

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with HCA held on 18 February 2014

Introduction

1. HCA began by describing the steps it had taken to reengineer its business model in London over the last six years. London was considered to be a very expensive market and HCA believed it needed to offer a level of service that patients and physicians would seek out, to stay ahead of its competitors and the NHS. Quality became its key differentiator in the central London marketplace. As HCA hospitals on average were each less than 100 beds, by themselves they could not provide great patient care. What HCA sought to do was find a way to operate as ‘one hospital’ with multiple locations, to provide the scale necessary to deliver world-class healthcare.
2. To do so, HCA invested in new IT systems, so that its doctors and consultants could access patient medical records at any time from any location. It hired specialist consultants to work with doctors about how to break down barriers between hospitals and centralize governance. It introduced multidisciplinary teams, whereby the best doctors across its hospitals were able to sit down in a room together and agree on the best patient care pathway for a particular individual—an initiative, it said, that no other hospital operator in the private sector was doing. Once HCA was able to operate as ‘one hospital,’ it began setting up sub-specialty centres within its facilities. For example, it developed the [redacted] at the London Bridge Hospital and the [redacted] at the Princess Grace. It found that by pushing all of its patients with particular conditions to those specialty centres, it had enough patient volume to justify innovation and new treatments, such as introducing the Da Vinci Robot, 3T MRI scanning and the source breast biopsy machine, the first of its kind in the country.
3. HCA was concerned about the lack of focus by the Competition Commission (CC) on quality in its investigation and the CC’s failure to consider and evaluate the role of quality in patient healthcare. It perceived that the CC had given more careful consideration to quality impacts in its review of the merger between the NHS Trusts in Bournemouth and Poole. This lack of focus on quality had discriminated against HCA.
4. HCA raised concerns about the impact that the forced sale of the London Bridge Hospital and the Princess Grace hospitals would have on patient care. The forced sale would result in fragmentation of care, resulting in competing organizations operating with lower volumes of patients and a higher cost base, and as such, a new owner would not be able to make the same level of investment in innovation as HCA had done. HCA would not be able to invest in innovations such as the next CyberKnife technology or genetics lab [redacted]—which the CC was proposing to achieve through its divestments. It did not consider divestiture to be appropriate as it would not achieve the desired outcomes, punished HCA’s success and created uncertainty around future investment.
5. On the other hand, HCA believed that the CC’s proposed remedies concerning consultant incentives, restrictions on private patient unit (PPU) expansion and increased visibility around pricing and quality would create downward pressure on costs and prices, and empower patients to make informed decisions.

Divestiture in central London

6. HCA raised two broad concerns with the CC's proposed divestment remedy in central London—it considered that the foundation on which the remedies rested was unreliable, and secondly, that divestiture would be disproportionate.

Market definition

7. HCA did not consider that using the North–South Circular Road was an appropriate way of defining HCA's market, as it bore no relationship to how patients made choices over hospitals and how providers competed. [X] of HCA's customers came from within the North–South Circular Road, while [X] came from outside it. As the latter category of customers travelled into the central London area, they would pass a number of other private hospitals. Those hospitals acted as a competitive constraint on hospitals within central London.
8. The insurers that intermediated between HCA and consumers did not use the North–South Circular Road as a mechanism for defining the products they offered to customers. HCA thought it was not tenable for the CC to ignore other hospitals in the Greater London area, the rest of the UK and internationally in its assessment of competition in London. HCA's business needed to consider all these competitive constraints.
9. The CC had adopted an arbitrary approach to market definition based on the North–South Circular Road which bore no relationship to the competitive constraints facing HCA. HCA understood that the CC normally defined a local market as the area in which 80 per cent of customers originated. It considered that the CC had departed from this approach and should at the very least give a robust explanation as to why it had set aside its normal approach to market definition in defining HCA's market. The CC pointed HCA towards the CC guidelines and stated that 'market definition is a part of our competitive analysis. It clearly doesn't define the whole competitive analysis'. HCA responded by noting that since the divestment remedies were based on reducing market share below 40 per cent, market definition was paramount.

Market concentration and market share

10. HCA did not consider that revenue was an appropriate basis for measuring market shares in the private hospital sector. This was in part because prices might reflect quality, which patients were willing to pay for. Secondly, some hospitals tended to have sicker patients than others and those patients were likely to cost more to treat. Share by revenue also penalized successful hospitals which were doing well in markets such as international or outpatient activity in respect of which the CC had made no AEC findings. In addition, the use of revenue gave rise to a 'double hit' in the context of the divestment remedy: the CC hypothesized that post-divestment, prices would decrease, and if so, revenue would not be an appropriate indicator of post-divestment market share.
11. Measuring market share by number of admissions may also punish successful hospitals. Successful hospitals that were fuller with the same number of beds were likely to have a higher market share than hospitals that were less successful with the same number of beds, and therefore had lower occupancy. HCA thought that capacity was the correct measure of market shares, as it reflected the ability of consumers and PMIs to choose and because it was consistent with the CC's concerns regarding barriers to entry relating to capacity. If the normal method for defining a local market was used and market share was measured by capacity, then HCA's market share

was [redacted] per cent. It submitted that the CC should choose a measure of market share and be clear about which measure it was using. Market share had been critical to the adverse effect on competition (AEC) finding and remedy design, yet the CC had not chosen meaningful market share measures.

Barriers to entry and expansion

12. HCA considered that there was insufficient evidence to justify lack of site availability in central London as a barrier to entry. At least 20 available sites in central London for possible hospital developments had been brought to HCA's attention over the last six years. There had also been actual evidence of competitors, such as The London Clinic (TLC), locating and developing sites in central London. Simply because some competitors were not as vigorous as TLC in locating sites, this did not mean that entry could not be achieved. Competitors who were focused had demonstrated the ability to develop new sites. The CC should be very sceptical about evidence submitted by HCA's competitors on this subject. HCA was aware of three sites in central London which property developers were currently promoting, and many more sites already designated for healthcare use would be made available via NHS trust re-configuration in 2014 and beyond.
13. HCA questioned why PMIs like Bupa and AXA PPP had not taken steps to sponsor the entry or expansion of new or existing hospital operators, if they considered that there were no alternatives available to them in central London. It thought that the key to what was inhibiting new competition in London was the actions of PMIs. In HCA's experience, PMIs were not conducive to supporting hospital operators expanding their operations. [redacted] HCA thought that if the CC required PMIs to recognize new facilities, this would lead to increased new entry.
14. PMIs sold insurance policies and whether they made more or less money depended on how much the policy was used by people. Increased capacity and quality for the same amount of policies sold was very clearly against the interests of PMIs. PMIs would make more money if more people used the NHS and fewer people chose private hospitals. This was a fundamental part of recognizing the incentives of PMIs. PMIs only had the incentive to recognize new facilities if the additional capacity or improvements in quality would allow them to sell more policies, rather than just to increase the usage of existing policies.
15. It was not sensible to conflate PMIs and consumers as if they had the same interests—quality was really important to patients, but PMIs were interested in cost. As an example of this, [redacted]. PMIs were also dramatically reducing their medical loss ratios (ie reducing the amount they paid out in claims and increasing the amount they kept in profit). HCA regularly experienced PMIs refusing to cover things [redacted]. PMIs were also incentivizing subscribers to cut costs by taking up NHS treatment, eg AXA PPP had a policy whereby if a patient could be treated in the NHS within six weeks, they must be treated in an NHS hospital.
16. HCA considered that quality was critical to influencing demand for healthcare services. Studies HCA had undertaken in the past showed that 30 to 40 per cent of people who had private health insurance used the NHS, for a number of reasons including loyalty and perceived quality. HCA had introduced ITU facilities into its hospitals to raise its quality offering. It also gave an example where [redacted].

Demand in Central London

17. It was not correct to say that demand was static in central London. The central London market had experienced growth, including within the period investigated by the CC. PPU's had grown by 10.8 per cent over this period, while the rest of the market had grown by 8 per cent. The Government had recently lifted the cap on how much money an NHS Trust could earn from private practice, and as a result there had been a wave of new and planned supply coming into the market. Therefore the most significant barrier to entry identified by the CC—the absence of market growth—did not apply to the central London market.
18. HCA noted that NHS Trusts were increasingly realizing that private patient revenues could be critical to the future success of their trust. NHS hospitals were under immense financial pressures, so were looking for new income and expanding numbers of private patients to make up those deficits.
19. Market studies had shown that there was likely to be strong growth for the PMI and self-pay markets in the UK over the next ten years. The cancer growth rate was expected to grow by 24 per cent over that period and it was one of the top reasons why people took out PMI cover. [✂]

Innovation and quality

20. HCA said that it had led innovations in the industry more than any other hospital operator. It referred to a list it had provided to the CC containing 117 examples of where it had innovated. For example, the introduction of CyberKnife technology, which it had also trained its competitors in how to use. Innovation was one of the key ways that HCA attracted the best consultants and key to being successful in the international market.
21. HCA pointed out that successful innovators quite often had leading market shares, which might be one of the reasons why HCA's market share was at the level it was. There was an accepted relationship between the success of innovators and the share of the market that innovators had—quite often one of the characteristics of their success was that it led to a higher market share.
22. HCA believed that divestment of its hospitals in central London would lead to a reduction in innovation in London on the whole. It referred to innovations it had led in the treatment of prostate cancer, such as High Frequency Ultrasound (as an alternative to prostate removal), where patients could be treated and walk out the same day. It also gave the example of MRI prostate mapping which was revolutionizing prostate cancer diagnosis and treatment. These innovations would not have taken place but for HCA's scale and approach in central London. It did not think that other providers would have the scale or volume of patients to lead innovation in the market.

Pricing analysis

23. HCA did not understand why the CC had chosen to measure episode cost in its insured prices analysis and not price, when it had the information available to it to allow it to undertake a comparison on price. Further, the price concentration analysis (PCA) undertaken by the CC excluded each of its major competitors in central London, and therefore it was not relevant to that market. When the insured prices analysis and PCA were considered separately, they raised concern about their robustness, but when considered together, the flaws and inconsistencies in analysis

were even more apparent. They did not represent a reliable or robust basis upon which to force the break-up of a successful company.

24. HCA thought that there were three problems with the comparison the CC had made between the prices HCA charged with those charged by TLC: it is an analysis of charges, not prices, which introduced a likely bias in the analysis; the statistical significance between the charges of HCA and TLC did not reflect the conclusions drawn by the CC; and the analysis did not show a connection between prices and concentration, and in fact, it was in direct contrast to what the data was actually showing.
25. By way of example, HCA referred to some example procedures included in the basket of treatments insured prices analysis. [redacted] Therefore this could not be described as a price analysis. It was an analysis of mixtures of prices that were being charged under a single identifying code. This introduced potential biases and the need to control for the differences in the procedures. Higher-end procedures and more complex cases—which HCA received a disproportionate number of—could easily skew the results. The CC had made no attempt to control for these factors.
26. There was not a statistically significant difference between the prices charged by HCA and by TLC to [redacted]. For a large number of CCSD codes (or procedures), HCA's charges were in fact lower than TLC's. No link had been established between price and concentration for reasons including: there were a lot of differences in the data; there were some charges for which HCA was lower than others; and the indices varied over time for Bupa and AXA PPP and across hospitals. HCA's own testing of this analysis showed that the CC should conclude that [redacted]—a stand-alone hospital operation—was able to extract better terms and charge higher prices than HCA. Although the level of concentration did not vary over time across procedures or hospitals, the relevant charges were changing all the time. This must mean that something else was driving those charges, rather than the level of concentration, for example by factors surrounding the complexity of the treatment.
27. If the CC analysis did not control for the factors that influenced charges, the results of its test of statistical significance and link between price and concentration, each individually undermined the CC's conclusions from this analysis, both as evidence of an AEC and as a foundation for remedies.
28. In terms of the PCA, HCA had a number of concerns about the analysis. 55 per cent of invoices were not available for the PCA around the central London area, and [redacted] per cent of HCA self-pay customers were covered by the treatments which were considered. Secondly, the analysis did not identify a relationship between concentration at HCA's hospitals and the prices it charged. Once the data for Nuffield was removed, the results showed no relationship at all between price and concentrations. Finally, HCA considered that the attempts that the CC had made to control for complexity and quality were inadequate. On the basis of these problems with the PCA analysis, HCA submitted that the CC was in no position to use them to support its AEC finding and for the basis of a divestment remedy.

Remedies

29. HCA considered that the divestment remedy did nothing to address the CC's AEC finding. The CC's proposed break-up of HCA did not address the problems it had identified—such as site availability and whether or not the London market was growing. The CC had not explained how its market structure was linked to pricing, quality and innovation.

30. However, HCA considered that the CC had proposed four remedies which would transform the market and the basis on which competition operated. It questioned whether, in addition to these remedies, it was also necessary to break up HCA. It thought that the information remedy around hospital and consultant performance was very comprehensive, and would enable consumers to compare things such as survival rates between hospitals once implemented. It had seen this sort of initiative working in other markets and it would also mean that certain providers, such as TLC, would no longer be able to hide behind non-disclosure.
31. HCA considered that the proposed consultant fee remedy would also provide price transparency. When consumers could see survival rates next to prices, they could make informed decisions and that would move the market forward a long way by transforming the basis of competition to quality, which in HCA's experience would be welcomed by patients. It also thought that the PPU remedy would open up the market and increase the number of providers in London. In its view, the CC had a collection of remedies that would increase rivalry, would change the market and would be more effective than divestment.

Divestment in central London

32. HCA had three main comments about the proposed divestiture package: the use of the 40 per cent market share cap used by the CC in its analysis; whether the CC could justify the divestiture of two sites rather than one; and whether HCA should be given the option as to which hospital it may divest. It noted that proportionality required the least onerous solution, not what PMIs were seeking to achieve or what caused the maximum harm to HCA. The CC's guidelines said that it meant creating the smallest divestiture package to create an effective, viable, stand-alone competitor to HCA.
33. HCA raised concerns with the 40 per cent market share cap used in the CC's analysis of divestment options. This method did not ask what it took to create a viable, effective, stand-alone competitor, rather it asked the wrong question—that was, how to limit the ability of HCA to compete in central London. HCA also considered it to be a completely arbitrary threshold, which was unprecedented in any case law or guidelines. Although the CC had referred to the DG Comp Guidelines, those guidelines merely suggested that any market share below 40 per cent generally would not raise concerns or it was a 'safe harbour'. The CC could not take from that the principle that market shares above 40 per cent necessarily raised competition issues, or indeed, should be prohibited. HCA questioned that if the CC was to apply such a cap, it at least needed to do so on the basis of a coherent market definition. The share of supply calculated in central London had not taken into account key competitive constraints outside central London and did not even include all of the PPUs in central London.
34. Secondly, even if the 40 per cent market share cap was applied, HCA did not see how the CC could arrive at two divestments, as the correct measure of market share should be share by capacity, not share by revenue or admission. If the aim of the CC was to create an alternative competitor which could absorb the capacity that PMIs could use as an alternative to HCA, by the CC's own objectives, market share by capacity was the right way to measure the effect of divestiture. It submitted that there was sufficient alternative capacity available in central London but the CC had disputed that.
35. HCA's bed capacity in central London was (on the CC's own figure) [REDACTED]. Since private healthcare was a differentiated market, it did not think that undifferentiated market share was the right tool to use.

Specification of hospitals for divestment

36. Notwithstanding its view that no divestment was required, HCA submitted that whatever the remedy package ended up being, it should be given the option to choose which hospitals were divested. Divestiture was an extreme and onerous remedy which involved the loss of [X], major disruption to its clinical network and future investment plans. It should be given the chance to elect how best to mitigate the effects this was going to have on its business.
37. HCA did not see the case for designating the London Bridge and the Princess Grace specifically. The CC had already argued that the catchment areas of all of its facilities were geographically indistinguishable. Furthermore, all of HCA's hospitals would meet the test of being effective, viable, stand-alone competitors. With the exception of The Portland which was a specialist hospital, each offered a wide spectrum of services, and offered level 3 intensive care facilities (including The Portland). HCA noted that AXA PPP had described all of these as 'elite' hospitals. It did not consider that there were grounds for differentiation between its hospitals on location or the extent to which they were dependent on PMI business. Each of its other hospitals—if HCA accepted the CC's case for divestment—would be effective, viable, stand-alone competitors, so it should be given the chance to configure the package in the way that mitigated the effects. HCA said that there should be no discrimination in the treatment of hospital operators in terms of being given a choice of assets to be included in any divestiture package.

Price benefits of divestment

38. The CC's assessment of the costs and benefits of divestment assumed that there was a relationship between the level of concentration and the prices charged in the market, and somehow stated that improvement in prices would also translate in an improvement in quality and innovation. However, it had not seen any assessment that the CC has completed concerning the relationship between concentration and the level of innovation, investment or quality in the market.
39. HCA consistently invested more than its multihospital operator competitors nationally as well as internationally. It questioned why it would do so if it was subject to low competitive pressures. It also said that there was a prima facie assumption that if ownership was moving to another operator that expenditure might well decrease. There was no basis for the CC to argue that divestment would cause any price effect whatsoever—there was no evidence in the price comparison with TLC or in the PCA. The CC also had not carried out any analysis to link any price effects to international patients.
40. Taking this into account, the net present value of the proposed divestments could only be negative. The CC should carefully reassess its net present value calculation, in particular with respect to the price effect of divestment, in terms of the rationale for any price benefits, the size of those price benefits and removing any overestimates.

Impact of divestment on patient care

41. The CC has made a fundamental and serious error in asserting that the fragmentation of the HCA group of hospitals would improve quality—HCA believed the precise reverse of this was true, and had provided evidence to support this. It would be interested to hear from which clinicians the CC sought advice about its flawed conclusion. The CC's remedy was contrary to advances in first-world medicine where there had

been a trend toward agglomeration of services and development of integrated networks with seamless informatics to support patient care and improve outcomes.

42. HCA was the only private hospital group which had teams which mirrored what was going on in the NHS, for example its real-time multidisciplinary team meetings for cancer treatment. These meetings occurred in real time and had the breadth and depth of infrastructure to record data on key performance indicators in a number of common cancers such as colon, bowel, lung and breast. This replicated what was available in the NHS, but was not available in other private hospitals. [✂] This could not be replicated to the same standard or quality, or with the same outcome in fragmented setting.
43. Every PPU and NHS hospital in London had the ability and scale to do what HCA did. HCA thought that each of its private hospital operator competitors had the capability and capacity to do what it had done—for example, HCA transformed the Lister Hospital from averaging [✂] patients per night and introduced an ITU facility in each of its hospitals. Other hospitals would also be able to put ITU into their facilities. Also other operators such as BMI and Spire had publicly stated that they intended to develop tertiary services.
44. Divesting two of HCA's hospitals would have negative impacts on quality and patient care because HCA operated as one hospital with multiple sites and locations. If the CC required it to divest two of its hospitals, no longer would all of its doctors have immediate access to their peers. It would no longer be able to facilitate doctors from different hospitals within its network agreeing the care pathway of patients as they would become competitors. HCA would have to try and replicate these arrangements, but with far fewer patients.