

PRIVATE HEALTHCARE REMITTAL

Summary of hearing with AXA PPP Healthcare Limited on 12 August 2015

Introduction

1. AXA PPP stated that its views on competition remained unchanged, and that in its view, HCA had an extremely strong market position in central London and that it was very difficult for AXA PPP to do without HCA, particularly in certain business segments. It considered that HCA charged more than its peers and there was no evidence to suggest that the quality or acuity of the HCA patients is any different from that of other providers.

Quality and complexity

2. AXA PPP explained that it considered there were a number of different aspects to considering whether HCA and The London Clinic (TLC) differ in terms of quality and complexity.
3. In terms of complexity, AXA PPP referred to three different areas which often get confused between each other. The first indicator was whether HCA undertook more complex treatments, such as oncology or cardiology, when compared to TLC. The second factor was whether, in relation to a specific treatment, HCA delivered better outcomes (eg mortality), from TLC. The third factor was whether, in relation to the same treatment, HCA's patients are in some way different/more complex to those being treated at TLC (for example, whether patients who were older, more obese or had co-morbidities).
4. In relation to the first area of complexity, AXA PPP accepted that HCA carried out some complex treatments that TLC did not do (eg cardiology), however in relation to treatments done it could not see any material differences in complexity between HCA and TLC.
5. AXA PPP stated that there was some available data from the National Joint Registry relating to hip and knee replacements, which compared revision rates and mortality data for different hospitals against the national average for all hospital providers using data from 2003-2014. This dataset also included data on the type of patient mix, eg age, obesity, co-morbidity against the national average, which could give an indication of whether HCA were treating

different types of patients to other hospitals. AXA PPP also noted that there may be some data missing, particularly from private hospitals, as participation was voluntary for private hospital operators.

6. AXA PPP considered that this available data did not support HCA's assertions on quality and complexity. In the case of HCA's Wellington Hospital, based on that data, it appeared to treat less complex patients than the average. In relation to HCA's London Bridge hospital and the Princess Grace hospital, there was also no strong evidence that either of the hospitals were treating more complex patients, in terms of age, obesity and co-morbidities. AXA PPP was of the view that, in general in comparison with NHS hospitals, private hospitals tended to treat patients who were younger, less obese and less subject to other medical problems. It also noted that NHS hospitals gathered more data on the state of the patient's health before and after specific types of operations than private hospitals did.
7. AXA PPP said that in assessing the relative quality of different providers to inform its decisions about referrals, it wanted to see more information on the type and the volume of treatments individual surgeons were undertaking.
8. AXA PPP considered that it was possible in some respects to distinguish between the complexity of treatments based on the data used in the Insured Pricing Analysis, for instance in the case of different surgical procedures where there was a well-defined complexity categorisation and in relation to diagnostic tests. However, this would be more difficult in relation to oncology and cardiology.
9. AXA PPP stated that the number of line items within an invoice, for example the number of pathology tests, was not necessarily indicative of greater complexity as HCA appeared to be claiming. If the pathology tests were necessary, then this might indicate greater complexity, but if they were not necessary, then it would not. For example, AXA PPP said that it may be that there were different practices within hospitals and by clinician, which would mean that more tests were ordered as a routine than might be the case for other hospitals/clinicians.
10. AXA PPP gave the recent example where it had challenged protocols which had resulted in unnecessary tests being undertaken from a particular consultant – after challenging this, the protocols and testing were brought into line with NHS protocols and this had significantly lowered the amount AXA PPP was being charged (eg from £ [X] per week to £ [Y] per week for a patient). In general, AXA PPP explained that it had sought to agree 'common profiles' based on the proportion of pathology tests being undertaken and it agreed these with the different hospital groups.

11. AXA PPP had also experienced issues with HCA in relation to [X].
12. AXA PPP considered that HCA undertook some unnecessary tests and certainly did a lot more tests than the NHS would do, and in many cases these were of marginal benefit. Although AXA PPP said that in theory it was the consultant who determined what tests need to be done, in many cases for the sake of supposed convenience and efficiency, tests were undertaken on a more automatic basis, or in some cases had pre-filled in forms. Some of these were necessary, but others were clearly not.
13. AXA PPP had not seen any evidence that more complex patients were being directed to HCA hospitals over TLC, and was not sure how this mechanism would work in practice. To do so would rely on the GP's ability to somehow ascertain that a patient had different characteristics that were not necessarily observable, and to therefore send them to the appropriate specialist. AXA PPP thought that because some people saw HCA as a 'high-technology' hospital, they may also think that it treated more complex patients and got better outcomes, but this was a separate issue. In terms of the perception of quality, it thought that both TLC and HCA were regarded by customers as being of equal high quality. AXA PPP had not surveyed GPs on their perception of quality, but thought that GPs probably similarly based their views on quality based on the reputation of different hospitals. However, GPs generally referred patients to particular surgeons/consultants as opposed to specific hospitals, and therefore it was the choice of consultant that drove the decision about which hospital the patient would be treated at.
14. In terms of whether HCA had a higher calibre of consultants than other hospitals, AXA PPP stated that the larger London hospitals clearly had a disproportionate number of consultants and professors at teaching hospitals which were likely to carry more weight, but this was true of both TLC and HCA. For example, both hospitals had internationally renowned oncologists. AXA PPP thought it was likely that HCA would be receiving a higher proportion of oncology customers because HCA owned Leaders in Oncology Care, where a significant proportion of private sector oncologists worked and referred cancer cases. However, despite this, there was no evidence to support the proposition that 'easier' cancer cases went to TLC and that HCA treated more complex cancer cases.
15. AXA PPP did not consider there were any measures within the line item data contained in the invoices that could be potentially used as a proxy to assess patient complexity. The quality of the data was also likely to be poor and it was likely to be incomplete.

16. AXA PPP was not aware of whether there were any specific treatments which might be driving any price difference between HCA and TLC, and had not undertaken any analysis to assess this.
17. In relation to the introduction of ICD-10 and whether this would improve measurement of clinical quality, based on prior experience, AXA PPP's view was that the quality of ICD coding was relatively poor. Therefore, it was unsure that this new code would necessarily significantly improve the way in which information was recorded.

Bargaining

18. AXA PPP stated that its price negotiations with HCA primarily related to the total amount paid rather than a detailed negotiation around individual prices of treatments. The only time discussions focused on individual treatments was when there was a new treatment or a technological advance.
19. AXA PPP had not been able to consider in detail the IPA analysis undertaken by the CMA, but based on the information available to it, the assumptions behind the analysis appeared to be reasonable. Nonetheless, based on a number of other indicators, it considered that HCA was more expensive than other hospitals. It made a number of business decisions, such as the pricing of its products and access to hospitals, based on its belief that HCA was materially more expensive than TLC, and extremely more expensive than operators in the next tier. The strength of HCA's bargaining position was also evident in the nature of the negotiations AXA PPP had with HCA.
20. AXA PPP offered one product that was an open referral product called 'The Healthcare Pathway' (THP), which was launched at the beginning of the CMA's original market investigation. [REDACTED]. Within those who had subscribed to THP, a significantly less than average number lived in central London. Compared to the standard corporate product, approximately [REDACTED] lived in central London. THP was less attractive to people because six of the top hospitals in central London were not included in its coverage, whereas those employers who had a more geographically spread employee base might be more relaxed that those hospitals were not included. However, AXA PPP said that the proportion of claims that were still going to HCA under THP and more generally under open referrals was still quite high. So for example, there would be a reasonably protracted period of time to redirect customers, particularly those with ongoing treatment at HCA hospitals.
21. [REDACTED]. The effect of this had also been diluted in central London, where there were much less open referrals overall and customers with open referrals continue to have strong views that they would like to be treated at particular

hospitals. The resulting effect was that HCA still picked up a material proportion of open referral customers, and therefore it was not having a material impact on the central London market.

22. AXA PPP explained that it was apparent that HCA was concerned about open referrals, and HCA was monitoring it closely. It was required by HCA to report on a monthly basis on how many open referrals HCA received. The existence of open referral products had not reduced the overall bill paid to HCA. In fact, it had increased pressure from HCA to increase the amount paid by AXA PPP because of the concern that business was being taken away from it.
23. AXA PPP did not consider that there had been any change in the balance of negotiating power and the outside options available to insurers. Even if AXA PPP was to redirect treatment into standalone outpatient clinics, it was still the case that HCA delivered much of the day case and inpatient treatments, and a majority of diagnostics and outpatient treatments were delivered at hospitals.

Competitive constraints

24. In relation to whether competitive constraints and the nature of the market in London had changed, AXA PPP thought that neither had changed significantly, and in some respects the situation had worsened. It thought that HCA had accelerated its development plans in terms of capacity, and would expect HCA's market share to increase in the next few years, not decrease. It remained the case that insurers could not credibly threaten to delist or switch away sufficiently from HCA because the collective capabilities of rivals, in particular in relation to consultants as opposed to beds, were not a credible alternative. HCA hospitals were needed in AXA PPP's networks in order to have a credible proposition for its large corporate customers, which represented a large proportion of AXA PPP's business base. This had not changed over the last 18 months since the original market investigation.
25. Furthermore, AXA PPP had the impression that insured patients represented a smaller proportion of HCA's total customer base than that of other hospitals, given HCA's international presence. It was likely that the proportion of HCA's business that came from UK-insured or UK-self pay patients was materially lower than other hospital operators, and lower than TLC. Given that AXA PPP represented a smaller proportion of HCA's UK-insured customers relative to the proportion of AXA PPP spend attributable to HCA, there was no real parity in the balance of power between the different insurers and HCA.
26. Regarding spare capacity, AXA PPP stated that there may theoretically be sufficient capacity in relation to available beds and operating theatre hours

among other hospital operators which might mean it would conceivably be able to redirect its business in a mathematical sense. However, even if that was the case, only a small subset of its clients would be prepared to submit to redirection because of HCA's reputation. In terms of factors constraining insurers' ability to delist or switch away from HCA, capacity – even if it was more broadly defined as including consultants, equipment, facilities and beds – was only one factor, but the second important factor was reputation.

Barriers to entry and expansion

27. The two cases of possible entry AXA PPP was aware of related to [redacted], which it understood to both be interested in entering central London. However, AXA PPP said that if no changes came about from the CMA's investigation in central London, then it suspected any plans would be abandoned. The other area of potential was in relation to KIMS; however, AXA PPP said it understood that it may have got more of its business from local NHS hospitals and there was very little evidence of any customers travelling out of central London to go there. The other hospital that was being developed was St Anthony's in Cheam, which had been bought by Spire.
28. In relation to potential new entry from VPS at the vacant hospital site in Ravenscourt Park, AXA PPP's view was that it was likely to have a plan to attract international business.
29. AXA PPP was concerned that an opportunity had been lost to create two strong competitors in the London Bridge area, given that HCA had won the PPU contract for Guy's and St Thomas' and had recently moved its outpatient activity to The Shard, thereby allowing it to link its cardiology and oncology specialisms in one place. This was a key example of HCA's growing strength in that area.