

PRIVATE HEALTHCARE REMITTAL

Summary of hearing with HCA International Limited on 15 December 2015

Introduction

1. In summary, HCA International Limited (HCA) highlighted three important issues:
 - (a) First, the Competition and Markets Authority (CMA) had not established a link between HCA's market share and what was driving higher prices in central London. In that regard, there was no evidence for the CMA's contention that HCA's prices were higher than those of The London Clinic (TLC), or if there were price differences that was driven by market share. HCA noted that its spare capacity analyses, line item analysis and recent co-morbidities analysis undermined any such link.
 - (b) Second, the market in central London was changing. New entry in small- and large-scale form would occur, as reported by LaingBuisson.
 - (c) Third, HCA saw no case for remedies, and if they were to be imposed, they must be proportionate, recognising that new entry was underway.
2. Overall, and based on the evidence, HCA did not see a reason for an adverse effect on competition (AEC) finding for central London and for any remedies.

Market entry

3. HCA noted that, based on the views of independent commentators, the central London market had been growing at a rate of 8 or 9% a year, which made it very attractive to investors.
4. HCA said it was aware of five large-scale market entry announcements over the last 12 months which included VPS Healthcare Group (VPS) (an Emirati-based hospital provider that had announced its forthcoming investment in a site at Ravenscourt Park); Cleveland Clinic (a US-based hospital provider that recently spent over £200 million to secure the site at 33 Grosvenor Place); Spire Healthcare Group plc (believed to be interested in sites at Earl's Court and Paddington) and Barts Health (which was about to announce that it had

chosen Nuffield Health as its preferred provider for its private patient unit (PPU)).

5. HCA also noted disruptive entry and expansion by smaller-scale providers that focused on the whole care pathway in relation to a single specialty (the super-specialty entrants), which LaingBuisson referred to as 'effectively cutting out the hospital'. Three providers of this type included the Fortius Clinic (orthopaedics and sports injury), Nuada (diagnostic imaging) and Optegra (eye health care). Such super-specialty entrants were particularly attractive to consultants interested in equity ownership because they did not currently have inpatient facilities. As such, they were not captured by the CMA Order capping equity ownership in inpatient facilities to 5%.
6. HCA further pointed out that existing operators in the market also had plans for further expansion. TLC had recently acquired a £65 million line credit which it planned to use to increase its theatre capacity and improve its radiology and intensive care facilities. In addition, King Edward VII's Hospital would be growing its capacity by around 30%. Further growth was also planned by Aspen Healthcare, the Royal Marsden, Royal Brompton and Imperial College hospitals.
7. HCA also reiterated the fact that there were numerous sites becoming available in central London which would support entry by interested operators. HCA was worried that the CMA process was now subject to regulatory gaming where some hospital operators might not be willing to confirm to the CMA that they might be committed to acquiring sites in central London.
8. HCA noted that it considered that the CMA was holding HCA to a different standard from the one to which it held BMI and Spire in the original market investigation. In particular, HCA noted that the CMA identified numerous uncompetitive markets outside of London, none of which had the same number of competitors or new market entrants that HCA currently faced in central London.
9. HCA had taken a number of actions in response to planned new entry and expansion by existing operators:
 - (a) First, HCA operated as one network of facilities and not six individual hospitals (appointing leads of service lines to facilitate rotation of staff among its hospitals and to ensure they had the right skill and experience). This approach ensured that HCA was able to attract and retain the best consultants and to drive significant economies of scale ([REDACTED]).
 - (b) Second, [REDACTED].

(c) Third, [REDACTED].

(d) Fourth, HCA was looking to expand the market by bringing in new products, [REDACTED].

10. HCA also noted that new entry would impact on its negotiations with private medical insurers (PMIs). It expected BUPA and AXA PPP to be able to drive prices down as a consequence of the proposed new entry by Cleveland Clinic and VPS. This was likely to happen over the next contracting period (ie before the new hospitals were up and running).

Bargaining power

11. HCA noted the recent announcement of the joint venture between Aviva and VitalityHealth. HCA reported that these insurers had confirmed they had formed the joint venture in order to compete more effectively with Bupa and AXA PPP, using their combined market power. HCA noted that this further consolidation meant three PMI groups now represented around 92% of the PMI market.
12. HCA also noted that the major insurers were imposing large cuts to consultant fees (approximately [REDACTED]) for complex procedures, which was reducing the incentive for consultants to do these procedures and which were instead sent to the NHS. HCA noted that patients and insurers' customers were not happy with these arrangements.

Capacity

14. HCA's second spare capacity report looked at a number of different capacity dimensions, which the CMA had highlighted in its provisional findings, and confirmed that there was sufficient spare capacity for PMIs to move all of their patients away from HCA, in central London, to competing facilities.

Quality and complexity

15. HCA confirmed that it had been collecting ICD-10 data from 2013 onwards. HCA was committed to the idea of developing quality indicators and benchmarking them. HCA considered that it needed to make an investment in meaningful quality information which was risk-adjusted. In HCA's view, using ICD-10 data was the only way of achieving this outcome.
16. HCA also confirmed that it had used its ICD-10 data to undertake its latest co-morbidities analysis as regards cardiac co-morbidities patients.

17. HCA discussed its latest analysis on cardiac comorbidities, which in its view showed that failing to appropriately account for patient and episode complexity led to an analysis which was not conducted on a like-for-like basis and was not statistically robust. Its latest analysis found that patients with cardiac co-morbidities were being treated at a higher rate at HCA cardiac facilities than it would expect: for example, in some cases for some cardiac co-morbidities [X] of those patients were being treated at an HCA cardiac facility. In HCA's view this clearly showed that there was an active mechanism that was directing patients who had cardiac co-morbidities to those facilities that were better suited to treating them. HCA also noted that this analysis was likely to underestimate the percentage of patients because it did not take into account that HCA operates as a network, where patients requiring cardiac care could efficiently access those services.
18. HCA had two additional observations with this analysis. First, patients with cardiac co-morbidities were more expensive to treat (on average by around [X]) which was in part due to their higher intensive care unit usage. Second, when performing an Insured Price Analysis (IPA) -like analysis, with and without controlling for cardiac co-morbidities, the results changed quite significantly. In order to undertake its co-morbidities analysis HCA developed a scenario where it treated its cardiac hospitals as one hospital operator and its non-cardiac hospitals as another operator – under this scenario it postulated that there should be no pricing differential. However, the results showed that HCA's cardiac hospitals were statistically significantly more expensive than its non-cardiac hospital for Clinical Coding and Schedule Development Group codes (CCSDs) within the common basket. When it then controlled for cardiac co-morbidities this pricing differential fell away.

Views on the remedies

19. HCA noted two caveats in respect of its views on remedies:
 - (a) HCA provided that any of its views on remedies were made without prejudice to the fact that it did not accept there was any basis for an AEC finding; and
 - (b) given the limited information provided by the CMA on how any of the remedies might be implemented, HCA had found it difficult to comment on the costs and benefits in relation to each remedy.

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

20. HCA noted that remedy 1 was grossly disproportionate. Given that HCA's hospitals operated as one network, divestment would put at risk clinical standards and patient care. Further, HCA did not see any basis for a divestment remedy, given its review of the IPA, the spare capacity analyses, the line item analysis and the co-morbidities analysis.
21. HCA also noted that, even if one were able to place any reliance on the price estimates coming out of the IPA (which HCA did not believe was possible) these could not be reconciled with the underlying market shares. Furthermore, the CMA itself recognised that competition on quality was working well.
22. HCA noted that the possibility of a divestment was influencing some of the existing providers' incentives to seek to acquire capacity through a divestment rather than investing in additional capacity.
23. HCA also confirmed that it had previously argued that there was no evidence that insurers passed on price reductions to their subscribers (save possibly in the case where insurance was provided by a trust).
24. [REDACTED], but had since made considerable investments to upgrade it to a more full-service hospital. It also noted that when the [REDACTED] was built originally, 30 years ago, it was done so with the idea of converting it into flats, if it failed as a hospital. Finally, it reiterated its view that when calculating its return on capital employed the CMA should value its assets based on residential use and clarified that when assets were valued on this basis there was no finding of excess profitability.

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

25. Although this remedy could be seen as a short-term solution until new entrants came into the market, in HCA's view it was nonetheless a form of divestment. HCA noted that remedy 2 would create the same costs and adverse consequences as a divestment remedy: namely, it would impact on its economies of scale, it would lead to reductions in network benefits and it would disrupt patient pathways. On this basis, HCA did not believe that this remedy would be proportionate.

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

26. HCA confirmed that it had put some of its hospital expansion plans on hold pending the outcome of the CMA market investigation into private healthcare (for example, regarding [REDACTED]). HCA did not see the logic in extending remedy 3 to outpatient or GP facilities, noting that it believed the CMA’s concern primarily rested with sites for large hospitals, particularly sites upwards of 120,000 sq ft. HCA did note that it was looking at plans to [REDACTED].
27. In HCA’s view, a restriction on its ability to expand in central London was not required as there were plenty of sites available. In fact, HCA noted that a lot of sites which were dormant were now coming back onto the market: HCA itself was approached [REDACTED]. HCA also mentioned changes to the Westminster planning strategy where commercial properties were being encouraged to sell and operate as commercial properties rather than revert to residential – this change in itself was making it unattractive for organisations to buy large properties and convert them into residential ones.

Remedy 4 – Light-touch price control

28. HCA believed there was no basis for such a remedy, but noted that a short-term cap on the percentage increase in prices to PMIs would be a more proportionate alternative to divestment, if any remedy was still considered necessary. HCA also considered it was practicable in the sense that there were annual percentage uplifts on PMI prices and therefore it was at least hypothetically possible to have a cap linked to some kind of index; perhaps an index of healthcare inflation. HCA proposed, for example, the use of medical inflation as a proxy for annual tariff uplifts. There were two factors which HCA considered relevant to this remedy. First, there was no reliable evidence of a price difference between itself and TLC (the CMA’s own analysis could not conclude on the absolute level of this price difference or how much of it could be attributed to patient complexity). Second, HCA’s cost base increased year on year: for example, [REDACTED]. With this context in mind, there were several different indices that were used for various forms of healthcare cost inflation, of which medical inflation was only one. Although medical inflation was usually higher than both consumer price indices and retail price indices, its use was justified given the various levels of innovation in healthcare and the high labour costs.
29. As to the question of which services should be subjected to a light-touch price control, based on the CMA’s own analysis, HCA proposed that the CMA might consider its application on the [REDACTED].

30. In relation to the duration of the light-touch price control, HCA suggested one that would last for three years (until 2018) [X]. HCA also briefly explained the process of adjusting its prices at the start of each [X] contract period: there was a well-established routine in the industry where at the anniversary of the relevant contracts HCA adjusted its charge master to the agreed percentage which PMIs policed closely. This process also allowed it to address historical anomalies: for example, [X].

Remedy 6 – Facilitate site availability in central London

31. HCA understood that the NHS was gearing up to sell off a significant number of surplus sites onto the market. It also noted that there were changes being introduced to the planning regime which would potentially take the heat out of the residential property market in central London and make it more difficult for residential developers to get a change of use from commercial to residential use on existing hospital sites. Furthermore, HCA noted that the NHS sites coming onto the market (eg the Heart Hospital and Masonic Park Hospital at Ravenscourt Park) were already hospitals and therefore they would not need a long period of time to become operational again as private hospitals.