

## **PRIVATE HEALTHCARE REMITTAL**

### **Summary of hearing with HCA International Limited on 13 August 2015**

#### **Quality and complexity**

1. HCA International Limited (HCA) said that it was difficult to address questions about differences in quality and complexity without knowledge of which procedures it might apply to. HCA then provided hypothetical examples illustrating why more complex patients end up at HCA. First, HCA gave the example of a patient referral for a vascular problem. HCA explained that such a case with co-morbidities might be dealt with at The Wellington as opposed to The London Clinic (TLC) on the basis that, if something went wrong, for example, with a cardiac catheterisation, there would be cardiac surgery back-up available. HCA said that TLC did not have the same cardiac surgery capability as the Wellington. Second, HCA gave the example of a patient referral for a haematological transplant. HCA said that if such a patient was treated at its University College Hospital Private Patient Unit, the patient would be likely to receive more chemotherapy and interventions than if treated at TLC, as TLC did not have the same infrastructural support as UCH and was unable to treat the level of complex cases admitted to its UCH PPU.
2. With regard to other components of treatment costs being indicative of complexity, HCA explained that more pathology tests might be indicative of more complex cases. The types of drugs and other supportive medication and therapies that patients receive during their inpatient stay may also be indicative of complexity. [REDACTED]
3. HCA believed that the patients typically going to HCA hospitals were on the whole more complex than those at TLC. HCA explained that, by way of the example of histopathology work, this was because TLC had a well-established endoscopy unit that had been seeing patients for a long time. As a consequence, it would maintain a large roster of patients where routine follow-up examinations would be required, and it would therefore be recalling more of its patients on a routine basis. As such, TLC, HCA argued, would treat a higher proportion of patients that required just a visual check with no associated histopathology work being required. In contrast, HCA said that HCA hospitals, which were associated more with cancer treatment, might see fewer of these sorts of routine patients and a higher proportion of patients who

were symptomatic being referred (because of the HCA hospitals association with cancer treatment).

4. With regard to determining which hospital patients were referred to, HCA said that either the GP would refer to a hospital or consultant (typically on the basis of reputation) or the consultant treating the patient would express a preference for a particular hospital (because of its additional support capability).
5. HCA noted that many gastroenterologists and GI physicians operated out of TLC because of its Endoscopy Unit and because the referral pathway with GPs to TLC was well established. HCA said that it consequently had to compete very hard to build its business, particularly at The Wellington and Princess Grace, and encourage consultants to use HCA hospital facilities instead.
6. HCA said that it would further marshal the evidence it had that showed that its patients were more complex, within that same CCSD, than patients that were referred to TLC and provide a further submission to the CMA. HCA noted that ICD-10 coding may be used to account for these differences in complexity.
7. With regard to quantitative and qualitative evidence that assessed the comparability of quality of central London hospitals, HCA said that there were a 'few things that could [compare the quality of central London hospitals], but there was not enough benchmarking information available in Central London for the independent healthcare sector to assess comparability'. HCA repeated its strong support for the CMA's information remedy and explained that it invested significantly in the Private Healthcare Information Network (PHIN) process before it became mandatory, noting TLC had not contributed any investment to the process.
8. HCA said that it did submit its data regularly to NICOR, the cardiothoracic registry, but that The Cardiothoracic Society had stopped publishing HCA data. HCA said that it had requested an explanation from The Cardiothoracic Society, as it did not know why it had stopped publishing its data. HCA noted that The Cardiothoracic Society had recently confirmed that it would start publishing HCA data again. HCA noted that TLC did not provide data to NICOR (as it does not treat cardiothoracic patients). HCA said that there was comparability information available on joints (hips and knees) but that it was not aware of any other sources of published information of this type that would enable hospitals to benchmark quality.
9. With regard to pathology services in particular, HCA confirmed that PMIs did sometimes challenge pathology invoices where the insurer believed a

particular patient may have been over-treated. HCA said that such situations may arise in circumstances where a patient may be difficult to diagnose. Where invoices were challenged, HCA said the parties would review the line items charged, the patient's medical record and any relevant ward protocols and, if both parties agreed that there had been over-treatment, provide a refund. [✂]

10. HCA said that there was no systematic reason, having adjusted for complexity within the same CCSD, why patients with the same degree of complexity within the same CCSD might receive more pathology tests at HCA than they would at TLC. HCA observed that ward protocols were dynamic and would differ between hospitals and networks.

## **Bargaining**

11. From a methodological perspective, HCA said that there were two main questions to consider in assessing bargaining power. The first question was to consider what options PMIs had to treat their patients elsewhere, and HCA said this was the side that the analysis by the CMA had so far been focused on. The second question was what happened to a hospital like HCA if it did not reach an agreement with the PMI. HCA said that, from its point of view, the consequence of not reaching an agreement was 'a dire one'. HCA agreed that it was relevant to assess the difficulty that a PMI may have in moving some of its patients, but that this difficulty was irrelevant because of the dire consequences to HCA if it failed to reach an agreement with a PMI. HCA said it had to reach an agreement with PMIs, given the scale of its investments. HCA noted that if it failed to reach an agreement with Bupa, it understood Bupa would be able to accommodate its patients with other providers in central London. Further, if Bupa delisted a hospital, it was likely that a consultant registered with Bupa would take their entire patient list to another hospital. HCA acknowledged that while some PMIs were more important to it than others, its consultants would expect to be able to accept patient referrals at their preferred hospital, even if the patient referral was from one of the smaller PMIs.
12. In respect of PMIs steering patients out of central London, HCA explained that it was perceived by the PMIs as 'expensive' because private healthcare was different in central London compared with other parts of the UK, in that private hospitals in central London did take and treat complex tertiary cases that were more expensive on average, whereas outside central London those cases typically went to the NHS. HCA said that insured patients' treatment under the NHS was free to PMIs.

13. HCA also noted that the PMIs were not customers in the traditional sense of the term, and that they did not steer patients or behave in a way that was necessarily aligned with patients' incentives. HCA stated that the incentives of the PMIs were determined by what sold more policies and what lowered their cost once those policies were sold. In that connection, HCA said that its own bargaining strength derived from its customers (ie individuals, corporates and consultants) receiving good service and healthcare from HCA hospitals, which it believed encouraged a pro-consumer dynamic.
14. With regard to open referrals, HCA said that this was now embedded in the marketplace, being offered by all major PMIs. In the past, open referrals were a product choice where customers would choose an open referral product and the insurer would steer them. HCA said that open referrals had moved beyond product choice and now meant that PMIs could steer or redirect to their preferred hospital or consultant patients that did not have a named consultant on their referral. HCA said that this was a growing trend, mainly because NHS practice was for GPs not to make referrals on a named consultant basis. As a consequence, HCA had noted that its admissions from [redacted] had significantly declined over the last 18 months. [redacted]
15. HCA said that open referral may mean that the PMI directed patients away from consultant A to consultant B, but both may work at the same HCA hospital. Open referral was not, therefore, solely about steering patients out of HCA hospitals. It was about steering patients to the PMI's consultant of choice as well as their hospital of choice. HCA said that open referrals did represent a fundamental shift in the market dynamics.
16. HCA noted three other factors that have impacted on its relative bargaining power with PMIs, which were:
  - (a) the network configuration of PMIs (ie PMIs offering products that excluded access to HCA hospitals);
  - (b) service line tenders; and
  - (c) the development of pathway guidance.
17. HCA said that the network configuration of a particular PMI may mean that HCA got fewer admissions from that particular PMI. By way of example, HCA noted that [redacted] of a PMI's customers did not have access to HCA.
18. Service line tenders might also have an impact. HCA said that this was where the PMI decided to tender for particular services that may previously have been provided by the hospital provider. HCA said that there were contractual terms with Bupa that put a cap on the number of service line tender

arrangements that a PMI could enter into. HCA said, in respect of these contractual restrictions, that these were there to protect HCA in circumstances where it had negotiated a price based on certain volume assumptions that the insurer then failed to meet because it had, subsequent to the contract negotiation being concluded, decided to steer or direct its patients elsewhere. [✂]

19. HCA said that PMIs were all now producing pathway guidance. For instance, HCA said there was musculoskeletal pathway guidance – the purpose of which was to steer and direct GP and consultants’ referral of patients with musculoskeletal conditions to particular providers and hospitals.
20. HCA was asked to provide some figures on these trends in relation to the proportion of business derived from each PMI, as well as trend information showing the impact of open referrals and self-pay.

### **Competitive constraints**

21. HCA said that the most important and significant changes that had occurred in the marketplace and impacting on competitive conditions since the publication of the final report were the following changes.
22. First, the VPS announcement that it was going to develop a private hospital of 150 beds in the Ravenscourt site of what was the Masonic Hospital. VPS would compete with the central London hospitals within the next two years. HCA said that it was unlikely that it would have any problem attracting sufficient business from consultants away from HCA or TLC. Consultants would take into account that VPS operated high quality hospital facilities elsewhere in the world and be attracted to the new medical facilities on offer. HCA would respond to this challenge and encourage its consultants to stay by continuing to provide a high quality service and medical facilities.
23. HCA also commented that the number of sites it had identified 18 months ago (at the last CMA hearing) in central London as suitable for development likely to come on to the market had now been confirmed as coming onto the market by 2017, for example The Heart Hospital and The Western Eye Hospital. In the light of these market changes, HCA noted the need for a review of the findings concerning barriers to entry.
24. Second, the increase in open referrals. HCA said that open referrals had over the period become mainstream, and that they were changing the way the industry operates. As evidence for this, HCA pointed to a Bupa statement made towards the end of 2014 stating that it had been able to deliver the lowest price increases in the market ever, which Bupa attributed to its cost

containment efforts. HCA noted the market had therefore reached a point where Bupa was able to address a majority of its cost containment concerns.

25. Third, the significant increase in the growth of PPUs. HCA noted that in 2012 the government lifted the cap on how much trusts could earn from private practice and that since then foundation trusts had grown their private practice revenue at a faster than market average rate. HCA observed a ‘take-off trajectory’ in respect of PPU provision. HCA said that it had made significant investments with a number of foundation trusts in different parts of the UK to investigate developing more PPUs, as it believed there were significant competitive advantages in NHS clinical infrastructure.
26. Fourth, improvements in the economy over the last 18 months. HCA noted an upturn in investment over the period, including Mediclinic investing £430 million in Spire, and Genesis, the Australian specialist radiation therapy, investing over £100 million to buy Cancer Partners UK. HCA said that there was strong investor appetite in the private healthcare market.
27. With regard to the effect that the opening of KIMS has had, HCA noted that it had only been open for about 18 months and that the majority of its activity was related to the NHS. HCA noted that it did not currently pull a lot of patients in from Kent. Further, the patient pathways for KIMS had not yet developed fully. As such, KIMS has not yet had a major impact on HCA’s business, but HCA was nevertheless of the view that it would in the future.
28. HCA said that there was sufficient alternative capacity for the PMIs to re-direct their business to go elsewhere in central London. HCA agreed that spare capacity analysis was not solely about bed availability, but nevertheless bed availability was the primary driver of spare capacity because it was the key pinch-point (more so than, for example, availability of surgery theatres and consultants, most of whom had practising privileges at other private hospitals and so were not tied to HCA).

## **Barriers to entry and expansion**

29. HCA said that, in relation to its previous assertion in its submission that the vast majority of fixed costs of setting up a hospital were not sunk, it would provide further written representations in support of this specific point.
30. [X] used for outpatient diagnostic services, such as MRI scans, consulting rooms and physiotherapy. [X]