Nuffield Health's response to the Competition Commission's provisional findings report on 28th August 2013

Introduction

0.1 Nuffield Health welcomed the progress made by the CC in its provisional findings document, and continues to appreciate the opportunity to respond to developments in the CC's thinking

0.2 Nuffield Health will use this submission to clarify areas of alignment and outline those theories of harm where Nuffield believes the CC's findings require further refinement

0.3 In summary:

- We agree with the CC's view that HCA, BMI, and Spire have market power over insurers, which leads to higher prices and reduced choice for the consumer.
- We are similarly aligned with the CC on the difficulty of entering new markets as a hospital operator. In addition to the CC's correct identification of high structural barriers to entry (e.g. sunk costs), Nuffield also believes non-structural barriers play a significant role. These non-structural barriers arise from the terms that hospital operators with market power are able to negotiate during national bargaining with insurers.
- Nuffield agrees that consultant incentives (in cash or kind) are problematic, and is concerned that their use might redirect volumes to the detriment of patients, whilst also placing upward pressure on price.
- As regards local market power, there remain certain areas where Nuffield is unsure of the CC's methodology. However, we have confidence in those findings the CC has disclosed relating to central London.
- Nuffield is also aligned with the CC around the need for consumers to be able to access better data relating to both hospital and consultant performance, and supports the CC's desire for greater transparency around consultant fees.

0.4 In line with the structure of the summarised provisional findings we have divided our response into the following sections:

0.5 In addition to this document, Nuffield Health will make another submission addressing the CC's proposed remedies. As the CC's thinking around specific remedies evolves, we anticipate further opportunities for feedback to ensure that adverse effects on competition are appropriately mitigated.

0.6 As with previous submissions, if an issue raised by the CC is not addressed directly by this response, please do not infer tacit agreement. We reserve the right to comment on any unaddressed market characteristics at a later time.

1. Barriers to entry and expansion

1.1 Nuffield Health broadly agrees with the provisional findings of the CC around barriers to entry. The CC was right to point out the high level of sunk costs an operator must incur to establish a new facility.

1.2 Furthermore, Nuffield Health agrees that the presence of economies of scale at the individual hospital level does mean that smaller markets are only able to sustain a limited number of efficiently sized hospitals.

1.3 These two factors, along with site availability, can be considered the primary structural barriers to entry. Where the CC's analysis seems less certain, however, is around the identification of non-structural barriers, which have been erected to protect the strategic interests of dominant hospital operators.

1.4 The best examples of these non-structural barriers are exclusive and infrequently tendered insurer networks, and consultant incentivisation schemes.

Infrequently tendered insurer networks

1.5 While Nuffield Health agrees with the CC's assertion that '*PMI recognition, in itself, is not a barrier to entry*', that does not preclude the possibility of certain network configurations deterring entry. This issue is explored in greater depth in our response to the CC's provisional remedies, but the high level argument is laid out below:

- As was reinforced by the CC's findings, outside London a degree of leverage is conferred by the number of [Redacted] 'must-have' hospitals. This affords price making power during national negotiations with PMIs.

- Such leverage can result in [Redacted] presenting PMIs with heavily inflated prices unless they agree to contract high volumes with the hospital operator.
  - [Redacted]
  - In the case of other insurers, as the CC has acknowledged, the capacity of a PMI to direct patients to specific hospitals on its network is limited. Insurers are therefore hamstrung into approving [Redacted] hospitals on their network in an attempt to meet aggressive volume targets, despite the higher prices that may be charged across specific local markets by these operators.
- A further impact of these negotiating tactics is that they incentivise infrequent retendering of exclusive networks.
  - [Redacted]
- This leaves hospital operators with only 2 available options in [Redacted] excluded markets: divestment or diversification (through the treatment of NHS patients, for example). It also limits the appetite of potential new entrants in markets [Redacted] due to probable network exclusion.
- Such network configurations are ultimately detrimental to the consumer in that they reduce choice and drive up concentration nationally.

1.6 Nuffield Health therefore believes that long term contracts on exclusive acute hospital networks constitute a material barrier to de novo market entry.

1.7 For a more detailed exploration of the adverse effects on competition (AEC) created as a consequence of exclusive PMI networks, we refer to our response to the AIS[1].

1.8 We would also welcome the opportunity to discuss further the satisficing behaviour of PMIs more generally, as was raised in our previous CC hearing. [Redacted]

Consultant incentivisation schemes

1.9 The second non-structural barrier to entry involves consultant incentivisation schemes.

1.10 Nuffield Health fully appreciates that the CC has already deemed these arrangements to have an AEC, but also believes that they constitute a non-structural barrier to entry.

[1] *Submission and response to Annotated Issues Statement, pg 12*

- The CC has noted that in order to establish a new hospital, the entrant must first secure sufficient consultant buy-in to ensure volumes flow through the facility.

- To secure this buy-in, a generous incentivisation package is often required. By the CC's own reckoning, '*such schemes would constitute a barrier to entry if incumbents were able to provide greater incentives to consultants than were potential entrants and thus deny entrants access to sufficient consultants to make the new hospital viable'.*

- Nuffield Health does believe that incumbents in a given market are able to provide greater incentives to consultants than prospective entrants. To elucidate why this is the case, consider the business case for incentivisation.

- From an incumbent's perspective, consultant incentivisation is compelling for two reasons:

  1. It secures volumes for the hospital, driving up utilisation
  2. It deters new entry, protecting the hospital from downward pricing pressure

- On point 1, despite the incentive to secure hospital volumes existing for new entrants and incumbents alike, there are more options available to the incumbent. For example, entrenched unnamed referral patterns can be leveraged by the incumbent and passed on to those consultants who drive the greatest volumes. If consultants are to transfer their practice to a new entrant, they must consider the cost of forgoing these unnamed referrals, which are likely to remain with the incumbent.

- On point 2, it is likely that the business case is unviable from a new entrant's perspective, given that any new entrant is likely to project revenues which already include considerations around downward pricing pressure, as their entry will (by definition) increase levels of local competition.

- This leads us to conclude that should they so desire, incumbents could justify more varied and generous incentivisation packages than new entrants.

1.11 When viewed in this way, consultant incentives can be understood as not only influencing referral decisions, but also as a barrier to market entry.

2. Local competitive constraints

2.1 The CC's investigation has considered local competitive constraints separately in central London and the rest of the UK, which we therefore respond to in turn.

Central London

2.2 Nuffield Health was unsurprised to see that the CC has confirmed that HCA has a position of market power in central London (the largest and most important regional market in the UK). [Redacted]

2.3 Methodologically, Nuffield is aligned with the CC's claim that competitive assessments in London require a separate approach. This is due to the distinctive features of the London market both on the supply-side (number of private hospitals, higher acuity procedure capabilities, levels of vertical integration) and the demand-side (level of PMI-penetration, concentration of corporates, willingness of patients to travel to central London).

2.4 It is interesting to note the CC's concern around HCA's dominance despite what Nuffield Health feels is an unnecessarily broad definition of the central London market.

2.5 If the CC were to delimit central London in accordance with the way insurers think about the market (predominantly zone one centred around Harley Street), then its analysis would yield even greater levels of market concentration. [Redacted]

Rest of the UK

2.6 Nuffield Health was unsure whether the CC has made material progress in its thinking on local concentration since working papers have been released.

2.7 As the CC is aware, Nuffield Health still disputes the classification of some [Redacted] hospitals, and refers back to the 'Response to CC's assessment of hospitals of potential concern' document previously submitted[2]. Disagreement tends to centre on one of three factors:

1. Omitted local competitors (either recent market entrants or PPUs)
2. Omitted private NHS Trust revenues
3. Misclassification of asymmetric duopolies as symmetric [Redacted]

2.8 In addition, we remind the CC of the concerns we previously raised around the comparability of pricing data used in its PCA work. We again reference our previous submissions for a description of the fully inclusive nature of Nuffield Health's prices in both the self-pay and insured market.

2.9 That said, we do not think it unreasonable that the CC has found that certain hospitals have local market power, and would appreciate clarity around exactly how such findings are being used to inform remedial action.

[2] *Specifically the table on pg 5 - 6*

3. National bargaining between PMIs and hospital operators

3.1 Nuffield Health was pleased to see the level of overlap between the CC's finding [Redacted] and its own analysis of must-haves conducted and submitted at the outset of this investigation.

3.2 Given the CC's acknowledgement of the market power afforded to Nuffield Health's competitors by their scale and local market concentration, we would once again like to take the opportunity to highlight the main way in which such power is leveraged.

One-in, all-in

3.3 We were pleased to see references to one-in, all-in negotiations in the CC's provisional findings[3]. In line with BUPA's comments and as we outlined in point 1.5, Nuffield Health believes disproportionately punitive volume-based price tiering constitutes de-facto tying. [Redacted]

3.4 Furthermore, our claims around these anticompetitive behaviours should be relatively easy to substantiate. Consider the following quantitative analysis:

3.5 A hospital operator's cost base can be divided into three main buckets:

1. Group overhead
2. Hospital by hospital fixed costs
3. Hospital by hospital variable costs

3.6 If cross network price discounting were simply the passing on of cost-saving to PMIs, we would expect volume-based pricing that falls in line with average cost per procedure.

$$Av.\ cost\ per\ procedure = \frac{total\ hospital\ variable\ cost}{total\ hospital\ procedures} + \frac{total\ hospital\ fixed\ cost}{total\ hospital\ procedures} + \frac{group\ overhead}{total\ group\ procedures}$$

3.7 On a hospital by hospital basis, as volumes rise average variable cost would remain broadly constant[4]. Conversely, average fixed costs would decline as they are spread more thinly over a growing number of procedures. It is at this level that a hospital operator can justify the passing on of volume-based savings to the consumer, offering tiered pricing accordingly.

3.8 At the group level however, only one of these categories of cost can be used to justify a cross-network price discount beyond what would be expected on a hospital by hospital basis – **average group overhead per procedure**. Nuffield Health asserts that this saving is negligible on a procedural basis, and that supposed deep volume-based discounting is a

[3] *Provisional findings, 6.180 – 6.187*

[4] *Nuffield Health appreciates there may be a negligible decline owing to the incremental purchasing power afforded to the hospital group when negotiating with suppliers*

negotiating ploy used to obfuscate anti-competitively high operator charges to PMIs at low volumes.

3.9 This calculation needn't be theoretical, and given the CC's access to hospital group financials, they could calculate the average group overhead per procedure. Nuffield contends that this cost would comprise a very small percentage of total average cost per procedure. This implies that the maximum justifiable volume-based price tiering (beyond what could be offered on a hospital by hospital basis) should be a negligibly small fraction of this figure.

3.10 Nuffield Health strongly encourages the CC to pursue this line of argument to its logical conclusion: [Redacted]. This issue cuts across many aspects of the investigation, and represents both a distortion to nationally competed insurer contracts, and a material barrier to entering new markets owing to the risk of network exclusion.

CC methodology

3.11 Our final comment around national bargaining concerns the CC's methodology. As with previous submissions, Nuffield wants to impress upon the CC the central importance of considering the level of corporate PMI activity.

3.12 As the primary purchasers of private medical insurance, the concentration of corporates in a given area is inexorably linked to the strategic importance of that market from an insurer's perspective. It is therefore important to overlay this consideration when evaluating the operator leverage conferred by concentration in local markets. We once again refer back to our previous submissions for a more thorough exploration of the impact of corporates in defining 'must-have' hospitals.

- Nuffield Health appreciates that 'weighted local concentration' formed one of five considerations in assessing different operators' hospital portfolios. While this weighting mechanism may go some way to accounting for corporate activity, we remain as yet unconvinced given the paucity of information released by the CC in this area.

- Nuffield Health would like to see analysis from the CC that attempts to identify the number of 'must-have' hospitals across each operator's portfolio. We once again remind the CC that a 'must-have' hospital is defined by two primary factors:

    1. High operator market share locally
    2. Location – the region is of strategic importance to PMIs due to high concentration of corporates

3.13 As such, we believe it is essential that the CC pays due consideration to both factors rather than focusing on point 1. Only then will the CC correctly identify 'must have'

hospitals and therefore accurately assess the market power of a hospital operator's portfolio in the context of national insurer negotiations

4. Consultant behaviour

4.1 In aggregate, Nuffield Health acknowledges the CC's finding that consultant groups caused no widespread harm in the market. Having said that, Nuffield Health has experienced certain instances where the collective bargaining power afforded by group membership has been used to levy higher costs on patients through demands around incentive schemes, which erodes consumer surplus.

4.2 Nuffield Health balances this concern against the potential benefits of consultant groups, particularly around emergency cover and the dissemination of best practice. Nuffield Health therefore removes its objection to such groups subject to the complete banning of consultant incentive schemes, financial or otherwise.

4.3 Nuffield Health was a little surprised to hear the CC's position change since the publication of the AIS around consultant fee-capping. We are a relatively neutral party in this debate, but see no reason why top-up fees should not be permitted by PMIs. Nuffield Health believes consultants should be able to charge fees that reflect their experience and expertise, providing any anticipated excess is made evident to the patient at the first available opportunity.

5. Information availability and asymmetry

5.1 Nuffield Health is aligned with the CC around the importance of freely available accurate information to the functioning of competition in private healthcare.

5.2 We view the need for better consultant fee and performance data as a consensus issue, and similarly support the development of hospital performance metrics to better inform patient, consultant, and insurer evaluations of treatment options.

5.3 Nuffield Health's main concern in this area, which will be addressed in greater detail in the remedies submission, relates to the timing of publication and the appropriateness of metrics published. The CC is no doubt aware that publishing the wrong information can have an even more distortionary impact on competition than the current asymmetries.

5.4 In terms of timing, Nuffield Health would like to voice a concern around publishing fee data in advance of the availability of reliable quality metrics for consultants. The concern here is that in the absence of outcomes based data, insured patients may use fees as a proxy for quality, which is problematic when many do not directly incur the cost of treatment.

6. Omitted distortionary factors

6.1 As Nuffield Health has mentioned previously, the competitive neutrality of PPUs remains an unaddressed concern. This is becoming especially pertinent as NHS Trusts increasingly look to partner with the private sector.

- A recent BMJ study found that one in six hospitals have increased the range of private patient treatment options over the past year, with 89% of trusts now offering private or "self-funded" services[5].

6.2 Given this trend, Nuffield Health is concerned that an unlevel playing field will be generated in markets where remedial action is proposed. Existing benefits available to PPUs include lower financing, capital, equipment, and ancillary service costs, none of which are being charged to PPUs at market rates.

6.3 For an in depth exploration of the harmful effects of cross-subsidisation in this market segment, please refer back to section 5 of Nuffield's Issues Statement response, and page 18 of Nuffield's AIS response.

7. Conclusion

7.1 In conclusion, Nuffield Health welcomes the CC's progress with its provisional findings. In our view, there remain two key areas that require the CC's on-going consideration:

1. The barriers to entry presented by **anticompetitive price-tiering** during national negotiations between hospital groups and PMIs. It is these arrangements which encourage the development of infrequently tendered, exclusionary insurer networks[Redacted]. These networks increase levels of market concentration longer term, which will ultimately reduce consumer choice, embed current artificially high pricing levels, and reduce the incentive to innovate.

2. The role of corporate hotspots in determining whether or not a hospital is 'must-have'. It is this overlay which reveals the true leverage conferred by a hospital operator's portfolio during national bargaining with insurers.

[5] *BMJ 2013;347:f4524*