

PRIVATE HEALTHCARE REMITTAL

Summary of hearing with AXA PPP healthcare Limited on 16 December 2015

Market entry

1. AXA PPP healthcare Limited (AXA PPP) said that it did not know much about the Cleveland Clinic and its plans for entering the central London market. AXA PPP indicated that, for the Cleveland Clinic to be a credible entrant in central London and be able to constrain HCA, it would need to offer cardiology and oncology (including radiotherapy). In addition, it would need to attract a significant number of specialists. AXA PPP considered that it would take seven to ten years for it to become a credible competitor in central London. Further, AXA PPP said that while the Cleveland Clinic would compete with The London Clinic (TLC) and the Wellington from the proposed Grosvenor Square site it would not be competing with the London Bridge Hospital. AXA PPP confirmed that it had not had any discussions with the Cleveland Clinic.
2. With regard to another potential entrant, VPS Healthcare Group, AXA PPP did not consider that it would, because of its location, have any impact on competition between private healthcare providers in central London.
3. In AXA PPP's view, a credible new entrant healthcare provider would need to be able to offer an end-to end cancer service to deal with all of the patients' potential needs. For example, a suspected breast cancer case may require various specialist treatments, including oncology, surgery, radiotherapy, chemotherapy and the ability to deal with any other related co-morbidities.
4. AXA PPP said that the investment cost required of a new entrant providing a full range of oncology services was significant. As an example of such costs, linear accelerators (an essential piece of equipment for radiotherapy) and cyber-knives (a more specialist piece of equipment for certain types of tumour) were discussed. AXA PPP noted that, as well as being expensive pieces of equipment, the facilities required to house radiotherapy equipment were costly too and required specific types of site (as a result of the need for facilities to be surrounded with lead and concrete to prevent irradiation).
5. AXA PPP noted that specialist consultants, particularly in the area of oncology, were likely to be more 'sticky' than other specialists when it came to

moving between hospitals or to a new entrant healthcare provider because treatment took place over a longer period than, for example, an orthopaedic procedure, and cancer specialists would therefore build long-term relationships with both patients and the staff team of specialist nurses that they worked with. Such specialists would therefore be faced with a choice of either practising from a number of different facilities (which many specialists disliked), or breaking links with patients or other members of multidisciplinary teams. Neither choice was likely to be attractive, which might make it difficult to migrate specialists to a new facility.

Competitive constraints

6. Roughly [REDACTED]% of AXA PPP's central London spend on oncology was with HCA International Limited (HCA). AXA PPP said that the majority of the remaining [REDACTED]% was accounted for [REDACTED].
7. AXA PPP said that the main characterisation of what constituted a 'must have' brand was determined by the private medical insurers' (PMIs') major corporate customers who wanted access to the main flagship hospitals in central London. AXA PPP said that this was largely a matter of brand (both in terms of individual hospitals and HCA generally) and the locational 'monopoly' London Bridge Hospital had in relation to corporate clients in the City and Canary Wharf.
8. While AXA PPP agreed that price was important to many customers, it was not currently able [REDACTED]. AXA PPP maintained that such a proposition would in any event simply not be viable for many corporate customers.
9. AXA PPP concluded its most recent pricing negotiations with HCA in [REDACTED]. These negotiations took place [REDACTED]. AXA PPP confirmed that there was no [REDACTED].

Capacity

10. AXA PPP did not consider that there was an immediate need for additional capacity in the central London market from the perspective of a PMI.
11. AXA PPP also commented that the issue of sufficient or spare capacity was more about the availability of linear accelerators, specialist high-dependency nurses and doctors, and so forth. The number of empty beds at any one time was not of itself indicative of spare capacity.

Quality and complexity

12. AXA PPP said that, on the basis of the limited evidence available to it, it appeared that TLC would have slightly more complicated cases (notwithstanding the fact that TLC did not have the same cardiology capability as HCA). AXA PPP noted that the evidence available in the public domain, for example, National Joint Registry information relating to hip and knee replacements, had markers of complexity. The American Society of Anaesthesiologists (ASA) scores, AXA PPP contended, did not show that HCA was treating more complex patients. Further, AXA PPP considered it extremely unlikely that TLC would be turning down such patients because it did not have the related depth of cardiac services needed to treat them.
13. AXA PPP said that it did not regard higher pathology test costs to be necessarily indicative of greater complexity. Referring back to the example of hip and knee replacements, AXA PPP noted that TLC appeared to be treating slightly more complex patients than HCA, but that its invoices contained [redacted] and that its pathology costs were [redacted]. AXA PPP also noted that practices such as ward-based pathology protocols (whereby all patients on a particular ward had the same tests regardless of their individual conditions) may result in unnecessary testing for some patients.

Views on the remedies

Remedy 1 – Divestiture of one or more hospitals and/or other assets owned or operated by HCA in central London

14. AXA PPP considered that a divestment of HCA hospital(s) would increase the chance of more people coming into the market. AXA PPP's view was that a new entrant coming into the central London market, absent any divestment, was unlikely to be able to do so on a sufficient scale to remove AXA PPP's dependence on HCA. As such, its impact on the overall central London market was likely to be 'trivial'. Further, any potential cost savings to PMIs from doing business with the new entrant would most likely be offset by [redacted].
15. AXA PPP indicated that its preferred divestment option would be the London Bridge Hospital (including the recently opened London Radiotherapy Centre) and The Princess Grace Hospital (rather than the Wellington Hospital) as this could potentially address the current locational monopoly issue and encourage new entrants to open private healthcare facilities in Canary Wharf.
16. AXA PPP considered that a divestment remedy requiring HCA to divest the Wellington Hospital alone would be inadequate because it was not a credible end-to-end supplier of oncology services. As such, the acquirer would need to

be able to provide the wider range of related treatments in order to be a credible competitor to HCA. In this regard the Wellington Hospital did not have a radiotherapy facility, and it would be necessary to include the Harley Street Clinic in the divestment package. AXA PPP contended that the least intrusive divestment option would be the London Bridge Hospital (including the London Radiotherapy Centre) and the Princess Grace Hospital.

17. AXA PPP said that, if London Bridge were divested to a third party, Guy's PPU, which would remain an HCA hospital, could potentially become an effective competitor to London Bridge Hospital.
18. AXA PPP said that, in relation to Leaders in Oncology Care (LOC), it was concerned that HCA's continued ownership and influence in LOC could act as a frustration to any divestment. It did not presently consider that LOC should be included in a minimum divestment package, but said that LOC should continue to be monitored prospectively.
19. AXA PPP said that there were sufficient potential purchasers among the existing private healthcare providers. Potential purchasers based in the Middle East and the USA would also be in a position to acquire any divested hospital(s).
20. With regard to how PMIs would pass through lower prices to their customers following a divestment, AXA PPP noted that [X] % of its major corporate customers were on open book, cost plus, trust schemes. As such, any price reduction negotiated would automatically be passed through to its customers.

Remedy 2 – Require HCA to give competitors access to its hospital facilities to compete

21. AXA PPP indicated in its response to the CMA's Notice of Possible Remedies that it did not consider that providing HCA's competitors with access to its hospital facilities would be an effective remedy. AXA PPP said that, when asked whether access to a subset of specialist service facilities might be beneficial to a new entrant/existing healthcare provider, this did not seem to be an effective solution. AXA PPP commented that, if required to share facilities and equipment in a particular hospital, HCA would be unlikely to invest or put its best equipment in such a location. Further, the short-term nature of such a remedy would mean that it would not solve the adverse effect on competition (AEC).

Remedy 3 – Restrictions on HCA’s further expansion in central London

22. AXA PPP said that, with regard to the remedy proposing limits on HCA’s expansion in central London, it could see no connection between the problem and the solution. It was not aware of any specific evidence to suggest that HCA outbidding potential entrants for new sites was, of itself, a cause for concern, and considered that restricting HCA’s ability to expand would not create the opportunity for a new entrant to open new facilities (nor would it address the current situation).

Remedy 4 – ‘Light-touch’ price control

23. AXA PPP’s view was that a short-term price control would be ineffective. It considered that such controls could be circumvented through, for example, the introduction of new service lines. Further, even if they were capable of limiting the potential to increase prices and stop the current situation worsening, this would not address the current problem that HCA prices were already too high. In addition, at the end of the price control period, HCA would still have sufficient market power to be able to raise prices above the competitive level.