

PRIVATE HEALTHCARE REMITTAL

Summary of hearing with Bupa on 17 May 2016

Introduction

1. Bupa said that it strongly agreed with the CMA's conclusion that there were adverse effects on competition in central London caused in particular by HCA's high market concentration and dominant share. Bupa said that it was hugely disappointed at the CMA's change of direction in its provisional remedies decision. Bupa said that it had three major areas of concern:
 - (a) There was no sufficiently robust evidence to support the CMA's view that Cleveland Clinic would be an effective constraint on HCA by 2022.
 - (b) The CMA's NPV analysis contained material errors which, when corrected, would show that divestment would be proportionate.
 - (c) The CMA had not discharged its statutory duty by properly considering alternative remedies to address the clear customer detriment the CMA has identified such as a more limited divestment, the removal of restrictive clauses in insurer contracts or the imposition of price control mechanisms.

New entry

2. Bupa said that it did not believe that the evidence available supported the conclusion that Cleveland Clinic would enter the market in the time frame envisaged by the CMA and effectively constrain HCA by 2022. Previous experience suggested that new hospital facilities were often hit by unexpected issues that caused delays. Bupa said that the evidence provided by Cleveland Clinic described its entry as 'complicated'.
3. Moreover, there was no robust evidence to conclude that if Cleveland Clinic did enter in the predicted timeframe it would effectively constrain HCA. In particular, Bupa said that Cleveland Clinic had itself told the CMA it would be smaller than The London Clinic, and would not offer the key specialism of oncology. Bupa said that a new entrant offering 200 beds was very different to a divestment of a 200 bed hospital. In one scenario (divestment), the result would be a smaller HCA, with the purchaser of the divested hospital getting an already established hospital and doctors with the referral flows from those doctors, and insurers gaining improved bargaining power to deliver better

value for money to customers around five years earlier than awaiting still uncertain entry. In the other scenario, with no divestment and new entry, HCA would be very substantially larger with five years of further unconstrained growth and the new entrant would still be in its start-up phase of its operation.

4. Bupa said that in the absence of oncology services being provided by Cleveland Clinic, HCA would continue to have a stranglehold in oncology and be able to leverage its market power in this core specialism across all of its business. Bupa said that HCA would significantly grow in strength in the period to 2022, and that even if Cleveland Clinic was open for business in 2022, HCA would by this point account for [redacted] of Bupa's total central London claims spend. Bupa also said that HCA was already demonstrating how it could tie in the highest revenue-generating consultants to the exclusion of competitors through equity holdings and types of employment. Entrants must be able to attract and retain sufficient consultants, so this behaviour directly compromised the ability of any entrants to compete effectively with HCA. Bupa said that Cleveland Clinic had stated in a meeting with them that [redacted].
5. Bupa said that it had spoken to a number of other small scale providers that were looking to enter the market. However, it said that these conversations usually went nowhere. Bupa considered that, while there had been talk of new entry for many years, it is very difficult to make that happen.

NPV analysis

6. Bupa said that there were numerous technical issues with the CMA's NPV analysis which, once corrected, would completely change the CMA's proportionality assessment in favour of divestment. In particular, Bupa said that the CMA had incorrectly treated HCA's ongoing costs, as explained in detail in item J of its PDR response. There were a number of concerns, including that the CMA's inclusion of these costs in the proportionality assessment in effect assumed that: (i) HCA could not achieve the levels of efficiency of The London Clinic and other providers, which were substantially smaller in scale, and so compete at the prices determined by the well-functioning market; and (ii) HCA's management would not be able to drive efficiencies and scale the business over time. Bupa said that the effect of such treatment was to protect HCA's excess profits at the cost of consumers. Bupa said that it believed there was economic evidence to support the CMA not including HCA's ongoing losses of economies-of-scale costs at all. If the CMA decided to include them, it should include them at a lower level and have them decay within five years to zero. Bupa said that the appropriate mechanism with which to discount those costs was the HCA cost of capital, not the social cost of capital.

7. Additionally, Bupa said that there were a number of key assumptions or scenarios which had been used in the analysis, and in all cases those assumptions were the most extreme assumptions which supported a no action remedy. Bupa said that the CMA had not justified this approach. Correcting even some of these issues would mean that the NPV analysis supported the view that the divestment packages put forward would be a proportionate and effective remedy.

Oncology and consultants

8. Bupa said that, in the main, GPs directed their patients to specific consultants, with insurers having limited ability to influence the flow. Insurers had even less ability to influence patient flows so in the case of oncology, where people come in to the treatment pathway through many different routes. For example, Bupa explained that, [REDACTED].
9. Bupa said that of the oncologists practising in central London, it believed that approximately 15% had equity stakes in HCA facilities (based on information HCA published on its website). The oncology consultants with these equity stakes accounted for approximately [REDACTED] of all of the oncology activity taking place in central London. Bupa had submitted evidence showing that when you looked at the patient flows of consultants with equity relationships and compared them to consultants that did not have these equity relationships or arrangements, you found that the consultants with such relationships took a far higher proportion of their work to HCA than the consultants that did not. As well as the consultant relationships, HCA had also been very acquisitive in oncology, out-investing other competition for example by acquiring entities such as Leaders in Oncology, to build up its strength.
10. Bupa said that HCA used its dominance in specialisms like oncology to leverage across all of its operations in other specialisms, in terms of negotiating power, with the result that it is able to extract higher prices. It was the harmful effect that was coming out of this dominance on which Bupa were asking the CMA to take action.
11. With regard to the ability of Bupa to design policies using cheaper providers and excluding HCA, Bupa said that [REDACTED] (given the substantial share it occupied of the central London market and the geographic locations of its facilities, particularly The London Bridge Hospital). Furthermore, HCA has imposed restrictive contractual clauses in its contract with Bupa, such as: HCA mandates that [REDACTED]. While Bupa said it did have a product on sale that did not feature HCA and the Cromwell network, [REDACTED]. This was because customers that want PMI want general coverage for all medical conditions and comprehensive hospital coverage, [REDACTED].

12. With regard to the ability of other providers expanding into oncology, Bupa said that other players like The London Clinic have attempted to expand in oncology but despite this remained 'relatively unencumbered by patients'. Bupa said that HCA had built such a strong position in oncology and was so attractive to consultants that it was very challenging for another provider to come in to that market. Bupa said that the solution was not as easy as another hospital provider paying more money to get those consultants because where consultants have an equity interest in HCA it was not straightforward to unwind. More generally, Bupa noted that it was not in patients' interests for hospitals to influence consultants' treatment decisions with an arms race of financial payments to consultants, which Bupa understood to have been a key conclusion of the CMA's Final Report in the original inquiry.

Negotiating power

13. With regard to negotiating power, Bupa said that HCA had grown in its underlying strength since the original report, so the balance continued to tip in HCA's favour. HCA accounted for more of Bupa's claims spend, a higher percentage of Bupa patients were treated there, it was even more dominant in critical specialisms like cancer and cardiology and it controlled more primary care referrals into its system through its GP franchises in the City. Bupa estimated that it accounted for approximately 20% of HCA's revenues. [✂]
14. Bupa said that any significant divestment would allow Bupa to be able to negotiate lower prices with HCA so that over time, the rate of HCA's price growth would be significantly less than it was today. This would also have a wider impact on prices in the overall market because HCA's price levels set a reference point for other providers in London.

The London Bridge location

15. With regard to the London Bridge location, Bupa said that this was extremely important for corporate customers because of its convenient location for the City and Canary Wharf for both inpatients and outpatients. Bupa said that it would be tough for HCA's competitors to get sites of any significant scale in the same area, if they were to attempt to set up outpatient clinics in the area. It would also be practically unattractive for consultants to travel to a different facility in other parts of central London to perform their outpatient consultations.
16. In regard to London Bridge being a 'must-have' hospital, Bupa noted that its corporate customers had [✂]. Bupa said that this was consistent with London

Bridge being a 'must-have' for corporates, and HCA had consolidated its position in the same area with a new outpatient facility at the Shard, and the Guy's and St Thomas' PPU. Conversely, around the Harley Street and the Wellington areas, there was more local competition. Bupa said that if The London Bridge were divested, its purchaser would not then have the same 'must-have' status as HCA does currently because there would still be competition in that area as HCA would retain its major outpatient facility at the Shard and the Guy's and St Thomas' Hospital nearby, and it also had its primary care clinics in the City through which it could direct patient flow.

17. Bupa said that the key point was that it was not one factor but a combination of dominance in oncology (and other important specialisms), the London Bridge location and HCA's overall size that made the London Bridge 'must-have' for Bupa.

Alternative remedies

18. Bupa said that if the CMA concluded its divestment packages were disproportionate it was beholden to the CMA to explore a wider range of remedies which could have the effect of addressing some of the consumer detriment in London. Alternative remedies included narrower divestments or price controls backed up by the removal of restrictive contract clauses for insurers.
19. With regard to a temporary price control, Bupa said that this would be an effective remedy. HCA's current prices with each insurer could be frozen for a period of time, either until new entry had occurred and reached a scale to effectively constrain HCA or until HCA stopped making a certain level of return from its business in the UK. Bupa also considered the removal of restrictive clauses unilaterally from all provider contracts with HCA would be sufficiently effective as a supporting remedy.