



Private healthcare market investigation

Response to invitation to comment

Bupa

May 2015

Non-confidential version

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1. INTRODUCTION

- 1.1 Bupa UK welcomes the opportunity to engage with the Competition and Markets Authority ("CMA") on competition in the Central London market.
- 1.2 This paper responds to the 'Invitation to comment and submit further evidence' published on the CMA's website on 15 April 2015. It contains commercially sensitive information and should not be published. A non-confidential version of the response will be provided separately.
- 1.3 This submission is made by the insurance business of Bupa UK, referred to as "Bupa" in this submission.
- 1.4 Bupa emphasises the following key points:
 - i. **There are a number of adverse effects on competition ("AEC") in Central London** due to high barriers to entry and expansion and the significant power of Hospital Corporation of America ("HCA"). The AECs are particularly acute in certain key specialisms such as [X].
 - ii. **There has been a material deterioration in competition in Central London** since the CMA completed the analysis underpinning its Final Report in April 2014. HCA has expanded and strengthened its position in the market. The AECs have not diminished or disappeared.
 - iii. The AECs cause detriment to consumers in Central London and across the UK. They will not be resolved without the CMA's urgent intervention.
 - iv. **A structural solution remains necessary to remedy the AECs in Central London**, and it is an essential, proportionate and appropriate element of the package of remedies ordered by the CMA in April 2014¹. Its importance is not diminished or replaced by the other elements of the CMA's final remedies package.
 - v. **HCA should be required to divest a package of several hospitals**. Indeed, as we have said before², the divestment package must have a wider scope than was ordered by the CMA in April 2014 if it is to address competition issues in key specialisms in which HCA holds significant market power. As HCA's strength in the market has increased since the Final Report there is an even greater need for the divestment package to be expanded.
 - vi. The insured price analysis is just one element of the evidence the CMA must take into account when assessing Central London. It should not, alone, take on disproportionate importance in the CMA's assessment or the decision-making process. The CMA must

¹ The CMA's remedies package included also (i) a competition test to be applied to private hospital operators entering into management arrangements with NHS Private Patient Units ("PPUs"); (ii) restrictions on the type and value of clinician incentive schemes offered by hospital operators to medical consultants; and, (iii) obligations for healthcare providers to participate in a set of information remedies, including establishing an Information Organisation to be fully operational by April 2017.

² See further BHF's response to the Provisional Decision on Remedies in February 2014.

look at all the evidence in the round. Evidence such as the persistent excessive profits earned by HCA should be updated and given appropriate weight.

1.5 Bupa is committed to supporting this inquiry. We will submit additional information and evidence as it becomes available. Bupa is the largest customer of private hospital services in Central London and we would really value a meeting with the CMA Inquiry Group and staff team to discuss the developments in the market since the Final Report.

1.6 The paper is structured as follows:

- i. Section 2 of this paper updates some of the key evidence and analysis on Central London Bupa has submitted previously to the CMA.
- ii. Section 3 gives an update on how our relationship with HCA has evolved since the Final Report.
- iii. Section 4 briefly answers the CMA's eight questions, including linking the answers to relevant evidence in Section 2.

2. UPDATE ON CENTRAL LONDON

- 2.1 Bupa submitted substantial amounts of information about private healthcare, and Central London in particular, during the two year inquiry. We will not revisit all aspects of that evidence here. However, we draw the CMA's attention to some key strands of evidence updated to reflect our more recent experience.
- 2.2 The section explains that:
- i. A well-functioning Central London market remains critical to private healthcare and private medical insurance in the UK;
 - ii. HCA dwarfs other hospital operators in the highly concentrated Central London market, and its market power has increased since the Final Report;
 - iii. Barriers to entry and expansion in Central London remain high;
 - iv. [REDACTED];
 - v. [REDACTED]; and
 - vi. Patient satisfaction scores do not justify [REDACTED]. There are also no comparable clinical outcome measures justifying [REDACTED].

j) A well-functioning Central London market is critical

- 2.3 Central London – the area within the North and South Circular Roads³ – has substantially different dynamics of competition to other markets in the UK. The CMA is correct to define it as a separate geographic market.
- 2.4 It is an absolutely critical area for the sustainability of private medical insurance and must function well if private healthcare is to remain affordable and accessible to customers in Central London and across the UK.
- 2.5 It is a market of growing importance. Central London accounted for [REDACTED] of total Bupa claims spend in 2014, up from a level of [REDACTED] in 2011⁴. It has a substantial effect on premium inflation not only for Bupa's personal and corporate customers in Central London but also across the UK.
- 2.6 Central London hospitals have significant power given their impact on insurers' corporate business. Access to key Central London hospitals is vital to many large corporate clients, and for the insurer the national business of these clients relies on offering access to the key Central London hospitals. If the insurer fails to give access it could lose the nationwide business from

³ In this paper, "Outer London" refers to the area within the M25 but outside Central London, and "Greater London" the combined area of Central and Outer London i.e. the area within the M25.

⁴ Outer London accounted for [REDACTED] of total claims spend in the year. Therefore, Greater London accounted for [REDACTED] of BHF's claims spend in 2014.

these clients. As costs rise rapidly in Central London, pushing up the corporates' premiums, so corporates may reduce benefits to employees both in Central London and across the UK. Therefore, an unaffordable Central London market has negative fallout for employees across the UK.

2.7 Personal customers in Central London have faced very significant premium inflation.

ii) HCA dwarfs other hospitals in a highly concentrated Central London market

2.8 HCA has dominant market shares in the Central London, and its strength is growing⁵. In 2014, HCA accounted for [30] of Bupa's total hospital spend in Central London (and [30] in Greater London). It has even higher shares in a number of the strategically important specialisms (such as [30]), which can themselves be defined as separate markets⁶.

2.9 The CMA's Final Report presented several pieces of evidence showing the highly concentrated nature of the Central London market. The Final Report (page 6(10)-8) explained⁷:

"The shares of supply results ... indicate that central London is a highly concentrated market. HCA has a share of supply in central London of above 45 per cent by admissions (inpatient or total) and a share of supply of above 55 per cent by revenue (inpatient or total). TLC has the next largest shares, at around [10 to 15]. All other private hospital operators individually have shares below 10 per cent, and all PPU's individually have shares of 5 per cent or lower."

2.10 Table 1 summarises the CMA's findings in the Final Report on HCA's market shares of certain key specialisms and treatments.

⁵ A 40% market share, in an undifferentiated market, is a threshold often used in the merger guidelines and by DG Comp as a level above which dominance concerns may arise. In the Competition Commission's investigation of the proposed joint venture between Anglo American PLC and Lafarge S.A., the Competition Commission used a lower 33% threshold because of the degree of product and geographic differentiation in that case. Private healthcare has a high degree of product differentiation (even within a specialism). Therefore, we consider that a share of around 33% should be applied as a threshold on dominance concerns here.

⁶ The CMA Final Report found that different specialisms can be considered separate product markets.

⁷ The Final Report noted also that *"HCA's shares including hospitals and PPU's in Greater London are still high, particularly in terms of inpatient revenue. HCA has shares of supply, in this case, above 30 per cent by admissions (inpatient or total), above 40 per cent by total revenue and just below 50 per cent by inpatient revenue. BMI is the second largest operator after HCA and TLC is the third"* (page 6(10)-9).

Table 1: CMA’s disaggregated analysis of HCA’s shares in Central London

1	HCA had a share by admissions of over 40% in 10 of 17 specialities reviewed by the CMA. Bupa notes that this review omitted a number of smaller specialisms, such as [redacted], in which HCA is also dominant.
2	HCA had a share by admissions of over 55% in each of the four most common specialities (oncology, trauma and orthopaedics, gastroenterology, obstetrics and gynaecology).
3	HCA had a share of over 60% in specialities that might be considered more complex (i.e. oncology and cardiology).
4	Among those hospitals that provide critical care level 3, HCA had high shares of supply, over 50% by total admissions and just below 60% by total revenue.
5	HCA had shares of supply of tertiary treatments of over 60% by inpatient admissions and over 70% by inpatient revenue.
6	HCA operated around 47% of all overnight bed capacity installed by private hospitals and PUs in central London. When excluding PUs, HCA’s share of private hospital theatres was 48% and its share of consulting rooms was 55%, and in the case of beds for critical care level 3, HCA had an even higher share at 67%.
7	HCA was orders of magnitude larger than rival hospitals in Central London. In terms of market share of total admissions, HCA was around four times larger than its next closest competitor, The London Clinic, and almost eight times larger than its second closest competitor The Cromwell Hospital.

Source: CMA Final Report

2.11 The CMA’s findings in the Final Report continue to align with Bupa’s own more recent (2014) experience in Central London. HCA’s market power has increased since the Final Report, in particular in certain key and complex specialisms.

2.12 At [redacted] of Bupa’s total annual spend with hospitals in Central London in 2014, up from [redacted] in 2013, HCA is now almost [redacted] times larger than the next largest operator in Central London, The London Clinic (“TLC”), which had a share of [redacted] share in 2014.

2.13 Table 2 shows HCA’s share of Bupa spend in Central London for key specialisms:

- i. HCA’s share is above [redacted] of these important specialisms, which together account for [redacted] of Bupa’s Central London hospital spend.
- ii. In several specialisms, HCA’s share is over [redacted].
- iii. The next closest competitor in each specialism is much smaller, dwarfed by HCA. Indeed, the closest competitors to HCA typically have a share of only [redacted] of Bupa spend.
- iv. In [redacted] HCA has grown its market share from the already high bases in 2009. [redacted]

Table 2: HCA’s shares in Bupa’s Central London hospital spend

[redacted]

[redacted] Bupa, from time to time, re-evaluates and refreshes the classifications within its claims system for procedure codes and the consultants linked to specialisms.

[redacted]

2.14 HCA’s market power in individual specialisms is reinforced by having substantial strength across a number of key specialisms. Figure 1 shows that the overwhelming majority of Bupa’s spend with HCA ([redacted]) is concentrated in specialisms where HCA has [redacted] of Bupa’s spend on

the specialism in Central London. HCA's market share within a specialism is reflected by the height of the column, the quantum of Bupa's spend is represented by the width of the column.

Figure 1: Bupa's Central London HCA spend by specialism and market share, 2014

[X]

Source: Bupa claims data

2.15 Therefore **the scale and scope of HCA makes it a 'must have' hospital group in Central London.** [X].

iii) Barriers to entry and expansion in Central London remain high

2.16 Bupa believes that the significant barriers to entry and expansion in Central London identified by the CMA in its Final Report remain present. We have not observed any substantive entry by new players since April 2014. Indeed, some entrants that HCA claimed would emerge in 2014 have failed to so do, such as The London International Hospital.

2.17 Hospital operators from outside Central London have continued to speculate about entry, but we are not aware of any firm plans.

2.18 Spire and Bupa signed a new contract in November 2014 which agreed pricing [X].

2.19 In terms of expansion of existing players, some PPUs in Central London have discussed with Bupa plans to expand e.g. [X]. However, we do not believe these plans have yet been executed. Bupa remains of the view that PPUs do not, individually or in aggregate, provide an effective constraint on HCA⁸. Even the strongest PPUs focus only on a niche of specialisms and are dwarfed by HCA. The Royal Marsden, for example, has a well-respected oncology service, but it remains small compared to HCA's oncology business in Central London [X]. PPUs also continue to face significant barriers to expansion, such as political uncertainty, and as such we do not see the effectiveness of the constraint changing materially⁹.

2.20 HCA is, however, expanding in Central London:

- i. HCA opened a radiotherapy centre for private patients on the Guy's Hospital campus in October 2014. Construction has also begun on a new £100 million NHS and private patient cancer centre at Guy's Hospital next to London Bridge. We understand that HCA will be building a private cancer hospital on four of the 12 floors of the new building¹⁰.
- ii. There are plans underway to occupy three floors of The Shard near London Bridge.

⁸ This view was shared by the London Clinic which notably said: "In The Clinic's opinion, PPUs are not close competitors to HCA, The Clinic or the other private hospitals because they do not offer a comparable service", The London Clinic, letter to the Competition Commission dated 15 May 2012.

⁹ See further evidence of PPUs in Annex A of BHF's Issues Statement Response, July 2012, and Annex A of BHF's Annotated Issues Statement Response, April 2013.

¹⁰ See news release at: <http://www.hcahospitals.co.uk/press-releases/britains-newest-radiotherapy-centre-opens-at-guys-hospital-campus-in-london/> (accessed 26 April 2015).

- iii. XVII, a division of HCA International, opened The Centre for Advanced Screening in March 2015¹¹. HCA is partnering with clinicians (consultants and GPs) in this venture.
 - iv. There is planning approval to extend the Portland Hospital into an adjacent building, which aims to double the paediatric activity at the hospital¹².
- 2.21 So HCA already occupies a strong position in Central London and since the publication of the Final Report it has set in motion further expansion. Other private hospital operators have not entered Central London or expanded materially.
- 2.22 Bupa considers that there is clear evidence that actions taken by HCA are increasing barriers to entry and expansion in Central London, including:
- i. [REDACTED] (see, for example, paragraph 3.4 below).
 - ii. HCA's acquisition of private GP practices, such as Roodlane. Bupa remains concerned that these vertical links, taken together with HCA's other actions to increase barriers to entry and expansion in Central London, have influenced referral patterns and we believe that the CMA must update its analysis to take this into account.
 - iii. HCA's partnerships with clinicians, such as The Centre for Advanced Screening, Leaders in Oncology, Robotic Radiosurgery LLP¹³.

iv) [REDACTED]

- 2.23 HCA has substantially increased its strength in Central London (and in new regions such as Manchester¹⁴), and has clear plans to grow this position further (e.g. at the Portland Hospital and in the Shard). It is growing its dominance in strategically important specialisms such as oncology (e.g. through expansion at Guy's Hospital). It maintains entrenched relationships with key consultants. And large corporates continue to demand access to HCA given the location of its facilities. It would therefore be extremely costly and risky for an insurer to enter a contract dispute with HCA.
- 2.24 Further, HCA appears to be reducing its exposure to private insurer revenues. LaingBuisson estimates that only around 55% of HCA's funding is from privately insured patients¹⁵. This suggests that even the largest insurer, Bupa, accounts for only around 20% of HCA's business.

¹¹ See news release at: <http://www.hcahospitals.co.uk/press-releases/xviii-the-centre-for-advanced-screening-opens-its-doors/> (accessed 26 April 2015).

¹² See news release at: <http://www.hcahospitals.co.uk/press-releases/the-portland-hospital-to-double-the-size-of-its-specialist-childrens-hospital/> (accessed 26 April 2015).

¹³ LaingBuisson, "*Private acute medical care in Central London, Market Report*" (February 2015) lists a series of HCA partnerships with clinicians on page 76 of the report.

¹⁴ HCA is also expanding in Manchester (beyond its existing PPU at The Christie Clinic). It opened an outpatient and day care centre at 52 Alderley Road, Manchester in June 2014. It is also developing, in a joint project with Manchester City Council, Manchester City Football Group and Sport England, a third facility, The Manchester Institute of Health and Performance (MIHP), a multi-disciplinary diagnostic, education, research and development facility, located in the Etihad Campus.

¹⁵ LaingBuisson, "*Private acute medical care in Central London, Market Report*", February 2015.

2.25 Therefore, HCA faces little threat from insurer buyer power and, given that HCA's exposure to private insurer revenue is decreasing even as it increases its overall market power in Central London, we believe that insurer buyer power has reduced since the publication of the Final Report (and is likely to continue reducing).

Open Referral restricted in Central London

2.26 HCA has suggested that Bupa's Open Referral policies have increased our buyer power since the publication of the Final Report.¹⁶ This is incorrect.

2.27 Bupa began selling Open Referral policies to corporate customers in 2012. There was strong customer uptake. We reached a peak in terms of customer uptake in [redacted] customer lives were on Open Referral policies.

2.28 As of December 2014 we had just [redacted] lives on Open Referral policies, so the number of customers on Open Referral policies has not grown materially since the Final Report. In addition, [redacted]. See paragraph 3.4 below for further information.

NHS Cash Benefits

2.29 HCA has suggested that Bupa constrains it by offering customers the option, completely at the customer's discretion, of having certain treatments in the NHS in exchange for a cash payment¹⁷. However, the effect on private provider revenues is very small as NHS Cash Benefits account for [redacted] of our total claims spend in each year.

2.30 In 2013, across the UK just over [redacted] members chose to use NHS cash benefits. We estimate that, had these customers had the specified treatments in the private sector, we would have paid approximately [redacted] in claims costs. Within our total claims spend of approximately [redacted].

2.31 We have yet to conclude our 2014 NHS cash benefit numbers, but based on figures to June 2014, we estimate it will be no more than [redacted] in the year, meaning it remains [redacted] of our claims spend – such a proportion cannot be said to lead to the NHS constraining HCA to any material degree.

Service line tenders

2.32 Bupa cannot use service line tenders to constrain HCA's dominance in Central London effectively. [redacted]¹⁸.

2.33 Bupa has used service line tenders in a small number of treatments to enhance competition among hospital operators. The number of treatments suitable for service line tender is naturally small as the treatment needs to be highly standardised across operators and relatively separable from other services (such that it can be provided and contracted separately). Service line tenders can reduce costs and improve quality, but take significant effort to launch and

¹⁶ See HCA's initial submission to the CMA, dated 15 April 2015, paragraph 5.3.

¹⁷ Ibid, paragraph 5.3

¹⁸ [redacted].

administer. [X]¹⁹. As a consequence, the use of service line tenders is relatively limited (by Bupa or by other insurers), and [X] of Bupa's UK claims spend has historically been subject to service line tender.

- 2.34 Bupa introduced one new specialist treatment network, through service line tender, in 2014.
- 2.35 Following discussions with hospital operators (including HCA) an *Outpatient CT Scan* network was tendered in London in February 2014 and outside of London in April 2014²⁰. This network aimed to save Bupa a target of [X] per annum across the UK, a saving of approximately [X] on its existing CT spend (although still an immaterial amount, [X], in terms of Bupa's total hospital claims spend in the UK). The launch of the network took over a year to agree with hospital operators.
- 2.36 The network was projected to save around [X] on CT scan spend at HCA. We discussed this with HCA during the contract negotiation in early [X].
- 2.37 Since the Final Report, we have also re-tendered the following established specialist treatment networks²¹:
- i. The MRI network, re-tendered in November 2014; and
 - ii. The TAVI network, re-tendered in April 2015.
- 2.38 As explained in paragraph 3.4 below, [X].

Automatic screening of invoices

- 2.39 A development of note in our relationship with hospital operators since the Final Report is that Bupa has introduced an automated invoice screening process.
- 2.40 Under this process, hospitals submit invoices to Bupa, through Healthcode, for each patient's treatment. These invoices must meet specified rules so that we pay the correct amounts, pay only for what is eligible, and the correct treatment information is attached to each patient's claim and medical history. It also helps us to identify fraud. The accuracy and integrity of hospital invoices is, therefore, critical.
- 2.41 In 2014, we began automated screening of electronic invoices (replacing a system of manual checking). This led to a significant number of invoices being identified as incorrect and therefore declined and returned to hospitals to be corrected and reissued. While we understand that there has been some consequent cash flow delay for hospital operators, and we are working to address these issues, Bupa considers that this is a necessary process to ensure that operators comply with their contractually agreed prices and we can maintain accurate information and premiums for our policyholders.

¹⁹ See our response to the Issues Statement in July 2012 for further information and examples of service line tenders, which we referred to as 'specialist treatment networks'.

²⁰ A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are also sometimes known as CAT scans.

²¹ We also refreshed the list of facilities on our Bowel Care network in December 2014. This is a quality network where any willing provider who meets specified quality standards can participate on the network (it is not a service-line tender).

2.42 We do not consider this invoice screening process to be a material change in our negotiating power. Indeed, the process is merely an administrative change to our recording processes which has had no material impact on our commercial relationships (either with HCA or other hospital providers) as it seeks only to give effect to our agreed contracts.

v) HCA is [redacted] than other hospital operators

2.43 Bupa is very keen to engage more with the CMA on pricing, including the CMA's contested Insured Price Analysis (IPA).

2.44 Bupa's view is that the IPA can, taken in the round and in the context of wider qualitative evidence on the Central London market, be useful and informative evidence as to [redacted]:

- i. [redacted];
- ii. [redacted]; and
- iii. [redacted].

Annual headline price increases

2.45 At a headline level HCA [redacted] than other hospital operators.

2.46 Table 3 shows the annual price increases incorporated into the contracts Bupa has, or has had, in place with the main hospital operators. The level of the increase is agreed during the contract negotiation²².

²² Please note, however, that the 'effective' price increase BHF may face from a hospital operator in a year depends not only on the contracted price increase but also on factors such as treatment patterns and volume related discounts/penalties triggered in the year. For example, a hospital operator can in effect increase the price of treatment by including additional diagnostic tests.

Table 3: Annual^(a) price increases in contracts across Bupa’s main hospital operators

[REDACTED]

Notes:

(a) The price change is applied at the point of the contract being signed and then at each subsequent anniversary of the contract. As contracts are typically agreed and signed at different times during the year, rather than all providers contemporaneously on 1 January, the above table simplifies the presentation of the information by showing the price increases that were applied during each year (although the increase may have, for example, come into force in May if that was the anniversary of the contract being signed).

[REDACTED]

2.47 [REDACTED]²³.

Figure 2: Illustration of cumulative effect of contractual price increases

[REDACTED]

Notes:

[REDACTED]

2.48 We note also that hospital revenues per claimant have consistently increased faster than the price increases agreed with hospitals (and so even faster than general inflation). This is due to ‘evolution of service’ such as extra or new treatment being delivered, new drugs and tests, and treatment of more conditions over a greater period of time.

Further considerations on pricing

2.49 In the CMA’s re-examination of HCA’s pricing, the following points should also be considered:

- i. HCA is very substantially larger than any other private operators in Central London [REDACTED].
- ii. [REDACTED].
- iii. The level of price competition between the hospitals in Central London is not strong given: (i) the market’s very high concentration; [REDACTED].

2.50 Further, we note that the CMA found in its Final Report that, irrespective of the IPA, HCA was making returns “*substantially and persistently in excess of the cost of capital*”. This suggested HCA’s prices do not reflect costs.

2.51 Bupa does not believe that HCA’s returns will have softened since the Final Report. **HCA’s continued growth and strength means Bupa believes it is vital the CMA updates its profitability analysis.** It is Bupa’s view that the analysis will demonstrate that HCA’s prices remain substantially above costs and are not under sufficient competitive pressure.

2.52 For example, analysis by LaingBuisson (in

²³ [REDACTED]

2.53 Figure 3 and Figure 4 below) shows that HCA – the combination of HCA International Ltd. and St Martin’s Healthcare Ltd. – is on a rapid growth trajectory with strong EBITDAR performance.

Figure 3: Revenue growth by independent hospitals (in Central London)

[X]

Source: LaingBuisson, “Private acute medical care in Central London, Market Report”, Figure 3.9

Figure 4: EBITDAR as % of revenue

[X]

Source: LaingBuisson, “Private acute medical care in Central London, Market Report”, Figure 3.11

vi) [X].

2.54 We use an independent survey company – MSB – to conduct satisfaction surveys on a sample of our members who have recently received care in hospital. We conduct these surveys on a rolling basis.

2.55 Table 4 shows feedback on how patients rate the care they received while in hospital. Levels of satisfaction are high overall, with the main private hospital operators in a fairly tight range.

2.56 In 2014, [X].

Table 4: Patient feedback on care received in hospital

[X]

Source: Patient Satisfaction Results, Q4 2014, prepared by MSB

Notes: “Q: Overall, how would you rate the care you received?”

Results represent the percentage of ‘Excellent’ and ‘Very Good’ responses combined.

2.57 Table 5 shows feedback on the likelihood the patient would refer a friend or family member to the hospital. There is a wider range of satisfaction results across hospitals, [X].

Table 5: Patient feedback on likelihood to recommend the hospital to friends or family

[X]

Source: Patient Satisfaction Results, Q4 2014, prepared by MSB

Notes: “Q: How likely, or unlikely are you to recommend this hospital in future to friends, family and colleagues?”

Results represent ‘Definitely would’ and ‘Very likely’ responses combined

2.58 [X]. While these are valued dimensions in patient experience, they are unrelated to the quality of care received by the patient and we do not believe justify [X].

3. Update on Bupa's relationship with HCA

3.1 In this section we provide a brief update on our relationship with HCA over the past year. We explain, first, relevant aspects of our existing contract with HCA and, second, some amendments agreed through contractual discussions during the year.

Existing contract

3.2 The CMA will recall that Bupa signed its existing contract with HCA on [REDACTED] and that this contract was expected to run for three years (finishing [REDACTED])²⁴. [REDACTED].²⁵

3.3 We will not revisit the negotiation or terms of the contract here, but would note to the CMA that:

i. [REDACTED]²⁶;

ii. [REDACTED]²⁷.

3.4 [REDACTED]²⁸:

i. [REDACTED].

ii. [REDACTED].

iii. [REDACTED]²⁹.

On-going contractual discussions

3.5 [REDACTED].

3.6 [REDACTED]:

i. [REDACTED].

ii. [REDACTED].

iii. [REDACTED].

iv. [REDACTED].

²⁴ [REDACTED]

²⁵ *Bupa Global is our international insurance business that covers people for treatment anywhere in the world, including in the UK*

²⁶ [REDACTED].

²⁷ [REDACTED].

²⁸ [REDACTED].

²⁹ [REDACTED].

Charging of surgical procedure packages

3.7 [~~✗~~].

3.8 [~~✗~~].

3.9 [~~✗~~].

Billing audits

3.10 [~~✗~~].

3.11 [~~✗~~].

3.12 [~~✗~~].

3.13 [~~✗~~].

4. SUMMARY RESPONSES TO THE CMA'S QUESTIONS

4.1 This section responds in brief to each of the eight questions in the 'Invitation to comment and submit further evidence' published on the CMA's website on 15 April 2015. We cross-refer to relevant evidence set out in Section 2 above.

Market definition

1. Has there been any change in demand and supply side characteristics in the relevant market?

- For example, on the demand side relevant changes could include changes in the ability of private medical insurers (PMIs) to steer patients towards NHS or non-central London private hospital providers.

- On the supply side, a relevant change may include any strengthening of the competitive constraint that private hospital providers outside central London exert on central London private hospital providers, or any increase in the competitive constraint exerted by NHS providers.

4.2 On the supply side of the market we note in particular:

- i. HCA is expanding its strength in Central London (see para 2.12 and para 2.52), and has clear plans to expand further (see para 2.20). This is leading to an even more concentrated market on the supply side in Central London – we estimate that the HHI for the market, based on Bupa hospital claims spend, is now well in excess of [redacted].
- ii. HCA has growing strength in key specialisms such as [redacted] – see para 2.13 – which we have seen no sign of stopping since the Final Report.
- iii. There is little evidence of new entry or expansion in Central London by other hospital operators. We have not aware of any evidence of hospitals outside Central London materially increasing their constraint on Central London hospitals and we have not seen the competitive constraint from NHS providers increase materially (see para 2.16).

4.3 On the demand side, we do not believe there is evidence that Bupa has materially increased its ability to direct patients to non-Central London providers or the NHS – see para 2.23 onwards. Further, we are not aware of any other insurer significantly improving its own ability to direct patients outside Central London.

Barriers to entry and expansion/competitive constraints

2. Has there been any entry/expansion or exit of private hospital providers or PPUs in the period since the Final Report was published in April 2014?

- 4.4 We have not seen any material entry or expansion by hospital operators, other than HCA, since the Final Report – see para 2.16.

3. Have there been any changes in the above which affect particular specialisms that we should take into account? For example, have any providers broadened the range of services that they provide in central London, or have changes in any non-central London providers impacted on the competitive conditions in central London in relation to a specific specialty?

- 4.5 We have not seen evidence in our claims data for 2014 or from the market to suggest that rival hospital operators or PPUs are materially broadening their range of services into new specialisms.

4. Have there been any changes in the market as a consequence of planned (as opposed to actual) entry, expansion or exit (as covered in Question 2 above)?

- 4.6 We have not observed any changes to the market due to announced plans of entry. Indeed, some previously announced entry plans, such as The London International hospital, have failed to come to fruition.
- 4.7 Further, we are not aware of any public, concrete plans of entry into Central London that would be of such significant scale, scope and pace that it would effectively constrain HCA.
- 4.8 We recommend that the CMA is cautious to accept any argument that alleged ‘plans’ of entry will materially change market dynamics. Entry by various operators has been speculated for many years, with little real evidence of action or success. Further, HCA remains in a position to constrain the entry of another rival – see para 2.22.

5. More generally, we would also be interested in any evidence suggesting that there have been changes in:

- costs of entry/expansion, for example, cost of acquiring a suitable site
- time taken for entry/expansion
- healthcare regulation
- site availability
- planning regulations
- strategic barriers, for example, PMI recognition for new providers or facilities

If so, are any of these particularly relevant to specific specialties?

- 4.9 Bupa has no further evidence to submit here showing a material change in entry and expansion barriers since the Final Report.

Bargaining power

6. Is there any evidence to suggest that there have been any changes in the bargaining power of the relevant parties in the period since the Final Report was published in April 2014? For example, have relevant changes occurred in relation to:

- Managed care pathways
- Open referral products sold by PMIs
- Changes in PMIs' abilities to control recognition for new hospital facilities
- Policy networks
- PMIs' abilities to 'steer' patients
- Changes in the competitive landscape
- Prevalence of PPU's in central London

If so, how have these impacted on the relative bargaining power of hospital providers in central London and PMIs? If so, does this differ across specialties?

4.10 Bupa believes that HCA's bargaining power has increased since the Final Report – see para 2.23 onwards.

4.11 We are not aware of evidence to suggest that the power of other insurers in Central London has increased materially in this period.

7. Have any changes in bargaining power resulted in changes in the level of prices that PMIs pay to providers, for example, as a result of any contract negotiations in the past two years?

4.12 Within Central London, HCA's growing strength means [redacted].

4.13 The most material hospital contract Bupa negotiated since the Final Report is with Spire Hospital Group, although this affects local markets outside of London. Bupa and Spire agreed the contract in November 2014. Commencing on 1 April 2015 the agreement has a minimum term of four years with prices agreed for the six years through to 31 March 2021³⁰.

4.14 [redacted].

³⁰ For more information, see <http://www.bupa.com/media-centre/press-releases/uk/bupa-and-spire-reach-agreement-on-contract-renewal/>

Quality

8. Is there any evidence that the quality of provision in central London has changed since the CMA published the Final Report in April 2014 or that the relative quality of different providers has changed in this period? For example, have there been relevant changes in relation to:

- **Clinical quality, for example, patient outcomes**
- **Patient experience**
- **Quality of processes, for example, data collection**

4.15 [X] Our survey data does not show a material improvement in quality of overall patient experience since the Final Report.

4.16 As the CMA is aware, there is still no data on clinical outcomes comparable across hospital operators. Therefore, there is no robust evidence of an improvement in clinical outcomes since the Final Report.

4.17 Bupa welcomes the launch of the Information Organisation and that hospital groups appear to be engaging with the new Information Organisation. For example, the planned change to ICD-10 coding could deliver positive effects. However, we emphasise that this must be implemented fully and effectively before it will improve market dynamics.

4.18 We note also that Bupa improved its invoicing screening processes during 2014 – see para 2.39. Over time, we hope this will drive up standards in invoicing which will improve hospital coding and our ability to identify, and take action against, unwarranted treatment variation or fraud at particular operators.