

## Supplemental submission following HCA's remedies hearing

December 2013

### 1. PMI cost pass through

*HCA supports the CC's recognition that an assessment of pass-through is required to understand the impact of its remedies on patients*

- 1.1 The CC noted during HCA's hearing that it was exploring the extent to which PMIs would be likely to pass cost-savings through to policyholders.
- 1.2 As a result of the PMIs' incentives, even if there were to be any price reduction from the CC's proposed remedies (HCA has in fact provided evidence that the *opposite* is more likely), the CC has no evidence that any price reductions arising from divestiture would be passed through by PMIs to policyholders. This was noted in HCA's response to the CC's Notice of Possible Remedies<sup>1</sup> and is explained further in this submission.
- 1.3 In order to assess the pass-through of any price reductions arising from the remedies, the CC needs to conduct a proper and in-depth analysis of competition in the supply of PMI<sup>2</sup>. Such an assessment would need to include a consideration of issues such as: the highly concentrated and oligopolistic structure of the market; PMIs' market power; the ability of policyholders to switch; the lack of clear full information available to PMI customers; the lack of innovation in the PMI market; the role played by GPs and consultants; and the misalignment of PMIs' incentives with patients' interests. A proper analysis of these issues is crucial if the CC is to reach robust conclusions about the degree to which any proposed remedies will be effective in delivering reductions in prices for patients and corporate customers.
- 1.4 HCA remains concerned that, thus far, the CC has failed to carry out any considered analysis of the PMI market. The PFs briefly note the highly concentrated nature of the PMI market but fail to consider the lack of competitiveness in PMI and how this affects the provision of private healthcare. The terms of reference for this inquiry are "the supply or acquisition" of private healthcare". The CC has, to date, focused entirely on the *supply* of private healthcare and has wholly ignored demand-side factors relating to the *acquisition* of private healthcare by PMIs and how these bear upon the private healthcare market. HCA welcomes the CC's belated acceptance that it will now look at the issue of pass-through, but it is a matter of concern that this important issue has been left to a very late stage in this inquiry.
- 1.5 HCA is also concerned that the CC is contemplating a very limited and somewhat superficial assessment of pass-through. The letter from Treasury Solicitors dated 7 October 2013 to the parties in the context of the litigation in *BMI v Competition Commission* stated (para 34): "*However, the CC does not currently envisage a detailed empirical or quantitative analysis of the extent of pass-through, nor does it have the data which would be required for such a quantitative analysis. The most pertinent evidence the CC has is evidence requested from the*

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<sup>1</sup> HCA, Response to the CC's Notice of Possible Remedies, paragraph 2.6.

<sup>2</sup> Such an assessment is also necessary to assess PMI bargaining power, as HCA has already highlighted to the CC (HCA, Response to CC Issues Statement, paragraph 4.2).

*insurers on the interrelationship between their prices and the prices charged to them by the hospital operators, which the CC will review."* The CC is in a position to get from the PMIs all the data it requires to carry out a proper assessment of pass-through. In a divestiture case, the CC has a particularly high burden of proof to discharge to demonstrate that its proposed remedy creates benefits to consumers which outweigh the considerable detriments and economic costs which HCA has highlighted. It is unsatisfactory for the CC to claim that it does not have the relevant data required for a proper analysis. HCA notes that Treasury Solicitors' letter (para 36) states that the parties will be entitled to make an application for disclosure of the CC's analysis of pass-through once the CC has carried out this exercise. HCA reserves its right to seek disclosure in due course.

***An assessment of the role of PMIs in allowing the flow of any benefits from investments and improvements in quality to patients is equally required***

- 1.6 As well as assessing the likely degree of pass-through of any supposed price effects from its remedies, it is crucial that the CC considers the effect of its divestiture remedy on investment and innovation and, as a result, on the quality and range of private healthcare available to patients. In addition to competing on price, hospitals compete by investing and innovating in order to drive improvements in the quality of clinical care and patient outcomes. As set out in its Response to the CC's Notice of Possible Remedies<sup>3</sup>, HCA considers that divestiture would have serious and adverse consequences on the high standards of quality, clinical care and innovation it currently provides.
- 1.7 HCA already operates in a highly competitive market and invests considerably in order to attract patients and consultants (and, as a result, PMI recognition). [REDACTED] This is to the benefit of private healthcare patients and also has wider spillover benefits into other aspects the healthcare market, including, for example, to the NHS<sup>4</sup>. The high quality, high acuity, innovative care available in London will be put at risk through divestiture – not only in HCA's remaining hospitals, where synergies in HCA's current network will be damaged and investment dampened, but also in [REDACTED] where there is no guarantee that [REDACTED] will pursue HCA's strategy or be able to implement it to the same standard. Given HCA's quality of care and superior patient outcomes, for example its higher breast cancer and cardiac survival rates<sup>5</sup>, HCA considers that the CC must be certain of the benefits of [REDACTED] given the very real risks to patients' lives.
- 1.8 HCA submits that the proposed divestiture remedy, to the extent that it leads to any margin being shifted from an innovative hospital to a PMI, will reduce hospital operators' incentives to invest and innovate, with no compensating benefit, because PMIs do not invest in quality enhancement. However, even to the extent that the CC is (spuriously, in HCA's view) confident that the proposed divestiture remedy will increase the competitive pressures on HCA to invest in quality and innovation, HCA submits that this does not imply that such quality improvements will be taken up by PMIs and passed through to their customers. As noted in its Response to the PFs<sup>6</sup> and set out again in the rest of this section, HCA submits that PMIs' incentives are not aligned with those of patients and as a result PMIs have resisted investments to innovate and expand capacity offered by private hospital operators.

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<sup>3</sup> HCA, Response to the CC Notice of Possible Remedies, section 5, for example.

<sup>4</sup> HCA, Response to the CC Notice of Possible Remedies, paragraph 5.16.

<sup>5</sup> As set out in Annex 2 to HCA's Response to the CC's Notice of Possible Remedies, HCA's observed five-year survival rate for breast cancer is significantly higher than the national age-standardised relative rate (93% vs. 85%). This means 28 HCA patients who would have died are still alive five years after diagnosis. For cardiothoracic surgery HCA has half the national average mortality rate.

<sup>6</sup> HCA, Response to the CC PFs, paragraph 7.76.

- 1.9 In order, therefore, to understand the potential effect of divestiture on innovation, it is crucial for the CC to analyse PMIs' incentives to recognise these innovations. In deciding whether to recognise a new facility or treatment a PMI would weigh the costs and benefits of recognition. The costs include the expected payments it would be required to make to innovating hospital operators for treating patients at the new facility and/or with the new treatment. These investments/innovations by a hospital operator may increase the range of treatments available to PMI patients, for example where previously the conditions were untreatable or could be treated only at the NHS. The PMIs themselves have referred to "supplier induced demand", whereby demand for private healthcare has increased, as a result of new, innovative treatments being provided by private hospital operators. Some of these innovations will simultaneously lead to a reduction in costs, but others will be high cost, high acuity treatments. Nevertheless, regardless of how this increased provision of healthcare is defined, it is unquestionably to the benefit of patients from both an economic and a clinical perspective.
- 1.10 However, PMIs have opposed innovations and investments in higher quality care, which may increase claim incidence by making new treatments available to private patients, as HCA outlined during the Remedies Hearing. Indeed HCA has provided the CC<sup>7</sup> with a number of examples where PMIs, through leveraging their buyer power, have stifled investments in facilities and treatments. This is because increased claim incidence may lead to an increase in overall claims costs to PMIs, the effect of which on PMIs' margins can be offset only by any additional PMI premium generated through attracting new policyholders or being able to increase charges to existing policyholders (either generally, or through targeted co-payments).
- 1.11 HCA submits that the PMIs' resistance to quality improvements and innovation is consistent with an uncompetitive PMI market, where PMIs see little incentive to improve the quality of their offering to policyholders in order to attract new patients.
- 1.12 Overall, and as explained previously by HCA, if the CC envisages that its remedies will lead to the PMIs having more bargaining power, it will need to assess the consequence of this increase for their "gatekeeping" role for new investment. This is important in determining whether any additional incentives to invest will effectively be "passed through" to patients and indeed, whether the proposed remedy (as HCA has set out clearly) will make matters worse.

***There is no evidence that there will be a reduction in hospital operator charges to PMIs as a result of the CC's remedies***

- 1.13 In relation to the impact of the proposed divestiture remedy on prices, the CC has noted that *"the level of such consumer detriment will depend in part on the extent to which any reduction in insured prices would be passed through to consumers"*<sup>8</sup>.
- 1.14 HCA submits that it cannot be assumed that there would be any reduction in its charges to PMIs following divestiture. As noted in its Response to the PFs,<sup>9</sup> HCA considers that the CC's insured price analysis does not demonstrate that it charges *"significantly higher prices"* than other central London operators, or that the revenue it generates from PMIs is associated with market power, as claimed by the CC. To the extent that any of HCA's episode charges are higher than those of its competitors, this arises from the higher costs HCA faces as a high

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<sup>7</sup> HCA, Response to CC Market Questionnaire; see also HCA's reply to AXA PPP's submission, dated 22 February 2013.

<sup>8</sup> Letter from the Treasury Solicitors to the CAT, paragraph 35.

<sup>9</sup> HCA, Response to the CC PFs, Appendix 4, paragraph 4.125, for example.

quality operator focused on providing complex, acute treatments in its hospitals, which are located predominantly in central London.

1.15 Therefore, HCA considers it unlikely that divestiture would result in any reduction in the prices it charges to PMIs at its remaining facilities. HCA's cost base would, if anything, increase because of the loss of economies of scale and other synergies. In the PruHealth Remedies Hearing Summary, the CC highlighted that "*PruHealth did not necessarily believe that the sale of one or more of HCA's hospitals would exert downward pressure on prices and in all likelihood a new entrant would charge the same as HCA*". HCA agrees with this position and in its view this provides evidence that its prices are already competitive.

1.16 Furthermore, HCA considers that if prices were to fall at [§] this could only come about from a reduction in the quality and range of treatments available, to the detriment of patients.

#### ***Any reduction in HCA's charges would not significantly affect PMIs' cost bases***

1.17 In order to assess pass-through the CC needs to understand the extent to which a price reduction would affect PMI's variable costs. The CC's own analysis suggests that any price reductions that may arise out of its remedies package are likely to be extremely minimal. In this context, such reductions are likely to have a very small impact on PMIs' variable costs.

1.18 Furthermore, and crucially, each of the PMIs already offers network policies which exclude HCA. There would be no impact on the costs of providing these policies and thus no reduction in policy premiums for those individual or corporate customers. As submitted in previous responses, the number of PMI patients taking up these policies is increasing rapidly. For example, as HCA has previously pointed out to the CC, [§] of Aviva's customers are on its network "key list" product which excludes HCA hospitals<sup>10</sup>. The CC must therefore exclude those patients that are likely to choose such policies, not only current patients, but also any additional patients that are likely to choose these policies over the time horizon the CC is using to conduct its proportionality assessment, from its analysis of the impact of divestment of [§].

#### ***Assessing the degree of pass through of any cost reductions requires careful analysis***

1.19 There are prima facie reasons for believing that the supply of PMI is not competitive. Supply is highly concentrated (the four major PMI providers, Bupa, AXA PPP, Aviva and PruHealth, accounted for 87% of the market in 2012)<sup>11</sup> and concentration has been stable over time (ranging from only 87 – 87.5% during 2008-2012)<sup>12</sup>. Furthermore, in HCA's experience, patients and a substantial number of corporate clients do not readily switch between different PMI providers.

1.20 In any market,<sup>13</sup> the degree of pass through of cost reductions to final consumers is complex to assess, and requires detailed analysis of factors including the elasticity of demand, the elasticity of supply and the curvature of the demand curve<sup>14</sup>.

1.21 Assessing the price elasticity of demand for PMI policies is not straightforward as this is likely to differ across different customer groups and at different points in time (e.g. at the time of

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<sup>10</sup> See para 3.4, HCA's observations on Aviva's response to the AIS.

<sup>11</sup> Laing & Buisson, Health Cover 2013, p126

<sup>12</sup> HCA market shares in 2008 and 2009 for PruHealth have been calculated including Standard Life.

<sup>13</sup> Other than in the theoretically extreme case of a "perfectly competitive market".

<sup>14</sup> Weyl, E.G., and Fabinger, M., "Pass-through as an Economic Tool: Principles of Incidence under Imperfect Competition, Forthcoming in the Journal of Political Economy".

making the decision whether to purchase PMI cover or rely on the free alternative of the NHS and at the time of deciding whether to switch at policy renewal dates). The CC will need to assess market demand in addition to firm demand to understand the effects of any PMI policy price changes on demand and the incentives for PMIs to pass through cost reductions to their customers.

- 1.22 HCA considers that its view of the lack of competition in the supply of PMI is supported by the existence of captive PMI policyholders who are unable to switch in response to changes in the value of a PMI's offering. A feature of PMI provision for individual policyholders is customer lock-in which arises due to medical conditions policyholders develop whilst holding a PMI policy which would not be covered (or only at a prohibitively high cost) if they were to switch to an alternative PMI. The result is that policyholders who have made claims for treatment face considerable barriers to switching due to their pre-existing medical conditions. Estimates from the US<sup>15</sup>, suggest that 20 to 66% of the adult population (with a midpoint estimate of 32 per cent)<sup>16</sup> reported having medical conditions in 2009 that could result in a health insurer denying coverage, requiring higher-than-average premiums, or restricting coverage through the use of exclusionary terms. For the potentially large number of individual policyholders locked in due to pre-existing medical conditions, PMIs would have no incentive to pass through any reduction in costs arising from divestiture. The CC would therefore need to exclude this customer base from its analysis of any benefits flowing from the divestment remedies.
- 1.23 Furthermore, for those corporate PMI contracts that are negotiated on a bilateral basis between a customer and a PMI provider, an assessment of pass through would require an analysis of how any change in charges would affect the bargaining position of the customers relative to that of the PMIs. The existence and magnitude of any pass-through in this context cannot simply be assumed. Given that there is a greater proportion of corporate PMI customers in London, this is particularly important in the context of understanding the potential pass through arising from any reduction in prices arising from the divestment of [X].

***The existing evidence suggests that PMIs have not historically passed through cost reductions***

- 1.24 HCA considers that there is no evidence to suggest that patients would benefit from any price reductions arising from divestiture – on the contrary, the only evidence it has seen suggests that PMIs have been able to extract increases in premiums above the increase in claim costs. Market data, as set out in Figure 1 below, shows that in recent years the PMIs' loss ratios (the cost of claims as a proportion of premium income) have been decreasing and profits before tax have been increasing. Laing and Buisson also notes that, *"the wide use of cost containment practices by insurers is almost certainly likely to have exerted some downward impact on claims costs"*<sup>17</sup>. This, of course is a further example of the results of the PMIs exerting their bargaining power in negotiations with hospital operators. However, as Figure 1 shows, this data is also informative of the degree of pass-through.

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<sup>15</sup> United States Government Accountability Office, Report to Congressional Requesters, Private Health insurance, March 2012. Available at: <http://www.gao.gov/assets/590/589618.pdf>

<sup>16</sup> This range depends on the list of conditions used to define pre-existing conditions in each of five US estimates.

<sup>17</sup> Laing and Buisson, Health Cover UK market report, 2013, section 1.4.1.

**Figure 1 – Bupa / AXA PPP loss ratios and cost of claims over time**

	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Bupa - Loss Ratio	76.0%	74.3%	73.2%	72.5%
Bupa - Cost of Claims (£m)	1661	1608	1613	1631
Bupa – Profit before tax (£m)	105	97	160	156
AXA PPP - Loss Ratio	79.0%	77.5%	74.7%	74.1%
AXA PPP - Cost of Claims (£m)	809	795	789	812
AXA PPP – Profit before tax (£m)	43	65	53	70

Source: HCA analysis of Laing & Buisson data

- 1.25 Figure 1 above shows that the costs incurred by PMIs have been decreasing (measured by the reduction in the loss ratio from 76% to 72.5% for Bupa and 79% to 74.1% for AXA PPP between 2009 and 2012). However, over the same period, these PMIs' profits before tax have increased over the period (£105 to £156 million for Bupa and £43 to £70 million for AXA PPP). This suggests that these PMIs have failed to pass through, at least fully, the cost reduction that they have enjoyed.
- 1.26 For Bupa, the average revenue per policyholder has increased by an estimated 11% between 2009 and 2012 whilst the cost of claims per policyholder has increased by only 6 per cent. Similarly for AXA PPP, the average revenue per policyholder increased by 10% whilst costs of claims per policyholder increased by only 3 per cent.<sup>18</sup> In HCA's view this would suggest that the major UK PMIs do not face sufficient competitive pressures to reduce premiums.

***The failure to pass-through any savings arising from divestiture may negatively impact on patient welfare***

- 1.27 In assessing the potential relevant customer benefits of divestiture the CC appears to rely on customer benefits flowing from reduced PMI premiums which, as HCA sets out above, is highly uncertain. There is no evidence to suggest that the prices charged to PMIs would fall and, further, the existing available evidence suggests that any price reductions are unlikely to be passed through to patients. Unless the CC is in a position to analyse the degree to which its remedies will actually benefit patients, there is no justification for imposing a highly draconian and intrusive remedy. Such a remedy, in the absence of concrete evidence of PMIs passing through cost reductions to patients, can only be expected to confer a benefit to PMIs, rather than patients, and therefore does not address any supposed patient detriment.
- 1.28 Conversely, HCA has provided the CC with considerable evidence showing that divestiture would have a negative impact on the quality and range of treatments available to patients. Even if the CC were to consider, in spite of this concrete and extensive evidence, that its divestiture remedy is likely to increase the incentives on hospital operators to invest in quality and innovation, it needs to consider whether these investments will actually be allowed by the PMIs and therefore “passed through” to customers. In fact, as explained above, PMIs' incentives are not aligned with those of patients and lead them to be conservative (at best) or obstructive with respect to innovations and expansions. The CC's remedies do not address this issue and therefore the CC will have to consider this aspect with respect to its assessment of the effectiveness and proportionality of its remedies.

<sup>18</sup> HCA estimates using the distribution of PMI revenue based market shares to estimate the number of policyholders by PMI. Data sourced from Laing and Buisson, UK Health Cover, 2013.

1.29 Overall, therefore, it is imperative that the CC conducts a full analysis of the impact on prices and quality in order to assess the proportionality of its proposed divestiture remedy. In HCA's view, such an analysis can only result in the conclusion that the CC's proposed divestiture remedy is completely disproportionate.

## 2. PMI procurement strategies

2.1 During the remedies hearing, the CC referred to the possibility of PMIs separately procuring services that form part of the patient pathway, such as diagnostic or pathology services. This is far from being merely a potential development. It in fact reflects current trends in PMI procurement strategies.

2.2 HCA has already made a number of submissions to the CC<sup>19</sup> about the use of service line tenders by PMIs. These tenders involve specific services (that ordinarily form part of the patient's diagnostic or treatment pathway) being subject to separate recognition and price negotiations. PMIs, most notably Bupa<sup>20</sup>, are already implementing the sort of measures described by the CC, and there are an increasing number of such "specialty networks" already in existence.

2.3 In 2006, Bupa delisted HCA's hospitals for the provision of MRI services. As noted by HCA, this delisting caused severe disruption to the provision of HCA services at its hospitals. Furthermore, during this time, BUPA encouraged consultants practising at HCA to move their practice to rival hospitals in London<sup>21</sup>.

2.4 BUPA has also gone out to tender for CT (computed tomography) services and for TAVI (transcatheter aortic valve implantation) procedures. In the last few weeks alone, Bupa has announced its intention to create an ophthalmology network and to invite tenders for the delivery of cataract surgery, in which hospitals are being asked to bid as a "prime contractor" and package the fees of their consultants. Furthermore, AXA-PPP has created an oral surgery network.

2.5 At the remedies hearing, the CC invited HCA's views on these procurement initiatives. HCA's quality offering is, in part, derived from its ability to efficiently manage the entire patient pathway from diagnosis to treatment and possibly further diagnostic and follow-up services. This has enabled HCA to design patient pathways that maximise the probability of accurately diagnosing a patient, minimise the time by which a patient requiring treatment is admitted, and ensure that all necessary post-treatment services are provided to monitor properly the patient's progress.

2.6 This trend, of picking and choosing specific elements, has the potential to have a highly disruptive effect on the patient's route through a treatment pathway and degrade the quality of service to the patient. A PMI's clinical decision-making will tend to be driven by its desire to limit costs, and this can be at the expense of a higher quality service. As has been witnessed with guided referral products, in which PMIs have similarly intervened in the patient referral

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<sup>19</sup> For example, see HCA's Response to the Issues Statement (IS) (section 6 and 10), HCA's Response to the Annotated Issues Statement (AIS) (section 5, para 5.136 – 5.145), HCA's Response to the working paper on central London Horizontal Competitive Constraints (section 8), and HCA's Response to the PFs (section 7).

<sup>20</sup> For example, for the provision of MRI, PET CT, Bone Marrow Transplant (BMT), Ophthalmology and TAVI services.

<sup>21</sup> HCA's Response to the CC's AIS, para. 5.21. See also HCA's Response to question 43 of the CC's market questionnaire.

process, this can mean (among other things) slower care, less joined-up care, unnecessary duplications and improper cross-referrals.

- 2.7 However, it is clear that the major PMIs are intent on going out to tender for an increasing range of clinical services, including diagnostics. This reflects their bargaining power over private hospitals. Whatever HCA's views may be about the implications for quality and continuity of care, it is likely that the PMIs will increasingly look at independently procuring specialist services.

### 3. Barriers to entry and expansion

- 3.1 HCA has a few supplemental points concerning the CC's findings on barriers to entry and site availability.

#### *NHS sites*

- 3.2 HCA has submitted evidence to the CC of the wide availability of sites for new entry and expansion in central London. In addition to an extensive range of privately-owned commercial sites which are available for re-development, the NHS is also embarking on a programme of disposals of surplus property suitable for new hospital developments.
- 3.3 As previously indicated, the NHS is reconfiguring clinical services within the capital in order to concentrate NHS facilities with a smaller number of locations across London. This restructuring programme is freeing-up NHS sites which are being sold off for private development. NHS properties are already being used as hospital facilities and therefore have the appropriate planning consents. They are highly suitable for any private operator seeking to enter into, or expand within, central London.
- 3.4 McKinsey & Co. has carried out research for HCA into the extent to which NHS surplus land is available for redevelopment and its report is attached (Annex 1).

- 3.5 [REDACTED]

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

- 3.6 [REDACTED].

- 3.7 [REDACTED].

#### *King Edward VII*

- 3.8 HCA has recently written to the CC about the current expansion plans of the King Edward VII Hospital in the Harley Street area. As further confirmation of this, there have been recent press reports that the hospital has received a grant, worth up to £30 million, to fund this expansion (Annex 2). The hospital has indicated that it will use the grant to build additional operating theatres, consulting rooms, and new wards. Chief Executive John Lofthouse has stated: "*This gift will enable us to reinforce our position as one of the world's most outstanding hospitals.*" It



is one further example (amongst many others) of significant and ongoing expansion in central London, indeed in the Harley Street area.

3.9 To recap, HCA has over the last few months provided to the CC in its various submissions<sup>22</sup> a substantial body of evidence of new entry and expansion in central London:

- There is clear evidence that the London market has grown substantially and is continuing to expand.
- The factors driving growth in demand in London – an increasing population, resilient PMI penetration, a buoyant economy and higher disposable income – make this an attractive market for investment. This is despite the depressed economic environment of the last four years.
- There is widespread availability of privately-owned sites coming onto the market and HCA has submitted concrete evidence of currently available opportunities.
- [redacted]<sup>23</sup>.
- As indicated above, there are also a significant number of surplus NHS properties which are coming onto the market as a result of the reconfiguration of NHS services in central London.
- BMI has entered central London in recent years, and Spire is looking to do so currently.
- A new, tertiary hospital, the London International is planning to open next year and [redacted].
- All of HCA's central London competitors have expanded significantly in recent years.
- The London Clinic ("TLC") has recently gone through a major expansion and has successfully launched a major new cancer facility, which is the subject-matter of the CC's own case study;
- The King Edward VII is also currently undertaking significant expansion within the Harley Street area, as one example amongst many of the ability of competitors to expand within central London.

3.10 In the light of the above, it is clear that the CC has seriously erred in its PFs as to the existence of barriers to entry and expansion in central London. No reasonable decision-maker could, on this evidence, come to the view that there are significant entry barriers in either inpatient or outpatient facilities in central London. This invalidates a central plank of the CC's provisional findings concerning the structural features of the market, as far as London is concerned. It also removes the basis for a highly intrusive divestiture remedy: it is abundantly clear that divestiture cannot conceivably be justified as a market-opening remedy, since rival hospital operators have the opportunity, incentive, means and ability to enter the market and / or grow their activities in central London.

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<sup>22</sup> See in particular: HCA's Response to the PFs; HCA's note to CC dated 18 November 2013 concerning site availability in and around Harley Street; HCA's note to CC dated 1 November 2013 concerning the London International Hospital; HCA's Response to the CC's Working Paper on central London, dated 28 June 2013; HCA's comments dated 7 June 2013 on the London Clinic case study.

<sup>23</sup> [redacted].

#### 4. Consultant equity partnerships – materiality threshold

- 4.1 During HCA's remedies hearing, the CC sought HCA's views on the scope for a materiality threshold to apply to a remedy relating to the prohibition of consultant equity partnerships. Mr. Witcomb asked whether "*there is a line to be drawn*".
- 4.2 HCA notes that the CC is in the process of weighing up the pro-competitive aspects of consultant equity partnerships against the concerns it has identified. HCA reiterates the pro-competitive features of consultant / hospital equity partnerships, both in respect of new healthcare facilities and new treatment technologies. In its response to the CC's Notice of Possible Remedies, HCA noted<sup>24</sup> that equity schemes can unlock new investment and encourage the delivery of new products and clinical services which would not come to fruition without full consultant engagement. HCA also observed that consultant equity participation encourages consultants to be involved in the strategic direction of the new venture and devote their time to the improvement of quality and the development of new clinical services.
- 4.3 The introduction of a specified materiality threshold raises a question over what the optimum threshold should be, particularly as each joint venture will represent varying levels of capital investment. Therefore, the "materiality" of the equity stake will be specific to each joint venture.
- 4.4 In addition, new consultant joint venture partnerships can begin life with a relatively more concentrated equity distribution, but, as the partnership grows over time, the level of equity ownership may become increasingly dispersed.
- 4.5 Furthermore, it is difficult to see how (to use Mr. Witcomb's phrase) a "line could be drawn" in terms of the level of any equity stake held by a consultant. There are many 100% consultant-owned facilities (e.g. the Fortius Clinic) where the consultants own the outpatient and diagnostic facilities outright. If the CC imposed a cap on the level of the consultants' shareholdings, it is difficult to see how these consultants could continue with their existing business model. HCA repeats that any remedy would need to apply, in exactly the same way, to all providers. A cap on consultant shareholdings could have a detrimental impact on these consultant-owned facilities.
- 4.6 It is not clear that the CC has fully understood the implications of this remedy for many consultant-owned ventures. At the hearing, Mr. Roberts asked about how consultant JVs could be terminated and suggested: "*that they could buy you out*". HCA struggles to see how such an outcome would address the CC's concerns, since the consultants would then be left with a 100% ownership stake in the facility. The CC is not suggesting in the PFs that 100% consultant ownership is a better outcome than ownership which is shared with a hospital provider.

#### 5. Quality measures

- 5.1 As indicated in HCA's Response to the CC's Notice of Possible Remedies, HCA believes that the collection and publication of HES and PROMS and the collection of ICD10 coding data are necessary in order to develop meaningful outcomes data, but in themselves will not guarantee better outcomes data. HCA referenced a transition to OPCS coding, and during the remedies hearing, HCA also referred to a number of process measures that it believes could meaningfully improve patient care. The submission below expands on those themes.
- 5.2 Within healthcare systems, there are, generally, three different modes of quality measurement:

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<sup>24</sup> See HCA's Response to the CC's Notice of Possible Remedies, section 9.

- Structural quality measures
- Process quality measures
- Outcome quality measures

### *Structural Quality Measures*

- 5.3 Structural measures are those that ensure that the facility, equipment and staffing are fit for purpose.
- 5.4 Regulating these factors is the domain of the CQC and as such, HCA will not explore this further here. It would, however, urge the Commission to review the Francis Report and associated documents. The report identifies a number of issues that pertain specifically to governance measures within hospitals to relate to patient safety, and the CQC is currently reviewing these.

### *Process Quality Measures (measuring quality of care at the time of delivery)*

- 5.5 Process measures are indicators of care as and when it is delivered to the patient – for example whether each surgical patient has been given all appropriate pre-surgical medication, or that their catheter is removed within 48 hours of surgery.
- 5.6 In the UK, there is no system for publishing (public or private) hospital operators' scores against process measures. HCA therefore discusses the system in the US via the Joint Commission, which has driven an industry wide incentive to perform to research-driven protocols in healthcare. These protocols were referred to during HCA's remedies hearing.
- 5.7 The Joint Commission is an independent, not-for-profit organisation that accredits and certifies more than 20,000 health care organisations and programs in the US. As such, the Joint Commission enforces the measurement of performance against a series of processes that are all supported by clinical research.<sup>25</sup> Since beginning to measure these processes in 2002, the Joint Commission has seen a steady improvement in industry wide performance against these measures<sup>26</sup>.
- 5.8 It should be noted that not all of these process measures are relevant to the UK private healthcare, but a significant number of them are, for example, in respect of stroke care or surgical care. These processes are measurable by auditing medical records.

### *Outcomes Quality Measures: (measuring quality of care retrospectively)*

- 5.9 Remedy 7 of the CC's Notice of Possible Remedies largely relates to the publication of outcome measures, which are retrospective measurements of the quality of care delivered. HCA believes that the CC could assist the industry in two specific ways: pushing for the publication of existing data with validation requirements; and laying the foundations for more sophisticated outcome measures.

<sup>25</sup> [http://www.jointcommission.org/assets/1/6/NHQM\\_v4\\_3a\\_PDF\\_10\\_2\\_2013.zip](http://www.jointcommission.org/assets/1/6/NHQM_v4_3a_PDF_10_2_2013.zip)

<sup>26</sup> <http://www.jointcommission.org/annualreport.aspx>

(i) **Publishing existing data**

In HCA's view, PHIN should be supported in its plans to publish all providers' existing outcomes data:

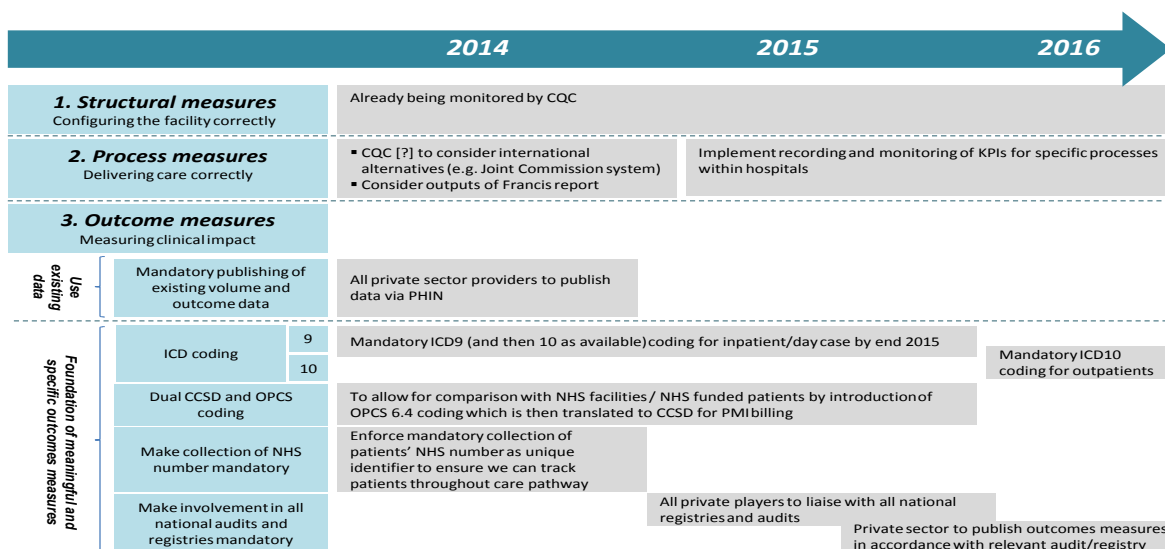
- Volumes (HES)
- PROMS
- Length of stay
- Day case rate
- Surgical site infections
- Patient experience
- Unplanned transfers
- Readmissions
- Mortality

(ii) **Laying the foundations for more sophisticated outcome measures:**

There are four key actions that need to be taken to build the foundations for risk adjusted, procedure specific outcomes (for example, breast cancer five-year survival rates adjusted for the stage of cancer when the patient was diagnosed):

- **ICD coding** – ICD coding allows for patients disease type / progress to be accurately coded to make comparisons of data more meaningful. It is estimated by PHIN members that ICD coding adds c. £5 - £10 cost to each patient's treatment and HCA would expect that most hospital operators would comply with this coding by employing coders to review medical records and note the relevant aspects of the patient's case (as HCA does).
- **OPCS coding** – In order for patient data to be comparable with patient data in the NHS and to track patients, it would be judicious of the private sector to code procedures using the same codes as the NHS. Currently, the private sector uses Clinical Coding and Schedule Development codes (CCSD), the NHS uses Office of Population Censuses and Surveys Classification of Interventions and Procedures codes (OPCS). A pragmatic solution is for the private sector to code the procedure using OPCS and then translate that into a CCSD code for PMI billing purposes.
- **Mandatory NHS number collection** – To track patients through both private and public systems, it is imperative that a common unique identifier is collected. Mandating the collection of NHS numbers would allow this to happen for all UK patients. To facilitate this, the CC could require that open and free access is provided to the NHS number look-up service.
- **Mandatory submission to the national registries/audits** – Ultimately, it will be the national registries and audits that guide the sector on the appropriate quality metrics to measure. As such, it should be mandatory for all private sector players to be fully engaged with all national registries / audits.

Please see below a suggested timeline that HCA considers reasonable for the actions laid out above:



## 6. TLC and HCA

- 6.1 At the remedies hearing, there was some discussion about the comparisons to be drawn between HCA and the TLC in terms of differences in quality, clinical environments, and the breadth of their services. HCA has already made some submissions on this issue in Appendix 4 of its Response to the PFs, but it may be helpful to expand on these.
- 6.2 This issue, concerning the differentiation of HCA's and TLC's offerings, is relevant in two separate contexts:
- (i) First, as HCA has consistently submitted, the CC's own comparisons of insured prices between HCA and TLC is vitiated by the fact that it has ignored differences which could have a significant impact on their respective cost base. Please refer to Appendix 4 of HCA's Response to the PFs for a detailed discussion of these points.
  - (ii) Secondly, this issue is highly relevant to the question of the impact of a divestiture remedy and the extent to which a buyer would be able to replicate the quality of HCA's service offering arising from its current network of hospitals.
- 6.3 The CC is right to identify TLC as a significant, successful and close competitor to HCA. It has successfully launched, within a very short space of time, a major new cancer centre and competes vigorously with HCA on a wide variety of clinical services. However, there are important ways in which HCA's service offering can be differentiated from that of other providers such as TLC on grounds of quality of care, resulting in significantly higher costs for HCA. This quality offering will be put at risk through any divestment remedy.

### *Investment in staff to support capital investment*

- 6.4 HCA has invested more in its clinical staff in order to assist consultants in delivering better care to patients:

- HCA employs more Resident Medical Officers (RMOs) and Clinical Nurse Specialists (CNSs) than TLC. RMOs and CNS play a key role in providing continuous and high quality care to patients.
- HCA offers patients a high staff : patient ratio to ensure timely care and post-care monitoring and support.
- It offers a broader range of complex, tertiary services than TLC. These services often necessitate investment in the clinical environment and in the calibre of support staff.

6.5 These differences can significantly affect any comparison of quality of care available and the cost per admission between the two hospitals.

6.6 Obviously, it is open to the CC to carry out its own comparisons of quality between these facilities. [X].

### *Management responsiveness*

6.7 [X].

### *Quality of clinical services*

6.8 HCA has been a market leader in introducing a number of clinical technologies that improve the quality of care to patients (for example, see Appendix 6 of HCA's Response to PFs). HCA has also invested in specialties that TLC does not offer to its patients, for example, in paediatrics, neuro-rehabilitation, and, whilst TLC does provide a limited range of cardiac and gastroenterological services, it does not offer the same depth of services as HCA in these specialties. For example, HCA's Wellington Hospital has launched a new centre of excellence for the treatment of neuroendocrine tumours.

6.9 HCA also operates its own, wholly-owned clinical research unit for cancer patients (at SCRI), which it has integrated into its cancer network.

6.10 [X].

6.11 [X].

6.12 HCA recognises that there is limited public data which enables quality comparisons to be drawn. However, HCA performs better than TLC on various quality comparisons which are available. For example, HCA has markedly lower infection rates than TLC (see Annex 3). HCA would add that an effective information remedy would assist in allowing consumers to make better comparisons between hospitals, e.g. comparing 5-year post-operative breast cancer survival rates at HCA as against TLC. Disclosure of this kind of outcome would trigger a competitive process focused on quality that would be hugely valuable to consumers.

### *Interaction with doctors*

6.13 HCA has referred to the high value it places on how it interacts with consultants and believes that this is one of its key strengths. [X].

### *Patient comfort*

6.14 HCA believes that across its hospital facilities, it is able to offer patients a higher level of comfort and customer service. [X].

*Consultant feed-back - examples*

6.15 [X].

6.16 [X]:

- [X];
- [X];
- [X];
- [X];
- [X];
- [X];
- [X];
- [X];
- [X].

6.17 [X]:

- [X];
- [X];
- [X];
- [X];
- [X].

6.18 [X].