COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Nuffield held on 4 April 2013

Opening statement and background

1. Nuffield considered that the healthcare industry had reached and was likely to have surpassed a critical point. Volumes in the industry had been relatively constant over a period of time, prices had risen above inflation and there had been little or no innovation. Volumes had declined, most markedly in relation to individual private medical insurance (PMI) policies, but also within the corporate market.

2. Nuffield considered that a key barrier to effective competition which needed to be addressed in the industry was in relation to the central London market. Nuffield saw London as a key area as it was the single largest private medical insurer market in the UK and it therefore had a disproportionate impact on PMI pricing. This led to increased prices for consumers in both London and also on a national level.

3. Outside of central London, Nuffield considered that the market dominance of BMI and Spire provided them with market power in negotiations with private medical insurers in strategic insurer markets. Strategic insurer markets were those located in regions with high levels of corporate activity. On a general basis, this had led to increased price to the consumer and reduced choice to the consumer in those markets.

4. While Nuffield acknowledged that increased information being made available to consumers and intermediaries about healthcare services would improve market conditions, this on its own would not be the solution. Nuffield considered that without addressing other issues to improve and increase competition, such as avoiding restrictive networks, increasing the quality of information available to consumers would have little impact.

5. In terms of the remedies which the Competition Commission (CC) should consider, Nuffield considered that the CC should concentrate on devising remedies that would remove barriers to entry in the central London market as this would have the greatest impact on PMI prices and affordability for consumers across the UK. Secondly, the CC should focus on devising remedies that removed barriers to entry and expansion in certain strategic PMI markets outside of central London.

6. Nuffield also believed that the CC should look at remedying other potential barriers to new competition over the long term, such as consultant incentives, which it considered would ensure industry competitiveness and affordability for the consumer over the longer term. Nuffield identified the future of the industry as being about creating an affordable market where hospital operators competed for consumers on the basis of price, service and clinical quality, and where the individual consumer and the corporate customers could exercise choice and control.

Nuffield strategy in the UK

7. Over recent years, Nuffield had sought to diversify its revenue streams to manage the risks that it saw in the hospital market. On this basis, Nuffield sold ten of its hospitals in order to expand into the well-being industry. This strategy was focused

on supplying services to consumers and corporate customers to promote health and well-being to encourage individuals and employees to stay well.

8. Nuffield operated 31 hospitals in the UK. Its goal was to provide a national offering and to expand its hospital operations into further strategic markets which it had identified, but which had proved difficult to enter.

9. Nuffield currently operated 65 fitness and well-being centres for consumers across the UK, which it would like to [✂] in future. These centres provided Nuffield members with access to a gym, as well as a range of therapist and health mentors. In addition, Nuffield had over [✂] contracts with corporate customers to provide on-site health and well-being services across the UK, which might include providing a small gym with a personal trainer on site or a physiotherapy contract.

10. Nuffield's hospital business accounted for approximately two-thirds of its annual revenue and the well-being business accounted for around one-third of revenue. Revenue earned by the well-being business was split equally between the consumer and corporate business.

11. Nuffield was seeking to expand its hospital business, but considered that there were a number of key barriers to it doing so in certain markets, including barriers associated with PMI network positions within those markets and relationships that consultants had with incumbent providers. [✂]

Hospital groups

12. HCA remained Nuffield's main competitor in London while BMI and Spire were competitors outside of London. Private patient units (PPUs) in some markets had been competitors to Nuffield. Nuffield considered Ramsay to be a less close competitor due to its policies and focus on dual provision of services with the NHS.

13. Nuffield had identified hospitals in particular regions it considered were important or 'must-haves' from the perspective of private medical insurers. For example, Nuffield identified a particular hospital in Manchester which it considered would be a 'must-have' for private medical insurers as it was the only hospital of sufficient scale and breadth of services in the region. Due to its size and complexity, an insurer would be able to accommodate all of its corporate volumes at this location.

14. Nuffield did not have a problem with exclusive networks, as long as they were transparent, frequently tendered and given clarity.

15. Nuffield gave an example of a hospital which it operated in Leeds which had been excluded from the AXA Acute Hospital network. [✂] Nuffield suggested that if it were able to participate in a tender for participation in the market then it might have the effect of driving prices down.

16. Nuffield considered that HCA had a 'must-have' set of hospitals in central London, as it had a disproportionate number of the hospitals in that market. HCA had the most desirable hospital locations, particularly as they were located near to teaching hospitals.

17. Nuffield did not consider that hospitals outside of central London were able to effectively constrain hospitals in central London, due to limitations in their scale and complexity, drive-time and patient preferences for location and consultants. Nuffield believed that private medical insurers had tried to drive patients outside of central London in the past but had failed.

18. Nuffield considered that if it wanted to offer services to the London market it had to establish a hospital in central London, to enable it to attract the consultant base required to be successful and required scale and complexity. Nuffield had considered entering the central London market by bidding to operate PPUs, but it would be unlikely to be able to compete with HCA on this basis, as it would not offer the size, complexity, consultant base and price which HCA was able to achieve from private medical insurers as a result of its bargaining power. Also, HCA tended to win all the PPU tenders, as it was able to produce commercially attractive business models based on higher service prices derived from its market dominance.

19. Nuffield said that HCA had a significant advantage in PPU tenders. The higher prices HCA negotiated with insurers enabled it to guarantee much higher returns to PPUs under the standard revenue or profit-sharing PPU deals. [✄]

20. Nuffield had been looking for some time to enter the central London market. [✄]

Pricing

21. Following a review in 2005 and 2006, Nuffield said that it attempted to get standard pricing across all insurers with no volume discounts. Nuffield said that this did not work. Instead, what derived was a procedure-based approach which was a fully inclusive procedure-based approach for all surgical procedures and built a cost model from the bottom upwards to arrive at its prices.

22. Nuffield set a national price for self-pay, but locally the hospital director had discretion to discount from that self-pay price, in response to conditions in the market or to secure referrals from consultants. Prices for insured patients were also set on a national basis.

Negotiations with private medical insurers

23. Nuffield indicated that in its negotiations with private medical insurers over the last five years, it had been able to achieve some increases in the price of procedures. [✄]

24. Nuffield considered that Bupa and AXA were 'must-have' insurers for hospital groups because of their size in the PMI market. Nuffield considered that Bupa in particular had a strong negotiating position, given that it was the largest insurer in the market.

25. Nuffield did not raise any concerns about private medical insurers formulating a national price to join their PMI network, so long as access to the network was granted on a non-exclusive basis.

26. Nuffield said the private medical insurers must have a national network to meet the requirements of their customers. Nuffield considered that the strategic PMI markets were those targeting corporate customers, as these customers comprised as much as 80 per cent of the market.

27. Nuffield considered that BMI and Spire had the most significant presence in 'must-have' or strategic PMI markets outside of central London, which gave them a dis-proportionate bargaining power with PMI networks.

28. Nuffield believed that every PMI network needed to have London hospitals included. As HCA had a virtual monopoly of central London, it would always be recognized in every PMI network. As a result, Nuffield considered that HCA would have significant

negotiating power with private medical insurers. Nuffield considered that once PMI networks had secured relationships with HCA, BMI and Spire, they were able to access the 'must-have' hospitals in the UK and achieve sufficient national coverage, which placed it at a weaker negotiating position compared with those hospital operators.

29. Nuffield would like to expand by adding new hospitals to its network in key markets which it had identified, but that exclusion from key PMI networks would be a barrier to expansion.

30. In 2008, Nuffield sold nine of its hospitals which had been excluded by AXA PPP from recognition in its network. One of those nine hospitals, a hospital in Nottingham, had also been excluded by Bupa. The nine hospitals had been excluded by AXA PPP since it carried out its initial tendering 11 to 12 years ago. Nuffield had been unsuccessful in obtaining recognition in subsequent negotiations. This was also the case in relation to recognition by BUPA of the Nottingham hospital, which had not been recognized by BUPA prior to Nuffield acquiring it. Nuffield said that the hospitals had been underperforming because of exclusion from AXA PPP, which was in part why it decided to sell them. In addition, Nuffield also looked at the hospitals' dependence on NHS activity in areas where there was low PMI penetration. Nuffield said that BMI initially purchased all nine hospitals from it in 2008 (except for two which were subsequently divested to other parties following an investigation by the Office of Fair Trading), and the majority went on to be recognized by AXA PPP.

31. Nuffield believed that to have a successful hospital business there was a need for recognition in both the AXA and the Bupa networks because they represented such a large part of the PMI market. If a hospital group lost recognition from AXA, then consultants would typically refer all of their other insured patient work to an AXA-recognized hospital, given that they might prefer to practise from a single location. Nuffield described this as a 'consultant drag' impact.

32. Nuffield considered that 'consultant drag' might also impact the price paid by consumers. If consultants were referring work away from a Nuffield facility to an AXA-recognized facility, smaller insurers might end up paying a higher price. Nuffield believed that the net price for consumers might also be potentially increased by the existence of restrictive networks. However, Nuffield did not have access to evidence to support this.

33. Nuffield continued to have eight hospitals nationally that were excluded by AXA PPP. In some of these areas, Nuffield had been able to diversify into a service which its competitors did not offer to mitigate the impact of exclusion from AXA PPP's network.

34. Nuffield identified overdependence on NHS work as a high-risk strategy, due to the volatility and uncertainty surrounding volumes of work which may be referred by the NHS. [✂]

35. There had been instances in Nuffield's negotiations with private medical insurers [✂] where the insurer had threatened to delist some of its hospitals as part of their negotiating strategy. [✂]

Private medical insurer service line tenders and open referral schemes

36. Nuffield did not raise any concerns about the use of service line tenders by private medical insurers, so long as the processes conducted were open and transparent. Nuffield considered that these types of processes were quite common and were also

conducted by corporate customers directly, by carving certain treatments out of their PMI.

37. Nuffield was not opposed to the use of open referral schemes by private medical insurers, so long as there were processes in place to direct the consumer towards the right clinician to undertake the required care. Nuffield said that if open referrals were based purely on price, it would be concerned and it would not be in the best interests of the consumer.

38. In regard to whether private medical insurers were in a position to effectively make clinical judgements on which consultants were suitable, Nuffield said that patients had been sent to the wrong consultants on occasion. Private medical insurers did not have the information and processes available to them to make appropriate judgements on which consultants were suitable for which patients. The hospitals were better placed to make those decisions. However, if private medical insurers had transparency on consultant practice, procedures and their outcomes, they would be in a better position to make open referrals.

39. Nuffield said that open referrals would give private medical insurers more ability to direct patient volume, providing them with greater bargaining power.

Consultant power

40. Nuffield explained that there was a broad spectrum of incentive schemes which hospital operators might offer to consultants. One end of the spectrum included creating a joint venture, where the consultants made an equity investment in a hospital, incentivizing them to refer patients to that facility due to the risk that they had undertaken. Other incentive schemes included hospital operators providing consultants with a cash advance which they earned over a period of time or providing consultants with a return in relation to the volume of work they referred. Nuffield considered that each of the various types of incentive schemes could be anticompetitive.

41. Nuffield indicated that it had used a joint venture incentive scheme in entering the Cardiff market, because this minimized the commercial risk to the hospital if it were prevented from obtaining PMI network recognition.

42. Nuffield said that the number of consultant groups in the industry had been growing. It did not normally negotiate with anaesthetists as a group. Anaesthetists charged insurers directly and therefore Nuffield did not negotiate on price. The only time Nuffield negotiated with anaesthetists around price was when it came to NHS activity and occasionally there might have been debates around parity with surgeons.

43. Nuffield said that its relationships with consultant groups did not tend to include negotiating price. Its discussions with consultant groups were normally around whether consultants would undertake activity in Nuffield's facility, direct their patients towards Nuffield, equipment they required, marketing support and whether they would earn a split of revenue.

Barriers to entry and expansion

44. Nuffield said that NHS work was too volatile to support a business case for new market entry. Between 2003 and 2005, Nuffield had been very successful in bidding for NHS work, but experience showed that NHS work displaced private patient work and there were significant additional administrative costs associated with it. [✂]

45. As there were likely to be more funding cuts in the NHS in future, Nuffield predicted that the NHS would need to drive efficiency by driving greater volumes through NHS facilities to sustain them. [✂]

46. Nuffield outlined the model which it adopted to enter the Cardiff market, whereby it established a satellite unit with consulting rooms in the centre of the city and operated the main hospital on the city outskirts. [✂]

47. [✂]

48. Nuffield considered that planning applications and objections to planning permission might act as a barrier to entry. For example, a third party objected to Nuffield expanding its hospital in Bristol, although the site was already designated for hospital use, which delayed the development at this site. In some cases, Nuffield was aware that planning objections had stopped developments by other hospitals, citing an example where BUPA attempted to build a hospital in Bradford, which was objected to by a competitor and the planning application was ultimately denied.

49. Nuffield did not consider that there were any significant barriers to exit in the private hospital industry. It considered that hospital assets were generally saleable.

Incentives and vertical integration

50. Nuffield did not agree with incentives being paid by hospital groups to GPs for referrals. It was aware that some operators such as Circle, through its partnership model, carried out this practice.

51. Nuffield introduced its own incentive scheme, Practice Privilege Plus, between 2009 and 2012. The scheme was developed in response to consultants being incentivized to refer to its competitors. The aim of this scheme was to reward loyalty and this scheme was not based on exclusivity. After a review, the scheme was abandoned as it was shown not to have had any impact on driving growth for Nuffield's business or preventing it from losing any business. [✂]

52. Nuffield did not have any concerns about hospital groups offering non-financial incentives to consultants, so long as they were disclosed. Nuffield said that in some instances, non-financial incentives could support the development of a market in terms of innovation and increasing competition. Hospital groups might provide non-financial incentives including free consulting services to new consultants to assist them in becoming established in the industry, thereby increasing competition. Hospital operators might also support consultants on the development of a new service by paying for a therapist or a practitioner.

53. Nuffield admitted that by having a financial stake in a hospital, even where there might be no exclusive referral arrangement in place, consultants were unlikely to divert volumes away from a hospital in which they had an equity stake. Nuffield would be against any equity participation by consultants in hospitals going forward.

54. Nuffield did not have any concerns about private medical insurers owning hospitals, so long as the private medical insurers did not have a critical mass. Nuffield believed that when BUPA owned its hospital group it did not get any major advantage from it in terms of commercial position in the marketplace.

Costs and profitability

55. Nuffield had a charitable trust status. Although as a charity it was subject to a different tax regime (whereby it did not pay some VAT or corporation tax) it did not consider that this provided it with a competitive advantage. Nuffield explained that the provision of healthcare services was exempt from VAT. However, Nuffield did not need to pay VAT on some of its inputs. Nuffield considered that a number of its competitors did not need to pay corporation tax either as they might operate tax-avoidance schemes.

Future outlook

56. [✂]

57. [✂]

58. [✂]

59. Nuffield considered that the single most significant impact on the competitiveness of the private health industry in the long term was the London market, as it accounted for approximately 50 per cent of the overall market in the UK. As a result, Nuffield said that the London market had a disproportionate impact in terms of prices. Nuffield would consider that addressing issues in this market would have the biggest impact on the industry overall.