ Poole Hospital NHS Foundation Trust.

¹⁰ See para. 6.84 of the CC's Final Report into The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/ Poole Hospital NHS Foundation Trust. While price may also be a relevant factor to a patient's choice of private hospital, it is not the most important factor. Patients using private healthcare facilities place significant weight on quality of facilities when choosing a hospital (see paras. 3.18 - 3.20 below).

¹¹ See para. 66 of the OFT's decision on University College London Hospitals NHS Foundation Trust / Royal Free London NHS Foundation Trust neurosurgery services.

¹² See selected CC cases, as set out in HCA, Response to CC Issues Statement, para. 4.27.

¹³ Department of Health, *NHS Improvement & Efficiency Directorate, Innovation and Service Improvement, (2011), Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS*, discussed in HCA, Response to the Issues Statement, para. 4.28.

- 3.13 In its Guidelines,¹⁴ the CC recognises that, "*outcomes of the competitive process in their different forms in a market – e.g. ...levels of innovation, product range and quality – can also provide evidence about its functioning*" and that "*evaluating these outcomes helps the CC determine whether there is an AEC*". Whilst the CC acknowledges that quality and innovation may be less quantifiable, it highlights that they are, "*no less important to customers*".
- 3.14 Furthermore, the CC Guidelines¹⁵ highlight that, "*poor quality, lack of innovation, or limited product ranges are prominent among other indicators of weak competition in a market*". On that basis, the extensive evidence submitted to the CC showing lively and continuous innovation with an increasing range of treatment choices should be acknowledged as evidence of strong competition.
- 3.15 Despite numerous CC and OFT precedents for recognising the importance of investment in innovation,¹⁶ the CC has ignored relevant evidence of this competitive process at work in London. Instead, the CC blindly focuses on price outcomes. For example, as part of its insured price analysis, the CC acknowledges that there is "*some quality variation between hospitals*",¹⁷ but decides to proceed "*without factoring in any effects of variation in quality*".¹⁸ In effect, the CC sweeps this important issue under the carpet. Were hospital operators to similarly ignore quality and purely focus on price competition, as those PMIs taking a short-term view may prefer, the effect would be to substitute competition on quality with competition purely on cost-management, resulting in a "race to the bottom".
- 3.16 St. Anthony's Hospital, a London based hospital operator that is not a party to this investigation, felt compelled to state candidly: "*the Competition Commission could have tried harder... **the whole issue of quality has not been considered by the Competition Commission**. Yet its own reports state that quality of clinical care is what the patients wish to have*".¹⁹
- 3.17 The patient's expected quality of care is a key factor in the decision of which consultant and hospital the GP / patient selects. This applies to UK self pay, international self pay and UK/international PMI patients alike.
- 3.18 With respect to UK self pay patients:
- They choose to pay for private treatment instead of using the free NHS alternative. This choice is based on the desire to receive a better quality of care, e.g. a greater choice of treatments, faster and more joined-up care and better customer service. If private hospitals failed to maintain this quality differential, private hospitals would simply be unable to attract UK self pay patients.
 - The CC's patient survey shows that factors related to quality are the most important reasons why self-pay patients choose to have a treatment privately rather than on the NHS, including length of waiting time, availability of appointment times, ability to choose

¹⁴CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013, paras. 103 – 104.

¹⁵ CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013, para. 127.

¹⁶ HCA, Response to the CC's Issues Statement, July 2012, box on page 25.

¹⁷ CC, PFs, para. 6.213.

¹⁸ *Ibid.*

¹⁹ St. Antony's Hospital's comment on the PFs Report, page 6.

consultants, clinical outcomes and quality of care. The single most frequently given reason was to reduce the waiting time.²⁰ Indeed, the desire to reduce waiting times is linked to the recognition that obtaining faster access to treatment, e.g. in cancer care, is likely to improve clinical outcomes. Indeed, the CC cited views from employers that: "*Rapid access to diagnostic services was seen as beneficial in that early diagnosis might result in more effective treatment...*".²¹

- 3.19 International patients have a range of alternative private healthcare providers available across the world (most notably in the US, Germany and Singapore). In this hotly contested market, patients tend to be well-funded, highly mobile, and determined to seek the best quality of care available. Accordingly, competitive strategies are formulated around the sizeable investments required to keep up with the best hospitals in the world.²²
- 3.20 For PMI patients, their insurance coverage means that, at the point of seeking care, quality, rather than price, is their main consideration.²³ The CC's survey evidence demonstrates that patients using London based hospitals are well-informed and place a greater focus on quality in choosing healthcare treatments.²⁴ In the case of GP referrals, the CC's GP survey revealed that 74% of Greater London GPs listed clinical expertise as a reason for referral to a private consultant. A large proportion of London based GPs also cited feedback from previous patients (64%) and reputation (64%).²⁵
- 3.21 HCA has previously submitted that investment in hospitals is crucial in attracting consultants to its facilities.²⁶ Consultants chiefly locate their practice at the facility that enables them to deliver the best possible care, e.g. due to the quality of the facility, staff or technology. As noted by Consultant 19 (in response to the CC's PFs), "*HCA hospitals provide a high quality of care which attracts the best specialists*".²⁷
- 3.22 The role of quality and innovation in healthcare, particularly in London, is recognised by the NHS in its document "A Framework for Action, Healthcare for London" (July 2007) which points out the growing role of technology in the provision of healthcare in London:²⁸

"In the next 10–20 years there are likely to be considerable technological breakthroughs in medicine including ... further developments in minimally invasive surgery, forecast to account for half of all surgical interventions within 10-15 years, and in image-guided surgery, exploiting developments in magnetic resonance imaging [and] use of robotics in surgery, increasing accuracy and consistency, and in rehabilitation."

²⁰ CC Patient Survey Tables, pages 82-84.

²¹ CC, PFs, Appendix 2.1, para. 23.

²² One example is the Cleveland Clinic (one of HCA's top competitors for international patients) which in 2012 invested [£] of total revenue ([£] of operating income before interest, depreciation and amortisation) in fixed assets. Analysis by McKinsey (Exhibit 1) shows that Cleveland's investments include a partnership in Abu Dhabi which is expected to meet around [£] of the emirate's healthcare needs.

²³ However, some PMI patients may be offered cash incentives to be treated on the NHS rather than seeking private treatment. Furthermore, the use of PMI directional policies which adopt a selection criteria based on cost will also dictate the patient's choice on the basis of price of care.

²⁴ See section 4 below, "Patients accessing private healthcare in London".

²⁵ Question E6 of the CC's GP survey.

²⁶ HCA, Response to Issues Statement, July 2012, para. 4.20.

²⁷ Consultant 19's response to the PFs and Remedies Notice.

²⁸ www.nhshistory.net/darzilondon.pdf, see pages 35 – 36.

3.23 Hence, it is vital that any high quality provider such as HCA needs to invest in order to stay competitive in a rapidly evolving market.

HCA's competitive strategy on quality

3.24 When HCA entered the UK private healthcare market in 1996, it understood and embraced the importance of quality of care to patients and consultants, and that is why it is such a focal point of its competitive strategy. Accordingly, HCA revamped its hospitals' competitive strategy to focus on achieving the best possible care. HCA adopted the ethos that quality is the cornerstone of its service and vigorously competed on this front.²⁹ Internal strategy documents dating from 2006 submitted to the CC evidence this strategic focus. This included investing in:

- The expansion and upgrade of its healthcare facilities to offer the patient the optimum clinical environment for the delivery of care and support.
- The institution of a clinical governance regime across all of its hospitals that places the focus on quality of care.
- New diagnostic, treatment and life-support technologies that offer enhanced clinical outcomes for the patient.
- The recruitment and training of high-calibre clinical staff to support consultants.
- The development of hospital practices and patient pathways that optimise the consultant's ability to successfully diagnose and treat patients.
- Attracting consultants practising at the top of their respective fields and collaborating with them to reshape how care is delivered to private patients.

3.25 As a result of those strategic decisions, today, HCA does not provide a commoditised hospital service but, as termed by AXA PPP, it runs "elite" hospitals.³⁰

3.26 HCA's higher quality offering is measurable and quantifiable³¹. For example:³²

- HCA achieved a 100% compliance with all CQC clinical outcomes – the only private operator to do so.
- HCA has the first and only private integrated rehabilitation unit in the UK to win UK and international quality accreditations.
- Unplanned returns to the operating theatre are over 10 times lower than the national average.
- The results of HCA's 2012 patient surveys were a 99% patient approval rating and 99.6% respect and dignity rating.
- HCA is the only private hospital operator to have all of its hospitals independently accredited via Comparative Health Knowledge System (CHKS), a leading independent

²⁹ HCA also explained the history of its London operations in HCA, Response to the Issues Statement, July 2012, section 3.

³⁰ AXA PPP, Response to the AIS, para. 12.

³¹ See, for example, HCA, Response to the Remedies Notice, para. 5.7.

³² Further examples can be readily provided to the CC.

quality audit and accreditation body, and also have program specific accreditation such as from the Joint Accreditation Committee (JACIE)³³ for its Bone Marrow Transplantation Unit program.

- HCA has won a series of awards for its healthcare offering. Most recently, HCA won both the HealthInvestor Public/Private partnership award and the Laing & Buisson Healthcare Award for Private/Public partnership. Highlights of its NHS Ventures division include [X] investment in facilities and equipment and 99% patient satisfaction.

3.27 Submissions made by third parties, including competing hospitals and PMIs also evidence HCA's market-leading quality offering. BMI told the CC that HCA ran "*excellent quality hospitals*".³⁴ AXA PPP classified all of HCA's hospitals as "elite". AXA PPP considered "elite" private hospitals to be characterised by: "*their UK wide and indeed international reputation for excellence, attracting high profile specialists and elite facilities; and coverage of the full range of high-acuity treatments*" and a "*leading role in introducing technological innovation in the UK*".³⁵ These are not characteristics that arise in a market devoid of competition, but must be earned and sustained through continuous investment.

3.28 The NHS Outcomes Framework³⁶ sets out the outcomes and indicators used to hold the NHS Commissioning Board to account for improvements in health outcomes. The development of this framework highlights the focus on how well services are improving patient outcomes. Similarly, HCA adopts several measures to monitor and achieves the best possible patient outcomes.³⁷ For example:

- HCA monitors and reports clinical KPIs to the CQC on a quarterly basis, including hospital mortality, unplanned readmissions, returns to the operating theatre and transfers out and MRSA and MSSA bacteraemia.
- HCA compiles quarterly hospital performance scorecards³⁸ that assess performance on a variety of indicators by reference to national (where available) and internal benchmarks.
- HCA conducts annual Quality and Clinical Governance reviews across all of its hospitals.
- HCA supports a number of professionally led clinically rich databases, and in some cases is the only private hospital operator to do so, allowing HCA to benchmark its outcomes using valid case mix adjustments.

3.29 HCA produced a separate report on its quality offering (Annex 2 to HCA's response to the Remedies Notice). The report illustrates, through a number of case studies, how HCA's investments in clinical innovation to improve outcomes for patients (e.g. in terms of mortality rates, speed of recovery, overall patient satisfaction).

3.30 HCA is also an active participant in the initiatives that have arisen in the context of the CC's market investigation to enhance the information available on the comparative quality of

³³ ISCT (International Society for Cellular Therapy) and EBMT (European Group for Blood and Marrow Transplantation).

³⁴ BMI Hearing Summary, para. 24.

³⁵ AXA PPP Response to the AIS, para. 2.2.

³⁶ Details available at: www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

³⁷ HCA, Response to the CC's Market Questionnaire, September 2012, question 24.

³⁸ Provided as Exhibit 23.3 to HCA's response to the CC's Market Questionnaire, September 2012.

private hospitals. These initiatives will give even more importance to competing on quality of care.

HCA's record on investing in quality

- 3.31 Disappointingly, the CC has overlooked how HCA has, over time, competed to sustain its position in the market as a provider of excellent healthcare.
- 3.32 In its description of the main parties, the CC merely states that "*HCA submitted to us that it has significantly invested in each of these hospitals*".³⁹ HCA has indeed invested significantly in its hospitals. However, this vastly understates the information provided to the CC demonstrating HCA's investments and how this enables it to compete effectively:
- HCA highlighted the major investments it has made (e.g. see HCA's responses to the Issues Statement, Annotated Issues Statement (AIS) and working papers).
 - HCA provided financial statements for its facilities for the period 2000 to 2012.⁴⁰
 - HCA provided details relating to the sums invested in switching hospital capacity for the provision of new medical treatments, expanding HCA's facilities and developing new ones.
 - HCA provided details of its capital expenditure at its hospitals over the past six years.
- 3.33 We refer the CC to the box below entitled "HCA's history in the market" and **Table 1** for HCA's major investments between 2000 and 2012.

³⁹ CC, PFs, para. 3.16.

⁴⁰ Financial information provided by HCA 2012 included forecast figures for October to December 2012 as, given the timing of the CC's request for this data, actual figures were not then available.

HCA's history in the market

- In 1996, HCA and PPP Healthcare Limited jointly acquired the Harley Street Clinic, Portland, Princess Grace and Wellington Hospitals from BMI. BMI divested these London hospitals because of the high cost of operating them in an increasingly competitive landscape.
- HCA had a different vision for the future of the hospitals, namely to transform them through large-scale investment and clinical expertise into world-leading hospitals that can offer complex care that was otherwise only available in the NHS.
- In 2001, HCA took over the London Bridge, the Lister and the Arrazi hospitals through its acquisition of St. Martin's Healthcare Limited from the Kuwait Investment Office.
- The OFT recommended that the transaction be cleared as it considered there were "*unlikely to be competition concerns whether the relevant market is for all acute private health care or for a series of separate markets for individual specialisms*" as there was "*substantial competition to the parties*" and the "*availability of other facilities*".
- The London Bridge Hospital had been starved of capital expenditure, but following substantial cumulative investment, the hospital is now one of the most popular hospitals in the UK. For examples of these investments, see **Appendix 6**, **Appendix 7** and HCA's response to the Remedies Notice.
- Following the increasing trend away from inpatient activity to outpatient and day case work, HCA has in recent years invested in upgrading and developing outpatient, diagnostic and ambulatory care centres, including the UK's largest, the Platinum Medical Centre.
- HCA has won competitive bids to invest in and operate a number of successful NHS PPU's, for which it has received acclaim in the industry.
- Through HCA's involvement with Leaders in Oncology Care ("LOC") and the Sarah Cannon Research Institute UK ("SCRUK"), the first private clinical trials clinic in the UK, HCA has invested in the advancement of medicine. For example, in April 2013 HCA announced a collaboration involving its hospitals, SCRUK and UCL-Advanced Diagnostic to conduct molecular profile testing in a new, innovative laboratory. The aim is to pioneer cost effective tumour tests to give doctors a better chance of identifying the optimum treatment for cancer patients. The emerging term for this pioneering practice is "precision medicine".

- 3.34 In **Appendix 6**, HCA provides a considerable list of innovative treatments, practices and procedures that it has launched at its hospitals, often as the first UK private hospital operator to do so. The Appendix demonstrates how HCA has strived to be the first to introduce new clinical technology and how these investments directly benefit patients.
- 3.35 By observing how different hospitals compete to invest in quality of care, it is apparent why HCA vigorously disagrees that its hospitals are subject to "weak competitive constraints". Rather, competition has generated enormous benefits to patients. It also has wider economic benefits. For example, without such investment, the fruits of R&D into new drugs, equipment and treatment pathways would not be channelled toward UK patients.

Table 1 HCA major investments in London, 2000 - 2012

<p>2000-2006</p>	<p>HCA</p> <ul style="list-style-type: none"> ▪ HCA purchases St Martins Group and PPP's share of existing facilities ▪ Centralised laboratory, services merged ▪ Bedside medication verification system [✂] ▪ Investment in plant services [✂] ▪ Major investment in Picture Archiving and Communication System (PACS) [✂] ▪ Major investment in decontamination systems [✂] <p>Tristar</p> <ul style="list-style-type: none"> ▪ Devonshire Hospital converted to outpatient and day case facility ▪ Harley Street Clinic enters radiotherapy market ▪ Harley Street Clinic radiotherapy expansion [✂] <p>LBH</p> <ul style="list-style-type: none"> ▪ London Bridge and Lister undergo extensive refurbishment ▪ St. Olaf House becomes part of London Bridge Hospital for consulting rooms, angiography and outpatient services [✂] <p>Lister</p> <ul style="list-style-type: none"> ▪ London Bridge and Lister undergo extensive refurbishment <p>Wellington</p> <ul style="list-style-type: none"> ▪ Major refurbishment of Wellington Hospital including neuro rehab and ITU expansion [✂] <p>NHSV</p> <ul style="list-style-type: none"> ▪ HCA enters NHS Ventures market at UCH [✂], subsequent refurbishment [✂]
<p>2007</p>	<p>HCA</p> <ul style="list-style-type: none"> ▪ Centralise laboratory automation [✂] <p>LBH</p> <ul style="list-style-type: none"> ▪ London Bridge Hospital operating theatre expansion <p>Wellington</p> <ul style="list-style-type: none"> ▪ Golders Green diagnostics centre established [✂]
<p>2008</p>	<p>Tristar</p> <ul style="list-style-type: none"> ▪ CyberKnife introduction [✂] ▪ Expansion of operating theatre capacity at Princess Grace to meet demand and to respond to the competitiveness of the London Clinic [✂] ▪ Portland MRI systems [✂] <p>LBH</p> <ul style="list-style-type: none"> ▪ Investment in inpatient capacity [✂] <p>Wellington</p> <ul style="list-style-type: none"> ▪ Circus Road diagnostics established [✂] <p>Lister Hospital</p> <ul style="list-style-type: none"> ▪ IVF expansion [✂]
<p>2009</p>	<p>HCA</p> <ul style="list-style-type: none"> ▪ Laboratory relocation and expansion [✂] ▪ 93 Harley St (SCRI) site upgraded and refurbished [✂] <p>Tristar</p> <ul style="list-style-type: none"> ▪ Harley Street Clinic PET CT [✂] ▪ Harley Street Clinic linear accelerator renewal [✂] ▪ Harley Street Clinic intensive care unit upgrade [✂] <p>LBH</p> <ul style="list-style-type: none"> ▪ London Bridge operating theatre expansion [✂]

2010	<p>HCA</p> <ul style="list-style-type: none"> ▪ LOC joins HCA group and is subsequently franchised to hospital facilities [X] ▪ Investment in scanning and archiving technologies, including [X] <p>Tristar</p> <ul style="list-style-type: none"> ▪ Launch of 13 - 14 Devonshire Street outpatient and diagnostic centre [X] ▪ Launch of outpatient centre in New Malden [X] ▪ Princess Grace Heron House development [X] <p>Lister</p> <ul style="list-style-type: none"> ▪ Chelsea Outpatient Centre [X] <p>NHSV</p> <ul style="list-style-type: none"> ▪ HCA's partnership investment at the Christie Clinic [X]
2011	<p>HCA</p> <ul style="list-style-type: none"> ▪ New cardiology PACS investment [X] <p>Tristar</p> <ul style="list-style-type: none"> ▪ Princess Grace, 15 - 18 Devonshire Street diagnostic centre [X] <p>Wellington</p> <ul style="list-style-type: none"> ▪ The Platinum Medical Centre [X]
2012	<p>HCA</p> <ul style="list-style-type: none"> ▪ LOC upgrade to 81 Harley St [X] <p>LBH</p> <ul style="list-style-type: none"> ▪ Expansion of London Bridge Hospital day case unit [X] ▪ London Bridge Hospital - low dose SPECT-CT system [X] ▪ London Bridge - chemotherapy investment [X] ▪ MRI services at Broad Street [X]
2013	<p>HCA</p> <ul style="list-style-type: none"> ▪ Quality and compliance improvements (bar coded technologies, clinical documentation, infrastructure [X]) <p>Tristar</p> <ul style="list-style-type: none"> ▪ Institute of Sports Exercise and Health [X] ▪ Portland Hospital – operating theatre upgrade [X] <p>Wellington</p> <ul style="list-style-type: none"> ▪ Wellington Hospital – south building ITU refurbishment [X] <p>NHSV</p> <ul style="list-style-type: none"> ▪ Wilmslow Outpatient and diagnostic centre [X]

(2) The CC's analysis has not captured the dynamic nature of the provision of healthcare

- 3.36 The CC has failed to reflect in its PFs the dynamic nature of competition in the market for private healthcare. It is a competitive process that is influenced by continuous investment, market growth, entry and repositioning and service innovation, all of which is observable over a period of time.
- 3.37 A static assessment of competition, for example, based on shares of supply, is simply not informative of competition in the provision of private healthcare, particularly in London, where the rate of medical innovation is acknowledged as being higher.
- 3.38 The OFT's guidelines on the assessment of market power⁴¹ state that market shares alone might not be a reliable guide to market power. Specifically, it notes that: "*in a market where undertakings compete to improve the quality of their products, a persistently high market share might indicate persistently successful innovation and so would not necessarily mean that competition is not effective*".

⁴¹ http://www.of.gov.uk/shared_of/business_leaflets/ca98_guidelines/of415.pdf

- 3.39 The Guidelines⁴² recognise that: *"In some cases incumbency advantages may result from good commercial decisions made in the past (e.g. to invest in and patent a successful new technology) and intervention to overcome these sources of competitive advantage may risk undermining dynamic incentives to invest and innovate"*.
- 3.40 In a recently published BIS response to the consultation on the statement of strategic priorities for the CMA, BIS notes that *"the CMA should take full account of longer-term dynamic competition through innovation and the development of new business models, as well as short-term competition in the market"*.⁴³
- 3.41 HCA is under constant pressure to invest in its services, whether because of other private hospitals or leading NHS teaching hospitals, each of whom compete strongly on quality. **Figure 1** below shows how HCA has invested more on average than its competitors.

Figure 1 Capex as a percentage of revenue, HCA, BMI, Spire and Nuffield Health, 2008 - 2011

[✂]

Source: HCA analysis

- 3.42 As with any competitive market, it is commonplace to observe competitors responding to another competitor that introduces a new, better technology for providing services. This is no different in private healthcare.
- 3.43 The CC's own case study is a very good example of this competitive process. When describing the rationale for the London Clinic's Cancer Centre, the case study notes that the *"ability of TLC to provide a radiotherapy service to complement its existing oncology services was considered vital if it was to maintain and enhance its reputation as a leading private sector provider in the treatment of cancer"* as *"the inability to provide a comprehensive range of treatments, ie the lack of radiotherapy facilities, represented a considerable threat to TLC's position in the future."*
- 3.44 It was further noted that: *"TLC had no radiotherapy facilities, unlike HCA's Harley Street Clinic which had two Linear Accelerators on stream at that time with a third being introduced in 2003 or The Cromwell (two Tomotherapy machines). Other private radiotherapy facilities in or close to London were the Parkside Hospital in Wimbledon and King Edward VII in Midhurst as well as NHS PPUs such as the Royal Marsden"*. In short, the competitive force that drove the London Clinic to make this substantial investment was the need to "keep up" with the competition.
- 3.45 The need to keep up is by no means isolated to just the London Clinic and HCA. The Hospital of St. John and St. Elizabeth claims that a *"continual investment programme ensures that the hospital maintains the facilities it needs to stay at the front of medical technology and achieve the highest level of individual patient care"*.⁴⁴

⁴² CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013, para. 58.

⁴³ Annex 1, para. 6, The Department for Business, Innovation and Skills, 'Response to consultation on statement of strategic priorities for the CMA', October 2013.

⁴⁴ <http://www.hje.org.uk/index.php/About-HJE/accommodation-a-facilities.html>

3.46 When HCA has been "first to market" with new treatment/diagnostic technologies, competitors have been quick to follow suit. For example:

- CyberKnife, first introduced at HCA's Harley Street Clinic in early 2009, was quickly adopted by the London Clinic later in that year and is also available at a number of NHS facilities. The CyberKnife facility at HCA was used to train consultants at other hospitals.
- The da Vinci robotic surgery system, first introduced into private hospitals in 2004 at the Princess Grace, but following investments by other competitors in the market, this advanced treatment technology is now available at the Royal Marsden and at 19 other locations within a 100-mile radius of London.
- HCA was the first private hospital to invest in intraoperative radiotherapy (IORT) using a novel Intrabeam radiotherapy machine. This pioneering new treatment for breast cancer delivers a single dose of radiotherapy into the breast following the removal of a tumour and before the completion of the operation, thereby potentially avoiding the need for up to 6 weeks of radiotherapy after the patient's operation. This innovative technology is also available at the Hospital of St. John and St. Elizabeth.
- HCA was the first private hospital to offer patients an ultrasound guided endoscopy. This technology combines endoscopy and ultrasound in order to obtain images and information about the digestive tract and the surrounding tissue and organs. This diagnostic procedure is now available at other private hospitals, such as the Bupa Cromwell.
- HCA was the first private hospital to offer capsule endoscopy. This procedure enables a complete examination of the gastrointestinal tract and overcomes certain limitations with traditional endoscopy. The patient swallows a pill-sized wireless video capsule, which records images of the area of interest. This procedure is now available at a number of HCA's competitor hospitals, including BMI's Clementine Churchill and Blackheath hospitals.
- Following HCA's investment in critical care level 3 facilities at each of its hospitals, other London operators including BMI and Spire have expanded their critical care capabilities and have signalled their intent to continue doing so.⁴⁵ By way of further example, on 24 November 2010, the King Edward VII Hospital opened a new state-of-the-art Critical Care Unit. The new "Michael Uren Critical Care Unit" was fully funded by a £762,000 donation from the Michael Uren Foundation.⁴⁶

3.47 Similarly, HCA has responded to other competitors' investments. For example:

- In respect of a planned investment at the Harley Street Clinic cardiology unit,⁴⁷ HCA noted that: "[X]".
- Another business case, relating to HCA Laboratories, also demonstrates HCA's proactive investments to stay ahead of its competitors. It notes that "[X]".⁴⁸

⁴⁵ <http://www.talkinghealthmagazine.co.uk/506/bmi/critical-care-one-standard-excellence/>. Also, see BMI Annual Report 2011-12, page 22 ("Investment"), Netcare Annual Integrated Report 2012, page 84.

⁴⁶ http://www.kingedwardvii.co.uk/information_news.cfm?id=12

⁴⁷ See case 13 of Appendix 7.

⁴⁸ See case 6 of Appendix 7.

- An internal HCA document in 2007⁴⁹ notes of the Cromwell Hospital: "[redacted]". HCA subsequently responded by investing in its own Gamma Knife unit, which is now run in conjunction with St. Bartholomew's Hospital. The same document lists as the top strategic priority for 2007: "[redacted]".
- In 2006, an internal HCA document notes:⁵⁰ "[redacted]". It further notes, in respect of NHS activity, "[redacted]". HCA's strategic response includes committing "[redacted]".

- 3.48 **Appendix 7** outlines a number of business cases for new technologies, quality improvements and expansion, which highlight this competition. **Appendix 7** should give the CC a better idea of the range and scale of investments that HCA makes to stay ahead of its competitors in offering consultants an increasingly wider and more effective platform to deliver care to patients.
- 3.49 The same competitive dynamic also applies to the development of new clinical services. In 2011, the Princess Grace Hospital was London's first private hospital operator to launch an urgent care centre as a walk-in service for patients. The Hospital of St. John and St. Elizabeth launched its own urgent care centre under the brand "Casualty First"⁵¹ in September 2011, which it claims has been a success with patients. In 2012, HCA's Wellington Hospital opened its own Acute Admissions Unit for patients.
- 3.50 HCA also faces competitive pressures from overseas providers for international patients. Analysis conducted by McKinsey on competition from global competitors and how this is expected to change over time is set out in **Exhibit 1**. McKinsey's analysis shows that this competition is intensifying, especially in the Middle East, which provides a significant threat to HCA's international patient base. For example, McKinsey find that in Saudi Arabia, Kuwait and the UAE alone, [redacted] investment will have taken place in healthcare between 2004 and 2018.
- 3.51 Being first to market does not provide a hospital with a sustained competitive edge. Rather, there is a need for vigilant monitoring of innovations in the market and new investment to stay ahead of competitors who are also vying for consultants and patients. Over time, this competitive dynamic leads to increasingly sophisticated treatments in the market that can treat higher acuity patients. Indeed, Nuffield submitted to the CC that: "*In recent years, Nuffield has seen the prevalence of higher acuity procedures in a private setting increase*" and that there had been a "*shifting composition of procedures*".
- 3.52 According to the CC's Guidelines,⁵² "*although there may be circumstances in which analysis can be conducted only on the basis of the current state of the market, the CC always considers how a market may evolve*". HCA considers that, despite observing important evidence on expansion (for example in relation to the London Clinic) and the development of new / improved services, the CC has not sufficiently analysed or taken into account how competition plays out in London.
- 3.53 It is crucial that the CC takes account of this dynamic competitive feature of the market. HCA's current position in the market as the operator of elite hospitals was not predicated on

⁴⁹ See Exhibit 14.2, HCA, Response to the Market Questionnaire.

⁵⁰ See Exhibit 14.1, HCA, Response to the Market Questionnaire.

⁵¹ <http://casualtyfirst.co.uk/>

⁵² CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013.

a strategy based on "price", but rather on continuous investment in the face of domestic and international competition.

(3) The CC has failed to assess the whole market and full range of competitors for private patients

- 3.54 In assessing the market for the supply of private healthcare in the UK the CC has failed to consider the entire market and account for the full range of competitors for private patients. This is a fundamental flaw in the CC's analysis that is discussed in greater detail in section 5 below.
- 3.55 The obvious consequence of sidelining competition on quality of care is that the CC does not then see how private hospitals based in London compete with NHS hospitals. The list of NHS hospitals in London comprises a formidable array of top-quality hospitals, including the world-renowned Royal Marsden and Great Ormond Street hospitals. HCA must not only maintain similar standards of quality and clinical resources but also sustain a quality differential with the likes of these hospitals to convince patients to opt for private treatment as an alternative to the NHS.
- 3.56 The CC recognises that HCA is reliant on international patients for a significant proportion of its revenues. However, the CC fails to then consider the competition that HCA faces for these patients, how this affects its competitive behaviour and the outcomes observed. HCA has previously described the competition it faces from providers in countries such as the US, Germany and Singapore.⁵³ This competition has an important role in driving HCA's incentive to offer the best care possible, and it benefits all of HCA's patients.

Conclusion on the CC's overall approach to assessing competition

- 3.57 By failing to assess the strategic incentive to invest and innovate to improve quality of care to patients, the dynamic nature of healthcare markets, and the full range of competitive constraints, the CC's analysis of competition between hospital operators in London is, at its core, inherently flawed. It is incumbent upon the CC to assess whether the evidence of hospitals fiercely competing on quality is at all consistent with its other provisional findings. In the absence of this analysis, the CC has simply failed to take account of a highly relevant feature of the market.

⁵³ HCA, Response to the CC's Issues Statement, July 2012, para. 5.3; HCA, Response to the CC's Market Questionnaire, Question 12.

4. PRIVATE HEALTHCARE IN LONDON

Key points

- The provision of private healthcare in London is different to other parts of the country – it is a lively, dynamic and competitive market.
- Competition to improve quality of care is stronger in London, where patients place particular emphasis on the quality of their care and have more complex treatment requirements.
- There has been strong growth in the provision of private healthcare in London historically, in contrast to other areas in the UK. Far higher than average increases in London's population, resilient PMI penetration, a buoyant economy and increasing disposable income will fuel further growth in demand.
- London has a much more robust record of new entry and expansion than other parts of the country, and there is also further significant planned entry and expansion to come.

Introduction

- 4.1 As part of its assessment of the market for private healthcare the CC has undertaken a separate competitive assessment for central London. However, throughout its PFs, the CC attempts to draw conclusions that are valid for private healthcare provision across the UK, despite the CC expressly recognising that there are differences in quality, innovation and patient demand in London compared with the rest of the UK.
- 4.2 In this section, HCA sets out the key differences in drivers of demand in London compared to other parts of the UK and how they should impact the CC's analysis of competitive constraints and indicators of outcomes of the competitive process.
- 4.3 HCA believes that the CC's assessment of private healthcare provision in London is unsound, both in terms of the interpretation of the evidence and the CC's lack of analysis in key areas, including:
- failing to recognise that patients in London are better informed of their alternatives, and place a greater emphasis on quality than patients on average in the rest of the UK;
 - placing insufficient weight on the more complex treatments that are delivered by London based providers, including leading NHS teaching hospitals;
 - mistakenly dismissing the international dimension of competition between HCA and its competitors; and
 - not taking into account the likely changes and growth in the demand for private healthcare in London.

(1) Patients accessing private healthcare in London are more focused on quality

- 4.4 The CC recognises that there are special demand and supply characteristics in London.⁵⁴ This is, in part, because of the specific features of the patients accessing care in London, who tend to be better informed and have a greater focus on quality.

⁵⁴ CC, PFs, Summary, para. 18.

- 4.5 The evidence gathered by the CC reflected HCA's views and demonstrates that patients using London based hospital facilities are well informed and are more focused on quality of care. Specifically, the CC provisionally found that patients using London based private healthcare providers were more likely, on average, to have looked up relevant information online (63% compared with 47% on average), visited the websites of private consultants (41% compared with 25% on average), and visited the websites of private hospitals / PPU's (36% compared with 24% on average).⁵⁵ Further, the CC's evidence found that patients choosing to use London based providers place greater importance on the consultant's reputation (46% compared with 36% on average) and their clinical expertise (43% compared with 38% on average).⁵⁶
- 4.6 HCA notes that previous evidence provided to the CC⁵⁷ has demonstrated the willingness of patients to travel for treatments at HCA facilities. In undertaking its locational analysis, HCA found that self-pay patients typically have longer travel times to HCA facilities than those who are insured. It commented that this is likely to show that self-pay patients "*travel further to access the provider they perceive is offering the highest quality*".⁵⁸ The analysis also shows that for the most complex, market leading treatments, patients are also willing to travel longer distances. For example, the 80th percentile for travel times to HCA's CyberKnife unit in 2011 was [X] regardless of transport method.⁵⁹ These patients are not "captive" to any narrowly defined geographic area, rather, patients are demonstrating their capacity to travel long distances to find the highest quality of care available.
- 4.7 The CC also recognises that quality of care in London is seen to be very high, and that this is a key factor attracting patients to London for treatment.⁶⁰

(2) Private healthcare in London is characterised by a greater range and complexity of treatments

- 4.8 Patients in London are more likely than patients in the rest of the UK to be accessing healthcare services for complex, higher acuity areas of care.
- 4.9 HCA has a relatively strong focus on tertiary specialisms, for example on complex and evolving forms of cancer treatment, neurosurgery and cardiac surgery. In the CC's insured price analysis the CC recognised that there may be a "*different mix of treatments and cases provided in London compared with the rest of the UK (e.g. high acuity and complex cases)*".⁶¹
- 4.10 The specialist consultants required to safely deliver the type of complex treatments demanded by patients are often based in London. Given the greater focus on quality by patients, it is imperative that HCA attracts the top consultants. Particularly given that patients also have access to the consultants practising at major NHS teaching hospitals, such as Guy's and St. Thomas', St. Bartholomew's, King's College, UCH and the Royal Marsden, all of whom host leading practitioners in their respective fields.

⁵⁵ CC, PFs, Appendix 6.10, para. 13.

⁵⁶ CC, PFs, Appendix 6.10, para. 12.

⁵⁷ HCA, Response to the CC's Market Questionnaire, Question 10.

⁵⁸ HCA's response to the CC's Market Questionnaire, para. 10.25.

⁵⁹ HCA, Response to the CC's Market Questionnaire, table 10.7. Transport methods assessed are road and public transport.

⁶⁰ CC, PFs, Appendix 6.10, paras. 6 – 13.

⁶¹ CC, PFs, Appendix 6.12, para. 20.

- 4.11 With this greater focus on quality of service provision and complex treatments, competition in London is characterised by a significant impetus on innovation and investment compared to other parts of the country. Indeed, AXA PPP informed the CC of "*the fact that new technology will tend to be introduced in London before other locations*".⁶²
- 4.12 This should be acknowledged by the CC to ensure that the intensity of competitive constraints is recognised and market outcomes (such as pricing and margins) are interpreted correctly against this background.

(3) HCA competes in an international market

- 4.13 As a result of the high quality and complex healthcare treatments available in London, it is recognised as a centre of international excellence. The CC notes in its PFs that FIPO considers "*patients were attracted to London due to its international reputation and the high quality of consultants*".⁶³ The CC also recognises that overseas patients are a source of funding for private acute healthcare at private hospitals,⁶⁴ and that HCA earns a significant proportion of its revenue from overseas patients ([§]).⁶⁵ Therefore, competition over quality of care has an elevated importance in London. Yet the CC has not considered the importance of international patients and the constraint from leading international providers in its market definition or competition assessment. As discussed in section 5 below, if the CC excludes competing international providers from its share of supply analysis, it must also exclude the revenues from international patients.

(4) Current and future trends in London private healthcare provision

- 4.14 The evidence in this section shows sustained growth in the London private healthcare market in recent years. HCA, among other hospital operators, has reacted strategically to this, with the result of enhanced competitive rivalry for patients. In addition to historical growth, analysis shows that demand for private healthcare in London will continue to grow, due to increased PMI penetration alongside an ageing and expanding population. In addition to demand side factors, HCA expects significant growth in the provision of private healthcare from PPUs.
- 4.15 HCA discusses the impact of such growth for the CC's competitive assessment of London in section 5 below.

London has seen sustained growth

- 4.16 In its PFs, the CC considers that demand for the provision of private healthcare services has been largely static.⁶⁶ The CC has evidently not considered the growth trends specifically in the case of London. This is a serious omission which prevents the CC from appropriately evaluating competition and the likelihood of entry / expansion.
- 4.17 HCA sets out evidence below showing the extent of past growth and that the trend is likely to continue due to a growing and ageing population.
- 4.18 Far from being static, the data on the majority of central London based hospitals during 2007 - 2011 shows that the market has seen a compound annual growth rate in revenues of

⁶² AXA PPP, Response to the AIS, para. 12.

⁶³ CC, PFs Appendix 6.10, para. 8.

⁶⁴ CC, PFs, para. 2.30.

⁶⁵ CC, PFs, para. 3.22.

⁶⁶ CC, PFs, para. 8.

approximately [X] in nominal terms.⁶⁷ In real terms – regardless of the deflator used – revenues have risen at least [X] over the period. This is shown in **Figure 2** below using 2007 as an index value.

Figure 2 Index of central London private healthcare revenue,⁶⁸ 2007 - 2011

- 4.19 The data above does not include all private healthcare providers in central London. Nonetheless, it provides a useful insight as to historical market growth in London.
- 4.20 HCA urges the CC to undertake a detailed analysis of growth trends in London itself given its increased access to data from all of the main private hospital providers and its ability to obtain information from NHS PUs. To that end, HCA can readily provide to the CC the additional data (that the CC appears to have been unable to source) relating to private patient income derived by a number of NHS trusts in London.

Demand for private healthcare services in London is set to rise

- 4.21 The CC has not undertaken a forward looking assessment of the supply of healthcare in London. This contradicts statements made by the CC in its consultation on the Guidelines, where the CC noted that market investigations are "*forward-looking exercises*".⁶⁹ Below, HCA outlines the future expectations for the London market.

London's population is expected to grow considerably

- The population of London is estimated to grow around 10.8% from 2013 to 2021, compared with 5.9% for the rest of England excluding London. This growth in population bears a considerable significance when considering its distribution across age categories. **Table 2** below shows expected population growth against the proportion of HCA's patient base for 2011.

⁶⁷ HCA recognises that the CC has typically used a mixture of admissions and revenue data to assess the market. However, HCA has only been able to obtain reliable data on revenue from those providers which make such data available.

⁶⁸ Hospitals for which data was available for all five years: Imperial College Healthcare NHS Trust, The Royal Marsden NHS Foundation Trust, Royal Free London NHS Foundation Trust, Royal National Orthopaedic Hospital NHS Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, University College Hospitals London NHS Foundation Trust, The London Clinic, King Edward VII, Bupa Cromwell, St. John and St. Elizabeth Hospital, and HCA (excl. NHS Queens, NHS Christie, NHS UCH, Galen Healthcare, HCA Labs and HCA Group. Figures for the NHS Trusts relate to private and overseas patients where available; where unavailable 'Non-NHS Patient Care Income' was used.

⁶⁹ For example, see the CC's Market Investigation Guidelines consultation, April 2011, para 8.

Table 2 Age composition of HCA's patients and projected growth in London's population⁷⁰

Age group	Proportion of HCA's patient base	Proportion of HCA's patient base by revenue	Expected population growth (London) 2013-2021
0-10	[X]	[X]	[X]
11-20	[X]	[X]	[X]
21-30	[X]	[X]	[X]
31-40	[X]	[X]	[X]
41-50	[X]	[X]	[X]
51-60	[X]	[X]	[X]
61-70	[X]	[X]	[X]
71-80	[X]	[X]	[X]
81 and over	[X]	[X]	[X]

Source: HCA analysis

- The data above shows considerable growth in population across key demographics for HCA's customer base, with the population size of patient ages accounting for 90% of admissions and around 85% of revenue growing faster than the average population for England excluding London. HCA expects the growth in key age groups of the London population to fuel further demand for private healthcare services in London. The NHS Framework for Action for London (July 2007) notes these demographic trends and comments: "A population that is both bigger and older will have a significantly greater need for healthcare".⁷¹

London's PMI penetration is already high, and expected to remain resilient

- As the CC notes, London is the most affluent region in the country, with disposable income per head 30% higher than the national average in 2010. The CC notes that "this affluence, together with the presence of major corporations whose employees may benefit from employer healthcare schemes, drives penetration of private medical insurance, with an estimated 17.5 to 18.5 per cent of the population being covered by a policy".⁷² This is also far higher than the UK average, which at last estimate stood at around 12%.⁷³ HCA notes that Laing & Buisson's "neutral" forecast expects stable demand for private medical cover in 2013 alongside "healthy demand for company paid medical cover".⁷⁴

⁷⁰ This data was cleaned applying the methodology used by the CC in its initial PCA from Q1 2013. It only considers patients where CCSD codes were present, and takes 2011 as the most recent year for which data was whole.

⁷¹ www.nhshistory.net/darzilondon.pdf, page 6, para. 7.

⁷² CC, PFs, Appendix 6.3, para. 21.

⁷³ CC, PFs, Appendix 6.10, para. 19.

⁷⁴ Laing & Buisson, Health Cover 2012, page 51.

Economic indicators highlight positive signs going forward

- It is noted in Laing & Buisson that "*the business cycle, which determines corporate and personal incomes, is the underlying determinant of private medical cover spending*". HCA notes that based on most recent forecasts UK GDP is expected to be around 11% higher in 2017 compared to 2011. Further, average earnings are expected to see strong increases, gaining around 2.7% year on year in 2014, increasing to 3.6% year on year to 2015 and 4% year on year to 2016.

Disease prevalence is difficult to predict – but indicates the potential for growth

- After undertaking research into a number of potential sources for forecast data, HCA considers that, whilst there is evidence illustrating the likely increase in the penetration rate of some acute diseases going forward,⁷⁵ there is no reliable predictor to say whether this holds across the industry as a whole. Historically, disease prevalence has been somewhat difficult to forecast. However, as the London population continues to grow, and live longer, the absolute number of patients demanding private healthcare will increase.

4.22 The evidence set out above indicates that patient numbers in London are likely to grow significantly, alongside continued growth in the number of end consumers with PMI cover. As outlined in section 6, HCA submits that the anticipated ongoing growth in demand for private healthcare in London will increase the incentives for new entry and expansion. Indeed, HCA notes that new entry is already planned next year targeted at central London referrals from two new private providers as well as expected significant growth in PPUs. Further detail of this future entry and expansion is set out in section 6.

⁷⁵ For example, recent research by the British Journal of Cancer projects that the number of people living with cancer in the UK is increasing by around 3.2% each year. Further, it finds using all four of its scenario analyses that increases in cancer prevalence are expected from 2010 to 2040. See Maddams, Utley and Moller, Projections of cancer prevalence in the United Kingdom, 2010-2040 (British Journal of Cancer, 2012, pp 1195-1202).

5. COMPETITIVE ASSESSMENT IN LONDON

Key Points

- The CC's conclusion that competition is not working well in London and that HCA faces weak competitive constraints is at odds with the high quality of care in the capital and with the CC's own case study in London.
- The CC's conclusion is based on a flawed and incomplete market definition analysis.
- The CC has underestimated the strength of competition faced by HCA, which drives its high quality of care and high levels of investment – including from other private hospitals and PPU's in central London, Greater London and beyond, NHS-funded providers and leading international providers.
- The CC has underestimated the potential for supply-side substitution between specialties.
- The CC provides no convincing evidence that the market is not functioning competitively: the CC's shares of supply are unreliable and not appropriate without a full market definition analysis; the CC's self-pay Price-Concentration Analysis is not robust and provides no reliable evidence in relation to London; the CC's profitability analysis significantly overestimates HCA's and the market's profitability.
- The CC provides no evidence that HCA's management of PPU's or acquisition of GP practices gives it any competitive advantage now or in the future.

Introduction

- 5.1 As set out in section 3, the core element of HCA's commercial strategy is continuous investment in its services to achieve a superior level of quality compared to its rivals. HCA's level of investment has been consistently higher than that of other providers and continues to increase. HCA's high quality offering is measurable and quantifiable and supported by submissions from PMIs. The CC also recognised that quality of care in London is seen to be high and this is a key factor attracting patients to treatment in the capital.⁷⁶
- 5.2 However, the CC found *"the central London market to be highly concentrated and that the competitive constraints currently exerted on HCA by other private hospital operators and PPU's in central London are weak. [It] also considered hospitals in the greater London area and the NHS, and found these to be weak constraints on HCA"*.⁷⁷
- 5.3 HCA's track record in competing to create high quality, efficient hospitals is simply inconsistent with the CC's conclusion that it faces only "weak" competitive constraints. It is only as a result of strong domestic and international competition that HCA has attained and then sustained its position as a high quality provider.
- 5.4 A competition analysis that takes into account all evidence, including on quality, investment and innovation, would reveal that HCA operates in a highly competitive market.
- 5.5 This section sets out HCA's concerns with the CC's analysis of market definition and competitive constraints in London. This includes the following sub-sections:
- The flaws in the CC's analysis of market definition.
 - The underestimation of a number of important competitive constraints on HCA.

⁷⁶ CC, PFs, Appendix 6.10, paras. 6 – 13.

⁷⁷ CC, PFs, para. 29.

- Concerns with the CC's analysis of outcomes, including its use of shares of supply, its price concentration analysis and its profitability analysis.
- The flaws in the CC's conclusion that vertical relationships with consultants and PPUs might reinforce HCA's position.

(1) The CC has not performed a robust market definition analysis

5.6 HCA submits that the CC's conclusions on market definition are incorrect and not supported by robust evidence or a proper analysis of that evidence.

- The CC has not applied a robust methodology to define the boundaries of the relevant market in the supply of private healthcare services, and in particular has failed to conduct a proper analysis of patient preferences and demand.
- The CC has interpreted incorrectly the evidence it has collected, including the evidence that is contained in its patient survey.
- The CC's methodology, interpretation of evidence and conclusion on market definition in the PFs is at odds with the CC's Guidelines.

5.7 As a result of these three failings, the CC has drawn too narrow a boundary around the market in which HCA competes, on both the product and geographic dimensions.

Incorrect methodology to analyse the relevant market in which HCA competes

5.8 Although the CC noted that in relation to its analysis of demand-side alternatives it will consider patient reactions to a small increase in price or a decrease in quality,⁷⁸ in practice it has not conducted such an analysis. It has instead used evidence only on patients' willingness to substitute between alternatives (different products and locations) at *current* price and quality levels. This is not an appropriate or robust basis on which to draw conclusions about market definition, or on the degree of competition that is exercised by certain categories of providers.

5.9 In relation to the NHS, the CC has looked only at patient choice between private and NHS-funded care based on the current competitive offer of individual private healthcare providers, rather than considering what patients would do if that offer changed for private healthcare providers as a whole. For example, when patients were asked which other hospital they would have used if the hospital they attended had not been available, one of the options provided by the CC was to go to "another private hospital".⁷⁹ This question therefore implicitly assumes that the offer at alternative private hospitals remains unchanged (both in terms of price and quality of care).

5.10 In other words, the CC's patient survey provides information only about each patient's "next best alternative". This information is simply not appropriate in the context of analysing competitive constraints in a market investigation. These questions cannot provide information on how many patients would actually change to any one of these alternatives if the value for money of their current provider were to change. They help even less in answering the appropriate question for the definition of the relevant market, which is whether patients would switch to public healthcare options if the offer of all private hospital operators

⁷⁸ CC, PFs, para. 5.9.

⁷⁹ CC, Patient Questionnaire, Question D6.

was to worsen at the same time. While there can be some use for similar questions in merger cases, where it is important to understand the closeness of competition of *individual players* (including the merging parties),⁸⁰ they are clearly unhelpful in a market inquiry.

- 5.11 The CC's own guidelines "*Good practice in the design and presentation of consumer survey evidence in merger inquiries*" discuss best practice on asking customers (in this case, patients) about their response to hypothetical changes in the value for money of a product.⁸¹ The CC asked patients of the Royal Bournemouth and Christchurch Hospital and Poole Hospital NHS Foundation Trusts what they would do in the event of an increase in waiting times, as a proxy for quality.⁸² The CC could have chosen to ask these questions in this inquiry, instead of the far less relevant question on the next best alternatives in the event that a facility closed down.
- 5.12 A similar point applies in respect of the CC's analysis of patient willingness to substitute between hospitals in different locations, it has looked only at current travel patterns or patients' willingness to travel based only on the current competitive offer of private hospitals in different locations. The CC has not therefore conducted an analysis of patient behaviour in the event of a small but significant worsening of the value for money of all private healthcare facilities in central London.
- 5.13 Therefore, the right approach (consistent with the market definition methodology and CC precedent and the Guidelines) would have been to test whether patients would consider NHS-funded care in a situation where the value for money of all private healthcare providers deteriorated in a small but significant way.
- 5.14 Even if the CC sought to obtain a "ranking" of different providers, the CC's patient survey does not allow it to do this. The CC has asked all patients what they would do in the event that their current provider was unavailable. In so doing, it has obtained information on the *average* patient choice but has not isolated the choices of *marginal* patients. It is the response of marginal patients that will provide information on how providers should be ranked in terms of competitive constraints. In a purely horizontally differentiated market (such as grocery retail markets, in the context of which these questions are often asked), it may be reasonable to assume that average and marginal patients' preferences on the ranking of competitors will be the same. However, this assumption cannot be made in a vertically differentiated market, as recognised in the CC's own guidelines "*Good practice in the design and presentation of consumer survey evidence in merger inquiries*".⁸³ Healthcare provision is a vertically differentiated market (the CC accepts there are quality variations between providers), and marginal patients may be more likely to consider the NHS than patients are on average (for example, patients that are particularly price sensitive).
- 5.15 Furthermore, when asking the question: "*Had the hospital you attended not been available (e.g. say it had closed down), which other hospital would you have used?*", the CC only permitted patients to input one answer to this question. It may have been the case that patients valued each of the alternatives equally or that patients considered attending an NHS PPU a "very close" second preference. A consumer's second or third choice product

⁸⁰ In particular, these questions can be useful to understand "Diversion Ratios".

⁸¹ CC, Guidelines on Good practice in the design and presentation of consumer survey evidence in merger inquiries, paras. 3.33 - 3.38.

⁸² CC, Final report into The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust / Poole Hospital NHS Foundation Trust, para. 6.96.

⁸³ CC, Guidelines on Good practice in the design and presentation of consumer survey evidence in merger inquiries, footnote 5.

substitute can also form part of the same relevant market. However, such preferences were not recorded due to the CC's survey format.

5.16 In addition, HCA believes that patients would not necessarily understand the meaning of the term "PPU", and it cannot be assumed that patients would necessarily understand that this meant the private patient services at an NHS hospital such as the Royal Marsden.

5.17 The CC has therefore simply adopted the wrong methodology in its analysis of product and geographic market definition. This methodology is one that is bound to produce results that point to a much narrower market than actually exists.

Incorrect interpretation of the evidence on market definition

5.18 HCA sets out below the CC's incorrect interpretation of evidence on patient preferences in relation to both a) the NHS and b) healthcare providers outside of central London.

a) CC's analysis of the evidence on patient demand for the NHS

5.19 The NHS interacts in a number of ways with the privately-funded healthcare sector, including as:

- a supplier of national health services to patients free at the point of delivery, representing an alternative to privately-funded healthcare;
- a main employer of most consultants who also practice privately; as a supplier of privately-funded healthcare services through dedicated and non-dedicated NHS facilities;
- a partner with private healthcare providers (e.g. PPU partnerships; development/provision of specialist treatments, equipment or research);
- a customer of private healthcare providers when NHS patients are treated in private hospitals; the main funder of most GPs; and
- the source of all training for almost all medical and clinical professionals.⁸⁴

5.20 HCA is pleased that the CC has recognised the competitive tension between NHS-funded care and private healthcare providers. For example, the CC noted that "*[i]mprovements in the fabric of NHS hospitals, and, in particular, reductions in the length of waiting lists for surgery increased the degree of competitive tension between private healthcare and its free rival*".⁸⁵

5.21 However, when it comes to its market definition analysis the CC has stated that:

- "*privately-funded medical treatments appear to be in a separate product market from NHS-funded medical treatments*".⁸⁶

5.22 HCA's view is that this conclusion does not apply to London. In reaching its conclusion that NHS-funded medical treatments are outside of the relevant product market for private healthcare providers, the CC relies on previous CC, OFT and EU merger investigation decisions. These past decisions, however, did not have the benefit of the evidence before

⁸⁴ CC, PFs, para. 4.15.

⁸⁵ CC, PFs, para. 2.9.

⁸⁶ CC, PFs, para. 5.16.

the CC relating to NHS competitive constraints in London and do not represent a rigorous analysis of such constraints. It is not appropriate for the CC to reach a conclusion about market definition by simply citing older precedents, which contain no robust analysis, especially given the evidence before the CC to the contrary.

- 5.23 In addition, the CC concluded that the results of its patient survey are consistent with the conclusion of these previous merger decisions, namely that NHS-funded medical treatments are in a separate market to private healthcare providers.⁸⁷ As set out in the previous sub-section, the methodology used by the CC to analyse market definition will necessarily underestimate patient willingness to substitute between different providers in the event of a small but significant worsening in the value for money across all providers. However, the CC has failed to recognise this and has misinterpreted the survey evidence it has available.
- 5.24 In fact, as the CC should recognise, the relatively low number of patients considering NHS options at **current** price/quality levels is entirely consistent with healthy competition between private healthcare providers and with patients being satisfied with their existing private healthcare provision. Indeed, the finding by the CC that around one fifth of insured patients would consider the NHS as an alternative, even at current levels of price and quality, is a clear indication of how closely these alternatives are seen by patients. That proportion would clearly be significantly higher if the offering of *all* private healthcare providers deteriorated in a small but significant way (the appropriate market definition test). In a market where, as the CC recognises, there are significant fixed costs, this clearly points to a readiness to switch that presents a current and compelling competitive constraint on HCA.
- 5.25 The CC survey also found that 12% of self-pay patients consider NHS-funded care as their next best alternative. HCA submits that at current price and quality levels, this is a high proportion, a proportion that would inevitably be higher if patients were asked instead about their willingness to consider the NHS when confronted with a worsening of the offering of *all* private healthcare providers. In a high fixed cost industry even the underestimate of 12% is a very significant proportion of demand. It is hard to see how the CC could claim that an even higher proportion under an appropriately framed scenario would not point to a clear and present constraint from NHS providers.
- 5.26 The CC has stated that 90% of PMI patients said that the reason for them choosing privately-funded healthcare was to make use of their PMI. However, the CC failed to ask the questions required to establish PMI customers' willingness to consider the NHS at the point of purchasing their policies, and furthermore the CC failed to query whether policyholders' preferences change for highly complex procedures that may require intensive care support. In addition, if the CC wished to understand the competitive position of HCA in a particular area, it should have asked patients why they choose one policy over another, including one with or without HCA hospitals. Again, the CC failed to do this.
- 5.27 Lastly, we note that the CC failed to account for the fact that, in general, a patient follows clinical advice from their GP/consultant. Any analysis of demand-side substitution therefore needs to take into account the preferences and incentives of GPs and consultants. Looking only at patients' preferences, which the CC has done in the PFs (and incorrectly at that), will necessarily be incomplete. In its surveys of consultants and GPs, the CC has failed to include questions that would allow it to properly analyse the willingness of GPs and consultants to recommend NHS-funded care, in particular in response to a small but significant reduction in the value for money of all private healthcare providers.

⁸⁷ CC, PFs, para. 5.15.

5.28 The CC's survey of GPs suggests that GPs may be more inclined than patients to consider NHS-funded care. Specifically, the CC's GP survey shows GPs felt that the option of choosing private healthcare was more commonly raised by patients than by GPs.⁸⁸

b) CC's analysis of patient demand for hospitals outside of central London

5.29 The CC has concluded in its market definition assessment that "*special demand- and supply-side features*" mean that central London is a "*separate geographic market*".⁸⁹

5.30 HCA agrees that London presents certain features that make it different from the rest of the UK, for example, the high quality of care in private and NHS hospitals as well as PPU's located in London. As set out in section 3, HCA has made substantial investments in its hospitals to respond to the relatively higher quality of care available in London NHS hospitals.

5.31 However, HCA disagrees that the demand and supply side features identified by the CC mean that central London is a separate geographic market. In order to draw this conclusion, the CC implicitly relies on two assumptions, namely:

- that customers resident in central London are unwilling to substitute to hospitals outside of central London in response to a small but significant reduction in the value for money of private hospitals in central London (i.e. that they are somehow 'captive'); and
- that the remaining customers, i.e. those that are resident outside of central London, and comprise a significant proportion of HCA's business, who obviously do have a range of alternative local hospitals in their area, are not sufficient to prevent HCA from being able to exploit its supposed market power in relation to its so-called 'captive' customers.

5.32 The evidence before the CC clearly shows that both of these assumptions are incorrect.

5.33 HCA's hospitals draw [X] of patients from postcodes outside central London,⁹⁰ demonstrating that patients are prepared to travel to receive the quality of care that is right for them and that represents the best value. However, by the same token, these patients are also able to consider a more local hospital if the relative competitiveness of the hospitals changed. It is clear that all of these patients have alternative hospitals close to where they live.

5.34 Furthermore, HCA cannot and does not discriminate between patients with a central London and Greater London postcode, either in the prices or in the quality it offers to these patients. Nor is HCA able to discriminate between these patients on the basis of their willingness to travel. Therefore, the choices available to patients resident outside central London necessarily influence HCA's pricing strategy towards and quality of care for PMI and self-pay patients in a way that affects all HCA's customers, regardless of their location. The CC has either ignored or failed to grasp this fundamental point.

⁸⁸ 50% of Greater London based GPs stating that the option of going private was first raised by patients, as opposed to only 21% stating that it was raised by the GPs. For those patients without private medical insurance, 63% of Greater London-based GPs stated that using a private healthcare provider was first raised by patients, with only 12% stating that it was first raised by the GP. CC GP survey.

⁸⁹ CC, PFs, para. 5.70(c)(i).

⁹⁰ HCA, Response to the CC's London working paper, para. 3.4. Note that this analysis is based on identifying the proportion of patients that do not have a "London" postcode.

- 5.35 It is important because, even if the CC were correct to conclude that there were some so-called "captive" patients at central London hospitals (which HCA strongly disputes), these patients are not and cannot be treated in any way differently by HCA to those patients that are clearly able to substitute between providers inside and outside of central London. It therefore follows that HCA's offering to all its customers is constrained by the behaviour of a substantial proportion of its patients and their ability to substitute between central London and Greater London (and in some cases outside of Greater London) hospitals.
- 5.36 HCA notes Bupa's argument, set out by the CC, that:
- "Commuting patterns into central London overstate the catchment areas over which central London hospitals 'compete'. [...] For these customers [travelling into London for work] it may appear that hospitals closer to their home postcodes are possible alternatives [...] However, for many their local hospital may continue to be a weak alternative because they will begin their treatment journey with a consultant location inside central London who, being close to their place of work, is convenient to meet during their working day for their first consultation or diagnostic. Once the patient has met the consultant it becomes highly likely that they will receive inpatient care at a facility at which that consultant has practicing privileges".⁹¹*
- 5.37 Whilst the CC evidently gives weight to Bupa's view, the CC has not taken into account HCA's evidence on this issue.⁹² There is no evidence to support Bupa's assertion that commuting patterns overstate the competitive constraints from hospitals outside of London, and the lack of evidence has still not been addressed in the PFs. Nor has the CC looked into whether consultants in London hold practising privileges at hospitals in central and Greater London.
- 5.38 It is highly unlikely that commuters who work in central London but live outside of central London do not view hospitals more local to their home as alternatives to those in central London, and evidence previously supplied by HCA (which the CC fails to refer to) supports this.⁹³
- 5.39 The CC has previously cited evidence from employers indicating that *"employees would probably prefer to be treated at a hospital close to their home rather than to their workplace"*.⁹⁴ This has particular resonance in the case of inpatient care, which, by its definition, means spending a night in a hospital. It is after inpatient care that there is value in being closer to home immediately after treatment. Bupa itself acknowledges that patients prefer to go locally for inpatient treatment.⁹⁵
- 5.40 Therefore, the CC has no basis for its conclusion that commuters to central London are somehow "captive" to central London hospitals, despite residing outside of central London. Their choice of central London hospitals is entirely driven by the competitiveness and quality of service. Put simply, HCA must provide a compelling quality proposition to compete with Greater London hospitals and attract patients to its hospitals. If HCA's quality deteriorated, it would be very difficult to convince patients to travel past their local hospitals.

⁹¹ CC, PFs, Appendix 6.10, Annex A, para. 9.

⁹² See, for example, HCA, Response to the CC's working paper "Private healthcare in central London: horizontal competitive constraints".

⁹³ HCA, Response to the CC's working paper "Private healthcare in central London: horizontal competitive constraints", para. 3.14.

⁹⁴ CC, PFs, Appendix 2.1, para. 23.

⁹⁵ HCA, Response to CC working paper on the London market, para. 3.14 (iii).

- 5.41 As for the view that patients resident in central London are somehow "captive" to central London hospitals, the evidence before the CC simply does not allow it to form such a view.
- 5.42 The CC's evidence is based on an observation (on an incomplete data set) that the area from which central London hospitals currently attracts patients is wider than the area from which hospitals outside of central London attract patients, and that its analysis suggested that 94.5% of patients resident in central London attended a central London hospital and 53.4% of patients resident in Greater London chose a central London hospital.
- 5.43 This evidence relates only to central London patients' historical travel patterns between central and Greater London hospitals. Therefore, the analysis is based on the current (and historical) relative competitive offering of hospitals in central and Greater London. This therefore provides no information about what patients' travel patterns would look like if the competitive offering of the central London hospitals worsened (e.g. on choice, quality and price) relative to those outside of central London.⁹⁶ Without this, the evidence that the CC pointed to is entirely consistent with a healthy, competitive market where the quality of HCA's hospitals is able to attract a wide range of patients.
- 5.44 Indeed, the CC's own analysis suggested that patients choose to be treated at hospitals in central London because they view the quality at these facilities as higher.⁹⁷ The CC does not present any evidence to suggest that patients based in central London would not be similarly willing to travel if they felt the most competitive offer – based on price and quality – was located elsewhere. Instead, the CC simply observes that a large number of patients resident in central London went to central London hospitals, but this observation is still consistent with hospitals from outside of central London acting as a competitive constraint on hospitals within central London.
- 5.45 It should also be noted that the list of hospitals and PPUs used by the CC to conduct its comparison of Greater London and central London hospital usage is significantly incomplete, casting doubt on the reliability of the CC's evidence.
- 5.46 PMIs have a role in directing patients to hospitals outside of central London.⁹⁸ The CC correctly observed that: "*Bupa's move to open referrals gives it more control over the flow of patients and is likely to enhance its ability to direct patients to its hospitals*".⁹⁹ PMIs do indeed have the ability and incentive to control patient pathways, including the geographic location of the services patients receive. HCA submitted evidence showing that Bupa's Open Referral strategy in London was predicated on moving patients to outer London hospitals,¹⁰⁰ and that there has been a successful take-up of this directional policy.¹⁰¹ HCA also noted that AXA PPP had been similarly successful in increasing the uptake of its Corporate Pathways product. As this trend continues, the impact on HCA will be material. [X].
- 5.47 In addition, the CC has noted that the speciality mix appears to be different in central versus Greater London.¹⁰² However, the CC has been highly selective in its summary of that

⁹⁶ In particular, whether the 94.5% and 53.4% of patients resident in central London and Greater London respectively that used a central London hospital would continue to do so if the competitive offer of that central London hospital worsened compared to others in Greater London.

⁹⁷ CC, PFs, Annex 6.10, paras. 6 – 13.

⁹⁸ HCA, Response to the AIS, paras. 3.18 and 6.98 – 6.102.

⁹⁹ CC, AIS, para. 156.

¹⁰⁰ HCA, Response to the Market Questionnaire, Exhibit 11.1.

¹⁰¹ HCA, Response to the CC's London market working paper, paras. 3.14(ii), 8.13.

¹⁰² CC, PFs, Appendix 6(10), para. 23.

information. In fact, the specialty mix in central and Greater London is broadly similar. Even where there are some differences in the specialty mix, this is not informative of providers in these two areas being in separate markets. There will always be differences in the exact specialty mix and quality levels cross different providers, but this is not evidence of a systematic difference that suggests that providers are in separate geographic markets.

5.48 For areas outside of central London, the CC conducts a catchment area analysis, which, as the CC notes,¹⁰³ provides a conservative view of which hospitals might be a competitive constraint within a geographic area. The CC did not apply such an analysis to central London. Nothing in the CC's evidence on patient preferences justifies this departure. In taking the arbitrary decision to use a strict cut-off point based on "roads", the CC makes an absurd assumption that a patient is unwilling to visit a hospital, no matter how good or convenient, simply because it means crossing the London South Circular (A205). The CC must conduct a catchment area analysis for HCA's facilities. HCA does so (see the results at paragraphs 5.86).

5.49 Overall, the CC has no basis in its analysis of patient preferences to provisionally conclude that hospitals outside of central London are outside the geographic market for central London hospitals. The available evidence compels the CC to extend the geographic boundaries of the market to include competitors located outside central London.

The CC's analysis is inconsistent with the Guidelines

5.50 The Guidelines afford the CC some flexibility in conducting a hypothetical monopolist test.¹⁰⁴ However, the Guidelines also make clear that a robust market definition analysis is important if the CC seeks to rely on measures of market share:

- *"The calculations of market shares, numbers of firms, concentration ratios and the HHI generally depend on being able to identify the boundaries of the market concerned".¹⁰⁵*
- *"The HMT is more likely to be used to check that the market has not been defined too narrowly in cases where the CC's findings include a finding that high concentration is a feature harming competition".¹⁰⁶*
- *"The CC will consider how confident it is that it has defined the market neither too widely nor too narrowly before identifying market concentration as a feature harming competition".¹⁰⁷*

5.51 The CC's analysis in this market investigation is at odds with its Guidelines. The CC has not conducted a robust market definition analysis and the geographic boundary it uses for central London can hardly be described as reliable. In particular, the CC has failed to assess patient substitution patterns in the event of a small but significant worsening in the value for money of private healthcare providers.

5.52 In spite of this inherent unreliability in its market definition, the CC has proceeded to not only place heavy reliance on share of supply metrics based on this definition of the market but also identify the level of concentration itself as a feature of the market that adversely effects

¹⁰³ CC, PFs, para. 5.64.

¹⁰⁴ CC, Guidelines, para. 140.

¹⁰⁵ CC, Guidelines, Annex A para 8.

¹⁰⁶ CC, Guidelines, para. 141.

¹⁰⁷ CC, Guidelines, para. 195.

competition. In the absence of a robust market definition, the CC cannot reasonably place such weight on the shares of supply it derives when coming to broader conclusions about the level of competition in the market. HCA is also concerned that the CC does not appear to have conducted any robustness checks using its patient database to assess if its market definition is too narrowly defined.

5.53 In summary, the CC's overly narrow approach has severely distorted the product market scope (e.g. by excluding important competitors such as major NHS and international hospitals) and geographic market scope (e.g. excluding hospitals purely because they are located the other side of the A205) of its market definition analysis. The CC should not heavily rely on crude measures of shares of supply, but should instead have conducted a more rigorous competitive assessment.

(2) The CC has underestimated the competitive constraints in London

5.54 Even if one accepts the CC's overly narrow market definition, HCA faces strong competitive constraints from other private healthcare providers, particularly when taking into account competition on quality of care.

5.55 Following a description of the evidence on the strong competition between it and other central London private providers, HCA describes the weaknesses in the CC's analysis of the following competitive constraints, which the CC has so far ignored:

- Hospitals located outside of central London (whose catchment areas overlap with those of HCA's hospitals);
- The strength, capabilities and growth of other central London providers – there is little real analysis of individual competitors, such as the Bupa Cromwell, King Edward VII and BMI;
- Leading overseas hospitals;
- NHS hospitals; and
- The high potential for supply-side substitution among providers.

Strong competition from other private healthcare providers in central London

5.56 The CC found "*the central London market to be highly concentrated and that the competitive constraints currently exerted on HCA by other private hospital operators and PPUs in central London are weak*".¹⁰⁸

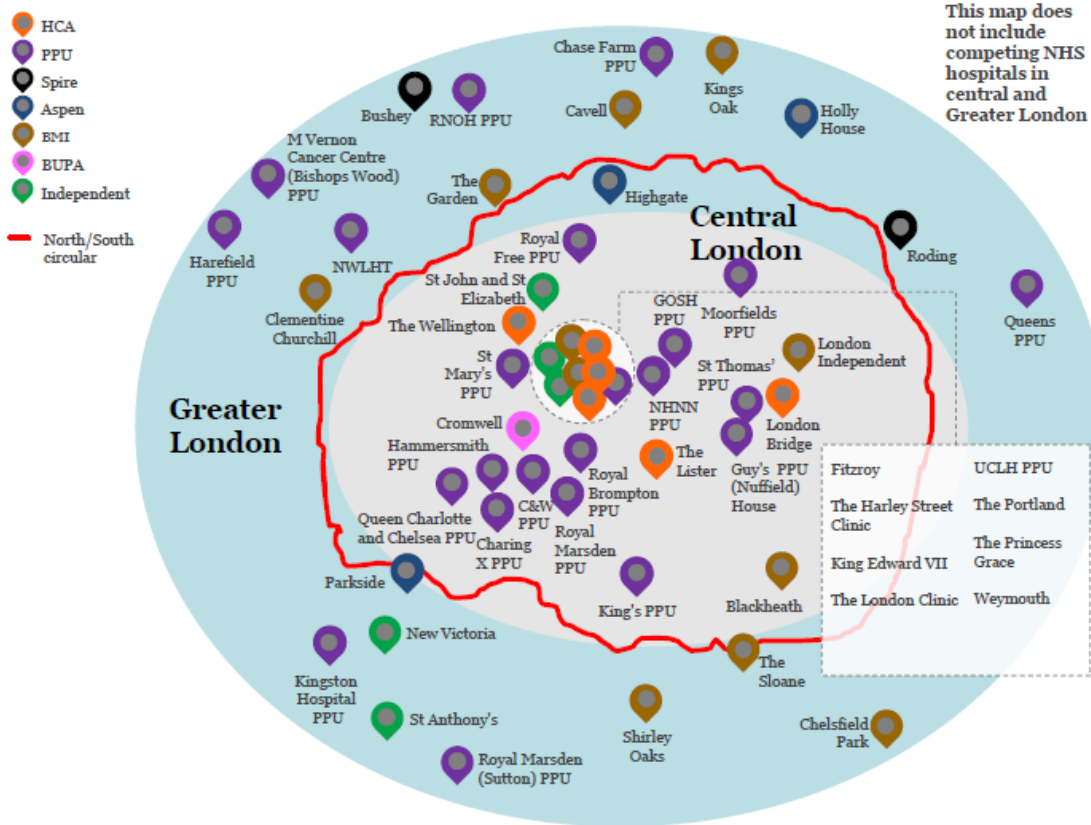
5.57 HCA submits that this provisional conclusion is incorrect and not supported by the available evidence.

5.58 The CC heavily relied on its analysis of shares of supply in order to draw this conclusion. However, these shares of supply do not provide evidence that HCA's offering to patients is anything other than competitive. Similarly, there is no such evidence in the CC's pricing or profitability analysis, as discussed later in this response. The shares of supply computed by the CC are also highly unreliable and overstate HCA's share.

¹⁰⁸ CC, PFs, para. 29.

- 5.59 HCA has described, at length, the strength of competition it faces from other private hospitals in London, and we refer the CC to those submissions.¹⁰⁹ In section 3 above, HCA described how it competes with other hospital operators (including the NHS) on quality, and in section 4, HCA described why competition over quality of care had particular importance in London.
- 5.60 HCA competes with over 50 private healthcare facilities across London. See **Figure 3** below for an illustration of the vast number of competing private hospitals and PPUs in London. In central London alone, HCA competes with more than 20 other private hospitals and PPUs.

Figure 3 Map of private hospitals and NHS PPUs¹¹⁰ in London (excludes competing NHS hospitals)



- 5.61 HCA's quality and investment is driven by the strong competition HCA faces to attract patients from other private providers in London. **Appendix 7** sets out a number of business cases submitted by HCA UK hospitals for requests for funding. These business cases show that there have been a sizeable number of investments made by HCA in direct response to investments made by its competitors in London and internationally. For example, in response to competitors in London expanding or upgrading their services, as a result of competitors launching medical technologies, or as a result of improvements in the level of comfort to patients offered by competitors. Section 6 below describes how these competitors have been able to significantly expand and upgrade their facilities.

¹⁰⁹ HCA, Response to the Issues Statement, Section 5; Response to the CC's London working paper; See also, HCA, Response to the Market Questionnaire, Exhibit 12.2.

¹¹⁰ The above illustration is a conservative snapshot of private healthcare providers, as some NHS Trusts do not operate dedicated PPUs, but do nonetheless offer private patient services, such as St. George's Healthcare NHS Trust in south London.

Competition from London based PPUs

- 5.62 In relation to PPUs specifically, the CC includes private patients services provided through NHS PPUs and correctly finds that PPUs in central London "*appeared to be more effective competitors than in other parts of the country*".¹¹¹ HCA agrees, and sets out evidence in **Appendix 1** (and section 6 below) describing how London based PPUs are set to significantly expand their operations, including the development of standalone PPU facilities.
- 5.63 Despite forming the view that London PPUs are more effective competitors, the CC provisionally concludes that PPUs are likely to be a weak constraint on operators in London.
- 5.64 The CC's view appears to be based on the CC's flawed share of supply findings (which HCA addresses from paragraph 5.133 below) and on the results of one incorrectly framed question from the CC's patient survey report.
- 5.65 The CC interpreted the results of this survey question as indicating that "*patients typically do not view PPUs as a substitute for private hospitals*". However, such an interpretation is deeply flawed:
- First, the CC's survey result was not only based on patients using London private hospitals / PPUs, but on patients across the UK. The CC itself recognised that PPUs in London are more effective competitors, but the results of the CC's patient survey will necessarily downplay this relatively stronger competitive constraint as it fails to isolate responses of patients using London based facilities.¹¹² In other words, the same (properly formulated) question posed to London patients would be likely to elicit that in London PPUs are seen as an effective alternative to private sector hospitals.
 - Secondly, the survey design raises questions about the reliability of this evidence. The CC chose to use the term "PPU" in the survey. HCA has often found from its own experience that its patients do not necessarily understand the term "PPU". Patients could have misunderstood the term or conflated it with the notion of an amenity pay bed. Patients on the whole do not distinguish in their own minds between "PPUs" and "private hospitals", and it is likely that the poor way this question has been formulated, putting forward PPUs as distinct from private hospitals, has inadvertently encouraged the patients questioned to assume that an NHS PPU is something inferior to a private hospital. If the choice had been presented differently, for example, "the private patient services at the Royal Marsden Hospital" in respect of cancer care, the CC would probably have found there was a very different outcome to this question.
 - Thirdly, the survey evidence that the CC cites (there is only one question referenced by the CC) cannot be used to support the conclusion being reached by the CC. The flawed survey design meant that each patient was forced to only enter a single choice as to where they would alternatively visit should the private hospital they attended not be available. However, the patient could have valued PPUs and private hospitals equally, or could have ranked them as very close substitutes, but this would not be captured due to the crude, binary format of the survey.

¹¹¹ CC, Appendix 6.3, para. 26(b).

¹¹² HCA submitted in response to the CC's consultation on the draft patient questionnaire that the survey sampling methodologies, which failed to ensure statistically significant samples for particular regions would make it virtually impossible to make effective comparisons or draw effective conclusions within or across regions.

- Fourthly, the CC has ignored the fact that it is consultants that are a key decision-maker in terms of which hospital facility they practise at and so treat patients. As observed by the London Clinic, "*consultants had a huge influence on where patients received their treatment*".¹¹³ Yet the CC's assessment of competition in London does not analyse the important views of consultants. HCA finds that consultants are motivated to practise at those facilities where they can deliver safe, high quality care.¹¹⁴ Indeed, there is a contradiction in the CC's own survey, in that it finds that patients will largely follow the recommendations of their consultants – many of whom (in London) have practising privileges in PPUs.

- 5.66 HCA has previously described how PPUs based in London offer a quality service and serve as a significant constraint on HCA's business.¹¹⁵
- 5.67 As the CC's own data shows, nine of the top 10 PPUs by revenue are based in London.¹¹⁶ These nine PPUs are responsible for close to half of the total private patient income in the UK overall.
- 5.68 The high level of quality at PPUs is attributable to that fact that many PPUs (especially in London) are attached to well-respected NHS facilities with strong reputations and/or teaching hospital status.¹¹⁷
- 5.69 PPUs have ready access to a large base of consultants working at the same facilities, as the majority of consultants perform a portion of their work at the NHS. As noted in HCA's Response to the Issues Statement,¹¹⁸ whilst a consultant holding an NHS post can take his/her private practice either to the Trust's own PPU or to an independent hospital (or both), NHS Trusts provide financial incentives to consultants to expand their practice within the Trust's PPU facility and disincentives to treat patients elsewhere. As highlighted by a number of private healthcare providers, patients' choice of hospital is highly consultant led, which further increases PPUs' competitive advantage over private healthcare providers.¹¹⁹ The CC has failed to take this analysis into account as part of its assessment.
- 5.70 In addition, as outlined in its response to the CC's London market working paper,¹²⁰ PPUs enjoy many advantages over private sector operators, such as HCA. These advantages were echoed by AXA in its response to the PFs, where it noted that PPUs, particularly in London, often had access to high acuity services and potentially lower cost diagnostics and consumables than stand-alone private hospitals.¹²¹ For example, the ability to readily transfer private patients into the ITU of the main NHS hospital (at no cost to the patient or insurer) provides PPUs with an enormous advantage in the areas of complex care that necessitate such support.
- 5.71 Insurers have made comments indicating that PPUs in London are not weak competitive constraints. For example, AXA PPP describes the Royal Marsden's PPU (one of HCA's

¹¹³ TLC Hearing Summary, para. 4.

¹¹⁴ See, for example, Consultant submissions 19, 36, 38 and 39 to the CC.

¹¹⁵ HCA, Response to the CC's London working paper, section 4; HCA, Response to the Market Questionnaire, Exhibit 12.2.

¹¹⁶ CC, PFs, table 2.2.

¹¹⁷ OFT, Private Healthcare Market Study, April 2012, para. 4.24.

¹¹⁸ HCA, Response to the AIS, para. 7.3(ii).

¹¹⁹ [redacted].

¹²⁰ HCA, Response to the CC's working paper "Private healthcare in central London: horizontal competitive constraints", para. 4.7.

¹²¹ AXA PPP, Response to the PFs and Remedies Notice, para. 2.44.

closest competitors) as an "elite" hospital.¹²² With regards to PruHealth's and Simplyhealth's hospital networks, a number of London based PPUs are only available to patients on its top-end network products, the Premier network and Metropolitan network, respectively.¹²³ In its brochure for corporate clients, Aviva refers to the PPUs in its Trust Care network as comprising "excellent private patient units of NHS Trust and partnership hospitals".¹²⁴

5.72 Internal HCA documents submitted to the CC [REDACTED].¹²⁵ [REDACTED].¹²⁶ [REDACTED].

5.73 In addition to the domestic constraints faced by HCA from PPUs, HCA's internal documents note that PPUs also constrain HCA's hospitals in respect of international patients. For example, [REDACTED].¹²⁷ [REDACTED].¹²⁸

5.74 In respect of the CC's share of supply tables, the CC has failed to obtain data from all PPUs (as well as some private hospitals). The result is not only that HCA's share of supply is overstated, but that the competitive presence of PPUs is understated. These technical errors in the CC's analysis are described in more detail below (see from paragraph 5.133 below).

Strong competitive constraints from Greater London

5.75 HCA has previously submitted that there are alternatives outside of central London available to patients, which exert a competitive constraint on its central London hospitals:

- HCA has already provided the CC with a list of private hospitals and PPUs that exert a significant competitive constraint on each of its hospitals,¹²⁹ including in Middlesex, Hertfordshire, Essex, Herts, Surrey, Berkshire and Kent – well outside central London.
- In its response to the CC's London market working paper, HCA provided an analysis showing that there are substantial and credible alternative providers which compete in all of the "top 10" areas of residence for HCA's patients outside of central London.¹³⁰ The mere fact that HCA draws a large number of patients from an area extending to Greater London and the Home Counties means that a large proportion of HCA's customer base is in competition with providers located outside central London.¹³¹
- Hospitals in outer London offer advanced medical facilities, for example, level 3 intensive care units (e.g. BMI's Clementine Churchill Hospital in Harrow) and complex tertiary services (e.g. cardiac services at St. Anthony's in Cheam, or cancer care at BMI Bishops Wood in Northwood, where a CyberKnife system is available to patients).¹³²

¹²² CC, PFs, Appendix 6.10, page 26.

¹²³ For PruHealth, this includes the Royal Brompton Hospital's Reginald Wilson Ward and the Royal Marsden Hospital - Granard House. For Simplyhealth, this includes the Great Ormond Street Hospital and the National Hospital for Neurology.

¹²⁴ Aviva, "Solutions for companies covering 2-249 employees... ..At a glance".

¹²⁵ [REDACTED].

¹²⁶ [REDACTED].

¹²⁷ [REDACTED].

¹²⁸ [REDACTED].

¹²⁹ HCA, Response to the CC's Market Questionnaire, Exhibits 12.1 - 12.2.

¹³⁰ For example, Harrow, Kingston upon Thames, Watford, Bromley, Chelmsford, Redhill, Twickenham and Hemel Hempstead, etc.

¹³¹ HCA, Response to the CC's London market working paper, paras. 3.9 - 3.10.

¹³² HCA, Response to the CC's Market Questionnaire, Exhibit 12.2.

- HCA also noted that PMIs typically market both central and Greater London providers to their policyholders, something which confirms that they consider hospitals outside central London as viable, competitive alternatives to HCA's central London hospitals.¹³³
- 5.76 The CC has incorrectly concluded that central London is a separate geographic market, thereby ignoring all of this evidence. Although the CC notes that it will consider the constraints from hospitals located outside of London in its competitive assessment of the central London "market", it concludes that hospitals in the Greater London area are a "*weak constraint on HCA*".¹³⁴
- 5.77 In HCA's view, the CC's assessment of where the London market starts and ends appears to be completely arbitrary, (based, it would appear, on which side of a road a hospital is located) and does not take into account many private hospitals and PPUs that pose a significant competitive constraint on HCA. Some of these facilities are illustrated in Figure 3 above.
- 5.78 In its discussion of defining geographic markets, the CC states that hospitals' catchment areas can overlap, and this may provide an indication of the extent to which different hospitals are considered by patients to be substitutes,¹³⁵ and therefore competing with each-other.
- 5.79 The CC also recognises that this kind of analysis is conservative, as it can significantly underestimate the size of the relevant geographic markets: "*the catchment area around a hospital reflects the area from which the hospital draws the majority of its patients and does not necessarily fully reflect patients' willingness to travel in response to a small change in the price or quality of the services provided by the hospital they have attended. This may result in geographic markets defined on the basis of catchment areas possibly being too narrow in some instances*".¹³⁶ This is particularly the case in industries characterised by substantial fixed costs and where the loss of even a small number of patients is likely to be unprofitable.
- 5.80 Furthermore, for hospitals in central London, a catchment area analysis is likely to be more conservative than for many other geographic areas in the UK. This is because where a patient is recorded as coming from a central London postcode, this may correspond to their work address, rather than their residential address. This may therefore mask the main residence of the patient and underestimate the extent to which patients travel to central London hospitals from outside of London, if those main residences are more likely to be outside of central London. This was fully explained to the CC in HCA's response to the CC's Working Paper on London, but again this point is wholly ignored in the PFs.
- 5.81 However, the CC has not applied this conservative catchment area analysis in central London, instead using catchment areas only to define the geographic markets for those private hospital and PPUs located outside central London. This contrasts with the methodology that the CC has adopted in its AIS to define geographic relevant markets, in which it used catchment areas for both central and non-central London hospitals.
- 5.82 As set out from paragraph 5.18 above, there is no robust evidence from patient preferences to suggest that the geographic boundaries of the London market should be defined more narrowly than the rest of the country. In this context, HCA submits that the CC should apply

¹³³ HCA, Response to the CC's London market working paper, paras. 3.17.

¹³⁴ CC, PFs, para. 29.

¹³⁵ CC, PFs, para. 5.67.

¹³⁶ CC, PFs, para. 5.64.

a consistent methodology to HCA's London hospitals as it does for other private hospitals located elsewhere in the UK.

- 5.83 The CC's decision not to do this is not based on evidence and appears to be completely arbitrary. As a result, it generates absurd results. For example, hospitals with a strong offering (even in tertiary care), such as the Aspen Parkside, are not considered at all because they are on the "wrong" side of the A205. This omission is made all the more bizarre by the fact that these hospitals are actually closer to some central London hospitals than the distance between the central London hospitals themselves. For example, HCA's Lister Hospital is nearly three miles closer to the Aspen Parkside than the Aspen Highgate Hospital, yet it is the latter that has been included in the central London competition assessment because it happens to be on the "right" side of the North Circular (A406).
- 5.84 As noted in paragraph 5.33, HCA's hospitals typically draw [redacted] of their patients from well outside of central London. More detailed catchment area analysis carried out by HCA, using its own patient data, suggests that catchment areas around its hospitals extend far beyond the central London boundary suggested by the CC, [redacted]¹³⁷[redacted]. This analysis also shows that many patients travel from beyond Greater London to HCA's facilities, such as from the Home Counties.¹³⁸
- 5.85 Setting aside the weaknesses of the CC's own catchment area methodology (applied to other parts of the UK), noted by HCA previously,¹³⁹ HCA has also analysed the catchment areas of its hospitals using the CC's own methodology as set out in the CC's AIS.¹⁴⁰
- 5.86 **Figure 4** below shows the location of the main HCA hospitals and their respective catchment areas as defined by the CC.¹⁴¹ It clearly shows that HCA hospitals attract patients from geographic areas much wider than central and even Greater London.

Figure 4 HCA's main hospitals and their respective catchment areas

[redacted]

- 5.87 The CC's catchment area analysis, applied to HCA's facilities, also shows that the catchment areas of competitor hospitals outside of central London significantly overlap with the catchment area of all of HCA's main hospitals. For example, **Figure 5** below, shows that the catchment areas of three BMI hospitals located outside central London (i.e., Chelsfield Park Hospital, Fawkham Manor Hospital and The Sloane Hospital)¹⁴² overlap with the catchment area of the London Bridge Hospital (as well as several hospitals within central London).^{143,144}

¹³⁷ [redacted].

¹³⁸ HCA, Response to the AIS, para. 3.57.

¹³⁹ HCA, Response to the AIS, paras. 3.51-3.56.

¹⁴⁰ In producing the maps for our catchment area analysis, we have used the catchment areas calculated by the Competition Commission in Annex I to the AIS. These catchment areas are segregated by region, and are denoted in road-distance (miles). Please note that in Figures 4 and 5 we have used the Commission's analysis to graphically approximate the relevant hospitals' catchment areas using circular radials, instead of isochrones that represent road distance.

¹⁴¹ The catchment area drawn by the CC around a hospital is defined on the basis of the distance travelled by 80% of its patients.

¹⁴² Indicated by HCA to be the key competitors to its London Bridge Hospital, HCA MFQ response, Exhibit 12.1.

¹⁴³ HCA has already provided the CC with a spreadsheet indicating the closest competitors for each hospital. See HCA, Response to the CC's Market Questionnaire, Exhibit 12.1.

¹⁴⁴ For HCA's competitors located in Greater London, HCA has used the median catchment area calculated by the CC in its PFs (CC, PFs, Appendix 6.10, Table 4). For the hospitals located in the

This in turn shows that these private hospitals and PUs located outside of central London pose a competitive constraint on HCA's London Bridge Hospital. In the absence of actual catchment area data for other facilities, HCA has used the catchment area for the relevant region as calculated by the CC, for BMI's facilities.¹⁴⁵ It is likely that in some cases these catchment areas may be an underestimate.

Figure 5 London Bridge Hospital, its BMI competitors located outside central London, and their catchment areas

[REDACTED]

- 5.88 Similar results are also obtained for each of HCA's main central London facilities - the estimated catchment areas for competitor hospitals located outside of central London overlap significantly, and in most cases fully, with the catchment areas of each of HCA's facilities.
- 5.89 Overall therefore, when applied to HCA's hospitals the CC's catchment area methodology shows that:
- HCA hospitals attract patients from areas much wider than central London and in some cases from further than Greater London; and
 - there are a number of private hospitals and PUs located outside central London that represent a significant competitive constraint on HCA.

Competitive constraints from international providers

- 5.90 The market definition exercise carried out by the CC has only looked at UK patients and therefore has ignored an important segment of demand for private healthcare in London, namely that of patients resident outside of the UK. The CC recognises the importance of international patients to hospital operators such as HCA. However, it has failed to take into account what this means for its analysis of competition.
- 5.91 HCA has already made this point in its response to the CC's London market working paper,¹⁴⁶ and it is incumbent on the CC to consider that analysis and explain how it has taken account of the competition HCA faces from international providers.
- 5.92 As submitted to the CC in HCA's response to the first day letter, [REDACTED]¹⁴⁷ considers this competitive landscape in detail. In that document, HCA explores competitive strategies across key markets, including the Middle East, Europe and North Africa, Asia and Australia, and Latin America. It also considers its competitors for those patients, including Ramsay, Capio and Parkway. In addition to its [REDACTED], other internal documents have discussed the levels of overseas competition increasing across locations such as Singapore, Germany and the US,¹⁴⁸ the emergence of new local providers,¹⁴⁹ and threats specific to individual

South East region, HCA has used the minimum catchment areas calculated by the CC in its AIS (CC, Appendix B, Annex 1, Slide 11), therefore producing conservative results. According to the CC, the BMI Fawkham Manor Hospital is located in the South East region (CC, PFs, Appendix 6.6), and therefore HCA has used a catchment area of 9 miles, considerably lower than the 16 miles median catchment area calculated by the CC for the hospitals located in that region.

¹⁴⁵ CC, PFs, Appendix 6.10, table 4.

¹⁴⁶ HCA, Response to the CC's London market working paper, paras. 6.1 - 6.5.

¹⁴⁷ See paras. 11.4 and 14.25 of HCA, Response to the Market Questionnaire.

¹⁴⁸ [REDACTED].

¹⁴⁹ [REDACTED].

specialities.¹⁵⁰ The CC has completely ignored this evidence in its assessment of competition in London.

- 5.93 HCA also faces strong competition for international patients from PPUs, a fact which again the CC has failed to refer to in its competitive assessment of London. As previously stated,¹⁵¹ major NHS teaching hospitals, including the Royal Marsden, Great Ormond Street, Kings College and Guy's and St. Thomas' are increasingly marketing their services overseas. For instance, Great Ormond Street recently launched a new website for international and private patients with content in English and Arabic.
- 5.94 In addition, there has been recent entry into new countries by NHS providers, such as Moorfields Eye Hospital Dubai,¹⁵² which enhances the competitive profile of such NHS facilities in London. More generally, HCA is aware that public and private entities are investing in tens of thousands of hospital beds across the Middle East, which challenges HCA's international patient base. Examples of new facilities in the Middle East include investments by SickKids Canada, John Hopkins Medicine International (USA-based), RED House Group and Rizk Healthcare (Lebanon-based), Cleveland Clinic (USA-based), Sidra Medical and Research Centre (Qatar-based) and DNA Healthcorp (USA-based).
- 5.95 HCA submits that the CC must include these international competitors in its market definition and competitive assessment of HCA's hospitals.
- 5.96 As set out in section 3, international patients are attracted to healthcare providers in central London in particular because of the quality of care and the complexity of treatments that can be catered for. For international patients, therefore, HCA competes with other providers in particular on the quality of its offering and its ability to provide new, complex treatments. Further detail on the importance of investment and innovation is set out in section 3. In general terms, these international patients coming to HCA's facilities are suffering from more complex conditions, and therefore to compete for these patients, HCA has to invest in a highly specialised clinical infrastructure, e.g. neuro-rehabilitation. It is therefore this international competition which helps to drive HCA's investments in quality and innovation.
- 5.97 The CC noted¹⁵³ that in certain of its measures of shares of supply,¹⁵⁴ it has included revenues from international patients. If the CC does that, in HCA's view, international providers must be included in the CC's figures, given that they are important competitors for a significant group of patient revenues included in the analysis. If the CC persists in excluding international providers from its shares of supply analysis, then it must also exclude HCA's revenues from international patients from that analysis. A failure to do this will be completely inconsistent and overstate HCA's shares of supply.

¹⁵⁰ [redacted].

¹⁵¹ Section 6 of HCA, Response to the CC's London market working paper.

¹⁵² <http://www.moorfields.ae/en/Default.aspx>

¹⁵³ Email from [redacted] to [redacted], 6 November 2013.

¹⁵⁴ CC, PFs, Appendix 6.10, tables 6, 7 and 8.

Strong competition from the NHS in London

5.98 The CC notes that, instead of including the NHS in its market definition, it will instead consider the constraint from the NHS in its competitive assessment on a case by case basis.¹⁵⁵ However, the CC found:

- "[the CC has] not received widespread compelling evidence that shows that private hospitals monitor the NHS product and quality offering, or adjust their competitive offering in response to changes made at NHS hospitals, e.g. quality improvements, or consider any reduction in waiting time at NHS hospitals to influence price outcomes for PMIs or self-pay patients";¹⁵⁶ and that
- "*HCA has also argued that it faces competitive constraints from outside London and the NHS. We [the CC] have received very limited evidence in either regard*".¹⁵⁷

5.99 These conclusions are incorrect. The CC has failed to take account of the extensive evidence that HCA has already submitted that demonstrates the strength of the competitive constraint exerted by the NHS on private healthcare providers.

5.100 Below, in part a), HCA reiterates its previously submitted evidence as well as setting out further evidence of how competition with NHS-funded providers has impacted its offering. In part b), HCA highlights the flaws and limitations in the CC's competition analysis of the NHS.

a) The extensive evidence on the constraint from the NHS

5.101 HCA has submitted extensive evidence of the competitive constraints placed on its business from the NHS.

5.102 This evidence includes extensive examples of HCA having consistently monitored the NHS and considering it as a competitive threat to its business. In particular, that HCA monitors:

- the launch of new NHS services that improve care to patients;¹⁵⁸
- how regulatory changes in the NHS may impact on demand for private healthcare;¹⁵⁹
- the use of NHS facilities by PMI patients who would otherwise be eligible for private care;¹⁶⁰ and
- demand-side factors that influence patients to use the NHS rather than private hospitals.¹⁶¹

5.103 HCA has also informed the CC that it compares a number of key performance indicators for its patient outcomes with the NHS.¹⁶² [redacted]¹⁶³ [redacted].¹⁶⁴ HCA has also previously submitted

¹⁵⁵ CC, PFs, para. 5.54(d).

¹⁵⁶ CC, PFs, para. 6.112(g).

¹⁵⁷ CC, PFs, para. 6.140.

¹⁵⁸ [redacted].

¹⁵⁹ [redacted].

¹⁶⁰ [redacted].

¹⁶¹ [redacted].

¹⁶² [redacted].

¹⁶³ [redacted].

¹⁶⁴ [redacted].

analysis to the CC showing PMIs' views of the NHS¹⁶⁵ and the quality of staff in London teaching hospitals.¹⁶⁶

- 5.104 HCA submitted evidence of private healthcare providers modifying their competitive offering in response to the NHS. For example, HCA submitted analysis on the correlation between NHS performance and demand for HCA's services.¹⁶⁷ In addition, as previously noted by HCA,¹⁶⁸ the CC's own case study of Circle's entry into Bath demonstrated that the NHS is taken into account by private healthcare providers upon market entry.
- 5.105 **Appendix 2** to HCA's Response to the Remedies Notice describes HCA's quality compared to other private and NHS funded-providers. In several instances the NHS is shown to better meet requirements for high quality care than other private providers.¹⁶⁹ In addition, it shows that for various HCA investments, HCA has been the first private operator to offer a particular treatment, but that these were already offered by the NHS. For example, cutting-edge treatments that were adopted by HCA into its breast cancer pathway¹⁷⁰ and cardiac care pathway¹⁷¹ were already on offer in London-based NHS hospitals.
- 5.106 Given such evidence, in the case of London, HCA cannot see how the CC can possibly support the statement that "*[the CC has] not received widespread compelling evidence that shows that private hospitals monitor the NHS product and quality offering, or adjust their competitive offering in response to changes made at NHS hospitals*".¹⁷² Such a statement is also at odds with the CC's observation that the presence of the UK's main teaching hospitals is a distinguishing feature of competition in London.¹⁷³ Given the CC's view that the NHS does constrain private healthcare, and given that one particular feature of London is a high concentration of major renowned NHS teaching and research hospitals, it is not credible for the CC to ignore the role of the NHS in constraining HCA's hospitals.
- 5.107 The CC's analysis also ignores the important role of PMIs in driving patient substitution between the NHS and private hospitals. In its response to the CC's AIS, HCA stressed that PMIs have taken action to encourage, or require, policyholders to opt for the NHS rather than a private healthcare provider, therefore further increasing the competitive constraint exerted by the NHS over privately-funded healthcare services. In relation to this point, HCA has previously highlighted two schemes offered by PMIs to their policyholders which encourage the use of NHS providers, namely the "six-week rule" policy¹⁷⁴ and the provision of cash-back incentives.¹⁷⁵ These schemes clearly demonstrate how PMIs can drive substitution towards the NHS.

¹⁶⁵ HCA, Response to the CC's London market working paper, para. 5.8.

¹⁶⁶ HCA, Response to the CC's London market working paper, para. 5.3.

¹⁶⁷ HCA, Response to the CC's London market working paper, para. 5.5.

¹⁶⁸ HCA, Response to the CC's London market working paper, para. 5.11.

¹⁶⁹ For example, for breast cancer care, in prospective multi-disciplinary team meetings, joined up clinical trials, integrated radiotherapy facilities and supportive care programmes. In cardiac care, patient outcome data capture and publication, the latest surgery technology, specialised wards and staff, fully integrated services, quality of cardiologists and surgeons.

¹⁷⁰ [redacted].

¹⁷¹ [redacted].

¹⁷² CC, PFs, para. 6.112(g).

¹⁷³ CC, PFs, Appendix 6.3, para. 26.

¹⁷⁴ The "six-week rule" is a scheme implemented by PMIs whereby a PMI customer is only allowed to have insured private treatment if the treatment is not available on the NHS within six weeks.

¹⁷⁵ HCA, Response to the AIS, para. 3.39.

5.108 HCA notes that it is an industry-held view that such cash payments to PMI patients to use the NHS have had an impact on demand¹⁷⁶ for private healthcare. For example, in the 2013 Health Cover UK Market Report, Laing & Buisson state that the wide use of cost containment practices by insurers is almost certainly likely to have exerted some downward impact on claims costs (i.e. has resulted in more insured patients using the NHS).¹⁷⁷ Given such evidence, it is not clear how the CC can confirm its provisional conclusion that it “[has] not received widespread compelling evidence that shows that private hospitals monitor the NHS product and quality offering, or adjust their competitive offering in response to changes made at NHS hospitals”.

b) The CC's flawed analysis

5.109 Given the CC's provisional conclusion on market definition, NHS supply and capacity has not been reflected in its analysis of shares of supply. This is particularly relevant for the CC's calculation of shares of supply of critical care level 3 (CCL3). In considering total capacity of critical care beds in London, the CC needs to take account of NHS critical care facilities. First, the NHS is an important competitor for higher acuity treatments and the PPU's run by such hospitals in London openly market the fact that such intensive care support is readily accessible to the patient. Secondly, NHS critical care facilities are available to all patients, even those transferred from another private healthcare provider.

5.110 The Department of Health estimated that in the NHS there are 843 critical care beds in hospitals within the London Strategic Health Authority, of which 485 are at level 3 and 358 at level 2. This dwarfs the critical care capacity offered by private operators such as HCA. There is substantial critical care capacity within the NHS which competes alongside critical care offered within private hospitals and is available for private hospitals without their own critical care facilities, if required. BMI's response to the CC's AIS gives the example of BMI's investment in an ICU at its Blackheath hospital, in an area where critical care provision was only available within the NHS.¹⁷⁸ The same applies to other areas of tertiary care, such as radiotherapy, where private operators are increasingly creating facilities which offer an alternative to the NHS.¹⁷⁹

There is strong potential for supply-side substitution by other providers

5.111 The CC has considered whether other hospitals, providing non-substitute products, are able to redirect production to goods and services that would be a substitute for those products in the market, such that those hospitals should also be treated as part of the relevant market. The CC has also analysed the potential for this supply-side substitution from providers or alternative treatments and specialties, discussed in part a) below.

5.112 HCA submits that the CC is incorrect to have concluded that there is limited supply-side substitution between providers of different specialties.¹⁸⁰ HCA also disagrees with the CC's different treatment of oncology compared to other specialisms.

5.113 The CC also considered supply-side substitution between in-, out- and day-patient care, concluding that substitution from the latter two to the former is more likely than vice versa.

¹⁷⁶ An example of the sort of redirection of demand that may occur was provided by Consultant 16's submission to the CC, in response to the PFs.

¹⁷⁷ Laing & Buisson, Health Cover UK Market Report (2013), p29.

¹⁷⁸ BMI, Response to the AIS, para. 4.24.

¹⁷⁹ HCA, Response to the CC's London market working paper, para. 5.12.

¹⁸⁰ CC, PFs, para. 5.40.

HCA submits that there is a lack of a clear demarcation between in-, day- and outpatient services which has an impact on the possibility for supply-side substitution and more generally the competitive constraints between them. As HCA previously highlighted to the CC,¹⁸¹ certain procedures which previously required inpatient care can now be performed with only day- or outpatient care, without necessarily having inpatient care available at the same facility as backup. There has also been growth in outpatient facilities and the treatment of more patients in ambulatory care settings. Whilst HCA accepts that it may be more difficult for an outpatient facility to expand into inpatient care, it submits that an outpatient facility can still pose a strong competitive constraint on suppliers of inpatient care. Furthermore, as discussed in detail in section 6 entry into the provision of day- and outpatient care is also likely to be easier.

a) Strong potential for supply-side substitution from providers of other treatments and specialties

- 5.114 In the provision of hospital services, the CC has provisionally found a significant degree of supply-side substitution across treatments within the same specialty – with a greater degree of substitution for more routine treatments. Conversely, the CC has provisionally found more limited evidence of hospitals switching to treatments in new specialties.¹⁸²
- 5.115 HCA welcomes the CC’s acknowledgement that there appears to be a significant degree of supply-side substitution across treatments within an existing specialty. HCA agrees with the CC that supply-side substitution between specialties is possible as private hospitals retain spare capacity and, as a result, face a relatively low opportunity cost of introducing new treatments.¹⁸³ As the CC itself mentions in its PFs, it is important for private hospitals to maintain a planned level of spare capacity in order to deliver quick access to privately-funded healthcare services,¹⁸⁴ and the evidence received by the CC suggests that these levels of spare capacity are maintained.¹⁸⁵
- 5.116 However, HCA strongly disputes the CC’s conclusion that switching to treatments in new specialties is more limited.
- 5.117 The CC has acknowledged that the fewer examples in the period under its analysis of hospitals starting to provide new specialties may simply be due to the fact that most hospitals already provide the majority of the main specialties typically available in private healthcare.¹⁸⁶ For instance, the cluster of 16 specialties the CC focuses on in its PFs are provided by 80% or more of the 215 general private hospitals and PPUs considered in the analysis.
- 5.118 Therefore, to get to the position today where most hospitals offer most specialties, the CC ought to recognise that, historically, supply-side substitution into new specialties has been a common occurrence. By way of example, it was during HCA’s period of ownership that the necessary investments in new technology and clinical staff were made in order for the Lister Hospital to offer patients cardiology services and for the Princess Grace Hospital to offer patients oncology services.

¹⁸¹ HCA, Response to the AIS, section 3.

¹⁸² CC, PFs, para. 5.31.

¹⁸³ CC, PFs, paras. 5.29-5.30.

¹⁸⁴ CC, PFs, para. 4.8.

¹⁸⁵ CC, PFs, para. 5.29.

¹⁸⁶ CC, PFs, footnote 17.

- 5.119 In this context, any further examples of hospitals starting to provide new services should be seen as strong evidence of the possibility of supply-side substitution.
- 5.120 As HCA has pointed out in its response to the CC's AIS, several facilities, such as the London Independent Hospital, have invested and are now able to compete with HCA for specialties that they had not offered previously.¹⁸⁷ More recently, the Highgate Hospital announced that, following investments in the hospital and the appointment of a leading neurosurgeon, it would now be able to offer neurosurgery from the hospital.¹⁸⁸
- 5.121 In response to the CC's Market Questionnaire, HCA has provided the CC with a number of examples of its hospitals switching into new specialties, including the costs and time involved.¹⁸⁹
- 5.122 One recent example of supply-side substitution in a new service is the Acute Admissions Unit built at the Wellington Hospital in February 2012. This is a direct medical admission unit allowing for expedited GP or consultant referrals of urgent cases. It provides immediate access for adult private patients referred by their GP or consultant to early specialist management of a wide range of medical or surgical conditions. It is a 10-bed unit that caters for all eventualities from minor injuries to the most challenging cases requiring Level 3 intensive care support. It offers immediate admission, access to state-of-the-art diagnostic and imaging services, and to High Dependency and Intensive Care beds if required. It is the first such private unit in the UK. The space for the acute admissions unit was created because of the development of the nearby Platinum Medical Centre into which a high proportion of the Wellington Hospital's outpatient and diagnostics services had been moved. It took approximately eight months to build the new unit. [§].¹⁹⁰
- 5.123 In addition, a selection of HCA's own business cases, summarised in **Appendix 7**, refer to rivals starting to provide new specialties.
- 5.124 The examples above, along with the evidence previously submitted,¹⁹¹ show that switching into the provision of treatments within new specialties is feasible and does not entail a long period of time.
- 5.125 Furthermore, the OFT in a recent NHS hospital merger case¹⁹² examining the provision of neurology services in London noted that two years would constitute a "timely period" for supply-side substitution. HCA believes this period of time is more than enough to launch a new service line. The CC could corroborate this by examining the period of time taken by hospital operators in the past.
- 5.126 The CC has also stated that the ease with which private hospitals switch into the provision of new treatments in new specialties also depends on the availability of qualified consultants, which, according to the CC, constitutes the main factor constraining supply-side substitution.
- 5.127 HCA, on the contrary, believes that private hospitals have the ability to attract more consultants in order to expand or switch into new specialties. HCA does not consider that

¹⁸⁷ HCA, Response to the AIS, para. 3.26.

¹⁸⁸ <http://www.highgatehospital.co.uk/news/new-neurosurgical-expert-for-highgate-hospital/>

¹⁸⁹ HCA, Response to the CC's Market Questionnaire, Question 9.

¹⁹⁰ HCA, Response to the CC's Market Questionnaire, paras. 9.28 - 9.35.

¹⁹¹ HCA, Response to the AIS, para. 3.28.

¹⁹² OFT's decision on University College London Hospitals NHS Foundation Trust / Royal Free London NHS Foundation Trust neurosurgery services, para. 36.

there are significant, if any, constraints on the availability of qualified consultants. London, in particular, counts 7,500 consultants with NHS posts.¹⁹³ The CC has provided no evidence to suggest that consultants are in fact scarce. Consultants are available in a short enough space of time, and certainly within two years, to facilitate supply-side substitution.

- 5.128 Moreover, as the CC itself has pointed out, the British Medical Association suggested that the number of consultants has grown by about 41% in the last decade, although fewer than 10% of these new consultants practise privately.¹⁹⁴
- 5.129 Consultants face low switching costs as they can practice at more than one hospital and private healthcare provider.¹⁹⁵ This is confirmed by the consultant survey published by GfK in August 2011 for the OFT, which shows that most privately practicing consultants treated patients at two or more private facilities. The most important reasons cited by consultants for using more than one private facility was to access necessary specialist treatment facilities, to meet preferences of insured and self-pay patients, to treat at a network hospital for insured patients, and also to meet affordability requirements of self-pay patients.¹⁹⁶ The survey also suggests that the majority of privately practising consultants have spare capacity for further private work.¹⁹⁷

b) The CC's analysis of private healthcare providers across specialties is appropriate, but a separate approach for certain specialties is unjustified

- 5.130 Given that 80% or more of the private hospitals and PPUs considered by the CC are already active in the provision of treatments across 16 specialties, the CC decided for part of its analysis to aggregate these specialties together in order to assess competition in the market. Broadly speaking, HCA agrees with this approach given that it in fact thinks that all providers should be treated as part of the same market, due to the ease of supply-side substitution.
- 5.131 However, elsewhere in its analysis the CC has considered shares of supply at the specialty level. In particular, oncology, has been analysed separately by the CC.¹⁹⁸ HCA disagrees with this approach because of the evidence discussed in the previous sub-section on the strong potential for supply-side substitution across specialties.
- 5.132 In addition, the CC's justification for treating it differently to other specialisms in its analysis of shares of supply is not clear. According to the CC's own analysis¹⁹⁹ Oncology accounted for 3.9% of total insured and inpatient admissions in central London in 2011 and was provided by a wide range of providers. Furthermore, as HCA sets out in section 6, there may have been recent expansion of providers in to this speciality, notably The London Clinic's Cancer Centre, indicating that supply-side substitution is viable. Furthermore, the Oncology specialism covers a wide range of diagnosis and treatment services in both outpatient and inpatient settings and as HCA highlighted to the CC previously,²⁰⁰ there is a wide range of

¹⁹³ HCA, Response to the AIS, para. 3.28.

¹⁹⁴ CC, PFs, para. 3.54. However, it appears that the CC has mis-quoted the original source, and the 10% of new consultants, actually refers only to new consultants in England (see Lang & Buisson Acute Medical Care 2012, page 123).

¹⁹⁵ HCA, Response to the AIS, para. 3.25.

¹⁹⁶ Lang & Buisson Private Acute Medical Care 2012, page 124.

¹⁹⁷ Of those surveyed who were carrying out private work, the large majority (81%) reported having spare capacity on a regular basis, and of these, well over a half (58%) sought to use their spare hours for private work. Lang & Buisson Private Acute Medical Care 2012, p125.

¹⁹⁸ CC, PFs, para. 5.54(b).

¹⁹⁹ CC, PFs, Appendix 6(10), Tables 2 and 7.

²⁰⁰ HCA, The London Clinic Case Study: HCA's Comments, June 2013, para. 8.

providers of oncology services in London who compete vigorously with HCA. Given that a number of core oncology treatments, such as chemotherapy and radiotherapy, can be provided in either a day- or outpatient setting, there is even greater potential for enhanced competition.

(3) The CC's analysis does not provide reliable evidence that outcomes in London are indicative of an AEC

5.133 Section 3 described how competition in the provision of healthcare services occurs over a number of parameters that have been incorrectly sidelined by the CC in its analysis, and that HCA's facilities have competed vigorously through continuous and substantial investments aimed at improving quality of care to patients. Section 4 set out how competing over quality of care is particularly important in London. Against that background, it is unclear how the CC has concluded that outcomes for patients in London are indicative of, or consistent with, an AEC in London.

5.134 The CC has conducted a largely static analysis, which fails to reflect the importance of dynamic competition to provide high quality care. Moreover, the CC's analysis of competition in the market is flawed in a number of respects and does not provide reliable evidence that outcomes for patients indicate an AEC:

- The CC's conclusion that competitive constraints on HCA are weak is based on a flawed analysis of shares of supply, which ignores a number of key competitors. Even setting aside HCA's concerns that key competitors, such as providers in Greater London and the NHS are excluded from the shares of supply analysis, HCA submits that the CC's analysis is plagued by technical flaws and overstates HCA's share, and therefore is unreliable.
- The Price-Concentration analysis is characterised by serious methodological flaws and based on assumptions which do not apply to London. Even setting aside these concerns, the magnitude of the effect that the CC suggests it has found, is extremely small.
- The CC's analysis of HCA's profitability overstates HCA's profitability. In fact, HCA's level of profitability is consistent with strong competition in private healthcare provision.

5.135 The rest of this sub-section discusses each of the CC's static analyses in more detail, setting out HCA's concerns.

The analysis of shares of supply and capacity is flawed

5.136 As part of its competitive assessment, the CC has carried out a shares-of-supply analysis for private hospitals and PUs located in central London. The analysis has been conducted at an aggregate level (i.e. across all specialties and all treatments), and disaggregated level (i.e. for particular segments).²⁰¹ However, even setting aside HCA's more fundamental concerns including the lack of inclusion of competitors the CC has viewed as "outside" of the market, the CC's analysis contains a number of concerning errors and omissions, which overstate HCA's share of supply.

5.137 Furthermore, the CC has failed to understand the implications of the differences in HCA's share of revenue and capacity and the evidence this provides of HCA's relative efficiency.

²⁰¹ CC, PFs, Appendix 6.10, para. 35.

Specifically, the CC's figures show HCA's share of admissions is greater than its share of capacity, a finding that supports the view that HCA is a more efficient provider than some of its rivals and that HCA's position in the market is not dictated because of its hospital capacity, but because of its ability to attract more patients to its facilities than its rivals through a higher quality offering. Indeed, the CC believed that there was "spare capacity" in the market.²⁰²

a) HCA's share of supply and capacity is overstated

5.138 HCA submits that several of the measures of shares of supply and capacity that the CC has used overstate HCA's position, and there are basic mistakes in the CC's calculations.

5.139 One such issue relates to the inpatient bed capacity for the Hospital of St. John and St. Elizabeth. This is noted by the CC as being 49 beds. The hospital actually has over 150 inpatient beds, each with their own private room (as stated on the hospital's website).²⁰³

5.140 In addition, the CC has failed to include a number of other central London private hospitals (such as the Aspen Parkside) as well as several important London PPUs in its analysis. This, again, has the effect of overstating HCA's share of supply.

5.141 Worryingly, the CC has completely omitted PPU capacity from its shares of capacity analysis, citing a lack of "*reliable data*" on PPU capacity.²⁰⁴ This is despite the CC confidently having stated in an earlier section of the PFs that:

- "*There are 77 PPUs in the UK with a total of 1,195 dedicated beds and approximately 1,500 non-dedicated beds*";²⁰⁵ and
- "*60% of PPU beds are in London*".²⁰⁶

5.142 In fact, there is significant data available in the public domain (including on the NHS Trust website) in regards to PPU capacity. If there were one or two PPUs for which data was unavailable (notwithstanding the ample time the CC has had to resolve this), there was no justification for deciding to omit all PPUs from the share of capacity assessment. Furthermore, the CC has the power (indeed the duty) to obtain whatever information is required to complete its assessment of market share – it cannot simply ignore the issue.

5.143 Overall, the CC's errors and omissions in its share of supply / capacity assessment include:

- The CC's failure to obtain data for a number of private hospitals and PPUs in its analysis in tables 1, 2, 4 and 5. Some of these are listed in the CC's note to these tables, but the failure to include others has not even been acknowledged by the CC. These include prominent London private hospitals, such as Aspen's Highgate and Parkside facilities, alongside highly regarded PPUs, including the Royal Marsden and Imperial College Healthcare NHS trust. In total, the CC has failed to gather data from 15 of the 44 facilities listed in Appendix 6.6 of the PFs.
- In relation to PPUs in particular, HCA's analysis of PPU revenues, set out in **Appendix 1**, shows that PPUs account for around 27% of total private patient revenues

²⁰² CC, PFs, Executive Summary, para. 9.

²⁰³ <http://www.hje.org.uk/index.php/About-HJE/accommodation-a-facilities.html>

²⁰⁴ CC, PFs, Appendix 6.10, para. 49.

²⁰⁵ CC, PFs, para. 3.50.

²⁰⁶ CC, PFs, para. 2.25 and footnote 22.

in central London, whereas the CC has included in its share of supply analysis only a small number of these PPUs due to lack of available data.

- HCA believes that the shares-of-supply by specialty calculated by the CC are not meaningful as most of the data on patient admissions is missing. As the CC itself notes, data on patient admissions for some BMI hospitals was not available. The missing data refer to the following specialties: dermatology, obstetrics and gynaecology, trauma and orthopaedics. The CC also acknowledged that data for Aspen is not available for ophthalmology and rheumatology. Finally, the CC notes that data on patient admissions is not available for some specialties provided by some PPUs (estimated to be around 3% of all central London patient admissions).
- As HCA has previously highlighted to the CC,²⁰⁷ it is inappropriate for the CC's estimates of installed capacity in central London (Table 10 of Appendix 6.10) to exclude PPUs. PPU beds account for a significant proportion of total bed capacity in London, approximately 25% according to Laing & Buisson,²⁰⁸ **and the CC's own analysis indicated that NHS facilities account for 62% of critical care beds in central London.**²⁰⁹ Failing to account for these has overestimated HCA's installed bed capacity in central London and presents a vastly incomplete picture of supply. This issue equally applies to the analysis of operating theatre and consulting room capacity where PPUs have access to theatres within the NHS hospital as well as dedicated outpatient facilities in some cases.
- The shares of supply of CCL3 computed by the CC are substantially inflated, and, more importantly, do not measure the shares of supply of CCL3 in central London. This is because the CC computes shares of supply including all treatments and specialties, instead of considering only those requiring CCL3.²¹⁰ HCA believes this approach is fundamentally wrong as some of the specialties the CC focuses on do not require any CCL3, and the CC's approach overestimates its share of supply.
- Critical care facilities in the NHS are available for use by, not only the associated PPU, but also any other hospital operator. NHS PPUs openly market to their private patients that critical care facilities are available in the NHS hospital (and it is therefore a relevant feature of their private patient offering). Therefore, even if the CC disagrees that the NHS is a constraint on private healthcare providers, the capacity available within the NHS (and accessible to the Trust's PPUs and, for that matter, to all providers) should be included in the CC's measures of critical care capacity. Without doing this, the CC necessarily overstates HCA's share of capacity.

²⁰⁷ HCA, Response to the CC's working paper "Private Healthcare in central London: horizontal competitive constraints", section 4.

²⁰⁸ Laing & Buisson, Laing's Healthcare Market Review 2011-12, Table 2.13, pp. 85-86.

²⁰⁹ The CC notes at para. 28 of the working paper "Private Healthcare in central London: horizontal competitive constraints" that 225 critical care beds are in central London. In table 10 of Appendix 6.10 of the PFs, the total number of critical care beds identified by the CC at private hospitals in central London was 85. As NHS PPUs were not included in table 10, the remainder of central London critical care capacity is attributed to NHS facilities (which therefore represent 62% of critical care bed capacity).

²¹⁰ CC, PFs, Appendix 6.10, para. 44.

b) Lack of information on PPU specialty mix

5.144 Furthermore, HCA finds it troubling that the CC states it is unable to obtain figures on the mix of specialities from six of the PPUs for its analysis of the vast speciality mix in the London market, presented in Table 2 of Appendix 6.10. If the CC does not know the specialty mix of these units, HCA finds it difficult to understand how the CC has been able to consider the potential competitive constraint a PPU has on relevant specialities in its local market analysis. As a result, its analysis under-represents the constraints PPUs have on the market. In addition, and confusingly, further on in this Appendix the CC attributes a proportion of market share to the Royal Marsden in Oncology²¹¹, suggesting that some data is in fact available.

The Price-Concentration Analysis provides no reliable evidence of an AEC in London

5.145 HCA submits that the results of the Price-Concentration Analysis (PCA) presented in the PFs cannot be seen as evidence of a meaningful relationship between local market concentration and prices in London for four broad reasons:

- First, the PCA's results are not robust.
- Secondly, the CC's PCA is methodologically unsound, for a number of reasons which are set out in this sub-section and in **Appendix 2**, thus undermining the CC's provisional finding that there may be a causal relationship between local market concentration and self-pay prices.
- Thirdly, the results concerning the relationship between local market concentration and self-pay prices are based on an analysis that is not relevant to London or to HCA.
- Finally, in any event the PCA's results are not economically significant.

5.146 HCA summarises its views on these points in the rest of this sub-section. HCA's full critique of the CC's PCA is set out in **Appendix 2**, and the CC must take account of these comments before seeking to draw any conclusions from its PCA.

a) The CC's results are not robust

5.147 The results from the CC's PCA are, at best, very weak from a statistical perspective, and therefore cannot be seen as providing evidence that local concentration is associated with higher prices for private healthcare.

5.148 In the analysis the CC set out in its AIS, and in its working paper on "Price-concentration analysis for self-pay patients", the CC relied on Ordinary Least Squares (OLS) models. Using these models in the PCA presented in its PFs, the CC found no statistically significant effect of local market concentration on self-pay prices in five specifications out of six (the sixth identified only a weakly statistically significant effect, only at the 10% level).

5.149 In the PCA presented in its PFs, the CC also used Instrumental Variable (IV) models, which it preferred to the OLS specifications, arguing that the IVs it employed are valid instruments. HCA does not agree that these are valid instruments, as set out below. However, even setting aside that concern, HCA notes that although six out of eight of the IV specifications used by the CC found a statistically significant relationship between local market

²¹¹ CC, PFs, Appendix 6.10, para. 42. HCA would further question on what basis the CC estimates the missing data in Table 7 to be "around 3 per cent".

concentration and self-pay prices, the relationship identified in these specifications was very weak.

- 5.150 The results' lack of robustness is also clearly shown by the fact that the CC's results lose statistical significance across the *entire* hospital population if Nuffield Health's hospitals are excluded from the PCA. This is true both under an OLS model and under the IV specification preferred by the CC (specification L7).
- 5.151 Put otherwise, the PCA has not identified a "*general relationship*" between local market concentration and self-pay prices that holds across treatments and across operators. The PCA has identified some correlation between local market concentration and self-pay prices which may exist for four treatments and is driven by a single hospital operator.

b) Serious methodological flaws render the analysis unreliable

- 5.152 The CC has failed to properly control for key variables such as quality (including technological differences), episode complexity (including comorbidities and expectation of complications) and episode cost in the PCA. This casts serious doubt on the reliability of any results from the CC's PCA. In particular, these factors, not controlled for in the model, jointly impact on both prices and concentration. As a result, concentration is endogenous in the CC's PCA. In other words, even if the CC observed a reliable statistical relationship between price and concentration in its analysis (which HCA submits the CC has not done), this does not imply that the relationship is causal. That is, without controlling for factors such as quality and complexity, the CC cannot conclude that higher prices in more concentrated areas result from that concentration, rather than from other factors such as quality and case complexity, among others.
- 5.153 Indeed, HCA notes that there is extensive industrial organisation literature establishing that demand models that do not account for unmeasured product or service quality are inadequate. In addition, HCA notes that CC's decision not to conduct a PCA-type analysis in its market investigation into statutory audit services, in significant part due to missing demand- and supply-side variables,²¹² such as quality and complexity in this case.
- 5.154 In order to address this issue of "endogeneity", the CC has sought to use instrumental variables. However, HCA submits that the instrumental variables used by the CC for this analysis are inappropriate, as set out in more detail in **Appendix 2** and they fail to meet the standards that instrumental variables should meet and that the CC itself recognised in the PFs.
- 5.155 Finally, HCA notes that the CC's reliance on the Logit Competition Index (LOCI) in its PCA renders the analysis unreliable. First, LOCI lacks any robust theoretical support and instead there are well-recognised problems with the logit model, on which LOCI is based. Secondly, there is substantial measurement error in the CC's calculation of LOCI, due to omissions of a large number of key competitors, especially in London. Finally, there are serious methodological issues in the computation of LOCI at the network level, which HCA sets out in more detail in **Appendix 2**.

²¹² CC, Final Report into the market investigation into statutory audit services for large companies, para. 7.71.

c) The assumptions of the CC's analysis do not hold for London

- 5.156 The PCA has been conducted in a way such that even if the CC concluded the analysis is reliable for the rest of the UK (which HCA submits it is not), it cannot be treated as providing reliable evidence of the relationship between local concentration and self-pay prices in London. In particular, the results (i) apply only to treatments which are not representative of HCA's private healthcare activity;²¹³ and (ii) rely on a measure of concentration (LOCI), which has measurement errors that are particularly severe in London, as 55% of invoices are missing, as the CC itself acknowledged.
- 5.157 In addition, independent hospitals such as the London Clinic, the Bupa Cromwell Hospital, the St. John and St. Elizabeth, King Edward VII, BMI London Independent and Aspen Parkside were entirely omitted in the CC's PCA, because data from these hospitals was not available. As such, the results of the PCA do not have any bearing on the provision of private healthcare in London, and thus on HCA.

d) The economic effects are very small

- 5.158 Even on the basis of its preferred model specification, using LOCI as a proxy for local market concentration, the CC's results from the PCA are very weak from an economic perspective. Specifically, the CC has concluded that a 20 percentage point increase in the weighted average market share of a given hospital is associated with only about a 3% higher price for a self-pay treatment.²¹⁴
- 5.159 In other words, even if the CC has robustly identified a relationship between local concentration and self-pay prices (which HCA submits it has not), its analysis shows that this effect is very small. Therefore the CC's results from the PCA should be seen as providing evidentiary support that local concentration does not lead to any meaningful increase in prices and correspondingly that areas of high concentration do not raise any competition concerns.
- 5.160 This is even more the case given the inherent uncertainty in these types of analyses and the lack of robustness in the CC's analysis, as set out above. In particular, the CC's failure to control for quality is likely to lead to an overestimate of any observed correlation between local concentration and self-pay prices, so the true economic effect will in fact be even smaller than any the CC has observed. HCA comments on this further in **Appendix 2**.
- 5.161 Overall, therefore, HCA submits that the CC's decision to use the results of the PCA analysis to come to the provisional conclusion that local concentration gives rise to higher prices is unsound and cannot be confirmed. The PCA is statistically unreliable and provides no evidence of a causal link between concentration and prices, in particular, in London. Furthermore, even setting aside all such serious concerns, the magnitude of any effect is very small.
- 5.162 The CC therefore cannot use evidence from its PCA to support its provisional conclusion that there are weak competitive constraints in London, and therefore, for the CC's provisional

²¹³ The 4 focal treatments chosen by the CC jointly accounted for [%] of HCA's UK self-pay inpatient episodes (or [%] of HCA's UK self-pay inpatient revenues) between 2009 and 2012.

²¹⁴ The CC's preferred model specification, using fascia counts as a proxy for local market concentration, suggested that adding one competing hospital within a 9 mile radius of a hospital is associated with about a 4% price reduction for a self-pay treatment, keeping all other factors equal.

AEC finding in London²¹⁵. Similarly, the PCA's results do not support a structural remedy on HCA in the form of a divestment.

The CC's profitability analysis is seriously flawed

- 5.163 In the PFs, the CC has conducted an analysis of HCA's Return on Capital Employed (ROCE) and compared that to the CC's calculation of a Weighted Average Cost of Capital (WACC) for HCA. As a result, the CC has provisionally found that HCA has earned *"returns substantially and persistently in excess of the cost of capital"* and suggested that this indicates that there are high barriers to entry (which in turn are a feature that gives rise to an AEC).
- 5.164 HCA fundamentally disagrees with the CC's findings on profitability. The CC's estimates of both ROCE and WACC are incorrect, and result from flaws in the CC's methodology and assumptions. As a result, the CC has overstated HCA's profitability. In particular:
- [REDACTED].
 - The CC's WACC estimate uses unreasonable assumptions for: inflation; the equity risk premium; and company beta comparators. Adjusting the CC's analysis for more appropriate values of these variables gives an estimate of WACC in the range of 11.7% - 17.8% (compared to the CC's 7.2% - 9.9%).
- 5.165 In addition, the CC's approach to assessing profitability fails to take into account [REDACTED].
- 5.166 [REDACTED].
- [REDACTED].
- 5.167 In HCA's view, its analysis clearly demonstrates that under a range of reasonable assumptions HCA does not earn a return substantially and persistently in excess of its cost of capital.
- 5.168 The CC's analysis is insufficient in scope or duration to assess how competition has played out in the market and it failed to follow its own Guidelines relating to the interpretation of profitability analysis, as explained in more detail in **Appendix 5**. The CC included no analysis to support its conclusion that HCA's level of profitability results from a lack of effective competition.
- 5.169 In fact, HCA's success and profitability are the result of a track record of innovation, its appetite to accept the inherent financial risk in investing in cutting edge technology, and its constant focus on providing the highest quality standards and patient outcomes which have enabled it to earn returns that are wholly consistent with a competitive market.

(4) Vertical integration and PPU contracts do not enhance HCA's position

- 5.170 In its PFs, the CC has considered factors that it considers may reinforce HCA's position in central London. It stated that it has *"formed the view that HCA's position in central London can may [sic] also be potentially reinforced by any ability it has to outbid its competitors for future PPU management contracts and to acquire further GP practices"*.²¹⁶ HCA strongly disagrees with this statement and submits that the CC appears to have reached this view

²¹⁵ CC, PFs, para. 72.

²¹⁶ CC, PFs, para. 29.

without any supporting evidence or analysis. HCA sets out its response to the CC's incorrect assertion below.

HCA's ownership of GP practices does not reinforce its position in central London

- 5.171 HCA has ownership links in three GP practices. These GP practices are limited in size, with a total of around [X] GPs (of which around [X] are part time) and represent a negligible proportion of the total number of GPs making referrals to HCA's secondary care facilities. In the PFs the CC has acknowledged the evidence that HCA presented highlighting the insignificance of these three GP practices in terms of the proportion of GPs in London and the share of GPs making referrals to HCA facilities.²¹⁷
- 5.172 The CC itself acknowledged that the vertical relationships between HCA and GP practices are "*limited in size (i.e. account for a small proportion of private and NHS GPs that refer patients to HCA's facilities).*" Moreover, the CC accepted that, they "*do not appear to have influenced GP referral rates (i.e. they have remained similar before and after HCA's acquisitions)*" and that "*evidence did not indicate that it was likely that vertical integration is currently leading to significant harm*".²¹⁸ HCA contends that there is no evidence of any harm arising from the vertical integration with GP practices.
- 5.173 Despite this evidence and the views that the CC has reached, as outlined above, the CC has gone on to claim that "*the ownership of GP practices is likely to reinforce HCA's current position (for example, by resisting attempts by PMIs to direct patients away from HCA, particularly with respect to key corporate clients) and that further acquisitions of GP practices would only further strengthen HCA's current position*".²¹⁹ However, the CC has presented no evidence or analysis to explain how it has reached this view. Without such evidence the CC's view is clearly inconsistent.
- 5.174 HCA submits that this conclusion is incorrect, internally inconsistent and based on no supporting evidence. Where a patient requires secondary care, a GP will refer the patient to the consultant best placed to meet their specific treatment requirements. This may, or may not, be a consultant with practising privileges at an HCA facility. In fact, the CC has acknowledged that the agreements in place at HCA's GP facilities contain no referral obligations or incentives and that GPs must act in the patients' best interests when recommending treatments and referrals. This, coupled with the clear evidence showing no changes in referral patterns after HCA's acquisition of the GP practices, demonstrates that HCA's current ownership of GP practices in no way reinforces its position in the market.
- 5.175 Moreover, HCA disagrees that its ownership of GP practices allows it to resist attempts by PMIs to direct patients away from HCA. This would imply that HCA is able to, and has, influenced referral patterns, which the evidence clearly shows is not the case.²²⁰ Furthermore, the strategies that PMIs adopt to direct patients away from HCA's facilities are out of HCA's control, regardless of any vertical integration. As discussed in detail in section 7, PMIs influence the referral paths by employing tactics such as excluding HCA facilities from their networks and adopting open referral policies where the GP has no influence over the consultant and facility of its patient. Clearly, HCA's ownership of GP practices will have no impact on the PMIs' ability to exercise their bargaining power in such ways.

²¹⁷ CC, PFs, para. 54, based on HCA, Response to the AIS, section 8.

²¹⁸ CC, PFs, para. 6.141.

²¹⁹ *Ibid.*

²²⁰ As recognised in CC, PF, para. 6.141.

No evidence that HCA's position would be reinforced by any ability it has to outbid its competitors for future PPU management contracts

- 5.176 In addition to concerns about HCA's ownership of GP facilities, the CC has asserted that any ability it has to outbid competitors for PPU contracts will reinforce HCA's market position. HCA notes that the CC has provided no evidence or supporting arguments in making this assertion. Indeed, it is noted only in the conclusion sections of 6 of the CC's PFs without any further supporting views of evidence. HCA submits that if the CC is to make such statements in its PFs it must provide supporting evidence and analysis.
- 5.177 Any acquisition of a PPU contract would be subject to review under the Enterprise Act 2002 and/or Competition Act 1998, which would thereby deal with any competition concerns on a case by case basis.
- 5.178 In any case, HCA faces considerable competition for PPU contracts, where they become available. These contracts are procured through a rigorous OJEU process where bidders are assessed on a range of criteria. Criteria for assessing bids vary across different procurement processes. They include (but are not limited to): the specifics of the technical and clinical aspects of the bid and how well those match the provider's needs; how closely a bidder's strategic vision and policy matches that of the tendering body; the strength of the bidder's business plan for generating patient numbers and growth; the quality of the bidder's proposals for engaging with consultants; the bidder's clinical and governance standards; the quality of the bidder's proposals for development of the physical building and infrastructure; the quality of the bidder's proposals for transition to the new contract; the quality of the staff included in the proposal; the bid's financials including value for money and the financial structure of the contract (for example the balance sheet status of the bid, the assumptions made on tax); and the various legal aspects of the bid.
- 5.179 The CC's views concerning any ability of HCA to outbid its competitors for future PPU management contracts are therefore purely speculative and not evidence-based. Indeed, other providers have successfully bid for and won London PPU opportunities.

Conclusions on the CC's competitive assessment of London

- 5.180 The CC has not conducted an appropriate market definition analysis (both in terms of the evidence considered and the way in which it is analysed and interpreted). In its analysis of market definition and competitive constraints, it is incumbent on the CC to conduct a full and robust analysis of patient preferences and demand, including patient behaviour following *changes* in the competitive offering of private healthcare providers. Without this, the CC's provisional conclusion in relation to market definition cannot be confirmed.
- 5.181 Referring to views of insurers and other providers (the London Clinic), who all have their own incentives and agendas,²²¹ is not a substitute for a proper analysis of patient preferences.
- 5.182 Setting aside these concerns and accepting the CC's inappropriately narrow market definition, HCA submits that the CC has also underestimated the competitive constraint placed on HCA from those providers it has included within the relevant market, namely, from other private providers and PPUs in central London.

²²¹ As an aside, the vast array of complaints made by patients toward insurers such as Bupa during this market investigation demonstrates why the views of the patient cannot be substituted for an insurer.

- 5.183 Without a robust market definition analysis, the CC must assess in its competitive assessment the constraint from healthcare suppliers "outside" of the market it defines. However, the CC has not done this and has underestimated key competitive constraints in both its market definition analysis and its competitive assessment of HCA's London hospitals. In particular, the CC:
- Underestimated the competitive constraint exerted by NHS-funded medical treatments on providers of privately-funded healthcare services in London, and has failed to engage with evidence provided by HCA previously on the constraint from the NHS.
 - Dismissed the competitive constraints posed by hospitals located in Greater London over central London hospitals. The CC has failed to apply a catchment area analysis in central London. A catchment area analysis clearly shows that HCA faces competitive constraints from a number of hospitals outside of central London.
 - Ignored the strong competition HCA faces from leading international providers for patients. These patients account for a substantial proportion of HCA's revenue, and drive higher quality standards for all patients.
 - Underestimated the ability of private healthcare providers to substitute between treatments across different specialties, as they can rely upon spare capacity and a large pool of available qualified consultants, meaning the CC has incorrectly measured shares of supply at the specialty level.
- 5.184 HCA's view that the CC underestimated these competitive constraints on its business is evidenced by the fact that the CC has no reliable evidence that outcomes for patients are worse in London or are even consistent with the CC's provisional finding that HCA faces only "weak" competitive constraints.
- 5.185 First, the CC referred to "concentration" in the market. However, the CC's reliance on shares of supply and capacity, without a robust market definition analysis, is inappropriate. Setting aside these concerns, the CC's analysis is undermined by technical flaws that lead to an overestimate of HCA's share of supply.
- 5.186 Secondly, the CC's PCA cannot be seen as evidence of a meaningful relationship between concentration and market power, in particular in relation to London where HCA operates.
- 5.187 Thirdly, the CC's profitability analysis has significantly overestimated HCA's and the market's profitability. Actual profitability is consistent with HCA being an efficient and successful private healthcare competitor.
- 5.188 Fourthly, there is no robust evidence from the assessment of bargaining between HCA and PMIs or from the analysis of insured prices supporting the view that local concentration in London may enable HCA to charge higher prices.
- 5.189 Fifthly, HCA disagrees with the CC's conclusion that "*HCA's position in central London can may [sic] also be potentially reinforced by any ability it has to outbid its competitors for future PPU management contracts and to acquire further GP practices*".²²² There is no evidence to support such a conclusion and future contracts, such as to manage PPUs, would in any event be subject to regulatory review under UK merger / competition law.

²²² CC, PFs, para. 29.

6. ENTRY AND EXPANSION

Key Points

- There has been considerable new entry and expansion in London in recent years.
- Entry and expansion is expected to continue, with further entry planned in the near future, including London International Hospital, Kent Institute of Medicine and Surgery and significant PPU expansion.
- In London, demand for private health services is not static, but growing and this is expected to provide increased incentives for entry and expansion.
- The CC's assessment of structural barriers to entry and expansion in London is incorrect: costs of development and obtaining planning permission have not deterred profitable new entry or expansion in London.
- Moreover, trends towards care increasingly being delivered in day- and outpatient settings will allow entry at a lower cost in the future.
- HCA agrees with the CC that securing consultant commitment is not a barrier to entry - there is a significant number of consultants in London available for new and existing private healthcare providers. The only significant barrier to entry and expansion in London is PMI recognition, as powerfully demonstrated by the examples of the Heart Hospital and HCA's Brentwood and New Malden Medical Centres.

Introduction

- 6.1 The CC's PFs identified a number of barriers to entry and expansion with respect to the UK private healthcare sector as a whole. In reaching its provisional conclusion, the CC has failed to consider if (and the extent to which) such barriers to entry may apply specifically to London.
- 6.2 HCA strongly believes that the CC's provisional findings in relation to barriers to entry and expansion do not apply to London. Specifically, HCA shows that:
- The record of past entry and expansion in the London market, and the evidence of further planned entry or expansion going forward, is inconsistent with there being any meaningful barriers to entry.
 - Significant growth in the demand for private healthcare in London is anticipated, providing increased incentives for new entry and expansion in London.
 - The CC's provisional views of structural barriers to entry and expansion do not apply to London. There is no evidence that the costs of development in London, or site availability and the obtaining of planning permission, have deterred new entry or expansion. Indeed there is considerable evidence of profitable new entry and expansion. HCA presents evidence of numerous sites available in London for private healthcare providers and highlights evidence demonstrating that planning permission is obtainable based on HCA's own and other providers' experience of expansion. Moreover, HCA shows that London is clearly of sufficient size to support considerable new entry and expansion.
 - The CC's provisional views around certain strategic barriers to entry and expansion are incorrect. There are a significant number of consultants in London and competition for

them drives improvements in the quality of healthcare provision. Whilst PMI recognition acts as a barrier to entry and expansion in general, there is no evidence to suggest that large hospital groups are able to "induce" PMIs to prevent accreditation of other private hospitals in London.

(1) Significant evidence of entry and expansion in London

6.3 The Guidelines state that "[t]he CC will examine the history of entry and evidence of planned entry. This assessment will include the extent to which past entrants and smaller firms have successfully gained market share [...] and, more generally, the cost of gaining a significant share of the market. [...] evidence of past entry (or lack of it) can be helpful in assessing the significance of entry barriers in a market".²²³ HCA strongly considers that the significant number of recent entries into private healthcare provision in London demonstrates that there are not high barriers to entry in London.

Private healthcare providers have already entered or expanded in London

6.4 HCA has previously submitted a list of its competitors who have entered or expanded in London over recent years.²²⁴ The CC will also have obtained details of the expansion of existing hospital providers through its Market Questionnaire. Examples of recent entries into, and expansions in London, include:

- The development of the London Clinic's Cancer Centre in 2009. The new centre, with 47 new inpatient rooms, state-of-the-art treatment technologies and new diagnostic facilities illustrated the ability to significantly and profitably²²⁵ expand the scope and depth of hospital services in central London through the development of a new, standalone facility.
- The King Edward VII Hospital is in the process of a major new site development programme to expand its facilities. This involves the redevelopment of Mackintosh House and Agnes Keyser House, which will provide the hospital with a total area of 100,000 square feet (a substantial increase from the present 66,000 present square footage). This expansion follows on from a £3 million investment programme over three years in a new state-of-the-art imaging facility and equipment as well as the development of new staff accommodation.
- After securing planning permission, in 2007 the Hospital of St. John of St. Elizabeth successfully redeveloped Brampton House (formerly a convent building) as an advanced outpatient and diagnostic centre (including 30 new consultation rooms and a new endoscopy suite) at an estimated cost of £4 million.²²⁶ In 2011, the site of the former outpatient department was redeveloped into a new urgent care centre (which competes with an equivalent centre first opened by HCA). Also in 2011, the Hospital significantly upgraded its Imaging Department.

²²³ CC, Guidelines, para. 232.

²²⁴ CC, London working paper, 7.6; Response to the AIS, para. 5.23.

²²⁵ Laing's Healthcare Market news (October 2013) reported that "*The London Clinic's income tops £130m in a strong London market the London Clinic's trading income rose by 5.5% in calendar year 2012 to £131.1m (2011: £124.3m), going some way to justify the £152m that the Trustees have spent on ambitious capital programmes over the last 5 years*" (page 22).

²²⁶ <http://www.slideshare.net/jamesphillips188/hospital-of-st-john-st-elizabeth-a-history>
<http://davidmorleyarchitects.co.uk/projects/hospital-of-st-john-and-st-elizabeth>

- In 2013, the central London based Highgate Private Hospital announced the launch of the "New Highgate Private Hospital". The hospital's website states: "*The hospital is currently undergoing a £13 million extensive redevelopment and expansion programme which when completed in December 2013 will include 43 patient rooms (all en suite), a high dependency unit, four fully-equipped operating theatres, a state of the art endoscopy suite, a physiotherapy suite, 15 outpatient consulting rooms, a diagnostic suite and a private GP service*".²²⁷ The development, which will increase inpatient capacity by over 50%, notably includes the construction of a new "State-of-the-Art Diagnostic Centre (launched in August 2013)".²²⁸ In September 2013, the hospital also announced a major consultant coup in attracting a pre-eminent neurosurgeon to the hospital. The hospital's website notes that: "*Her appointment means Highgate Hospital can now carry out neurosurgery in-house*" and that "*patients can now come to Highgate for an even wider range of treatments and services*".²²⁹
- There are three separate instances of new hospital entry by BMI in London over the last 3 years, each of which has altered the competitive landscape for HCA's hospitals:
 - BMI acquired the Fitzroy Square Hospital in London (2009).
 - BMI acquired a stake in Phoenix Hospital Group which operate a 17-bed hospital in Weymouth Street and a consulting and diagnostic clinic in Harley Street (2009). AXA PPP has described the BMI Weymouth as an example of an "Elite Hospital" in London.²³⁰
 - BMI secured the contract to operate the 22-bed Coombe Wing at Kingston Hospital (2009), an area of Greater London in which HCA competes for patients.
- Aspen's development of the Parkside Cancer Centre in Wimbledon in 2003 was undertaken to provide "*one of the UK's premier cancer treatment facilities*" that is "*at the forefront of cancer care in London, with internationally renowned cancer specialists and doctors*".²³¹ AXA PPP refers to this hospital as a "London Elite Hospital",²³² a feat that is no doubt supported by this significant investment in cancer care.
- Bupa Cromwell Hospital's 3-year, multi-million pound investment programme (the "Advance Programme") will, according to Bupa, "*expand the number of areas in the hospital offering specialised care at its Cromwell hospital*" in addition to "*installing clinically leading-edge technology*" and "*creating a five star environment*".²³³ The programme will bolster the hospital's infrastructure and introduce new equipment to develop its cancer care, neurosciences, diagnostics, paediatrics, family medicine, endoscopy and orthopaedic services.

²²⁷ <http://www.highgatehospital.co.uk/news/new-neurosurgical-expert-for-highgate-hospital/>

²²⁸ For details of the construction project at the new diagnostic centre, see <http://www.highgatehospital.co.uk/news/announcing-the-new-diagnostics-suite-at-highgate-private-hospital-for-summer-2013/>

²²⁹ <http://www.highgatehospital.co.uk/news/new-neurosurgical-expert-for-highgate-hospital/>

²³⁰ AXA PPP, Response to the AIS submission, table 2.

²³¹ Aspen description of Parkside Cancer Centre, <http://www.cancercentrelondon.co.uk/working-at-ccl/>

²³² AXA PPP, Response to the AIS submission, table 2.

²³³ <http://www.bupacromwellhospital.com/about-our-hospital/hospital-redevelopment/>

Significant future entry and expansion is expected

- 6.5 There is also evidence of planned future entry and expansion by private healthcare providers, as well as PPUs. HCA submits that the CC is required to take this into account in its assessment of barriers to entry and expansion and more widely in its competitive assessment of London.

London International Hospital

- 6.6 London International Hospital is a new, multidisciplinary hospital entering into London. The facility, backed by the C&C Alpha Group, is expected to launch next year. The hospital itself is a new, 150-bed facility and will offer sophisticated, tertiary services. HCA finds it is extremely surprising that the CC has not made a single reference to this fast-approaching development in its analysis of entry/expansion or competition in London. HCA has recently written to the CC about the new hospital developments.

- 6.7 London International Hospital will be set in Ravenscourt Park in a state-of-the-art building. The C&C Alpha Group (CCAG) describes the project as follows:

*"We are developing London International Hospital (LIH), a super-speciality private hospital in central London. Our vision is the creation of a centre of excellence for treatment of cancer and conditions of the heart and brain. In its 150 beds, LIH will combine the provision of specialist care and a 5–Star customer experience for a mixture of overseas and UK private patients. The hospital will seek to provide a one-stop-shop with world-class specialised staff, services, facilities and technology. The site is currently undergoing refurbishment and redevelopment and is scheduled to re-open in 2014".*²³⁴

- 6.8 In an online video illustrating the hospital's strategic vision, the Operations Director for the hospital notes that:²³⁵

"The vision and focus of London International Hospital is to be a super speciality hospital. We will have the latest in diagnostic and therapeutic equipment to support these specialities. In the diagnostic equipment we will have the latest MRI scanners and the latest in CT scanning and PET CT scanning".

[The narrator of the video adds:] *"This will be the first UK hospital and one of very few worldwide to offer the full range of state of the art robotic, radiosurgery and nuclear medicine treatments. Robotic surgery is clearly changing the face of the way we think about surgery..."*.

- 6.9 [REDACTED].

Spire

- 6.10 Spire has publicly announced their intention to invest in London.²³⁶ A spokesman for Spire observed *"Central London represents 30% of UK private healthcare spend. The market is forecast to continue to benefit from favourable trends."* The report notes that Spire's is seeking to develop a hospital with 8 – 10 operating theatres and around 100 bedrooms and will represent a new flagship hospital.

²³⁴ http://www.ccalphagroup.co.uk/?page_id=90

²³⁵ A transcript has been produced of the video available at: <http://www.hijackit.com/?id=198>

²³⁶ <http://www.propertyweek.com/spire-nurses-london-ambition/5062589.article>

KIMS

- 6.11 Further entry is expected in 2014 with the launch of the Kent Institute of Medicine and Surgery (KIMS).
- 6.12 KIMS is a new 100-bed private hospital being developed in Maidstone at a project cost of £80 million. It is also set to launch in 2014.
- 6.13 The facility recognises that it is in direct competition for the patients currently being served in London, and openly states that it will be competing with operators based in the capital. The KIMS website prominently states: *"patients will no longer need to travel to London for complex cardiac and neurological treatments,"* adding, *"We are building a centre of clinical excellence in Kent. A world-renowned teaching hospital where the best clinicians want to be and where patients requiring acute care want to go".*²³⁷
- 6.14 Of further relevance is the hospital's intent to offer *"continuing care - meaning that, even once you have left our hospital we will follow up the progress of your treatment, and ensure you receive the appropriate support, e.g. physiotherapy, rehabilitation etc..."*. That is, KIMS will offer a full pathway service that rivals HCA's offering.
- 6.15 KIMS' submission to the CC makes it abundantly clear that the very *"premise"* of KIMS is to provide competition to HCA's hospitals.²³⁸ The submission notes the hospital's intention is *"to compete with the more expensive Central London hospitals and generally to increase competition by creating a full service hospital that will represent a local alternative for patients and their families"*. It further notes that it has full PMI backing: *"PMIs have expressed support for KIMS given our ability to perform tertiary procedures at a price that will be less than that being charged by [Redacted]"*.
- 6.16 There is no doubt that the entry of KIMS will result in a new and strong competitive constraint on HCA's hospitals, and particularly on the London Bridge Hospital.

Ramsay

- 6.17 HCA's attention has also been drawn to another major tertiary care and research development albeit outside London, this time involving Cambridge University Hospitals Trust, John Laing Infrastructure (who have raised a record £242 million for investment in hospitals)²³⁹ and Ramsay Health Care to launch a new £120 million private hospital and research facility,²⁴⁰ featuring 64 inpatient beds, 8 critical care beds and advanced radiotherapy facilities. The complex will include a high-tech research facility, the Forum, to collaborate on innovative new treatments. Construction commences in spring 2014, and when complete, the hospital will represent particularly strong competition in attracting patients from important commuter belt Home County towns, such as St. Albans (see HCA's patient catchment area maps).²⁴¹

²³⁷ <http://www.kims.org.uk/about-kims/about-kims-article/our-mission>

²³⁸ KIMS, Response to the PFs.

²³⁹ <http://www.cityam.com/article/1380845279/john-laing-infrastructure-raises-242m-hospital-investment>

²⁴⁰ <http://www.hsj.co.uk/hsj-local/acute-trusts/cambridge-university-hospitals-nhs-foundation-trust/cambridge-hospitals-reveals-partners-for-120m-private-hospital-and-hotel-complex/5058051.article>

²⁴¹ HCA, Response to the Market Questionnaire, Exhibit 10.1.

Nueterra

- 6.18 Nueterra is the London based subsidiary of Nueterra Healthcare International, and is an affiliate of Nueterra Holdings (which operates 79 hospitals in the US). Nueterra submitted to the CC that over the last 4 years Nueterra has been developing its operations outside the US, including, in the last 2 years, its potential entrance into the UK.

London NHS PPUs have been growing and are set to expand significantly

- 6.19 PPUs in London already exert a strong competitive constraint on HCA. Nine of the top ten PPUs by revenue are located in London. HCA has previously commented at length about some of the major PPU developments that have recently taken place and are currently underway. As the CC correctly acknowledges, the NHS PPUs in London have a "*strong reputation*" and these PPUs have leveraged their strong reputations by investing in and expanding their service offering to attract both domestic and international patients. The CC also correctly noted that the top 10 NHS Trust PPUs (accounting for 48.2% of total PPU income in 2012²⁴² and of which 9 are based in central London) have collectively exhibited a "*high*" level of average revenue growth – specifically, 13.5% over a single year.²⁴³
- 6.20 **Appendix 1** considers the history of and potential for growth for London-based PPUs based on a number of sources, including forward-looking plans, annual reports and reviews. Notably, it finds:

- **There has been significant recent growth:** revenues from private patients at the 12 NHS Trusts / Foundation Trusts (FTs) that have PPUs in central London have grown by 36% over the last three years, with an average of around 12% growth in the last year. This high growth meant that in 2012/13 these 12 central London PPUs accounted for a total private patient spending of £285 million. Based on the CC's estimate of the total size of the market for private healthcare in central London at around £1 billion, this would mean that PPUs represent 28% of the central London market. This figure of 28% is substantially different from the percentage recorded by the CC of 14%. The difference is likely due to the exclusion from the CC's calculation of six central London PPUs including Great Ormond Street (£44 million), Moorfields Eye Hospital (£19.5 million) and University College London (£20.5 million), and the use of data from 2011, since which PPUs have grown at a faster rate than private hospitals.
- **Observed growth is planned to continue:** 11 of the 12 central London NHS Trusts / FTs made specific mention of private patients strategies in their annual reports over the last three years, nine making reference to plans to grow their private patient activity. In addition, all but two of the nine central London NHS FTs made specific references to the private patient activity cap in their annual reports over the last three years, indicating that the cap was holding back their preferred rate of PPU growth and therefore indicating that there is likely to be a step change in growth at these FTs now that the cap has been removed.

²⁴² CC, PFs, section 2, Table 2.2.

²⁴³ CC, PFs, paras. 2.26 - 2.27.

- 6.21 There is also evidence that they will compete for overseas patients in London as well as in dedicated international operations.²⁴⁴ The CC referenced Laing & Buisson's 2012 UK Private Acute Medical Care report heavily in forming its provisional view of the future of PPUs, a report which supports many of the points HCA makes in this response.
- 6.22 Major NHS hospital developments are already planned in London, including a large PFI redevelopment project at the Royal London Hospital and at St. Bartholomew's Hospital, which will raise the standards of care through new, state-of-the-art facilities, including one of Europe's largest renal units.
- 6.23 The evidence also shows that PMIs have recognised the quality of London based PPUs²⁴⁵. For example, one PMI offers an extended insurance policy whereby on top of the more traditional private hospitals, patients can elect to choose a PPU too. The option to include PPUs in a customer's policy comes with an additional premium.
- 6.24 HCA's view that PPUs will grow in central London, uninhibited by any barriers to entry and expansion, and will increasingly provide a significant competitive constraint to HCA's operations, was supported statements made by the CC, which it later appeared to disregard without reason. For example, within Appendix 3.1 of the PFs the CC stated that London-based PPUs are "*positioning themselves to take advantage of the lifting of the cap more quickly than those outside London by, for example, investing in additional capacity, refurbishing their existing facilities, and specializing in the provision of privately-funded healthcare services, such as cancer services*".²⁴⁶
- 6.25 Therefore the current wave of new PPU expansions and development projects (see **Appendix 1**) may well represent the beginning of an even more profound series of investments in the market. [§]. This is demonstrative of the scale of the ambition of NHS hospitals to expand their private patient services. In summary, the CC must consider the extent to which the market is still "playing out" following these legislative changes.
- 6.26 In its summary of Appendix 3.1 the CC noted that the Department of Health (DH) undertook an Impact Assessment of the Health and Social Bill 2011. The CC considered that DH found certain FTs were not close to their private patient cap as it stood, and that many FTs would not automatically make use of any ability to earn private income offered to them.²⁴⁷
- 6.27 However, the CC was selective in its references to DH's Impact Assessment. Notably:
- DH's rationale for lifting the cap includes removing the "*perverse consequences*" arising from the cap, including preventing well respected operators to generate significant revenue and exploit the power of their brand abroad.
 - DH considers that in removing the cap, FTs wishing to generate additional private sector income will do so from private patients (insured and self-pay), additional overseas patients (that, due to caps, could not previously be treated), and "*patients who would have otherwise been treated on the NHS but for whom reduced private prices (due to increased competition) now makes private treatment just affordable*".²⁴⁸

²⁴⁴ CC, PFs, Appendix 3.1, paras. 19 - 23.

²⁴⁵ HCA, Response to the London market working paper, para. 4.16.

²⁴⁶ CC, PFs, Appendix 3.1, para. 9.

²⁴⁷ CC, PFs, Appendix 3.1, para. 5.

²⁴⁸ Health and Social Care Bill 2011 Impact Assessments, Department of Health, para. B152.

- 6.28 The CC discussed further concerns around growth and the factors likely to limit PPUs expansion.²⁴⁹
- 6.29 Specifically, the CC noted that a rise of over 5% will have to go through a PPU's board of governors, tempering growth. However, the CC should recognise that this 5% growth figure is of the total patient base – not a 5% increase on the previous private patient cap - leaving significant room for sustainable growth for those operators that have smaller caps in London. In addition, the evidence to date shows that, for London at least, there is evidence of operators already expanding at a considerable pace. **Appendix 1** shows that many trusts have seen significant growth in 2012 - 2013. In its 2012/13 annual report Great Ormond Street noted that they had been able to revise their IPP (International and Private Patients) strategy for 2013/14 in response to the relaxation of the private patient income cap. It has plans to increase capacity for patients, enabling it to treat a further 490 patients in its private wards.²⁵⁰ At Royal Marsden governors have agreed to aim to achieve an increase in private activity by 50 to 60% as soon as is realistically possible. The requirement for the board of governors at PPUs to agree to rises does not appear to have been any constraint in either of these cases.
- 6.30 The CC also noted that there was an "*overall reduction in the amount of private work brought about by the recession*".²⁵¹ As HCA discusses in section 4 above, London faces very different economic conditions to the UK overall, and the demand for private healthcare continues to rise.
- 6.31 HCA considers the other "obstacles" outlined by the CC, including the lack of insurer recognition, capacity constraints and ceding to NHS priorities in **Appendix 1**.
- 6.32 In summary, the evidence outlined by HCA above clearly demonstrates that in recent years there have been significant levels of entry into and expansion of the market, and going forward this is expected to continue to increase. In addition, the substantial growth of PPUs, especially in London, combined with entry from other operators offering high complexity tertiary care, is set to only strengthen the competitive landscape HCA currently competes in.

(2) Demand for private healthcare in London is growing

- 6.33 As explained in section 4 above, the CC has failed to recognise the current and future growth in London. It is not the case that demand in London is static as the CC found is the case for the UK as a whole. This critically undermines the CC's analysis of barriers to entry and expansion with respect to London.
- 6.34 There is compelling evidence on why private healthcare provision is expected to grow for the foreseeable future in London faster than the rest of the UK. This assessment is based on a number of factors. First, the London population is expected to increase 10.8% from 2013 - 2021. In addition, population growth is expected to occur disproportionately, adding to an ageing population. Notably, the age demographics making up 90% of HCA's patient base (by admissions) and 86% (by revenue) are expected to grow faster than the UK average.

²⁴⁹ CC, PFs, Appendix 3.1, para. 20.

²⁵⁰ Great Ormond Street Hospital Meeting of the Member's Council, 27 June 2012, Attachment D.

²⁵¹ CC, PFs, Appendix 3.1, para. 20.

- 6.35 As a result, HCA expects increased demand in London for private healthcare services. Further, PMI penetration in London – already higher than the national average – is expected to remain resilient. Overall, the analysis shows that for Greater London private healthcare patient numbers are expected to rise 6% between 2013 and 2018, and 23% by 2023.
- 6.36 HCA submits that the CC should take account of how the growing private healthcare demand in London will result in further entry and expansion – whether from new entrants or HCA's current competitors. Local demand characteristics have a significant effect on the likelihood of entry in different local areas. It stands to reason that increases in demand, creating a larger market, will fuel the motive for entry from new operators and encourage further investment from existing operators to serve and compete for these patients.

(3) The CC's provisional views on barriers to entry and expansion do not apply to London

- 6.37 HCA comments below on the CC's assessment of entry barriers. It submits that the CC's provisional views do not apply to the London market, and sets out a substantial evidence base that addresses the CC's concerns. HCA highlights that the costs of designing, building and equipping a private hospital have not been so significant a barrier as to deter new entry and expansion in London.

Costs of development in London have not deterred new entry or expansion

- 6.38 Whilst HCA recognises the need to invest substantial capital in building or acquiring a new hospital facility in or around London, there is no evidence in the PFs that prospective or established hospital operators have, as a consequence, been deterred from entering or expanding in London and its surrounding areas. On the contrary London has experienced record levels of investment and expansion by private healthcare providers, suggesting that new healthcare facilities can operate profitably.
- 6.39 HCA, Aspen, the London Clinic, Bupa Cromwell, BMI and, looking ahead, KIMS and the developers of London International Hospital, have demonstrated both willingness and ability to fund the acquisition, expansion or development of large medical facilities, all of which are intended to compete for patients accessing healthcare in and around London. Indeed, the CC correctly notes that the London Clinic's Cancer Centre, among other developments, *"illustrates the willingness of some providers, particularly TLC and HCA, to make very significant investments in equipment and facilities to try and secure an increased share of certain segments of the healthcare market, particularly oncology"*. More recently, Spire has very publicly announced its intentions to develop a presence in London.
- 6.40 The major NHS expansion projects which are taking place in London are further evidence that the cost of developing hospitals in this part of the UK is not proving to be prohibitive. The PFI redevelopment of the Royal London Hospital will involve developing hospital facilities over 144,000 square metres of new floor space through a cluster of new building developments. The same PFI redevelopment of St. Bartholomew's Hospital will create 60,000 square metres of new floor space for the hospital to house leading medical facilities.
- 6.41 Moreover, HCA submits that in the event of entry being unsuccessful there are considerable opportunities for the entrant to recoup costs through the sale of its assets. As the CC will be aware from its profitability analysis a significant proportion of the capital employed in a London hospital is represented by the land and buildings. The London property market is such that these could be sold to a range of existing, or any new, private healthcare providers as well as marketed more widely to property developers. [REDACTED]. Furthermore, HCA outlined a

number of examples of former hospital sites being sold and developed in an alternative residential use. This suggests that the CC's assertion that there is limited ability to recoup entry or expansion costs does not apply in London.

Changes in the delivery of healthcare are expected to lead to increased entry at a lower cost

- 6.42 The PFs correctly identified that the way in which healthcare is being delivered to patients is changing (including the increasing shift from inpatient activity towards day-case and outpatient services). The CC also considered the number of specialised day-care facilities entering in recent years.²⁵² However the CC appears to have failed to consider how this affects its analysis on entry and expansion.
- 6.43 The CC focused its assessment on the ease of entry and expansion in general hospital sites. However, given the evidence set out above showing that there has been a shift away from inpatient care towards treatment in day- and outpatient settings, HCA submits that the CC should consider entry and expansion in relation to day- and outpatient facilities rather than focussing solely on general hospital (inpatient) sites, given that the former will exert an increasing competitive constraint in future.
- 6.44 Industry commentators have observed significant entry from more specialised healthcare providers. For example, Laing & Buisson note that since 2007 there has been an increase in day only facilities becoming registered as hospitals by the CQC, with the estimated number of hospitals growing from 68 to 291.²⁵³
- 6.45 Indeed, one of HCA's most prominent developments over the past five years was the construction of the Platinum Medical Centre (launched in 2011). This development, which offers day-case medical procedures, is an example of a hospital operator expanding in a market by realising an opportunity to deliver high-quality, cost-effective medical services through a day- rather than inpatient setting. The centre is the largest private day- and outpatient care centre in the UK, spanning seven floors and hosting 50 consulting rooms, four day surgery theatres, a 12-bed day surgery unit, a 10-bed chemotherapy ward, and one of the most advanced imaging centres in the country.

Demand for London healthcare facilities is sufficient to support considerable new entry and expansion

- 6.46 The CC provisionally concluded that, because of the size of local markets, the existence of substantial fixed costs and the economies of scale associated with a private hospital, small-scale entry as a provider of inpatient facilities is unlikely to be profitable. Importantly, the CC then qualified its conclusion, noting: "*...unless there is substantial unsatisfied local demand, or the local market is very large (as may be the case in a few large conurbations), if a new hospital enters, the outcome may well be that all of the hospitals become unprofitable*".²⁵⁴
- 6.47 HCA agrees with the CC's qualification that its provisional conclusion does not apply to large conurbations. However, the CC contradicted itself by failing to take this into account in its analysis of central London, the largest conurbation in the UK.

²⁵² CC, PFs, para. 23.

²⁵³ Laing & Buisson, Private Acute Medical Care, page 36 (2012).

²⁵⁴ CC, PFs, para. 6.48.

6.48 Taking into account the particularly high and growing demand for complex, high acuity care in London,²⁵⁵ the CC's generic finding that local markets can only support a small number of hospitals simply does not hold. Whether one considers central London (which hosts at least 30 hospitals and PPUs) or Greater London (which has more than 50 hospitals and PPUs), these geographic areas cannot reasonably be characterised as local markets capable of only supporting a "small number of hospitals". Furthermore, as demonstrated in section 4 above, private healthcare provision in London has grown substantially and this shows no signs of abating. The future entry of The London International Hospital demonstrates this, as does the view of its developer: "over the coming decades, premium and specialised healthcare services particularly will provide attractive development opportunities and CCAG is therefore developing international healthcare ventures to cater to this demand".²⁵⁶

The London Clinic case study demonstrates that any issues with site availability and planning permission do not prevent profitable expansion

6.49 Summarising the London Clinic case study, in the PFs, the CC noted that "while TLC had been successful in expanding in central London it had encountered difficulties in doing so, the main ones being acquiring and obtaining permissions for a suitable site...".²⁵⁷

6.50 The CC had in fact carried out its case study on the London Clinic prior to the publication of its AIS. Following its analysis, the CC concluded: "Our case studies do not suggest that either capital requirements or planning issues constitute a significant barrier". The CC added:

*"The London Clinic told us that, given the nature of some of the radiotherapy equipment it was installing, strict health and safety requirements had to be met as regards radiation shielding, and that there were some **minor planning issues but none of these caused significant delays**. The planning issues arose from objections raised by English Heritage over the height of the atrium and by Transport for London over the removal of a tree".²⁵⁸ (**emphasis added**).*

6.51 Given the above, HCA finds it surprising that the CC has elected to use this case study to support its provisional finding that planning permission represents a barrier to entry. This finding is almost diametrically opposed to that reached months before in the AIS and the CC did not publish further analysis or evidence to support this change of view.

6.52 In a later working paper, the CC noted that it may be difficult to find, acquire and build on a site in the "immediate vicinity of Harley Street".²⁵⁹ Even if there are difficulties in the "immediate vicinity of Harley Street", this does not imply that site availability constitutes a barrier to entry or expansion in central London (or Greater London) more generally, and the CC provides no evidence to suggest that it does. In fact, HCA has provided evidence in its working paper response of a number of sites available and suitable for a private medical provider in central and Greater London, including in the vicinity of Harley Street.²⁶⁰ [3<].

²⁵⁵ See section 4 above.

²⁵⁶ http://www.ccalphagroup.co.uk/?page_id=90

²⁵⁷ CC, PFs, para 6.48.

²⁵⁸ CC, AIS, Appendix E, para. 33.

²⁵⁹ CC Entry and Expansion Case Study: The London Clinic, para. 80.

²⁶⁰ See, by way of example, Response to the London Clinic Case Study. Also, see from para. 6.62 below.

6.53 Furthermore, the CC acknowledged that the London Clinic succeeded in obtaining planning permission. Due weight must be given to the fact that the London Clinic was not thwarted by planning or site availability and had in fact succeeded in launching what is now a profitable Cancer Centre in central London. Indeed, the CC recognised that, "*Any restrictions on expansion encountered by TLC in developing its Cancer Centre have not prevented it from operating profitably*".²⁶¹

6.54 Therefore, the CC's London Clinic case study demonstrates that while in some instances planning issues can pose challenges (normal in any business that involves the use of physical premises to deliver its services) overall, these are easily surmountable and sites are available for profitable entry or expansion in London. The CC has provided no robust evidence to suggest otherwise and therefore its provisional conclusion that planning issues and site availability are barriers to entry or expansion cannot be upheld in relation to London.

HCA's internal documents on the London Bridge Hospital's capacity expansion do not suggest site availability is a barrier

6.55 The CC stated in paragraph 6.36 that: "*internal documents indicate that HCA has itself found difficulties in identifying suitable sites in Central London*". However, HCA submits that, when considered in its entirety rather than in the selective way it was considered by the CC, the "document"²⁶² referred to by the CC does not support the CC's statement above, for the reasons set out below.

6.56 First, and to put the document²⁶³ in its proper context, [REDACTED].

6.57 Secondly, the document notes that [REDACTED].

6.58 Thirdly, it is very disappointing that the CC has failed to acknowledge that the London Bridge Hospital had already undertaken large development projects that had significantly expanded its capacity, including the redevelopment of the adjacent St. Olaf House and development of the hospital's atrium space, for which it had successfully obtained planning permission.

A lack of pre-existing relationships with landlords would not prevent entry

6.59 In consideration of HCA's successful planning application to develop a medical facility on Devonshire Street, the CC noted that "*HCA already had a presence in the Harley Street area and had relationships with landlords there which may have, for example, facilitated the use-swap which made the package acceptable to the City of Westminster*".²⁶⁴

6.60 In relation to this particular issue concerning its investment in the Harley Street Area, HCA has previously put the following points to the CC.²⁶⁵

- [REDACTED].

²⁶¹ CC, PFs, Appendix 6.3, para. 74.

²⁶² HCA also notes that the CC refers to HCA "documents" in the plural. As HCA informed the CC during the "putback" process it is not aware of any other internal documents from which the CC could, correctly or otherwise, infer that there are difficulties in finding new sites for expansion.

²⁶³ HCA also notes that the CC refers to HCA "documents" in the plural. As HCA informed the CC during the "putbacks" process it is not aware of any other internal documents from which the CC could, correctly or otherwise, infer that there are difficulties in finding new sites for expansion.

²⁶⁴ CC, PFs, para. 6.61.

²⁶⁵ Email to the CC from Cyrus Mehta to Marvin Narayanan dated 6 August 2013.

- [REDACTED].
- [REDACTED].
- [REDACTED].²⁶⁶

6.61 None of these points submitted by HCA have been addressed by the CC in its PFs. HCA submits that the suggestion that a relationship with landlords would provide a meaningful advantage in the context of development projects considered here really appears far-fetched.

Numerous sites are available in London to support the new entry and expansion of private healthcare providers

6.62 HCA has submitted to the CC an extensive list of sites in central London that were available to bid on for hospital development projects.²⁶⁷

6.63 These development opportunities are continuously brought to the attention of HCA's management team by property developers. No account has been made of these development opportunities in the CC's PFs. [REDACTED].

6.64 Since then, further site development opportunities have been presented to HCA (and it understands, to other hospital operators):

- [REDACTED].
- [REDACTED].
- [REDACTED].

6.65 There are a range of NHS sites available that could be obtained by new and existing hospital operators to enter or expand in London. It has been noted that "*the NHS has many underutilised properties*"²⁶⁸ amounting to 1.5 million square metres country wide. HCA is aware of significant opportunities to acquire suitable NHS sites in London from this extensive property portfolio, and notes that these sites benefit from existing planning consents.

6.66 HCA recently informed the CC²⁶⁹ that [REDACTED].

6.67 HCA was recently informed of a [REDACTED] NHS site available for redevelopment. The NHS is reportedly planning to sell buildings at St. Mary's Hospital at the hospital's main site in Paddington and the Western Eye Hospital in Marylebone.²⁷⁰ These buildings would be available for a new entrant to the London market or for the expansion by an existing hospital operator.

²⁶⁶ [REDACTED].

²⁶⁷ See HCA, Response to the London Clinic case study. See also, HCA, Hearing Transcript.

²⁶⁸ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-estates-nhs-property-nigel-edwards-jul13.pdf

²⁶⁹ By way of email, 6 August 2013.

²⁷⁰ <http://www.healthinvestor.co.uk/ShowArticleNews.aspx?ID=2974>

- 6.68 Similarly, a recent article in the Health Services Journal (HSJ) (**Exhibit 2**)²⁷¹ reports that the Royal Brompton and Harefield Hospital Foundation Trust intend to sell off *roughly half of its land in Chelsea*, representing prime locations in London.
- 6.69 Far from there being a lack of suitable sites, there is a continuous flow of opportunities for entry and expansion that are available to new or existing hospital operators. The CC should take full account of the availability of NHS sites in its assessment of barriers to entry and expansion in its Final Report. To that end, HCA strongly suggests that the CC contacts the NHS Development Authority for detailed information on the availability of NHS sites to private sector providers in London.
- 6.70 Presently, NHS Trusts do not get charged the full economic costs of property. However, HCA understands that the NHS is likely to introduce fair market value rates to NHS Trusts for their property in the near future. This would add a further incentive for NHS Trusts to sell off vacant or underutilised property registered for medical use. The CC is well placed to help crystallise such measures through recommendations to the DoH.
- 6.71 To demonstrate the array of potential sites in central London alone, HCA commissioned a general statement (**Exhibit 3**) from property consultants, Altus Edwin Hill, on the potential availability of premises in central London for private acute healthcare purposes. [REDACTED].²⁷² A schedule was generated alongside the general statement following a search for premises around 30,000 – 50,000 sq ft in size and where the owners have indicated that they would in principle accept the accommodation being let for private acute care use. The list of premises includes sites at:
- [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED]
 - [REDACTED].
- 6.72 The statement stresses that the above list is the outcome of a "*preliminary trawl*" and that "*a full search would almost certainly yield more opportunities*".²⁷³
- 6.73 The evidence detailed above shows that there are a vast range of potential sites for hospital development. Furthermore, HCA notes that even relatively small sites can be developed in order to create successful, specialised medical facilities that compete with larger hospitals in terms of quality of care. There are also options available to existing hospital operators to expand their services through more efficient use of the facilities and space they currently have.

²⁷¹ <http://www.hsj.co.uk/acute-care/london-trust-plans-land-sell-off-worth-hundreds-of-millions/5065103.article>

²⁷² [REDACTED].

²⁷³ [REDACTED].

Obtaining planning permission has not prevented entry and expansion in London

6.74 HCA has successfully obtained planning permission for a series of hospital developments in London. [REDACTED]. Recent successful applications submitted by HCA for planning permission in London include:

- The Platinum Medical Centre (2011), a major new ambulatory care facility that cost [REDACTED] to develop. The development included an extensive diagnostic and imaging centre, chemotherapy centre, pharmacy, and day case unit (with four operating theatres and 12 beds).
- Heron House (adjacent to the Princess Grace Hospital) (2012): The Princess Grace Hospital's expanded into the building adjacent to the hospital.
- Leaders in Oncology Care (LOC) (2011): The LOC doubled its size by expanding into the adjacent building (97 Harley Street), providing 6 additional consulting rooms and a significantly larger treatment suite. The project cost was [REDACTED] and included the complete refurbishment of a six storey Grade II listed building over a 36-week period.
- Sarah Cannon Research UK (2010): HCA redeveloped 93 Harley Street to launch SCRI UK. The 13,000 square foot facility has 12 treatment chairs and separate testing areas.
- The London Bridge Hospital successfully obtained unconditional permission in 2005 to change the use of and redevelop St. Olaf House, a listed building adjacent to the London Bridge Hospital which now serves as an additional site for the facility. The development involved a large-scale office to medical facility conversion.
- The London Bridge Hospital obtained listed building consent for an expansion into its main atrium. This innovative project enabled the hospital to build an additional 10 bed state-of-the-art critical care unit and inpatient bedrooms.
- HCA has also sought to identify instances of planning permission being granted for medical use across Greater London in the last five years (see **Exhibit 4**). The research, conducted by Rolfe Judd Planning²⁷⁴, found that since 2008 there have been a larger number of accepted planning applications in London boroughs for medical use. The list shows that planning permission for healthcare facilities is frequently granted. **Table 3** below outlines some examples from the analysis.

²⁷⁴ London based architects and planning consultants.

Table 3 Sample of granted planning permissions in Greater London

Year	Council	Address	Project description	Nearest HCA facility
2013	Camden	Royal Free Hospital, Pond Street, London NW3 2QG	Erection of two storey extension to accommodate additional operating theatres plus plant equipment for existing hospital.	The Wellington Hospital
2013	City of Westminster	34 - 35 Dean Street, London, W1D 4PR	Use of ground and basement areas as a health clinic for the Chelsea and Westminster NHS foundation trust.	Harley Street Clinic
Awaiting decision	Kensington and Chelsea	Chelsea and Westminster Hospital, 369 Fulham Road, SW10 9NH	Extension of roof level accommodation to create a 20-bed intensive care unit with additional ancillary accommodation.	The Lister Hospital
2012	Kensington and Chelsea	Royal Marsden Hospital, 203 Fulham Road, SW3 6JJ	Part demolition, rebuild and extension of existing fourth floor Marsden Wing for a new MRI Diagnostic imaging suite, office support and rooftop plant area to rear.	The Lister Hospital
2012	Lambeth	Kings College Hospital, Denmark Hill, SE5 9RS	Extension of time limit to implement a partial removal of an existing hospital wing and the erection of a 4 storey building to be used as a Haematology centre.	London Bridge Hospital
2012	Southwark	Guys Hospital, Great Maze Pond, SE1 9RT	Demolition of existing buildings and erection of a 14 storey building for a Cancer Treatment Centre of around 312,000 sq ft.	London Bridge Hospital

Source: Rolfe Judd analysis, Exhibit 4

6.75 HCA further notes that the CC has reached a view that obtaining planning permission could raise the costs and risks of entry and expansion, thus giving incumbent hospitals a costs advantage. However, the CC presented no evidence of the costs of obtaining planning permission in its analysis nor gave any indication, other than in its conclusions that there was evidence to support the view that incumbent hospitals would have a cost advantage as a result. Equally, the CC presented no evidence as to the impact of obtaining planning

permission on the risks of entry and expansion. Indeed, the only evidence presented indicated that entry and expansion had been achievable in the past.

- 6.76 Notwithstanding the above, if the CC does have material concerns about planning acting as a barrier to entry and expansion, HCA would query why the CC has not also consulted on a remedy seeking to modify the planning regime to promote healthcare developments (see HCA's response to the Remedies Notice). Indeed, the CC's Market Investigation Guidelines list "*Recommendations to Government or regulatory bodies to address any barriers to entry which are caused or created by government laws or regulatory actions (e.g. planning rules)*" as an illustrative remedy approach where there are restrictions on competitive entry or expansion.²⁷⁵

(4) The CC's concerns that large hospital groups "induce" PMI providers to refuse recognition in London are unsound

- 6.77 The CC provisionally found that PMI recognition is not in itself a barrier to entry, but larger hospital groups may "*induce*" a PMI to refuse recognition of a new entrant".²⁷⁶ Again, there is no evidence that this has deterred new entry and expansion in London.
- 6.78 Obtaining access to PMI networks is critical to the financial viability of a hospital operator. PMI network strategies (whether at facility, speciality or procedure level) means private hospital operators compete with each other to obtain network recognition. As a direct result, some private hospital operators are included on a PMI network and others excluded. The need of private healthcare providers to have PMI recognition and be included on key networks, by its very nature, represents a barrier to entry and expansion.
- 6.79 PMIs have willingly implemented network strategies as the volume assurance that they can offer hospital operators included in a given network provide them with greater bargaining power. For example, AXA PPP created the Corporate Pathways Product, which excluded every other hospital operator and awarded exclusive coverage to BMI. It is likely that AXA PPP created this network to leverage its bargaining power.
- 6.80 Submissions by PMIs during the market investigation have acknowledged that PMIs are willing parties to contractual arrangements that may exclude new hospital providers. Bupa acknowledged that granting recognition to a new hospital was by no means guaranteed for any provider as: "*insurers must take into account several commercial factors before recognising a new facility (in addition to the quality and regulatory requirements)*".²⁷⁷
- 6.81 Bupa accepted that it was a willing party to certain types of volume-discount arrangements with hospital operators. For example, Bupa noted in its response to the AIS:²⁷⁸

"The economics of the hospital industry – high fixed costs and economies of scale – mean that higher volume leads to lower cost, and so it is efficient that the purchaser that delivers higher volume is rewarded with a lower price. As an insurer seeking best value on behalf of our members, it is correct that BHF enters into volume discount arrangements, willingly, if this leads to lower prices for our customers".

²⁷⁵ CC3 (Revised), Guidelines for market investigations: Their role, procedures, assessment and remedies, April 2013, Table 1.

²⁷⁶ CC, PF, para. 6.72.

²⁷⁷ Bupa, Response to the AIS, para. 2.163.

²⁷⁸ Bupa, Response to the AIS, para. 2.157.

6.82 These statements indicate that insurers are not at all "induced" into the sort of contractual outcomes that award volume to one hospital operator to the detriment of another, but are willing parties in contractual arrangements.

Conclusions

6.83 In summary, the CC's PFs in relation to barriers to entry and expansion are simply not applicable to London:

- There has been considerable new entry and expansion in London and this is expected to continue, with further entry planned in the near future. This is direct evidence contradicting any view that there are barriers to entry and expansion in London.
- Demand for private healthcare services is expected to grow in London, providing increased incentives for entry and expansion.
- The costs of development, site availability and obtaining planning permission have not deterred profitable new entry or expansion in London and do not constitute barriers to entry or expansion.
- Trends towards care increasingly being delivered in day- and outpatient settings will make future entry in London even easier and less costly.
- There are a significant number of consultants in London available for new and existing private healthcare providers and competition for them drives improvements in the quality of healthcare provision, as the evidence shown in **Appendix 7** demonstrates.
- PMI recognition acts as a barrier to entry and expansion, but there is no evidence that this is driven by large hospital groups being able to "*induce*" PMIs to prevent accreditation of other private healthcare providers.

7. BARGAINING²⁷⁹

Key Points

- The CC's own conclusions on the relative bargaining strength of hospital operators and PMIs do not support the CC's provisional finding of an AEC.
- The CC has overestimated the alternatives available to a hospital operator, and in particular to HCA, when negotiating with a PMI. HCA cannot replace the volume lost following a temporary or permanent delisting and simply cannot survive without recognition by the largest PMIs.
- Conversely, the CC has underestimated the alternatives available to a PMI when negotiating with a hospital operator. Open referral policies, restrictive networks, strategic recognition of new facilities and service-line tenders are all strategies available to PMIs which (compounded by the consultant drag effect) confer upon them very significant bargaining power. Furthermore, there is sufficient spare inpatient capacity in central London *alone* for any of the largest PMIs to have a viable alternative to HCA's hospital facilities.
- PMI market conduct in recent years demonstrates that PMIs such as Bupa can and do leverage their bargaining power against hospital operators, including by way of delisting. The consequences of such delisting are much more severe for a hospital operator compared to a PMI.
- The CC's assessment of bargaining is inconsistent with economic theory, as it has largely ignored the effects on the negotiating parties of a *temporary* disagreement.
- The CC's insured price analysis does not measure prices appropriately and has serious omissions and methodological flaws which render its results unreliable. It also cannot be informative of relative bargaining power, since it failed to account for other important features of the private healthcare market, including quality and other cost differences between hospital operators.
- Furthermore, HCA considers that the results of the CC's insured price analysis do not support the CC's provisional findings. Tests of statistical significance on the London price index results are inconsistent with the CC's assertion that "*prices charged by HCA were significantly higher than those of other operators*". The CC's results for the analyses of the national price index and average revenue per admission are also entirely consistent with higher average charges resulting from HCA's higher costs compared to other national operators arising from the central London location of its facilities and the high quality provision of complex treatments to insured patients.
- The PMIs' strategies aimed at controlling the patient pathway reflect the PMIs' strong bargaining power and can bring about adverse effects, in the form of patient detriment.

Introduction

7.1 In its PFs the CC carried out an assessment of the relative bargaining strength of the hospital operators and the PMIs.²⁸⁰ Based on that assessment, the CC concluded: "*We did not find that the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power.*"²⁸¹

²⁷⁹ The redacted version of this section (i.e. excising confidential non-HCA information) has been prepared by HCA's advisers following a very conservative approach to redactions of non-HCA data (i.e. removing material which may not be confidential in respect of disclosure to HCA). HCA reserves the right to request disclosure of redacted text. As to confidential information which relates to HCA, HCA will submit separate confidentiality representations to the CC.

²⁸⁰ PFs, paras. 6.145–6.189.

²⁸¹ PFs, para. 6.189.

7.2 HCA submits that this conclusion does not fully recognise the weight of the evidence that shows that PMIs are in a much stronger bargaining position than hospital operators. Further, even if the CC's view on the balance of bargaining power was confirmed, the CC is not in a position to confirm its provisional conclusion that:

*“weak competitive constraints in many local markets including central London [that together with high barriers to entry for full service hospitals] give rise to AECs in the markets for hospital services that are likely to lead [...] to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with PMIs.”*²⁸²

(1) The CC has overestimated the value of the alternatives available to hospital operators (and in particular to HCA)

7.3 HCA sets out below why the CC has largely overestimated the value of the alternatives available to hospital operators, and in particular to HCA.

HCA agrees with the CC that there are a number of ways in which PMIs are able to, and do, exert their bargaining strength, limiting the options available to hospital operators

7.4 HCA agrees with the CC that:

- Contracts between hospital operators and PMIs do not generally specify a volume of business and that PMIs may influence the volume of business of a hospital operator through a number of channels, including guided referrals, use of restricted networks and delistings.²⁸³
- The key to understanding the negotiating position of hospital operators and PMIs is the extent to which PMIs can exert “*meaningful control*” over where their policyholders are treated.²⁸⁴
- If a hospital operator suffered the delisting of one or more of its facilities, it would be severely impacted, as it would lose PMI revenues, as well as consultants, leading to further revenue reductions.²⁸⁵ In particular:
 - [redacted].^{286,287}
 - HCA also agrees with the CC's recognition of the consultant drag effect, in that if a major PMI delisted a hospital, many consultants practising there would be likely to move their practice to a different hospital where they could see patients from all of the PMIs, as well as their self-pay patients. The additional loss of business due to the consultant drag effect may therefore be significant for a hospital operator and compound the loss of business from the PMI that delisted a given facility.²⁸⁸

²⁸² PFs, para. 72.

²⁸³ PFs, para. 6.147.

²⁸⁴ Appendix 6.11 to PFs, para. 5.

²⁸⁵ PFs, para. 6.159.

²⁸⁶ Appendix 6.11 to PFs, para. 241.

²⁸⁷ [redacted].

²⁸⁸ PFs, para. 6.159.

- Restricted networks have a significant impact²⁸⁹ and, in particular, one important form of restrictive network involves the exclusion of many central London hospitals (often HCA hospitals). The CC stated that “*policies which enable corporate clients to contain costs [...] appear to be growing in attractiveness among corporate customers.*”²⁹⁰
- The PMIs’ strategic recognition of new facilities has a significant impact and, in particular, PMIs have a strong negotiating position where a hospital operator asks a PMI to recognise a new facility that was not previously included in the PMI’s networks.²⁹¹ As HCA submitted to the CC, this is a very powerful lever in the PMIs’ favour during negotiations with hospital operators. HCA provided evidence of this [X].²⁹²[X]

7.5 HCA submits that these factors confer upon the PMIs significant bargaining power in their negotiations with hospital operators, which also in part arises as a result of the limited options available to hospital operators, discussed below. HCA believes that the CC has significantly underplayed or misunderstood the relevance of a number of factors in relation to the PMIs’ bargaining strength and to HCA’s weak bargaining position.

A delisting by one of the large PMIs would inflict unsustainable losses on HCA

7.6 HCA submits that the high concentration in the supply of private medical insurance implies that losing the business of even one large PMI entails a very significant loss of revenues for a hospital operator.

7.7 Any initial direct loss from delisting would inevitably be compounded by an additional loss due to the consultant drag effect. As the CC itself acknowledges,²⁹³ following a delisting of a hospital or a hospital network, a number of consultants will move their main private practice to a competing hospital operator. In doing so, these consultants will bring with them a number of their self-pay (including international) patients, as well as patients from the non-delisting PMIs.

7.8 Taking the example of AXA PPP, HCA estimates that if this PMI decided to delist HCA’s hospitals, [X].^{294,295}

7.9 In the case of Bupa, HCA estimates that if such PMI decided to delist HCA’s hospitals, [X].²⁹⁶

7.10 Either delisting by AXA PPP or Bupa would cause [X]²⁹⁷[X]²⁹⁸[X].^{299,300}

7.11 HCA also notes that while the above scenario has been set out in the context of a potential complete delisting of HCA’s facilities, a similar effect (though on a smaller scale) would come

²⁸⁹ However, HCA believes that the CC did not give sufficient weight in the PFs to the evidence on PMI networks in London set out in Appendix 6.11 to the PFs, paras. 119–120 and 157–163.

²⁹⁰ PFs, para. 6.172.

²⁹¹ PFs, para. 6.175.

²⁹² [X]

²⁹³ PFs, para. 6.159.

²⁹⁴ [X]

²⁹⁵ [X]

²⁹⁶ [X]

²⁹⁷ [X]

²⁹⁸ [X]

²⁹⁹ [X]

³⁰⁰ [X]

about as a result of an HCA hospital or set of hospitals failing to be included on a network of one of the large PMIs.

- 7.12 HCA also notes that smaller PMIs too are in a position of substantial bargaining power in their negotiation with HCA. [30]. The key in determining the relative bargaining strength of even smaller PMIs is the fact that HCA would not be able to replace the business lost following a delisting, while the PMIs' customer base would not reduce significantly. This is also demonstrated (for example) by the existence and success of their networks that exclude HCA and by further evidence set out in this section.
- 7.13 From the perspective of a hospital operator, the financial harm of, for example, a lack of recognition of a facility by Bupa is that the viability of that hospital facility is threatened. [31]. AXA PPP's decision not to recognise the then new, state-of-the-art, London Heart Hospital resulted in the eventual closure of that private hospital (see box below) following a delay of over a year by Bupa to recognise this facility.³⁰¹ While such events may not occur on a yearly basis, they are clear examples of the consequences of delisting and as such leave an indelible impression of PMI bargaining power on the mind of any hospital operator.

The London Heart Hospital – An example of the potential consequences of PMI bargaining power

- The market exit of the London Heart Hospital in 2000/2001 is an illustration of the high dependence of hospitals on PMIs. The facility was a new, state of the art cardiac facility owned and operated by Gleaneagles UK Limited which opened in the Harley Street area in 1999. This constituted a £45 million investment by a Singaporean investment group. The new facility failed to obtain recognition by PPP in that year, and as a result suffered a severe financial impact.
- The Hospital filed a Complaint with the OFT in relation to PPP's refusal to recognise it, and closed shortly afterwards, exiting the market. The land and buildings were sold to the NHS. Christiane Kent, currently Inquiry Director of the CC's market inquiry, was at that time the OFT case officer handling the Complaint and is therefore in a position to verify these matters. We also refer to the extensive press articles at that time about the Complaint (see e.g. "OFT inquiry into health insurers", Guardian, 12 February 1999). Whatever the justification which PPP advanced at that time about its reasons for refusing to recognise the new facility, this case demonstrates that in the absence of recognition from a major insurer, a new hospital is unviable and cannot survive.
- Sir Richard Needham, Chairman of the Heart Hospital publicly alleged that "the powerful PPP health insurance group had 'frozen out' the Heart Hospital" and that PPP had engaged in a "blatant abuse of market power to retain its grip in the private health sector"
(See <http://www.theguardian.com/business/1999/feb/12/5>).

- 7.14 In the case of the PMIs, the financial downside from a delisting is that a proportion of corporate clients may decide not to renew their policy with the PMI. However, large parts of PMIs' customer base are inherently sticky and higher margin. It is telling that only a year after Bupa delisted a series of BMI hospitals, it reported a growth in profits of over 120%.³⁰²

³⁰¹ The Heart Hospital was subsequently taken over by the NHS.

³⁰² Bupa reported in its 2013H1 results that its UK "underlying profits" had increased by 124% year-on-year. See Bupa, Half Year Statement for the six months ended 30 June 2013, pages 8 and 9. HCA is

[redacted]. On balance, compared to the serious harm that can be inflicted on a hospital operator, the financial downside of a hospital delisting on a PMI is considerably lower.

Guided referral policies are increasingly successful and weaken the relative bargaining strength of hospital operators

7.15 HCA submits that the CC significantly underestimated the extent to which guided referral policies have substantially strengthened the negotiating positions of PMIs. Not only do guided referral policies have “*the potential to change the balance of negotiating power*” between hospital operators and PMIs,³⁰³ as the CC stated, but this has already happened to a significant degree.

7.16 For example, Bupa has stated that “[e]ight out of ten of Bupa’s new and current corporate clients had chosen the open referral scheme”.³⁰⁴ As for AXA PPP, the number of policyholders on its Corporate Pathways product grew from [redacted] in 2012 to [redacted] in 2013 (an increase of over [redacted] in only one year).³⁰⁵ Open referral clauses for consultants also constitute a relevant factor in negotiations between hospital operators and PMIs, because they allow PMIs to direct policyholders towards consultants that practise at certain hospitals rather than others.³⁰⁶ AXA PPP itself clearly agrees that directing patients to consultants can be used as a way of directing patients to specific hospitals (or hospital operators): as the CC put it, “AXA PPP explained that [redacted]”.³⁰⁷

7.17 HCA wholly disagrees with Bupa’s view that its contract with HCA has limited Bupa’s ability to direct volume (e.g. through Open Referral) to cheaper providers.³⁰⁸ The evidence before the CC simply does not support such a proposition.

- **The existence of Open Referral:** The very fact that Bupa launched Open Referral is at odds with Bupa’s view. HCA submitted a Bupa document showing that a key objective behind Open Referral was to redirect demand to hospitals outside central London.³⁰⁹ Figure 4 (an extract of a Bupa document) of Appendix 6.11 to PFs clearly demonstrates that Bupa’s strategic intention is to influence the choice of hospital. The CC, too, observed that the main tool for directing patients, other than through its networks, is guided referral products.³¹⁰

- **Targeting consultants means targeting hospitals:** Bupa possesses information on where consultants practise, therefore by targeting specific consultants, Bupa can and does effectively redirect demand to the private hospitals of its choosing. This is demonstrated by Bupa’s own internal documents. For example the CC cites a Bupa presentation which admits that [redacted].³¹¹ Furthermore, Bupa itself admits that Open

conscious that this figure refers to the whole of Bupa’s UK business, but in the same presentation Bupa made clear that its health insurance profits had also increased over the previous year.

³⁰³ PFs, para. 6.179.

³⁰⁴ Summary of hearing with Bupa held on 20 March 2013, para. 70.

³⁰⁵ Appendix 6.11 to PFs, para. 135.

³⁰⁶ As HCA already submitted to the CC, it would be in the interest of consumer transparency that Bupa’s Open Referral algorithm (purported to be based on quality) should be subject to independent external scrutiny. See HCA’s response to Competition Commission’s AIS, 12 April 2013, paras. 6.17–6.18.

³⁰⁷ Appendix 6.11 to PFs, para. 195.

³⁰⁸ Appendix 6.11 to PFs, para. 179.

³⁰⁹ HCA’s Response to Market Questionnaire, Exhibit 11.1.

³¹⁰ Appendix 6.11 to PFs, para. 185.

³¹¹ Appendix 6.11 to PFs, para. 186.

Referral is intended to make consultants more concerned about costs such that they become more interested in “where they practised”.³¹²

- **The impact of Open Referral:** The impact of Open Referral on HCA’s hospitals is likely to become apparent in the near future, taking account of Bupa’s track record of transferring corporate clients onto Open Referral combined with Bupa’s desire to roll Open Referral out to individual policyholders too.³¹³

7.18 HCA similarly disagrees with Aviva’s view that its contract with HCA “[redacted]”.³¹⁴ The CC reported Aviva as making a similar claim about its contractual arrangements with HCA.³¹⁵ The evidence before the CC is that Aviva has, in fact, taken action clearly demonstrating its freedom and ability to direct patients. For example, in July 2013, Aviva launched its own corporate open referral product, “Guidewell”, which is also marketed in London, as Aviva’s marketing materials make clear. Aviva’s press release noted that the product “uses an open referral pathway to manage claims costs and deliver sustainable and competitive pricing”, including “no shortfall on hospital charges”.³¹⁶ The press release adds: “Further Aviva research highlights the increased use of open referral by GPs. 18% of all Aviva PMI claims met in 2012 were on an open referral basis”. Aviva has also been able to redirect patients away from HCA through material changes to its core network, the Key List, which now incorporates a large number of HCA’s competitors in London, but continues to exclude HCA’s hospitals.

7.19 The evidence above suggests that, far from being “limited” in directing patients, Bupa and other PMIs have enjoyed significant freedom and success in strategically influencing patient demand for private healthcare through guided referral.

Restrictive networks and service-line tenders weaken the relative bargaining strength of hospital operators

7.20 As noted in paragraph 7.4 above, HCA agrees with the CC’s recognition of the importance of restricted networks. HCA submits that a PMI’s decision about restricting its network involves a number of separate options for different ways of presenting their product to their customers – relating to hospitals and/or specific medical procedures. These all constitute viable alternatives to possible outcomes of a bargaining process with a hospital operator:³¹⁷

- HCA notes that each of the top six PMIs has been able to exclude HCA hospital facilities from at least one of their key networks and, on each of those networks, the PMIs have included some of HCA’s major rivals based in London and the South East. The PMI networks excluding HCA hospitals are important. These include prominent networks operated by:

- (1) Bupa (Extended Choice)
- (2) AXA PPP (Corporate Pathways and Health-on-line)
- (3) Aviva (Key List)

³¹² Appendix 6.11 to PFs, para. 178.

³¹³ Appendix 6.11 to PFs, para. 185.

³¹⁴ Appendix 6.11 to PFs, para. 180.

³¹⁵ Appendix 6.11 to PFs, para. 155.

³¹⁶ See <https://www.aviva.co.uk/media-centre/story/17164/aviva-launches-guidewell-making-pmi-more-sustainable/>

³¹⁷ HCA’s response to Competition Commission’s AIS, 12 April 2013, para. 5.16.

(4) PruHealth (Countrywide)

(5) SimplyHealth (National List and Connections List)

(6) WPA (Provincial – scale 2).

- HCA further notes that AXA PPP, commenting on HCA's view that all PMIs sold products that did not include HCA, stated that *"these products, such as lower cost networks, demonstrated that PMIs had sufficient bargaining power against HCA"*.³¹⁸
- HCA also notes PruHealth's comment that *"it had offered products to corporates in London that did not include HCA, and that over the past year it has worked relatively well"*.³¹⁹

7.21 By contrast, HCA disagrees with AXA PPP's comment that *"its weakened bargaining position in London was reflected in the low take up of products in London that did not include HCA"*.³²⁰ First, TLC was only added to AXA PPP's Corporate Pathways network in late 2012. HCA's advisers understand that AXA PPP's Corporate Pathways network product has been more broadly relaunched in October 2012, and that Bupa Cromwell Hospital, Aspen Parkside and St. John's and St. Elizabeth's (among other HCA's competitors) have been added to it as part of this relaunch. As these are all important hospital operators in London, one should expect the performance of AXA PPP's Corporate Pathways network product to reflect this going forward. Moreover, the existence of a network that does not include HCA demonstrates that such a network constitutes a viable product. The fact that such a network is not as successful as a network that does include HCA is clearly a function of the quality of HCA's hospitals and the result of a competitive market resulting in consumers choosing the better alternative. AXA PPP does not provide any evidence as to why this outcome would result from a non-competitive market. For the CC to draw on AXA PPP's views, it would have to also consider pricing of these network products to corporate customers and assess how they compare from both a quality and overall value-for-money perspective.

7.22 HCA also notes that the fact that Aviva demanded a [X] discount for HCA's hospitals to join the Key List [X]. In effect, Aviva has wilfully excluded HCA from its core list.³²¹

7.23 The CC must recognise the impact of these alternative restrictive networks on the PMIs' bargaining strength. In addition, the CC must give sufficient weight to the PMIs' increasingly frequent use of service-line tenders to create separate specialty networks.³²² HCA submits that the CC should have recognised that the options for service-line tenders available to PMIs also constitute viable alternatives to possible outcomes of a bargaining process with a hospital operator.

³¹⁸ Appendix 6.11 to PFs, para. 125.

³¹⁹ Appendix 6.11 to PFs, para. 159.

³²⁰ Appendix 6.11 to PFs, para. 158.

³²¹ HCA submitted evidence to the CC in its response to the Market Questionnaire showing [X].

³²² HCA's response to Competition Commission's AIS, 12 April 2013, para. 5.136. In fact, the CC only refers to the evidence on service-line tendering in Appendix 6.11 to the PFs, paras. 209-220.

(2) The CC has underestimated the value of the alternatives available to PMIs

7.24 HCA also believes that the CC has largely underestimated the value of the alternatives available to PMIs.

The CC has erred in its geographic market definition and this also led to an incorrect assessment of the alternatives available to PMIs

7.25 The CC has drawn the geographic boundaries of the market in which HCA operates too narrowly, concluding that central London is a separate market and that hospitals outside of central London are only a weak constraint on HCA. As HCA sets out in section 5, this assessment is incorrect for a number of reasons. The CC cannot ignore the ability of PMIs to have their patients treated at these alternative facilities, many of which will be close to the patients' home location (as opposed to close to their employer's location in central London). Guided referrals enable PMIs to take advantage of this, directing patients to consultants and facilities farther afield. HCA notes that the CC referred to some of the PMIs' ways of assessing whether there are alternatives to specific hospital sites, including the use of catchment areas.³²³ Due to the limited time available in the Data Room, and the non-disclosure of the relevant internal documents of the PMIs, HCA's advisers are not in a position to fully engage with any such material nor to perform further analysis on such issues. HCA therefore reserves the right to supplement its Response with further analysis in due course.

The CC underestimated the PMIs' bargaining power that flows from their existing vertical integration and from their ability to expand or enter into the private healthcare market

7.26 The CC has failed to fully recognise that vertical integration or expansion in the provision of private healthcare services is a viable alternative available to PMIs. PMIs' vertical integration into primary care (and into secondary care, as in the case of the Bupa Cromwell Hospital, for example), combined with managed care strategies, further strengthens the PMIs' bargaining position.³²⁴

7.27 HCA also notes that if PMIs such as Bupa or AXA PPP genuinely believed that there was limited competition in the supply of private healthcare in London (or in the UK) they could easily expand their existing operations in or (re-)enter into any parts of the market. As discussed in detail in section 6 of this Response, there are no significant barriers to entry or expansion in the provision of private healthcare in London. The fact that these companies do not, is another sign of the competitiveness of the market where HCA operates.

The CC should closely scrutinise the PMIs' claims around their outside options, if the CC wants to rely on any such "evidence"

7.28 The CC concluded that the number of hospitals, their locations and the competitive conditions in each area are important factors in the negotiations between hospital operators and PMIs.³²⁵ However, no analysis of the importance of these factors is provided. The CC appears to have simply relied on the PMIs' assertions and figures (redacted in the non-confidential version of the PFs, Appendix 6.10 and Appendix 6.11). In fact, HCA is

³²³ See, for example, Appendix 6.11 to PFs, para. 24.

³²⁴ HCA's response to Competition Commission's AIS, 12 April 2013, paras. 5.124–5.125.

³²⁵ PFs, para. 6.188.

particularly concerned that the CC seems to have both reported and relied on only a small set of internal documents from the PMIs.

- 7.29 HCA's advisers have not been allowed access (even on a confidential basis) to a broader range of the PMIs' internal documents submitted to the CC, several of which may well have contained evidence that went against the PMIs' arguments.³²⁶
- 7.30 In several instances, HCA's advisers have simply been unable to corroborate some of the PMIs' claims that refer to HCA own data because of lack of full disclosure of the original document by the PMI.
- 7.31 For example, HCA's advisers have reviewed Figure A1 of Annex A to Appendix A6.10 of the PFs. In this figure, the CC reports a chart prepared by Bupa which shows the share of its corporate spending at different HCA hospitals. According to Bupa, the London Bridge Hospital accounted for [redacted]% of its corporate customers' expenditure at HCA. HCA's advisers, however, noticed that Bupa's analysis (as reported by the CC) does not specify what timeframe those shares refer to. More generally, HCA's advisers cannot corroborate the reported overall Bupa corporate customers' expenditure at HCA (£[redacted]) with HCA's own data on Bupa's total expenditure at HCA. While HCA's database cannot distinguish between personal PMI expenditure and corporate PMI expenditure, the difference between the value reported in Figure A1 (£[redacted]) and Bupa's total expenditure at HCA over any of the recent years cannot be attributed to personal PMI expenditure alone. HCA's advisers are therefore not in a position to ascertain the correctness of those estimates and they cannot ultimately engage with the evidence presented by the CC.

AXA PPP

- 7.32 HCA's advisers have reviewed part of the analysis submitted to the CC by AXA PPP, which estimates the effect of delisting HCA on both AXA PPP and HCA, as reported in Table A1 of Annex A to Appendix A6.10 of the PFs.
- 7.33 In this regard, HCA's advisers first note that they are not in a position to fully comment on nor engage with this analysis, as the CC did not agree to the disclosure of the original underlying documents by AXA PPP. For example:
- It is not clear what "lapse rates" are. Presumably, they measure the percentage of AXA PPP current customers (i.e., large corporate clients, SMEs and individuals) who decide to switch PMI or stop contracting with AXA PPP (at contract renewal) following the delisting of HCA hospitals;
 - It is not clear whether the lapse rates used by AXA PPP measure what would happen to AXA PPP's business at the UK level or capture the reaction of those customers based in London; and
 - It is not clear how AXA PPP modelled the profit and loss statement impact of a delisting on HCA's business.

³²⁶ Another example is the way in which the CC summarised an AXA PPP presentation that was prepared in the context of contractual negotiations between this PMI and HCA as vague and does not allow HCA's advisers to check whether the arguments summarised by the CC have been taken out of context, or whether the CC omitted important pieces of evidence from that document or from other similar documents (Appendix 6.11 to PFs, para. 117).

7.34 On the basis of the limited information made available, HCA's advisers have a number of concerns, including:

(1) AXA PPP has assumed that it would not be able to redirect at least [redacted]% of patients, even after 12 months of delisting. Over the first three months since a delisting, its model assumes [redacted]; over 3–6 months it assumes [redacted]; and over 6–12 months it assumes [redacted]. According to AXA PPP, its limited ability to redirect patients is due to a number of reasons, including:

- “[redacted]”;
- “[redacted]”;
- “[redacted]”.
- AXA PPP has significantly overstated the significance of these issues and thus its modelling assumptions significantly underestimated its ability to redirect patients.
- On the first point raised by AXA PPP, the CC should be well aware that PMIs can easily change network composition to personal PMI policyholders (this applies to corporate policyholders too, albeit to a lesser extent).
- As for the second point raised by AXA PPP, HCA's patient data suggests that [redacted] of AXA PPP inpatients in 2012 had an episode that lasted for 9 days or fewer; that is, from a statistical perspective, it is difficult to believe that many AXA PPP patients would be affected by the issue raised by AXA PPP, in that the probability of any one of them being under treatment at a given point in time is very low. Therefore, it is not clear the extent to which the reasons suggested by AXA PPP have a material impact on its ability to redirect patients.
- On the last point raised by AXA PPP, AXA PPP has itself acknowledged that “out-of-network” claims only account for [redacted]% of AXA PPP total value of claims, so this is unlikely to be a major driver of AXA PPP's modelling assumption.
- In sum, the CC should critically assess AXA PPP's assumption that it could hardly redirect any patient in the short term and that even in the long term it could not redirect [redacted]% of HCA's patients, in case of a delisting.

(2) AXA PPP has also stated that, in its negotiations with HCA, it expects that [redacted]

- [redacted]
- [redacted]

(3) AXA PPP estimated the effects on HCA's profit and loss statement following a delisting by AXA PPP, under different scenarios. However, on the basis of the information made available by the CC, it is totally unclear how AXA PPP arrived at those estimates. In fact, AXA PPP severely underestimated the actual loss that HCA would incur (for example, it is highly unlikely that AXA PPP accounted for the consultant drag effect in its estimates). As discussed at paragraph 7.7, any initial

direct loss from delisting would inevitably be compounded by an additional loss due to the consultant drag effect. Following a delisting of a hospital or a hospital network, a number of consultants will move their main private practice to a competing hospital operator. In doing so, these consultants will bring with them a number of their self-pay (UK and international) patients, as well as patients from the non-delisting PMIs (see paragraphs 7.8ff for HCA's view of the effect of a delisting by AXA PPP or Bupa on HCA's business).

- (4) AXA PPP has estimated that, depending on the lapse rates applied to large corporate customers, SMEs and individual customers, as well as on the percentage price discount offered to its customers, AXA PPP would lose between £[redacted] in the year following the delisting of HCA. It is not clear at all how AXA PPP computed its expected losses under the various scenarios.
- (5) The magnitude of the lapse rates chosen by AXA PPP under the optimistic, realistic and pessimistic scenarios (i.e., [redacted]) suggest that between [redacted]% of AXA PPP customers would not switch to a different PMI provider, nor stop contracting with AXA PPP following a delisting of HCA's facilities. While these figures may be an overestimate of the customers who would switch, this shows that AXA PPP expects that the vast majority of its customer base would prefer to use alternative hospital operators were HCA hospitals no longer included in the network of hospitals covered by AXA PPP, rather than choose a PMI provider that includes HCA hospitals in its network. Further, AXA PPP provides no support for its assumptions on lapse rates. In fact, AXA PPP had already submitted to the CC (Response to the AIS, paragraph 5.37) that *"it is difficult for insurers to determine with accuracy the impact of client losses as a consequence, inter alia, of de-listing a hospital or hospital group"*. The CC should therefore recognise the high degree of uncertainty surrounding any modelling exercise put forward by AXA PPP.

7.35 To the extent that the CC wishes to use this evidence to reach a conclusion on the relative bargaining power of the PMIs and the hospital operators, the CC will need to test the credibility of the figures provided by AXA PPP, including the assumptions on which those rest. In the form provided by the CC in Annex A to Appendix 6.10, the "analysis" performed by AXA PPP cannot be treated as anything more than an assertion or a view of an interested party in this inquiry. Furthermore the CC should consider the parts of this evidence that confirm the views expressed by HCA, for example in relation to PMIs being likely to only lose a small proportion of their customer base following a delisting.

Bupa

- 7.36 HCA's advisers have also reviewed some of the analysis prepared by Bupa for the latest round of negotiations with HCA [redacted], as reported in Figure A2 of Annex A to Appendix A6.10 of the PFs. In particular, this analysis sets out the expected financial impact on Bupa's business under different scenarios. In each scenario, Bupa considered different levels of HCA's price increases and different levels of patient redirection by Bupa (target and actual).
- 7.37 In this regard, similarly to the case of AXA PPP, HCA's advisers first note that they are not in a position to fully comment on or engage with this analysis, as the CC did not agree to the disclosure of the original underlying documents by Bupa.
- 7.38 On the basis of the limited information reviewed, HCA's advisers point out the following:

- (1) Bupa itself acknowledged that it expects that HCA may have the ability to raise prices by no more than [redacted]%, in response to a significant volume of its Bupa patients being redirected to alternative hospital operators. That is, Bupa does not consider that HCA can increase prices beyond this level on the non-redirected Bupa patients.
- (2) The difference between target redirection and actual redirection (for example [redacted]%) suggests that Bupa believes that it would be able to redirect [redacted]% of the patients it sought to redirect.
- (3) No information was available on how Bupa computed its expected losses (of between £[redacted] per year) in case the scenario set out at point (2) arose. To the extent that the CC wishes to use this evidence to reach a conclusion on the relative bargaining power of the PMIs and the hospital operators, the CC will need to test the credibility of the figures provided by Bupa, including the assumptions on which those rest.
- (4) Bupa's own analysis clearly suggests that Bupa expects that if it were to attempt to redirect [redacted]% of HCA patients, it would succeed in redirecting [redacted]% of HCA patients and that as a result of HCA's likeliest price increase response ([redacted]%, according to Figure A2) the impact on Bupa's revenues would actually be [redacted]). This suggests that Bupa itself is aware of the value of its outside option and therefore of its strong bargaining power vis-à-vis HCA.
- (5) The proportions of patients that Bupa considers it can redirect, while clearly understating Bupa's ability to redirect,³²⁷ are substantial [redacted].

7.39 In summary, as in the case of AXA PPP, to the extent that the CC wishes to use this evidence to reach a conclusion on the relative bargaining power of the PMIs and the hospital operators, HCA submits that the evidence available supports HCA's view that it is the PMIs who hold the upper hand in negotiations. HCA believes that the CC will need to test the credibility of the statements and figures provided by Bupa if it wishes to rely on them to support a different conclusion.

The CC should closely scrutinise the PMIs' claims around any "must-have" hospitals, if the CC wants to rely on them

7.40 As set out in paragraphs 7.28 and 7.29, HCA submits that the CC seems to have both reported and relied on only a small set of internal documents from the PMIs. As HCA's advisers have not been allowed access to a broader range of the PMIs' internal documents submitted to the CC, it has not been possible for them to engage with many of the arguments put forward by the PMIs.³²⁸

7.41 For example, it is not clear at all how Aviva reached the conclusion that HCA has [redacted] "must-have" hospitals (Appendix 6.11 to PFs, paragraph 12c), given that HCA only has six

³²⁷ The CC should recall, for example, that eight out of 10 of Bupa's new and current corporate customers are on an open referral scheme (Summary of hearing with Bupa held on 20 March 2013, para. 70).

³²⁸ Due to the limited time available in the Data Room, and the non-disclosure of the relevant internal documents of the PMIs, HCA's advisers are not in a position to fully engage with any such material nor to perform further analysis on such issues. HCA therefore reserves the right to supplement its Response with further analysis in due course.

inpatient facilities in London. This clearly indicates that Aviva's analysis is conducted in a way that simply is inconsistent with how the CC has been assessing the market. It can only be assumed that Aviva must have considered outpatient facilities. This not only throws into question the basis of Aviva's statement, but also raises questions as to the reliability of its broader views, given the availability of plenty of options in and around London for outpatient facilities. The CC should closely scrutinise any similar statements by the PMIs if it wishes to rely on them.

- 7.42 Likewise, HCA's advisers have reviewed some of the analysis prepared by Bupa in preparation to the latest round of negotiations with HCA [REDACTED], as reported in Figure A4 of Annex A to Appendix A6.10 of the PFs. This analysis focuses on the [redacted] Bupa corporate customers by expenditure at HCA. Figure A4 also shows the value of claims at HCA and [redacted] for each of these [redacted] corporate clients in 2011.³²⁹
- 7.43 However, even considering those customers that spend the most at HCA's facilities, Figure A4 would suggest that HCA's hospitals are by no means "must-have" from Bupa's perspective. Specifically, for none of these customers does HCA have a share higher than [redacted]%. That is, HCA is at most attracting [redacted] of a corporate customer's expenditure. However this itself is a limit case that only applies to one customer among the most reliant on HCA. As can be clearly seen from the chart, for [redacted]% of these customers HCA actually has a share lower than [redacted]%. Further, for [redacted]% of these [redacted] customers by HCA claims, corporate expenditure at [redacted] is equal to or larger than that at HCA.
- 7.44 More generally, the CC should note that HCA is mainly active in the provision of high acuity care, which is typically costlier to provide and thus more expensive. Therefore, Bupa's analysis actually overstates the significance of the value of claims at HCA, in that the analysis does not lend itself to a like-for-like comparison of the level and quality of care provided.
- 7.45 In summary, Bupa's own analysis of its customers' expenditure at HCA, focusing on the corporate customers with the largest expenditure at HCA, clearly shows that HCA's facilities are not "must-have" (for Bupa, or any other PMI). HCA's competitors can clearly offer Bupa (and other PMIs) the capacity Bupa needs to cater for the policyholders of its large corporate clients. Moreover, even if the share of expenditure at HCA by these Bupa corporate customers was significantly higher, Bupa would still have an ability to redirect these corporate customers to HCA's competitors. [REDACTED].
- 7.46 More generally, HCA submits that the CC misconstrued the notion of "must-have" facilities. If PMIs believe that their corporate customers and consultants – and ultimately their policyholders and patients – chose HCA's hospitals and are reluctant to switch to other hospital operators because HCA is able to offer high quality care and clinical excellence, this is perfectly consistent with the outcome of a competitive process based on investments and innovation to provide better quality, as discussed in section 3. Further, referring to HCA's London Bridge Hospital and to corporate customers located in the City of London, the CC appeared to suggest that Bupa itself implicitly acknowledged that City-based corporate customers do consider alternative provision (although Bupa overlaid its own views on those of the corporate customers it reported).³³⁰

³²⁹ The CC reported that "Bupa stated that a hospital operator's bargaining power stemmed not just from the number of 'must have' hospitals within its portfolio but also [redacted]" (PFs, para. 6.149).

³³⁰ PFs, para. 6.149, footnote 3.

Bupa's documents show that the success of HCA is due to its quality rather than to any undue market power

- 7.47 Among the documents that have been disclosed in the Data Room of late October 2013, there is a chart from an internal document from Bupa, setting out its “*framework for guiding patients to provider of choice*”.³³¹ This is an interesting piece of evidence in many respects.
- 7.48 First, as discussed below, it clearly shows that Bupa aims to substitute Bupa’s GPs and “case managers” to the choice of independent GPs.
- 7.49 Second, and importantly, Bupa states that it considers this will determine a broader change in the market: a change that moves from what Bupa refers to as the “[h]istoric positioning” where “[redacted]” to Bupa’s “[s]trategic positioning” where “[redacted]”.
- 7.50 In other words, Bupa sees the alleged “*dominant position*” of hospital operators as arising from the independent choices of GPs, rather than from the ownership or location of key hospitals (which are not mentioned in the chart disclosed).
- 7.51 This is consistent with HCA’s view that it is the high quality of its hospitals that drives the success of its facilities in the market, and that Bupa’s open referral policies, and broader managed care strategies, seek to undermine this success and create harm for patients in the process (see paragraph 7.76).

High concentration in the PMI market and low levels of switching give PMIs further bargaining power

- 7.52 HCA submits that high concentration in the supply of private medical insurance implies that corporate customers have limited ability to switch PMI if one or more hospitals were no longer available because of a delisting. Thus any delisting is unlikely to prove consequential for a PMI, given that its customers would be restricted in their ability to switch to a different PMI purely to retain access to the delisted facilities. HCA also believes that there is likely to be some switching inertia, driven by the PMIs’ ability to engage with brokers and corporate customers, thus influencing corporate customers’ perceptions and propensity (or lack thereof) to act.
- 7.53 Further, in relation to the personal (non-corporate) segment of the PMI market, patient lock-in (for example, due to existing medical conditions) further restricts the policyholders’ ability to switch PMI, reinforcing concentration in the PMI market. In this case too, patients would be lost and they could not be replaced within a reasonable amount of time, from the perspective of the delisted hospital. And in this case too, the PMI would be highly unlikely to suffer from any loss of revenues (premiums from policyholders) following a delisting of a facility or a reconfiguration of a network.

There is alternative capacity available in London to accommodate any number of HCA’s patients redirected by a PMI

- 7.54 The CC wrongly dismissed an analysis previously submitted by HCA showing that the number of any PMI’s patients admitted at its hospitals every day was so small in comparison to the total capacity of HCA’s competitors that these patients could [redacted].³³²

³³¹ Appendix 6.11 to PFs, para. 182, Figure 4.

³³² HCA’s response to the London Working Paper, para. 9.5.

- 7.55 The CC argued that its share of supply analysis suggests that patients do not see non-HCA hospitals as substitutes for HCA hospitals. However, the CC has not conducted a robust market definition analysis in order to be able to identify reliably the boundaries of the market concerned, as set out in section 5, and has in fact defined its market too narrowly (at both the product and geographic level) and its reliance on these measures of shares of supply (calculated according to this incorrect market definition) therefore underestimates key competitive constraints on HCA.
- 7.56 The CC has also dismissed HCA's analysis on the basis that it "*takes no account of: the existing number of patients in rival hospitals (reducing the amount of available capacity)*".³³³ As mentioned in HCA's response to the London Working Paper, "*at the peak time of an average day, HCA has [X] Bupa patients and [X] AXA PPP patients admitted to its facilities*",³³⁴ with the highest number of Bupa patients admitted across HCA facilities on a single day [X] being [X]. In the London Working Paper, the CC estimated total inpatient capacity in London, excluding HCA, to be 593 beds.³³⁵ HCA believes that this is a significant under-estimate, especially as the CC has omitted all central London PPUs, which even the CC considered are in the same relevant market as HCA.³³⁶ However, even using the CC's under-estimate, spare capacity at peak times would only need to be [X] across non-HCA facilities to absorb the highest number of Bupa patients admitted at HCA facilities on a single day (and only [X] to absorb the [X] AXA PPP patients admitted at HCA facilities on an average day). Although HCA does not have access to capacity utilisation figures of its competitors, it would be very surprised if its competitors did not have this level of spare capacity available, even during periods of peak utilisation. The CC could easily investigate this, having access to the data of HCA's competitors.
- 7.57 The CC also argued that HCA has not taken into account "*the availability of consultants to perform procedures*". However, there is no evidence to support the argument that consultant availability would be an issue. In fact, the CC itself recognised the "consultant drag effect" as amplifying the PMIs' bargaining power when they negotiate with hospital operators.³³⁷ Further, the CC has identified no significant entry barriers in the provision of consultant services.³³⁸ HCA therefore believes that such consultant drag effect, combined with the current availability of consultants who already practise at non-HCA facilities, would be large enough to absorb Bupa or AXA PPP patients.
- 7.58 In sum, the CC has incorrectly dismissed HCA's analysis that showed that the number of any PMI's patients admitted at HCA's hospitals could be absorbed by competing hospitals in the case of a breakdown in the negotiation between HCA and a PMI.

³³³ PFs, para. 6.132.

³³⁴ HCA's response to the London Working Paper, para. 9.5.

³³⁵ London Working Paper, Table 10.

³³⁶ HCA's response to the London Working Paper, para. 9.3.

³³⁷ PFs, paras. 6.159 and 6.170.

³³⁸ PFs, para. 7.5(c).

The CC also underestimated other ways in which PMIs can exercise their bargaining power

7.59 HCA submits that the CC did not give sufficient weight to the PMIs' ability to offer cash-back to policyholders where they use the NHS for treatment and to utilise co-payment mechanisms with its policyholders.³³⁹ These are further strategies that PMIs can use to direct patients, thus further increasing the PMIs' bargaining power vis-à-vis hospital operators.

7.60 HCA also submitted evidence to the CC on a range of PMI conduct (most notably by Bupa), which has been unreasonable, highly disruptive to the effective operation of HCA's hospitals and harmful to HCA's reputation as a provider of excellent healthcare. [REDACTED].³⁴⁰[REDACTED]. Other examples that HCA has highlighted in relation to Bupa include:

- [REDACTED]³⁴¹[REDACTED].
- [REDACTED].³⁴²[REDACTED].
- [REDACTED].
- [REDACTED].
- [REDACTED].
- [REDACTED].³⁴³

7.61 Whilst HCA can provide many more examples of unreasonable actions, such conduct is both another means by which PMIs weaken the bargaining position of hospital operators and further evidence of PMI bargaining power. It shows that Bupa has no qualms [REDACTED]. It also highlights [REDACTED] that are similar to practices that the CC has in other inquiries denounced as unjustified and linked to the bargaining power of powerful firms. In short, the fact that such conduct routinely occurs is completely inconsistent with the view that it is hospital operators that wield bargaining power over PMIs.

(3) The CC has adopted a flawed bargaining framework from a theoretical perspective

7.62 In order to correctly determine the extent of the relative bargaining power between two negotiating parties, the value of the alternatives available to each party in the case of a breakdown in their negotiations needs to be assessed. Even setting aside HCA's concerns (set out above) that the CC has understated the alternatives available to PMIs and overstated those available to hospital operators, HCA submits that the CC carried out this assessment incorrectly in its PFs. This is because it largely focused on the effects of a *permanent* breakdown in the negotiations (for example, permanent delisting of a hospital by a PMI), rather than a *temporary* one (i.e. where there is an opportunity for re-negotiation).

³³⁹ HCA's response to Competition Commission's AIS, 12 April 2013, paras. 5.105–5.111. In fact, in its assessment of bargaining set out in its PFs, the CC did not consider the PMIs' ability to offer cash-back to policyholders or to utilise co-payment mechanisms with policyholders.

³⁴⁰ [REDACTED]
³⁴¹ [REDACTED]
³⁴² [REDACTED]
³⁴³ [REDACTED]

- 7.63 Appendix 3 sets out a theoretical model – based on standard bargaining theory – which considers the values of alternatives (or outside options) available to negotiating parties (hospital operators and PMIs) that are relevant either in the case of a permanent breakdown in their negotiations or in the case of a temporary breakdown.³⁴⁴
- 7.64 This model considers the value of both of these outside options. This is done in order to reflect how negotiations take place in the real world, and in particular in the case of hospital operators and PMIs. These parties expect that if they disagree at a point in time, and this leads to a temporary breakdown in negotiations, they may nevertheless have an opportunity to negotiate again at a later stage and may eventually reach an agreement.
- 7.65 The model describes a scenario where a PMI and a hospital operator are negotiating over the renewal of a contract. The model formally examines the key drivers of bargaining power for the hospital operator and the PMI. Appendix 3 sets out in detail the assumptions and the results of the model.
- 7.66 The model allows the isolation, in a theoretically rigorous and transparent way, of the key drivers of bargaining power for the hospital operators and the PMIs. The key findings are:
- The larger the proportion of total revenue before breakdown in the negotiation with the hospital operator that the PMI would manage to retain in the short run (following a *temporary* breakdown in the negotiation), the stronger its bargaining power (i.e. the weaker the hospital operator’s bargaining power).
 - The larger the proportion of total revenue before breakdown in the negotiation with the hospital operator that the PMI would manage to retain in the long run (following a *permanent* breakdown in the negotiation), the stronger its bargaining power (i.e. the weaker the hospital operator’s bargaining power).
 - The larger the volume of business that a hospital operator would earn through self-pay patients (UK and international) and/or the NHS (following a *temporary* breakdown in negotiations, i.e. over and above what it would have earned through these channels if there had not been a *temporary* breakdown in negotiations with the PMI),³⁴⁵ the stronger the bargaining power of the hospital operator will be (i.e. the weaker the PMI’s bargaining power will be).
 - The larger the volume of business that a hospital operator would manage to earn through self-pay patients (UK and international) and/or the NHS (following a *permanent* breakdown in negotiations, i.e. over and above what it would have earned through these channels if there had not been a *permanent* breakdown in negotiations with the PMI),³⁴⁶ the stronger the bargaining power of the hospital operator will be (i.e. the weaker the PMI’s bargaining power will be).

³⁴⁴ In economic jargon, the latter is sometimes referred to as an “inside option”. Appendix 3 will use this terminology (and refer to “outside option” in relation to a permanent disagreement) to distinguish between the two and to ease the comparison with existing economic literature. However both constitute alternatives to a negotiation breakdown and therefore are “outside options” as defined by the CC.

³⁴⁵ Expressed as a proportion of the PMI business lost.

³⁴⁶ Expressed as a proportion of the PMI business lost.

7.67 In practice, the total revenue before breakdown in the negotiation with the hospital operator that a PMI would be able to retain in the short run following a temporary breakdown in the negotiation with a hospital operator is likely to be higher (all else equal):

- **The larger the proportion of PMI's contracts with corporate clients that contain guided (or open) referral clauses** – Guided (open) referral products are very successful: according to Bupa, “[e]ight out of ten of Bupa’s new and current corporate clients had chosen the open referral scheme”.³⁴⁷
- **The less corporate clients respond to a change in hospital networks offered by a given PMI by changing PMI provider** – Corporate clients are very sensitive to cost factors. As Bupa itself noted, “78% of large corporates say that cost remains the main influence on their decisions to buy, or to continue to offer, healthcare benefits”.³⁴⁸ Therefore, as a PMI removes a facility from a network, large corporate clients may consider the cost implications of this choice by the PMI over and above other features. This would make them more (rather than less) likely to stay with the incumbent PMI.
- **The greater the extent to which the PMI can, at least temporarily, substitute a certain hospital facility with another, as part of their agreement with a corporate client** – In HCA’s experience, PMIs often modify and set up new policy networks (i.e. varying the composition of the hospital available) without even informing HCA and corporate clients are easily diverted from a network product to another, often driven by cost considerations (see previous point).
- **The higher the switching costs for a corporate PMI client wishing to change PMI (these costs may include transaction costs and administration costs, for example due to having to deal with own staff; they may also include PMI brand loyalty)** – While HCA does not have data on the administrative costs faced by a large corporate customer in switching PMI, it finds it difficult to believe that these would be negligible, given the size of their employee base.
- **The greater the ability of a PMI to delay, at least temporarily, a treatment (so that a patient may eventually be treated at a given hospital, after temporary delisting)** – PMIs do have the ability to delay, for some time, pre-authorisation for a treatment (and in any event can offer the policyholder other readier options at alternative facilities).
- **The higher the proportion of locked-in patients, i.e. patients who are unable to switch PMI provider due to existing medical conditions** – While HCA does not have figures on the exact proportion of PMI policyholders who are locked in to their policy, it believes that nearly all individual PMI policyholders with existing medical conditions would not switch PMI because of the consequences of doing so (i.e. the loss of cover for existing conditions or a prohibitive price increase in their premium), following the delisting of a facility or a chain of facilities.

7.68 As for the hospital operator, the volume of business that it would manage to earn through self-pay patients (UK and international) and/or the NHS following a temporary breakdown in negotiations,³⁴⁹ expressed as a proportion of PMI business lost, is likely to be higher, all else equal:

³⁴⁷ Summary of hearing with Bupa held on 20 March 2013, para. 70.

³⁴⁸ See Bupa’s Response to the CC’s Notice of Remedies, September 2013, para. 3.10.

³⁴⁹ Over and above what it would have earned through these channels if there had not been a temporary breakdown in negotiations with the PMI.

- **The lower the volume of PMI business lost at the temporarily delisted facility** – Should Bupa or AXA PPP delist an HCA hospital, the volume of PMI business lost would be very significant (see analysis set out at paragraphs 7.8ff).
- **The higher the volume of pent-up demand through other channels (e.g. longer NHS waiting lists)** – Volumes of pent-up demand through other channels are limited (HCA already seeks to attract patients through other channels, where commercially viable).
- **The weaker the consultant drag effect (i.e. the lower the proportion of consultants who would stop practising at the delisted private healthcare facility due to the loss of patients from a given PMI)** – The consultant drag effect is strong, particularly in London, where consultants have several alternative high-quality facilities to choose from (the CC itself recognised the significance of the consultant drag effect).³⁵⁰

7.69 A possible permanent breakdown in negotiations between HCA and a major PMI may result in [REDACTED].

(4) The CC’s insured price analysis has not measured prices appropriately and is undermined by serious omissions and methodological flaws; its results do not support the CC’s provisional findings

7.70 As part of the CC’s assessment of the bargaining power between hospital operators and PMIs the CC conducted an analysis of “insured prices”, looking at the amounts charged by hospital operators to various PMIs. The CC suggested that its analyses can provide a “*useful insight*” into the extent of any market power held by hospital operators in negotiations with PMIs and the degree of buyer power held by PMIs.³⁵¹ HCA strongly contends that this is not the case.

7.71 The CC itself acknowledged that “*comparing insured prices is not a straightforward task*”³⁵² and HCA considers that the difficulties the CC faced are apparent in its analysis which failed to deal with the complexities of the negotiations between PMIs and hospital operators, and of private healthcare more generally.

7.72 Specifically, the CC’s insured pricing analysis is deeply flawed and unreliable as:

- It is not informative of insured prices since, instead of prices, it analysed episode charges which themselves are subject to considerable variation (due, for example, to the complexity of cases and patient characteristics). Considerable episode charge variation within CCSDs is observed in the data and can be explained by clinical reasons leading to different services being provided (rather than by “price” differences for different episodes). The CC failed to control for these factors in its analysis or recognise them in interpreting its results.
- It cannot be informative of the level of bargaining power held by hospital operators, since it failed to account for other important features of the private healthcare market which affect hospital operators’ prices, namely quality and cost differences between operators. HCA is a high quality operator with a focus on providing complex and high acuity treatments at its predominantly central London facilities, and as such incurs significantly

³⁵⁰ PFs, para. 6.159.

³⁵¹ Appendix 6.12 to PFs, para. 3.

³⁵² Appendix 6.12 to PFs, para. 4.

higher costs than other hospital operators. These include TLC, which faces lower costs due to factors such as its charitable status.

- The CC also failed to account for retroactive rebates paid to PMIs, which can represent material payments (and effectively are additional price discounts to the PMIs).
- There were also a number of important methodological issues with the CC's analysis. The CC's analysis used flawed data, containing invoicing inconsistencies across hospital operators and CCSD coding imperfections. The CC's data was also incomplete for the PMIs, with insufficient data over the time period for the majority of PMIs. Some PMIs, such as Cigna, were completely omitted and other PMIs, such as Bupa and Bupa International, incorrectly grouped together. Crucially, the baskets of treatments used to construct the CC's price indices were too small for a robust analysis in a number of cases and were unrepresentative of HCA's overall treatment mix. The treatments used in the London price index baskets for 2011 only accounted for approximately 9% of HCA's total insured revenues from Bupa and AXA PPP.

7.73 Given these considerable flaws, the CC's analysis cannot be used to support its provisional findings in relation to HCA's "price" compared to other hospital operators and certainly not to determine HCA's bargaining position in negotiations with insurers. Moreover, even setting aside the considerable flaws detailed above, the results obtained by the CC from its "insured price" analysis do not support its provisional findings and there is insufficient evidence to sustain the CC's position on bargaining power of HCA over PMIs:

- The London price index does not show that HCA's "insured prices" are "significantly higher" than TLCs. In particular:
 - [REDACTED].
 - [REDACTED].
 - [REDACTED].
 - [REDACTED].
- The results of the CC's average revenue per admission analysis do not suggest that differences in the measure across hospital operators arise as a result of bargaining power:
 - [REDACTED].
 - [REDACTED].
- The national price index also does not demonstrate that HCA has bargaining power as the CC suggested:
 - [REDACTED].
 - [REDACTED].

7.74 Appendix 4 sets out HCA's detailed views on the CC's insured price analysis together with supporting evidence, addressing each of the points above.

(5) The CC has failed to consider the adverse effects of the PMIs' strong bargaining power

- 7.75 HCA sets out below some of the adverse effects (in the form of patient detriment) that flow from some specific strategies by the PMIs, reflecting their strong bargaining power.
- 7.76 First, the profit incentives of the PMIs will necessarily lead them to direct patients towards low cost treatments and facilities whenever possible, and will typically have little incentive to ensure that new and higher quality treatments are introduced and delivered to patients unless they have a clear cost advantage.³⁵³ As noted in paragraph 7.4, HCA agrees with the CC that contracts between hospital operators and PMIs do not generally specify a volume of business: these contracts only stipulate that a PMI *may* send a patient to one of the hospital operator's facilities. Put otherwise, PMIs are far from being retailers of private healthcare services. In fact, private healthcare services represent a cost to PMIs. Thus, PMIs have incentives to reduce demand for private healthcare services, subject to acquiring a sufficient number of new policyholders and retaining a sufficient number of existing policyholders.
- 7.77 Second, the profit incentives of the PMIs, coupled with a highly concentrated PMI market, have also led to individual PMI customers being charged close to their reservation price for healthcare benefits. Bupa itself noted that there was little room for further price increases to its individual PMI customers:
- "The critical concern is the limited headroom for further premium inflation....Conjoint analysis was used to reveal the willingness to pay range for different customer groups. It indicated that the premiums were already towards the upper bound of what most customer groups were willing to pay for PMI".*³⁵⁴
- 7.78 Without an assessment of the nature and extent of competition in the PMI market, the CC is not in a position to determine the key reason(s) for the fact that individual PMI customers would not bear further premium increases. HCA submits that this evidence is perfectly consistent with a lack of competition in the PMI market and with Bupa's exercise of market power against its customers.
- 7.79 Third, the reluctance of PMIs to recognise new facilities or treatments (examples include, but are not confined to, the London Heart Hospital, [redacted]) may well have a "chilling" effect on investment in innovative facilities or treatments by hospital operators. The reluctance of PMIs to support new treatments has had the effect of slackening the pace at which new treatments are implemented in the private healthcare sector.³⁵⁵ Patients may be negatively affected, in that failure to recognise a new facility or an innovative treatment would prevent patients from accessing this care. More importantly, a reduction in the incentives for hospital operators to invest in innovative new treatments resulting from the PMIs' strategies will have a substantial detrimental effect on patients, reducing over time the quality of care they would otherwise have received.
- 7.80 Finally, and crucially, the PMIs' strategies of guided referrals, and more generally their strategies aimed at controlling the patient pathways and ultimately the market for private healthcare, harm the quality of care to patients and disrupt efficient clinical pathways.³⁵⁶ The PMIs' managed care objectives are evident. Referring to an internal Bupa document, the CC

³⁵³ See HCA's response to Competition Commission's AIS, 12 April 2013, para. 5.93.

³⁵⁴ Bupa's Response to the CC's Notice of Remedies, September 2013, para. 3.9.

³⁵⁵ HCA's response to Competition Commission's AIS, 12 April 2013, para. 5.94.

³⁵⁶ HCA's response to Competition Commission's AIS, 12 April 2013, para. 5.101 and Exhibit 5.3.

stated that in that document “*Bupa [set] out its aim to [redacted]*”.³⁵⁷ The CC next reported a chart taken from Bupa’s original document clearly indicating its managed care ambitions, [redacted]³⁵⁸

- 7.81 Likewise, if negotiations between a hospital operator and a PMI break down and one of the hospital operator’s facilities is delisted, that PMI’s patients will no longer have the option of being treated at that hospital under their existing PMI policy. If corporate or private PMI customers do not change their PMI provider to one which still includes the now delisted hospital (for example, because they are locked in due to existing medical conditions), they will have to use a different facility (unless they decide to pay themselves for a treatment). This will lead to harm to the quality of care to patients.

³⁵⁷ Appendix 6.11 to PFs, para. 182.

³⁵⁸ Appendix 6.11 to PFs, para. 182, Figure 4.

8. CONSULTANT INCENTIVES

Key points

- HCA agrees that there may be a case for prohibiting schemes which provide benefits directly linked to patient referrals.
- However, equity partnerships should be assessed in detail separately by the CC given their possible pro-competitive effects, through adding new competition as well as innovations by existing providers.
- The CC has incorrectly drawn distinctions between schemes related to clinical treatments and those encompassing only diagnostic procedures.
- The CC does not have evidence to support its view that consultant incentives may lead to excessive diagnostic tests or consultations. The CC is incorrect to assert that consultant incentives such as those for HCA's CyberKnife Centre have adverse effects.
- Schemes in place between PMIs and consultants which incentivise consultants as to where, or how, they treat patients could have the same effects on competition as those operated by hospitals and should be considered by the CC.

Introduction

- 8.1 The CC recognises that a key way in which private healthcare providers compete is through attracting leading consultants to practise at their facilities in order to attract private patients.³⁵⁹ Given that 85% of GP referrals are to an individual consultant, rather than a specific hospital, HCA invests heavily in order to provide the right clinical environment and latest technologies to motivate leading consultants to choose its hospitals for their private patients (see section 3 above). There is intense competition for consultants, particularly in London where leading consultants practise at the NHS teaching hospitals.
- 8.2 The CC has reviewed the various schemes adopted by private healthcare providers which incentivise clinicians and, in particular, consultants to use their facilities. It considered whether any or all of these schemes may distort competition between private healthcare providers and provisionally concluded that "*the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities, whether in cash or kind and whether related to the value of referrals or not, are a feature of the market that gives rise to an adverse effect on competition*".³⁶⁰
- 8.3 HCA discusses the specific remedy the CC has proposed in relation to consultant incentive schemes in its response to the Remedies Notice. In this section it sets out key issues it has identified in relation to the CC's finding of an AEC arising from the operation of consultant incentive schemes. HCA specifically highlights:
- More detailed analysis of the potential pro-competitive effects of incentives linked to patient volumes and value, and in particular those arising from equity partnership schemes, is required. Additionally, the distinctions the CC drew in its analysis and findings regarding incentive schemes relating to entire medical facilities, the use of technologies, treatments and diagnostics are inappropriate.

³⁵⁹ CC, PFs, para. 4.13.

³⁶⁰ CC, PFs, para 8.134.

- The CC failed to consider PMI schemes in its assessment of consultant incentives despite the potential for these schemes to have the same effect on competition as those operated by hospitals.

(1) Analysis of potential pro-competitive effects and a reassessment of distinctions drawn between types of schemes

8.4 HCA considers that it was a constructive first step for the CC to have distinguished between promotional activities conducted by hospitals, such as seminars for GPs, and "*incentive schemes*".³⁶¹ Promotional activities are a positive aspect of the private healthcare providers' interactions with clinicians as they raise awareness about the breadth and quality of services and consultants at a given hospital or clinical unit. HCA considers that such activities are in line with the CC's intention to improve information availability and transparency in the market.

8.5 With respect to "*incentive schemes*", the CC broadly distinguished between:

- Schemes where the benefit to the consultant varies according to the volume or value of business brought to the hospital.
- "Direct" and "indirect" incentives schemes.
- Schemes related to clinical treatments and those that only encompass diagnostic procedures.
- Schemes that relate to an entire medical facility and those that relate only to clinical equipment or technologies.

8.6 HCA sets out its high-level views on the CC's assessment of each of these broad categories of incentive schemes in turn below, highlighting the additional analysis required by the CC and the inappropriate distinctions it drew between different types of consultant incentive schemes. Further detailed comments are set out in HCA's Response to the Remedies Notice.

The CC should analyse in detail the competitive effects of consultant incentives linked to patient volumes and value

8.7 HCA acknowledges that consultant incentive schemes through which consultants are financially rewarded in proportion to the volume or value of tests or treatments that a consultant performs in a given facility may present a greater cause for concern and scrutiny by the CC. Whilst the CC has found that such clauses are relatively less common,³⁶² there remains scope to address such contractual arrangements where they take effect outside of the context of an equity partnership. These might include arrangements between hospital operators and consultants which contain:

- Payments or other benefits for achieving a minimum referral commitments expressed in terms of volume or value of referrals;

³⁶¹ HCA has previously highlighted to the CC that "incentives" is not a helpful generalisation to use in describing the wide range of arrangements in place as it misrepresents their wide nature. Considering all types of incentives collectively risks the CC reaching broad conclusions on schemes where some are entirely appropriate and are pro-competitive arrangements with consultants.

³⁶² CC, PFs, para 8.131.

- Payments or other benefits which are, directly or indirectly, tied to the volume or value of referrals;
- "Lock-in" provisions, pursuant to which a consultant must commit to bringing a minimum proportion of his/her practice to the hospital (the PFs provide examples of these, e.g. Circle's scheme which requires consultants to "*commit to undertake a given proportion of their work at a Circle hospital*"); and
- Arrangements having equivalent effect, e.g. exclusivity requirements in practising privileges which prevent or restrict consultants from practising in rival facilities.

8.8 As outlined in the response to the Remedies Notice,³⁶³ HCA sees the case for the prohibition of such schemes.

The CC should consider equity partnership schemes, and the pro-competitive effects arising from them, in detail

8.9 The CC refers to "direct" incentives as being in the form of rewards for referrals in either cash or equity, or in the form of subsidised consulting rooms, nurses and administrative support, the provision of which is explicitly or implicitly linked to hospital income generated. "Indirect" incentives were found by the CC³⁶⁴ to usually take the form of equity or some other form of profit sharing with the incentive arising as a result of the increase in profits of the hospital in the longer term arising from the directing of a patient to it. With respect to "direct" and "indirect" consultant incentive schemes HCA submits that it is important for the CC to carefully and separately consider equity partnership schemes.

8.10 HCA considers that equity partnerships should be assessed in detail separately given their potential pro-competitive effects. These pro-competitive effects can arise through a closer partnership between a consultant or a group of consultants and a private healthcare provider. Certain innovative treatments or the development of specific units may only be brought about through a firm commitment of effort and resources over a certain time period from both a consultant or a group of consultants and a private healthcare provider. In these circumstances an equity partnership may be the only viable option for the innovation to take place. Prohibiting all equity partnerships may therefore prevent the development of certain innovative treatments or units and may therefore cause consumer harm. The CC has recognised the potential pro-competitive role of equity partnerships when they add competition to the existing market players. However, it failed to recognise that equity partnerships facilitating innovation by existing market players, working closely together with leading consultants, is also an important pro-competitive effect of these schemes.

8.11 HCA comments in further detail on the pro-competitive aspects of such equity partnership schemes in its response to the Remedies Notice.³⁶⁵

The CC's differing conclusions between schemes related to clinical treatments and diagnostic procedures are incorrect and not based on evidence

8.12 HCA submits that distinctions the CC drew between schemes related to clinical treatments compared to those that encompass only diagnostic procedures are not helpful and unnecessarily confuse the CC's analysis. Furthermore, the differing provisional conclusions

³⁶³ HCA, Response to the Remedies Notice, section 9.

³⁶⁴ CC, PFs, para 8.123.

³⁶⁵ HCA, Response to the Remedies Notice, section 9.

reached by the CC with regard to each type of scheme are not supported by robust evidence.

- 8.13 The CC provisionally found that incentive schemes related to clinical treatments, "*may lead to over-treatment, having regard to ethical and regulatory constraints we think the competition effects are likely to be minimal*".³⁶⁶ However, it considered that, "*such incidents are likely to be few and far between*".³⁶⁷
- 8.14 With respect to equity partnerships involving diagnostic equipment, the CC similarly finds that consultant incentives may affect "*some (probably very few) consultants, on some occasions*".³⁶⁸ Despite this finding, the CC arrives at the provisional conclusion that "*the evidence indicates that incentives schemes are likely to lead to excessive diagnostic tests or consultations*".³⁶⁹ The CC does not provide any evidence to support this view, other than to simply observe that diagnostics are less invasive.
- 8.15 There is no substantive evidence put forward by the CC as to the extent of this issue (other than the observation that it probably only affects a few consultants) and why the same ethical and regulatory considerations are any less relevant to diagnostic work undertaken by consultants. Nor is there any examination of the potential materiality of the equity share payment. [§].³⁷⁰ This is hardly the sort of financial inducement that would "tempt" a consultant to compromise the integrity of his/her professional practice.
- 8.16 The above suggests to HCA that even if such an issue did exist (as there is no supporting evidence), it is not likely to be material or a significant feature of the market. HCA submits that the CC should reconsider its assessment and that the CC's differing conclusions between equity partnership schemes related to clinical treatments and diagnostic procedures are incorrect and not evidence based.

The distinctions drawn by the CC between consultant incentive schemes relating to entire medical facilities, use of technologies and treatments is inappropriate

- 8.17 In relation to the CC's assessment of consultant incentive schemes that relate to an entire medical facility compared to those that relate only to clinical equipment or technologies, the distinction that the CC has drawn is inappropriate. Furthermore it is inappropriate to draw a distinction between these schemes and those relating to clinical treatments, given that the use of medical facilities, equipment and technologies are inherently linked to treatments.
- 8.18 The CC noted that, with respect to collaborations involving specific equipment (specifically citing the example of the CyberKnife system), the "*incentive properties are closer to those of a referral fee than those of a more dilute share in the profit from a wide range of health activities, such as a whole general hospital*". The CC further noted that: "*[i]t is less clear that any benefits that may arise from such schemes, such as encouraging investment in new equipment, outweigh their adverse effects*". HCA disagrees with this assessment.
- 8.19 First, HCA's CyberKnife Centre (the first ever in the UK), is an advanced treatment modality for patients with serious forms of cancer. In some cases, the cancer is of a type that is inoperable (for example, because of the cancer's proximity to major organs), and CyberKnife

³⁶⁶ CC, PFs, para 8.133.

³⁶⁷ CC, PFs, para 8.129.

³⁶⁸ CC, PFs, para 8.130.

³⁶⁹ CC, PFs, para 8.133.

³⁷⁰ [§]

therefore may be the only remaining option to treat the patient. Perversely, in HCA's opinion, the CC does not apply its conclusions relating to the low risk of overtreatment here. Furthermore, HCA has previously emphasised the rigorous clinical governance framework (involving non-equity clinicians) for the vetting and approval of all admissions into the CyberKnife Centre. Disappointingly, the CC has not made reference to such governance arrangements or seemingly considered them in reaching its provisional conclusions.

- 8.20 Secondly, HCA submits that the distinction between hospitals investing (in collaboration with consultants) in a new medical facility and investing in new treatment/ diagnostic technologies is far from clear. The development of the CyberKnife system involved significant capital expenditure and included the use of dedicated hospital facilities, the employment of specialist clinical staff and the commitment of consultants to support the sizeable investment being made. Therefore, the CC's finding that: "*consultant equity participation can be an effective way of incentivizing them to commit in advance to working at a new hospital, which may take several years to build and equip. Such commitments strengthen the viability of a business plan and the ability to obtain financing. They can thus be an important way of lowering a barrier to entry...*"³⁷¹ is equally relevant and applicable to the investment in new and innovative clinical technologies that expand the scope (or improve the quality) of services being made available to patients.

(2) The CC failed to consider PMI consultant incentive schemes

- 8.21 Whilst the CC has analysed the consultant incentive schemes operated by private healthcare providers, HCA submits that it has failed to fully consider the impact of schemes in place between PMIs and consultants which incentivise consultants as to where, or how, they treat patients. HCA submits that these could have the same effects on competition as hospital-operated incentive schemes. Despite the evidence the CC has obtained through the course of its inquiry in relation to the impact of PMI conduct on consultants, particularly the numerous submissions made by consultants,³⁷² the CC considers that it does not have persuasive evidence of a competition problem,³⁷³ HCA submits that the actions of PMIs do have a significant impact on the market and agrees with the CC's view that the evidence, including criticisms that have been directed at how PMIs, most notably Bupa, have set about acquiring consultant services, "*raise matters of importance*".³⁷⁴
- 8.22 HCA considers that the CC should analyse in detail the incentive schemes operated by PMIs, particularly given the evidence of their increasing influence in the market, which the CC itself acknowledges: "*As PMIs increasingly determine not only fee levels but also which consultants a patient may see and, depending on how rigidly and extensively they do so... there is a risk that competition between consultants will become distorted*".³⁷⁵
- 8.23 Given that the CC's terms of reference includes the "acquisition" and supply of private healthcare services, HCA strongly contends that the CC should consider, alongside hospital schemes, the potential distortive effect on competition of PMI-consultant incentive schemes. Such PMI schemes which incentivise consultants, through financial rewards or other means, to recommend cheaper treatments or less expensive hospitals should be fully assessed in

³⁷¹ CC, PFs, para 8.123.

³⁷² Summarised by the CC in the PFs, Appendix 7.3.

³⁷³ CC, PFs, para 7.77.

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid.*

the CC's assessment of consultant incentive schemes. This includes schemes such as Bupa's premier consultant partnership scheme.

9. INFORMATION AVAILABILITY

Key Points

- HCA believes all patients should be informed customers, and has been at the forefront of a number of initiatives to increase the amount of information available on hospital performance. Over recent years it has invested significantly in the collection and publication of this information.
- It considers that data on consultant performance could be improved, and that charges should be clear and made upfront when possible. However, HCA notes limitations due to the fact that, in some more complex cases, information on costs is difficult to predict and present in advance.
- HCA believes that treatment should be the result of a conversation between an informed patient and skilled consultant. It has real concerns that PMIs guidance on treatment options may be overly influenced by cost containment, influencing patient pathways to their detriment.

Introduction

- 9.1 As set out in section 9 of the PFs, the CC has considered the points in the patient pathway where patients make a choice. The CC focuses on the information availability and asymmetry in relation to choosing a consultant, a treatment option and a private hospital. The CC's provisional findings in relation to each of these are as follows:
- **Choosing a private hospital:** performance data for private hospitals is below the standard of information available for NHS hospitals. Recent changes as a result of PHIN are expected to lead to improvements, but at present the available information is insufficient to promote effective competition between private hospitals;
 - **Choosing a consultant:** publicly available information on consultant performance and fees is insufficient, preventing effective competition between consultants; and
 - **Choosing a treatment option:** information on treatment options is available to patients, enabling an informed discussion between the patient and consultant.
- 9.2 In this section HCA sets out its views on information availability. HCA has played a leadership role in relation to initiatives to provide further information on quality and pricing of private healthcare. This increase in transparency is to the benefit of patients and GPs. As discussed in section 3, achieving greater quality in its services is a key element of HCA's strategy. It underpins HCA's investment strategy and is the major driver of HCA's success.
- 9.3 Providing patients and consultants with greater ability to assess the relative quality of care provided by different operators increases the hospital operators' and consultants' incentive to ensure high quality performance. Clearly, this has the potential to deliver even better outcomes for patients.
- 9.4 HCA believes that all customers should be "informed customers". It considers that availability of a standard framework of quality information is vital to ensure patients and consultants make an informed choice. It is essential to make the patient's wellbeing a priority and this can only be achieved when the patient is able to clearly choose the right hospital and the right consultant based on quality markers instead of being directed by the PMI. Customers should be wary of their choices being guided or controlled by PMIs, particularly if the PMI is more concerned about cost containment than quality or value. HCA continues to have particular concerns about the largest insurers in this regard. HCA's concerns appear to

be substantiated by the large volume of submissions to the CC by members of the public, consultants, consultant associations and from a range of differently sized hospital operators about the transparency of such directional initiatives adopted by PMIs, most notably by Bupa.³⁷⁶ Despite calls for greater transparency on the selection "algorithm" used by Bupa to guide patients, Bupa has, to date, refused to release its methodology for independent professional review.

- 9.5 Recent trends towards the more frequent use of PMI "guided" treatment pathways, and the use of hospital networks as directional tools, is also likely to reduce the expected benefits of increased information availability to the patient.
- 9.6 Under Bupa's Open Referral system, it is Bupa, not the GP, who makes the choice of consultants for patients. Other PMIs also offer policies which contain guided referrals, including AXA PPP and Aviva. In addition, PMIs offer other specialist referral schemes which do not require a GP referral; these include, for example, Aviva's musculoskeletal rehabilitation service and Bupa patients with muscle, bone or joint conditions.
- 9.7 Improving meaningful information on quality and pricing will only enable patients and GPs to make informed choices, encouraging effective competition, where they are able and free to exercise that choice.

(1) Choosing a hospital

- 9.8 HCA believes that through Private Healthcare Information Network (PHIN) the industry has made significant progress towards improving the availability and quality of information about clinical outcomes over the past year. Given the importance of quality for patients, HCA welcomes a discussion on how more information can be made available for the benefit of both patients and GPs.

HCA understands the importance of quality as a key differentiator in a competitive marketplace

- 9.9 HCA already collects, monitors and publishes detailed data on its quality and performance. HCA believes that it leads the way in terms of transparency of information on the care provided within its hospitals. As explained in more detail in section 3 above, in a competitive marketplace quality is a key differentiator and driver of commercial success. Therefore, it makes commercial sense for HCA to promote its hospitals' records in areas of quality such as survival rates, quality accreditations, waiting times and cleanliness. For hospital operators to compete as effectively as possible on quality, it is important that decisions on where to get treatment are based on reliable information on similar process and outcome indicators. That is why HCA has been, and remains, a strong supporter of PHIN.
- 9.10 As explained in its response to the CC's Market Questionnaire,³⁷⁷ HCA considers itself to be a learning organization that collects and monitors information on clinical performance and outcomes in its hospitals. This is not only for the purposes of meeting CQC mandatory requirements but also for the purposes of assessing its own performance and identifying opportunities for improving patient outcomes. HCA also closely monitors and measures patient satisfaction and publishes the overall results on its website.

³⁷⁶ See, for example, submissions by "Consultants" 3, 4, 6, 7, 9, 12 (GP), 14 (GP), 17 and 18, in response to the PFs.

³⁷⁷ HCA, Response to the CC's Market Questionnaire, September 2012, Question 24.

Substantial progress has been made towards the provision of information on quality and clinical outcomes

- 9.11 HCA actively supports relevant national studies, audits, registries and databases³⁷⁸ and allows open reporting of its outcomes on third party websites and in professional publications. HCA provides quality metrics and information about its facilities in an accessible and understandable format. HCA's regularly updated quality report is published on its website.³⁷⁹ This includes areas such as rates of infection, survival rates, unplanned transfers and returns, patients and consultant feedback, fertility clinic birth rates and waiting times.
- 9.12 All other hospital operators are registered with and regulated by the CQC on 28 outcomes,³⁸⁰ each reflecting a specific regulation. The results of compliance inspections are publicly available on the CQC website. HCA hospitals audited by the CQC in 2012 achieved 100% compliance with all inspected standards. The NHS is similarly regulated, but only to 16 core quality and safety standards.
- 9.13 Private hospital operators have spent three years, initially through the Hellenic Project, developing a robust, secure and comprehensive process for collecting and collating information on independent hospitals' inpatient activities. Over the past year this process has been developed as the PHIN.³⁸¹ The PHIN website went live in April 2013. This enables patients and GPs to assess the performance of local hospitals by procedure.
- 9.14 PHIN collects data that represents more than 98.5% of independent hospitals inpatient activity. To date, PHIN's website has focused on presenting information on inpatient and day-case activities that are predominantly used by self-pay patients. It is now working to extract and present information about the inpatient and day-case activities used by insured patients. PHIN has published on its website a clear plan and timetable to expand the scope and scale of its activities.³⁸²
- 9.15 Success in achieving PHIN's objectives is largely dependent on further developing and sustaining recent collaborative arrangements with the Department of Health (DH), Health and Social Care Information Centre (HSCIC) and various national audits and registries. PHIN has already established relationships with the National Joint Registry (NJR), the National Institute for Cardiovascular Outcomes Research (NICOR), and the National Cancer Intelligence Network (NCIN).
- 9.16 HCA has been actively involved in the Hellenic Project and PHIN over the past three years, and has played a central role in the transformation of PHIN's activities over the past 15 months. In particular, HCA was an early supporter of PHIN's decision to change its principal supplier of services from Dr Foster Intelligence to Northgate IS in October 2012.³⁸³

³⁷⁸ See, by way of example, Annex 1 to HCA's response to the Issues Statement.

³⁷⁹ <http://www.hcaqualityreport.co.uk/>

³⁸⁰ Defined in the Essential Standards of Quality and Safety under the Health and Social Care Act 2008.

³⁸¹ The initiative was originally undertaken as the Hellenic Project.

³⁸² <http://www.phin.org.uk/About.aspx>, 'Development' tab.

³⁸³ Over a three year period Dr Foster had yet to produce a quality assured database of either activity or quality indicators for the sector. Northgate have considerable experience in this type of data collection from running the NHS HES and National Joint Registry (HJR). As such, HCA supported PHIN's decision to appoint Northgate. HCA note that within four months of Northgate being appointed a database was up and running, and within six months an online website.

- 9.17 In addition, HCA has wholly funded and led industry-wide collaborative work on price transparency through the Private Healthcare Quality Consortium (PHQC). At the request of the Private Healthcare Alliance (PHA) Board,³⁸⁴ PHQC (supported by PHIN and Healthcode) developed a common online presentation format for prices of over 70% of self-pay procedures. This protocol was adopted industry-wide in February 2013, and by June 2013 all six of the largest hospital groups had published the majority of their self-pay prices in the common format.
- 9.18 Further, HCA submits data to the Intensive Care National Audit Research Centre (ICNARC) study which fosters improvement in critical care. The ICNARC carries out audits through the provision of comparative data, allowing it to derive actual and predicted survival rates. This comparative survival information has been provided to HCA patients for a number of years. [X].
- 9.19 HCA discusses its views on the CC's remedy 7, which relates to this area, in section 12 of its response to the CC's Remedies Notice.

Improvements in the comparability of data are taking place in order to maximise the benefits of increased transparency for GPs and patients

- 9.20 There are presently differences in the way in which providers publish their data. Healthcare provision is not homogenous and services vary from small scale facilities carrying out simple procedures through to large hospitals providing tertiary care for a host of complex conditions. There is scope to improve comparability, but crude indicators may be misleading. For example, mortality rates at treatment centres carrying out simple day-case procedures are likely to be zero but that does not imply anything about the relative quality compared to a provider offering higher acuity care. Whilst comparing clinical outcomes across a range of providers is an extremely difficult task, there is a wide-range of quality metrics, measuring both process and outcomes, alongside registries which could allow for benchmarking.
- 9.21 The aim of the PHIN project is to address the lack of consistent and comprehensive data on private hospital performance. HCA fully supports the PHIN initiative, and believes it is important for sufficient funding to be made available to PHIN to allow it to continue to develop its activities over the coming years. It is disappointing that not all other private hospitals have shared HCA's level of commitment to greater transparency through the PHIN project.
- 9.22 It must be emphasised that the capture of valid, clinically-rich data which allows for relevant risk adjustment is labour intensive and requires significant organisational effort and resources. HCA has already made considerable investments in staff whose function is to capture, validate and submit data in order to improve the quality of care information available to patients.
- 9.23 An important point for the CC to bear in mind is that the CQC Inspector of Hospitals, Sir Mike Richards, presently has the power to require hospitals to disclose clinical quality information in any form considered appropriate. Therefore, a statutory framework for the mandated publication of information already exists, and the CC is in a good position to support the CQC to further develop its remit in the private healthcare market.

³⁸⁴ Now the Association of Independent Healthcare Organisations (AIHO) Board.

- 9.24 HCA believes that a framework for the mandated publication of clinical quality information should, in the medium term, include PMIs as well as private hospitals. HCA believes that any work related to the evaluation of clinical quality, clinical information or directional purchasing undertaken by PMIs should be regulated by CQC, in the same way that CQC plans to regulate the activities of NHS Clinical Commissioning Groups (CCGs) and Clinical Support Groups (CSGs). Such regulation of PMIs should also be as transparent as all other regulatory activities undertaken by CQC.

(2) Choosing a consultant

HCA supports initiatives to improve clinical data for consultants in conjunction with the relevant medical organisations

- 9.25 Practising privileges are granted only to those consultants holding substantive NHS consultant appointments or to doctors who can demonstrate equivalent experience. This in itself ensures a level of professional achievement and experience. Robust clinical governance processes also ensure that clinical performance is strictly monitored and that action is taken with immediacy where required. HCA recognises the introduction of data on NHS consultants' performance in 10 specialities in England from July 2013. Nevertheless, HCA would support initiatives to improve clinical data for consultants throughout the UK in conjunction with the relevant medical organisations. As noted in HCA's response to the CC's Remedies Notice, it considers that the proposed list of 10 specialities for which performance data will be available is practicable as a starting point. However, HCA believe this list should be expanded over the coming decade to include all medical and surgical specialities. Ideally, performance indicators should be updated every six months.
- 9.26 HCA also thinks it is important for Bupa to operate with greater openness and transparency with respect to the consultant selection criteria used in its Open Referral product. Bupa has informed HCA that it does not publish the criteria for its consultant search tool as these are commercially confidential to Bupa. However, increased transparency would be of benefit to patients and GPs, as they would be in a position to determine whether Bupa's criteria for consultant selection are relevant to their own. Furthermore, consultants and hospital operators would benefit from such transparency by working towards meeting the standards set by Bupa. The fact that Bupa apparently does not appear to have an incentive to publish such information clearly suggests that, unlike HCA, its strategy is not aligned with the incentives of patients in providing higher quality treatments, but instead its incentives are to push patients to the minimally acceptable level of care to achieve a reduction in costs, even if this leads to less innovation, quality and choice for patients.

HCA agrees that there should be transparency over consultant charges and the likely costs of treatment

- 9.27 For outpatient fees, HCA agrees that consultation charges should be clearly indicated as far in advance as practicable of the initial consultation and that clear estimates and charging structures should be provided in advance of the diagnostic and treatment procedures. There may be some urgent cases where this is impractical,³⁸⁵ but as a general rule consultants should adopt a practice of informing patients in advance of the likely costs of treatment. Consultants should also be encouraged to inform patients of anaesthetists' charges. However, as outlined in its response to the Remedies Notice, this may become cumbersome

³⁸⁵ For example, where a routine treatment develops unforeseen complications that result in additional treatment and/or monitoring of a patient.

for day-case and inpatient fees. Notably, there are concerns around the practicality of this eventuality given the dynamic nature of the care pathway.³⁸⁶

9.28 In addition, the issue of shortfalls is something which needs to be addressed by the insurers. There are some insurers (notably WPA) which do not have any problems with shortfalls. There are others, particularly Bupa and AXA PPP, which have a poor track record. HCA's experience is that AXA PPP may change its benefit maxima to consultants without prior notice, exacerbating the problem of any shortfalls arising. Whether a shortfall arises depends entirely on the insurer's reimbursement rates which vary between insurers' policies and the level of excess. This is not something which the consultant will necessarily know.

(3) Choosing a treatment option

Recent trends towards the more frequent use of guided processes by PMIs influences the choice of treatment to the detriment of patients

9.29 The CC concludes that, despite the inevitable information asymmetry between the consultant and the patient as regards to different treatment options, patients have access to sufficient information on treatment options to enable effective competition between consultants and alternative healthcare pathways.

9.30 HCA is concerned that where PMIs give guidance on treatment options, this may be influenced by commercial considerations, influencing patient pathways to the detriment of patients. HCA comments on the increased use by PMIs of guided and open referral products in relation to bargaining power in section 7 above. As set out in Appendix 7.3 of the PFs, this view has also been expressed by consultants.

9.31 Furthermore, HCA notes the following submissions made by third parties to the CC in response to the PFs and Remedies Notice:

- The British Medical Association (BMA) submitted that the "*confusion that is created by PMIs redirecting patients to consultants based on their fee levels is damaging to individual consultants and limits patient choice*" and that it "*distorts the traditional referral process taking clinical decisions away from GPs to PMI case managers and case teams*".³⁸⁷ The BMA agreed with the CC that Bupa, in particular, should provide patients with further information about why they are directing patients to one consultant rather than another, but was disappointed this did not translate into a possible remedy.
- The Independent Doctors Federation (IDF) submitted a series of complaints from GPs regarding Bupa's Open Referral scheme, including comments from a GP who "*wholly disagree with Open Referral Policies*";³⁸⁸ another GP who felt so strongly against Open

³⁸⁶ At present consultants working in HCA hospitals mostly charge their day-case and inpatient work on a "fee for service" (FFS) basis. This can, where necessary, reflect the actual rather than predicted complexity and time spent on individual patients. HCA believes that FFS remains an appropriate and fair basis for consultants to charge for complex tertiary treatment and care. HCA does not believe that consultants (or hospitals) should be confined, by transparency requirements, to more rigid prospective "cost per case" fees schedules for complex tertiary care. Metrics such as ICD 9 diagnostic and co-morbidity coding would allow for some adjustment of fees to reflect complexity. However it remains the case that the complications, time and cost of complex tertiary care can never be completely predictable in advance.

³⁸⁷ BMA response to the PFs, paragraph 3.1.

³⁸⁸ Submission 1, the Independent Doctors' Federation "Responses to Referral Issues raised in the CC Findings".

Referral, that he/she abandoned his own Bupa membership; a GP who observed that *"Open referral is already causing problems in a number of ways"*³⁸⁹ (followed by explanations); and a private GP who could *"hardly see how an employee of a health insurance company"*³⁹⁰ would have the same depth of knowledge or experience about consultants' expertise. The range of concerns about directional policies is extensive and consistently highlights Bupa's Open Referral policy as a cause for concern.

- The Private Patients Forum (PPF) highlighted specific concerns arising from insurers determining the choice of hospital and consultants relating to the transparency of such directional initiatives.³⁹¹
- Individual consultants also voiced concerns. For example, Consultant 7 noted his incredulity at the CC's PFs as regards the discriminatory practices of Bupa and other PMIs. The consultant felt that *"practices by PMIs are insidious and difficult to expose"*.³⁹² The consultant expressed the belief that *"there is a deliberate practice of directing patients to preferred clinics and practices with which Bupa and others have prior arrangements without openly informing patients of available choice,"*³⁹³ and that it was *"only when pressed by a savvy patient"*³⁹⁴ that the option of choice under Open Referral was exercised.

9.32 The CC's finding that patients are not currently making full use of the available information on treatment options, in order to test the advice they are given, is a particular concern in light of the move towards the increasing use of guided processes by PMIs. Furthermore, as PMIs exert increasing influence over patient pathways under guided processes which take into account commercial considerations; this is likely to lead to distortions which may affect competition between consultants and alternative healthcare pathways. HCA urges the CC to formulate a remedy requiring Bupa to respond to these serious concerns expressed by numerous professional bodies. Particularly given that, in contrast to the constructive response by hospital operators to the CC's concerns relating to information availability, Bupa has yet to offer a meaningful solution to the information concerns expressed by patients, GPs and consultants.

³⁸⁹ Submission 4, the Independent Doctors' Federation "Responses to Referral Issues raised in the CC Findings".

³⁹⁰ Submission 3, the Independent Doctors' Federation "Responses to Referral Issues raised in the CC Findings".

³⁹¹ PPF, Response to the PFs.

³⁹² Consultant 7, Response to the PFs.

³⁹³ *Ibid.*

³⁹⁴ *Ibid.*